COMMUNITY HEALTH NEEDS ASSESSMNET

2025

PREPARED FOR

Community Care Network

Rutland Mental Health Services | Rutland Community Programs

PREPARED BY

TRX Development Solutions, LLC

Table of Contents

Executive Summary

Community Care Network is a consortium of programs providing behavioral health, developmental disabilities, volunteer, and early childhood education services to the greater Rutland Region in Southern Vermont. The mission of CCN is to enhance the health and well-being of the community, individuals and families through responsive, innovative and collaborative services.

Communities in Southern Vermont and across the United States face increased behavioral health challenges and system complexities. These challenges have reinforced and exacerbated the health inequities in our communities that CCN has long been working to address. Community input is more important than ever to identify these problems and find solutions to them. As such, CCN is committed to conducting and updating a needs assessment at minimum every three years to ensure meaningful community engagement occurs on a recurring basis.

This needs assessment was completed between November 2025 and January 2026. It consists of population surveys; focus groups; and publicly available data collected by government agencies and service providers.

Priority Health Needs and Recommendations

The major needs identified in this assessment were related to behavioral health care access, workforce capacity, social drivers of health, and improved coordination of care. These findings were reflected in the results of the 49 surveys completed by community members and the six focus groups and key informant interview conducted with CCN Advisory Committee members, leadership, direct service staff, and early childhood community partners.

Findings from the environmental scan, survey and focus groups were explored to develop a series of high and medium priority recommendations to better address community needs.

High Priority

1. Expand timely access to behavioral health care
2. Strengthen workforce capacity and role support
3. Enhance crisis response and substance use treatment capacity
4. Address housing instability, transportation barriers, and other social drivers of health

Medium Priority

1. Strengthen care coordination, wraparound supports, and peer services
2. Improve service integration for individuals with developmental disabilities
3. Expand culturally responsive, trauma-informed, and linguistically accessible services
4. Deepen community collaboration to support continuity of care

Introductions and Methods

About Community Care Network

Community Care Network (CCN) is comprised of Rutland Mental Health Services (RMHS) and Rutland Community Programs. The mission of CCN is to enhance the health and well-being of the community, individuals and families through responsive, innovative and collaborative services. The programs of CCN serve more than 3,000 people each year throughout Rutland County. In 2024, RMHS was chosen by the Vermont Department of Mental Health to become one of the first Certified Community-Based Integrated Health Centers (CCBHC) in the State. This certification provides RMHS with access to new funding to better support an integrated care network encompassing mental health, substance use treatment and primary care services. This funding also supports the addition of new services such as rapid access to medication for opioid use disorder and peer support.

Purpose of the Assessment

The purpose of this assessment is to identify the needs of the community served by CCN. The assessment includes an overview of the population served and the needs and concerns of the community as they relate to behavioral health and other related services. To determine community needs, CCN and its consulting partner, TRX Development Solutions, LLC, completed a needs assessment with the community and priority population to determine the cultural, linguistic, and treatment needs of the community, and determine the accessibility and availability of the identified needed services. The needs assessment was completed between November 2025 and January 2026. It consists of population surveys; focus groups with CCN Advisory Committee members, leadership, direct service staff, and early childhood community partners; as well as publicly available data collected by government agencies and service providers.

Methods of Data Collection

Overview of Data Collection Approach

The data collection approach for the community needs assessment was multi-faceted, drawing from multiple primary sources to ensure a comprehensive report on the community served by CCN. The primary sources included internal CCN data and previous assessments; publicly available datasets from local, state, and national sources; qualitative input from six targeted focus groups; a key informant interview; and a quantitative population survey of CCN consumers and community members. This approach allowed for a holistic understanding of community needs, service gaps, and barriers to care, with data points spanning demographics, behavioral health trends, service utilization, and social drivers of health.

An environmental scan supplemented these data sources by systematically reviewing literature and datasets across a wide range of health and social indicators, using an extensive set of search terms related to behavioral health, substance use, and social inequities. Focus groups were conducted in person and via Zoom with informed consent protocols and were transcribed and analyzed for thematic content. The community survey, available in English and other languages upon request, was distributed electronically and in paper form at CCN locations, incorporating accessible design features. These combined qualitative and quantitative efforts were designed to provide a robust foundation for identifying both current needs and emerging trends in the communities CCN serves.

Data Sources

Environmental Scan

An environmental scan for a needs assessment consists of researching information from data sources to include local, regional, state, and national data. The environmental scan for this community needs assessment included a literature review using a generalized list of topics. Topics include demographic profiles; identified needs; service provision; barriers to adequate and effective service delivery; social drivers of health; behavioral health conditions and treatment; substance use statistics including substance use disorders, addiction, treatment, and recovery; and other health-related data. Articles, interactive data websites, and data download links were then selected for use or designated as unneeded based on a ranking criterion.

Research terms included combinations of the following: “data”, “Vermont”, “Rutland”, “Rutland County”, “community”, “health”, “mental health”, “behavioral health”, “substance use”, “substance”, “illicit substance”, “overdose”, “opioid”, “tobacco”, “smoking”, “drug”, “inequities”, “medical”, “disparities”, “disparate”, “needs”, “assessment”, “segregation”, “demographics”, “language”, “profile”, “racism”, “hospital”, “barriers”, “income”, “justice involvement”, “arrest”, “prison””, “discrimination”, “stigma”, “LGBTQIA+”, “disability”, “veterans”, “socioeconomic status”, “income”, “benefits”, “poverty”, “social determinants of health”, “social drivers of health”, “prevention”, “suicide”, “transportation”, “housing”, “food security”, and “food insecurity”

Primary Data Collection

As part of the data collection, TRX staff surveyed community members and completed six focus groups.

49 Surveys

Clients and community members

Mixed-methods approach, collecting multiple choice and

6 Focus Groups

Advisory Committee Members

CCN Leadership

Direct Service Staff

Early Childhood Community Partners

1 Key Informant Interview

Qualitative Data Collection

The TRX team conducted six focus groups with distinct groups of individuals to include CCN Advisory Committee members, leadership, direct service staff, and early childhood community partners. Each group received a tailored focus group guide based on their specific role in the CCBHC. Focus groups began on December 10, 2025, and concluded on January 8, 2026. All focus groups were conducted in person at CCN or virtually over Zoom. Each focus group began with verbally informed consent to record the focus group. Any individual who did not want to be recorded was given the opportunity to leave. All participants who appear in the recording consented to be recorded. Once all participants provided informed consent, the moderator started the recording and began the focus group. Once the focus group was completed, the audio recording was transcribed, and the interview team conducted a thematic analysis. Focus group guides can be found in Appendix A. A key informant interview was also conducted in January 2026 with an individual who was identified for focus group participation but unable to attend.

Quantitative Data Collection

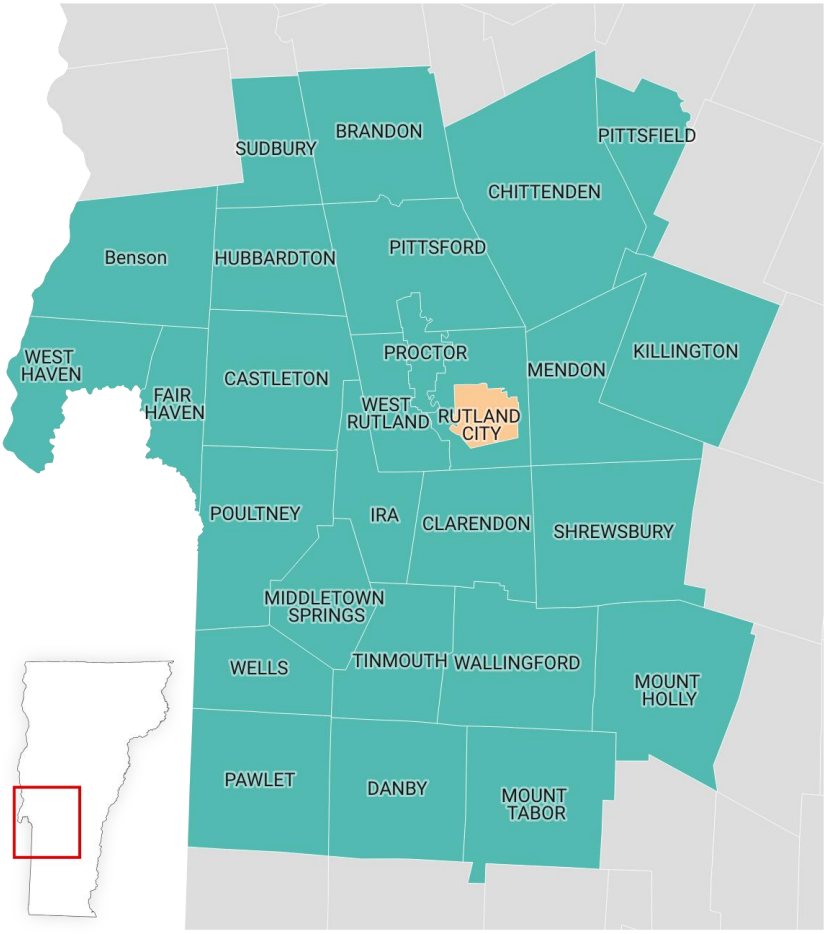
In 2025, while focus groups were being conducted, TRX fielded the survey to individuals served by CCN and surrounding community members. The evaluation team created a survey that included various demographic questions, the types of services currently received from CCN, service needs, barriers to care, trust in their behavioral health providers, and the respondents’ thoughts on substance use, addiction,

treatment, and recovery. The English language version of the Community Needs Assessment Survey can be found in Appendix B, and the English language version of the recruitment materials can be found in Appendix C. The survey began with a statement of accommodation to ensure there was equal access to the survey. The survey was available in English and Spanish and contained contact information to request further accommodations and assistance as needed. The English and Spanish versions of the survey were available electronically and on paper. The paper version of the survey was available at both CCN locations.

Community Characteristics

Community Care Network (CCN) provides comprehensive behavioral health services throughout Rutland County, Vermont. Situated in South Central Vermont, Rutland County spans 930.6 square miles and is the second largest county in the state[1]. The county is comprised of 27 towns and one city: Rutland City which is the seat of Rutland County. Rutland City is at the center of the county and is approximately 65 miles north of Massachusetts, 35 miles west of New Hampshire, and 20 miles east of New York. CCN's service area includes urban, suburban, and some rural communities, with more than 67% of the population living in rural or "low population density areas".[2] The population density in Rutland City, Vermont, is approximately 2,100 people per square mile.

Figure 1. CCN Rutland County Service Area



The eligible CCBHC population is any individual who requests mental health or substance use treatment. CCBHC services are available to any person in need, including but not limited to those with serious mental illness, serious emotional disturbances, long-term chronic addiction, mild or moderate mental illness, and substance use disorders. CCN provides services to all individuals regardless of residency or ability to pay. The sections that follow — Demographics, Health Conditions and Disparities, and Social Drivers of Health — provide a comprehensive description of the eligible CCBHC population.

Demographics

According to American Community Survey data from the U.S. Census Bureau[3], Vermont has an estimated population of 642,254 people. The CCBHC service area of Rutland County has an estimated population of 60,484. Table 1 below provides a demographic overview of Rutland County, Vermont and the United States. Nearly a quarter of the population of Rutland County (24%) are 65 years or older, a much larger percentage than the State (20.8%) or the Nation (16.8%). Similarly, Rutland County has a smaller percentage of children, transition age youth, and young adults than the State. These figures are in the context of a downward trend in population growth across the state.[4] Rutland County is predominantly White (94%) and evenly split between men and women (50%). According to the Vermont Behavioral Risk Factor Surveillance System 2023 Report, approximately 1% of Vermont residents identify as Transgender. Most survey respondents identified as heterosexual (89%), followed by bisexual (5%), lesbian/gay (3%), or another sexual orientation (3%).[5] County-level data is not currently available for gender identity or sexual orientation.

Table 1. Demographic Overview, U.S. Census Bureau 2023

	Rutland County	Vermont	United States
Total Population	60,484	645,254	332,387,540
Senior: 65+	14,500 (24.0%)	134,141 (20.8%)	16.8%
Middle-Aged Adult: 40–64	20, 576 (34.1%)	211,897 (32.8%)	31.5%
Younger Adult: 25–39	9,988 (16.5%)	116,958 (18.1%)	20.4%
Transition Age Youth: 18–24	4,811 (8.0%)	65,081 (10.1%)	9.1%
Children: 0 - 17	10,609 (17.5%)	117, 177 (18.2%)	22.0%
Asian	333 (0.6%)	10,700 (1.7%)	5.8%
Black or African American	412 (0.7%)	7,887 (1.2%)	12.4%
Hispanic	1,279 (2.1%)	16,058 (2.5%)	19.0%
Indigenous	88 (0.1%)	1,273 (0.2%)	0.9%
White	56,765 (93.9%)	589,835 (91.4%)	63.4%
Male	30,251 (50%)	320,321 (49.6%)	49.5%
Female	30,233 (50%)	324,933 (50.4%)	50.5%
Married/Partnered with Children under Age 18	2,881 (11.3%)	40,181 (14.9%)	18.2%
Single with Children under Age 18	982 (3.9%)	12,765 (4.7%)	6.1%

Culture & Language

Approximately 4.2% of the Rutland County population speak a language other than English at home with 1.7% speaking Spanish, and 1.9% speaking other Indo-European Languages. Across Vermont, about 5.5% of the population age 5 years and older speak a language other than English at home [6] with French (1.4%) and Spanish (1.0%) being the most common languages spoken.[7] According to the American Immigration Council, from 2018-2024, approximately 1,260 refugees resettled in Vermont. The top nationalities reported were Democratic Republic of Congo (47%),

Afghanistan (12.5%) and Syria (7.1%).[8] City-level data was not provided to protect the privacy of refugees. As of 2023, 1,200 Rutland residents (2%) were born outside of the United States.[3]

Table 2. Language Spoken Among Population Age 5 Years and Older

	Rutland County	Vermont	United States
Speak only English	55,578 (95.8%)	583,277 (94.5%)	244,601,776 (78%)
Language other than English spoken at home	2,438 (4.2%)	33,924 (5.5%)	68,845,865 (22%)
Spanish	962 (1.7%)	7,829 (1.3%)	42,064,953 (13.4%)
Other Indo-European languages	1,127 (1.9%)	18,763 (3.0%)	11,892,212 (3.8%)

Key Findings – Demographics

1. Aging Population - Nearly 24% of Rutland County residents are age 65 or older, exceeding state and national averages, while the county has a smaller share of children, transition-age youth, and young adults—highlighting growing needs for services tailored to older adults amid population decline.
2. Language Access - Although most residents speak English at home, a small but meaningful population speaks other languages or were born outside the United States, underscoring the importance of culturally responsive, trauma-informed, and linguistically accessible behavioral health services.
3. Limited Demographic Diversity - Rutland County is predominantly White and less racially and ethnically diverse than Vermont and the U.S.; county-level data on gender identity and sexual orientation are not available, limiting the ability to assess needs for LGBTQ+ populations locally.

Health Conditions and Disparities

The following section summarizes key indicators of behavioral health need, quality of life, and related disparities among residents of Rutland County, drawing on the most recent state- and county-level data available. Findings highlight elevated prevalence of mental health challenges, substance use, overdose, and suicide, with pronounced disparities by age, gender, sexual orientation, and other social drivers of health. Together, this data underscores significant unmet need and reinforces the importance of accessible, coordinated, and equitable behavioral health services across the continuum of care.

Mental Health

1 in 6
Vermont Adults report poor mental health

Youth, young adults, females, and LGBTQ+ individuals were more likely to report poor mental health

Data from the 2023 Vermont Behavioral Risk Factor Surveillance System Report reveals that approximately one in six Vermont adults report poor mental health (16%).[5] Though limited data is available, similar findings were observed at the county-level with 15.7% of adults aged 18 and older report experiencing 14 or more days of poor mental health each month. [9] Individuals aged 18-24 were most likely to report poor mental health (29%), compared to 20% of adults age 25-44, 15% of adults age 45-64, and 8% of adults age 65+. The BRFSS report also found that females were statistically more likely to report poor mental health (18%) compared to males (14%). The 2023 Vermont Youth Risk Behavior Survey finds that high school students are disproportionately impacted by poor mental health. More than a third of high school students (34%) said their mental health was not good most of the time or always. Female students and LGBTQ+ students are more than two times as likely as their male and heterosexual cisgender students to report poor mental health.[10] These findings demonstrate substantial mental health need across the lifespan, with particularly high prevalence among youth, young adults, females, and LGBTQ+ individuals, indicating a need for early intervention, youth-focused services, and culturally responsive care within Rutland County's behavioral health system.

Quality of Life

A recent landscape analysis from Social Tinkering entitled Social Connection, Isolation, and Loneliness in Rutland County is a comprehensive report that identifies the indicators and risk factors associated with social isolation, loneliness, disconnection in the region. Nearly 1/3 of Rutland residents (32%) report feeling socially isolated, which is exacerbated by the mental health findings detailed above. Rutland's rural, aging population faces unique risks such as geographic distribution, limited transportation, and lower broadband access which make connection harder for many residents. Further, certain groups such as older adults, youth, LGBTQ+ individuals, people with disabilities, those living alone, financially insecure residents, and BIPOC populations face higher rates of disconnection. [12]

Nearly 1/3 of Rutland residents (32%) report feeling socially isolated

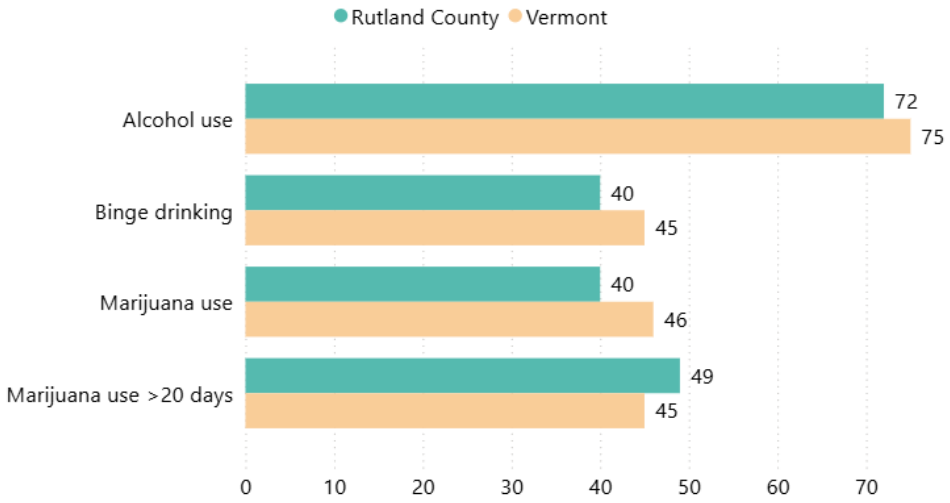
The report details how social isolation and loneliness are strongly associated with poorer mental health outcomes, increased substance use, and elevated suicide risk. For individuals already experiencing behavioral health challenges, limited social connection can further reduce engagement in treatment and increase reliance on crisis and emergency services. The populations experiencing higher rates of social isolation (older adults, youth, LGBTQ+ individuals, people with disabilities, those living alone, financially insecure residents, and BIPOC populations) overlap significantly with CCBHC priority populations. These groups may benefit from targeted outreach, peer support, community-based engagement, and flexible service delivery models. Ultimately, addressing quality of life factors such as social connection, mobility, and community inclusion is critical to improving behavioral health outcomes and reducing crisis utilization in Rutland County.

Prevalence of Alcohol and Substance Use Disorder Service Needs

Despite being the second least populated state in the nation, Vermont ranks consistently high for alcohol and substance use disorders. A report published by the Vermont Department of Health ranked Vermont number 3 in the country for prevalence of alcohol use in the past month at 57%. Further, Vermont had the greatest prevalence of cannabis use in the

country (24%). Vermont also ranked in the top five for a substance use disorder in the past year (22%).[11] At the county level, the Vermont Department of Health Rutland County Community Profile finds that Rutland County ranks consistently with the state for high level youth binge-drinking and marijuana use. Nearly half of students in Rutland County (49%) reported frequent marijuana use (10+ times) in the past 30 days. The figure below displays the prevalence of substance use in young adults aged 18-25 in Rutland County and Vermont.[12]

Figure 2. Percent Prevalence of Substance Use in Young Adults Aged 18-25, 2020



In correspondence with high rates of substance use, the rate of MOUD treatment utilization in Rutland County is the highest in the state at 190.0 per 10,000 people aged 18-64. The overall statewide average for MOUD treatment rate is 132.0 per 10,000 people aged 18-64.[13] High rates of alcohol and substance use, coupled with elevated utilization of MOUD services, indicate both significant treatment need and ongoing demand for sustained, low-barrier substance use disorder services in Rutland County.

Overdose Rates

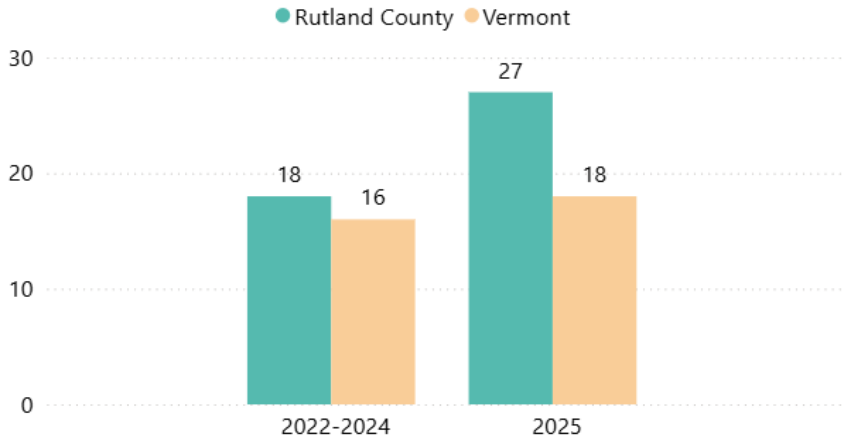
Further highlighting substance use prevalence and significant treatment needs is the high overdose rates exhibited in the county. In 2023, the rate of opioid nonfatal overdose per 10,000 ED visits in Rutland County (23.8) was higher than the state (21.4). At 17.4, the rate of EMS calls involving naloxone administrations per 10,000 residents was also higher in Rutland County than the state (11.2). Statewide, the rate of opioid-related deaths is 12.5, compared to 13.3 in Rutland County.[14] Elevated overdose indicators relative to statewide rates point to continued risk of morbidity and mortality and reinforce the need for timely access to treatment, harm reduction, and crisis response services.

Suicide

Suicide is a critical public health issue in Vermont and across the United Sates. The Vermont Department of Health develops an Annual Suicide Data Report to better understand and address the factors contributing to suicide in the state. Based on the latest data available, residents of Rutland County are experiencing a higher rate of suicide-related ED visits compared to Vermont as a whole. In 2025, the statewide rate of suicide-related emergency department visits per 10,000 is 248.5, compared to a rate of 300.5 for Rutland County – the second highest rate in the state. Statewide, the suicide rate per 100,000 residents increased from 16.0 in 2022-2024 to 17.6 in 2025. Alarming findings were observed in Rutland County where the suicide rate increased from 17.6 in 2022-2024 to 26.5 in 2025. In 2025, the suicide rate was

much higher for males (39.8) compared to females (13.2). Further, individuals aged 45-64 were the largest age group represented with a rate of 47.6.[15]

Figure 3. Rates of Suicide per 100,000 Residents, 2025



Data from the 2023 Vermont Youth Risk Behavior Survey finds that one in seven high school students (14%) reported making a plan about how they would kill themselves. Female students, younger students, LGBTQ+ students, BIPOC students, and students with an Individualized Education Program were statistically more likely to report making a suicide plan. New initiatives such as Facing Suicide VT and youth-focused resources aimed at suicide prevention are being implemented by the Vermont Department of Health and the Department of Mental Health to address this growing concern.[16] Rising suicide rates and high levels of suicide-related emergency department utilization highlight an urgent need for comprehensive suicide prevention efforts, including outpatient treatment access, crisis stabilization, and targeted interventions for high-risk populations.

Key Findings - Health Conditions and Disparities

1. High and inequitable behavioral health need - Mental health challenges and suicide risk are elevated in Rutland County, with disproportionate impact among youth, young adults, LGBTQ+ individuals, and other priority populations.
2. Elevated substance use and crisis indicators - Rutland County has the highest MOUD utilization rate in Vermont and higher-than-average overdose, naloxone administration, and opioid-related mortality rates, indicating sustained demand for substance use treatment and crisis services.
3. Growing emergency service utilization - Suicide-related emergency department visits and suicide rates are increasing more rapidly in Rutland County than statewide, particularly among middle-aged adults and males, underscoring the need for coordinated, community-based care.

Social Drivers of Health

Social Drivers of Health (formerly Social Determinants of Health) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks.[17] The following section explores social drivers such as income and poverty, education and employment, access to transportation, and health insurance coverage in Rutland County and across Vermont.

Income and Poverty Rate

According to American Community Survey data from 2023, the median household income in Rutland County is $64,778 which is approximately 17% less than the state ($78,024) and the nation ($78,538)[18]. The rate of children under age 5 in

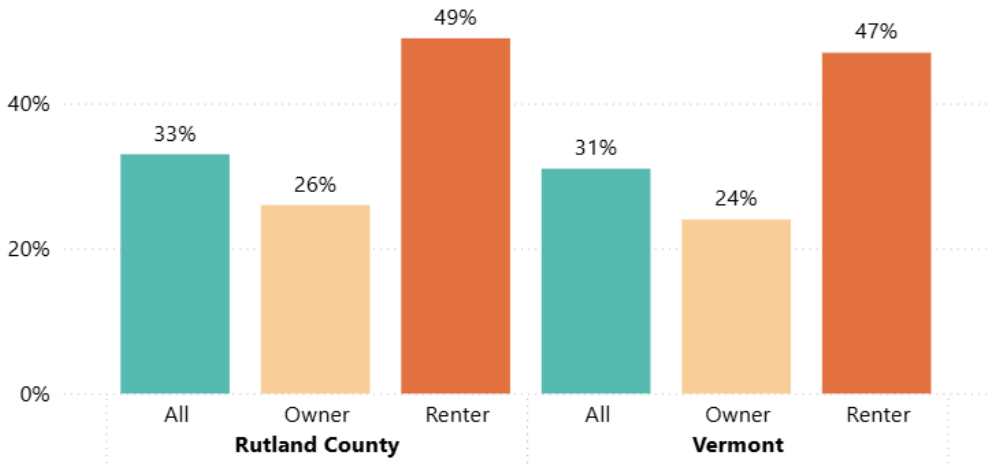
poverty in Rutland County (11.4%) is on par with the state (11.5%), both of which are less than the nationwide average of 17.6%.[19] Income affects many aspects of health including access to healthcare, quality of housing, access to nutritionally adequate food, and overall mental health and stress levels.

Table 3. Income and Poverty

	Rutland County	Vermont	United States
Median household income (2023 dollars)	$64,778	$78,024	$78,538
Income below poverty level	7,068 (12.0%)	63,902 (10.3%)	40,390,045 (12.4%)
Children under age 5 in poverty	280 (11.4%)	3,147 (11.5%)	3,268,155 (17.6%)

Housing cost burden is one way to assess housing affordability in Rutland County. A cost burdened household is defined as a household that spends more than 30% of its income on housing costs. Housing cost burden creates increased financial pressure and impacts the amount of money households have to spend on food, healthcare, transportation, and other necessities. Overall, about one third of households in Rutland County are considered cost-burdened, which is slightly higher than the rate across Vermont. Renters also tend to experience higher rates of cost burden than homeowners. Almost half of rental households in Rutland County are cost-burdened compared to about a quarter of owner households. [20] A full Cost Burdened Household table can be found in Appendix D.

Figure 4. Cost Burdened Household Rate, ACS 2023



Education & Employment

Education and employment are also closely linked to health outcomes. Educational attainment levels in Vermont are generally higher than the national average. About 47% of Vermonters aged 25 or older have a high school diploma or equivalent, and about 45% have a higher degree. In Rutland County, just over half (53%) have a high school diploma or equivalent and 38% have a higher degree.[21]

Table 4. Highest Level of Education Among People Aged 25 Years and Older

	Rutland County	Vermont	United States
Higher Degree	16,400 (37.9%)	196,000 (44.7%)	82,200,000 (38.5%)
H.S. Diploma or equivalent	22,900 (53.0%)	206,000 (47.1%)	104,000,000 (48.5%)
No H.S. Diploma	3,941 (9.1%)	35,400 (8.1%)	27,800,000 (13.0%)

Almost 60% of adults aged 25 to 64 in Rutland County are employed, similar to 63% across Vermont and 58% nationally. The percentage of unemployed adults in Rutland County (3.5%) and in Vermont (3.3%) is lower than the rate across the United States (4.7%).[21] A full employment status table can be found in Appendix D.

Figure 5. Employment Status in Rutland County, Population Aged 25 to 64 Years Old

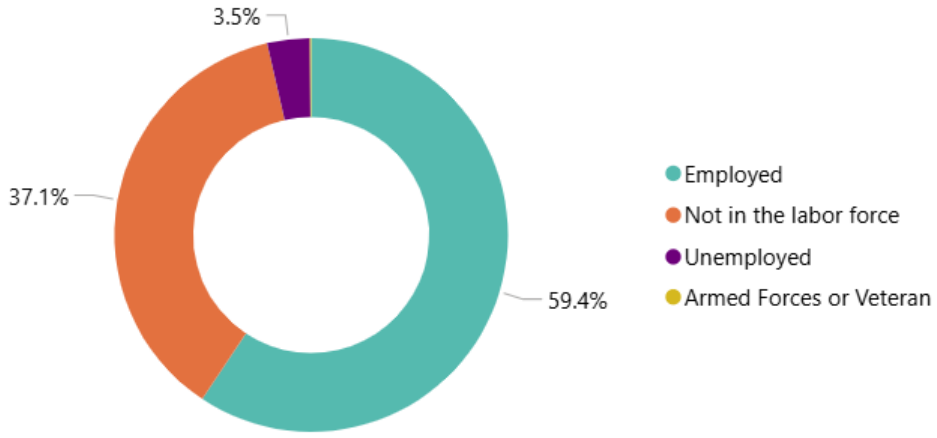


Table 6 below shows School Enrollment Status Among Children/Youth Aged 18 Years and Younger.[21] The breakdown of school enrollment is similar at the county and state level. Rutland County has almost 3,000 high school aged students.

Table 6. School Enrollment Status Among Children/Youth Aged 18 Years and Younger

	Rutland County	Vermont	United States
High School	2,983 (5.1%)	31,500 (5.17%)	17,000,000 (5.53%)
Grades 5-8	2,531 (4.33%)	27,300 (4.49%)	16,500,000 (5.37%)
Grades 1-4	2,310 (3.95%)	26,600 (4.37%)	16,300,000 (5.32%)
Kindergarten	544 (0.93%)	6,591 (1.08%)	4,180,000 (1.36%)
Preschool	826 (1.41%)	8,741 (1.44%)	4,960,000 (1.62%)

Transportation

Transportation can have significant impacts on health and access to care, especially in rural areas. According to the 2024 Vermont State Health Assessment, 6% of adults experienced transportation insecurity in the past year.[22] Transportation insecurity refers to a lack of reliable transportation that kept someone from medical appointments, meetings, work or from getting things needed for daily living. ACS data in the table below shows that in Rutland County and across Vermont, individuals rely overwhelmingly on cars to get to work. Only about 1% of individuals reported taking public transportation to work.

Table 7. Means of transportation to work, workers over age 16 by State and County, American Community Survey 2023[23]

	Rutland County	Vermont	United States
Car, truck, or van	24,249 (87%)	257,339 (77%)	123,514,326 (79%)
Public transportation*	197 (1%)	4,389 (1%)	5,425,912 (3%)
Walked	469 (2%)	13,137 (4%)	3,190,476 (2%)
Other means**	235 (1%)	4,367 (1%)	2,956,330 (2%)
Worked from home	2,618 (9%)	53,964 (16%)	21,029,425 (13%)

*excluding taxicab ** including taxicab, ride-hailing services, motorcycle, and other means

Access to Support Programs and Benefits

Food insecurity, or limited or uncertain access to adequate food, is another critical social driver of health. Overall, 14% of individuals in Rutland County are considered food insecure. About 17% of children ages 0-17 in Rutland County are food insecure, which is slightly higher than the percentage across Vermont.[24] In federal fiscal year 2024, one in ten Vermont residents (66,500 residents) participated in the Supplemental Nutrition Assistance Program (SNAP). More than 51% of SNAP participants in Vermont are in families with children and more than 53% of recipients are in families with older adults or family members who are disabled.[25]

Table 8. Food Insecurity

	Rutland County	Vermont	United States
Overall	8,440 (14%)	79,010 (12%)	47,389,000 (14%)
Food insecure adults (18+)	6,670 (13%)	63,050 (12%)	33,560,000 (13%)
Food insecure children (0-17)	1,770 (17%)	15,960 (14%)	13,829,000 (19%)

Health Coverage

Data from the 2025 Vermont Household Health Insurance Survey reveals that 97% of Vermont residents reported having a primary source of health insurance while the remaining 3% were uninsured. More than half (52%) of residents have private insurance, 23% have Medicare, and 19% have Medicaid.[26] County-level data for all health insurance types is limited but an estimated 1,800 adults are uninsured in Rutland County, equivalent to the statewide rate of 3%. The number of uninsured Vermont residents has decreased over time from 7% in 2012 to 3% in 2025; a percentage that has

remained stable since 2018. Vermont residents aged 25 to 34 represented the largest group of uninsured residents at 8%.

Table 9. Health Coverage

	Vermont
Medicare	147,900 (23%)
Medicaid	121,100 (19%)
Military	15,800 (2%)
Private Insurance	336,900 (52%)
Uninsured	19,400 (3%)

Additional Indicators

Experience with intimate partner violence can significantly impact physical and behavioral health outcomes and is influenced by and contributes to broader social, economic, and environmental factors. In September 2024, the National Network to End Domestic Violence (NNEDV) conducted a count of domestic violence services with the 13 domestic violence programs in the state of Vermont. During the 24-hour survey period, participating programs served 313 victims through emergency shelters, transitional housing, and other supportive services like transportation or counseling. Victims made 24 requests for services that programs could not provide because of funding, availability of resources, or staffing constraints. Approximately 58% of these unmet requests were for emergency shelter, hotels, motels, transitional housing, and other housing.[27] Both the unmet needs and types of services provided underscore Vermont's need for specific domestic violence services.

Key Findings – Social Drivers

1. Lack of affordability especially around housing - Nearly one-third of households in Rutland County are cost-burdened, with renters disproportionately impacted, limiting financial flexibility for healthcare, food, and other basic needs.
2. Strong education and employment indicators mask participation gaps - While unemployment is relatively low and high school completion is high, lower rates of higher educational attainment and a large share of adults not in the labor force suggest barriers to economic mobility and workforce engagement.
3. Sustained reliance on public benefits reflects ongoing social need – Persistent food insecurity, continued SNAP participation, and a small but stable uninsured population indicate the importance of accessible benefits, transportation, and care coordination to support health and behavioral health outcomes.

Underserved Populations

Unhoused

According to the state's Point-in-Time (PIT) Count, on a single night in January 2024, 3,458 Vermonters were identified as experiencing homelessness, including 737 children and 199 seniors over the age of 64, This number marks a more than 200% increase in homelessness since 2020 underscoring a rapidly escalating crisis across the state.[28] In Rutland County, the 2024 Community Health Needs Assessment revealed that the County accounts for 21% of the state's homeless individuals in emergency housing, despite comprising less than 10% of the state population. Further, Rutland County's homeless population increased over 600% in a five-year period, rising from 96 individuals in 2019 to 682 in 2024, reflecting a disproportionate local impact.[29]

Unhoused individuals in Vermont face extreme weather conditions, limited housing availability, and significant barriers to accessing consistent health and behavioral health services. The State of Vermont's Extreme Cold Weather Shelter Program outlines the conditions required for warming shelters to open as "The National Weather Service is forecasting severe weather of a duration of cold weather at or below -10° F including the wind chill." [30] Even when emergency shelter options are available, many individuals experience gaps in care related to transportation challenges, co-occurring mental health and substance use disorders, and limited access to ongoing outpatient services. These factors heighten the risk of medical and psychiatric crises and contribute to increased emergency department utilization among unhoused populations.

Table 10. Vermont - HUD 2024 Programs - Homeless Populations

	Sheltered	Unsheltered
Children under age 18	737	0
Age 18-24	233	10
Age 25-54	1,695	139
Age 55-64	434	11
Adults 64+	192	7
Total experiencing homelessness	**3,291**	**167**

In January 2026, Vermont lawmakers introduced legislation to overhaul the state's response to homelessness by significantly reducing reliance on motel-based emergency housing while increasing investments in shelters, transitional housing, and supportive services.[31] While intended to promote long-term housing stability, this transition is expected to increase demand for accessible, coordinated health and behavioral health services, particularly in high-need regions such as Rutland County, which bears a disproportionate share of the state's unhoused population. Unhoused individuals frequently experience co-occurring mental health and substance use disorders, transportation barriers, and gaps in continuity of care, increasing the risk of medical and psychiatric crises and emergency department utilization. As housing models evolve, CCBHCs will play a critical role in mitigating service disruptions through expanded outreach, crisis response, and care coordination, ensuring continuity of integrated behavioral health services regardless of housing status.

Black, Indigenous, and Persons of Color – Abenaki Tribe

Although Vermont has one of the smallest proportions of residents identifying as Black, Indigenous, or People of Color, these communities experience disproportionate behavioral health and social inequities. According to the 2023 Vermont BRFSS, adults identifying as non-White were more likely to report poorer self-rated health and frequent mental distress compared to White adults, reflecting persistent disparities despite Vermont's overall strong population health indicators.

The Abenaki people, Vermont's Indigenous population, continue to experience intergenerational trauma related to historical displacement, discrimination, and loss of cultural continuity. These factors contribute to elevated risks for depression, anxiety, substance use disorders, and barriers to seeking care, including mistrust of systems and lack of culturally responsive services.[32] Access challenges are compounded for Abenaki individuals living in rural areas where provider shortages and transportation barriers further limit engagement in behavioral health treatment.

CCBHCs play a critical role in addressing these inequities by incorporating trauma-informed, culturally responsive practices, partnering with tribal and community organizations, and reducing structural barriers to care. CCN has previously engaged Abenaki tribal elders to provide cultural competency training to staff. Continued collaboration with Abenaki leadership and sustained investment in culturally grounded, community-driven behavioral health services are essential to improving access, rebuilding trust, and advancing health equity for Abenaki and other BIPOC communities served by the CCBHC.

LGBTQIA+ Population

According to the 2023 Vermont BRFSS, approximately 1% of Vermont adults identify as transgender, and 11% identify as lesbian, gay, bisexual, or another sexual orientation. While county-level estimates are not available, these figures translate to thousands of Vermonters statewide who may face heightened behavioral health risks.

12% of Vermont adults identify as LGBTQ+

BRFSS data indicate that LGBTQ+ adults are more than twice as likely to report frequent poor mental health compared to heterosexual, cisgender adults. National and state-level data further demonstrate elevated rates of depression, anxiety, suicidal ideation, and substance use disorders among LGBTQIA+ populations, driven by stigma, discrimination, social isolation, and experiences of rejection or violence. For transgender and gender-diverse individuals, barriers such as lack of affirming providers, insurance limitations, and fear of discrimination further delay or prevent access to care. CCBHCs provide an essential access point for LGBTQIA+ individuals by offering inclusive, affirming, and trauma-informed behavioral health services and crisis supports.

Service Members, Veterans, and Families

There are approximately 3,685 total veterans in Rutland County, accounting for roughly 7.4% of the total population.

Vermont is home to a significant veteran population, many of whom reside in rural areas. Veterans experience higher rates of post-traumatic stress disorder (PTSD), depression, substance use disorders, and suicide compared to the general population. While many veterans access care through the Veterans Health Administration, barriers such as geographic distance, transportation challenges, eligibility limitations, and stigma result in unmet behavioral health needs, particularly for National Guard members, reservists, and family members who may not qualify for VA services. There are approximately 3,685 total veterans in Rutland County, accounting for roughly 7.4% of the total population. This figure is higher than both the statewide (6.5%) and national percent (6.4%).[33]

BRFSS data indicate that adults with a history of military service report higher rates of poor mental health and chronic conditions than non-veterans. Families of service members also experience secondary stressors related to deployment, reintegration, and caregiving responsibilities. CCBHCs help bridge gaps by providing community-based behavioral health services, coordinating with VA and military systems, and ensuring timely access to crisis intervention and ongoing treatment for veterans and their families.

Foster Care

Children and adolescents involved with Vermont's foster care system represent one of the state's most vulnerable populations. Youth who experience out-of-home placement are significantly more likely to have serious emotional disturbances, trauma-related disorders, and co-occurring behavioral health needs. Many have experienced abuse, neglect, parental substance use, or household instability prior to placement. [34]

Justice-Involved Individuals

The Vermont Department of Corrections Incarcerated Population Interactive Dashboard shows an increase in the average monthly number of incarcerated individuals from 1,403 individuals in 2024 to 1,550 individuals in 2025.[35] Adults and youth involved with the criminal and juvenile justice systems experience disproportionately high rates of mental illness, substance use disorders, and co-occurring conditions.[36] Individuals incarcerated in Vermont Department of Corrections (DOC) facilities frequently have unmet physical and behavioral health needs that contribute to recidivism, emergency department utilization, and poor health outcomes.[37] CCBHCs can play a critical role in supporting diversion, reentry, and continuity of care by coordinating with DOC, courts, and community partners to ensure timely access to treatment and crisis services.

The University of Vermont (UVM), Vermont Department of Corrections, and the Urban Institute collaborated to complete the first phase of the Prison Research and Innovation Network (PRIN) in Vermont.[38] Vermont is one of five states participating in the five-year effort to gather research and develop findings with the ultimate goal making prisons more humane, safe, and rehabilitative. Initial findings from surveys of 186 incarcerated individuals reveal significant gaps in mental health care and overall health and well-being. Nearly 70% of respondents indicated they disagree or strongly disagree with the statement, *"I get the mental health care/treatment I need in this prison when I need it."*

When asked, *"Since entering prison, have you developed the following health conditions?*", 70% of respondents reported developing anxiety, 65% reported developing depression, and 55% reported developing post-traumatic stress disorder. Regarding health and well-being, nearly 90% of respondents indicated that being in prison has been very bad for their mental health. Further, more than one-third of respondents (36%) reported having seriously considered suicide in the past 12 months. These findings underscore the critical need for improved access to comprehensive, coordinated behavioral health services for justice-involved individuals across incarceration, reentry, and community settings.

Population with Disabilities

According to the 2023 Vermont BRFSS, approximately 30% of adults in Rutland County report at least one disability, slightly higher than the statewide average (28%) and comparable to the national rate (30%). Disabilities include serious difficulty with mobility, cognition, hearing, vision, self-care, or independent living. A breakdown by disability was not available at the county level but a statewide breakdown is provided in the table below.

Table 11. Disability Status

	Vermont
Serious difficulty hearing or deaf	8%
Blind or serious difficulty seeing, even when wearing glasses	3%
Serious difficulty concentrating, remembering, or making decisions	13%
Serious difficulty walking or climbing stairs	11%
Difficulty dressing or bathing	3%
Difficulty doing errands alone such as visiting a doctor's office	8%

Adults with disabilities experience significantly worse physical and behavioral health outcomes than those without disabilities. BRFSS data show that adults with a disability are more than twice as likely to have chronic conditions such as asthma or arthritis and are more likely to experience cardiovascular disease, chronic kidney disease, COPD, and long-

term COVID-19 symptoms. Further, adults with disabilities were nearly four times as likely to report frequent poor mental health compared to adults without disabilities.

Barriers such as transportation limitations, inaccessible facilities, communication challenges, and fragmented care further exacerbate disparities for this population. CCBHCs are essential in reducing these barriers by offering integrated care, care coordination, and accommodations that promote equitable access to behavioral health services.

Key Findings – Underserved Populations

1. High prevalence of need - BRFSS and state data show elevated rates of frequent poor mental health, substance use disorders, chronic disease, and trauma among unhoused individuals, adults with disabilities, LGBTQIA+ residents, justice-involved individuals, foster youth, veterans, and BIPOC populations.
2. Disproportionate local impact and access barriers - Rutland County bears a disproportionate share of Vermont's homelessness (21% of emergency housing placements despite <10% of the population) and faces compounding barriers including housing instability, transportation limitations, rural access challenges, and system involvement that disrupt continuity of behavioral health care.
3. Critical role of CCBHCs - Same-day access, integrated behavioral health treatment, crisis services, outreach, and cross-system care coordination are essential to reducing emergency department utilization, preventing service gaps during housing and justice transitions, and advancing equitable access for high-need populations.

Behavioral Health Service Landscape

CCN operates across Rutland County offering a wide range of behavioral health services such as adult and child mental health, substance use treatment and recovery, and developmental services. Individuals accessing CCN services also have access to other health systems in the area facilitating comprehensive care. In addition to services provided by CCN, the population in the service area is also served by a range of medication-assisted treatment (MAT) providers, physical health providers, and safety-net federally qualified health centers (FQHCs). Additional behavioral health providers across Rutland County include Rutland Regional Behavioral Health and Community Health North Main. The table below provides a non-exhaustive overview of selected human service organizations in Rutland County.

Table 12. Selected Human Service Providers Serving Rutland County by Type

Organization Name	Provider Type
Community Health	FQHC
Rutland Free Clinic	Physical Health
Rutland Regional Medical Center (RRMC)	Physical Health
Turing Point Center Rutland	Peer-based Recovery Support
West Ridge Center (RRMC)	MAT

Existing Crisis Services

In January 2024, CCN launched an enhanced Mobile Crisis Program in response to the growing need for compassionate, community-based crisis intervention. This state-mandated initiative provides rapid, individualized support directly where people are, with the goal of reducing law enforcement involvement and preventing unnecessary visits to hospital Emergency Departments. The enhanced program deploys two-person teams into the field to de-escalate crises, meet individuals where they are, and connect them with appropriate resources. A key enhancement is

the expanded role of Peer Support Specialists—individuals with lived experience of mental health and substance use challenges—who help clients feel understood and supported through shared experience and genuine empathy.

In addition to mobile crisis response, CCN offers 24/7 crisis and emergency support through its crisis line, available by call or text to individuals of all ages. Emergency care access includes mobile crisis services, outpatient psychiatric urgent care, and direct support services such as crisis assessment, supportive counseling, mental health education, and connections to community resources. When needed, CCN also provides referrals to mental health and other service providers. Beyond CCN's services, the crisis response continuum in Rutland County includes the Vermont State Police and the Rutland City Police Department, both of which have embedded Crisis Clinicians who are able to provide mobile crisis response.

Workforce Shortages

Workforce shortages continue to be one of the most critical barriers to an effective behavioral health system in Vermont. The Health Resources & Services Administration (HRSA) has designated all of Rutland County as Health Professional Shortage Areas (HPSAs) for dental health, mental health, and primary care. An HPSA score is designated to determine priorities for assignment of clinicians. The scores range from 0 to 26 where the higher the score, the greater the priority. Rutland County has an HPSA Score of 20, indicating great need in the area.[39] According to a brief from the Vermont Department of Health in 2024, Rutland Mental Health Services (RMHS) has the lowest ratio of providers with 47.6 FTEs per 100,000 population.[40] Further, the overall ratio of population to mental health providers in Rutland County (240:1) is higher than the State (170:1).[41] These shortages are particularly acute in rural and underserved communities, where residents may rely on telehealth services to access providers based in urban areas. However, telehealth is not always an adequate substitute for hands-on, community-based care, especially for youth with complex needs.

In 2022, the Vermont General Assembly passed Section 32 of Act 183 to address shortages in the healthcare workforce. Section 32 of Act 183 appropriated funds to establish and maintain an integrated Health Workforce Data Center (HWDC). The data center is still in early stages of implementation, but its establishment highlights the need for data and reporting to address growing workforce shortages.

To further address workforce shortages and retain young professionals, in 2023 Vermont introduced a loan repayment program designed to help recent graduates reduce student debt and encourage them to remain in Vermont for work. By reducing student debt, the program aims to ensure a stable supply of healthcare practitioners to meet the growing shortages of healthcare workers in Vermont. A news article from 2023 highlights how one Vermont graduate took advantage of the program and became a Care Transition Coordinator with CCN.[42]

Access to Telehealth and After-Hours Services

Telehealth and after-hours services are strategies that increase accessibility for people who are homebound, have transportation barriers, or have other commitments during standard business hours. To promote access to care, CCN offers telehealth for clients to connect with a provider without needing to come to an in-person appointment. Despite availability of telehealth services, accessibility remains an ongoing concern for the service area, as U.S. Census statistics showing that broadband connectivity is lower in Rutland County at 84.2% than the rest of Vermont, which is at 87.9%.[43] In 2025, the Vermont Program for Quality in Health Care published a report to study telehealth trends and developments in Vermont before and during the COVID-19 Public Health Emergency (PHE). The report found that mental health services accounted for more than 80% of all telehealth services utilized during the PHE.[44] While the report focuses on telehealth utilization before and during the PHE, additional research will be necessary to understand the

long-term impacts of the PHE on telehealth services. Regarding after-hours services, CCN's office is currently open until 7:00 p.m., and select programs, such as Intensive Outpatient Services offer appointments during evening hours. CCN monitors utilization of after-hours services to assess ongoing demand. Preliminary survey data below indicates that weekday afternoons (12:00 p.m.–5:00 p.m.) are the most preferred time for services among respondents, followed by weekend evenings (5:00 p.m.–8:00 p.m.), suggesting continued need for flexible scheduling options.

Stakeholder and Community Input

To ensure diverse and comprehensive input, a wide variety of stakeholders were surveyed or interviewed as part of the community needs assessment process. Primary data collection included qualitative data from focus groups, quantitative data from the community needs survey which was distributed to clients and other community stakeholders. A full list of stakeholders that were included in the needs assessment is detailed in the table below.

Table 13. Community Partners and Stakeholders Engaged

Community Partner or Stakeholder Type	
Community members who reside in the service area	Current, past, or potential clients or their families
Hub and Spoke Providers	Advisory Committee Members: Adult, Child, Developmental Services
Local Service Providers	Preferred Providers
Community leaders from local schools	Community leaders from religious organizations
Emergency departments	Civic or Volunteer Groups
Social Services Organizations	Department for Children and Families
Healthcare Professionals	Individuals representing a state, local, and/or tribal govt agency

Qualitative Data from Focus Groups and Key Informant Interview

Overview of Participants

A total of six focus groups with 31 participants to include CCN Advisory Committee members, leadership, direct service staff, and early childhood community partners were conducted between December 2025 and January 2026. Each focus group included 1-7 participants and lasted approximately 60 minutes, allowing for detailed discussion and high-quality collection of data while remaining productive and respectful of participants' time. A key informant interview was also conducted in January 2026 with an individual who was identified for focus group participation but unable to attend. Focus group participants were identified by CCN and all participants received detailed information about the purpose of the focus groups prior to providing informed consent. Tailored discussion guides for each group were developed by TRX and can be found in Appendix A.

Several key themes emerged in the analysis of the six focus groups and key informant interview, including access to behavioral health care & service navigation, workforce capacity, care coordination, wraparound supports, & peer support services, behavioral health/developmental needs and structural barriers, and partnerships and collaborations. A thematic analysis of the topics and themes that emerged from the focus groups and interview are explored below.

Access to Behavioral Health Care & Service Navigation

Across focus groups and key informant interviews, participants consistently described significant barriers to accessing behavioral health care in a timely and effective manner. While services exist within the community, participants emphasized **that delays in access, complex referral pathways, and system fragmentation** often prevent individuals and families from receiving care before needs escalate. These barriers were described as contributing directly to increased use of emergency departments, and individuals "falling through the cracks."

Participants highlighted that entry into care is frequently slow and administratively complex, particularly for children and families. Referral processes can take months, requiring multiple steps and sustained engagement from caregivers who may already be overwhelmed. As one stakeholder noted, even when needs are identified early, the length of time between referral and service initiation can be substantial.

> *"The process alone to even get there is really long. If I find a child that I think needs assistance, I have to refer them. First of all, ask parents, "Can I refer them?" Refer them, wait for the referrals to get back… They come in, and they meet with us. It's like two to three months." Stakeholder Focus Group, P3, December 16, 2025; ccn ccbhc_fy25_fg04_trn: 201-205*

Delays and service discontinuities were also described when families move within the region, revealing how geographic and administrative boundaries disrupt continuity of care. Families are often unaware that services may not follow them, resulting in abrupt loss of support and regression in progress.

"All of a sudden, the family moved to West Rutland… 'Oh, your services don't follow you.' Now, your children aren't getting services anymore. Now, they're back to where they were when we first started."
Stakeholder Focus Group, P4, December 16, 2025; ccn ccbhc_fy25_fg04_trn: 258–265

Emergency departments were frequently identified as a default access point for individuals unable to navigate or access outpatient services. Participants described a pattern in which individuals present to the emergency department during crisis, receive brief stabilization, and are discharged back into the community without meaningful changes to their underlying circumstances.

"People go to the emergency room, they're in crisis. They spend six hours in the emergency room. By the end of that period of time, they're looking a little more stabilized and they're sent back out to kind of the same community that they were in six hours earlier." Key Informant Interview, January 9, 2026; ccn ccbhc_fy25_kii01_trn: 277-282

This reliance on emergency departments was compounded by unmet basic needs, including housing, food, and heat, which frequently drive crisis presentations but fall outside the scope of traditional clinical interventions.

"In crisis, we see people at the emergency department regularly. Most of the people we see are at the emergency department, and of those, a significant number are there because of housing needs, basic human needs, housing, food, and heat." Stakeholder Focus Group, P5, December 16, 2025; ccn ccbhc_fy25_fg05_trn: 133-137

Participants also expressed concern about individuals losing Medicaid coverage or insurance and subsequently being unable to access medications or ongoing care, further increasing the likelihood of crisis-level needs.

"There's a lot of people out there that need a lot more help. A lot more are losing their Medicaid or using this and don't have nowhere to go get help… someone can be without insurance, can use all their meds, and then they trickle down as a psych patient, and it's hard for them to get it and try to reestablish what they had prior." Stakeholder Focus Group, P1, December 10, 2025; ccn ccbhc_fy25_fg01_trn: 637-644

Several staff members described how federal and CCBHC-related requirements, while well-intentioned, have unintentionally limited flexibility in service delivery—particularly the use of telehealth to build community supports and maintain engagement with individuals facing transportation or housing barriers.

"The federal changes that impact us under CCBHC do not allow us to build community supports via telehealth, which has significantly impacted my ability to provide services to the maximum number of people who want them… And it shrunk my caseload and shrunk my ability to provide those day-to-day services" Staff Focus Group, P3, January 5, 2026; ccn ccbhc_fy25_fg06_trn: 113-125

Overall, participants emphasized that barriers to access are not solely the result of service availability, but rather the cumulative effect of administrative complexity, social drivers of health, and system-level constraints. Without earlier and

more flexible access points, individuals often enter care only once needs have escalated to crisis levels, placing strain on both families and the broader behavioral health system.

Workforce Capacity

Staffing shortages, burnout, and role strain emerged as major barriers to effective service delivery. Limited workforce capacity was said to impact the reach of services, timeliness of response, and the ability to provide specialized or culturally competent care. In rural areas, staff often perform multiple roles to meet client needs, which can exacerbate stress and turnover.

Participants emphasized that gaps in staffing not only affect availability but also quality of care, particularly for children and adults with complex behavioral health, developmental, or social needs. Staff shortages were linked to delays in intake, follow-up, and crisis response, leaving families without timely support.

> *"People are getting burned out because we don't have enough staffing. They're covering extra shifts, especially in our overnight locations. That's a big thing as well. I mean, I guess I would say the two most common are pay and the need for staffing so that people aren't getting burned out." Stakeholder Focus Group, P3, December 16, 2025; ccn ccbhc_fy25_fg05_trn: 299-303*

Housing instability also contributes to workforce challenges, limiting the ability to recruit and retain qualified staff.

> *"The housing market in this community is one of the things that's making it tremendously difficult to find qualified people to come in and fill all these roles. Because they can't find a place within a drivable distance that's rentable." Staff Focus Group, P2, January 5, 2026; ccn ccbhc_fy25_fg06_trn: 845-852*

To address staffing challenges, participants highlighted the need for ongoing professional development, including training in trauma-informed care, cultural competence, and strategies for working with neurodiverse populations. Without targeted support and manageable caseloads, workforce sustainability remains a key concern for the system.

> *"I wish there was more training around burnout and self-care and compassion fatigue. I think that those are really real issues that do contribute to that. But if we don't have training around compassion fatigue and ways to take care of ourselves, and those structural supports that we're talking about missing" Staff Focus Group, P3, January 5, 2026; ccn ccbhc_fy25_fg06_trn: 1236-1243*

Care Coordination, Wraparound Supports, & Peer Support Services

Participants consistently emphasized that effective **care coordination and wraparound supports are essential to meeting the complex behavioral health needs of individuals and families**, particularly those with co-occurring conditions, social instability, or involvement across multiple systems. While many participants described strong collaboration and dedication among providers, they also noted that care coordination is often highly dependent on individual staff capacity rather than a consistently supported system.

Several participants highlighted the extensive behind-the-scenes coordination required to maintain stability for individuals with high needs. Staff described spending significant time communicating with hospitals, schools, housing providers, and other agencies to prevent gaps in care, often without formal structures or reimbursement to support this work.

> *"We try to make it as seamless and easy as possible for the families. There's a lot of behind-the-scenes work that happens with us trying to pick up those pieces, so it's not all on the family." Stakeholder Focus Group, P3, December 16, 2025; ccn ccbhc_fy25_fg04_trn: 859-873*

Participants repeatedly stressed the importance of whole family, wraparound approaches, noting that individual-level interventions are often insufficient when broader family systems remain unsupported. This was particularly emphasized in relation to children experiencing emotional or behavioral challenges within unstable or highly stressed home environments.

> *"There needs to be actual wraparound supports for the entire family entity. Otherwise, there will never be success because no matter how regulated that child is, they're going back into an unregulated household." Stakeholder Focus Group, P2, December 16, 2025; ccn ccbhc_fy25_fg04_trn: 539-543*

Several participants shared examples of effective wraparound models, particularly those embedded within schools, where coordination across educators, clinicians, and families supported more comprehensive and accessible care.

> *"They had embedded supports in the local schools… general education teachers, special education teachers, the Rutland Mental Health professional, all on-site, really helped wrap around supports for my child." Stakeholder Focus Group, P5, December 16, 2025; ccn ccbhc_fy25_fg04_trn: 603–613*

Beyond wraparound supports, peer support was also highlighted as an emerging strategy to enhance engagement, continuity, and family support. Peers help clients navigate services, build rapport, and provide ongoing connection after crises.

> *"It's been really helpful because not only can they help build rapport with the clients in the moment, but then they can really do support with them after the crisis has ended and help them get connected with services, just be there, someone to talk to, whatever it might look like. We found it really beneficial." Staff Focus Group, P2, January 5, 2026; ccn ccbhc_fy25_fg06_trn: 692-704*

Participants also noted the importance of expanding peer supports to youth.

> *"We don't have youth peer supports…. that's absolutely something that we don't currently have that I feel would be helpful to add." Staff Focus Group, P3, January 5, 2026; ccn ccbhc_fy25_fg06_trn: 713-715*

Overall, participants described care coordination, peer support, and wraparound supports as crucial to meeting the needs of the community served. While providers demonstrate strong commitment and collaboration, continuity of care remains highly dependent on individual effort and informal problem-solving. Participants indicated that without more structured, resourced, and system-wide approaches to coordination, families with the highest levels of need remain at risk of service disruption and disengagement.

Behavioral Health/Developmental Needs and Structural Barriers

Participants across focus groups described a service landscape in which behavioral health and developmental needs intersect with significant structural, geographic, and administrative barriers. Trauma exposure, emotional regulation challenges, and repeated crisis episodes were reported among children, adults, and families, often alongside substance use, housing instability, and other social drivers of health. These needs were compounded by transportation challenges, long wait times, siloed service systems, and administrative complexity, which limited timely access to care and increased the risk of individuals cycling through crisis services without sustained support. For neurodiverse individuals and people with disabilities, gaps in coordination between mental health and developmental services further contributed to unmet needs and confusion about available supports. These barriers were described across multiple domains, including crisis access, transportation, administrative systems, organizational clarity, and unmet basic needs.

Participants frequently described how these structural barriers contributed to repeated crisis use when routine outpatient care was inaccessible. Participants consistently described elevated levels of trauma, emotional dysregulation, and recurring crises, affecting individuals across the lifespan. When ongoing outpatient care was inaccessible, individuals were more likely to rely on crisis lines, emergency departments, or short-term interventions rather than sustained therapeutic support.

These dynamics were often described in the context of repeated crisis use driven by unmet basic needs and limited access to routine care:

> *P6: "Well, they're calling crisis too, like, repeatedly. And so, even when we're trying to bring them into services to see an individual provider for therapy sessions, they can't get here. It's the same reason we have people utilizing the emergency room instead of having primary care.*
>
> *P3: Or they get here hungry, and they can't focus on the service anyway, so you struggle to make progress.*
>
> *P6: Or they're so stressed out because the number of times I've had clients who are just like, "I can't make my appointments because I don't know where I'm gonna be living. Like, I'm crashing on couches." You can't fix the pitfalls of capitalism. It's like, "I don't have the ability to do that. I can't believe the magic wand either." Staff Focus Group, P3 & P6, January 5, 2026; ccn ccbhc_fy25_fg06_trn: 1215-1228*

Rural geography and limited transportation infrastructure were repeatedly identified as primary barriers to accessing behavioral health services, particularly for individuals living outside Rutland City. While telehealth and outreach efforts have expanded access, participants noted these approaches cannot fully compensate for the lack of reliable transportation and proximity to services.

> *"I know people who are not directly here in Rutland City have a harder time accessing services due to the transportation and due to the knowledge of…the transportation piece makes it very difficult for people to access those*

services other than via telehealth services." Stakeholder Focus Group, P2, December 10, 2025; ccn ccbhc_fy25_fg01_trn: 186-193

Administrative complexity and siloed services between mental health, substance use, and developmental services were widely cited as barriers to coordinated care.

"The substance use staff have historically been under a director for many, many years. The staff who have been there have been working there for many, many years. It was very entrenched that substance use is substance use. This is a specialty, and mental health does mental health, and this is the way it goes, many years of this." Stakeholder Focus Group, P2, December 16, 2025; ccn ccbhc_fy25_fg05_trn: 835-840

Participants described duplicative documentation, conflicting regulations, and limited data sharing, which diverted staff time away from clinical work and contributed to service gaps for individuals with co-occurring needs.

"Every step of the way, for example, there's conflicting regs between substance use and CCBHC, so now the brawl is here. We're actually maintaining two sets of records or reporting two sets of data." Stakeholder Focus Group, P6, December 16, 2025; ccn ccbhc_fy25_fg05_trn: 469-478

Confusion about how services are structured and delivered extended beyond internal systems to public-facing organizational identity. Multiple participants cited confusion regarding the organization name and structure which ultimately impacts public understanding and engagement. Participants noted that the relationship between Rutland Mental Health and Community Care Network (CCN) is unclear, with many unsure which entity is actually responsible for providing services or what programs fall under the CCN umbrella. As one stakeholder explained,

"Rutland Mental Health falls under Community Care Network, but I don't even know what else falls under Community Care Network. And so, it is confusing to everyone" Stakeholder Focus Group, P2, December 16, 2025; ccn ccbhc_fy25_fg03_trn: 851-853

Other participants emphasized that the name "Rutland Mental Health" does not accurately reflect the breadth of services offered, leading to disengagement or misperceptions among community members.

Participants also identified **limited coordination between behavioral health and developmental services**, resulting in unmet needs for neurodiverse individuals and people with disabilities. Misunderstandings about eligibility criteria, IQ thresholds, and service scope contributed to perceptions that individuals were "disqualified" from care altogether, even when appropriate supports existed elsewhere within the system.

"We're trying to bring more attention to the fact that just because you have a DS diagnosis doesn't mean you don't also have a mental health diagnosis. So, there should be a bridge of the gap that you could get both sides of the agency but right now you just get development services." Stakeholder Focus Group, P4, December 16, 2025; ccn ccbhc_fy25_fg03_trn: 681-685

Across focus groups, participants emphasized that unmet basic needs fundamentally limited engagement in behavioral health services. Housing instability, food insecurity, and homelessness were frequently described as fundamental barriers to engagement in behavioral health services. Participants emphasized that without stable housing or basic resources, individuals struggled to attend appointments, focus during sessions, or sustain treatment over time.

> *"The homeless population is so vast here, and the resources are a drop in the bucket. So, you have lots of folks that you need to serve, and there's not enough hotel rooms, there's not enough spaces" Staff Focus Group, P6, January 5, 2026; ccn ccbhc_fy25_fg06_trn: 993-995*

Taken together, these findings illustrate that behavioral health needs in the community are not occurring in isolation, but are compounded by structural barriers, fragmented systems, and unmet social needs—underscoring the importance of CCBHC models that prioritize coordination, flexibility, and whole-person care.

Partnerships and Collaborations

Strong collaborations and partnerships were consistently identified as foundational to effective service delivery, particularly for individuals and families with complex behavioral health, developmental, and social needs. Participants emphasized that when agencies function well together—across education, child welfare, healthcare, law enforcement, and behavioral health—the primary beneficiary is the client.

Stakeholders identified schools and the Department for Children and Families (DCF) as especially critical partners in supporting children and families:

> *"Schools are critical partners. DCF is a critical partner… I think it's when we function well together, we're helping the client out." Stakeholder Focus Group, P4, December 16, 2025; ccn ccbhc_fy25_fg05_trn: 506-509*

Participants described effective partnerships as enabling wraparound care, rapid access to services, shared triage, and more holistic perspectives, allowing providers to respond flexibly and meet individuals where they are:

> *"Better wraparound, rapid access to clients, triaging, and a more well-rounded perspective. We're able to meet clients where they're at, from different angles and perspectives." Stakeholder Focus Group, P1, December 16, 2025; ccn ccbhc_fy25_fg05_trn: 541-543*

Another participant noted that longstanding relationships and shared values across agencies have helped sustain collaboration over time, even as systems and leadership change:

> *"The underlying value has been that we want to serve the same people, and we want to serve them in the same way, and we want to serve them well. That part has been consistently good for a long, long time." Key Informant Interview, January 9, 2026*

Despite these strengths, participants also identified gaps in interagency coordination, communication, and shared awareness of available resources. Staff reported uneven collaboration across agencies and noted that existing programs were not always well known—even among providers working within the same community.

> *"I keep hearing about more and more programs that are in the community that I had no idea about and that I know other coworkers on my team had no idea about. So, I feel like there are some good resources in the community. The word's just not getting out about them, and it's hard to find out about them." Staff Focus Group, P3, January 5, 2026; ccn ccbhc_fy25_fg06_trn: 982-987*

Overall, findings suggest that while strong partnerships are a key asset within the community, maximizing their impact will require continued investment in clear communication, shared understanding of roles and resources, and intentional alignment across systems, particularly for populations navigating multiple service sectors simultaneously.

Quantitative Data from Community Surveys

The community needs assessment survey distributed to clients and other community stakeholders included a mixed-methods approach, collecting multiple choice and open-ended responses. To analyze the survey responses, the data was cleaned to remove extraneous variables, open-ended responses were condensed into groupings or thematic categories, and variables were recoded so all multiple-choice questions with scales, such as "never, rarely, somewhat, mostly, completely" could be compared. The survey data were analyzed utilizing Qualtrics, Microsoft Excel, and Microsoft PowerBI.

All participants were told the purpose of the survey and given the option to quit the survey at any time and skip questions if they choose. The survey was available in multiple formats and accommodations or translations were able to be provided if needed but none were requested. Once the participants reviewed the above information, they were asked to proceed. A total of 49 valid and complete surveys were collected in December 2025.

Demographic Information

Table 14 below shows selected demographics from the 2025 CCN Needs Assessment Survey. Survey respondents were largely female (70%), straight (71%) and white (96%). One respondent identified as Hispanic/Latino, and two respondents selected multiple race categories. The multiracial respondents identified as Black or African American and White, and as Asian and Another race (please specify): Indian.

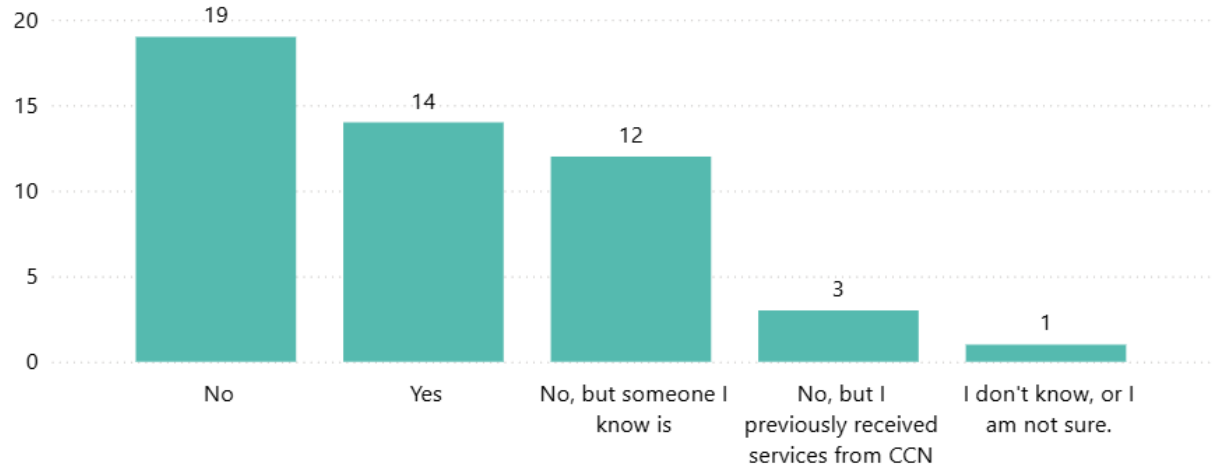
Table 14. Selected Demographics from the CCN Needs Assessment Survey (2025)

	Count	%
Gender Identity		
Male	11	23%
Female	33	70%
Transgender	1	2%
Gender non-conforming	1	2%
Prefer not to say	1	2%
Sexual Orientation		
Heterosexual or straight	32	71%
Gay or lesbian	3	7%
Bisexual	1	2%
Pansexual	2	4%

Queer	2	4%
Prefer not to say	5	11%
Race		
White	43	96%
Multiracial	2	4%
Ethnicity		
Hispanic/Latino	1	2%
Not Hispanic/Latino	41	93%
Prefer not to say	2	5%

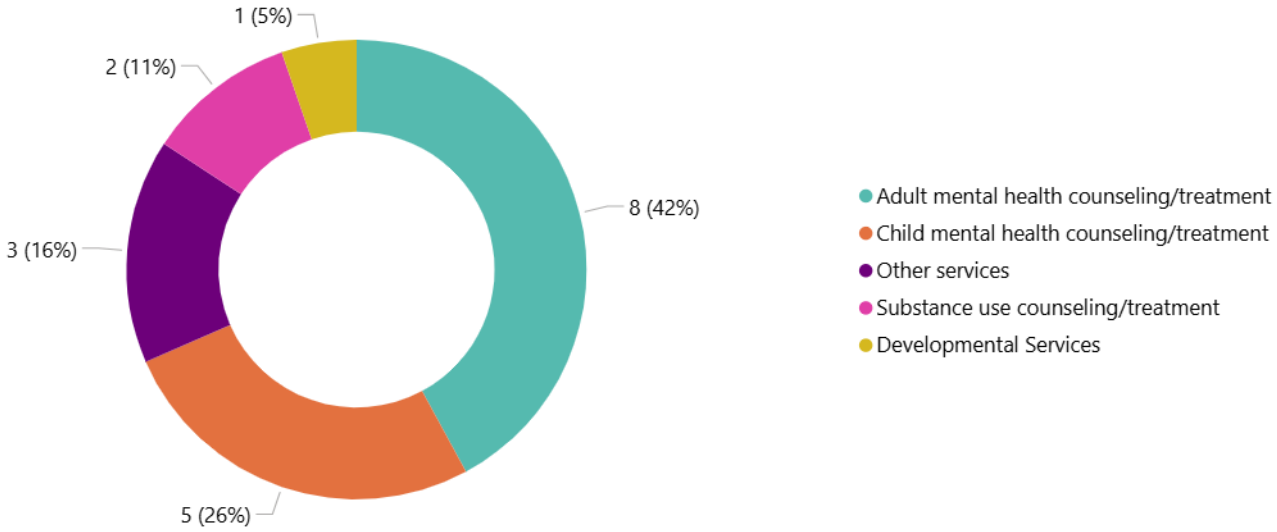
Of the 49 individuals that completed the survey, 14 respondents (29%) were currently receiving services from CCN at the time of the survey and three respondents (6%) had previously received services from CCN. The remaining respondents had either never received services from CCN (42%) or were not receiving services but knew someone who is (24%).

Figure 6. Are you currently receiving services from CCN?



Individuals receiving services at the time of the survey were asked to select all of the services they receive from CCN. Of the 14 respondents currently receiving services, a total of 19 services were selected as a few respondents selected multiple services. Of those 19 services, “Adult mental health or counseling and/or treatment” and “Child mental health or counseling and/or treatment” were the most frequently reported services received. A few respondents also reported receiving “Developmental Services”, “Substance use counseling and/or treatment”, and “Other services”. After selecting “Other services”, a few individuals specified additional services including “case worker” and “job counseling / case management”.

Figure 7. Types of Services Received, Current Clients



Survey respondents reported living in 14 different cities, though most (n=20) reported living in Rutland most of the time. Six respondents chose "Other" and specified a city, including Mount Holly, Burlington, Shrewsbury, and Hubbardton.

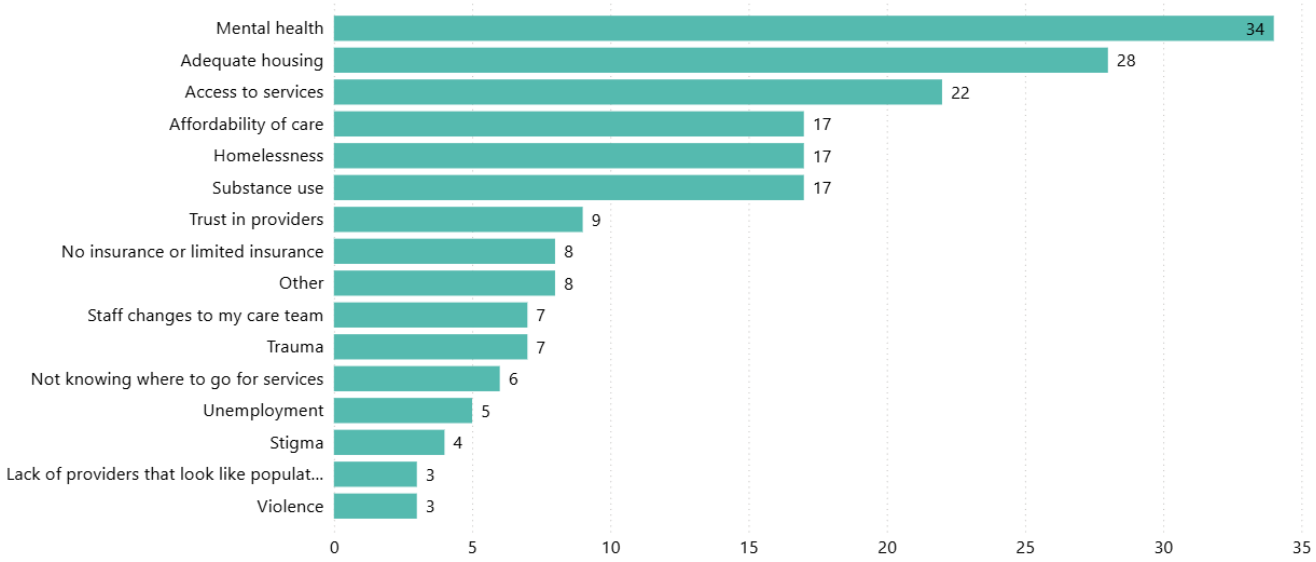
Table 15. Survey Respondents by City

City	Count	%
Rutland	20	43%
Brandon	5	11%
Fair Haven	4	9%
Castleton	2	4%
Pittsford	2	4%
Wallingford	2	4%
West Rutland	2	4%
Clarendon	1	2%
Poultney	1	2%
Proctor	1	2%
Another city	6	13%

Top Behavioral Health Concerns

To assess perceptions of behavioral health concerns, the survey asked, "What are your top 5 health or social concerns in your community?" Respondents could choose up to five options from a list of concerns. Overall, the most frequently reported concerns were mental health (n=34), adequate housing (n=28), and access to services (n=22). Affordability of care (n=17), homelessness (n=17), and substance use (n=17) also emerged as top behavioral health concerns among the 49 respondents. Eight respondents chose "Other" and specified concerns such as "Access to affordable and healthy food", "People can't afford to live", and "Need for increased family-centered services".

Figure 8. Top Health and Social Concerns (2025)

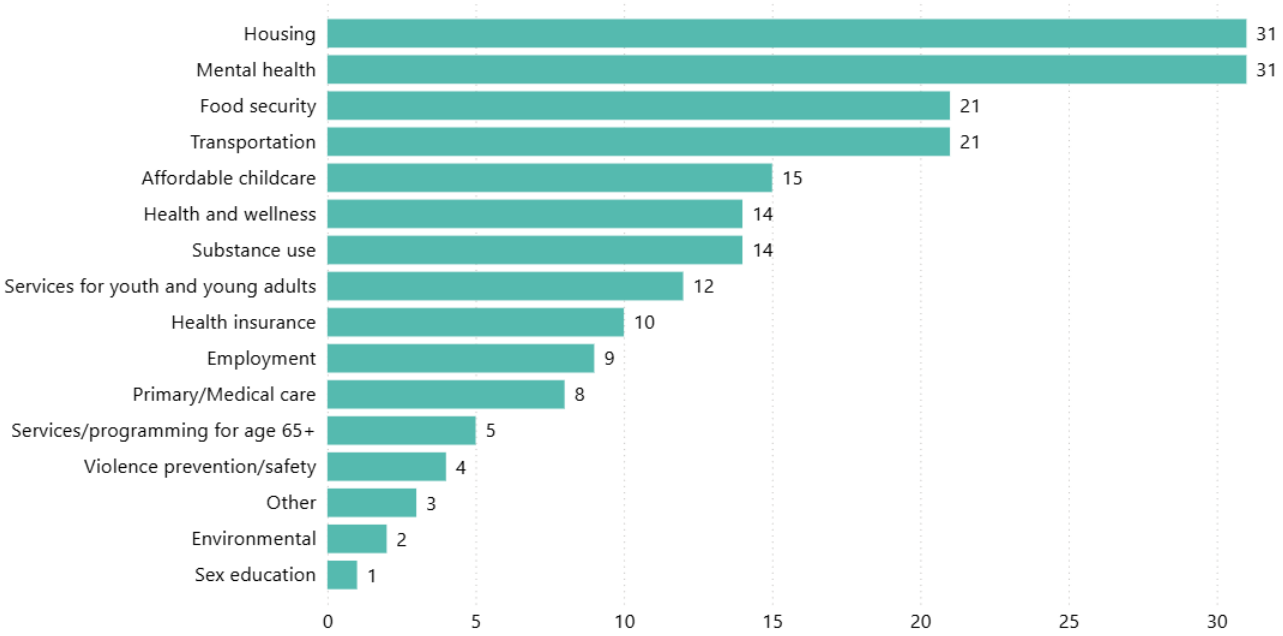


Barriers to Access

Respondents were also given the opportunity to further explain the challenges they face when seeking or receiving services for the health or social concerns that they selected. A total of 26 respondents provided additional details about challenges or barriers to care. Several themes emerged through an analysis of the open-ended responses. Five individuals mentioned challenges related to insurance or the cost of services. Eight individuals mentioned long waitlists, a lack of availability of services, and difficulties getting an appointment. Nine individuals cited housing-related challenges, including homelessness and a lack of affordable housing.

Respondents were also asked to identify the top 5 services that are needed to improve the health of the community. Respondents could select up to 5 services from the list. Almost two thirds of respondents selected mental health (n=31) and housing (n=31). Mental health and adequate housing were also the top two behavioral health concerns among respondents. The need for transportation and services that address food insecurity were also identified by over half of respondents.

Figure 9. Most Needed Services in the Community (2025)

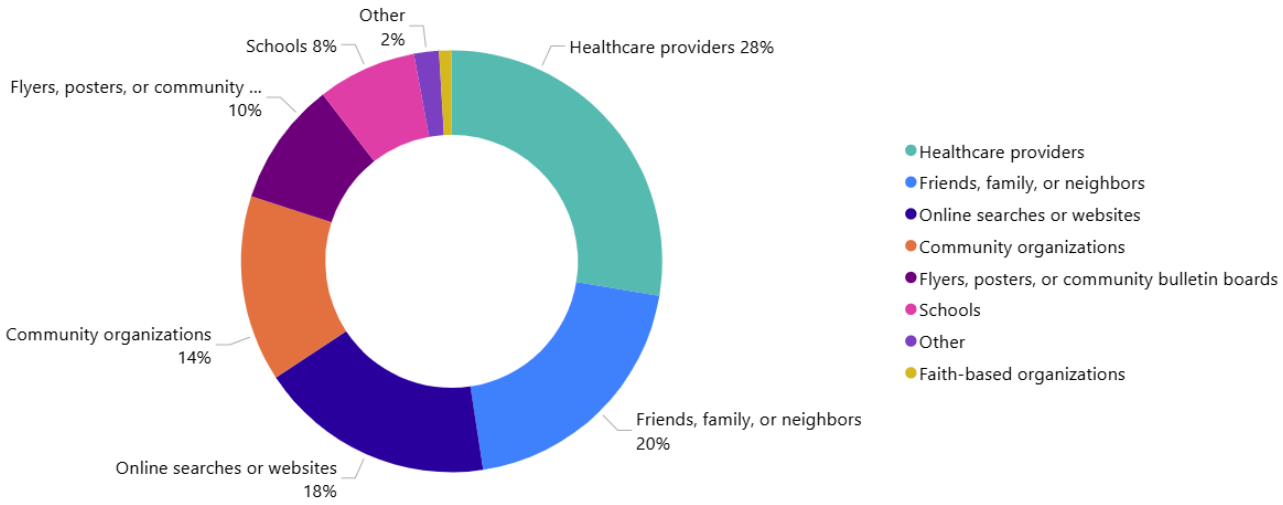


Respondents were also given the opportunity to further explain the challenges they face when seeking or receiving the services they selected. Of the 26 individuals that provided further description of the challenges they face, seven respondents mentioned transportation issues including inadequate public transportation and unreliable buses.

Seeking and Receiving Services

The survey also asked several questions about community perception of seeking services and their preferences for receiving services. Respondents were asked "How do you usually find out about or get referred to services?" The most common responses were Healthcare providers; Family, friends, or neighbors; and Online searches or websites.

Figure 10. How do you usually find out about or get referred to services?



The survey also asked, “When seeking services, how important are the following factors?” Respondents ranked four factors (Cost/affordability, Has evening or weekend hours, Close to home, and Meets my cultural and linguistic needs) on a scale from Not at all important to Very important. About 67% of respondents said that “Cost/affordability” was very important when seeking services. Most respondents (66%) ranked “Has evening or weekend hours” as Somewhat important.

When seeking services, how important are the following factors?

Figure 11. Close to home

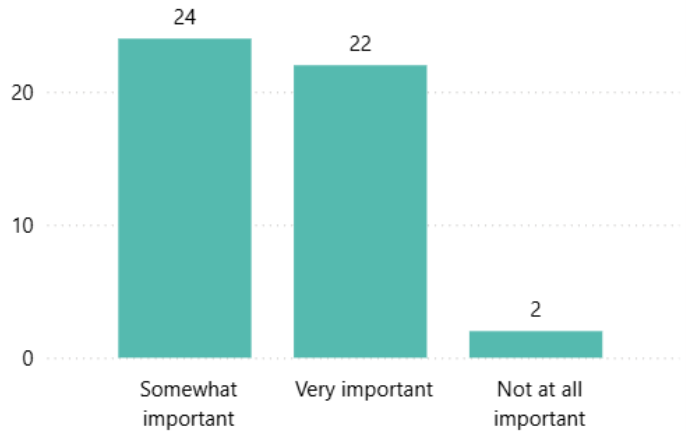
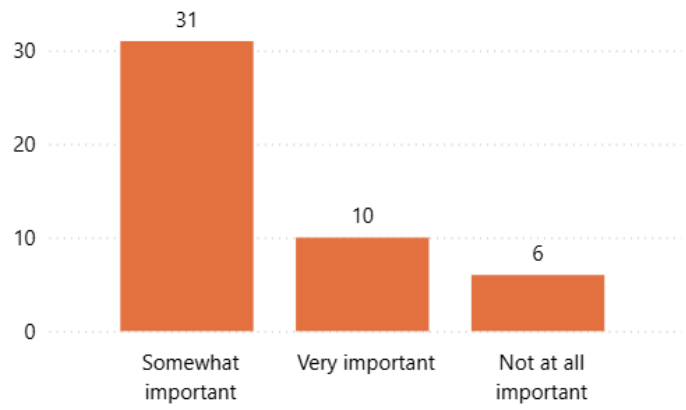


Figure 12. Has evening or weekend hours



Almost all survey respondents reported having reliable access to a phone, and 89% reported having reliable access to the internet. Overall, respondents demonstrated a preference for receiving services in-person compared to receiving services via telehealth. When asked, “How do you prefer to receive services at CCN?”, about half of respondents chose In-Person: Office-based, 26% of respondents chose In-Person: Community-based, and 23% chose Telehealth.

Figure 13. Do you have reliable access to a phone?

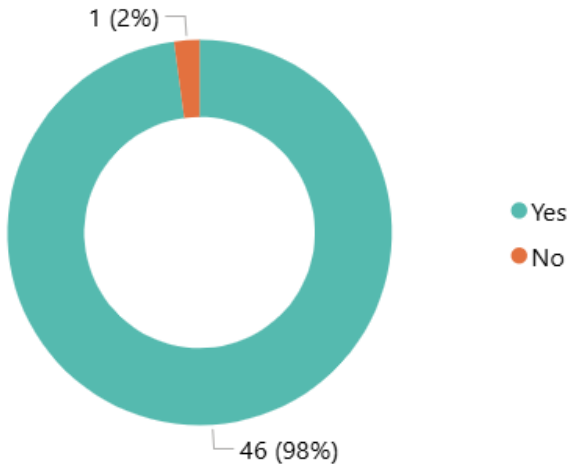


Figure 14. Do you have reliable access to the internet?

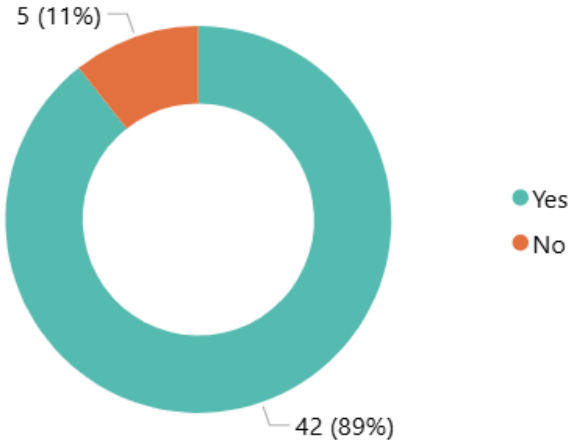
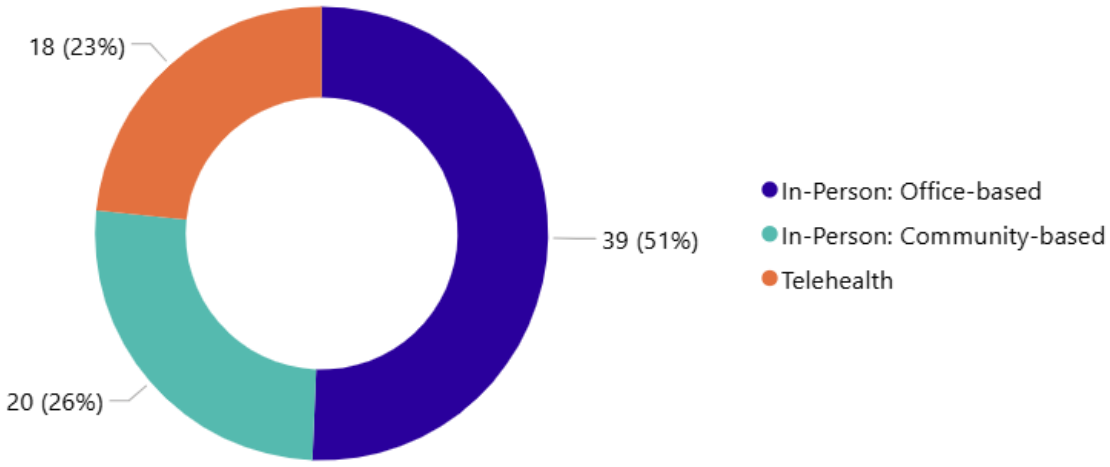
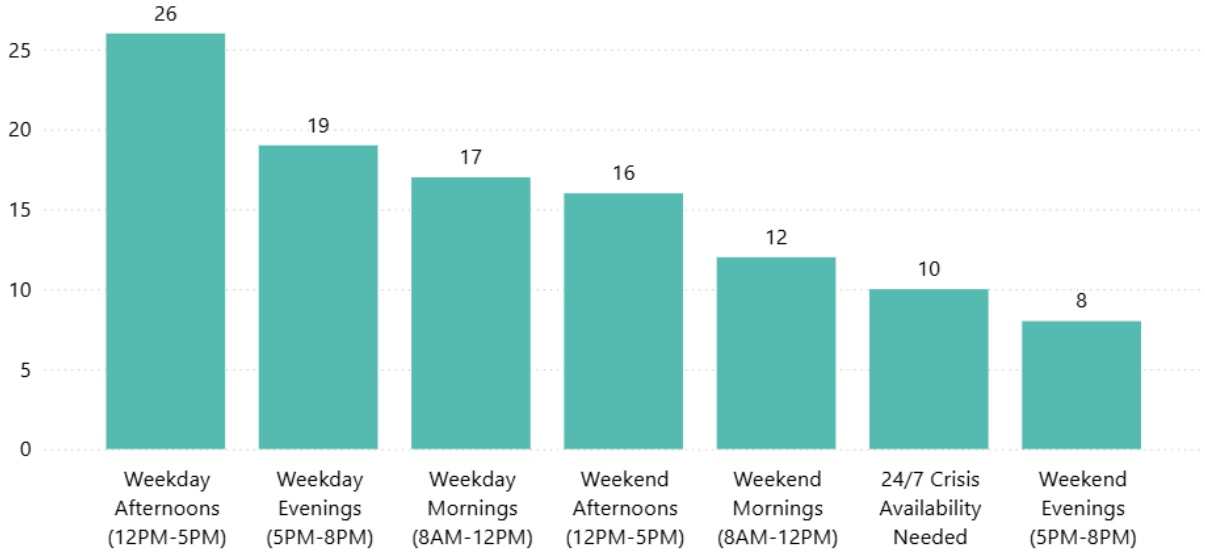


Figure 15. How do you prefer to receive services at CCN?



To further assess community members preferences and the accessibility of services, the survey asked respondents, "What days and times would work best for you to receive services?". Respondents could choose all days/times that applied to them. Responses varied, but over half of respondents selected "Weekday Afternoons (12PM – 5PM)".

Figure 16. What days and times would work best for you to receive services?



Conclusions and Recommendations

As a Certified Community Behavioral Health Clinic, Community Care Network is poised to improve upon existing program and service offerings and enhance the health and well-being of the community, individuals and families through responsive, innovative and collaborative services. Access to behavioral health services remains one of the most urgent and complex challenges facing the community served by CCN. Survey and focus group findings underscore multiple interconnected issues that must be addressed to strengthen the behavioral health system, especially among underserved populations such as unhoused individuals, adults with disabilities, LGBTQIA+ residents, justice-involved individuals, foster youth, veterans, and BIPOC populations. Unmet social drivers of health such as housing and transportation compounded access barriers and participants emphasized that these challenges are deeply interrelated, with workforce capacity, care coordination and accessibility being central to effective service delivery. Despite these challenges, strong collaborations and peer supports emerged as key strengths and strategic priorities moving forward.

Independent evaluators at TRX Development Solutions, LLC conducted an environmental scan, and collected primary source data through focus groups and surveys to help the CCN team make informed decisions to help increase capacity and improve the overall quality of care for individuals who seek services at CCN. The recommendations below are related to behavioral health care access, workforce capacity, social drivers of health and related barriers, and improved coordination of care. The recommendations are not, however, an exhaustive list of areas to improve upon. This needs assessment should be viewed as a dynamic project that will be reviewed at a minimum every three years, to review progress on goals, and make updates relevant to the current situation.

High Priority

1. **Expand timely access to behavioral health care** - Delays in access, fragmented referral pathways, and administrative complexity were consistently identified as drivers of crisis escalation and emergency department utilization. It is recommended that the CCBHC continue to strengthen same-day access, flexible entry points, and streamlined service navigation to ensure individuals can engage in care before needs reach crisis levels. Particular focus should be placed on simplifying referral processes, reducing wait times, and improving clarity around how to access services across the continuum of care. Strengthening care navigation and front-door coordination will be essential to reducing service gaps, preventing individuals from “falling through the cracks,” and improving continuity of care for individuals with complex needs.
2. **Strengthen workforce capacity and role support** - Workforce shortages, burnout, and role strain emerged as critical barriers to care, particularly in rural settings where staff often serve multiple roles. It is recommended to prioritize workforce stabilization strategies that address recruitment, retention, and staff wellness. This includes investing in trauma-informed and resiliency-focused supports for staff. Strengthening workforce capacity will be essential to improving intake timeliness, follow-up care, crisis response, and the delivery of specialized services for individuals with complex behavioral health, developmental, and social needs.
3. **Enhance crisis response and substance use treatment capacity -** Rutland County experiences elevated substance use indicators, high MOUD utilization, and increasing suicide-related emergency department visits and mortality rates, particularly among adults and males. It is recommended to continue strengthening crisis services and substance use treatment capacity through coordinated, community-based models that reduce reliance on emergency departments. This includes improving access to crisis stabilization, follow-up care after crisis

episodes, and integration between mental health and substance use services. Emphasis should be placed on continuity of care across settings to prevent repeated crisis utilization and support long-term stabilization.

4. **Address housing instability, transportation barriers, and other social drivers of health -** Housing instability, homelessness, transportation challenges, and unmet basic needs were consistently identified as barriers to accessing and sustaining behavioral health care. It is recommended to further integrate social drivers of health into behavioral health service delivery through partnerships, care coordination, and navigation supports. Prioritizing housing-related coordination, transportation solutions, and access to food and basic resources will be critical to improving engagement in care, reducing crisis use, and supporting whole-person outcomes, particularly for unhoused individuals and other underserved populations.

Medium Priority

1. **Strengthen care coordination, wraparound supports, and peer services -** Participants emphasized that effective care coordination is essential but often dependent on individual staff effort rather than formal systems. It is recommended to continue strengthening structured care coordination models, including wraparound supports and peer services, to support individuals with co-occurring conditions, system involvement, and social instability. Formalizing and resourcing coordination activities will help ensure consistency, reduce staff burden, and improve outcomes for individuals with complex needs.
2. **Improve service integration for individuals with developmental disabilities -** Gaps in coordination between behavioral health and developmental services were identified as a source of confusion and unmet need, particularly for neurodiverse individuals and people with disabilities. It is recommended to enhance cross-system collaboration, shared care planning, and clarity around service pathways to improve access and continuity of care. Improved integration will reduce service fragmentation and better support individuals whose needs span multiple systems.
3. **Expand culturally responsive, trauma-informed, and linguistically accessible services -** Although Rutland County has limited racial and ethnic diversity, findings highlight the importance of culturally responsive and trauma-informed care, particularly for underserved populations and individuals born outside the United States. It is recommended to continue strengthening language access, trauma-informed practices, and staff training to ensure services are responsive to diverse backgrounds and lived experiences. Improving data collection where feasible may also help better identify and respond to the needs of LGBTQ+ and other underserved populations.
4. **Deepen community collaboration to support continuity of care -** Strong partnerships across healthcare, education, housing, justice, and social service systems were identified as foundational to effective service delivery. It is recommended to continue deepening cross-sector collaboration through shared protocols, communication pathways, and coordinated planning. Strengthened partnerships will support smoother transitions across systems, reduce service disruptions, and improve outcomes for individuals with complex and intersecting needs.

Appendix A: Focus Group Guides

COMMUNITY CARE NETWORK (CCN)
CERTIFIED COMMUNITY BEHAVIORAL HEALTH CENTER (CCBHC) COMMUNITY NEEDS ASSESSMENT

FOCUS GROUP QUESTION GUIDE: CLIENTS AND COMMUNITY MEMBERS
v1.0 // 10 NOVEMBER 2025

NOTES TO FACILITATOR

- Questions to be asked are numbered in brackets and appear in Bold regular type.
- Probes and clarifying questions are in plain text.
- ASK all the BOLD, numbered questions. Ask probing questions as needed.
- Instructions to the interviewer are preceded by "Note:"
- Remember to hit the record button!

THE GOALS OF THE FOCUS GROUP ARE, FOR THE COMMUNITY SERVED BY CCN:

1) To identify clients' perceptions of community behavioral health needs, challenges, and supports.
2) To identify service gaps and disparities in access for different subpopulations.
3) To identify needs that apply to specific groups within the larger community.
4) To inform CCN and the CCBHC leadership how the CCBHC can best serve the community.
5) To gather more insight into the impact of COVID, technology access, and behavioral health urgent care.

INTERVIEWER SCRIPT TO BEGIN [Please follow this script closely.]

Thank you very much for agreeing to speak with us today. This focus group is part of a needs assessment being conducted by Community Care Network for the implementation of its Certified Community Behavioral Health Center program.

The purpose of our focus group today is to help us understand your perceptions and experiences—as clients and community members with behavioral health needs and concerns in your community. This conversation should help CCN's leadership create programming to address these needs and concerns.

This focus group will take about 40-45 minutes to complete, and we'll be done by [STATE TIME]. We, the facilitators of the focus group are from an independent consultant group, TRX Development Solutions, that has been contracted by CCN for the needs assessment.

As independent evaluators, we assure you that this focus group is confidential. This means that we are promising that your name will not appear on any needs assessment documents or in the transcript of this focus group. However, since we are all virtually face-to-face and some of you know may each other, the process is not perfectly anonymous. To help assure the confidentiality of our conversation today, we will ask that everyone commit that what is said today will "stay in the room." That means we ask you to not speak about this focus group with others after we conclude.

We are going to audio-record this focus group. The audio file will be digital and stored in a password-protected file system that only the TRX evaluators have access to. We will have the audio file transcribed so that we will have a paper version of the conversation today that we will study to understand your experiences. Any names said in the course of the focus group will be transcribed as initials (for example, Michael Jordan will be "MJ"). The audio files and transcripts will not be available to staff or leadership at CCN. The needs assessment report will be confidential and aimed at providing aggregate results to CCN.

Statements that you make in the focus group may be quoted in needs assessment reports. No individual will be identified by name, though the source of the focus group will be noted, as in: "A participant in a community focus group stated …"

If you wish to participate we will ask you to state, verbally, your consent to participating and to the recording of the conversation. If you do not wish to participate, you may decline and leave the group before we begin recording. Declining to participate will **not** affect the services you may receive from CCN and other organizations that provide health and human services. We can pause for a minute to see if anyone has questions.

Facilitator: After addressing questions, allow a minute for those who wish to leave to do so. When the group is settled, begin the audio recording with a statement of the date, location, focus group ID code, and the following:

"All persons included in this audio recording were given a statement of informed consent describing the purpose of this focus group before the start of this recording. All who appear on the recording have consented to participate in this focus group."

Let's begin by going around the room and sharing what your connection to CCN or the community is is.

Next, let's talk about behavioral health concerns that you feel are most important to people in your community.

Follow-up questions should be asked right away after a speaker identifies a concern:

- Why is this concern important to you or your community?
- Is it a new or ongoing concern?
- Has anything changed since COVID-19 (for example, technology access or crisis needs)?
- Has anything made it easier or harder to get help for these issues?

The assistant facilitator should type the issues into the chat in Zoom, so all can see them. The assistant facilitator will keep a tally of concerns so that the top three or four concerns can be specifically discussed in the following question.

Now, let's talk about how people find out about or get referred to services.

Follow-up questions and probes include: asking for specificity. Ask for participants to describe things, ask for specifics: names of agencies, distances, challenges, barriers to service.

- How do people usually learn about mental health or substance use services in your community?
- Are there particular organizations, community centers, schools, or healthcare providers that help connect people to care?
- How easy or difficult is it to get an appointment?
- How long do people usually wait to receive services or crisis support?
- Are the current hours of operation (weekday, weekend, or evening) convenient?

What things make it hard for you and people in the community to seek and continue receiving services?

Make sure clients address transportation, hours of operation, cost or insurance, language or cultural barriers, technology or internet challenges for telehealth, childcare, stigma, or privacy concerns

Follow-up questions and probes include:

- For example, staff who speak your language, who treat people respectfully, or offer flexible appointment times
- What makes it harder to keep attending appointments or programs?
- How important is it to be able to choose where or how to receive care (in-person, virtual, at home, in the community)?
- Are follow-up services after a mental health or substance use crisis helpful and consistent? What could make them better?

Do people in your community generally trust their behavioral health care and service providers?

Follow-up questions and probes include:

- What helps build trust?
- What causes mistrust or hesitation?
- What kinds of stigma do people face when seeking care?
- How could CCN or the CCBHC reduce stigma and build trust across different groups?

Have you heard about peer support services—where people with lived experience help others in recovery?

- What do you know about these kinds of services?
- Would you or others be interested in using or becoming peer supporters?
- How could CCN make peer support more visible or available?

Now let's talk about how services meet the needs of different cultural or language groups.

- Do people feel they can get care in their preferred language?
- What could CCN do to be more inclusive and welcoming for all communities?
- Are there community-specific spaces or resources that help people feel connected or supported (for example, cultural centers, ethnic grocery stores, LGBTQIA+ drop-in spaces)?

The CCBHC offers a comprehensive array of mental health and substance use services that address the needs of the whole person. What can CCN do to make community members aware of what they can offer through the CCBHC?

- What's the best way to share information (for example, social media, community events, schools, word of mouth, flyers, radio, etc.)?
- What can they do to help community members take advantage of the CCBHC's services and programs?
- How can CCN support people who have limited access to technology?

COMMUNITY CARE NETWORK (CCN)
CERTIFIED COMMUNITY BEHAVIORAL HEALTH CENTER (CCBHC)
COMMUNITY NEEDS ASSESSMENT

FOCUS GROUP QUESTION GUIDE: STAFF
v1.1 // 13 NOVEMBER 2025

NOTES TO INTERVIEWER

- Questions to be asked are numbered in brackets and appear in Bold regular type.
- Probes and clarifying questions are in plain text.
- ASK all the BOLD, numbered questions. Ask probing questions as needed.
- Instructions to the interviewer are in brackets [...]

THE GOALS OF THE INTERVIEW ARE:

6) To identify staff perceptions of community behavioral health needs, challenges, and supports.
7) To identify service gaps and disparities in access for different subpopulations.
8) To identify what staff need to do their jobs at the highest level of community service and alignment with CCN's mission.
9) To identify challenges faced by staff that could also hinder the implementation of the CCBHC.
10) To inform CCN and the CCBHC leadership how the CCBHC can best serve the community.

INTERVIEWER SCRIPT TO BEGIN [Please follow this script closely.]

Thank you very much for agreeing to speak with us today. This focus group is part of a needs assessment being conducted by CCN for the implementation of its Certified Community Behavioral Health Center program.

The purpose of this focus group today is to help us understand how you as a staff member, perceive the behavioral health needs and concerns in this community and how the CCBHC may serve the community members. This conversation should help CCN's leadership create programming to address these needs and concerns. This focus group will take about 40 to 45 minutes to complete, and we'll be done by [STATE TIME].

I am with an independent consulting group, TRX Development Solutions, that has been contracted by CCN to complete the needs assessment and provide program evaluation services to CCN.

As an independent evaluator, I assure you that this focus group discussion is confidential. This means that we promise that your name will not appear on any needs assessment documents or in the transcript of this disucssion. We will not provide the recording or transcript of the focus group to CCN staff or leadership, only my colleagues at TRX will read or work with your focus group data.

We are going to audio-record this discussion. The audio file will be digital and stored in a password-protected file system that only the TRX evaluators have access to. We will have the audio file transcribed so that we will have a paper version of the conversation today that we will study to understand your experiences. Any names said in the course of the focus group will be transcribed as initials (for example, Michael Jordan will be "MJ"). The audio files and transcripts will not be available to staff or leadership at CCN. The needs assessment report will be confidential and aimed at providing aggregate results to CCN.

Statements that you make in the focus group may be quoted in needs assessment reports. No individual will be identified by name, though the source of the focus group will be noted, as in: "A participant in a staff focus group stated ..."

If you wish to participate we will ask you to state, verbally, your consent to participate at the beginning of the recording. If you do not wish to participate, you may decline and leave. Declining to participate will not affect your work or any services you may receive from CCN and other organizations that provide health and human services. do you have questions about the process before we get started?

Facilitator: After addressing questions, allow a minute for those who wish to leave to do so. When the group is settled, begin the audio recording with a statement of the date, location, focus group ID code, and the following:

"All persons included in this audio recording were given a statement of informed consent describing the purpose of this focus group prior to the start of this recording. All who appear on the recording have consented to participate in this focus group."

Let's begin by going around and describing what you do here at CCN. That includes both service provision and administrative functions. [Ice-breaker questions – move quickly for folks to introduce themselves and get a feel for how the group relates to their clients.]

- How often do you interact with clients?
- Do you interact with clients mostly in person or using telehealth?
    - Have client preferences around telehealth vs. in-person changed over time? What trends are you noticing?
- How have your interactions with clients changed since the COVID-19 pandemic?
    - Has COVID changed your day-to-day responsibilities or work expectations? In what ways?

Based on your work, what would you say are the two or three most important behavioral health concerns in the community you serve?

Follow-up questions and probes include asking for details about issues they raise or an example of their concern if it isn't clear. Some types of follow-ups are:

- Why is this a concern?
- Where do you see this concern in the community or among your clients?
- Is this a new concern, or has it changed in recent years?
- How do these issues show up across different populations or neighborhoods?

The assistant facilitator should type the issues into the chat in Zoom, so all can see them. The assistant facilitator will keep a tally of concerns so that the top three or four concerns can be specifically discussed in the following question.

Of these concerns that we have listed, which can be addressed at CCN and which require referral partnerships?

Follow-up questions and probes include: asking for specificity. Ask participants for specific descriptions: names of agencies, distances, challenges, and barriers of service.

- What outreach or referral partnerships are most effective? Which could be stronger?
- Which referral relationships or processes work well? Which break down?

Let's talk about the barriers clients face in seeking or continuing care. What makes it difficult for people to start or stay engaged in services?

Follow-up questions can include:

- How do community members typically learn about or get referred to CCN services?
- Are there particular issues with transportation, location, timing, or costs?
- How do issues like stigma, cultural misunderstandings, or mistrust impact access?
- Have there been changes in demand for urgent care, walk-in, or telehealth access?

Are there populations for whom access or outcomes are significantly different?

Follow-up questions can include:

- By age, race, ethnicity, language, gender identity, or geography?
- How does CCN currently address cultural and linguistic needs?
- What more could CCN do to improve inclusion and responsiveness?

Let's talk about CCN's partnerships with other organizations. What kinds of collaboration are there between CCN and other organizations that serve the community?

Follow-up questions and probes include:

- Do you collaborate with other organizations to address client problems?
- Do you participate in collaboration to address cultural and linguistic responsiveness at CCN?
- Do you share information about persons served through referral pathways?
- Is there any institutional process for sending and receiving referrals?

Peer services are an important part of the CCBHC model. What is your awareness or understanding of peer support services at CCN?

Follow-up questions and probes include:

- How are peer specialists currently integrated into service delivery?
- Are clients aware of or interested in peer services?
- What barriers exist to expanding peer support or encouraging client to become peers?

How is CCN affected by staffing challenges?

Follow-up questions and probes include:

- Is it difficult to recruit and retain staff in certain roles?
- What positions are hardest to fill?
- Are staffing shortages affecting wait times or access to care?
- What additional resources, supports, or training would help you do your job more effectively?

Do people in your community generally trust their behavioral health care and service providers?

Follow-up questions and probes include:

- If not, why would that be?
- Are there stigmas around behavioral health issues?
- Are there specific barriers to services in these areas for people like yourself and those who share your experiences?
- What makes it easier or harder to trust service providers?
- What could change the feelings of mistrust that some people have?

The CCBHC offers a comprehensive array of mental health and substance use services that address the needs of the whole person. What can CCN do to make community members aware of what they can offer through the CCBHC?

- What can they do to help community members take advantage of the CCBHC's services and programs?

COMMUNITY CARE NETWORK (CCN)

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CENTER (CCBHC)
COMMUNITY NEEDS ASSESSMENT

FOCUS GROUP QUESTION GUIDE: CCBHC LEADERSHIP
v1.1 // 13 NOVEMBER 2025

NOTES TO INTERVIEWER

- Questions to be asked are numbered in brackets and appear in Bold regular type.
- Probes and clarifying questions are in plain text.
- ASK all the BOLD, numbered questions. Ask probing questions as needed.
- Instructions to the interviewer are in brackets [...]

THE GOALS OF THE FOCUS GROUP ARE:

11) To identify leadership perceptions of the most pressing behavioral health needs, community challenges, and support
12) To understand leadership goals for the CCBHC's current implementation, potential for expansion and sustainability.
13) To assess service gaps, duplications, and disparities in access—especially for high-need subpopulations.
14) To explore internal workforce challenges and what CCN staff need to provide high-quality, whole-person care.
15) To gather leadership insights on the effectiveness of current partnerships and identify opportunities for coalition-building and deeper interagency collaboration.

INTERVIEWER SCRIPT TO BEGIN [Please follow this script closely.]

Thank you very much for agreeing to speak with us today. This focus group is part of a needs assessment being conducted by CCN for the continued implementation of its Certified Community Behavioral Health Center program.

The purpose of this focus group today is to help us understand how you as a staff member in leadership at CCN perceive the behavioral health needs and concerns in this community and how the CCBHC may serve the community members. This conversation should help the team create programming to address these needs and concerns. This focus group will take about 40 to 50 minutes to complete, and we will be done by [STATE TIME].

I am with an independent consulting group, TRX Development Solutions, that has been contracted by CCN to complete the needs assessment and provide program evaluation services to CCN.

As an independent evaluator, I assure you that this interview is confidential. This means that we promise that your name will not appear on any needs assessment documents or in the focus group transcript. We will not provide the recording or transcript of the group to CCN staff or leadership; only my TRX colleagues will read or work with your focus group data.

We are going to audio-record this focus group. The audio file will be digital and stored in a password-protected file system that only the TRX evaluators have access to. We will have the audio file transcribed so that we will have a paper version of the conversation today that we will study to understand your experiences. Any names said in the course of the focus group will be transcribed as initials (for example, Michael Jordan will be "MJ"). The audio files and transcripts will not be available to staff or leadership at CCN. The needs assessment report will be confidential and aimed at providing aggregate results to CCN.

Statements that you make in the focus group may be quoted in needs assessment reports. No individual will be identified by name, though the source of the focus group will be noted, as in: "A participant in a leadership focus group stated ..."

If you wish to participate we will ask you to state, verbally, your consent to participate at the beginning of the recording. If you do not wish to participate, you may decline and leave. Declining to participate will not affect your work or any services you may receive from CCN and other organizations that provide health and human services. do you have questions about the process before we get started?

Facilitator: After addressing questions, allow a minute for those who wish to leave to do so. When the group is settled, begin the audio recording with a statement of the date, location, focus group ID code, and the following:

"All persons included in this audio recording were given a statement of informed consent describing the purpose of this focus group prior to the start of this recording. All who appear on the recording have consented to participate in this focus group."

Let's begin by going around and describing your role at CCN and in the CCBHC. That includes both service provision and administrative functions. [Ice-breaker questions – move quickly for folks to introduce themselves and get a feel for how the group relates to their clients.]

- How often do you interact with clients?
- Did you previously work as a clinician or service provider?
- What are general staff perceptions of clients?
- Are staff open-minded to clients' experiences, or regard them in a more disconnected way?

Based on your work, what would you say are the two or three most important behavioral health concerns in the community?

Follow-up questions and probes include asking for details about issues they raise or an example of their concern if it isn't clear. Some types of follow-ups are:

- Why is this a concern?
- Are certain demographic groups (age, race, ethnicity, geography, language) more impacted?
- What community factors (economic conditions, housing, social isolation, stigma) are contributing?
- What has CCN done to address cultural or linguistic barriers tied to these issues?
- What has been successful? What remains challenging?

The assistant facilitator should type the issues into the chat in Zoom, so all can see them. The assistant facilitator will keep a tally of concerns so that the top three or four concerns can be specifically discussed in the following question.

Which of these concerns can the CCBHC at CCN address directly, and which require external partnerships?

Follow-up questions and probes include: asking for specificity. Ask participants for specific descriptions: names of agencies, distances, challenges, and barriers of service.

- What barriers do you see in addressing these needs internally?
- What partnerships or referral processes are essential to meeting them?
- Are there services that CCN currently does not have capacity to offer (for example, after-hours, peer support, or bilingual services)?
- What lessons have you learned from other organizations who are addressing similar needs successfully?
- Are there areas where duplication exists—services offered by many agencies—versus areas of service gaps in your community?

Thinking more about your partnerships and specifically because they are a large part of the CCBHC model – your **Designated Collaborating Organizations**, **what are the characteristics of your strongest partnerships?**

Follow-up questions and probes include:

- What challenges do you encounter in your community collaborations?
- How do you share resources, data or other information with DCOs?
- Have you received feedback from DCO partners about how your organizations collaborate together?
- How could CCN leadership better support or collaborate with DCOs?
- What opportunities exist to co-create or expand regional coalitions?

At a leadership level, what do you see as the biggest barriers to service access across CCN programs?

Follow-up questions and probes include:

- How does CCN ensure culturally and linguistically appropriate access for diverse communities?
- What types of stigma still exist around mental health or substance use?
- What approaches could help CCN improve client retention and engagement in care?
- Are there specific community groups who are not connecting to care despite outreach efforts?
- What can leadership do to remove barriers for people with limited English proficiency or low trust in institutions?
- How might the CCBHC model help address these systemic barriers?

How is CCN or the CCBHC (or both) affected by workforce challenges?

Follow-up questions and probes include:

- Is recruitment or retention the bigger challenge for CCN?
- Which positions or specialties are hardest to fill?
- How are staffing shortages affecting wait times, service quality, or access?
- What innovative strategies (e.g., partnerships, internships, telehealth staffing) could help fill workforce gaps?

As CCN expands under the CCBHC model, how can CCN best promote awareness of its comprehensive behavioral health and substance use services?

- What strategies (e.g., marketing, social media, word of mouth, community events) are most effective in your region?
- Which community or cultural organizations should CCN engage with to strengthen outreach?

Looking ahead, what are your top strategic priorities for improving behavioral health care in your community?

- What should CCN focus on in the next year to make the CCBHC model successful?
- How can leadership ensure accountability and sustainability for these efforts?
- Is there anything else you'd like to share about the CCBHC, partnerships, or community needs?

COMMUNITY CARE NETWORK (CCN)
CERTIFIED COMMUNITY BEHAVIORAL HEALTH CENTER (CCBHC)
COMMUNITY NEEDS ASSESSMENT

FOCUS GROUP QUESTION GUIDE: COMMUNITY PARTNER
v1.1// 13 NOVEMBER 2025

NOTES TO INTERVIEWER

- Questions to be asked are numbered in brackets and appear in Bold regular type.
- Probes and clarifying questions are in plain text.
- ASK all the BOLD, numbered questions. Ask probing questions as needed.
- Instructions to the interviewer are in brackets [...]

THE GOALS OF THE INTERVIEW ARE:

16) To understand the scope of behavioral health services currently provided by DCOs, including populations served and key areas of expertise.
17) To identify service gaps and unmet community needs from the perspective of external providers and partners.
18) To explore opportunities for collaboration and co-design of services between DCOs and CCN, including shared service delivery, referral processes, and workforce strategies.
19) To surface barriers to effective partnership, including operational, funding, staffing, or communication challenges.
20) To identify potential coalition-building strategies, shared goals, or regional initiatives that could enhance collective impact.
21) To understand DCO perspectives on how the behavioral health system can better serve clients—particularly those facing stigma, access barriers, or intersectional needs.

INTERVIEWER SCRIPT TO BEGIN [Please follow this script closely.]

Thank you very much for agreeing to speak with us today. This focus group is part of a needs assessment being conducted by CCN for the continued implementation of its Certified Community Behavioral Health Center program.

The purpose of this focus group today is to help us understand how you as a Designated Collaborating Organization or partner with CCN perceive the behavioral health needs and concerns in this community. This conversation should help the team create programming to address these needs and concerns. This focus group will take about 30 to 40 minutes to complete, and we will be done by [STATE TIME].

I am with an independent consulting group, TRX Development Solutions, that has been contracted by CCN to complete the needs assessment and provide program evaluation services to CCN.

As an independent evaluator, I assure you that this conversation is confidential. This means that we promise that your name will not appear on any needs assessment documents or in the focus group transcript. We will not provide the recording or transcript to CCN staff or leadership; only my TRX colleagues will read or work with your focus group.

We are going to audio-record this focus group. The audio file will be digital and stored in a password-protected file system that only the TRX evaluators have access to. We will have the audio file transcribed so that we will have a paper version of the conversation today that we will study to understand your experiences. Any names said in the course of the focus group will be transcribed as initials (for example, Michael Jordan will be "MJ"). The audio files and transcripts will not be available to staff or leadership at CCN. The needs assessment report will be confidential and aimed at providing aggregate results to CCN.

Statements that you make in the focus group may be quoted in needs assessment reports. No individual will be identified by name, though the source of the focus group will be noted, as in: "A participant in a DCO focus group stated ..."

If you wish to participate we will ask you to state, verbally, your consent to participate at the beginning of the recording. If you do not wish to participate, you may decline and leave. Declining to participate will not affect your work or any services you may receive from CCN and other organizations that provide health and human services. do you have questions about the process before we get started?

Facilitator: After addressing questions, allow a minute for those who wish to leave to do so. When the group is settled, begin the audio recording with a statement of the date, location, focus group ID code, and the following:

"All persons included in this audio recording were given a statement of informed consent describing the purpose of this focus group prior to the start of this recording. All who appear on the recording have consented to participate in this focus group."

Let's begin with introductions. Please describe your role and your organization's primary services in the behavioral health space. [Ice-breaker questions – move quickly for folks to introduce themselves and get a feel for how the group relates to CCN.]

- Who are your primary clients or populations?
- What are your organization's primary services related to behavioral health or social support?
- What services are you often asked to provide but cannot?
- When did you begin collaborating with CCN and in what ways?

From your organization's perspective, what are the top behavioral health needs in your community?

Follow-up questions and probes include asking for details about issues they raise or an example of their concern if it isn't clear. Some types of follow-ups are:

- Why is this a concern for your clients or community?
- Is this a new or growing need? Has it changed since COVID-19?
- What populations are most affected (by age, race, language, location, etc.)?
- What needs are currently unmet, and why?
- How do social factors like housing, food insecurity, or transportation contribute to these needs?

What is your organization's current relationship with CCN?

Follow-up questions and probes include:

- What led to your organization initially collaborating with CCN?
- What is working well?
- Where could collaboration be improved?
- Are there formal or informal referral processes in place?
- Would deeper collaboration (e.g., shared programming or funding) be feasible or beneficial?

Are there services you wish you could offer but don't have the resources to provide?

Follow-up questions can include:

- Where are the largest service gaps in your community (e.g., crisis care, substance use treatment, peer support, culturally specific services)?
- Would CCN be a good partner to help fill those gaps?
- Are there barriers related to hours of operation, location, staffing, or funding?
- What types of supportive services (e.g., food access, housing, transportation) do your clients need most?

Let's talk about the barriers clients face when accessing behavioral health or related services. What makes it hard for people in your community to find, start, or continue care?

Follow-up questions and probes include:

- Do people experience barriers related to language, transportation, cost, or scheduling?
- Are there wait times that deter clients from following through with services?
- What hours of operation would better meet community needs (e.g., evening or weekend options)?
- Are there particular cultural or linguistic needs not well met in the current system?

How do workforce or operational challenges affect your ability to serve clients or strengthen your partnership or collaboration with CCN?

Follow-up questions and probes include:

- Is your organization facing difficulties in recruiting, hiring, or retaining staff?
- Are there particular roles that are hardest to fill (e.g., bilingual clinicians, peer specialists, care coordinators)?
- What kinds of supports or joint efforts would help (shared trainings, supervision, recruitment pipelines)?

What are some strategies that may help improve client experiences?

Follow-up questions and probes include:

- Are clients confused by where or how to access services?
- Do clients face language barriers or long waitlists?
- How can CCN support more seamless client experiences across organizations?

How aware is the community of the services your organization and CCN provide?

Follow-up questions and probes include:

- What are the most effective ways to reach people who need behavioral health support (e.g., outreach events, social media, schools, cultural networks)?
- Are there gaps in community awareness or education about behavioral health and recovery?
- How could community partners support CCN in spreading awareness and building trust?

Any final reflections?

Follow-up questions and probes include:

- What's one thing CCN could do to be a better partner to your organization?
- What is one change that would make the biggest impact on behavioral health access or coordination in your community?
- Any other thoughts on how to make collaboration through the CCBHC model more effective or equitable?

Appendix B: Community Needs Assessment Survey (English)

CCN Community Needs Assessment Survey 2025

Purpose of the Survey

Community Care Network (CCN) is working to improve services by finding gaps in their service delivery and adding services the community needs. In this survey, we will ask a few questions about your experience as a community member or as an individual receiving services at CCN. Your response will help us provide better care.

If you do not want to answer any question, just skip it. Some questions provide the option to say, "prefer not to say." The survey will not ask for your name, which means it is anonymous. The company implementing the survey for CCN, TRX Development Solutions, is an independent organization.

Accommodations

CCN and TRX Development Solutions want to welcome all to access this survey. The survey is available in other formats on request. For persons who need help completing the survey, please contact Gina Cramer at gmcramer@trxdevelopment.com or Maddy Hatch at mrhatch@trxdevelopment.com with a callback number.

We appreciate your participation in this survey. If you complete the survey in full, you can enter into a random drawing for a $50 gift card. If you wish to participate in the random drawing you will be asked to provide your name and email address so TRX can provide you with the gift card.

If you wish to proceed with the survey, please continue below:

Are you currently receiving services at CCN?

O No	O No, but I previously received services from CCN
O Yes	O No, but I am interested in services at CCN
O No, but someone I know is	O I don't know, or I am not sure

If you are not being served by CCN, what is your connection to CCN or the community? (Select all that apply)

O I am a youth (under 18) in the community	O I represent a local substance use treatment provider
O I am an adult (age 18-64) in the community	O I represent law enforcement
O I am an adult (age 65+) in the community	O I represent a religious or fraternal organization
O I am a parent in the community	O I represent a civic or volunteer group
O I represent the business sector	O I am a healthcare professional

O I am a media representative	O I represent a state, local, and/or tribal government agency
O I am a school representative	O I represent a Vermont Abenaki tribe
O I represent another local service provider	

If you are being served by CCN, what kinds of services do you receive? (Select all that apply)

O Adult mental health or counseling and/or treatment	O Developmental Services
O Child mental health or counseling and/or treatment	O Substance use counseling and/or treatment
O Other services: _____	

What are your top 5 health or social concerns in your community? Please select up to 5.

___Access to services

___Adequate housing (including affordable and safe housing)

___Affordability of care

___Cultural and/or language barriers

___Homelessness

___Lack of providers that look like the populations served

___Mental health

___No insurance or limited insurance

___Not knowing where to go for services

___Staff changes to my care team

___Stigma

___Substance use

___Trauma

___Trust in providers

___Unemployment

___Violence

___Other: _____

Please describe the challenges you face seeking or receiving services for these concerns.

_____

_____

_____

_____

_____

What are the top 5 services that are needed to improve the health of your community? Please select up to 5.

___Affordable childcare

___Employment

___Environmental (water/soil/air pollution, lead, etc.)

___Food security

___Health and wellness

___Health insurance

___Housing

___Primary/Medical care

___Mental health

___Services and programming for age 65+

___Services for youth and young adults

___Sex education

___Substance use

___Transportation

___Violence prevention/safety

___Other: _____

Please describe the challenges you face seeking or receiving these services.

_____

_____

_____

_____

How do you usually find out about or get referred to services? (Select all that apply)

O Friends, family, or neighbors	O Schools
O Healthcare providers	O Flyers, posters, or community bulletin boards
O Community organizations	O Online searches or websites
O Faith-based organizations	O Other: _____

When seeking services, how important are the following factors?

	Not at all important	Somewhat important	Very important
Cost/affordability	O	O	O
Has evening or weekend hours	O	O	O
It's close to home	O	O	O
Meets my cultural/linguistic needs	O	O	O

What days and times would work best for you to receive services? (Select all that apply)

O Weekday Mornings (8AM-12PM)	O Weekend Afternoons (12PM-5PM)
O Weekday Afternoons (12PM-5PM)	O Weekend Evenings (5PM-8PM)
O Weekday Evenings (5PM-8PM)	O 24/7 Crisis Availability Needed
O Weekend Mornings (8AM-12PM)	

What language would you like to use when receiving services at CCN?

O English	O French
O Spanish	O Another language not listed: _____

If you would like to use a language other than English, how hard is it to receive services in this language?

O Not at all hard	O Somewhat hard	O Very hard

How do you prefer to receive services at CCN? (Select all that apply)

O In-Person: Office-based	O Telehealth
O In-Person: Community-based	

Do you have reliable access to a phone?

O Yes	O No

Do you have reliable access to the internet?

O Yes	O No

Are there things that CCN could do to make the experience of seeking and receiving services better? Please describe them in a few words:

_____

_____

_____

_____

How important is substance use, addiction, or recovery in your community?

O Not at all important	O Somewhat important	O Very important

How much do mental health and substance use providers care about you?

O Completely	O Mostly	O Somewhat	O Rarely	O Never

Do your providers try to answer your questions in a way that you can understand?

O Never	O Rarely	O Sometimes	O Mostly	O All the time

Have you or a family member ever been connected to the U.S. Armed Forces, National Guard, or Reserves?

O Not a Veteran or Military Family Member	O Veteran (previously served, not currently active)
O Active Duty	O Military Family Member (immediate family)
O Activated Guard/Reserve	O Prefer not to say
O Guard/Reserve – Not Active	

Where do you live most of the time?

O Rutland	O Clarendon	O Poultney	O Brandon
O Castleton	O West Rutland	O Pittsford	O Proctor
O Wallingford	O Fair Haven	O Other: _____	

What is your age?

O Please write your age: _____	O Prefer not to say

How do you identify?

O Male	O Gender non-conforming
O Female	O Another gender:
O Transgender (male to female)	_____
O Transgender (female to male)	O Prefer not to say

Do you consider yourself as…

O Gay	O Pansexual
O Lesbian	O Heterosexual or straight
O Bisexual	O Any other sexual orientation not listed here
O Queer	O I would prefer not to say

Are you Hispanic, Latino/a, or of Spanish origin?

O No	O Yes	O Prefer not to say

What is your race? (Select all that apply)

O Black or African American	O Asian
O White	O Native Hawaiian
O American Indian	O Other Pacific Islander
O Alaska Native	O Prefer not to say
O Another race (please describe): _____	

Would you like to be entered into a random drawing for a $50 gift card?

O No	O Yes	

Please provide your name and contact information.

Name:	
Email Address:	

Appendix C: Survey Recruitment Materials (English)

WE WANT TO HEAR FROM YOU!

TAKE THE COMMUNITY CARE NETWORK COMMUNITY NEEDS ASSESSMENT SURVEY

Help Community Care Network (CCN) improve programming and expand care in our community. Answer a few short questions about your experience as a community member or an individual receiving services at CCN.

Scan the QR code or click the link to take the survey: https://tinyurl.com/yc2zktt3

Complete the survey for the chance to receive a $50 gift card!

Community Care Network
Rutland Mental Health Services | Rutland Community Programs

The survey is available in other formats on request. For persons who need help completing the survey, please contact Maddy Hatch at mrhatch@trxdevelopment.com with a callback number.

Appendix D: Additional Data Tables

Table D1. Cost-Burdened Households

	Rutland County	Vermont
Cost-burdened households (total)	8,245 (33%)	82,578 (31%)
Cost-burdened owner households	4,843 (26%)	47,948 (24%)
Cost-burdened rental households	3,402 (49%)	34,630 (47%)

Table D2. Employment Status of Populations Aged 25 to 64 Years Old

	Rutland County	Vermont	United States
Armed Forces Service Members, Veterans	44 (0.1%)	406 (0.1%)	1,100,000 (0.4%)
Employed	30,100 (59.4%)	327,000 (62.9%)	148,000,000 (58.4%)
Unemployed	1,757 (3.5%)	17,100 (3.3%)	11,800,000 (4.7%)
Not in the labor force	18,800 (37.1%)	175,000 (33.7%)	92,500,000 (36.5%)

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