# ADDICTION AND RECOVERY SERVICES IN THE CITY OF BOSTON

## A Blueprint for Building a Better System of Care

JANUARY 2015

FOUNDATION MASSACHUSETTS

prepared by

DMA Health Strategies

CITY OF BOSTON • MASSACHUSETTS

MARTIN J. WALSH
MAYOR

May 20, 2015

Too many Bostonians are all too familiar with the destruction that substance abuse addiction causes in our City's families and neighborhoods. We regularly see addiction's devastation in our homes, at our workplaces, and on our streets. However, where there are accessible recovery supports that readily assist people and families suffering from addiction, devastation can quickly transform into a wellspring of resilience and strength. This is why addressing Boston's addiction problem is one of my top priorities as Mayor of Boston.

Last year, my office partnered with the Blue Cross Blue Shield of Massachusetts Foundation (BCBSMAF) to conduct a thorough analysis of the scope of Boston's substance abuse addiction problem. DMA Health Strategies was selected to conduct the research for this project. We also assembled an Addiction Recovery Advisory Group comprised of addiction experts and community stakeholders to work closely with the researchers.

BCBSMAF has created an excellent report with thorough analysis and clear recommendations for the City of Boston. The researchers began by analyzing all available relevant data, including Federal, State, and local data sources. They conducted 29 face-to-face and phone interviews with State and local leaders with expertise and experience in addiction. There were also 11 community focus group discussions to gauge matters most pressing to Boston neighborhoods. This report provides an inventory of existing services, analyzes the scope of issues that have yet to be fully addressed, breaks down addiction trends by demographic, and makes projections for anticipated future needs.

Now that this report is finalized, it will act as a vital roadmap for the newly created Office of Recovery Services, which will soon open under the Boston Public Health Commission. This office will be charged with helping people find direct services, advancing progressive addiction recovery public policy, working across the public and private sectors to maximize easy avenues to support for all Bostonians.

I am incredibly grateful to BCBSMAF for spearheading this effort. I would also like to thank the Addiction Recovery Advisory Group for their hours of time and invaluable expertise.

I look forward to continuing to build upon our addiction recovery strategy through the Office of Recovery Services so that the City can better ensure that Boston's future generations will know exactly where to get help when this public health crisis touches their lives.

Sincerely,

Mayor, Martin J. Walsh

# EXECUTIVE SUMMARY

Despite significant and historic health care reform in the Commonwealth of Massachusetts, treatment for mental health and substance use disorders remains challenging in terms of access, capacity and cost. Boston's substance abuse prevalence is not substantially worse than that of other areas of the state or the nation; nonetheless, there are significant disparities among Boston residents in terms of need and access to services and serious weaknesses in the service continuum. The most recent data from the state's Center for Health Information and Analysis (CHIA) demonstrate a 76% increase in unintentional heroin overdose hospital encounters by Boston residents between 2010 and 2012.[1] Moreover, data from Boston Emergency Medical Services (BEMS) reveal a 25% increase in heroin-specific emergency response calls from January to November of 2013.[2] The current treatment and recovery system is complex, overburdened and in need of reform.

Mayor Martin J. Walsh has identified this issue as a top priority for his Administration and in the spring of 2014 announced the creation of an Office of Recovery Services, a first for the city of Boston. At that time, Mayor Walsh sought the support of the Blue Cross Blue Shield of Massachusetts Foundation (BCBSMA Foundation) to collaborate on a needs assessment of the addiction treatment and recovery services in the City. At a kick-off event at the Devine Recovery Center in South Boston, Mayor Walsh said, "There's a stigma around drug and alcohol addiction that keeps too many people from getting the help they desperately need, and that has to change." The Mayor further noted, "I know the battle against addiction can't be won alone. Increasing access to education and treatment options is one of the best things we can do to combat the stigma and give people a fighting chance at recovery."

Compounding the existing challenges with addiction treatment and recovery services capacity, and diverting immediate attention from the larger issue of reforming Boston's substance use recovery system, was the loss of 8 programs that were situated on Long Island. In October 2014, hundreds of homeless residents and recovery patients were displaced, when the bridge leading to the island was condemned. In addition to approximately 450 guests of the homeless shelter, roughly 225 people who were receiving addiction treatment services on Long Island were forced to leave the island. In response, at the time of this report, the City is planning to open 75 recovery beds in January 2015 at a facility on a Boston Public Health Commission property in Mattapan.

The purpose of this assessment is to identify concrete, actionable recommendations for the city of Boston to strengthen the substance abuse and recovery service system. Prevention was not in the scope of this specific assessment. The BCBSMA Foundation hired DMA Health Strategies (DMA) to conduct the research necessary to inform the development of these recommenda-

1 Boston Public Health Commission (BPHC), Research and Evaluation Office, Outpatient Emergency Department Discharge Database and Acute Hospital Case Mix Files, 2012. These statistics, and others cited below, were based on BPHC analysis of data provided by the Center for Health Information and Analysis (CHIA).

2 BPHC, Boston Emergency Medical Services (BEMS), Weekly NRI Report, 11/10/14–11/26/14.

tions. In addition, the assessment was guided by a Mayoral Advisory Committee comprised of 30 experts in the fields of substance use treatment and recovery services. The recommendations presented in this report include immediate and longer-term actions for the treatment and recovery delivery system at large and for the City's new Office of Recovery Services.

## ANALYTIC FRAMEWORK AND APPROACH

The primary goals of the assessment were to 1) identify the need and demand for and capacity of addiction and recovery services in Boston, and 2) based on identified gaps between need, demand and capacity, develop recommendations to enhance and improve the current system of care, with specific suggestions for the role and activities of the Mayor's Office of Recovery Services.

A mixed methods approach was used to gather data relevant to this assessment. During July and October 2014, DMA collected need, utilization and access data from a wide variety of city, state and federal sources. To gain additional information from those with knowledge and experience relative to Boston's addiction and recovery services, 11 discussion groups comprised of over 100 people were convened and 29 individual interviews were conducted. These perspectives constitute the qualitative data component necessary to explain nuances within particular neighborhoods or sub-populations that will be integral to the successful implementation of the project recommendations.

Data on demand, use and capacity of recovery treatment and support services (e.g., recovery support centers, family support programs, and case management services) in Boston is not currently collected in a systematic way. However, recovery support is an integral component of the substance use disorder treatment system. Therefore, as outlined, the recommendations developed for this report include several focused specifically on recovery support services (e.g., improving data collection, advocating for the use of evidence-based practices, and disseminating information pertaining to these programs and services).

## DATA LIMITATIONS

A limitation of this project, like many other projects on this topic, is the lack of data available pertaining to behavioral health services. In this particular case, the challenge was exacerbated by the dearth of data that assess the extent of substance use/misuse and the need or demand for treatment at the *local* (i.e., city) level.

The National Survey on Drug Use and Health (NSDUH) is the only survey that collects information on the extent of need for treatment. These data are only available on a statewide basis, and therefore there is no single indicator of need for treatment on a city level.

The Bureau of Substance Abuse Services (BSAS), the state agency that oversees the substance abuse and gambling prevention and treatment services in the Commonwealth, collects data pertaining only to those programs that it licenses. Therefore, these data are limited to capacity data (beds) for hospital and residential services and do not include outpatient treatment services (ambulatory and community service licenses are not provided by BSAS). Given this, as well as

the lack of consensus on a methodology for assessing capacity of outpatient services, it is not feasible to assess the extent to which outpatient capacity is meeting current needs.

Finally, the state's Health Planning Council (HPC) established as part of Chapter 224 of the Acts of 2012 and situated within the state's Department of Public Health (DPH), served as another potential source for data relevant to this project. Per statute, one of the primary objectives of the HPC is to develop a state health resource plan—inclusive of recommendations for the appropriate supply and distribution of resources, programs, capacities, technologies and services—based upon an assessment of the needs of the Commonwealth and existing health care services, providers, programs and facilities. Given the breadth of this task, the HPC prioritized its planning efforts in the behavioral health arena. However, the HPC was also constrained in its efforts because the substance use disorder treatment claims data available through the state's All Payer Claims Database (APCD) were limited to inpatient and emergency room services. Moreover, the regions used in the HPC analysis do not allow disaggregation of data for the city of Boston alone.

Given these limitations, this report relies upon the quantitative data that is available (at the national, state and local level). These data are then supplemented with qualitative information acquired through the stakeholder interviews and focus groups. Together, this information helps to credibly "tell the story" about the need for treatment, demand for treatment and utilization of treatment in Boston.

# FINDINGS

## CITYWIDE NEED AND DEMAND

Prevalence data on substance use and abuse are the best available indicators of the need for treatment and other services. Boston's rate of substance abuse prevalence (11.3%), based on respondents' indication of dependence or abuse of illicit drugs or alcohol in the past year, is roughly comparable to that of other regions within the state. Prevalence rates by region range from a high of 11.6% in Western MA to a low of 9.4% in the Metrowest region of the state.[3]

Boston hospital emergency department (ED) and inpatient admissions for substance use disorder diagnoses also demonstrate the need for treatment programs. For example, close to 1 in 10 of all Boston hospital ED visits and 1 in 20 of all inpatient admissions in 2012 were related to substance use disorder.[4]

Alcohol and heroin are the major drugs of choice for Bostonians. Available data suggest rates of alcohol abuse are high in Boston, with 25% of Boston residents reporting binge drinking and 10% reporting heavy drinking in 2012.[5] The rate of unintentional heroin overdose encounters among Boston residents increased by 76% from FY 2010 to FY 2012, according to data reported

3 Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health (NSDUH), 2009-2012.

4 BPHC, Research and Evaluation Office, Outpatient Emergency Department Discharge Database and Acute Hospital Case Mix Files, 2012.

5 BPHC, Boston Behavioral Risk Factor Surveillance System (BBRFSS), Boston Behavioral Risk Factor Survey, 2013.

by acute hospitals.[6] The number of non-overdose opioid dependence and abuse hospital discharges in Boston increased by 13% from FY 2011 to FY 2012.[7] Heroin-specific calls to Boston Emergency Medical Service (BEMS) increased 25% between January and mid-November 2013.[8] Discussion participants view heroin, with attendant violence, street crime and prostitution, as the number one drug problem. It is strongly linked to poverty and intergenerational cycles of substance abuse.

## CAPACITY

The substance use disorder treatment system is a statewide system, and treatment seekers are not prioritized for placement based on their city or town of residence. At any given time, as many as half of the residential treatment beds based in Boston may be filled by individuals living outside of the City. Therefore, Boston's capacity gap reflects needs beyond Boston residents. Nonetheless, it is worth noting that based on the analysis by the HPC, the City has a significantly higher density of treatment and recovery beds (detox, residential, transitional support services and Clinical Stabilization Service [CSS]) than any other area of the state. Boston has 152 beds per 100,000 residents, while the next largest areas, Central Mass and Cape Cod, have approximately 42 beds per 100,000 residents.

The following BSAS-licensed programs are located within the city of Boston:[9]

- 5 detox programs (153 beds[10]) (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[11]) (30% of statewide bed capacity)
- 2 family residential programs (34 beds) (29% of statewide bed capacity)
- 2 Transitional Support Services programs (71 beds[12]) (18% of statewide bed capacity)
- 1 Clinical Stabilization Service (CSS) 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).

6 BPHC, Research and Evaluation Office, Outpatient Emergency Department Discharge Database and Acute Hospital Case Mix Files, 2012.

7 BPHC, Research and Evaluation Office, Outpatient Emergency Department Discharge Database and Acute Hospital Case Mix Files, 2012.

8 BPHC, BEMS, Weekly NRI Report, 11/10/14-11/26/14.

9 Massachusetts Department of Public Health, Bureau of Substance Abuse Services, Office of Data Analytics and Decision Support, BSAS Licensed Programs Data for FY 2014.

10 Including 60 beds relocated from Long Island.

11 Including 157 beds relocated from Long Island.

12 Including 43 beds relocated from Long Island.

There are also a variety of additional addiction and recovery resources available in Boston. BSAS funds case management services, naloxone distribution programs, a recovery support high school and recovery support centers, among other programs and services. Community health centers provide a valuable treatment resource to Boston residents, as do several other organizations such as the Salvation Army, STRIVE, mutual aid groups (e.g., Alcoholics Anonymous [AA] and Narcotics Anonymous [NA]) and sober homes.

Interviewees and focus group participants, particularly providers, noted several capacity concerns associated with the current system. These concerns primarily focused on poor rates of reimbursement constraining available capacity and the lack of care coordination or integration of care for clients with multiple diagnoses. In addition, insufficient workforce training and a lack of adherence to evidence-based practices (EBPs) for delivering care were identified as areas of concern within the current system.

There are several factors that suggest 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 by 2020. Interviewees and focus group participants suggest this gap may be exacerbated based on factors like the advent of medical marijuana sales, legalized casino gambling and the continuing rise in prescription drug abuse. In addition, interviewed 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; and substance use disorders are often a co-morbidity of PTSD among veterans, especially female veterans.

## GAP ANALYSIS

### Service Capacity Issues

The research conducted as part of this assessment suggests there is insufficient detox and residential treatment capacity across the state. Much of Boston's capacity is used by individuals from outside the city of Boston, estimated to be as much as 50% of occupied beds.[13] Wait times for residential placements averaged approximately 23 days in 2014.[14] Detox programs in Boston are operating at 97% of capacity.[15] Advisory Committee members all agreed that it is clear there is a need for a greater number of level 3.7 and level 4 detox beds.

### System Issues

There was significant discussion among both consumers and providers about negative implications that disruptions in the transition from detox to residential treatment pose for individuals in recovery.

13 U.S. Department of Health and Human Services, Health Resources and Services Administration, Uniform Data System Health Center Data, 2013; Uniform Financial Reports and Independent Auditor's Report (UFR), 2013; Uniform Financial Statements, Operational Services Division (OSD), 2012.

14 Massachusetts Department of Public Health, Bureau of Substance Abuse Services, Recovery Home / Residential Treatment Enrollments, July 1, 2013- June 30, 2014.

15 U.S. Department of Health and Human Services, Health Resources and Services Administration, Uniform Data System Health Center Data, 2013; Uniform Financial Reports and Independent Auditor's Report (UFR), 2013; Uniform Financial Statements, Operational Services Division (OSD), 2012.

In addition to consensus on this area of concern, other gaps identified in the discussion groups and interviews included:

- There are vast disparities in need among, and access to treatment and services is not adequate for, certain populations including females, cultural and linguistic minorities and people who are homeless, have serious mental illness, traumatic brain injury and/or PTSD.
- Program policies can serve as barriers to access (admission criteria, length of stay limits, state policy barriers for moving between services and lack of treatment on demand or when first needed).
- Health insurance policies, coverage limitations and reimbursement can pose barriers (e.g., pre-authorization requirements, clinical criteria limitations, length of stay limits, insufficient reimbursement rates, wait times between levels of care, lifetime limitations, client confusion about coverage and differences in scope of benefits for public vs. private insurance). Many of these reflect a continuing lack of parity in the insurance system.
- There is a no-monitoring system for utilization of and adherence to EBPs. While many programs are attempting to deliver evidence-based practices, there is no systemic approach for reviewing these practices or providing ongoing training to ensure fidelity of practice.
- Primary care and/or mental health providers are insufficiently trained in identifying or treating substance use disorder issues, despite the high prevalence of substance use disorder, mental health and primary care co-morbidities.
- The supply of community-based recovery support services, including recovery coaches, sober housing and recovery centers tailored to the specific needs of Boston residents is inadequate.

## RECOMMENDATIONS FOR SYSTEM IMPROVEMENTS

Specific changes that can have a large-scale and system-wide impact on the service delivery system and resulting outcomes are:

- Augmenting existing capacity (beds) for detox and residential treatment
- Creating a central source of real-time information on available treatment beds and outpatient services
- 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
- More detailed data collection including needs of specific populations and cultural competence

- Advocacy for implementation of evidence-based practices
- Monitoring and training to ensure fidelity of 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 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

The following recommendations may serve as a "blueprint" to guide the city over the next three years in operationalizing the Office of Recovery Services and serving as a driving force in improving the current substance use disorder treatment system. The activities described below consider the role of the city of Boston within a statewide system of care and identify appropriate partnerships with state, federal and provider partners.

**Expanding Service Capacity** — work with BSAS and BPHC to expand access to and capacity of critically needed services:

- Recommendation 1: Expand capacity of level 3.7 and 4 detox, residential and recovery support services for residents of Boston.
- Recommendation 2: Ensure fair and equal access to all levels of treatment and recovery services.
- Recommendation 3: Advocate for the increased use of evidence-based treatment and recovery support practices in the city of Boston.
- Recommendation 4: Provide information to users' family and loved ones to support them in accessing treatment and recovery services.

**Forging Partnerships** — use the existing Advisory Council, a newly created Interagency Taskforce and members of City leadership to coordinate efforts and integrate systems, improve data collection and develop databases for shared information; establish a Boston Academy of Addiction and Recovery and increase collaboration among government, provider and other organizations:

- 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.
- Recommendation 2: Drive joint efforts to improve interagency coordination and drug use outcomes. Use trend indicators to identify target neighborhoods.
- Recommendation 3: Consistently collect, analyze and track data on addiction, treatment and recovery services to inform timely and appropriate interagency responses.

- Recommendation 4: Convene and support coordination of government, university and providers' efforts related to addiction, treatment and recovery services.
- Recommendation 5: In coordination with Boston universities, develop and operate a Boston Academy of Addiction and Recovery to raise the bar of professional practice to ensure excellence in Boston substance use disorder services and support. (Please see Appendix A for more information.)
- Recommendation 6: Encourage partnerships around joint programming and resource development to support addiction early intervention, treatment and recovery services.

**Increasing Public Awareness and Advocacy** – create visibility of and awareness and education about substance abuse, reduce stigma and develop outreach strategies to encourage Boston residents and families to seek services.

- Recommendation 1: Serve as the City's voice in increasing understanding and awareness of addiction prevention, early intervention, treatment and recovery services.
- Recommendation 2: Encourage more people who need services to seek services.

## CONCLUSION

Under the leadership of Mayor Walsh, the city of Boston has an incredible opportunity to strengthen the substance use disorder treatment and recovery support system for its residents. The Mayor's Office of Recovery Services can prioritize recovery, strengthen citywide partnerships and programs to provide services to individuals and families impacted by addiction, and lend its voice to reduce stigma and encourage individuals to seek treatment who need it. Through these activities, the city of Boston can become a national leader in combating drug use and related community challenges and serve as a model to other municipalities in the region and around the country.

# APPENDIX A:
# THE BOSTON ACADEMY OF ADDICTION AND RECOVERY

All evidence presented in this report points to the need for additional education in the pursuit of a strong and effective system of treatment and recovery. One related recommendation is the establishment of the **Boston Academy of Addiction and Recovery** (the Academy) to promote excellence in the delivery of substance abuse treatment and support. It is proposed as an entity to provide leadership, advocacy, information on best practices, research, support and/or training for the focus area of addiction and recovery services. The Academy can facilitate the collection of innovation standards and practices from around the nation, encouraging sharing and knowledge flow throughout the city. The Academy would be a specialized entity that may be sponsored or even managed by the Mayor's Office of Recovery. This entity could be located in a Boston-based university or other educational institution or it could represent a consortium of institutions convened by the Office of Recovery Services.

To accomplish these purposes, the Academy may perform a number of functions:

- Create a compendium of evidence-based practices and advocate for adoption of those practices;
- Convene leaders in the field; sponsor symposiums and forums for sharing knowledge;
- Provide a continuing focus on the importance of addiction and recovery services and be a source of information about the newest best practices;
- Advocate for ongoing research on important addiction topics among Boston institutions of higher learning, particularly on underserved populations;
- Broker access to training resources between those that offer it and those that need it; and
- Sponsor training and education directly for continuing education among Boston's provider workforce (see below).

The Academy may sponsor training and education directly for the purpose of continuing education among Boston's provider workforce such as:

### General

- Culturally informed practices for all care givers
- Trauma-informed practices for all care givers
- Evidence-based assessment practices

### Education certification/licensing for:

- Care coordinators/case managers
- Recovery coaches
- Navigators
- Peer navigators
- CADC and LADC
- Community health workers/substance abuse specialists (substance abuse and community education)

## Continuing Professional Education

Continuing Professional Education for physicians and other health care providers.
Topics may include:

- SBIRT
- Motivational interviewing
- Mental health first aid (youth and substance abuse specialties)
- Office-based opioid treatment
- Medication therapy management
- Training on screening tool use
- Psychopharmacology
- Diagnostic criteria for addiction issues
- Pain management
- Risk assessment
- Improving integration or linkages with addiction and other behavioral health specialists
- Short-term interventions
- Problem-focused treatment
- Treatment of special populations such as immigrants and refugees
- PTSD and trauma interventions

## Community Awareness

- Mental health first aid (youth and substance abuse specialties)
- CADC and LADC
- Community health workers/substance abuse specialists (substance abuse/community education)
- Curriculum for community coalitions to support the neighborhood mobilization and education activities

The Boston Academy of Addiction and Recovery would be an effective vehicle to raise the level of service quality and workforce expertise in the substance abuse system and help Mayor Walsh meet his goal of a world-class addiction and recovery service system.

# APPENDIX B: ADVISORY COUNCIL MEMBERS

**CO-CHAIRS:** **Hon. Martin J. Walsh**
Mayor of Boston

**Audrey Shelto**
President, Blue Cross Blue Shield of Massachusetts Foundation

**Chief Felix Arroyo**
Health and Human Services, City of Boston

**Jason Blanchette**
Department of General Internal Medicine, Boston Medical Center

**Barbara Cocci**
Behavioral Health Services, Health Care for the Homeless

**Jim Cramer**
BSAS, Massachusetts Department of Public Health

**Katherine Dukakis**
Former First Lady of Massachusetts

**Angela Fonseca**
Interim House

**Maryanne Frangules**
Massachusetts Organization of Addiction Recovery

**Michael Hamrock, MD**
Steward Health Care System

**Susan Howard**
AdCare Boston

**Hilary Jacobs**
BSAS, Massachusetts Department of Public Health

**Tom Johnston**
Arts, Tourism & Special Events, City of Boston

**Jack Kelly**
Senior Public Health Consultant

**Jim Kryzanski, MD**
Tufts New England Medical Center

**Andrew Laudate**
United States District Court, District of Massachusetts

**Brendan Little**
Mayor's Office of Jobs & Community Service, City of Boston

**Manny Lopes**
East Boston Neighborhood Health Center

**James Mahoney**
Bank of America

**Kaitlin McColgan**
MA League of Community Health Centers

**John McGahan**
Gavin Foundation

**Sylvia L. Mignon, PhD**
College of Public and Community Service, UMass Boston

**Myechia Minter Jordan, MD**
The Dimock Center

**Rita Nieves**
Addiction Prevention, Treatment and Recovery Support Services Bureau,
Boston Public Health Commission

**Willie Ostiguy**
Boston Fire Department, Employee Assistance Program, Retired

**Stephen Passacantilli**
Mayor's Office, City of Boston

**Leah Randolph**
Commonwealth Mental Health & Wellness Center

**David Rosenbloom, MD**
Department of Health Policy & Management, Boston University

**Jeffrey Samet, MD**
Department of General Internal Medicine, Boston Medical Center

**Jonathan Scott**
Victory Programs

**Tim Wilens, MD**
Center for Addiction Medicine, Massachusetts General Hospital

**Ludy Young**
Boston Medical Center

# APPENDIX C: DISCUSSION GROUP AND INTERVIEW PARTICIPANTS

## DISCUSSION GROUP PARTICIPANTS

**Katharine Collet**
Access to Recovery Program

**Fred Ruzanski and Susie Howard**
AdCare Boston

**Peter Barbuto**
American Addiction Centers

**Sherry Davis**
Bay Cove/Andrew House

**Eustace Payne Jr.**
Bethel AME

**Steve Brookes**
Block By Block

**Jessie Gaeta and Jim O'Connell**
Boston Healthcare for the Homeless

**David Wright**
Boston Ministerial Alliance

**Myra Kinds**
Boston Ministerial Alliance/Peoples Baptist

**Douglas Lomax**
Boston Public Health Commission, Men's Program

**Rebecca Bishop**
Boston Public Health Commission

**Sarah Mackin**
Boston Public Health Commission/AHOPE

**Timothy Iverson**
Boston Treatment

**Arlene Snyder**
Bridge Over Troubled Water

**Diliana De Jesus and Emily Stewart**
Casa Esperanza

**Joe White**
Catholic Church of South Boston

**Norma Reppucci**
Community Healthcare, Inc.

**Sarah Coughlin**
CSAC, Massachusetts General Hospital

**Barry Butler**
The Dimock Center

**Patricia O'Hagan**
East Boston Rehabilitation

**Frank Busconi**
Fenway Health

**John McGahan**
Gavin Foundation

**Lori McCarthy**
Gosnold Treatment Center

**Annette Geldzahler**
Hello House/Volunteers of America

**Fred Newton**
HOPE House

**Donna White**
Lemuel Shattuck Hospital

**Dominic Vangarelli and Liz Walker**
Marworth

**Leah Randolph**
MBAC & CMHWC

**Cherose Singleton**
Metro Boston League/Dimock

**Pristine Smith**
Metro Boston League/Phoenix House

**Joe Finn**
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**Maryann Frangules**
Massachusetts Organization for Addiction Recovery

**Robert Lewis**
Pathway to Redemption

**Michael Andrick**
Pine Street Inn

**Leo Adorno**
Pine Street Inn/Shattuck

**Roger Oser**
Ostiguy Recovery High School

**Kay Walsh**
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**Jack Kelly**
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**Heidi Primason**
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**Karen LaFranzia**
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**Deidre Houtmeyers**
St. Mary's Center for Women

**Windea Rodriguez**
StepRox Recovery Support Center

**Barbara Herbert and Caroline Ward**
Steward/ABSATF/St. Elizabeth's

**Nancy Parker**
Tewksbury Treatment

**Rainer Felber and Sarah Porter**
Victory Programs

## PERSON IN RECOVERY DISCUSSION GROUPS

**Host Organization/Location:** **Casa Esperanza**
**Sub-Population:** Consumers (Latino/a)

**Host Organization/Location:** **Gavin House**
**Sub-Population:** Consumers (male aftercare)

**Host Organization/Location:** **Pine Street Inn**
**Sub-Population:** Consumers (male)

**Host Organization/Location:** **Finland House**
**Sub-Population:** Consumers (females)

## INTERVIEW PARTICIPANTS

**Steven Tolman**
AFL-CIO

**Dr. Kenneth Duckworth and**
**Dr. Donald Markum**
Blue Cross Blue Shield of Massachusetts

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Boston Centers for Youth and Families

**Chief James Hooley**
Boston Emergency Management Services

**Chief Felix Arroyo and Lauren Jones**
Boston Health and Human Services

**Greg Davis**
Boston Housing Authority

**Dr. Craig Samet and**
**Dr. Edward Bernstein**
Boston Medical Center

**Chief Robert Ronquillo**
Boston Municipal Court

**Commissioner William Evans,**
**Commander Brian Larkin and**
**Deputy Superintendent John Brown**
Boston Police Department

**Dan Dooley**
Boston Public Health Commission

**Rita Nieves, Devin Larkin**
**and Yailka Cardenas**
Boston Public Health Commission

**Mayor Martin J. Walsh**
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**Dr. Timothy Wilens**
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**Trinh Nguyen**
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**Chief Daniel Mulhern**
Office of Public Safety–Boston

**Chief Francisco Urena**
Office of Veterans' Affairs–Boston

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Suffolk County Sheriff's Department

**Dr. Thomas A. Amoroso**
Tufts Health Plan

**Andrew Laudate**
United States District Court, District of MA

# APPENDIX D: DATA SOURCES

**Boston Police Department, Drug Control Unit and Office of Research and Evaluation, Drug Arrest Breakdown by BRA Neighborhood, Drug v. Total Arrests, 2012–August 2014.** The number of total arrests and drug arrests for the city of Boston were provided by the Boston Police Department. These data were reported by booking district, drug class and BRA neighborhood.

**Boston Public Health Commission, Addiction Treatment and Recovery Support Services, 2014, Addicts Health Opportunity Prevention Education (AHOPE) contacts.** Clients who access AHOPE may engage in several services, including treatment placement, needle exchange, overdose prevention, Narcan enrollment and risk reduction counseling. Treatment placement includes supported referrals to treatment, which can be for substance abuse, primary care, mental health, HIV care, HCV care or STI care. The AHOPE program provided data for July 2013-June 2014 on client demographics (gender, race/ethnicity, country of birth), health (HIV, Hepatitis C, past year STI), housing status (homeless or housed) and zip code.

**Boston Public Health Commission, Addiction Treatment and Recovery Support Services, 2014, Providing Access to Addictions Treatment and Hope (PAATHS) utilization.** PAATHS provides information about, as well as access to, substance abuse treatment services for anyone (e.g., individuals, families, community partners or other treatment providers) who requests it, regardless of insurance status. Data on (a) the number of clients seeking services by gender, age and race/ethnicity; (b) client drug(s) of choice; (c) referral source; and (d) requested service placement were provided for July 2013-June 2014 by the PAATHS program.

**Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System (BBRFSS), Boston Behavioral Risk Factor Survey, 2013.** Data on binge drinking and heavy alcohol consumption among Boston adults were obtained from the 2013 BBRFSS. *Binge drinking* was defined as having five or more alcoholic drinks if a male and four or more alcoholic drinks if a female during the past 30 days. *Heavy alcohol consumption* was defined as having 60 or more alcoholic drinks if a male and having 30 or more alcoholic drinks if a female during past 30 days. The Boston Public Health Commission Research and Evaluation Office provided both the number and percentage of Boston residents engaging in each of these behaviors for Boston residents in total as well as by gender, age, race/ethnicity and Boston neighborhood.

**Boston Public Health Commission, Boston Emergency Medical Services (BEMS), Weekly NRI Report, November 10–November 26, 2014.** Provided the number of narcotic-related illness transports to area hospitals in 2013.

**Boston Public Health Commission, Research and Evaluation Office, Outpatient Emergency Department Discharge Database and Acute Hospital Case Mix Files, 2012.** The Boston Public Health Commission Research and Evaluation Office provided the number and percentage of unintentional (including undetermined intent) drug overdose/poisoning and drug dependence/abuse hospital patient encounters for Boston residents in 2012 by age, gender, race/ethnicity, neighborhood and drug. These figures were derived from acute hospital case mix files provided by the Massachusetts Center for Health Information and Analysis. Patient encounters refer to discharges from hospital

inpatient care, observational care or emergency department (ED) care. Each patient encounter refers to a unique medical episode (i.e., visit to the hospital). Patients transferred from one hospital setting to another (e.g., ED to hospital inpatient) are counted once within the data. Cases were identified using relevant ICD-9-CM codes.

**Centers for Disease Control and Prevention, Youth Risk Behavior Survey (YRBS): High School, 2013**. This survey monitors health-risk behaviors that contribute to the leading causes of death and disability among youth and adults, including alcohol and other drug use. The percentage of Boston youth reporting alcohol and drug use behaviors was compared with the percentages of Massachusetts youth reporting the same behaviors, where possible.

**Massachusetts Department of Public Health, Bureau of Community Health and Prevention (BCHAP), Injury Surveillance Program, Hospital Admissions for Total Opioid Drug-related Poisonings/Overdoses, 2014**. The Department of Public Health's Office of Statistics and Evaluation provided these data as derived from acute hospital case mix files provided by the Massachusetts Center for Health Information and Analysis.

**Massachusetts Department of Public Health, Bureau of Substance Abuse Services, Center for Community Health, 2014.** Massachusetts League of Community Health Centers Survey Data.

**Massachusetts Department of Public Health, Bureau of Substance Abuse Services, Recovery Home/ Residential Treatment Enrollments, July 1, 2013–June 30, 2014**. Provided data on utilization trends by level of care for capacity.

**Massachusetts Department of Public Health, Bureau of Substance Abuse Services, Office of Data Analytics and Decision Support, BSAS Licensed Programs Data for FY 2014**. For each Boston neighborhood, the Massachusetts Department of Public Health provided the number of Boston residents enrolled in BSAS-licensed treatment in 2013 by gender, race/ethnicity, age group, past year injection drug use, primary or secondary drug type and service type.

**Massachusetts Department of Public Health, Bureau of Substance Abuse Services, Office of Data Analytics and Decision Support, BSAS Treatment Admissions Data as of June 30, 2014**. Health Resources in Action, Inc., provided Massachusetts Substance Abuse Information & Education Helpline data from FY 2014 for the city of Boston and the state of Massachusetts. These data included caller demographics (age, gender, language, region of residence), primary and secondary drug type, treatment sought and insurance status.

**Massachusetts Department of Public Health, Drug-related Poisonings/Overdoses: Boston Resident Deaths, 2010–2012**. The Boston Public Health Commission Research and Evaluation Office reported the number of unintentional overdose deaths among Boston residents by age, gender, race/ethnicity and neighborhood for 2012. Data were provided by Massachusetts Department of Public Health, Registry of Vital Records and Statistics. Cases were identified using relevant International Classification of Diseases (ICD)-10 codes.

**Massachusetts Department of Public Health, Naloxone Program Data, 2011–2014.** The Department of Public Health provided naloxone program data on enrollments, refills and rescues for Boston residents in 2013. Enrollments reflect the number of unique individuals who were trained and received a naloxone rescue kit; enrollments were reported by gender, ethnicity, race, age and user

status (user = known opioid user at risk of overdosing; non-user = friend or family of opioid users or staff of programs that serve opioid user). A refill was reported to occur when someone who was enrolled requested another kit (for any reason: because their naloxone was lost, stolen, given away, confiscated, or used in an overdose). A rescue was recorded when people reported that DPH program naloxone was used during an overdose. The numbers of enrollments, refills and rescues were reported by zip code.

**The Executive Office of the Massachusetts Trial Court** provided data on arraignments for drug crimes in 2013. For each court, the number of juveniles and adults arraigned for drug crimes by age, gender, race/ethnicity and charge were reported.

**Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health (NSDUH), 2009–2012.** Provides national and state-level data on the use of tobacco, alcohol, illicit drugs (including non-medical use of prescription drugs) and mental health in the United States. NSDUH is sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency of the U.S. Public Health Service in the U.S. Department of Health and Human Services (DHHS).

**U.S. Department of Health and Human Services, Health Resources and Services Administration, Uniform Data System Health Center Data, 2013; Uniform Financial Reports and Independent Auditor's Report (UFR), 2013; Uniform Financial Statements, Operational Services Division (OSD), 2012.** The Operational Services Division (OSD) is the oversight entity for complying with various federal and state requirements for human and social services contracts and private special education programs. Oversight is accomplished through the Uniform Financial Statements and Independent Auditor's Report (UFR), which contractors must file with OSD on an annual basis. Data from the 2012 UFR report on residential substance use disorder treatment providers who are required to provide a UFR were used to estimate capacity for detox and residential treatment services.