

# CITY OF BOSTON SUBSTANCE ABUSE TREATMENT AND RECOVERY SERVICES Findings and Recommendations



**FOUNDATION**  
MASSACHUSETTS

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prepared by:



**DMA**  
**Health**  
**Strategies**

[www.dmahealth.com](http://www.dmahealth.com)  
781-863-8003

# PRESENTATION OVERVIEW

- Project Objectives
- Research Questions
- Research Approach
- Assessment Activities, Data Sources and Limitations
- Findings and Recommendations (organized by research question)

# PROJECT OBJECTIVES\*

1. Identify the need, demand and capacity of addiction and recovery services in Boston.
2. Based on identified gaps between need/demand and capacity, develop recommendations to enhance and improve the current system of care, including specific suggestions for the role and activities of the Mayor's Office of Recovery Services.

\*Prevention is not in the scope of this report but will ultimately be addressed once the Office of Recovery Services is implemented.

1. What is the current need and demand for addiction and recovery services in Boston?
2. What is the current capacity (number of services or type of services) of substance use disorder services in Boston?
3. What are the gaps in Boston's addiction treatment and recovery services?
4. What are the most effective ways to close these gaps and expand access to addiction treatment and recovery for Boston residents?

# OVERVIEW: BOSTON ADDICTION AND RECOVERY SERVICES ASSESSMENT ACTIVITIES

## CULTURALLY COMPETENT INFORMATION-GATHERING PROTOCOLS

### Interviews

Policy officials

Providers  
(by level of  
care)

Payors

### Focus Groups

Neighborhood  
task forces,  
coalitions and  
community  
leadership

### Quantitative Data

Need and  
demand for  
treatment

Capacity  
(inventory  
of treatment  
and recovery  
services)

### Best Practices

Existing  
literature

Tailored  
approaches  
to effective  
strategies

### Blueprint

Summary of  
need (current  
and projected)

Matrix of  
best practices

Strategies to  
meet need

## NEEDS OF SPECIAL POPULATIONS AND THE UNDERSERVED

# BACKGROUND ON CITY OF BOSTON

The City of Boston covers 48 square miles and had a population of 645,966 in 2014.



- 11 focus groups:
  - Community and faith leadership
  - Detox providers
  - Addiction treatment providers at all levels of care
  - Persons in all phases of recovery
- 29 face-to-face and telephone interviews with state and local leaders with expertise and experience related to addiction treatment and/or recovery support services and health insurance

| NEED AND DEMAND  | CAPACITY   |
|--|--|
| National Survey on Drug Use and Health (NSDUH), 2012                     | DPH, Bureau of Substance Abuse Services (BSAS) Licensure Records |
| Boston Behavioral Risk Factor Survey Surveillance System (BRFSS)         | BSAS Enrollment Data   |
| MA Center for Health Information and Analysis (CHIA)                     |  |
| MA Department of Public Health (DPH), Bureau of Substance Abuse Services |  |

\*Data pertaining to the smallest geographic region (i.e., US, MA, Boston, Boston neighborhood) were used whenever possible. There are limited quantitative data available at the local level.



# DATA LIMITATIONS

| DATA SOURCE/ELEMENT  | LIMITATIONS  |
|--|--|
| <b>NSDUH</b>   | Can only be used to capture national and state trends; self-reported.  |
| <b>BSAS*</b>   | Licensing data include capacity data (beds) for hospital and residential services statewide (inclusive of services in the City, but not solely available/utilized by Boston residents); provider-reported (underreporting likely in most categories of service). |
| <b>APCD</b>  | Not available for this project.  |
| <b>Racial/Ethnic</b>                                       | Not available for all data sets.   |
| <b>Neighborhood Level Data<br/>(within City of Boston)</b> | Different agencies have different geographic boundaries (used BPHC neighborhoods except for BPD data that uses a derivation of BRA neighborhoods for police districts).  |

\*Does not include out-of-state or non-licensed facilities (such as ambulatory and community services or outpatient services).

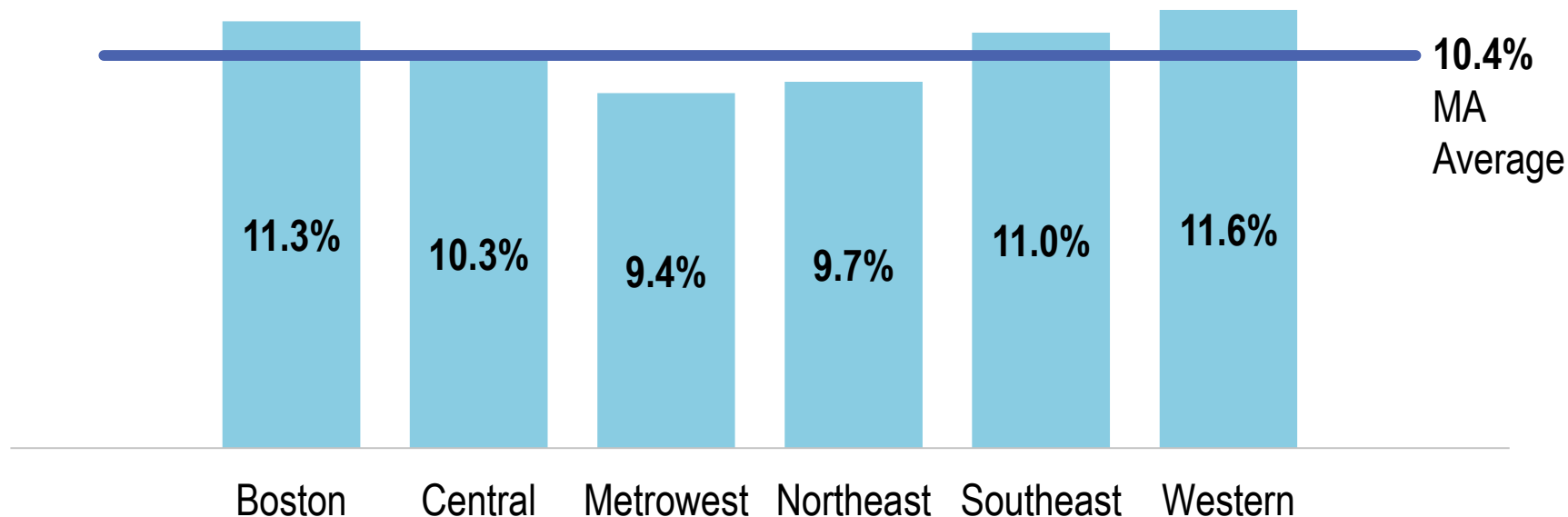
### KEY LIMITATIONS:

- There are limited data that assess the extent of substance use/misuse and the need or demand for treatment at the local (i.e., City) level.
  - To account for this limitation, the methodology employed in this report is to examine the quantitative data that is available (at the national, state and local levels). These data are then supplemented with qualitative information acquired through interviews and focus groups with individuals engaged at all levels of the substance use disorder services system within the City of Boston.
  - This approach enables us to credibly “tell a story” about the need for treatment, demand for treatment and utilization of treatment in Boston.



**What is the current need and demand for addiction and recovery services in Boston?**

## THE PREVALENCE OF SUBSTANCE USE DISORDER IN BOSTON (~11%) APPEARS COMPARABLE TO STATEWIDE TRENDS.



Note: For specific definitions of substate regions, see the “2008-2010 National Survey on Drug Use and Health Substate Region Definitions” at <http://www.samhsa.gov/data/NSDUH/substate2k10/RegionDefinitions/NSDUHsubstateRegDefs2010.htm>. The substate regions defined in the NSDUH are based on information provided by the state’s Bureau of Substance Abuse Services, Massachusetts Department of Public Health, and are defined in terms of census tracts from the 2000 decennial census within the State’s 14 counties.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health.  
Table 21 - <http://www.samhsa.gov/data/NSDUH/substate2k10/ExcelTables/NSDUHsubstateExcelTabsTOC2010.htm>

# THE PREVALENCE OF SUBSTANCE USE DISORDER IN MASSACHUSETTS IS HIGHER AMONG HISPANICS/LATINOS, MALES, PEOPLE LIVING IN POVERTY AND THE UNINSURED.

## KEY INDICATORS:

- In MA, rates of substance use disorder (SUD) are highest for Hispanic/Latino adults (15% ) as compared with Whites (10%), Blacks (6%) and Asians (6%) (National Survey on Drug Use and Health, 2012).
- In MA, poverty is strongly correlated with rates of SUD. Compared with the rate of SUD incidence among people whose incomes are over 200% of the federal poverty level (FPL), rates of SUD double when income is between 100% and 199% FPL and triple at less than 100% FPL (National Survey on Drug Use and Health, 2012).
- In MA, rates of SUD are highest for the uninsured (21% ) as compared with Medicaid members (17%) or those with private insurance (9%) (National Survey on Drug Use and Health, 2012).

## AVAILABLE DATA SUGGEST RATES OF ALCOHOL AND HEROIN ABUSE ARE HIGH — AND POTENTIALLY GROWING — IN BOSTON.

### KEY INDICATORS:

- In 2012, White respondents in Boston reported the highest incidence of binge and heavy drinking (33.1% and 13.6%) compared with other races/ethnicities. Within the City, South Boston had the highest incidence of binge drinking and heavy alcohol consumption (Boston Behavioral Risk Factor Survey, 2013).
- The unintentional heroin overdose hospital patient rate per 100,000 population in Boston increased by 76% from FY 2010 (37.6 per 100,000) to FY 2012 (66.1 per 100,000) (CHIA 2013).
- The number of patients in Boston hospitals for non-overdose opioid (including heroin) dependence and abuse (i.e., those with a heroin-related ICD-9 diagnosis) increased by 13% (from n=2,105 to n=2,384) from FY 2011 to FY 2012.

## BOSTON HOSPITAL ED AND INPATIENT ADMISSIONS FOR SUBSTANCE USE DISORDER DIAGNOSES DEMONSTRATE THE NEED FOR TREATMENT PROGRAMS.

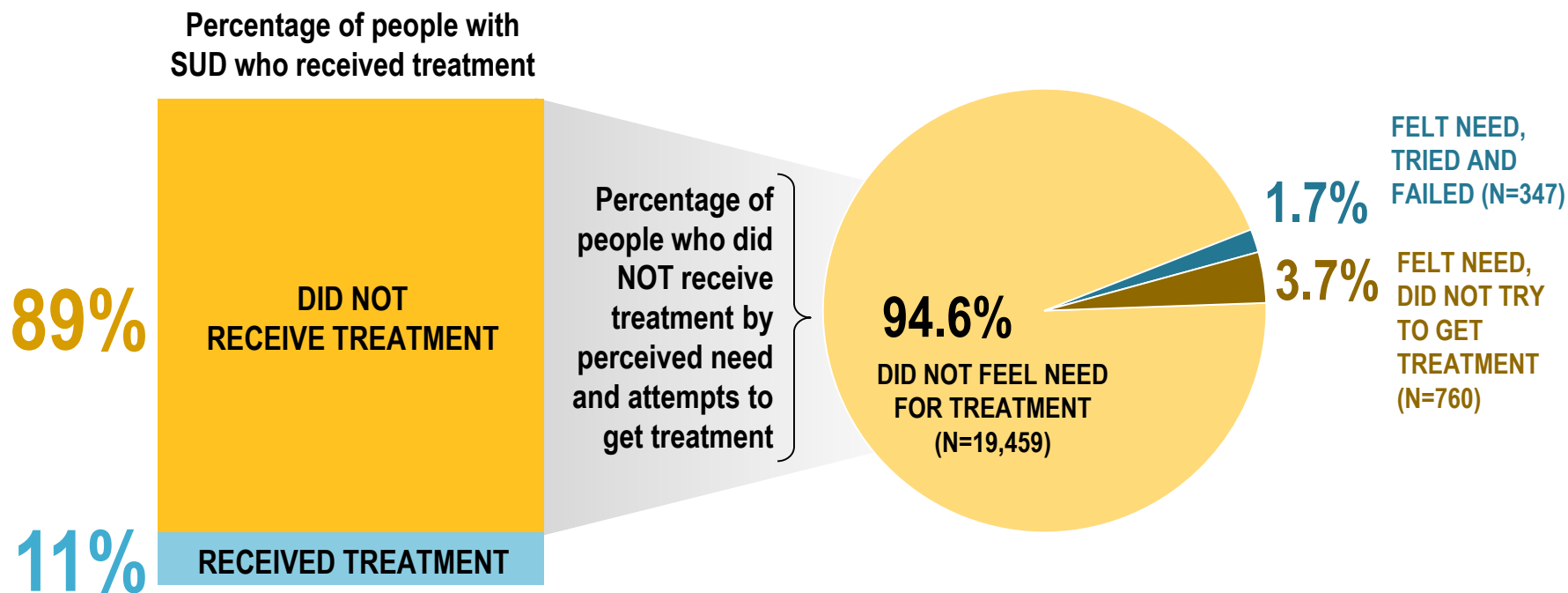
- Close to 1 in 10 (about 8% or 71,000) of all Boston hospital emergency department (ED) visits and 1 in 20 (about 5% or 291,000) of all inpatient admissions in 2012 were SUD-related (CHIA, 2012).
- The majority of SUD ED visits were by White (74%) and male (54%) patients.
- Opioids (including heroin) were most commonly implicated in unintentional overdoses/poisonings for ED patients, followed by alcohol, benzodiazepines and cocaine.
- The South End\* had the highest rate of SUD-related ED visits (12,086 per 100K population), followed by South Dorchester (6,825 per 100K population) and Mattapan (5,092 per 100K population).

\*Potentially explained by a high transitory population in this neighborhood.

## DATA SUGGEST THAT DESPITE THE NEED FOR SERVICES, DEMONSTRATED DEMAND FOR SERVICES MAY BE RELATIVELY LOW.

### National data indicate that the majority of people with SUD do not receive treatment.

(US NSDUH data; MA data not available)



Of the 89% of US respondents who indicated not receiving treatment, most of these (95% , N=19,459) did not “feel the need for treatment” (awareness). A very small number (<2%) tried to get treatment and failed (access).





**What is the current capacity of  
substance abuse treatment services  
in Boston?**

## OVERVIEW OF MASSACHUSETTS ADDICTION TREATMENT PROGRAMS (BASED ON BSAS LICENSURE)

- The Bureau of Substance Abuse Services (BSAS) oversees substance abuse prevention and treatment services in the Commonwealth.
- The substance use disorder treatment system is a statewide system.
  - Residents, including Boston residents, are not prioritized for programs based upon their address of residence.
  - Residents from any region can enroll in a treatment program in any location in the state.
  - As of 11/1/14, BSAS-licensed programs in MA include:
    - 25 adult detox programs, including 868 beds
    - 2 adolescent detox programs, including 48 beds
    - 11 clinical stabilization service programs, including 297 beds
    - 10 adult transitional support services programs, including 389 beds
    - 79 adult residential treatment programs, including 2,281 beds
    - 9 family residential programs, including 117 beds
    - 9 adolescent and young adult residential treatment programs, including 144 beds
    - 119 outpatient counseling programs
    - 38 opioid treatment programs (methadone and Suboxone)

## AMONG THE BSAS-LICENSED PROGRAMS IN MA, MANY ARE LOCATED WITHIN THE CITY OF BOSTON THOUGH NOT RESTRICTED TO BOSTON RESIDENTS.

BSAS-licensed programs located in Boston include:

- 5 detox programs (153 beds\*) (18% of statewide bed capacity)
- 3 adolescent and young adult residential treatment programs (45 beds) (31% of statewide bed capacity)
- 23 adult residential treatment programs (690 beds\*\*) (30% of statewide bed capacity)
- 2 family residential programs (34 beds) (29% of statewide bed capacity)
- 2 transitional support services programs (71 beds\*\*\*) (18% of statewide bed capacity)
- 1 clinical stabilization service program (22 beds) (7% of statewide bed capacity)
- 29 outpatient counseling programs (24% of statewide program capacity)
- 5 opioid treatment programs (methadone and Suboxone) (13% of statewide program capacity)

### Notes:

The Boston Public Health Commission (BPHC) operates several of the BSAS-licensed programs across the treatment continuum. BPHC relies on an allocation from BSAS and federal grant funds to support its operation of these services. Like all treatment services, these programs serve both Boston and non-Boston residents.

\*Including 60 beds relocated from Long Island.

\*\*Including 157 beds relocated from Long Island.

\*\*\*Including 43 beds relocated from Long Island.

## THE TOTAL VOLUME OF “ENROLLMENTS” IN AVAILABLE TREATMENT PROGRAMS AMONG BOSTON RESIDENTS HAS REMAINED CONSISTENT.

- From 2011 to 2014, the total number of “enrollments” (defined as unique treatment episodes for a given individual within a single level of care\*) for Boston residents in BSAS-licensed programs has held steady at about 16,000 per year.
- Analysis of treatment enrollments\* indicates:
  - Alcohol is the most frequently reported primary, secondary or tertiary drug of abuse among enrollments for Boston residents (58%), followed by heroin (52%), crack/cocaine (33%) and marijuana (21%).
  - A meaningful differentiation in enrollments among Boston residents exists between men (73%) and women (23%) and between Whites (56%), Blacks (21%), and Hispanics (18%).
    - Findings from the qualitative analysis also suggested that it is easier to access treatment if you are white; treatment providers indicated higher numbers of white clients referred to their programs.

\*This means that one individual may be counted several times in measuring enrollment. ***Therefore, analysis of these data are to be interpreted with significant caution, as statistics may be skewed by multiplicative representation of particular individuals.*** This approach also inhibits accurate neighborhood reporting.

Source: Office of Data Analytics and Decision Support, Bureau of Substance Abuse Services, Massachusetts Department of Public Health

## A VARIETY OF ADDITIONAL ADDICTION AND RECOVERY RESOURCES ARE AVAILABLE IN BOSTON.

- In addition to the BSAS-licensed programs described previously, in Boston BSAS also funds:
  - Case management to assist people in maintaining their recovery through supportive housing, community engagement and peer support
  - Naloxone distribution programs for bystanders and first responders (14 programs with 19 sites)
  - Learn to Cope Parent and Family Support Group (one program with 12 sites)
  - Recovery high school (Ostiguy)
  - Recovery support centers (Devine and StepRox)

## A VARIETY OF ADDITIONAL ADDICTION AND RECOVERY RESOURCES ARE AVAILABLE IN BOSTON. (CONT'D)

- Community health centers also provide a valuable treatment resource to Boston residents.
  - Working on accurate program counts in coordination with the Massachusetts League of Community Health Centers.
- In addition, several other organizations provide critical substance use disorder and recovery support services, including:
  - STRIVE
  - Salvation Army
  - Mutual aid groups (e.g., NA, AA)
  - 20+ sober homes
  - Private therapists who provide addiction treatment services



**What are the gaps in Boston's addiction treatment and recovery services?**

## BOSTON HAS PROPORTIONALLY MORE TREATMENT AND RECOVERY BEDS THAN THE REST OF MASSACHUSETTS.

- According to the State Health Planning Council, the City of Boston has a significantly higher density of treatment and recovery beds (detox, residential, transitional support services and clinical stabilization services) relative to its population than any other area of the state.
  - Boston has 152 beds per 100,000 residents.
  - The Metro Boston region\* has 20 beds per 100,000 residents.
  - Central Mass and Cape Cod have approximately 42 beds per 100,000 residents.
  - Metro West has the lowest bed density, at 10 beds per 100,000 residents.

\* The Census Bureau defines “Metro Boston” as Boston, Cambridge, Framingham, Newton, Peabody, Quincy, Waltham.



## HOWEVER, MUCH OF BOSTON'S CAPACITY IS USED BY INDIVIDUALS FROM OUTSIDE THE CITY OF BOSTON.

- As previously noted, the Massachusetts substance abuse treatment system is a statewide system. Referrals and placements are not limited to an individual's own geographic area.
- There are significant shortfalls in capacity in parts of the state outside Boston.
- At any given time, almost half of Boston's addiction treatment and recovery residential capacity is filled by individuals from outside Boston.
- Therefore, Boston's capacity gaps reflect needs beyond those of Boston residents.

## THERE IS NOT SUFFICIENT CAPACITY FOR CITY RESIDENTS IN NEED OF DETOXIFICATION.

- Interviews and focus groups with key stakeholders indicate a shortage of both level 3.7 and level 4 detox capacity.
  - Level 3.7 is medically monitored; level 4 is medically managed.
- BSAS-licensed detox programs routinely run at full capacity (97% occupancy).

## THERE IS ALSO INSUFFICIENT RESIDENTIAL TREATMENT CAPACITY FOR BOSTON RESIDENTS.

- According to state data, the wait times for residential placements averaged approximately 23 days in 2014.
  - Wait times ranged from 6 to 118 days.
- Residential treatment programs are operating at almost full (90%) capacity.
- Disruption in the transition from detox to residential treatment pose significant challenges to individuals in recovery.

## STAKEHOLDERS ALSO AGREE THAT THE LACK OF COORDINATION ACROSS THE SYSTEM IS A MAJOR GAP.

- Beyond any specific type of program capacity, stakeholders identify the challenges associated with any transitions in care as a major gap in the system.
- There are often gaps in time between discharge from one level of care and admission to another, presenting major risks for relapse.
- There is often insufficient discharge planning, a lack of “warm hand-offs” from one placement to another, insufficient case management and limited system navigation support.
- There is no easy-to-access, centralized source of information about the availability and location of treatment capacity to which to refer people in need.

## THERE ARE MANY OTHER GAPS IN WHAT BOSTON WOULD CONSIDER A HIGH-QUALITY SYSTEM OF CARE.

- According to all interviewed stakeholders, more community-based recovery support services are needed (recovery coaches, sober housing, recovery centers tailored to City residents' specific needs).
- Services are not adequate for certain populations (females, cultural and linguistic minorities and people who are homeless or have serious mental illness, traumatic brain injury and/or PTSD).
- Program policies can be barriers to access (admission criteria, length of stay limits, state policy barriers for moving between services, lack of treatment on demand or when first needed).
- Health insurance issues can be barriers (pre-authorization requirements, length of stay limits, insufficient reimbursement rates, wait times between levels of care, lifetime limitations, continued lack of parity, client confusion about coverage, differences in coverage by public vs. private insurance).

## THERE ARE MANY OTHER GAPS IN WHAT BOSTON WOULD CONSIDER A HIGH-QUALITY SYSTEM OF CARE. (CONT'D)

- While many programs are attempting to deliver evidence-based practices, there is no system for monitoring fidelity to those models or for ongoing training to ensure fidelity.
- Despite the high prevalence of substance use disorder, mental health and primary care co-morbidities, there are few primary care or mental health providers adequately trained in identifying or treating substance use disorder issues.
- Stigma around substance use disorders is a major barrier for individuals and families in recognizing problems and seeking care.

## ADDITIONAL SERVICES BEYOND TREATMENT ARE MISSING TO SUPPORT RECOVERY FROM ADDICTION.

- Housing – the lack of adequate permanent housing presents a major challenge for individuals attempting recovery.
- Employment – job training and employment support are critical components for sustained recovery for many individuals.
- CORI reform – current policies regarding criminal justice history can prevent access to both housing and vocational services.
- Alternatives to criminal adjudication and sentencing – many individuals, including a disproportionate percentage of people of color, end up in the criminal justice system rather than the substance use disorder treatment system.

## MANY FACTORS SUGGEST THAT THE BARRIERS TO ACCESS FOR BOSTON RESIDENTS WILL ONLY GROW IN THE FUTURE.

- The Metropolitan Area Planning Council projects the Boston population to grow 7.5% between 2014 and 2020.
- If capacity were to remain the same, the access gap would increase proportionately.
- However, several factors may further augment the need for addiction treatment and recovery services:
  - Given the established connection between gambling and alcohol use, the introduction of casinos to Massachusetts is likely to increase the prevalence of substance use disorder.
  - While data is not yet available from other states, it seems reasonable to anticipate that the introduction of medical marijuana and the potential of legalizing marijuana will increase the potential for substance use disorder.
  - There is a growing epidemic of opioid use and overdose, most evident in younger populations. This is evident through overdose data, EMS transport data, treatment enrollment data and qualitative information gathered in discussion groups and interviews.



## MANY FACTORS SUGGEST THAT THE BARRIERS TO ACCESS FOR BOSTON RESIDENTS WILL ONLY GROW IN THE FUTURE. (CONT'D)

- In addition, project stakeholders report that:
  - There are shifts in drug sale trends to younger dealers, potentially leading to younger involvement in drug use.
  - Alcohol abuse is on the rise within the elderly population.
  - Substance use disorders are often a co-morbidity of PTSD among veterans, especially female veterans.



### THE ROAD MAP

**What are the most effective ways to close these gaps and expand access to addiction treatment and recovery for Boston residents?**

## IN THE SHORT TERM, ADDITIONAL CAPACITY IS NEEDED.

- Based on our stakeholder interviews and available data regarding need and supply, occupancy rates and wait times:
  - Additional detox capacity is needed.
  - Additional residential treatment capacity is needed.
- Over the longer term, as more of the other gaps in the current system are addressed, including those in outpatient treatment, housing and recovery support services, the demand for inpatient and residential capacity should decrease.

## ADDITIONAL RESOURCES ARE NEEDED TO CLOSE THE GAPS AND EXPAND ACCESS.

- A central source of real-time information on available treatment beds and outpatient services
- A more cohesive and integrated continuum of care to reduce relapse and increase rates of retention during transition points
  - Encouragement of formal referral arrangements between organizations
  - Support for integration of levels of care within single organizations
  - Public and private payment reform to support such delivery system reform
- Expanded care coordination and system navigation services
- Better data collection and reporting regarding need, demand and capacity
  - Data collection including needs of specific populations and cultural competence\*

\*Effective data collection will require collaboration between the City, state and private sector, which will be difficult to achieve in a short period of time.

## ADDITIONAL RESOURCES ARE NEEDED TO CLOSE THE GAPS AND EXPAND ACCESS. (CONT'D)

- Advocacy for implementation of evidence-based practices
- Monitoring and training to ensure fidelity to evidence-based practices and services
- Support for pre- and post-trial alternatives with City, county and state criminal justice systems
- Expanded education and awareness programs in Boston public schools and other community settings
- Establishment of an Office of Recovery Services in the Mayor's Office to drive visibility, commitment, collaboration and accountability for improved access across the City

## RECOMMENDED ROLES AND ACTIVITIES FOR THE OFFICE OF RECOVERY SERVICES

- To increase access to a continuum of high-quality addiction treatment and recovery services in the City of Boston, the Office of Recovery Services should be the lead agency in the City to advance the following:
  - Client-centered service capacity
  - Partnerships with other government entities as well as private providers and other organizations
  - Increased public awareness and advocacy about addiction and recovery

## RECOMMENDATION 1: EXPAND CAPACITY OF DETOX, RESIDENTIAL AND RECOVERY SUPPORT SERVICES FOR RESIDENTS OF BOSTON.

### Activities: Year 1

- Work with the state to increase level 3 and level 4 detox beds and residential treatment capacity in Boston, and statewide.
- Advocate for increased capacity at PAATHS and AHOPE programs. Expand staff to see more clients, add new staff resources for screening and assessment, service navigation and peer recovery support, and extend hours of the programs.
- Advocate for the expansion of primary care substance use disorder navigation pilot at PAATHS to 3-4 community health centers in the neediest neighborhoods.
  - **Preliminary indicator:** The South End, South Boston and Mattapan have the highest rates of SUD ER visits; South Dorchester, Charlestown and Jamaica Plain have the highest rates of unintentional overdose; and South Boston has the highest rate of alcohol abuse.

## RECOMMENDATION 2: ENSURE FAIR & EQUAL ACCESS TO ALL LEVELS OF TREATMENT AND RECOVERY SERVICES.

### Activities: Year 1

- In order to provide real-time information about available capacity, collaborate with BSAS to support and enhance their new access and referral system and the proposed regional access center(s) in Boston.
- Propose a regional planning approach with BSAS to facilitate linkages within the broader Metro Boston region.
- Identify specific service gaps for special populations and ensure that existing and new programs are culturally competent.
- Employ an ombudsman for individuals and families to advocate for access to services and track and respond to client complaints. Collaborate with BSAS in review of experience and findings.



# CLIENT-CENTERED SERVICE CAPACITY (CONT'D)

## RECOMMENDATION 3: ADVOCATE FOR THE INCREASED USE OF EVIDENCE-BASED TREATMENT AND RECOVERY SUPPORT PRACTICES IN THE CITY OF BOSTON.

Activities: Year 2 & 3

- Develop an inventory of effective recovery support services, catalogue available services and develop an online database of services.
- Support the use of substance abuse navigation and SBIRT in Boston hospitals.
- Sponsor “Winner's Circles” (mutual self-help groups with special events such as job fairs, GED sign up, CORI seminars).

## RECOMMENDATION 4: PROVIDE INFORMATION TO USERS’ FAMILIES AND LOVED ONES TO SUPPORT THEM IN ACCESSING TREATMENT AND RECOVERY SERVICES.

Activities: Year 2 & 3

- Facilitate family support programs and ensure that recovery support programs offer services for family and loved ones.
- Support community organizations in identifying families at risk and assisting them with access to needed services.

# PARTNERSHIPS WITH GOVERNMENT, PROVIDER AND OTHER ORGANIZATIONS (CONT'D)

## RECOMMENDATION 1: DEVELOP A THREE-YEAR CITYWIDE INTERAGENCY ACTION PLAN TO ADDRESS ADDICTION PREVENTION, TREATMENT AND RECOVERY SUPPORT SERVICES, WITH STRATEGIC GOALS, OBJECTIVES, ACTION STEPS, TIMELINES AND RESPONSIBLE AGENCIES.

### Activities: Year 1

- Continue to convene the Mayor's Advisory Council on Treatment and Recovery Services to develop and oversee the Citywide action plan, consistently share information and identify responses to trends in drug use and related issues.
- Develop an emergency preparedness plan to ensure swift and coordinated responses to unforeseen incidents (e.g., the sudden closure of facilities).
- Convene a State and Local Government Interagency Task Force of senior officials to focus on the following issues:
  - Services for youth and young adults
  - Services for women with children
  - Community prevention
  - Payors, hospitals and other providers
- Ensure that people in recovery are represented in a meaningful way on the Mayor's Advisory Council, task forces and subcommittees.
- Develop a strategy in coordination with the City unions for ensuring access to treatment for union members.

# PARTNERSHIPS WITH GOVERNMENT, PROVIDER AND OTHER ORGANIZATIONS (CONT'D)

## RECOMMENDATION 2: DRIVE JOINT EFFORTS TO IMPROVE INTERAGENCY COORDINATION AND DRUG USE OUTCOMES. USE TREND INDICATORS TO IDENTIFY TARGET NEIGHBORHOODS.

### Activities: Year 1

- Work with other City agencies, the state and other public and private payers to develop a more robust system of housing, treatment and recovery supports.
- Implement a Boston Police Department/District Attorney/Boston Municipal Court Pre-Arrest Diversion pilot for adult drug offenders.
  - **Preliminary indicator:** BPD arrest data indicate that the Central Division, Mattapan and Roxbury have the highest rate of drug arrests.
- Support the continued statewide expansion and enhancement of Drug Courts.
- Develop Boston Community Center/Substance Abuse Navigator and Clinical Partnerships (youth and adolescents).
  - **Preliminary indicator:** City leadership discussed a need for greater youth and adolescent intervention in South Dorchester, East Boston, Mattapan and the South End.

# PARTNERSHIPS WITH GOVERNMENT, PROVIDER AND OTHER ORGANIZATIONS (CONT'D)

## RECOMMENDATION 3: CONSISTENTLY COLLECT, ANALYZE AND TRACK DATA ON ADDICTION, TREATMENT AND RECOVERY SERVICES TO INFORM TIMELY AND APPROPRIATE INTERAGENCY RESPONSES.

### Activities: Year 1

- Advocate that DPH/BSAS collect enrollment data by zip code to more clearly track patterns of neighborhood-level treatment enrollments.
- Ensure comprehensive and reliable data are collected from all sources at the City level related to substance use disorder need, demand and utilization of services.

## RECOMMENDATION 4: CONSISTENTLY COLLECT, ANALYZE AND TRACK DATA ON ADDICTION, TREATMENT AND RECOVERY SERVICES TO INFORM TIMELY AND APPROPRIATE INTERAGENCY RESPONSES.

### Activities: Year 2 & 3

- Develop and host a “dashboard” of the trends in key data indicators that provide a 360-degree perspective on need, demand and use of treatment (e.g., EMS NRI transports, BPHC AHOPE and PAATH admissions, hospital ER admissions, drug arrests, drug charge arraignments, naltrexone reversals).
- Ensure that the Office of Recovery Services and BPHC have access to the All-Payor Claims Database to monitor and analyze the use of treatment services.

# PARTNERSHIPS WITH GOVERNMENT, PROVIDER AND OTHER ORGANIZATIONS (CONT'D)

## RECOMMENDATION 5: CONVENE AND SUPPORT COORDINATION OF GOVERNMENT AND UNIVERSITY EFFORTS RELATED TO ADDICTION, TREATMENT AND RECOVERY SERVICES.

### Activities: Year 2 & 3

- Coordinate a U.S. Conference of Mayors, National League of Cities and Mass. Municipal Association summit to raise awareness and share best practices.
- Link to BSAS certification efforts and credit-granting educational institutions to provide participants with credit toward certifications and degrees to support a career ladder within the substance use disorder treatment system.

# PARTNERSHIPS WITH GOVERNMENT, PROVIDER AND OTHER ORGANIZATIONS (CONT'D)

**RECOMMENDATION 6: IN COORDINATION WITH BOSTON UNIVERSITIES, DEVELOP AND OPERATE A BOSTON ACADEMY OF ADDICTION AND RECOVERY (THE ACADEMY) TO RAISE THE BAR OF PROFESSIONAL PRACTICE AND ENSURE EXCELLENCE IN BOSTON SUBSTANCE USE DISORDER SERVICES AND SUPPORT.**

## Activities: Year 2 & 3

- Maintain an online inventory of technical-assistance and training providers and evidence-based practices for treatment and recovery.
- Leverage existing trainings through a comprehensive inventory of available training and education.
- Share technical assistance and cross-training: Agencies with a special expertise offer training to other agency personnel in exchange for training their staff. Joint training events with City agencies: The Academy can sponsor training days offered by state and City agencies.
- Co-sponsor trainings in the evidence-based strategies identified in the matrix, such as culturally competent practices, screening and assessment and trauma-informed treatment.
- Identify public and private funding: The Academy should seek funding for scholarships for various courses or funding for specific training events, curriculum development, symposia, etc.

Other potential partners include the New England Institute of Addiction Studies, MOAR, ATTC, the Center of Excellence for Specialty Courts, IHR, IHI, the National Center for Trauma-Informed Care, the Mass. Council on Compulsive Gambling, health care providers and hospitals.

# PARTNERSHIPS WITH GOVERNMENT, PROVIDER AND OTHER ORGANIZATIONS (CONT'D)

**RECOMMENDATION 6 (CONT'D): IN COORDINATION WITH BOSTON UNIVERSITIES, DEVELOP AND OPERATE A BOSTON ACADEMY OF ADDICTION AND RECOVERY (THE ACADEMY) TO RAISE THE BAR OF PROFESSIONAL PRACTICE AND ENSURE EXCELLENCE IN BOSTON SUBSTANCE USE DISORDER SERVICES AND SUPPORT.**

## Activities: Year 2 & 3

- Collaborate with providers and payors to launch discussions about delivery system reforms that might facilitate improved access and smoother transitions between levels of care.
  - Review models of providers organizing into treatment “systems.”
  - Review models where single provider provides multiple levels of care.
  - Identify payment reforms necessary to support such reforms.
  - Develop proposal for pilot program with BSAS and/or MassHealth.

# PARTNERSHIPS WITH GOVERNMENT, PROVIDER AND OTHER ORGANIZATIONS (CONT'D)

## RECOMMENDATION 7: ENCOURAGE PARTNERSHIPS AROUND JOINT PROGRAMMING AND RESOURCE DEVELOPMENT TO SUPPORT ADDICTION EARLY INTERVENTION, TREATMENT AND RECOVERY SERVICES.

### Activities: Year 2 & 3

- Provide information about funding opportunities for agency partners and providers via an electronic news blast or website.
- Partner with community- and faith-based organizations around pilot programs and grass-roots efforts (e.g., a City/coalition partnership around Narcan training or where to access help).
- Identify opportunities to standardize tools and practices that facilitate seamless consumer transitions and better data collection.
- Partner with teaching hospitals/universities for training and education around research and practice:
  - Clinical rotations/practicums/placements.
  - SUD research and evaluation (e.g., City SUD Need Study).
  - Convene Boston hospitals to talk about implementing evidence-based practices and strategic approaches to addictions in hospital services.



# INCREASED PUBLIC AWARENESS AND ADVOCACY

## RECOMMENDATION 8: SERVE AS THE CITY'S VOICE IN INCREASING UNDERSTANDING AND AWARENESS OF ADDICTION PREVENTION, EARLY INTERVENTION, TREATMENT AND RECOVERY SERVICES.

### Activities: Year 1

- Develop materials to brand and market the Office of Recovery Services.
- Complete informational brochures on City-based access and referral programs, such as PAATHS and AHOPE, to be distributed among every City agency, churches and community-based organizations, and at community venues.
- Collect or create and disseminate information to the public about current trends and issues related to addiction, treatment and recovery, including the use of medical marijuana.

# INCREASED PUBLIC AWARENESS AND ADVOCACY<sub>(CONT'D)</sub>

## RECOMMENDATION 9: ENCOURAGE MORE PEOPLE WHO NEED SERVICES TO SEEK SERVICES.

### Activities: Year 2 & 3

- Develop a multifaceted outreach plan (social and traditional media) about the cycle of addiction, the importance of early intervention and the effectiveness of treatment.
- Partner with other City agencies to identify multisystem-involved individuals and families in need of SUD treatment and recovery support services, and triage them to an appropriate point of access (e.g., SBIRT, mutual aid groups, PAATHS, recovery support services).
- Publish policy position white papers to publicize current trends and issues and to feature current culturally appropriate strategies and evidence-based practices used by Boston providers.
- Sponsor community conversations among community- and faith-based organizations to better understand the scope and nature of addiction in the community and to mobilize community resources.
- Raise the profile of the face of recovery through:
  - Public service announcements.
  - Recovery month activities.
  - Stigma reduction efforts.



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# APPENDIX

# EVIDENCE-BASED PRACTICES THAT ADDRESS THE GAPS:

## Continuum of Care:

- **Pre-Treatment:** needle/syringe exchange programs (SEP): AHOPE
- **Screening and Assessment:**  
AUDIT and AUDIT-C, CAGE (for alcohol), CRAFFT (for youth), DAST 10 (for drug abuse), NIDAMED (online screening tool for physicians), ASAM criteria
- **Detox:** Motivational interviewing and Twelve Step facilitation, and Twelve Step meetings
- **Residential Treatment:** Phoenix House Academy, Oxford House Model, the Modified Therapeutic Community (MTC)
- **Outpatient Pre-Service/Outreach & Education:**  
CRAFT, Psycho-Medical Intervention Model, Brief Strengths-Based Case Management (SBCM), Service Outreach and Recovery (SOAR), Community Promise, Medication Assisted Treatment

# EVIDENCE-BASED PRACTICES THAT FILL THE GAPS:

**These strategies can be employed at any point in the treatment and recovery process:**

- **Engagement:** Motivational Enhancement Therapy (MET), Motivational Interviewing, Twelve Step Facilitation, Interactive Journaling
- **Trauma-Informed Interventions:** Seeking Safety, and The Boston Consortium Model: Trauma-Informed Substance Abuse Treatment for Women (BCM)
- **Recovery Support:** Massachusetts Organization for Addiction Recovery, Recovery Coaching, Celebrating Families, Peer Recovery Centers, Mutual Self-Help Groups
- **System-wide Interventions:** Strengths-based case management (SBCM), Behavioral Health Navigation, SBIRT, Medication Assisted Treatment (methadone, Suboxone, Vivitrol)
- **Culturally Competent Programs:** Modelo de Intervención Psicomédica (MIP), The Boston Consortium Model