

Department of Public Health

Bureau of Substance Abuse Services

STANDARDS OF CARE



Prevent • Treat • Recover • For Life

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I. INTRODUCTION:

A. Purpose of Standards of Care:

The Massachusetts Department of Public Health, Bureau of Substance Abuse Services (BSAS) is the state authority responsible for substance use and addictions policy, regulatory oversight, system development and funding. BSAS oversees prevention, screening, intervention, treatment and recovery support services in Massachusetts, and recognizes that success in building and maintaining a comprehensive system depends on collaboration with individual, community, state and federal partners. The result of BSAS efforts and of collaboration is a comprehensive System of Care to prevent, reduce and treat alcohol, tobacco and other substance-related and addictive disorders (SRDs) including gambling disorders¹, and to support recovery from addictions. The System is built on recognition that substance-related and addictive disorders undermine all aspects of the health and well-being of individuals, families, and communities, including economic well-being, educational achievement, physical and mental health, and safety. To be effective the system must be capable of promoting the health and well-being of individuals, families and communities as well as ameliorating effects of unhealthy substance use and substance-related disorders.

This document describes Standards of Care (Standards) of the BSAS System of Care, including principles and framework guiding design, implementation and maintenance of programs and services; components and essential characteristics of the System; requirements of the Substance Abuse and Mental Health Services Administration Substance Abuse Block Grant (SABG); and essential operational and organizational components. These Standards set forth BSAS'S goals for the System of Care and the means by which purchase of services support these goals.

These Standards are incorporated into and made part of BSAS-issued Requests for Response (RFR) and any contracts for purchase of service resulting from an RFR. Thus, the Standards establish requirements for BSAS vendors. All BSAS vendors are required to affirm their agreement to meet these Standards.

BSAS MISSION:

WE FOSTER HEALTHY LIFE CHOICES THROUGH CULTURALLY RESPONSIVE SERVICES THAT PREVENT, TREAT AND PROMOTE RECOVERY FROM SUBSTANCE RELATED DISORDERS.

WE BELIEVE:

- **Substance related disorders can be prevented and must be treated as a chronic disease;**
- **In strengthening people through prevention, treatment and recovery;**
- **Everyone in the Commonwealth must be treated with dignity and respect and must have access to quality ongoing care;**
- **Our services must be diverse and responsive to all cultures;**
- **Eliminating the stigmas associated with substance related disorders is integral to our prevention and treatment efforts;**
- **Recovery works.**

¹ Note that DSM-V includes gambling disorder as a substance-related disorder given evidence that similar reward systems and behavioral responses are activated.

Substance use treatment programs licensed by BSAS are also governed by requirements of 105 CMR 164.000 Licensure of Substance Abuse Treatment.

NOTE: Specific contractual requirements are offset, marked with a ♦ symbol and in bold-face type.

BSAS recognizes that research into substance-related disorders as well as about prevention and treatment, continues to produce new understanding, and that the capacity to define and apply best practices evolves as evidence is tested and disseminated. BSAS is committed to working with vendors and partners to improve the capacity of the System of Care to identify and implement best practices, by working closely with communities, vendors and provider groups, and by providing training aimed at disseminating best practices and improving practice.

BSAS periodically produces [Practice Guidance](#)¹ to summarize current research and describe best practices, covering a variety of topics such as: Integrating Opioid Overdose Prevention Strategies into Treatment; Making Treatment Culturally Competent; and Engaging Veterans in Treatment. Specific references to BSAS'S Practice Guidance are contained in Section II Essential Characteristics of the System. Vendors are expected to be familiar with BSAS practice improvement efforts and to consider resources identified by BSAS in these Standards and in Practice Guidance, to assess their programs and services.

Similarly, BSAS monitors changes in patterns of alcohol and drug use, and acts to enhance the capacity of the System to respond to new or increased risks, by engaging partners – consumers, communities, other agencies and service providers – in developing programs and resources. Vendors are expected to participate in these efforts as well.

B. The System of Care:

1. *The Bureau of Substance Abuse Services:*

As described in its Strategic Plan, BSAS is committed to increasing interagency collaboration, and works closely with federal agencies such as the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Prevention (CSAP) and Center for Substance Abuse Treatment (CSAT); the Office of National Drug Control Policy (ONDCP); the Administration for Children and Families; and the Department of Justice, among others. Specific requirements and strategic goals of the SAMHSA Substance Abuse Block Grant (SABG) also guide establishment of standards, and purchasing decisions.

BSAS works closely with Massachusetts agencies including the Departments of Children and Families, Mental Health, Youth Services, Veterans Services, Correction, and Housing and Community Development, and the Executive Office of Elder Affairs. Within the Department of Public Health, BSAS works closely with bureaus and programs

addressing Early Intervention, Community Health, Injury Prevention, and Health Equity, among others, to ensure responsive, best practices in public health services.

BSAS has established structures to ensure collaboration with providers of service, and with individuals served and their families, for example through its Consumer Advisory Board, and meetings with providers in a variety of venues. Internally, BSAS'S organization highlights priorities such as Prevention, Youth and Young Adults, Quality Assurance and Licensing, Policy, Workforce Development, etc. This organization combined with broad collaboration allows BSAS to effectively coordinate and plan substance-related disorders prevention programming, treatment licensing, policy and practice guidelines, and funding in the Commonwealth.

- ◆ **Vendors are required to be knowledgeable about the BSAS System of Care, adhere to contract requirements described in these Standards and in RFRs, and to be actively engaged with BSAS, other agencies and communities in supporting BSAS goals.**

2. BSAS Strategic Plan and Principles:

To guide design and implementation of best practices in this system, BSAS uses the Massachusetts Substance Abuse Strategic Plan² and has established Principles of Care for Prevention, Treatment and Recovery. The Strategic Plan focuses on: maximizing interagency and inter-branch collaboration, and collaboration within the criminal justice system; identifying and addressing disparities; increasing prevention and linkages to services; improving screening and access to services, strengthening the array of recovery orientated services and workforce development, and improving performance throughout the System.

The Principles of Care³ are drawn from BSAS'S mission and from study of comparable national principles, such as National Institute on Drug Abuse (NIDA) [Principles of Drug Addiction Treatment](#)⁴ and [Principles of](#)

BSAS Principles of Care for Prevention, Treatment and Recovery

1. Substance-related disorders are complex: physical, social, spiritual and emotional. Treatment and prevention respond to the whole person.
2. Prevention and treatment recognize substance-related disorders as chronic, requiring both life span and life style approaches (i.e., a continuum of healing).
3. Care is guided by the individual's needs and recognizes that needs change as the individual develops and progresses in treatment and recovery.
4. Prevention and treatment are equitable and do not vary in quality because of personal characteristics, such as gender, gender identity, ethnicity, age, sexual orientation, geographical location, socioeconomic status or drug/alcohol use history.
5. Prevention and treatment are safe.
6. Program design and operating decisions are based on evidence of effectiveness.
7. Treatment is transparent. Knowledge and information is shared freely between the individual and treatment provider. Prevention strategies and goals are explicitly stated.
8. Prevention and treatment are provided by staff who are well trained and well supervised.
9. Cooperation among service providers is a priority.

[Prevention](#)⁵, National Quality Forum [Standards of Care](#)⁶ and [Standards for Treatment](#)⁷, and [Institute of Medicine](#)⁸ recommendations. Together, the Strategic Plan and BSAS Principles highlight collaboration, quality improvement, recovery support, prevention and recognition that addiction is a chronic condition requiring a continuum of services.

C. Ecological Framework:

The BSAS System of Care is essentially an ecological framework built on recognition that the health and behavior of individuals, families, and communities are interrelated, and that change in one area affects change in other areas. Success in effecting behavior change depends on targeting multiple areas, i.e. a system which both supports prevention, screening, intervention, treatment and recovery and engages individuals, families, communities, providers, local, state and federal governments. Without such support for families, communities and other environments, behavioral health change may be temporary and difficult to sustain.⁹

To ensure the System targets multiple areas, BSAS actively engages partners, including providers of service, individuals served, families and community representatives to plan and support services and programs. Existing service models have been refined and renewed to address needs of youth, transitional age youth, and young adults, families, and identified risks in specific communities. BSAS seeks, and has successfully obtained, grant funding to study new approaches and respond to newly identified needs. Current components of the System are described below. Vendors should also view the system from an ecological framework.

◆ **BSAS requires vendors to be knowledgeable about the full System of Care, understanding that action, or inaction, in one component affects outcomes in other components.**

D. Components of the System of Care:

Data support comprehensive and targeted efforts. The National Survey on Drug Use and Health (NSDUH)¹⁰ reports 9.1% of Massachusetts residents 12 and older are dependent on or abused drugs or alcohol in the past year. Youth and young adults are especially at risk. The same survey reports dependence or abuse among 18 – 25 year olds as 20.6%. The 2013 Massachusetts Youth Risk Behavior Survey (YRBS)¹¹ reports that 11% of high school students report having their first drink of alcohol before the age of 13 years. Early age of first use increases risk of dependence. The number of opioid-related poisoning deaths in Massachusetts is greater than the number of deaths from motor vehicle accidents. Despite gains in reducing tobacco use, the NSDUH reports nearly a quarter (23.8%) of Massachusetts residents report past month tobacco use.

1. Prevention:

BSAS works with its partners to develop a system that supports prevention strategies in two categories: universal prevention, which targets all residents in a community and

selective prevention, which focuses on sub-populations of individuals who are at high risk. In planning and implementing prevention programs, BSAS applies its ecological framework to address the multiple, interrelated systems of influence and to build capacity for sustained collaboration among those interrelated systems.

Primary prevention is a priority under the SABG and the BSAS Prevention Unit applies the SAMHSA Strategic Prevention Framework (SPF)¹² to prevention efforts at all levels. The SPF defines five steps for comprehensive prevention efforts:

- **Assessment:** Assess community needs and resources to identify barriers to behavior change, and to target prevention resources to regions, communities, and neighborhoods most in need;
- **Capacity:** Use training and technical assistance to build shared expertise and capacity on evidence-based prevention practices across multiple disciplines;
- **Plan:** Develop an operational plan to guide State and community efforts
- **Implementation:** Implement evidence-based prevention efforts to reduce risk factors and enhance protective factors affecting alcohol and other drug use; and
- **Evaluation:** Coordinate, monitor, support, and evaluate evidence-based prevention and activities across state agencies and communities.

Through the SPF process, prevention planners and implementers must address issues of sustainability and cultural competence. That is, one goal is establishing the prevention program and principles as norms, with well-established partnerships and financial and other needed resources which are secured long term. Cultural competence is demonstrated by knowledge of and effective communication and engagement with individuals and groups representing diverse ethnic, racial, cultural, economic, social, linguistic and geographic backgrounds.

- *Community Based Prevention Programs*

Using SAMHSA SABG funds, the BSAS Prevention Unit funds community-based prevention efforts utilizing evidence-based programs and strategies to prevent alcohol, marijuana and other drug abuse, focusing on the under 21 population. These community and neighborhood based programs are carried out by coalitions of community members, who view youth as resources in their communities, incorporating meaningful youth involvement in program planning, implementation, and evaluation; and focusing on positive outcomes for youth. The programs use environmental approaches to change the overall context of underage drinking i.e. availability, community norms, and regulations.

BSAS seeks and has obtained SAMHSA grant funding for selective prevention programs, targeted at priorities arising from epidemiological assessments related to substance use and community needs. As an example, one such grant focused on preventing prescription drug misuse and abuse. Such misuse/abuse can lead to cross over into opioids such as heroin.

- *Opioid Abuse Prevention*

Opioid use and abuse, and opioid overdose are also the focus of BSAS coalitions, which target multiple local systems using an ecological approach as well as the SPF. These programs aim to implement local policy, practice, systems, and environmental change(s) to prevent the use/abuse of opioids, prevent and reduce fatal and non-fatal opioid overdoses, and increase both the number and capacity of municipalities addressing these issues.

- *Public Information/Social Marketing Initiative*

The Prevention Unit Social Marketing Programs aim to prevent and reduce alcohol and other substance use across the lifespan, using social media, print, web-based and public relationships initiatives. The most effective social marketing campaigns use the evidence-based literature focused on positive behaviors and the environment; in-depth insight gained from discussion groups; and marketing and public health principles to promote healthy communities. BSAS uses:

- Mass media to engage the public.
- Evidence-based resources distributed electronically and in hard copies to support positive change.

All BSAS printed materials are available in bulk quantities or for downloading at no charge from the Massachusetts Health Promotion Clearinghouse: www.maclclearinghouse.com. Many of them can also be downloaded in several languages from the “Prevention Information” section of the BSAS website (www.mass.gov/dph/bsas).

- *Massachusetts Technical Assistance Partnership for Prevention (MasTAPP)*

BSAS funds MasTAPP to provide statewide substance abuse prevention support. MasTAPP offers technical assistance, capacity building, and other resources to BSAS-funded underage drinking prevention efforts, prescription drug and opioid abuse prevention programs, and other communities across the state. In addition, MasTAPP resources are available to all communities and coalitions seeking

technical assistance to support their substance abuse prevention efforts, regardless of their funding sources.

Engagement of individuals, families, communities and service providers is critical to building capacity to sustain these efforts.

- ◆ **BSAS vendors are required to be knowledgeable about community prevention efforts and to work with BSAS and its partners to assess need, implement and sustain prevention efforts.**

2. *Screening, Brief Intervention and Referral to Treatment.*¹³

Universal Screening, Brief Interventions and Referral to Treatment (SBIRT), as part of routine healthcare practice, including school health, has been shown to be a cost effective approach to reducing unhealthy alcohol and drug use, and to save lives and money. Early identification (through screening) and brief interventions can identify risky use, reduce harm caused by high risk and binge drinking and recreational drug use, forestall development of disorders and reduce need for intensive and/or multiple interventions. A key aspect to its success is integration and coordination of SBIRT components into a systematic continuum of services that link early intervention and referral activities conducted in medical and social service settings with treatment.

BSAS has worked to establish SBIRT in a variety of healthcare settings. Brief physician advice is a powerful tool, especially for women of childbearing age, or women who are pregnant. BSAS has developed obstetrical health care SBIRT tools, including a comprehensive toolkit for primary care physicians. Another tool kit for use with women of child bearing age aims to prevent fetal alcohol spectrum disorders, and effects of other drugs on women and infants.

Adolescence is a period of considerable risk, and BSAS has developed an SBIRT guide for pediatricians to screen and counsel pre-teens and teens, as recommended by the American Academy of Pediatrics and as required by MassHealth.

BSAS-funded MASBIRT Training & Technical Assistance provides training, coaching and consultations to help healthcare and public health professionals implement SBIRT in a variety of settings.

3. *Treatment:*

The largest and most comprehensive component of the BSAS System of Care, treatment encompasses acute treatment services, stabilization and transitional services, outpatient services (including Driver Alcohol Education, an early intervention program), medication assisted treatment (MAT) and residential rehabilitation services for youth, young adults, adults, adults with families and those with second driving under the

influence convictions. Many of these services are licensed by BSAS under 105 CMR 164.000.

In FY2013, there were 153,289 enrollments* in substance abuse treatment in Massachusetts, of which 40% were persons between the ages of 16 and 29 years old.¹⁴ Substance-related disorders are often chronic, requiring repeat courses of treatment. Each level of care is tailored to respond to specific treatment needs.

- ◆ **In determining need, developing treatment plans, and monitoring outcomes, BSAS requires vendors to apply criteria established by the American Society of Addiction Medicine¹⁵**
- ◆ **Although responding to specific treatment needs, each provider in each level of care is required to:**
 - **Be knowledgeable about and support the full range of services in the BSAS System of Care, and to and have well-established, well-utilized collaborative agreements with other treatment providers and community providers such as primary healthcare and mental health services, as evidenced by established effective referral and comprehensive service systems;**
 - **Provide treatment that is based on the individual’s past history of substance use, medical and psychiatric care, and social history; and**
 - **Have established the capacity to facilitate transitions from one level of care to another as needed for the individual.**
- **Acute Treatment Services (ATS):**

These are a range of services designed to ensure safe management of withdrawal from alcohol and/or drugs, medical stabilization and engagement in treatment. ATS may be provided in inpatient or outpatient settings, depending on the degree of care needed to manage withdrawal, and the degree of incapacitation that may result from intoxication, and from physical and mental health co-morbidities. These services are often referred to as detoxification or ‘detox’ services.

Inpatient detoxification services may be short-term, provided in a hospital setting or a community setting. Outpatient detoxification encompasses medical supervision, includes a physical examination, and offers a minimum of 9 hours of service each week. The least intensive detox service is acupuncture, which may be provided following a more intensive admission to help in management of withdrawal symptoms or cravings.

* Enrollments reported may include more than one enrollment per individual

Acute treatment services are usually a first step on the road to recovery, and, since the potential for relapse is present, some may take that step several times. ATS providers are required to assess with the individual the best next level of care for that individual, taking into account the individual's treatment history, and to effect referrals to ensure appropriate care. For individuals referred to Opioid Treatment Programs, Office Based Opioid Treatment or other outpatient setting providing medication assisted treatment, well-established transfer plans are critical, so that no delays in enrollment are encountered.

- ◆ **Therefore, BSAS requires that ATS and medication assisted treatment vendors establish referral and transition systems which ensure smooth transfers, by specifying means of ensuring uninterrupted medication assisted treatment;**
- ◆ **When individuals are referred to multiple levels of care, for example, Residential Rehabilitation and medication assisted treatment, all involved vendors, ATS, MAT and Residential Rehabilitation establish written transfer plans that specify means to ensuring uninterrupted medication assisted treatment.**

- *Stabilization and Transitional Services:*

Clinical Stabilization Services (CSS): Following detox, individuals needing additional time to stabilize and consider next steps may transfer to CSS, an inpatient service providing a longer period of care. These services are also referred to as Step-Down Services. In addition, those who do not need medical detoxification, such as individuals addicted to cocaine, or those with a high risk of relapse, benefit from CSS placement and can enroll directly into the service.

Transitional Support Services (TSS): TSS are residential services that include nursing and health monitoring, case management and other services to assist individuals in identifying longer-term treatment needs.

- ◆ **Providers of CSS and TSS are required to ensure well-organized case management, referral and follow up to obtain needed services during the individual's stay, and to ensure smooth transitions to the next, appropriate, level of care.**

- *Outpatient Services:*

Outpatient services vary in intensity from Driver Alcohol Education, an early intervention service, to counseling services and operating under the influence second/multiple offender aftercare, to more intensive day treatment, involving daily programming. Outpatient counseling includes individual and group counseling

provided directly, and couples and family therapy provided directly or through referral.

Outpatient services are both clinical treatment and recovery support services. For some individuals this may be a first, or an early entry point in treatment and recovery. For others outpatient services may support continued recovery following residential rehabilitation services.

◆ **As key sources of recovery support in the community, outpatient service providers are required to support community prevention efforts; be engaged in community groups promoting recovery; and have well-established, well-utilized collaborative agreements with community providers such as primary healthcare and mental health services.**

- Medication Assisted Treatment:

Research and experience provide an increasingly comprehensive understanding of the physiological changes that accompany or result from substance use. For example, we understand a great deal about substance-related changes in metabolism and brain activities such as increased or decreased neurotransmitter production. This expanding field of knowledge is accompanied by increased availability of effective treatments using medications which target those physiological effects, for example by disrupting metabolism of the substances, or modifying substance-related brain activity. The effectiveness of medication assisted treatment in stabilizing individuals and enabling them to build a recovery-based lifestyle is well documented.¹⁶ BSAS supports the use of proven, effective medication assisted treatment in a variety of settings:

- Opioid Treatment Programs: Medication assisted treatment in Opioid Treatment Programs (OTP's) provides a comprehensive, effective treatment, primarily using methadone, in combination with individual and group counseling, and other services. These services help individuals achieve stability.
- Office Based Opioid Treatment: BSAS funds Office Based Opioid Treatment services located in health centers across the Commonwealth. Office based opioid treatment with buprenorphine (OBOT-B) is a primary care model providing evidence based treatment (both detoxification and maintenance) for individuals addicted to opioids. OBOT patients receive integrated medical and addiction care, and evaluation for other opioid treatment needs.
- Injectable naltrexone is another medication that is offered in OBOT programs funded by the Bureau. This medication has been shown to be effective in stabilizing individuals and in receiving integrated medical and addiction care, and evaluation for other opioid as well as alcohol treatment needs.

- Other Medications:¹⁷ Research continues to provide insight into how medications can improve outcomes in treatment of substance related disorders, and a number of medications are currently used in treatment and in primary care settings. Examples of these are:
 - **Disulfuram:** a medication that disrupts metabolism of alcohol, causing severe reactions if alcohol is ingested;
 - **Naltrexone:**¹⁸ a medication that reduces craving for alcohol and/or opioids;
 - **Acamprosate:** a medication that modulates and normalizes alcohol-related changes in brain activity.

Medication assisted treatment can support recovery and reduce risk of relapse, overdose and other harms related to substance use.

◆ **All BSAS vendors are required to support access to medication assisted treatment and to:**

- **Be knowledgeable about effectiveness of medication assisted treatment as primary treatment, or in conjunction with other levels of care, and to provide accurate and up-to-date information about medication assisted treatment to individuals served;**
- **Facilitate access to medication assisted treatment whether in conjunction with existing treatment, or as a transition from one level of care to another; and**
- **Ensure that individuals who are properly prescribed medication for treatment of a substance-related disorder are given equal access to treatment services.**

- *Residential Rehabilitation Services:*

Residential Rehabilitation Services provide structured environments supporting residents' recovery from alcohol and/or other drug problems and residents' acquisition of skills needed for an independent lifestyle. Scheduled, goal-oriented rehabilitative services are provided in conjunction with ongoing support and assistance in developing and maintaining interpersonal skills necessary to lead an alcohol and/or drug-free lifestyle. BSAS supports residential rehabilitation services for adults, for adults with their families, for adolescents, transitional age youth, and for young adults.

4. Opioid Overdose Prevention:¹⁹

BSAS has established a nationally recognized program to promote prevention, recognition and response to opioid overdose. Participating programs in Massachusetts have trained potential bystanders to an overdose (drug users, friends, family members)

on how to reduce overdose risk, recognize signs of an overdose, access emergency medical services, and administer intra-nasal naloxone.

5. *Recovery Support:*

BSAS supports a range of programs and services aimed at supporting individuals, families and communities in maintaining recovery and in reducing stigma attached to substance-related disorders. Recovery support can be clinically, peer or community based. For example, outpatient counseling may serve as a clinical recovery support, while community and/or peer based resources such as recovery coaches, self-help groups, and faith based organizations help the person in recovery to form recovery-oriented relationships. As an essential component of the BSAS System of Care, Recovery Support provides resources for individuals and families to meet challenges of lifestyle changes which may be required to sustain recovery, and to reduce risks of relapse. Recovery support services and programs include:

- For adults (including young adults): Community-based peer-driven Recovery Support Centers; Recovery Coaches that are part of outpatient treatment, peer organizations or healthcare clinics; peer-run organizations; faith-based organizations; Community Support Program, a case management program;
- For families and friends: BSAS supports groups for parents, family members, partners and friends of persons with substance-use related disorders; dissemination of evidence-based parenting programs for parents in treatment, and development of a group curriculum for parents of youth in treatment.
- For youth: BSAS supports Recovery High Schools that allow students to continue their education while in treatment; BSAS also supports Assertive Community Care, a case management program for youth and their families.

6. *Supportive Case Management:*

The overall goal for Supportive Case Management is to assist homeless transition age youth, young adults, adults and/or families in recovery to help them achieve self-sufficiency. This goal is achieved through case management services provided within an environment that reinforces recovery through establishing community-based supports to maintain ongoing goals in the recovery process. Living environments include: transitional housing for single adults, families, transition age youth individually and transition age pregnant and parenting youth; permanent housing for single adults, as well as for transition age youth and families. Some of these programs are structured so that responses to relapse focus on continued engagement in recovery and maintenance in the supportive housing.

E. Conclusion:

This section has briefly summarized the comprehensive System of Care that BSAS and its partners have built, and continue to improve.

◆ **Vendors who contract with BSAS are critical partners in supporting and improving this system, and are required to actively promote coordination among components.**

Section II: Essential Characteristics of the System describes specific performance areas and practice goals, such as quality improvement, care integration and collaboration, person-centered care, cultural competency, ADA requirements, promoting a culture of recovery, and harm/risk reduction.

¹ <http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/providers/program-licensing/principles-of-care-and-practice-guidance.html>

² Substance Abuse Strategic Plan Updated 2010, available at: <http://www.mass.gov/governor/docs/strategic-plan-update-july-2010.pdf> Accessed June 2014

³ <http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/providers/program-licensing/principles-of-care-and-practice-guidance.html>

⁴ <http://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/principles-effective-treatment> Accessed June 2014

⁵ <http://www.nida.nih.gov/prevention/principles.html> Accessed June 2014

⁶ Available at: http://www.apa.org/divisions/div50/doc/Evidence_Based_Treatment_Practices_for_Substance_Use_Disorders.pdf Accessed June 2014

⁷ <http://www.drugfree.org/join-together/national-quality-forum-issues-consensus-standards-for-treatment/> PDF document available at: http://www.tresearch.org/download/policy_briefs/NQF_Standards_Summary.pdf Both accessed June 2014

⁸ http://books.nap.edu/openbook.php?record_id=11470&page=R1 Accessed June 2014

⁹ DiClemente et al *Ecological approaches in the new public health*, in Health Behavior Theory For Public Health: Principles, Foundations, and Applications, R.A. Crosby, L. F. Salazar and R.J. DiClemente, eds. Burlington, MA Jones & Bartlett Learning; 1 edition (December 1, 2011)

¹⁰ <http://www.samhsa.gov/data/NSDUH.aspx>

¹¹ <http://www.doe.mass.edu/cnp/hprograms/yrbs/>

¹² <http://beta.samhsa.gov/spf> Accessed June 2014

¹³ <http://www.integration.samhsa.gov/clinical-practice/SBIRT> Accessed 2014

¹⁴ Data from DPH-BSAS Service and Practice Presentation available at:

<http://www.mass.gov/eohhs/docs/dph/quality/drugcontrol/best-practices/20131218-bsas-presentation.pdf>

¹⁵ Mee-Lee, D., et al, eds. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions*. 3rd ed. Carson City, NV: The Change Companies; 2013

¹⁶ SAMHSA, Medication Assisted Treatment for Opioid Addiction in Opioid Treatment Programs, 2008. Available at: <http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214>. Accessed June 2014

¹⁷ For comprehensive descriptions of some of these medications, see: <http://store.samhsa.gov/product/TIP-49-Incorporating-Alcohol-Pharmacotherapies-Into-Medical-Practice/SMA13-4380>

¹⁸ For more information, see: <http://www.dpt.samhsa.gov/medications/naltrexone.aspx>.

¹⁹ <http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/prevention/opioid-overdose-prevention.html>

II. ESSENTIAL CHARACTERISTICS OF THE SYSTEM OF CARE:

This section describes the foundations of the System of Care. These essential characteristics should be evident throughout the system, varying according to the components.

◆ **BSAS requires all vendors in the System of Care:**

- **To adhere to the principles and practices of a Recovery Oriented System of Care;**
- **To establish and maintain quality improvement systems;**
- **To engage in effective collaboration and integrated care;**
- **To value and provide person-centered care;**
- **To understand and respond to individual strengths and needs as well as the individual’s environment of family and community; and**
- **To act to reduce disparities by demonstrating cultural competence and ensuring access for underserved populations and persons with disabilities.**

These characteristics, and evidence of compliance BSAS will assess, are described in detail below.

A. Committed to a Recovery Oriented System of Care:

BSAS is committed to ensuring that its System of Care is Recovery Oriented. That is, the system recognizes that there are many paths to recovery: some individuals recover on their own, or with the help of their family and friends; some repeatedly attempt to achieve recovery through formal treatment. For some, recovery means complete abstinence from substance use. For others reduction of the harm arising from use is a meaningful goal.

Similarly, the nature of effective treatment may vary widely: from a single episode to a series of treatment experiences, comprising different levels and numbers of episodes. An increasing range of medication assisted treatments are proving effective, in combination with other approaches, as well as through primary care.

Choices in treatment and in the path to recovery vary according to experiences with substances, age, culture, co-occurring conditions, availability of family and community supports and a range of other

Guiding Principles of Recovery

1. There are many pathways to recovery.
2. Recovery is self-directed and empowering.
3. Recovery involves a personal recognition of the need for change and transformation.
4. Recovery is holistic.
5. Recovery has cultural dimensions.
6. Recovery exists on a continuum of improved health and wellness.
7. Recovery emerges from hope and gratitude.
8. Recovery involves a process of healing and self-redefinition.
9. Recovery involves addressing discrimination and transcending shame and stigma.
10. Recovery is supported by peers and allies.
11. Recovery involves (re)joining and (re)building a life in the community.
12. Recovery is a reality.

factors.

- ◆ **Vendors are required to demonstrate characteristics of Recovery Oriented Systems of Care, and to establish and maintain a Culture of Recovery, and commitment to Harm Reduction as described below:**

1. Supporting a Culture of Recovery:

A culture of recovery focuses on building and sustaining an individual’s physical and mental health, engagement in supportive relationships, and productive participation in a community that promotes recovery. It recognizes the multiple and varied efforts individuals and their families make to achieve recovery. Within this culture, body, mind and spirit are sustained and enhanced.

The SAMHSA SABG describes the dimensions of recovery as:

- **Health:** a physically and emotionally healthy lifestyle;
- **Home:** A stable, safe and supportive place to live;
- **Purpose:** Meaningful daily activities such as a job, school, volunteerism, family caretaking, or creative endeavors and the independence, income, and resources to participate in society; and,
- **Community:** Relationships and social networks that provide support, friendship, love, and hope.

These principles are consistent with the ecological framework of BSAS’S System of Care: a total continuum of prevention, intervention, treatment, and recovery support services that is built upon available research and evidence-based models to determine best practices. The continuum has evolved from a melding of formal treatment styles and self-help philosophy.

Principles of Effective Treatment

1. Addiction is a complex but treatable disease that affects brain function and behavior.
2. No single treatment is appropriate for everyone.
3. Treatment needs to be readily available.
4. Effective treatment attends to multiple needs of the individual, not just his or her drug abuse.
5. Remaining in treatment for an adequate period of time is critical.
6. Behavioral therapies—including individual, family, or group counseling—are the most commonly used forms of drug abuse treatment.
7. Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.
8. An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs.
9. Many drug-addicted individuals also have other mental disorders.
10. Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug abuse.
11. Treatment does not need to be voluntary to be effective.
12. Drug use during treatment must be monitored continuously, as lapses during treatment do occur.
13. Treatment programs should test patients for the presence of HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases as well as provide targeted risk-reduction counseling, linking patients to treatment if necessary.

◆ **BSAS requires that vendors demonstrate a culture of recovery by:**

- **Applying the 13 Principles of Effective Treatment from the National Institute of Drug Abuse (NIDA: published 1999, revised 2012).**
<http://www.drugabuse.gov/publications/principles-drug-addiction-treatment>
- **Ensuring individuals are referred to the treatment that best matches their needs;**
- **Supporting individuals' dignity, demonstrating the transparency of the vendor's programs and services, i.e. information is shared freely and individuals are full participants in their treatment;**
- **Providing a treatment and recovery environment that is supportive, non-judgmental, and accepting of each individual seeking services; and**
- **Using a recovery oriented response to relapse, one with a primary aim of keeping individuals engaged in treatment.**

Resources:

- **NIATx: Promising Practices: Describe specific and concrete strategies which support individual's in building their foundation for recovery.**
<http://www.niatx.net/promisingpractices/Search.aspx?SPNID=19>
 - Ask Clients to Participate in Treatment Planning
 - Encourage Clients to Use PDSA Cycles to Test Their Own Change
 - Identify Clients at Risk for Leaving and Intervene
 - Assign peer buddies
 - Build Community Among Clients
- **BSAS Practice Guidance: Responding to Relapse, available at:**
<http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/providers/program-licensing/principles-of-care-and-practice-guidance.html>.

2. *Early Identification and Intervention and Supporting Engagement in recovery:*

Individuals, and their families, may approach treatment and recovery in many ways. BSAS is committed to ensuring that the System of Care is capable of responding to any approach or inquiry so that those who need help are effectively and efficiently identified and engaged. This requires that components of the System are welcoming, responsive and skilled, and that components of the system actively coordinate to ensure the System promotes engagement in Recovery.

◆ **BSAS requires that vendors:**

- **Respond to any inquiry by providing current information about the system of care, including community resources, hotlines, referral resources and support groups;**
- **Ensure that individual needs are accurately assessed and individuals are referred to the appropriate level of care;**
- **Have screening and assessment policies, procedures and tools that:**
 - **Ensure accurate collection of information;**
 - **Ensure screening for co-occurring physical and mental health needs;**
 - **Ensure screening for trauma, housing, criminal justice, employment, family, and other social support needs;**
 - **Are appropriate to the age and developmental capacity of the individual; and**
 - **Are inclusive of cultural and linguistic variations;**
- **Work with each other, and other System components, to ensure that referrals and transfers are carried out in planned, coordinated way, based on established, agreed upon procedures;**
- **Ensure that planning for discharge from treatment begins at assessment;**
- **Ensure that regardless of the circumstances of discharge, individuals are supported in continuing in recovery, and reducing harm from substance use;**
- **Establish mechanisms to promote peer relationships and resources by**
 - **Providing information and about peer resources including Recovery Support Centers, Recovery Coaches, and self-help groups; and**
 - **Providing information and referral for family support services and support groups.**

3. Targeting Harm and Risk Reduction:

ASAM describes harm reduction as:

A treatment and prevention approach that encompasses individual and public health needs, aiming to decrease the health and socio-economic costs and consequences of addiction-related problems, especially medical complications and transmission of infectious diseases, without necessarily requiring abstinence. Abstinence-based treatment approaches are themselves a part of comprehensive harm reduction strategies. A range of recovery activities may be included in every harm reduction strategy.²⁰

BSAS endorses this definition and adds ‘Risk Reduction’ as a characteristic of the System of Care, aiming to assist individuals, families and communities to identify risk behaviors in relation

to treatment goals and defining strategies related to those goals that decrease health risks. This approach incorporates principles of harm reduction as described by the Harm Reduction Coalition,²¹ which focuses on strategies that reduce negative consequences associated with drug use. These strategies represent a continuum from safer use, to managed use to abstinence. Combined, harm and risk reduction open a range of options which individuals can define as attainable goals.

- ◆ **BSAS requires vendors to demonstrate a Harm Reduction approach by working with individuals served to develop goals and strategies that decrease health risks and negative consequences of substance use.**

B. Committed to Evidence-Based Practice and to Quality Improvement:

BSAS is committed to improving practice throughout the System of Care. The Substance Abuse Strategic Plan focuses on improvement through enhanced availability and use of data; quality assurance; dissemination of evidence-based and best practices; and increasing responsiveness to needs of communities, families and individuals served. BSAS Principles of Care call for design and operating decisions to be based on evidence of effectiveness, and the SAMHSA SABG underscores the importance of using evidence in making funding decisions, and underscores the importance of assessing the effect of policies and programs on health disparities.

To support these efforts, BSAS has worked to refine data collection and analysis so that data is available to treatment vendors to support assessments of effectiveness and programming decisions. The Office of Data Analytics and Decision Support (ODADS) through the EOHHS application Enterprise Invoice Management and Enterprise Service Management (EIM/ESM), collects and analyzes data for needs assessments and program planning, trend analysis, understanding characteristics of and outcomes for persons served. This data is used to support program assessment, design and decision making. ODADS generates quarterly aggregate reports and provides training emphasizing helping clinicians – who complete forms – understand the purpose and uses of data.

- ◆ **Vendors are required to comply with standards related to accuracy and timeliness of data submission.**

The Quality Assurance and Licensing (QAAL) unit at BSAS assesses compliance with licensing regulations that define minimum standards for treatment services and addictions counselors.** The Unit has implemented e-licensing, which provides for more effective monitoring of compliance and speeds the licensing process; and oversees production and dissemination of BSAS Practice Guidance summarizing current research and best practices. QAAL also receives

**Note that these Standards require vendors to achieve and maintain higher standards of practice.

and investigates complaints relating to licensed programs and/or licensed addictions counselors.

BSAS'S own quality improvement commitments are extensive: BSAS has reviewed and revised procurement systems including redesign of procurements for youth, transitional age youth, and young adults – the population most at risk of substance-related disorders. As partner in demonstration and pilot programs, BSAS has sought and obtained grant funding to explore improvements in services for families, Recovery Support Services, Screening, Brief Intervention and Referral to Treatment (SBIRT), Prevention programming, opioid overdose prevention, and the criminal justice system, among many others.

SABG regulations (45 CFR Part 96.136), requires that BSAS coordinate annual peer reviews of 5% of programs supported in whole or part by federal funds. BSAS supports opportunities for vendors to participate in these independent peer reviews, whereby the quality and appropriateness of treatment services are reviewed by vendors' peers. BSAS contracts with an independent entity to oversee and manage this process, and to select a proportion of vendors to participate in this process each year. BSAS expects vendors to take advantage of this opportunity and to participate in peer reviews when invited.

Within Massachusetts, BSAS works collaboratively to develop resources in areas such as youth and young adults, serving LGBTQ youth and adults, and serving homeless individuals and families. BSAS meetings with providers of service ensure collaborative problem solving with treatment vendors. The Prevention Unit applies the Strategic Prevention Framework (SPF) at all levels, supporting communities in carrying out their own assessments, planning and evaluation of efforts.

Quality improvement need not be mysterious or complex. BSAS supports collaboration with NIATx,²² an 'easy and simple to use model of process improvement,' offering tools, promising practices and collaborative learning. The Addiction Technology Transfer Center Network²³ disseminates information about research and best practices, aiming to build skills at all levels of the system, from clinicians to executives. BSAS also supports training through AdCare Educational Institute and New England Institute of Addiction Studies.

These and other resources are readily available and BSAS expects vendors will utilize them for their own quality improvement efforts, which BSAS will support through mechanisms summarized above.

- ◆ **Vendors are required to establish and implement systems by which they assess:**
 - **Capacity to provide programs and services on the basis of evidence, including evidence from their own practice, and from best practices;**
 - **Effects of programs and services on the individuals and communities served;**

- Effects of programs and services on reducing disparities in access to, quality and outcomes of service in the community served;
- Action needed to improve practice and reduce disparities.
- Cultural competence of the organization and services (see Section II. E below); and
- Capacity to accommodate persons with disabilities (see Section II.F below).
- ◆ **In designing and carrying out these assessments, vendors are required to ensure their quality improvement systems incorporate:**
 - Mechanisms for participation of staff in designing and implementing assessment systems;
 - Process for participation of representatives of the community served in design and implementation of assessments systems, with particular emphasis on ensuring participation by consumers of services;
 - Process for periodic surveys of staff and individuals served to collect information on their satisfaction and suggestions regarding services and program operations;
 - Identification of needed data sources and mechanisms for obtaining and analyzing data;
 - Identification of staff responsible for overseeing assessment efforts;
 - Implementation of periodic consumer and staff satisfaction surveys, including publication and review of results;
 - Method for documenting ways in which results of quality improvement assessments, staff and consumer input, are utilized, and by which organizational change is monitored;
 - Collaboration with other agencies and community partners; and
 - Integration of workforce development.

Note that 104 CMR 164.000, Licensure of Substance Abuse Treatment Programs requires licensees to define goals and objectives (sections 164.037) and establish evaluation plans (section 164.038) that are reviewed annually. These Standards augment those requirements.

Data Resources:

- BSAS-ODADS provides quarterly reports to vendors, and vendors may request reports as part of their assessment efforts. EIM-ESM manuals and forms are available at: <http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/providers/forms/esm-assessment-forms-and-manuals.html>
- ODADS also produces periodic reports, available at: <http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/data/>.

- National data are available through: SAMHSA’s Office of Applied Studies (OAS) (<http://www.drugabusestatistics.samhsa.gov/>); and OAS’s Drug and Alcohol Services Information System (DASIS) Report (<http://samhsa.gov/data/dasis.htm>), which produced the Treatment Episode Data Set (TEDS) reports.
- The National Survey on Drug Use and Health collects and reports behavioral risk and prevalence data, which is available as state reports: <http://www.samhsa.gov/data/NSDUH.aspx>.
- Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System (YRBSS): <http://www.cdc.gov/HealthyYouth/yrbs/index.htm>
- Massachusetts YRBSS results: <http://www.doe.mass.edu/cnp/hprograms/yrbs/>

Program Assessment and Evaluation Resources:

- Network for Improvement of Addiction Treatment (NIATx): www.niatx.net.
- Addiction Technology Transfer Center Network: <http://www.nattc.org/home/>
- Reports on current research: National Institute on Drug Abuse, NIDA Notes: <http://www.drugabuse.gov/news-events/nida-notes>
- SAMHSA Evidence Based Practices Guide to Resources: http://www.samhsa.gov/ebpWebguide/appendixB_Treatment.asp
- BSAS Practice Guidance: Summaries of current research and best practices in substance abuse treatment. Topics include: opioid overdose prevention; responding to relapse; serving youth and their families; serving LGBTQ adults; drug testing as a treatment tool; serving older adults; pregnant women; working with DCF. New topics are added periodically. Available at: <http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/providers/program-licensing/principles-of-care-and-practice-guidance.html>.

C. Committed to Collaboration and Integrated Care:

BSAS expects vendors to apply an ecological framework by actively developing and using linkages with other components of the System of Care, with primary care and mental health care providers, the judicial system, state agencies such as DCF and DYS, and agencies with specific capacities to assist the community served, for example, persons with disabilities (see Section II.F. below). The SAMHSA SABG guidance calls for coordination and achievement of integration, in order to improve outcomes of treatment and increase access to primary care.

1. Collaboration:

Collaboration is individuals, groups, communities or agencies working together to identify needs of persons served, plan and develop systems to jointly address needs and access resources, and, then, jointly assess effectiveness of efforts.

◆ **Vendors are required to establish active collaborations, focused on identifying and developing resources, ensuring smooth transitions among levels of care, establishing effective care coordination, and improving individual and community outcomes. These efforts are evidenced by:**

- **Participation in collaborative groups such as community boards and prevention efforts;**
- **Development of mechanisms for ensuring smooth interface between and among participant systems;**
- **Monitoring provision and effectiveness of services for individuals or families served by multiple agencies, e.g., through case conferences and systematic information sharing (note information below about compliance with 42 CFR Part 2 and HIPAA in collaborative and integrated care); and**
- **Sharing and reviewing aggregate data on outcomes.**

The Affordable Care Act sets forth the model for fully integrated care as a 'health home': a team-based approach that includes the individual, his or her providers, and family members, when appropriate. The health home builds links to community supports and resources, enhancing coordination and integration of primary and behavioral healthcare to better meet the needs of people with multiple chronic illnesses.

See:

<http://www.integration.samhsa.gov/integrated-care-models/health-homes>

2. Integrated Care

Care integration takes collaboration further, aiming to bring together physical and behavioral health care on behalf of individuals. These services are usually provided in different places under different systems. Fully integrated care, as envisioned by the Affordable Care Act, involves physical health care and behavioral health care functioning as one integrated system. SBIRT and Office Based Opioid Treatment are prototypes of behavioral health care provided in primary care settings. Many treatment providers have structures that allow for integrated care, providing mental health and primary health care as well as treatment for substance related disorders within one program.

Integrated care responds to the reality that individuals often experience an array of conditions at any given time -- physical illness, substance-related and mental health disorders -- by establishing a team-based approach to provision of primary and behavioral healthcare.²⁴ The majority of individuals who enter treatment for substance related disorders (SRD's) experience combined effects of those disorders, mental illness and poor physical health. SAMHSA reports that 50% to 75% of persons being treated for substance-related disorders have co-occurring mental disorders²⁵ and that many people treated for behavioral health conditions also have at least one chronic physical health condition.²⁶ Effects of alcohol, tobacco and other drug (ATOD) use on physical health are comprehensive: causing illness, injury and disease; exacerbating non-substance use-related illness; and complicating medical treatment.²⁷ This combination burdens the

family and community, as well as the individual. Many physical and mental health conditions are known to be major contributors to relapse.^{28,29}

Integrated care also helps to reduce stigma associated with substance-related disorders, putting these properly within the sphere of a comprehensive System of Care, an intended effect of the Mental Health Parity and Addiction Quality Act.³⁰

◆ **Treatment providers are required to engage with primary care and mental health care providers to integrate care, and to promote the capacity of individuals and their families to manage their own care, as evidenced by:**

- **Qualified Service Organization Agreements (QSOAs) with primary care and mental health care providers describing means for:**
 - **Cross-consultation;**
 - **Collaborative treatment planning for individuals and their families;**
 - **Action planning to establish common language and understanding of terms;**
 - **Designation of staff responsibilities for ensuring joint planning;**
 - **Action planning for periodically assessing successes and challenges;**
 - **System for sharing information; and**
 - **Staff training on ways to facilitate joint treatment planning, including engaging individuals served and their families;**
- **Inclusion of mental health and primary care goals in assessments and treatment plans including identification of mental health and primary care providers and specification of agreed upon plan for communication.**

Resources:

- [SAMHSA-HRSA Center for Integrated Health Solutions \(http://www.integration.samhsa.gov\)](http://www.integration.samhsa.gov): includes resources about sharing of information between behavioral health and primary care providers, including information and samples for addressing 42 CFR Part 2 and HIPAA in developing integrated systems. The site also describes characteristics and models of integrated care in the page: <http://www.integration.samhsa.gov/integrated-care-models>.

D. Committed to Person-Centered Care

BSAS Principles underscore the importance of responding to the whole person. Addiction affects all life domains: development, brain function, behavior, and acquisition of life skills, relationships, employment, education and housing. Individual characteristics, family and friends, community and environmental factors can hinder or promote prevention and recovery.

◆ **Therefore, BSAS requires vendors to:**

- **Demonstrate understanding of individuals' varying strengths and vulnerabilities in relation to developmental status;**
- **Recognize the importance of family and significant relationships;**
- **Engage individuals and families in their various life circumstances, e.g., in the military; experiencing homelessness; building a family; or involved in criminal justice;**
- **Demonstrate understanding of sexual orientation and gender identity;**
- **Recognize and respond effectively to co-occurring mental health disorders and trauma; and**
- **Recognize and respond effectively to co-occurring conditions such as: HIV/AIDS, Viral Hepatitis and Tuberculosis; opioid overdose; tobacco use and nicotine addiction, and gambling disorders.**

Similarly, the SABG requires assurance that behavioral health is person- and family-centered. The following sections describe the importance of and required responses to these areas.

1. *Responsive to Developmental Status:*

The components of the System of Care (described in Section I, D) are attuned to risks and abilities associated with developmental status, and individual variations in development. Examples include: Prevention programs targeting youth, aiming to reduce age of first use; and SBIRT programs focusing on youth and women of childbearing age; specialized treatment programs designed to respond to specific developmental needs, for example, programs for youth and young adults, or for adults with children.

Key to success in being attuned to developmental status is understanding that, while it is convenient to refer to 'ages' as delineators of development, human development does not adhere to set timetables. Attunement depends on understanding major domains of human growth, which in addition to physical development include relational capacities, family and social roles and abilities, language, cognition, sexuality, gender identity, health, and personal sources of meaning. Wide variations in these areas arise from factors such as culture and socio-economics. Individual variations in development can arise from disabilities, injuries, trauma, physical health challenges, and substance use. Using this approach, an inability to anticipate consequences may be viewed as evidence of a cognitive developmental lag or loss, rather than risk-taking; and difficulty in understanding how others might feel may be viewed as evidence of trauma in early life, rather than indifference.

◆ **BSAS requires vendors to be attuned to developmental status in planning and implementing programs and services, as well as in assessing service needs of individuals.**

Of particular concern are children of parents with substance-related disorders, youth and young adults, and older adults. The SABG highlights the importance of care coordination for children, youth and young adults and older adults, given the number of systems these individuals may be involved with, and the variety of cultural and linguistic needs.

- Children:

More than half of all BSAS treatment admissions, across all levels of care, involve individuals with children, and two-thirds of pregnant women admitted to treatment have children. A parent's substance-related disorder does not unavoidably result in harm to children. Yet, children whose parents have a substance-related disorder are nearly three times more likely to be abused and four times more likely to be neglected than children whose parents do not have an SRD.³¹ Between 40% and 80% of children in foster care placement are affected by substance-related disorders.³² These children are at increased risk of developing substance use related disorders. Therefore, support of parents' capacity to care for their children can protect children from current harm and prevent future harm.

Once in recovery, parents' awareness of how their substance misuse may have undermined their ability to care for their children can result in guilt and uncertainty about how to carry out their roles and enjoy their children.

◆ **All treatment vendors, including those serving youth, are required to assess whether individuals, including men, have children. If the individual is a parent, vendors are required to explore the status of the parent-child relationship, and to assist the individual in setting and reaching goals in relation to his or her child(ren).**

BSAS and its partners support an array of programs to enhance parents' ability to care for their children, and to enjoy their roles as parents. BSAS also supports specialized programs for adults with their children.

◆ **Specialized family residential programs are required to build a supportive network of services, with active QSOAs.**

BSAS regulations require these programs to provide an array of assessment, treatment and care coordination for all family members. BSAS collaborates with DPH Early Intervention Program, MA Department of Children and Families and the Institute for Health and Recovery to develop and provide best practices for families

experiencing substance use and mental health disorders. This work aims to prevent removal of children from the home and to build recovery supports for parents and the family.

In partnership with the Institute for Health and Recovery, BSAS supports capacity building within the treatment component of the System of Care to provide evidence based parenting and parent-child services. The program includes staff training in the *Nurturing Program for Families in Substance Abuse Treatment and Recovery*, an evidence-based practice.

- ◆ **Treatment vendors are required to participate in enhancing capacity to provide best practices for families and enhance their capacity to support treatment and recovery for families.**
- ◆ **In addition, vendors are required to have:**
 - **Well established collaborative partnerships with:**
 - **Early childhood programs;**
 - **Area Department of Children and Families offices; and**
 - **Child behavioral health providers;**
 - **Up to date information about and system for referrals to services for families, such as Women, Infants and Children (WIC); and**
 - **Mechanisms for providing best-practices parenting programs either directly or by referral.**

Resources:

- BSAS Practice Guidance: Partnerships with DCF at <http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/providers/program-licensing/principles-of-care-and-practice-guidance.html>

- **Youth and Young Adults:**

BSAS supports a full continuum of services for youth and young adults: targeted prevention programs –which have resulted in a decrease in the number of youth using alcohol or drugs before age 13;³³ SBIRT in pediatric care and schools; technical assistance to the Department of Youth Services in building capacity; family support and psycho-educational programming; outreach to homeless youth; supporting DPH home visiting programs for teen parents. The Office of Youth and Young Adult Services (OYYAS) at BSAS is deeply engaged in building a comprehensive system of services for youth and young adult, including specialized acute care and stabilization services, youth residential and transitional age youth residential programs, and

outpatient treatment. OYYAS has overseen development of Recovery High Schools, creating environments where young people can work on recovery and continue their education. The Office works directly with shelters for homeless youth, the Interagency Work Group on Youth and Young Adults, parent support groups, and a range of demonstration and pilot programs. Critical system components are: use of evidence based practices, involvement of families and caregivers, care coordination (for example, the Central Intake and Care Coordination program), and developmentally attuned services.

These comprehensive efforts respond to significant need: forty percent (40%) of high school students reported current alcohol use and nearly one-quarter (22%) report binge drinking.³⁴ In Massachusetts³⁵ (as nationally), alcohol use peaks in the 18 – 25 year old group. Opioid use, including heroin, is steadily increasing. NSDUH reports lifetime prescription drug misuse among 18 to 25 year olds is reported at 26%.³⁶ Twenty-to-twenty-four year olds have the highest HIV incidence rates³⁷ and a rapidly increasing incidence of viral hepatitis.³⁸ This is also an age when mental health disorders begin to emerge, compounding effects of substance use (SAMHSA reports that at least one-fifth of youth admitted to treatment are diagnosed with a co-occurring mental health disorder³⁹).

Uneven cognitive development means adolescents and young adults have limited capacity for the abstraction and executive functioning that facilitates perception of risk, and supports a capacity to delay action. Neurological changes in adolescence and young adulthood (such as increased production of dopamine) can substantially increase sensation-seeking.

Two-fifths of BSAS FY2013⁴⁰ enrollments were between the ages of 16 and 29. These young people are a population with increasingly critical needs for responsive treatment: 65% report opiates as their primary or secondary drug of choice; 65% were unemployed; 11% were homeless; 20% had children under the age of 6.

- ◆ **Vendors serving youth and young adults (and/or their parents) are required to demonstrate programmatic capacity to respond to developmental status and needs by:**
 - **Using harm reduction strategies such as reward-based contingency management, best practices such as motivational interviewing;**
 - **Responding to relapse in ways which keep the young person engaged in treatment and recovery, and focus on harm reduction;**
 - **Applying service models which reflect accurate assessment of developmental status, e.g., opportunities for physical activities, shorter group times, help in developing friendships among peers in recovery;**

- **Ensuring program capacity and staff skill in addressing sexuality, gender identity and sexual behavior, including addresses risks of sexually transmitted diseases;**
- **Establishing capacity, directly or through referral, to respond to a range of youth and young adult vulnerabilities such as emerging mental health disorders;**
- **Accessing Recovery Support services for youth and young adults drawing on evidence based curricula and programing, framing decision making in the context of developmental status, and building positive relationships, including developing a network of peers in recovery;**
- **Engaging and supporting family and other supportive relationships in the young person’s life;**
- **Providing opportunities for meaningful participation by the youth/young adult population – opportunities that highlight youth and young adult strengths such as capacity to make intense commitments and invest enthusiastic interest and effort; these may include participating on advisory boards, in program planning, and in engaging other young people; and**
- **Demonstrating flexibility and inventiveness in outreach and engagement;**

Resources:

- BSAS Practice Guidance: Treatment Services for Youth and Their Families, available at <http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/providers/program-licensing/principles-of-care-and-practice-guidance.html>.
- SAMHSA TIP 31: Screening and Assessing Adolescents for Substance Use Disorders, available at: <http://store.samhsa.gov/product/TIP-31-Screening-and-Assessing-Adolescents-for-Substance-Use-Disorders/SMA12-4079>.
- SAMHSA Tip 32: Treatment of Adolescents with Substance Use Disorders, available at: <http://store.samhsa.gov/product/TIP-32-Treatment-of-Adolescents-With-Substance-Use-Disorders/SMA12-4080>.
- **Older Adults:**

In Massachusetts, 14.4% of the population is over age 65,⁴¹ a proportion that is expected to reach 20% by 2030. Metabolism slows as people age, with the result that alcohol and drugs stay in the body longer and have more powerful effects. Alcohol use and/or drug use problems may not be recognized, and may be misdiagnosed as dementia, or other stereotypical evidence of aging. Overall health can deteriorate and treatment of substance related disorders may be complicated

by the array of co-occurring conditions such as physical illness, medication side effects, cognitive impairments, and effects of loss and grief. Mobility limitations may prevent older adults from getting to help. These factors underscore the importance of early, integrated care for older adults. BSAS has produced an array of prevention and SBIRT resources for older adults providing information and screening guidelines focused on alcohol and medication. These are available at the Massachusetts Health Promotion Clearinghouse.⁴²

Current reports estimate that between 10% and 15% of older adults abuse alcohol or other drugs.⁴³ The 'baby boomer' generation is reported to have higher rate of substance use, especially polysubstance use, and to have started using at an earlier age than previous groups of older adults. It is estimated that nearly 50% of this group are at high risk of having substance abuse problems as older adults.⁴⁴

- ◆ **BSAS requires vendors to respond to the needs of older adults and recognize barriers they face in getting needed services by establishing:**
 - **QSOAs and active working relationships with elder care providers, including specifying methods of referral and providing cross-training;**
 - **Approaches aimed at reducing the impact of mobility limitations, e.g., home-based services, services at senior centers, and outreach efforts directed toward nursing homes, senior housing and senior/elder service providers; and**
 - **Adaptations of agency communication system and printed material to accommodate vision and hearing losses. [Note that accommodations for persons with disabilities often benefit older adults.]**

Resources:

- BSAS Practice Guidance: Treatment Services for Older Adults, available at: <http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/providers/program-licensing/principles-of-care-and-practice-guidance.html>.

2. *Committed to Engaging and Supporting Families:*

BSAS'S Ecological Framework underscores the intertwined effects each element has on the others. Substance-related disorders never affect only the person with the disorder. Nor did the individual with a substance-related disorder develop that condition in a vacuum. Family members – including siblings, children, parents, partners and family-by-choice – and friends exert influence on, and are influenced by the individual. These significant relationships may support or undermine treatment and recovery, and they may also be transformed by treatment and recovery.

- ◆ **BSAS requires vendors to acknowledge the importance of family relationships in program design and operations.**

- ◆ **Vendors are required to define families in the broadest sense (including ‘family of choice’) and are required to engage family members, to the extent desired by individuals served, by:**
 - **Providing information and education about substance-related disorders and treatment, and about supports and services available to families;**
 - **Ensuring family relationships are explored in assessments, and goals in relation to these relationships are stated in treatment plans; and**
 - **Providing, either directly or by referral, family therapy and, where indicated, interventions.**
- ◆ **In addition, vendors are required to provide, directly or through referral, evidence based parenting services to all individuals in treatment who have children, regardless of custodial arrangements. See Section II-D-1 for additional requirements related to supporting parents and families in treatment and recovery.**

3. *Committed to Engaging and Serving Lesbian, Gay, Bisexual, Transgender and Queer or Questioning Youth, Young Adults and Adults:*

BSAS is committed to equality in treatment services regardless of sexual orientation or gender identity. Deliberate and thorough attention must be paid to those whose substance use is exacerbated by discrimination and hostility, and whose treatment access is hampered by the same forces. These effects are felt particularly by lesbian, gay, bisexual, transgender and queer/questioning youth, young adults and adults (LGBTQ).

The SABG identifies LGBTQ individuals as at high risk and underserved. Data confirms this, suggesting that substance use and abuse rates among LGBTQ youth, young adults and adults are greater than rates in the general population. Lesbian, gay and bisexual individuals are more likely to report binge drinking and illicit drug use than are heterosexuals.⁴⁵ Data on LGBTQ youth and young adults confirm that these young people -- often living in environments where bullying, threats and rejection are common -- are more likely than their heterosexual peers to use substances: 65% of lesbian and gay youth and 60% of bisexual youth (vs. 46% of heterosexual youth) reported current alcohol use; 20% of lesbian or gay youth (vs. 2% of heterosexual youth) report having used heroin.⁴⁶

BSAS is committed to ensuring that LGBTQ individuals, and their families (including families of choice) can access and safely participate in the System of Care.

- ◆ **BSAS requires vendors to:**
 - **Provide environments that are welcoming to LGBTQ individuals and their families as demonstrated through inclusive images and language in posters, brochures and other materials in public spaces;**

- **Demonstrate safety for LGBTQ individuals by establishing policy, procedure and effective staff training to prevent harassment, discrimination and threats;**
- **Use data collection instruments, such as intake and assessment forms, which are free of assumptions related to gender and sexual orientation, for example, assumptions about the gender of a spouse or partner;**
- **Integrate LGBTQ culture into cultural competence efforts; and**
- **Develop capacity to reach out to and engage families, whether they are supportive or not (research has shown that rejection can be transformed into support and acceptance⁴⁷).**

Resources:

- BSAS has issued Practice Guidance: Serving LGBTQ Youth and Young Adults and Their Families; and Treatment Services for Lesbian, Gay, Bisexual, Transgender and Queer Adults. Both are available at:
<http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/providers/program-licensing/principles-of-care-and-practice-guidance.html>.
- A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual and Transgender Individuals, Substance Abuse and Mental Health Services Administration, 2001, available at:
<http://kap.samhsa.gov/products/manuals/pdfs/lgbt.pdf>

4. Committed to Engaging and Serving Persons Using Opioids:

Opioid use is rapidly increasing in Massachusetts. In Fiscal Year 2013, 55.1% of all admissions to substance abuse treatment identified opioids as the primary drug of choice. Of those, 86.5% reported heroin use.⁴⁸ Incidence of opioid overdose and resulting fatalities has increased apace.

BSAS is committed to ensuring that these individuals, many of whom are young adults, have access to all levels of the treatment system. This includes individuals needing and/or receiving medication assisted treatment, an evidence-based best practice for treatment of opioid dependence.

- ◆ **BSAS requires that all vendors admit individuals receiving medication assisted treatment – including methadone, suboxone and injectable naltrexone -- who also meet other admission criteria.**

Licensed programs may not deny admission solely because an individual uses medication prescribed by a physician outside of the licensee’s service or facility.⁴⁹

- ◆ **In addition, to ensure and coordinate residential services for this population, BSAS requires Residential Rehabilitation Services vendors to participate in**

BSAS'S training on integrating medication assisted and treatment, and other efforts to ensure services are available for individuals receiving medication assisted treatment;

- ◆ **BSAS requires Residential Rehabilitation Services vendors and Opioid Treatment Programs that are geographically near each other to establish and maintain Qualified Service Organization Agreements specifying:**
 - **System for making timely referrals, including plan for follow up;**
 - **Plan for transportation of individuals, as needed;**
 - **Process for submitting requests for exceptions to take home limits, if needed; and**
 - **Plan for safe storage of medications.**
- ◆ **All vendors are required to participate in BSAS'S work to prevent and reduce opioid overdose, by supporting community opioid abuse prevention collaboratives, and, for vendors of treatment programs, by incorporating opioid overdose prevention, recognition and response capacity into staff training, assessments and treatment plans, education, and family support.**

- *Committed to Opioid Overdose Prevention:*

Massachusetts is committed to preventing opioid overdose and improving response to overdose when it happens.⁵⁰ Since 2005, the annual number of opioid related overdose deaths in Massachusetts has exceeded the number of motor vehicle deaths.⁵¹ Opioid overdose deaths have increased six-fold,⁵² and non-fatal opioid-related hospital episodes increased nearly 100%.⁵³ At least half of opioid users report experiencing at least one overdose, and some more than one.⁵⁴ Effective responses are available: opioid overdose deaths were reduced in those communities that had implemented overdose prevention education, including naloxone rescue kits.⁵⁵

BSAS has implemented a range of efforts throughout the System of Care to prevent and reduce opioid overdose. These include the opioid abuse prevention collaboratives, overdose education and naloxone distribution; widespread training for providers of care, and for parents and friends of individuals who use opioids, on preventing, recognizing and responding to overdose; and issuing a Practice Guidance⁵⁶ on Integrating Opioid Overdose Prevention Strategies into Treatment.

- ◆ **Vendors are required to support Massachusetts' efforts to prevent and reduce opioid overdose, as evidenced by:**
 - **A stated commitment to prevent and reduce opioid overdose;**

- **Up-to-date knowledge of overdose prevention and response resources in their communities, including identification of pharmacies stocking naloxone and/or having standing orders for naloxone;**
- **Establishing an on-site overdose emergency response plan and ensuring all staff are trained in preventing, recognizing and responding to overdose;**
- **Including review of overdose history (including witnessing overdose) in treatment assessments;**
- **Educating individuals served about opioid overdose prevention, recognition and response;**
- **Allowing individuals served to retain possession of naloxone rescue kits while in the treatment program;**
- **Including opioid overdose risk reduction in treatment and discharge plans; and**
- **Referring families and friends of individuals served to opioid overdose prevention, recognition and response education resources, including community pharmacies which stock naloxone and/or have standing orders for naloxone.**

Resources:

- MA Opioid Overdose Prevention web page:
<http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/prevention/opioid-overdose-prevention.html>
- BSAS Practice Guidance: Integrating Opioid Overdose Prevention into Treatment, available at:
<http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/providers/program-licensing/principles-of-care-and-practice-guidance.html>.

5. *Committed to Engaging and Serving Pregnant and Post-Partum Women and Women with Children:*

BSAS is committed to ensuring that pregnant and post-partum women have priority access to treatment, a priority under the SABG. Pregnant women with substance-related disorders are exposed to a range of risks. They are less likely to seek timely prenatal care, and are more likely to experience pregnancy complications, including pre-term delivery. Infants born to substance dependent women are more likely to be low birth weight and, depending on the substance, to experience neonatal withdrawal syndrome. Smoking during pregnancy is linked to pregnancy complications such as pre-eclampsia, and to stillbirth and sudden infant death syndrome.⁵⁷ When the woman uses alcohol, the fetus is at risk of fetal alcohol spectrum disorders. Alcohol use during pregnancy is one of the most preventable causes of birth defects.

BSAS supports Screening, Brief Intervention and Referral to Treatment (SBIRT) initiatives to screen pregnant women in primary care settings and educate them to the risks of alcohol, tobacco, and other drug use during pregnancy. Allied with that effort, BSAS'S Task Force on Pregnant Women developed a set of informational materials about acute treatment (detox), for pregnant women and their families, as well as a guide for acute treatment providers.⁵⁸ BSAS funds inpatient acute treatment services for uninsured pregnant women and Specialized Residential Rehabilitation for pregnant women.

Pregnant women admitted to the BSAS system of care for treatment represent a population experiencing high risks: nearly one-third (32.93%) are between 18 and 25 years old; 76% report lifetime heroin use, and 57% report needle use in the prior year; 28% are homeless.

◆ **Consistent with BSAS priorities and with priorities of the SAMHSA SABG, BSAS requires vendors to:**

- **Give priority access to pregnant and post-partum women; ***
- **Establish mechanisms to ensure smooth transitions from one level of care to another, especially for women who are dependent on opioids, recognizing that medication assisted treatment, combined with prenatal care, is currently the standard of treatment for opioid dependent pregnant women, since medication assisted treatment substantially reduces risk of relapse, thus avoiding overdose, HIV and other dangers of illicit drug use;**
- **Establish collaborative partnerships with pre-natal and post-partum care, early intervention and early childhood services;**
- **Provide, directly or through referral:**
 - **Evidence based parenting services; and**
 - **Family recovery services, including family and couples therapy.**

In addition, women who are pregnant and using substances are at higher risk for depression during pregnancy and in the post-partum period,⁵⁹ and are at increased risk of experiencing violence.⁶⁰ To respond to this need:

◆ **Vendors are required to establish collaborative agreements with mental health care and domestic violence services and resources.**

6. *Committed to Engaging and Supporting Those Involved with the Criminal Justice System:*

Approximately 40% of BSAS admissions are involved with the criminal justice system, and this population is a priority for BSAS and the SABG. In the 2014-15 SABG, SAMHSA

* It is not unusual for a woman to learn she is pregnant as a result of detox admission pregnancy test.

estimates that six in ten inmates meet criteria for substance related disorders and one-third meet criteria for co-occurring disorders,⁶¹ but only 11% received any treatment.⁶²

Substance-related disorders and criminal justice involvement substantially increase recidivism, risks of violence and property loss, undermine public health and safety, and increase risks such as HIV and Viral Hepatitis.⁶³ Recognition of this synergistic relationship has led to changes in law and criminal justice functioning, in some cases with stricter sentencing, and in others with attempts to incorporate understanding of substance-related disorders into judicial processing (e.g., drug courts). These efforts acknowledge that failure to identify and treat these individuals almost assures continuation of the pattern.

BSAS is engaged in a wide range of efforts to promote collaboration with the criminal and juvenile justice systems to build capacity and improve responses. In interagency work groups and resource development, BSAS works closely with state agency partners, such as the Departments of Correction and Youth Services, with Parole and Probation offices, and with the Trial Court and local courts – BSAS has partnered in building collaboration among treatment resources and drug courts (courts with specialized dockets for individuals using substances). BSAS licenses programs for driving under the influence offenders; supports a system aimed at jail diversion through case management and residential treatment; and has worked directly with houses of correction to implement treatment behind the walls as well as peer overdose prevention training and Access to Recovery services. BSAS licensing regulations⁶⁴ prohibit categorical exclusion from admission of individuals with involvement with the criminal justice system.

Through efforts such as these, involvement in the criminal justice system may represent an opportunity for individuals to begin recovery and reduce recidivism. SAMHSA reports that offenders are best served when substance abuse treatment and criminal justice systems work together.⁶⁵

◆ **BSAS requires partners at all levels of the System of Care to support efforts to improve collaboration with the criminal justice system, as evidenced by:**

- **Giving priority access to individuals involved with the criminal or juvenile justice system;**
- **Establishing coordination with local drug courts;**
- **Recognizing that individuals recently released from incarceration are at high risk for opioid overdose by ensuring overdose risk is addressed in assessment, treatment planning and services;**
- **Providing case management services focusing on access to insurance, housing and primary care, and support to re-connect with family.**

7. Committed to Engaging and Serving Homeless Individuals and Families:

Homeless individuals and families are identified as an underserved population under the SABG. Those who are homeless suffer disproportionately from all ills, and face disproportionate barriers to services, such as housing, health care, education, mental health care, and opportunities for employment. The United States Interagency Council on Homelessness estimates that almost 50% of homeless individuals suffer from substance-related disorders.⁶⁶ The proportion is even higher for homeless veterans, where the estimate is 70%.⁶⁷ Homeless youth are particularly vulnerable. The Massachusetts Department of Elementary and Secondary Education estimates that 6000 high school students are homeless – this does not include homeless youth who have dropped out and were not counted.⁶⁸ Twenty-five percent (25%) of lesbian and gay youth, and 15% of bisexual youth reported homelessness.⁶⁹ Homeless youth are particularly vulnerable to violence, sexual assault and exploitation.

BSAS works in collaboration with many state and federal agencies, payers, providers, consumers, and advocacy groups to develop policies, best practices, and approaches to address the needs of homeless individuals and families. Through grants from the US Department of Housing and Urban Development, BSAS provides supportive case management, housing stabilization and recovery support for individuals, families, and in specialized programs for transitional age youth.

◆ **Treatment vendors are required to respond to the needs of homeless individuals and families, by:**

- **Establishing priority admissions for homeless individuals;**
- **Establishing relationships with local shelters and housing resources;**
- **Ensuring housing and employment needs are addressed during initial assessments and treatment planning; this includes determining at the outset whether the individual or family currently has permanent housing; and**
- **Utilizing resources such as SAMHSA’s Homelessness Resource Center,⁷⁰ to develop expertise in applying best practices to engage and serve homeless individuals and families. The Resource Center provides an array of training opportunities, research and guides for engaging homeless individuals, families and youth. Information is available at:
<http://homeless.samhsa.gov/Default.aspx>.**

8. *Committed to Engaging and Serving Those Who Served in the Military, and Their Families:*

BSAS is committed to building capacity within the System of Care to identify and engage those who have served in the U.S. military, and their families – individuals and families who are at high risk and are priorities under the SABG. The BSAS Veterans’ Services Coordinator works closely with the Massachusetts Department of Veterans’

Services, local Veterans' Services Organizations (VSO), Veterans Treatment Courts and other organizations serving veterans, focusing on building collaboration among systems, and capacity of the substance abuse treatment system to identify and respond to those who have served in the military.** BSAS has issued a Practice Guidance: Engaging Veterans in Treatment⁷¹ that summarizes the array of experiences and needs of the population, providing detailed descriptions of effective responses.

Those who have served in the military are a diverse population, including older women and men who served in conflicts including the Vietnam war (this group currently comprises the largest portion of surviving seriously injured veterans, 33% of the total⁷²) to young men and women who served in the post-9/11 military. Co-occurring factors include injuries such as traumatic brain injury (which may be mis- or undiagnosed); combat-related trauma; and military sexual assault, experienced by both women and men. Families and communities experience prolonged, frequent separations, and bewildering challenges in re-establishing relationships and family life.

Need for intervention related to substance abuse is well documented. The post-9/11 military has seen a tripling of prescription drug abuse.⁷³ Twenty percent (20%) of active duty personnel meet criteria for heavy alcohol use.⁷⁴ SAMHSA reports that 11% of those serving in OEF-OIF (Operation Enduring Freedom [Afghanistan] and Operation Iraqi Freedom [Iraq]) have a diagnosed substance use disorder.⁷⁵

- ◆ **In responding to treatment needs of those who have served in the military, BSAS requires vendors to:**
 - **Apply a definition of 'veteran' or 'those who served in the military' to include those who have other than honorable discharges, and/or have served in the National Guard or Reserves;**
 - **Build active collaborations, through formal Qualified Service Organization Agreement, with**
 - **Veterans services organizations and local veterans peer organizations; and**
 - **Resources for families, children and partners of those who have served;**
 - **Ensure collaboration includes cross-training, particularly training on military culture and including "Battlemind," a service-related set of values and behaviors which may inhibit help-seeking, and complicate return to civilian life;**

** BSAS recommends using the phrase 'served in the military' when inquiring about status, since some of those who served do not identify themselves as 'veterans'. See the BSAS Practice Guidance: Engaging Veterans in Treatment for more information.

- **Review policies which might adversely affect those who served, for example, policies requiring discharge for behavior that may be symptomatic of traumatic stress or traumatic brain injury;**
- **Ensure agency trauma training includes understanding service related trauma, affecting both those who served and their families; and**
- **In addition, staff training on co-occurring conditions should explicitly include recognition that between 37% and 50% of OEF and OIF forces have been diagnosed with a mental health disorder, most commonly PTSD and depression.⁷⁶**

9. *Committed to Engaging and Serving Persons with Co-Occurring Mental Health Disorders:*

The co-occurrence of substance use and mental health disorders is well documented. SAMHSA⁷⁷ has estimated that 50% to 75% of persons treated for substance-related disorders (SRD's) have co-occurring mental health disorders.

BSAS is committed to working with all partners at all levels to develop a seamlessly integrated service system for individuals with co-occurring substance related and mental health disorders (COD's). Given the incidence of co-occurrence, an integrated system should be the norm. Such a system would be built on shared understanding of: common definitions and terms; competencies needed by providers of substance-related disorder services and of mental health services; data elements for monitoring and evaluation; training priorities; standards and guidelines; and funding mechanisms. BSAS has worked closely with the Massachusetts Department of Mental Health (DMH) and the Massachusetts Behavioral Health Partnership (MBHP) in defining this system, drawing on Kenneth Minkoff's Continuous, Comprehensive and Integrated System of Care (CCISC) model.⁷⁸ This model highlights the fact that co-occurrence should be expected in behavioral health care and the System of Care should be designed to be welcoming and responsive.

BSAS works with vendors to implement these principles.

◆ Treatment vendors are required to assess their capacity to serve individuals with co-occurring disorders, and to ensure that:

- **Organizational leadership analyze existing systems and operations to identify and implement ways to ensure smooth care coordination; this analysis is included in vendor's quality improvement plans;**
- **Collaborative agreements with mental health service providers are in place and provide for systems for referral and follow-up, care coordination, and periodic review of obstacles and success;**

- **Screening and assessments include mental health needs; plans specify goals for mental health care;**
- **Treatment plans specify referral and follow up for mental health services, process for care coordination, plan for care management, specifically for ensuring proper medication management; and**
- **Staff are trained in mental health issues and disorders, and side effects of medications.**

Resources:

- SAMHSA Integrated for Co-occurring Disorders Evidence Based Practices Kit, available at: <http://media.samhsa.gov/co-occurring/news-and-features/integrated-treatment.aspx>.
- SAMHSA: Co-Occurring Center for Excellence: <http://store.samhsa.gov/list/series?name=Co-Occurring-Center-for-Excellence-COCE-Overview-Papers>.

10. Committed to Providing Trauma Informed Care:

The first National Comorbidity Study⁷⁹ found that in the general population, 61% of men and 51% of women had at least one traumatic experience (includes witnessing traumatic events, traumatic injury, disasters and life-threatening accident). More recently, the National Epidemiologic Survey on Alcohol and Related Conditions found that as many of 71% of persons with substance-related disorders had experienced traumatic events,⁸⁰ including domestic violence, combat-related trauma, and childhood abuse. By now, the prevalence of exposure to trauma among persons served in the behavioral health system is widely acknowledged. The SABG advocates for trauma-informed service systems, the benefits of which are – to individuals, families, agencies and programs – are increasingly evident SAMHSA describes benefits including a greater sense of safety, improved screening, assessment and treatment planning, and decreased risk of re-traumatization.⁸¹ Benefits can apply to staff as well as to individuals served. Trauma-informed care can reduce the impact of trauma and violence.

◆ Trauma-informed care is an approach to delivery of behavioral health services. Given the prevalence of trauma among persons with substance related disorders, and the benefits of trauma-informed approaches, BSAS requires vendors to establish trauma-informed treatment environments and provide trauma informed care, as evidenced by:

- **Stated commitment to trauma-informed care, with emphasis on individual choice and decision making;**
- **Collaborative systems which provide for access to trauma specific services;**
- **Inclusion of trauma screening in all assessments, and periodic reassessments;**

- **Prohibition of coercion or force in treatment;**
- **Recognition that children of individuals served have experienced trauma, and that they and their parents may require support and assistance in obtaining effective trauma treatment;**
- **Periodic assessments of the degree to which policies and procedures:**
 - **Ensure that the environment is safe and clearly provides a sense of safety, e.g., interactions are predictable; staff are aware of potential triggers in the environment; service provision is transparent;**
 - **Review questionnaires and interview/assessment questions to ensure they are trauma sensitive.**
 - **Recognize that some behaviors may be attempts to cope with trauma-related symptoms and respond accordingly; and**
 - **Ensure that program design and workforce development reflect understanding of:**
 - Pervasive effects of trauma, for example, on relationships, families and communities;
 - The complex links between trauma and addiction;
 - Trauma-informed services do not depend on staff knowledge of an individual’s trauma experiences, nor on an individual’s disclosure of trauma experiences;
 - Sensitive and effective methods of exploring trauma, making referrals and supporting individuals; and
 - Potential for staff to experience secondary trauma (or their own trauma) thus requiring organizational and supervisory supports.

Resources:

SAMHSA TIP 57 *Trauma Informed Care in Behavioral Health Services*, available at: <http://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/Most-Popular/SMA14-4816?sortBy=4>.

11. Committed to Prevention of and Reducing Harm From HIV/AIDS, Viral Hepatitis and Tuberculosis:

In recent years, rates of HIV infection among injection drug users (IDU’s) have dramatically decreased both in Massachusetts, and nationally, largely due to effective prevention and treatment programs. Nevertheless, HIV is increasingly a sexually

transmitted infection, with women and people of color more likely than white men to acquire HIV sexually.⁸² Further, reductions in HIV infection rates may be offset by an increase in Hepatitis C (Viral Hepatitis) infections, especially among young people age 15 to 24, whose viral hepatitis diagnoses increased by 74% between 2002 and 2009.⁸³ Young people are also at high risk for HIV. In 2010, youth aged 13 to 24 accounted for 24% of new HIV infections, yet nearly 60% of infected young people do not know their status.⁸⁴

Incidence of Tuberculosis infection has also decreased as a result of effective screening, testing, treatment and education. However, TB remains a co-occurring risk for persons with substance-related disorders, especially those who are also homeless, have been incarcerated or are HIV positive.

- ◆ **Therefore, vendors are required to ensure that all employees are screened at hiring and annually thereafter, and that individuals served are assessed for their risk for TB, and are provided screening, education and treatment either directly or through referral.**

HIV, viral hepatitis and TB compound risks, and those infected or at risk of infection are identified as a high risk population under the SABG. Education about HIV/AIDS, Viral Hepatitis and Tuberculosis prevention is an effective strategy, and BSAS has offered an array of trainings to support providers in complying with BSAS requirements regarding the provision of HIV, viral hepatitis and TB information to individuals served. BSAS also works closely with the MDPH Office of HIV/AIDS (OHA) and supports its goals and priorities, especially working to increase the number of people who know their status, to decrease the number of new HIV infections, and to improve the health and quality of life for infected and high-risk uninfected individuals.

- ◆ **BSAS has established a range of resources to promote education and prevention, and requires vendors to support these efforts by:**
 - **Designating staff to coordinate HIV/AIDS, Viral Hepatitis education, assessment, counseling and testing. BSAS expects this coordinator to attend regional Program AIDS Coordinator (PAC-Net) meetings;**
 - **Integrating HIV/AIDS, Viral Hepatitis and Tuberculosis education into treatment programming;**
 - **Including HIV/AIDS, viral hepatitis and tuberculosis risk, related to both sexual and drug use behaviors, in all assessments and psycho-educational programming;**
 - **Ensuring that family and couples therapy, whether offered directly or through referral, include education about HIV/AIDS/Viral Hepatitis risks and prevention;**

- Establishing active referral relationships, documented through a Qualified Service Organization Agreement (QSOA), with HIV/AIDS, Viral Hepatitis and Tuberculosis prevention, education, counseling, and clinical care providers including testing, and support services;
 - Ensuring that individuals who choose to be tested for these diseases are provided, either directly or through referral, support and counseling as to the process, results and care management, if needed; and
 - Encouraging pregnant women in treatment to consider HIV testing, and to offer HIV antibody testing, and support to access HIV care when indicated.
- ◆ **Programs working with youth and young adults are required to address sexuality and sexual behavior, including STD/HIV/Viral Hepatitis risks and transmission, using age-appropriate strategies to inform, assess, and approach these issues.**

Resources:

- MA-DPH Office of HIV/AIDS (OHA) is a central resource for information. OHA produces a Services and Resource Guide which is available at:
<http://www.mass.gov/eohhs/gov/departments/dph/programs/id/hiv-aids/services/>.

12. Committed to Addressing Tobacco Use and Nicotine Addiction:

Tobacco-related diseases are the leading cause of death among persons treated for substance-related disorders. Smoking and tobacco use are known to contribute to relapse.⁸⁵ Second hand smoke is known to causes a broad range of health problems from asthma and ear infections in children, to pregnancy complications, and coronary diseases in adults.⁸⁶

Research has found that simultaneous treatment of substance abuse and smoking can be more effective than treatment that does not address smoking.⁸⁷ MA-DPH and BSAS have developed and implemented an array of programs to prevent smoking and tobacco use, to help people stop smoking, and to address nicotine addiction. BSAS has supported integration of tobacco policy, education and treatment into treatment since 1994, in partnership with the Institute for Health and Recovery TAPE Project

- ◆ **Given the consequences of tobacco use and smoking, and the array of resources available, all partners in BSAS'S System of Care are required to prevent tobacco use and smoking and to provide treatment for addiction to nicotine, in a supportive environment, as evidenced by:**
- **Written policy prohibiting tobacco use and smoking in all buildings, including entrances, and vehicles owned or used by the vendor in provision of service;**

- **Written policies prohibiting staff smoking or using tobacco products with individuals served;**
- **Establishment of no-tobacco and no-smoking zones of at least a 20-foot perimeter around buildings;**
- **Prohibition of any display of tobacco or smoking related materials, including personal possessions displaying tobacco related logos;**
- **Ensuring bi-annual staff participation in training offered by the TAPE project every two years;**
- **Application of all tobacco and smoking restrictions to e-cigarettes, pending definitive research on the safety and addictive potential of these products;**
- **Designation of a staff person as Tobacco Education Coordinator; and**
- **Integration of nicotine addiction in assessments, treatment planning, services and education.**

Resources:

- Institute for Health and Recovery TAPE Project: <http://healthrecovery.org/our-work/tobacco/>
- Massachusetts Tobacco Cessation and Prevention Program: <http://www.mass.gov/eohhs/gov/departments/dph/programs/mtcp/>
- Massachusetts Smokers' Helpline: <http://makesmokinghistory.org>
- Center for Tobacco Treatment Research and Training: <http://www.umassmed.edu/tobacco/>
- Institute for Health and Recovery TAPE Project: <http://healthrecovery.org/our-work/tobacco/>

13. Committed to Addressing Problem Gambling:

The Massachusetts Council of Compulsive Gambling reports that nearly 80% of the general population has gambled during their lifetime – that is, have played a game for money or property, bet money or property on an uncertain outcome or as a stake on a contingency.⁸⁸ Gambling behaviors activate reward systems similar to those activated by drugs. Behavior patterns associated with addictions, such as persisting in maladaptive gambling despite disruptions in important spheres of life: personal, family, employment, etc., are also hallmarks of a gambling disorder.⁸⁹ While only a small proportion (2 – 3%) of those who gamble will experience a problem with gambling, of those who do, between one-third and four-fifths will also experience problems with alcohol or other drugs. Consequences of problems with gambling mirror those of substance related disorders: family dysfunction and disintegration, co-occurring disorders, suicidality, and involvement with the criminal justice system.⁹⁰

Efforts to address problem gambling and its consequences are supported through the Massachusetts Expanded Gaming Act, passed in November of 2011. The Act establishes a Public Health Trust Fund financed through an annual assessment and percentage of casino revenues for the purpose of addressing issues associated with problem gambling. BSAS seeks to build capacity to provide services related to problem gambling and to substantially increase the number of programs in the state that offer prevention, intervention, treatment, and recovery support services related to problem gambling.

- ◆ **To address this constellation of risks and harms, BSAS requires all vendors to establish written policies to establish a gambling-free environment, including prohibition of:**
 - **Use and display of gambling related items and activities including lottery games, sports betting, raffles and fundraising tickets, bingo or beano, games, including electronic or online games using gambling;**
 - **Illegal wagering of any kind;**
 - **Staff gambling or discussion of gambling;**
 - **Activities, such as off-site trips, to venues where gambling is available; and**
 - **Gambling machines (such as lottery machines) or opportunities.**
- ◆ **Licensed providers are required to address problem gambling in assessments, and, if problems are identified, to provide treatment either directly or by referral.**

Resources:

- BSAS Gambling-Free Policy Guidelines: <http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/providers/program-licensing/guidelines/gambling-free-policy.html>
- Massachusetts Council on Compulsive Gambling: Offers information, a helpline and training on gambling: <http://www.masscompulsivegambling.org>.
- Screening resources are available at: <http://www.ncrg.org/resources/brief-biosocial-gambling-screen> and http://www.divisiononaddiction.org/bbgs_new/.

E. Committed to Cultural Competence and Reducing Disparities:

BSAS is committed to a System of Care that is equitable, in which quality of, access to and outcomes of programs and services do not vary according to individual characteristics such as ethnicity, language, race, age or country of origin. Racial, ethnic, linguistic and cultural minorities consistently experience lower quality of care, as evidenced by differences in access, appropriateness and outcomes of care. Many individuals and families represent blended cultures and thus may experience disparities arising from a number of factors. Healthcare disparities are well documented and arise from broad system-wide factors, organizational

factors, and factors in the individual encounters between persons needing service and practitioners.⁹¹

Cultural competence is critical to ensuring equitable access to and engagement in treatment and recovery – a fundamental BSAS Principle of Care.⁹² Cultural competence:

- Reduces treatment disparities which adversely affect racial, ethnic, linguistic and cultural minorities;
- Supports best and evidence-based practices; and
- Improves outcomes.

BSAS embraces National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care which establish principles upon which organizations can “provide effective, equitable, understandable and respectful quality care and services, responsive to diverse cultural health beliefs and practice, preferred languages, health literacy and other communication needs.”⁹³ These standards define areas organizations should address to achieve cultural competence, including: governance, leadership and workforce, communication and language assistance, community engagement and continuous improvement and accountability.

The DPH Office of Health Equity (OHE) created *Making CLAS Happen*⁹⁴ and the U.S. Office of Minority Health has created *the Blueprint for Advancing and Sustaining CLAS Policy and Practice*⁹⁵ to provide detailed guidance on implementing CLAS and on maintaining continuous quality improvement efforts. OHE, with the Bureau of Health Information, Statistics, Research and Evaluation, has also developed Standards for Collection of Race, Ethnicity and Language Data,⁹⁶ which describes approaches to and resources for effective data collection.

◆ **Vendors are required to comply with cultural competence standards, as evidenced by:**

- **Completing the CLAS Agency Self-Assessment developed by the DPH Office of Health Equity, available at:**
<http://www.mass.gov/eohhs/gov/departments/dph/programs/admin/health-equity/clas/request-for-responses.html>;
- **Completing the Agency Staff Demographics Table, also available at**
<http://www.mass.gov/eohhs/gov/departments/dph/programs/admin/health-equity/clas/request-for-responses.html>;
- **Including results of these assessments in written Quality Improvement plans which state specific goals related to assessment results;**
- **Ensuring that staff cultural competence training includes exploration of CLAS standards and address effects of staff assumptions and beliefs on access to and outcomes of treatment;**
- **Workforce development efforts focused on hiring diverse, bilingual staff;**

- **Engagement with racial, cultural and/or ethnic community groups and organizations; and**
- **Specifically addressing language access using guidelines and tools described in *Making CLAS Happen: Six Areas for Action*, including:**
 - **Assessing language service needs; and**
 - **Developing resources and mechanisms for providing professional interpreter services and translations of written materials including brochures, informational materials and signage.**

Resources:

- See BSAS’S Practice Guidance: Making Treatment Culturally Competent for more information and for links to resource mentioned here, and available elsewhere. The Practice Guidance is available at:
<http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/providers/program-licensing/principles-of-care-and-practice-guidance.html>.

F. Committed to Providing Access for Persons with Disabilities:

Research documents high rates of substance-related disorders (SRD’s) among persons with disabilities,⁹⁷ ranging from 14% among persons with developmental disabilities to 50% among persons with traumatic disabilities.⁹⁸ Tobacco use rates are also high: in Massachusetts 24% of persons with disabilities smoke, compared to 17% of the general population. Excluded from these statistics are persons with disabilities who either have not been identified or assessed or who have not been reached by surveys omitting adaptive technology. SAMHSA estimates that 50% of persons with a substance use disorder and co-existing disability are not identified as such.⁹⁹

BSAS is committed to supporting efforts to ensure that programs effectively reach, engage and serve persons with disabilities, in ways that are fully integrated into all agency programs and operations. BSAS policy calls for programs to have an Access Coordinator in a senior management position. Licensing regulations (105 CMR 164.043) require that applicants for licensure demonstrate compliance with the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act.

- ◆ **Tools to guide vendors in achieving integrated accommodation are available, and vendors are required to complete the Massachusetts Facility Assessment Tool, available at:**
<http://www.mass.gov/eohhs/gov/departments/dph/programs/community-health/health-disability/ada-compliance/the-massachusetts-facility-assessment-tool.html>. This tool provides a comprehensive method of

determining whether physical plants are fully accessible for persons with disabilities, and identifying whether action needed.

- ◆ In addition, vendors are required to develop policies and procedures that comply with ADA, including employment policy, accommodations, integration, communications, transportation etc. Guidelines are included in ADA Guide for MDPH Contracted Providers at:
<http://www.mass.gov/eohhs/gov/departments/dph/programs/community-health/health-disability/ada-compliance/ada-guide-for-mdph-contracted-providers.html>.

- ◆ Vendors are also required to:

- Include goals related to access to and outcomes of service for persons with disabilities in Quality Improvement Plans;
- Ensure individual assessments explore disabilities or evidence of undiagnosed disabilities;
- Ensure that staff training includes:
 - Understanding requirements of law, regulation and policies related to access and accommodation;
 - Value of and process for individualized assessment and treatment;
 - Effects of staff attitude and bias on identifying and serving persons with disabilities, and effects of disparate or disproportionate care;
 - Awareness of community resources;
 - Importance of exploring the meaning of a disability to the individual;
 - Understanding the culture and experience of disability; and
 - Adapting treatment methods to meet individual needs;
- Establish Qualified Service Organization Agreements with providers of services to persons with disabilities such as Independent Living Centers, and local offices of the Massachusetts Commissions for the Blind and for the Deaf and Hard of Hearing.

Resources:

- BSAS Practice Guidance: Access for Persons with Disabilities, available at:
<http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/providers/program-licensing/principles-of-care-and-practice-guidance.html>.

G. Summary:

Standards contained in this section describe a System of Care that embraces a comprehensive, evidence based approach to preventing and treating substance related disorders and supporting recovery. Vendors' compliance with these standards assures effectiveness, integration and best practices throughout the system.

²⁰ Mee-Lee op cit

²¹ <http://harmreduction.org/about-us/principles-of-harm-reduction/>

²² <http://www.niatx.net>

²³ <http://www.nattc.org/home/>

²⁴ See: <http://www.integration.samhsa.gov>

²⁵ [TIP 42 Substance Abuse Treatment for Persons with Co-Occurring Disorders](#), Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services

²⁶ [Co-Occurring Chronic Conditions](#), SAMHSA-HRSA Center for Integrated Health Solutions

²⁷ [Co-Occurring Disorder Related Quick Facts: Physical Health](#). Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services

²⁸ Curran, G.M., et al. (2007) Recognition and management of depression in a substance use disorder treatment population. *American Journal of Drug and Alcohol Abuse*, 33: 563-569.

Suter, M., et al. (2011) Depressive symptoms as a predictor of alcohol relapse after residential treatment programs for alcohol use disorder. *Journal of Substance Abuse Treatment*, 41:225-233.

Shiffman, S., & Balabanis, M. (1996). Do drinking and smoking go together? *Alcohol Health & Research World*, 20:107-110.

Stuyt, E. (1997). Recovery rates after treatment for alcohol/drug dependence: Tobacco users vs. non-tobacco users. *The American Journal on Addictions*, 6, 159-167.

²⁹ Curran, G.M., et al. (2007) Recognition and management of depression in a substance use disorder treatment population. *American Journal of Drug and Alcohol Abuse*, 33: 563-569.

Suter, M., et al. (2011) Depressive symptoms as a predictor of alcohol relapse after residential treatment programs for alcohol use disorder. *Journal of Substance Abuse Treatment*, 41:225-233.

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Stuyt, E. (1997). Recovery rates after treatment for alcohol/drug dependence: Tobacco users vs. non-tobacco users. *The American Journal on Addictions*, 6, 159-167.

³⁰ <http://beta.samhsa.gov/health-reform/parity>

³¹ [No Safe Haven: Children of Substance Abusing Parents](#), National Center on Addiction and Substance Abuse, 1998

³² [Research Studies on the Prevalence of Substance Use Disorders in the Child Welfare Population](#), National Center on Substance Abuse and Child Welfare, SAMHSA

³³ MA 2011 Youth Risk Behavior Survey Report. <http://www.doe.mass.edu/cnp/hprograms/yrebs/>

³⁴ Ibid

³⁵ 2010-2011 National Survey on Drug Use and Health: Model-Based Prevalence Estimates

(50 States and the District of Columbia) Available at: <https://nsduhweb.rti.org/respweb/homepage.cfm>

³⁶ Spoth, et al. Longitudinal effects of universal preventive intervention on prescription drug misuse: three randomized controlled trials with late adolescents and young adults. *Am J Pub Health* 103(4) Apr 2013

³⁷ Center for Disease Control and Prevention, HIV/AIDS, Statistics Overview, <http://www.cdc.gov/hiv/statistics/basics/>.

³⁸ Massachusetts Department of Public Health Bureau of Infectious Disease Office of HIV/AIDS, Shifting Epidemics: HIV and Hepatitis C Infection among Injection Drug Users in Massachusetts (2010)

<http://www.mass.gov/eohhs/docs/dph/aids/shifting-epidemics-report.pdf>

³⁹ [Adolescents with Co-occurring Disorders, SAMHSA](#)

⁴⁰ Data from DPH-BSAS Service and Practice Presentation available at:

<http://www.mass.gov/eohhs/docs/dph/quality/drugcontrol/best-practices/20131218-bsas-presentation.pdf>

⁴¹ U.S. Census Bureau (2014a) State-level information. Information accessed at

<http://quickfacts.census.gov/qfd/states/25000.html>

⁴² <http://massclearinghouse.ehs.state.ma.us/BSASELD/SA1093.html>

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- ⁴³ SAMHSA [The impact of substance use and abuse by the elderly](#); and NYS <http://www.oasas.ny.gov/AdMed/FYI/FYIInDepth-Elderly.cfm>
- ⁴⁴ SAMHSA, [Substance Abuse by Older Adults: Estimates of Future Impact on the Treatment System](#)
- ⁴⁵ ⁴⁵ [A Health Profile of Massachusetts Adults by Sexual Orientation Identity: Results from the 2001-2006 Behavioral Risk Factor Surveillance System Surveys](#)
- ⁴⁶ Ibid.
- ⁴⁷ ⁴⁷ Ryan, C. et al, Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay and Bisexual Young Adults. *Pediatrics* 2009; 123; 346 Available at: <http://pediatrics.aappublications.org/content/123/1/346.full?ijkey=NrncY0H897IAU&keytype=ref&siteid=aapjournals>
- ⁴⁸ Data from DPH-BSAS Service and Practice Presentation available at: <http://www.mass.gov/eohhs/docs/dph/quality/drugcontrol/best-practices/20131218-bsas-presentation.pdf>
- ⁴⁹ 105 CMR 164.070(H)
- ⁵⁰ See *Opioid Overdose Prevention Strategies* which can be found at: <http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/prevention/opioid-overdose-prevention.html>
- ⁵¹ Walley, AY, et al. (2013) Opioid overdose rates and implementation of overdose education and nasal naloxone distribute in Massachusetts. *BMJ*: <http://www.bmj.com/content/346/bmj.f174>
- ⁵² See *Injury Surveillance: Drug Overdoses and Poisonings (2009 report)* at: <http://www.mass.gov/eohhs/gov/departments/dph/programs/health-stats/injury-suveillance/reports/drug-overdoses-and-poisonings.html>
- ⁵³ Ibid.
- ⁵⁴ MA Opioid Overdose Prevention Strategies, op cit
- ⁵⁵ Walley, et al., op cit.
- ⁵⁶ <http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/providers/program-licensing/principles-of-care-and-practice-guidance.html>
- ⁵⁷ [Tobacco Use Cessation During Substance Abuse Treatment](#), SAMHSA Advisory, Vol. 10, Issue 2, March 2011, available at: <http://store.samhsa.gov/product/Tobacco-Use-Cessation-During-Substance-Abuse-Treatment-Counseling/SMA11-4636CLIN>.
- ⁵⁸ Available at: <http://massclearinghouse.ehs.state.ma.us/category/ALCH.html>
- ⁵⁹ [Alcohol-use and depression among pregnant and postpartum women](#), Addiction Technology Transfer Center, available at: <http://www.nattc.org/explore/priorityareas/science/tools/asmDetails.asp?ID=0409c>.
- ⁶⁰ [Center for Disease Control, Violence and Reproductive Health](#). Massachusetts Maternal Mortality and Morbidity study reports homicide the leading non-accidental cause of death for pregnant women. Available at: <http://www.cdc.gov/reproductivehealth/violence/index.htm>
- ⁶¹ <http://beta.samhsa.gov/sites/default/files/fy2014-2015-bg-application.pdf>
- ⁶² Center on Addiction and Substance Abuse, *Behind Bars II: Substance Abuse and America's Prison Population*, New York: Columbia University, 2010, available at: <http://www.casacolumbia.org/addiction-research/reports/substance-abuse-prison-system-2010>
- ⁶³ Ibid.
- ⁶⁴ 105 CMR 164.070(A)(3)
- ⁶⁵ Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. Substance Abuse Treatment for Adults in the Criminal Justice System. Treatment Improvement Protocol (TIP) Series 44. HHS Publication No. (SMA) -4056. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005
- ⁶⁶ US Interagency Council on Homelessness, available at: http://usich.gov/issue/substance_abuse.
- ⁶⁷ TEDS Report, January 7, 2014, available at: http://usich.gov/issue/substance_abuse
- ⁶⁸ Fact Sheet for Homeless Unaccompanied Youth Act, available at Massachusetts Coalition for the Homeless, <http://www.mahomeless.org/component/content/article/78-mch/189-unaccompanied-youth>
- ⁶⁹ Corliss, H.L., et a. High burden of homelessness among sexual minority adolescents: findings from a representative Massachusetts high school sample. *Am J Public Health*. Sept 2011. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3154237/#!po=41.6667>.

⁷⁰ <http://homeless.samhsa.gov/Default.aspx>

⁷¹ Available at: <http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/providers/program-licensing/principles-of-care-and-practice-guidance.html>

⁷² Pew Research Center, *For many injured veterans, a lifetime of consequences*: <http://www.pewsocialtrends.org/2011/11/08/for-many-injured-veterans-a-lifetime-of-consequences/>

⁷³ Institute of Medicine (IOM) *Substance Use Disorders in the US Armed Forces*, <http://www.iom.edu/Reports/2012/Substance-Use-Disorders-in-the-US-Armed-Forces.aspx>

⁷⁴ Ibid.

⁷⁵ SAMHSA *Behavioral Health Issues among Afghanistan and Iraq U.S. War Veterans* <http://store.samhsa.gov/product/Behavioral-Health-Issues-Among-Afghanistan-and-Iraq-U-S-War-Veterans/SMA12-4670>

⁷⁶ SAMHSA *Behavioral Health Issues among Afghanistan and Iraq U.S. War Veterans* <http://store.samhsa.gov/product/Behavioral-Health-Issues-Among-Afghanistan-and-Iraq-U-S-War-Veterans/SMA12-4670>

⁷⁷ [TIP 42 Substance Abuse Treatment for Persons with Co-Occurring Disorders](#), Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services

⁷⁸ <http://kenminkoff.com/ccisc.html>

⁷⁹ Cited in Substance Abuse and Mental Health Services Administration. *Trauma-Informed Care in Behavioral Health Services*. Treatment Improvement Protocol (TIP) Series 57. HHS Publication no. (SMA) 14-4816. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

⁸⁰ El-Gabalawy, R. (2012) *Association between traumatic experiences and physical health conditions in a nationally representative sample*. Retrieved June 27, 2014, from: <http://www.adaa.org/sites/default/files/El-Gabalawy%20331.pdf>

⁸¹ Substance Abuse and Mental Health Services Administration. *Trauma-Informed Care in Behavioral Health Services*. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 14-4816. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014

⁸² Massachusetts Department of Public Health Bureau of Infectious Disease Office of HIV/AIDS Intersecting Risks: HIV Infection Among Heterosexual Women and Men in Massachusetts (2010)

⁸³ Massachusetts Department of Public Health Bureau of Infectious Disease Office of HIV/AIDS, *Shifting Epidemics: HIV and Hepatitis C Infection among Injection Drug Users in Massachusetts* (2010)

<http://www.mass.gov/eohhs/docs/dph/aids/shifting-epidemics-report.pdf>

⁸⁴ Centers for Disease Control and Prevention, *HIV Among Youth*, available at: http://www.cdc.gov/hiv/risk/age/youth/index.html?s_cid=tw_drmermin-00186 Accessed July 21 2014

⁸⁵ Curran, G.M., et al. (2007) Recognition and management of depression in a substance use disorder treatment population. *American Journal of Drug and Alcohol Abuse*, 33: 563-569.

Suter, M., et al. (2011) Depressive symptoms as a predictor of alcohol relapse after residential treatment programs for alcohol use disorder. *Journal of Substance Abuse Treatment*, 41:225-233.

Shiffman, S., & Balabanis, M. (1996). Do drinking and smoking go together? *Alcohol Health & Research World*, 20:107-110.

Stuyt, E. (1997). Recovery rates after treatment for alcohol/drug dependence: Tobacco users vs. non-tobacco users. *The American Journal on Addictions*, 6, 159-167.

⁸⁶ http://www.cdc.gov/tobacco/data_statistics/fact_sheets/secondhand_smoke/health_effects/

⁸⁷ (http://www.drugabuse.gov/NIDA_Notes/NNVol15N5/Craving.html). Taylor, R.C., Harris, N. A., Singleton, E.G., Mollohan, E. T., Heishman, S. J. (2000). Tobacco Craving: Intensity-Related Effects of Imagery Scripts in Drug Abusers. *Experimental and Clinical Psychopharmacology*, 8(1): 75-87.

⁸⁸ <http://www.masscompulsivegambling.org/resources/fact-sheets/>

⁸⁹ American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, Arlington, VA, American Psychiatric Association, 2013. Pp. 585-589.

⁹⁰ See <http://www.masscompulsivegambling.org/general-fact-sheet/> for details of research on these and other related issues.

⁹¹ Institute of Medicine *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*
<http://www.iom.edu/Reports/2002/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care.aspx>

⁹² Available at: <http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/providers/program-licensing/principles-of-care-and-practice-guidance.html>

⁹³ CLAS Standard 1, USDHHS, Office of Minority Health, CLAS and CLAS Standards:
<https://www.thinkculturalhealth.hhs.gov/Content/clas.asp>

⁹⁴ <http://www.mass.gov/eohhs/gov/departments/dph/programs/admin/health-equity/clas/making-clas-happen.html>

⁹⁵ Available through: <https://www.thinkculturalhealth.hhs.gov/content/clas.asp>

⁹⁶ <http://www.mass.gov/eohhs/gov/departments/dph/programs/admin/health-equity/data-and-statistics.html>

⁹⁷ [TIP 29 Substance Use Disorder Treatment for Persons with Physical and Cognitive Disabilities](#)

⁹⁸ West, S.L., The accessibility of substance abuse treatment facilities in the United States for persons with disabilities. *Journal of Substance Abuse Treatment* 33 (2007) 1– 5

West, S.L. et al. Physical inaccessibility negatively impacts the treatment participation of persons with disabilities. *Addictive Behaviors* 32 (2007) 1494–1497

Krahn, G., et al. A Population-Based Study on Substance Abuse Treatment for Adults with Disabilities: Access, Utilization, and Treatment Outcomes. *The American Journal of Drug and Alcohol Abuse*, 33: 791–798, 2007

⁹⁹ [TIP 29 Substance Use Disorder Treatment for Persons with Physical and Cognitive Disabilities](#)

III. ESSENTIAL CHARACTERISTICS RELATED TO THE SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

As described in Sections I and II, the BSAS System of Care and these Standards are closely aligned with goals of the Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SABG). The SABG provides substantial financial support for BSAS funded services, describes standards and actions required as conditions of funding, and requires that BSAS inform vendors of SABG standards and actions. BSAS requirements contained in Sections I and II which reflect SABG related goals describe BSAS'S commitment to ensuring that the System of Care is:

- Recovery Oriented;
- Committed to Evidence-Based Best Practices and Quality Improvement, including participating in Independent Peer Reviews;
- Committed to Care Coordination and Integration
- Committed to Person-Centered Care that:
 - Engages and supports individuals and families in ways that respond to their developmental capacities and needs; co-occurring conditions; and life circumstances;
 - Specifically addresses underserved and/or high risk populations such as LGBTQ youth, young adults and adults; homeless individuals and families; those involved in the criminal or juvenile justice systems; and persons with co-occurring disorders;
- Committed to reducing disparities and improving access and outcomes for racial, ethnic and linguistic minorities (cultural competence) and persons with disabilities;
- Trauma-informed; and
- Addresses HIV/AIDS, Viral Hepatitis and Tuberculosis.

This section describes additional requirements arising from the SABG that apply to injection drug users, pregnant women, tuberculosis (TB), and charitable choice. Reference to specific SABG regulations are included and links to these regulations are listed at the end of this section.

A. Injection Drug Users:

- ◆ **45 CFR Part 96.126: Treatment vendors are required to ensure timely access to treatment for injection drug users, as follows:**
 - **Provide priority access to injection drug users, including pregnant injection drug users; and**
 - **If there is insufficient capacity, establish waiting lists for injection drug users, maintaining contact with individuals on waiting lists.**

◆ **45 CFR Parts 96.126 and 96.131: If an injection drug user is placed on a waiting list, counseling and education about the following matters must be provided within 48 hours as interim service:**

- HIV and tuberculosis;
- Risks of needle sharing
- Risks of transmission to sexual partners and infants; and
- Steps that can be taken to ensure the HIV and TB transmission does not occur; and
- Referral to HIV or TB treatment services if necessary.

These interim services may be provided directly or through referral. The Department of Public Health, Office of HIV/AIDS publishes a Services and Resource Guide which is available at: <http://www.mass.gov/eohhs/gov/departments/dph/programs/id/hiv-aids/services/>.

Regulations contained in 45 CFR Part 96.126 describe procedures for establishing, maintaining and reporting on waiting lists for injection drug users, and for outreach to encourage injection drug users to enter treatment. Vendors are expected to familiarize themselves with these requirements. These regulations are available through the link listed at the end of this document.

B. Pregnant and Post-Partum Women:

◆ **45 CFR Part 96.131: Treatment vendors are required to ensure timely access to treatment for pregnant women, as follows:**

- If a capacity or bed is available, provide priority access to pregnant women, including pregnant injection drug users;
- If there is insufficient capacity, or no bed is available, the vendor must facilitate a referral to another treatment program than can admit her.

◆ **Further, 45 CFR Parts 96.126 and 96.131 require that if no other appropriate program is available, the vendor must establish a waiting list.**

◆ **If a pregnant injection drug using woman is placed on a waiting list, interim services listed in subsection A above must be provided, either directly or through referral.**

◆ **In addition, vendors must provide the following interim services, either directly or through referral, within 48 hours to pregnant women placed on a waiting list:**

- Counseling on the effects of alcohol and drug use on the fetus; and
- Referral for prenatal care;

- **Additional referrals based on the individual, for example, to self-help recovery groups, pre-recovery and treatment support groups; sources for housing, food and legal aid; case management; children’s services; medical services and Temporary Assistance to Needy Families (TANF).**

If the vendor needs assistance in referring a pregnant woman to treatment, or in providing interim services, the vendor may call the Institute for Health and Recovery at 617-661-2992. BSAS contracts with the Institute for Health and Recovery to assist vendors in serving pregnant women.

C. Tuberculosis – 45 CFR Part 96.127:

- ◆ **Section II-D-11 requires that individuals served are assessed for their risk for TB, and are provided screening, education and treatment either directly or through referral.**
- ◆ **In addition, if treatment vendors are unable to admit an individual due to lack of capacity, they are required to refer the individual to other providers.**
- ◆ **Similarly, BSAS regulations governing Licensure of Substance Abuse Treatment require assessment of TB risk status (105 CMR 164.072) and provision, directly or through referral, of screening for, education about and treatment of TB (105 CMR 164.074).**

D. Charitable Choice – 45 CFR Parts 54 and 54A:

Provisions regarding Charitable Choice ensure that religious organizations may compete on an equal basis with non-religious organizations for federal substance abuse funding administered by the Substance Abuse & Mental Health Administration (SAMHSA), without impairing the religious character of their organizations and without diminishing the religious freedom of individuals served (SAMHSA beneficiaries). These provisions apply to the SAPT Block Grant program. No SABG funds may be expended for inherently religious activities, such as worship, religious instruction, or proselytization.

- ◆ **If an organization conducts such inherently religious activities, it must offer them separately, in time or location, from the programs or services for which it receives funds directly from SAMHSA or the relevant State or local government under any applicable program, and participation must be voluntary for the program beneficiaries.**

States may allocate Block Grant funds to faith-based treatment programs that maintain their religious character and hire people of their same faith, who also meet state requirements for licensing or certification of substance abuse treatment programs and clinical staff.

- ◆ **An individual served by a faith-based treatment program may object to the religious character of the program, and in that circumstance the faith-based**

organization shall within a reasonable time refer the individual to an alternative provider.

- ◆ **BSAS regulations for Licensure of Substance Abuse Treatment, 105 CMR 164.076, Client Rights, provides for such transfer and requires that individuals served be free to practice their own religious faith. Treatment vendors are required to notify individuals served of this right by including this information in client policy manuals.**

Faith-based organizations can contact the Massachusetts Information and Education Helpline at 800-327-5050 or at www.helpline-online.com for an up-to-date list of alternative programs. Whenever a faith-based vendor of treatment services makes a referral in response to the request of an individual served, the vendor is required to notify BSAS by contacting Sarah Ruiz at 617-624-5136 or Sarah.Ruiz@state.ma.us.

Relevant Regulations:

Substance Abuse Prevention and Treatment Block Grant regulations are available at:

<http://www.gpo.gov/fdsys/granule/CFR-2005-title45-vol1/CFR-2005-title45-vol1-part96>

Charitable Choice regulations are available at:

<http://www.gpo.gov/fdsys/granule/CFR-2007-title45-vol3/CFR-2007-title45-vol3-sec1050-3>

IV. ESSENTIAL OPERATIONAL AND ORGANIZATIONAL COMPONENTS

A. Leadership and Workforce Development:

All of the essential characteristics defined in these Standards require committed leadership demonstrating vision and authority needed to lead organizational development and change. Growing evidence of the importance of care integration, challenges of serving diverse populations, effectiveness of medication assisted treatment, among other concerns, require both commitment to and belief in the importance of practice improvement. Information, presentation of evidence, workshops or instructions alone are insufficient. Leadership must address perceptions, be able to identify incompatible beliefs while engaging reconsiderations, and involve all staff in considering the potential benefits of change. This means that leadership must be capable of defining organizational values, assessing attitudes, values and beliefs, and engaging the whole organization. At the same time, workforce development efforts should focus on building capacity to apply techniques and interventions based on evidence and best practices and to ensure services are attuned to populations served and co-occurring risks and conditions.¹

1. Leadership:

Leadership in vendor organizations includes executive and management staff, as well as identify supervisors and/or practice leaders (individuals who demonstrate both interest and capacity in practice improvement efforts).

◆ BSAS requires that vendors demonstrate organizational leadership as evidenced by:

- Clear statement of agency mission and values;
- Professional development plans for agency management and leadership aimed at supporting capacity to manage change;
- System for identifying needed organizational changes, and for planning and implementing change, as described in Section II. B of these Standards; and
- Method for disseminating and supporting best practices.

2. Workforce Development

Workforce development is a primary focus area of the Massachusetts Substance Abuse Strategic Plan. BSAS supports effective and varied learning opportunities through AdCare Educational Institute programs, the New England Institute of Addiction Studies, regional meetings, and training programs offered directly by BSAS. The BSAS Strategic Plan links workforce development to organizational development, highlighting the importance of integrating workforce development in quality improvement goals, including essential components and priorities identified in these Standards.

- ◆ **Therefore, vendors are required to have in place a Workforce Development plan that is linked to their Quality Improvement plan. For example, workforce development should include understanding of human development so that vendors are able to provide age appropriate services and programs. Licensed programs serving children and youth are required to ensure staff training and education in child development.**
- ◆ **BSAS requires that**
 - **Staff training explicitly**
 - **Includes assessment of staff current knowledge, practice skills, beliefs about treatment, their roles, and individuals served; and**
 - **Addresses integration of subject matter into practice, and include follow-up to assess skill acquisition and retention;**
 - **Staff who work directly with individuals served attend at least one training every year covering each of the following topics:**
 - **HIV/AIDS/Viral Hepatitis, including prevention, etiology and transmission, symptomatology, at-risk populations; confidentiality; and effects on the immune systems;**
 - **Tobacco use and nicotine addiction, including effects of tobacco use and nicotine addiction, and benefits of cessation;**
 - **Gambling, including nature of gambling disorder and consequences of problem gambling;**
 - **Ethics & professional boundaries;**
 - **Pharmacology, including the array of effective medication assisted treatments for substance related disorders; psychopharmacology;**
 - **Confidentiality, including:**
 - **Requirements of 42 CFR Part 2 and HIPAA; and**
 - **Provisions for sharing information for the purpose of care coordination and integration;**
 - **Opioid treatment, including benefits and risks of medication assisted treatment, and benefits and risks of not being treated;**
 - **Co-occurring Disorders, including importance of care coordination and joint planning;**
 - **Harm/Risk Reduction, including skill in promoting engagement in treatment;**

- **Human Development;**
- **Working with families; and**
- **Cultural Competency.**
- **Vendors are required to ensure that professional staff licenses, where applicable, are current and continuing education requirements are met.**
- **For programs serving youth and young adults, vendors must ensure staff training and capacity to address:**
 - **Sexuality and sexual behavior; and**
 - **Sexual orientation and gender identity; expertise in this area must include capacity to ensure freedom from harassment;**

BSAS licensing regulations establish minimum training and supervision efforts. Full time staff working directly with individuals served must receive one hour of individual or group supervision every other week; supervision must address clinical and treatment processes, and be documented.

- ◆ **Workforce development efforts linked to cultural competence goals are required to include efforts to recruit and retain a diverse workforce representing the diversity of the community served in terms of race, ethnicity, language, sexual orientation and gender identify, and disability.**

BSAS supports staffing patterns that include recovering people and acknowledges the special contributions and commitment that they have made in the field of addiction.

- ◆ **Vendors are required to support professional growth for those recovering persons on staff, to augment their expertise.**

B. Confidentiality:

- ◆ **All BSAS-funded programs that are also licensed must comply with the Health Insurance Portability and Accountability Act (HIPAA) and with 42 Code of Federal Regulations Part 2 governing confidentiality of patient information.**

These rules apply to ‘any and all information that could reasonably be used to identify an individual’ and they require that ‘disclosures be limited to the information necessary to carry out the purpose of the disclosure.’²

- ◆ **BSAS requires vendors to review their confidentiality practices so that integration of care may be enhanced while safeguards are maintained.**

1. 42 Code of Federal Regulations (CFR) Part 2:

42 CFR Part 2 limits the disclosure and use of patient records which are established or maintained in connection with the performance of any federally assisted alcohol and drug

abuse program (42 CFR § 2.3(a)). The restrictions apply to any information disclosed by a covered program that “would identify a patient as an alcohol or drug abuser ...” (42 CFR §2.12(a) (1)). Generally, such information protected by 42 CFR Part 2 is any material, data, or information disclosed by a covered program that identifies an individual directly or indirectly as having a current or substance-related disorder, or as a participant in a covered program.

These regulations reflect the understanding that stigma, and fear of legal prosecution, might discourage persons with substance-related disorders from seeking or entering treatment. 42 CFR part 2 identifies specific and limited circumstances data and information about a patient’s treatment may be disclosed, and when patient consent is required. In nearly all circumstances, 42 CFR Part 2 prohibits disclosure of any information which may identify the individual as in treatment for a substance-related disorder, even when needed for treatment of other health-related conditions, for payment of health care, or for financial systems, without the written consent of the individual served. Consent for disclosing such material must always be in writing.

- ◆ **Vendors providing treatment for substance-related disorders must comply with these regulations, which also include information exchanged through technologies such as cell phones, video conferencing, text messaging or other similar technologies. These communications concerning individuals or communications between provider and the individual served are subject to the same regulations that apply to face-to-face communications and releases of information.**

2. HIPAA: Health Insurance Portability Accountability Act

Under the Health Insurance Portability Accountability Act (HIPAA) of 1996, any provider of health care services who seeks payment from a health plan by electronic transmission is a Covered Entity. Through the Enterprise Invoice Management and Enterpriser Service Management (EIM/ESM) systems, DPH-BSAS processes fiscal and client record data transactions in accordance with HIPAA requirements. All BSAS funded programs are ‘covered entities’ under HIPAA and must comply with HIPAA transactions standards.

- ◆ **Vendors are required to ensure that information technology (IT) systems and capabilities meet HIPAA transactions and procedure standards for information transmissions conducted via web interface.**
- ◆ **Vendors are required to conduct periodic staff training regarding both HIPAA and 42 CFR Part 2, noting that 42 CFR Part 2, is more stringent than the HIPAA privacy regulations (as is the Massachusetts Fair Information Practices Act**

(FIPA). HIPAA Privacy training and training on 42 CFR Part 2 is required for all covered entities.

Resources:

- SAMHSA, in conjunction with the Legal Action Center have developed an array of resources. These are available at <http://www.samhsa.gov/healthprivacy/>:
 - **Frequently Asked Questions:**
<http://www.samhsa.gov/healthprivacy/http://www.samhsa.gov/healthprivacy/docs/EHR-FAQs.pdf>
 - **Comparison of HIPAA and 42 CFR Part 2:**
<http://www.samhsa.gov/HealthPrivacy/docs/SAMHSAPart2-HIPAAComparison2004.pdf>
- Legal Action Center information is available at: <http://www.lac.org/>

C. Common Policies and Performance Standards:

The Bureau of Substance Abuse Services and the Division of Medical Assistance (DMA), through its partners, pay for many of the services provided in the BSAS System of Care. BSAS and the DMA have been working with provider partners to develop common policies and performance standards for jointly funded services. The goal of this initiative is to simplify and streamline the reporting and performance standards process. BSAS expects programs to participate in the process of developing common policies and performance standards and to adhere to these standards once they are promulgated.

SAMHSA Block Grant funding sets a distinct level of accountability for Block Grant funds. SAMHSA requires states to report on National Outcome Measures (NOMS) as defined by SAMHSA, which include reports on substance use, living status, employment status, arrest status, as well as infrastructure for handling co-occurring disorders, HIV/AIDS, tuberculosis (TB), and viral hepatitis. To every extent possible, BSAS is striving to integrate all of the state and federal requirements into one web-based reporting system.

D. EIM/ESM: Enterprise Invoice Management /Enterprise Service Management

All Bureau of Substance Abuse Services contracts are managed in the EOHS enterprise application, EIM-ESM (Enterprise Invoice Management/Enterprise Service Management). EIM/ESM is the system of record for all BSAS client and billing data.

◆ **All BSAS contracted providers are required to use the EIM-ESM application for the submission of client data: Intake, Enrollment, Assessments; and billing data: Cost Reimbursement Invoices, Service Delivery Reports, or Claims.**

- The data can be entered manually into EIM-ESM or submitted electronically.

- EIM-ESM accepts 837 electronic claims for billing all unit services.
- For most services, EIM-ESM accepts electronic client data transmitted via HL7 messaging through the Massachusetts Health Information Highway (MA Hlway). Please contact the Bureau for a list of excluded services.
- EIM/ESM is a web-based application and therefore, the Bureau will require that all BSAS providers have secure internet access at all sites where data entry will be performed and follow all DPH/POS and Virtual Gateway rules and requirements.

E. All-Hazards Emergency Preparedness

Natural and human-made disasters, utility outages, technological disruption, and local emergencies are among events that underscore the importance of preparing for emergencies. Planning for continuation of services, safeguarding staff and individuals served, and maintenance of business operations require thoughtful development of comprehensive response systems.

◆ **BSAS requires vendors to establish a written plan for response to emergencies, based on an ‘all-hazards’ approach, i.e., a capacity to respond to internal, local, community, state, regional or national emergencies, regardless of cause (natural or man-made).**

◆ **BSAS requires that vendors ensure that:**

- **The emergency response plan be developed in consultation with community emergency management and response agencies;**
- **The plan establishes a system of internal communication and notifications, specifying responsibility for notification of staff, individuals served and the Department;**
- **The plan describes purpose and operation of alarm systems and signals, and procedures for evacuation of the building, including specification of evacuation or relocation locations;**
- **Program records are securely stored and can be retrieved; electronic records are securely backed up on a regular schedule;**
- **The facility can be secured;**
- **Provision is made for safe storage of medication as well as continuity of care for individuals served who require continued medication;**
- **Provision is made for continuity of care for individuals served; this may include cooperative plans with other vendors in the community;**
- **Periodic training of staff and individuals served is carried out, including drills and reviews of procedures;**

- **The plan includes provision for response to community needs related to substance use, arising from emergencies.**

¹ ¹ Lundgren, L., et al. Addiction treatment provider attitudes on staff capacity and evidence-based clinical training: results from a national study. *Am J of Addiction Psychiatry*. 20:271-284, 2011, and Amodeo, M., et al, Introducing evidence-based practices into substance abuse treatment using organization development methods. *Am J of Drug and Alcohol Abuse*, 21: 555-560, 2006

² Substance Abuse and Mental Health Administration, Center for Substance Abuse Treatment, *The Confidentiality of Alcohol and Drug Abuse Patient Records Regulation and the HIPAA Privacy Rule: Implications for Alcohol and Substance Abuse Programs*, available at: <http://www.samhsa.gov/healthprivacy/> Note this document was issued in 2004. In 2014 SAMHSA is undertaking review of this and related information in light of the Affordable Care Act.

APPENDIX: SUMMARY LIST OF REQUIREMENTS

I. INTRODUCTION: REQUIREMENTS RELATED TO THE SYSTEM AND COMPONENTS OF CARE:

- ◆ Vendors are required to be knowledgeable about the BSAS System of Care, adhere to contract requirements described in these Standards and in RFRs, and to be actively engaged with BSAS, other agencies and communities in supporting BSAS goals.
- ◆ BSAS requires vendors to be knowledgeable about the full System of Care, understanding that action, or inaction, in one component affects outcomes in other components.
- ◆ BSAS vendors are required to be knowledgeable about community prevention efforts and to work with BSAS and its partners to assess need, implement and sustain prevention efforts.
- ◆ In determining need, developing treatment plans, and monitoring outcomes, BSAS requires vendors to apply criteria established by the American Society of Addiction Medicine.
- ◆ Although responding to specific treatment needs, each provider in each level of care is required to:
 - Be knowledgeable about and support the full range of services in the BSAS System of Care, and to have well-established, well-utilized collaborative agreements with other treatment providers and community providers such as primary healthcare and mental health services, as evidenced by established effective referral and comprehensive service systems;
 - Provide treatment that is based on the individual's past history of substance use, medical and psychiatric care, and social history; and
 - Have established the capacity to facilitate transitions from one level of care to another as needed for the individual.
- ◆ BSAS requires that ATS and medication assisted treatment vendors establish referral and transition systems which ensure smooth transfers, by specifying means of ensuring uninterrupted medication assisted treatment;
- ◆ When individuals are referred to multiple levels of care, for example, Residential Rehabilitation and medication assisted treatment, all involved vendors, ATS, MAT and Residential Rehabilitation establish written transfer plans that specify means to ensuring uninterrupted medication assisted treatment.

- ◆ Providers of CSS and TSS are required to ensure well-organized case management, referral and follow up to obtain needed services during the individual's stay, and to ensure smooth transitions to the next, appropriate, level of care.
- ◆ As key sources of recovery support in the community, outpatient service providers are required to support community prevention efforts; be engaged in community groups promoting recovery; and have well-established, well-utilized collaborative agreements with community providers such as primary healthcare and mental health services.
- ◆ All BSAS vendors are required to support access to medication assisted treatment and to:
 - Be knowledgeable about effectiveness of medication assisted treatment as primary treatment, or in conjunction with other levels of care, and to provide accurate and up-to-date information about medication assisted treatment to individuals served;
 - Facilitate access to medication assisted treatment whether in conjunction with existing treatment, or as a transition from one level of care to another; and
 - Ensure that individuals who are properly prescribed medication for treatment of a substance-related disorder are given equal access to treatment services.
- ◆ Vendors who contract with BSAS are critical partners in supporting and improving this system, and are required to actively promote coordination among components.

II. REQUIREMENTS RELATED TO ESSENTIAL CHARACTERISTICS OF THE SYSTEM OF CARE:

◆ BSAS requires all vendors in the System of Care:

- To adhere to the principles and practices of a Recovery Oriented System of Care;
- To establish and maintain quality improvement systems;
- To engage in effective collaboration and integrated care;
- To value and provide person-centered care;
- To understand and respond to individual strengths and needs as well as the individual's environment of family and community; and
- To act to reduce disparities by demonstrating cultural competence and ensuring access for underserved populations and persons with disabilities.

❖ RECOVERY ORIENTED SYSTEMS OF CARE:

◆ Vendors are required to demonstrate characteristics of Recovery Oriented Systems of Care, and to establish and maintain a Culture of Recovery, and commitment to Harm Reduction.

◆ BSAS requires that vendors demonstrate a culture of recovery by:

- Applying the 13 Principles of Effective Treatment from the National Institute of Drug Abuse (NIDA: published 1999, revised 2012).
<http://www.drugabuse.gov/publications/principles-drug-addiction-treatment>
- Ensuring individuals are referred to the treatment that best matches their needs;
- Supporting individuals' dignity, demonstrating the transparency of the vendor's programs and services, i.e. information is shared freely and individuals are full participants in their treatment;
- Providing a treatment and recovery environment that is supportive, non-judgmental, and accepting of each individual seeking services; and
- Using a recovery oriented response to relapse, one with a primary aim of keeping individuals engaged in treatment.

◆ BSAS requires that vendors:

- Respond to any inquiry by providing current information about the system of care, including community resources, hotlines, referral resources and support groups;
- Ensure that individual needs are accurately assessed and individuals are referred to the appropriate level of care;
- Have screening and assessment policies, procedures and tools that:
 - Ensure accurate collection of information;
 - Ensure screening for co-occurring physical and mental health needs;

- Ensure screening for trauma, housing, criminal justice, employment, family, and other social support needs;
- Are appropriate to the age and developmental capacity of the individual; and
- Are inclusive of cultural and linguistic variations;
- Work with each other, and other System components, to ensure that referrals and transfers are carried out in planned, coordinated way, based on established, agreed upon procedures;
- Ensure that planning for discharge from treatment begins at assessment;
- Ensure that regardless of the circumstances of discharge, individuals are supported in continuing in recovery, and reducing harm from substance use;
- Establish mechanisms to promote peer relationships and resources by
 - Providing information and about peer resources including Recovery Support Centers, Recovery Coaches, and self-help groups; and
 - Providing information and referral for family support services and support groups.
- ◆ BSAS requires vendors to demonstrate a Harm Reduction approach by working with individuals served to develop goals and strategies that decrease health risks and negative consequences of substance use.

❖ EVIDENCE-BASED PRACTICE AND QUALITY IMPROVEMENT:

- ◆ Vendors are required to comply with standards related to accuracy and timeliness of data submission.
- ◆ Vendors are required to establish and implement systems by which they assess:
 - Capacity to provide programs and services on the basis of evidence, including evidence from their own practice, and from best practices;
 - Effects of programs and services on the individuals and communities served;
 - Effects of programs and services on reducing disparities in access to, quality and outcomes of service in the community served;
 - Action needed to improve practice and reduce disparities.
 - Cultural competence of the organization and services; and
 - Capacity to accommodate persons with disabilities.
- ◆ In designing and carrying out these assessments, vendors are required to ensure their quality improvement systems incorporate:
 - Mechanisms for participation of staff in designing and implementing assessment systems

- Process for participation of representatives of the community served in design and implementation of assessments systems, with particular emphasis on ensuring participation by consumers of services;
- Process for periodic surveys of staff and individuals served to collect information on their satisfaction and suggestions regarding services and program operations;
- Identification of needed data sources and mechanisms for obtaining and analyzing data;
- Identification of staff responsible for overseeing assessment efforts;
- Implementing periodic consumer and staff satisfaction surveys, including publication and review of results;
- Method for documenting ways in which results of quality improvement assessments, staff and consumer input, are utilized, and by which organizational change is monitored;
- Collaboration with other agencies and community partners; and
- Integration of workforce development.

❖COLLABORATION AND INTEGRATED CARE:

- ◆ Vendors are required to establish active collaborations, focused on identifying and developing resources, ensuring smooth transitions among levels of care, establishing effective care coordination, and improving individual and community outcomes. These efforts are evidenced by:
 - Participation in collaborative groups such as community boards and prevention efforts;
 - Development of mechanisms for ensuring smooth interface between and among participant systems;
 - Monitoring provision and effectiveness of services for individuals or families served by multiple agencies, e.g., through case conferences and systematic information sharing (note information below about compliance with 42 CFR Part 2 and HIPAA in collaborative and integrated care); and
 - Sharing and reviewing aggregate data on outcomes.
- ◆ Treatment providers are required to engage with primary care and mental health care providers to integrate care, and to promote the capacity of individuals and their families to manage their own care, as evidenced by:
 - Qualified Service Organization Agreements (QSOAs) with primary care and mental health care providers describing means for:
 - Cross-consultation;
 - Collaborative treatment planning for individuals and their families;

- Action planning to establish common language and understanding of terms;
 - Designation of staff responsibilities for ensuring joint planning;
 - Action planning for periodically assessing successes and challenges;
 - System for sharing information; and
 - Staff training on ways to facilitate joint treatment planning, including engaging individuals served and their families;
- Inclusion of mental health and primary care goals in assessments and treatment plans including identification of mental health and primary care providers and specification of agreed upon plan for communication.

❖ **PERSON-CENTERED CARE:**

◆ BSAS requires vendors to:

- Demonstrate understanding of individuals’ varying strengths and vulnerabilities in relation to developmental status;
- Recognize the importance of family and significant relationships;
- Engage individuals and families in their various life circumstances, e.g., in the military; experiencing homelessness; building a family; or involved in criminal justice;
- Demonstrate understanding of sexual orientation and gender identity;
- Recognize and respond effectively to co-occurring mental health disorders and trauma;
- Recognize and respond effectively to co-occurring conditions such as: HIV/AIDS, Viral Hepatitis and Tuberculosis; opioid overdose; tobacco use and nicotine addiction, and gambling disorders.

1. Responsive to Developmental Status:

- ◆ BSAS requires vendors to be attuned to developmental status in planning and implementing programs and services, as well as in assessing service needs of individuals.
- ◆ All treatment vendors, including those serving youth, are required to assess whether individuals, including men, have children. If the individual is a parent, vendors are required to explore the status of the parent-child relationship, and to assist the individual in setting and reaching goals in relation to his or her child(ren).
- ◆ Specialized family residential programs are required to build a supportive network of services, with active QSOAs.

- ◆ Treatment vendors are required to participate in enhancing capacity to provide best practices for families and enhance their capacity to support treatment and recovery for families.
- ◆ In addition, vendors are required to have:
 - Well established collaborative partnerships with:
 - Early childhood programs;
 - Area Department of Children and Families offices; and
 - Child behavioral health providers;
 - Up to date information about and system for referrals to services for families, such as Women, Infants and Children (WIC); and
 - Mechanisms for providing best-practices parenting programs either directly or by referral.
- ◆ Vendors serving youth and young adults (and/or their parents) are required to demonstrate programmatic capacity to respond to developmental status and needs by:
 - Using harm reduction strategies such as reward-based contingency management, best practices such as motivational interviewing;
 - Responding to relapse in ways which keep the young person engaged in treatment and recovery, and focus on harm reduction;
 - Applying service models which reflect accurate assessment of developmental status, e.g., opportunities for physical activities, shorter group times, help in developing friendships among peers in recovery;
 - Ensuring program capacity and staff skill in addressing sexuality, gender identity and sexual behavior, including addresses risks of sexually transmitted diseases;
 - Establishing capacity, directly or through referral, to respond to a range of youth and young adult vulnerabilities such as emerging mental health disorders;
 - Accessing Recovery Support services for youth and young adults drawing on evidence based curricula and programing, framing decision making in the context of developmental status, and building positive relationships, including developing a network of peers in recovery;
 - Engaging and supporting family and other supportive relationships in the young person’s life;
 - Providing opportunities for meaningful participation by the youth/young adult population – opportunities that highlight youth and young adult strengths such as capacity to make intense commitments and invest enthusiastic interest and effort;

these may include participating on advisory boards, in program planning, and in engaging other young people; and

- Demonstrating flexibility and inventiveness in outreach and engagement.

◆ BSAS requires vendors to respond to the needs of older adults and recognize barriers they face in getting needed services by establishing:

- QSOAs and active working relationships with elder care providers, including specifying methods of referral and providing cross-training;
- Approaches aimed at reducing the impact of mobility limitations, e.g., home-based services, services at senior centers, and outreach efforts directed toward nursing homes, senior housing and senior/elder service providers; and
- Adaptations of agency communication system and printed material to accommodate vision and hearing losses. [Note that accommodations for persons with disabilities often benefit older adults.]

2. Committed to Engaging and Supporting Families:

◆ BSAS requires vendors to acknowledge the importance of family relationships in program design and operations.

◆ Vendors are required to define families in the broadest sense (including ‘family of choice’) and are required to engage family members, to the extent desired by individuals served, by:

- Providing information and education about substance-related disorders and treatment, and about supports and services available to families;
- Ensuring family relationships are explored in assessments, and goals in relation to these relationships are stated in treatment plans; and
- Providing, either directly or by referral, family therapy and, where indicated, interventions.

◆ In addition, vendors are required to provide, directly or through referral, evidence based parenting services to all individuals in treatment who have children, regardless of custodial arrangements.

3. Committed to Engaging and Serving Lesbian, Gay, Bisexual, Transgender and Queer or Questioning Youth, Young Adults and Adults:

◆ BSAS requires vendors to:

- Provide environments that are welcoming to LGBTQ individuals and their families as demonstrated through inclusive images and language in posters, brochures and other materials in public spaces;

- Demonstrate safety for LGBTQ individuals by establishing policy, procedure and effective staff training to prevent harassment, discrimination and threats;
- Use data collection instruments, such as intake and assessment forms, which are free of assumptions related to gender and sexual orientation, for example, assumptions about the gender of a spouse or partner;
- Integrate LGBTQ culture into cultural competence efforts; and
- Develop capacity to reach out to and engage families, whether they are supportive or not (research has shown that rejection can be transformed into support and acceptance).

4. Committed to Engaging and Serving Persons Using Opioids:

- ◆ BSAS requires that all vendors admit individuals receiving medication assisted treatment – including methadone, suboxone and injectable naltrexone -- who also meet other admission criteria.
- ◆ In addition, to ensure and coordinate residential services for this population, BSAS requires Residential Rehabilitation Services vendors to participate in BSAS’S training on integrating medication assisted and treatment, and other efforts to ensure services are available for individuals receiving medication assisted treatment;
- ◆ BSAS requires Residential Rehabilitation Services vendors and Opioid Treatment Programs that are geographically near each other to establish and maintain Qualified Service Organization Agreements specifying:
 - System for making timely referrals, including plan for follow up;
 - Plan for transportation of individuals, as needed;
 - Process for submitting requests for exceptions to take home limits, if needed; and
 - Plan for safe storage of medications.
- ◆ All vendors are required to participate in BSAS’S work to prevent and reduce opioid overdose, by supporting community opioid abuse prevention collaboratives, and, for vendors of treatment programs, by incorporating opioid overdose prevention, recognition and response capacity into staff training, assessments and treatment plans, education, and family support.
 - Committed to Opioid Overdose Prevention:
- ◆ Vendors are required to support Massachusetts’ efforts to prevent and reduce opioid overdose, as evidenced by:
 - A stated commitment to prevent and reduce opioid overdose;

- Up-to-date knowledge of overdose prevention and response resources in their communities, including identification of pharmacies stocking naloxone and/or having standing orders for naloxone;
- Establishing an on-site overdose emergency response plan and ensuring staff are trained in preventing, recognizing and responding to overdose;
- Including review of overdose history (including witnessing overdose) in treatment assessments;
- Educating individuals served about opioid overdose prevention, recognition and response;
- Allowing individuals served to retain possession of naloxone rescue kits while in the treatment program;
- Including opioid overdose risk reduction in treatment and discharge plans; and
- Referring families and friends of individuals served to opioid overdose prevention, recognition and response education resources, including community pharmacies which stock naloxone and/or have standing orders for naloxone.

5. Committed to Engaging and Serving Pregnant and Post-Partum Women and Women with Children:

- ◆ Consistent with BSAS priorities and with priorities of the SAMHSA SABG, BSAS requires vendors to
 - Give priority access to pregnant and post-partum women;*
 - Establish mechanisms to ensure smooth transitions from one level of care to another, especially for women who are dependent on opioids, recognizing that medication assisted treatment, combined with prenatal care, is currently the standard of treatment for opioid dependent pregnant women, since medication assisted treatment substantially reduces risk of relapse, thus avoiding overdose, HIV and other dangers of illicit drug use;
 - Establish collaborative partnerships with pre-natal and post-partum care, early intervention and early childhood services;
 - Provide, directly or through referral:
 - Evidence based parenting services; and
 - Family recovery services, including family and couples therapy.
- ◆ Vendors are required to establish collaborative agreements with mental health care and domestic violence services and resources.

* It is not unusual for a woman to learn she is pregnant as a result of detox admission pregnancy test.

6. Committed to Engaging and Supporting Those Involved with the Criminal Justice System:

- ◆ BSAS requires partners at all levels of the System of Care to support efforts to improve collaboration with the criminal justice system, as evidenced by:
 - Giving priority access to individuals involved with the criminal or juvenile justice system;
 - Establishing coordination with local drug courts;
 - Recognizing that individuals recently released from incarceration are at high risk for opioid overdose by ensuring overdose risk is addressed in assessment, treatment planning and services; and
 - Providing case management services focusing on access to insurance, housing and primary care, and support to re-connect with family.

7. Committed to Engaging and Serving Homeless Individuals and Families:

- ◆ Treatment vendors are required to respond to the needs of homeless individuals and families, by:
 - Establishing priority admissions for homeless individuals;
 - Establishing relationships with local shelters and housing resources;
 - Ensuring housing and employment needs are addressed during initial assessments and treatment planning; this includes determining at the outset whether the individual or family currently has permanent housing; and
 - Utilizing resources such as SAMHSA’s Homelessness Resource Center,¹⁰² to develop expertise in applying best practices to engage and serve homeless individuals and families. The Resource Center provides an array of training opportunities, research and guides for engaging homeless individuals, families and youth. Information is available at: <http://homeless.samhsa.gov/Default.aspx>.

8. Committed to Engaging and Serving Those Who Served in the Military, and Their Families:

- ◆ In responding to treatment needs of those who have served in the military, BSAS requires vendors to:
 - Apply a definition of ‘veteran’ or ‘those who served in the military’ to include those who have other than honorable discharges, and/or have served in the National Guard or Reserves;
 - Build active collaborations, through formal Qualified Service Organization Agreement, with
 - Veterans services organizations and local veterans peer organizations; and
 - Resources for families, children and partners of those who have served;

- Ensure collaboration includes cross-training, particularly training on military culture and including “Battlemind,” a service-related set of values and behaviors which may inhibit help-seeking, and complicate return to civilian life;
- Review policies which might adversely affect those who served, for example, policies requiring discharge for behavior that may be symptomatic of traumatic stress or traumatic brain injury;
- Ensure agency trauma training includes understanding service related trauma, affecting both those who served and their families; and
- In addition, staff training on co-occurring conditions should explicitly include recognition that between 37% and 50% of OEF and OIF forces have been diagnosed with a mental health disorder, most commonly PTSD and depression.

9. Committed to Engaging and Serving Persons with Co-Occurring Mental Health Disorders:

- ◆ Treatment vendors are required to assess their capacity to serve individuals with co-occurring disorders, and to ensure that:
 - Organizational leadership analyze existing systems and operations to identify and implement ways to ensure smooth care coordination; this analysis is included in vendor’s quality improvement plans;
 - Collaborative agreements with mental health service providers are in place and provide for systems for referral and follow-up, care coordination, and periodic review of obstacles and success;
 - Screening and assessments include mental health needs; plans specify goals for mental health care;
 - Treatment plans specify referral and follow up for mental health services, process for care coordination, plan for care management, specifically for ensuring proper medication management; and
 - Staff are trained in mental health issues and disorders, and side effects of medications.

10. Committed to Providing Trauma Informed Care:

- ◆ BSAS requires vendors to establish trauma-informed treatment environments and provide trauma informed care, as evidenced by:
 - Stated commitment to trauma-informed care, with emphasis on individual choice and decision making;
 - Collaborative systems which provide for access to trauma specific services;
 - Inclusion of trauma screening in all assessments, and periodic reassessments; and
 - Prohibition of coercion or force in treatment;

- Recognition that children of individuals served have experienced trauma, and that they and their parents may require support and assistance in obtaining effective trauma treatment.
- Periodic assessments of the degree to which policies and procedures:
 - Ensure that the environment is safe and clearly provides a sense of safety, e.g., interactions are predictable; staff are aware of potential triggers in the environment; service provision is transparent;
 - Review questionnaires and interview/assessment questions to ensure they are trauma sensitive;
 - Recognize that some behaviors may be attempts to cope with trauma-related symptoms and respond accordingly; and
 - Ensure that program design and workforce development reflect understanding of:
 - Pervasive effects of trauma, for example, on relationships, families and communities;
 - The complex links between trauma and addiction;
 - Trauma-informed services do not depend on staff knowledge of an individual’s trauma experiences, nor on an individual’s disclosure of trauma experiences;
 - Sensitive and effective methods of exploring trauma, making referrals and supporting individuals; and
 - Potential for staff to experience secondary trauma (or their own trauma) thus requiring organizational and supervisory supports.

11. Committed to Prevention of and Reducing Harm From HIV/AIDS, Viral Hepatitis and Tuberculosis:

- ◆ Vendors are required to ensure that all employees are screened at hiring and annually thereafter, and that individuals served are assessed for their risk for TB, and are provided screening, education and treatment either directly or through referral.
- ◆ BSAS has established a range of resources to promote education and prevention, and requires vendors to support these efforts by:
 - Designating staff to coordinate HIV/AIDS, Viral Hepatitis education, assessment, counseling and testing. BSAS expects this coordinator to attend regional Program AIDS Coordinator (PAC-Net) meetings;
 - Integrating HIV/AIDS, Viral Hepatitis and Tuberculosis education into treatment programming;

- Including HIV/AIDS, viral hepatitis and tuberculosis risk, related to both sexual and drug use behaviors, in all assessments and psycho-educational programming;
- Ensuring that family and couples therapy, whether offered directly or through referral, include education about HIV/AIDS/Viral Hepatitis risks and prevention;
- Establishing active referral relationships, documented through a Qualified Service Organization Agreement (QSOA), with HIV/AIDS, Viral Hepatitis and Tuberculosis prevention, education, counseling, and clinical care providers including testing, and support services;
- Ensuring that individuals who choose to be tested for these diseases are provided, either directly or through referral, support and counseling as to the process, results and care management, if needed; and
- Encouraging pregnant women in treatment to consider HIV testing, and to offer HIV antibody testing, and support to access HIV care when indicated.
- ◆ Programs working with youth and young adults are required to address sexuality and sexual behavior, including STD/HIV/Viral Hepatitis risks and transmission, using age-appropriate strategies to inform, assess, and approach these issues.

12. Committed to Addressing Tobacco Use and Nicotine Addiction:

- ◆ All partners in BSAS'S System of Care are required to prevent tobacco use and smoking and to provide treatment for addiction to nicotine, in a supportive environment, as evidenced by:
 - Written policy prohibiting tobacco use and smoking in all buildings, including entrances, and vehicles owned or used by the vendor in provision of service;
 - Written policies prohibiting staff smoking or using tobacco products with individuals served;
 - Establishment of no-tobacco and no-smoking zones of at least a 20-foot perimeter around buildings;
 - Prohibition of any display of tobacco or smoking related materials, including personal possessions displaying tobacco related logos;
 - Ensuring bi-annual staff participation in training offered by the TAPE project every two years;
 - Application of all tobacco and smoking restrictions to e-cigarettes, pending definitive research on the safety and addictive potential of these products;
 - Designation of a staff person as Tobacco Education Coordinator; and
 - Integration of nicotine addiction in assessments, treatment planning, services and education.

13. Committed to Addressing Problem Gambling:

- ◆ BSAS requires all vendors to establish written policies to establish a gambling-free environment, including prohibition of:
 - Use and display of gambling related items and activities including lottery games, sports betting, raffles and fundraising tickets, bingo or beano, games, including electronic or online games using gambling;
 - Illegal wagering of any kind;
 - Staff gambling or discussion of gambling;
 - Activities, such as off-site trips, to venues where gambling is available;
 - Gambling machines (such as lottery machines) or opportunities.
- ◆ Licensed providers are required to address problem gambling in assessments, and, if problems are identified, to provide treatment either directly or by referral.

❖ CULTURAL COMPETENCE AND REDUCING DISPARITIES:

- ◆ Vendors are required to comply with cultural competence standards, as evidenced by:
 - Completing the CLAS Agency Self-Assessment developed by the DPH Office of Health Equity, available at:
<http://www.mass.gov/eohhs/gov/departments/dph/programs/admin/health-equity/clas/request-for-responses.html>;
 - Completing the Agency Staff Demographics Table, also available at
<http://www.mass.gov/eohhs/gov/departments/dph/programs/admin/health-equity/clas/request-for-responses.html>;
 - Including results of these assessments in written Quality Improvement plans which state specific goals related to assessment results;
 - Ensuring that staff cultural competence training includes exploration of CLAS standards and address effects of staff assumptions and beliefs on access to and outcomes of treatment;
 - Workforce development efforts focused on hiring diverse, bilingual staff;
 - Engagement with racial, cultural and/or ethnic community groups and organizations;
 - Specifically addressing language access using guidelines and tools described in *Making CLAS Happen: Six Areas for Action*, including:
 - Assessing language service needs; and
 - Developing resources and mechanisms for providing professional interpreter services and translations of written materials including brochures, informational materials and signage.

❖ PROVIDING ACCESS FOR PERSONS WITH DISABILITIES:

- ◆ Tools to guide vendors in achieving integrated accommodation are available, and vendors are required to complete the Massachusetts Facility Assessment Tool, available at:
<http://www.mass.gov/eohhs/gov/departments/dph/programs/community-health/health-disability/ada-compliance/the-massachusetts-facility-assessment-tool.html>. This tool provides a comprehensive method of determining whether physical plants are fully accessible for persons with disabilities, and identifying whether action needed.
- ◆ In addition, vendors are required to develop policies and procedures that comply with ADA, including employment policy, accommodations, integration, communications, transportation etc. Guidelines are included in ADA Guide for MDPH Contracted Providers at:
<http://www.mass.gov/eohhs/gov/departments/dph/programs/community-health/health-disability/ada-compliance/ada-guide-for-mdph-contracted-providers.html>.
- ◆ Vendors are also required to:
 - Include goals related to access to and outcomes of service for persons with disabilities in Quality Improvement Plans;
 - Ensure individual assessments explore disabilities or evidence of undiagnosed disabilities;
 - Ensure that staff training includes:
 - Understanding requirements of law, regulation and policies related to access and accommodation;
 - Value of and process for individualized assessment and treatment;
 - Effects of staff attitude and bias on identifying and serving persons with disabilities, and effects of disparate or disproportionate care;
 - Awareness of community resources;
 - Importance of exploring the meaning of a disability to the individual;
 - Understanding the culture and experience of disability; and
 - Adapting treatment methods to meet individual needs;
 - Establish Qualified Service Organization Agreements with providers of services to persons with disabilities such as Independent Living Centers, and local offices of the Massachusetts Commissions for the Blind and for the Deaf and Hard of Hearing.

¹⁰² <http://homeless.samhsa.gov/Default.aspx>

III. REQUIREMENTS RELATED TO THE SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

❖ INJECTION DRUG USERS:

- ◆ 45 CFR Part 96.126: Treatment vendors are required to ensure timely access to treatment for injection drug users, as follows:
 - Provide priority access to injection drug users, including pregnant injection drug users; and
 - If there is insufficient capacity, establish waiting lists for injection drug users, maintaining contact with individuals on waiting lists.
- ◆ 45 CFR Parts 96.126 and 96.131: If an injection drug user is placed on a waiting list, counseling and education about the following matters must be provided within 48 hours as interim service:
 - HIV and tuberculosis;
 - Risks of needle sharing
 - Risks of transmission to sexual partners and infants;
 - Steps that can be taken to ensure the HIV and TB transmission does not occur; and
 - Referral to HIV or TB treatment services if necessary.

❖ PREGNANT AND POST-PARTUM WOMEN:

- ◆ 45 CFR Part 96.131: Treatment vendors are required to ensure timely access to treatment for pregnant women, as follows:
 - If a capacity or bed is available, provide priority access to pregnant women, including pregnant injection drug users;
 - If there is insufficient capacity, or no bed is available, the vendor must facilitate a referral to another treatment program than can admit her.
- ◆ Further, 45 CFR Parts 96.126 and 96.131 require that if no other appropriate program is available, the vendor must establish a waiting list.
- ◆ If a pregnant injection drug using woman is placed on a waiting list, interim services listed in subsection A above must be provided, either directly or through referral.
- ◆ In addition, vendors must provide the following interim services, either directly or through referral, within 48 hours to pregnant women placed on a waiting list:
 - Counseling on the effects of alcohol and drug use on the fetus;
 - Referral for prenatal care; and

- Additional referrals based on the individual, for example, to self-help recovery groups, pre-recovery and treatment support groups; sources for housing, food and legal aid; case management; children's services; medical services and Temporary Assistance to Needy Families (TANF).

❖ **TUBERCULOSIS: 45 CFR Part 96.127:**

- ◆ Section II-D-11 of these Standards requires that individuals served are assessed for their risk for TB, and are provided screening, education and treatment either directly or through referral.
- ◆ In addition, if treatment vendors are unable to admit an individual due to lack of capacity, they are required to refer the individual to other providers.
- ◆ Similarly, BSAS regulations governing Licensure of Substance Abuse Treatment require assessment of TB risk status (105 CMR 164.072) and provision, directly or through referral, of screening for, education about and treatment of TB (105 CMR 164.074).

❖ **CHARITABLE CHOICE – 45 CFR Parts 54 and 54A:**

- ◆ If an organization conducts such inherently religious activities, it must offer them separately, in time or location, from the programs or services for which it receives funds directly from SAMHSA or the relevant State or local government under any applicable program, and participation must be voluntary for the program beneficiaries.
- ◆ An individual served by a faith-based treatment program may object to the religious character of the program, and in that circumstance the faith-based organization shall within a reasonable time refer the individual to an alternative provider.
- ◆ BSAS regulations for Licensure of Substance Abuse Treatment, 105 CMR 164.076, Client Rights, provides for such transfer and requires that individuals served be free to practice their own religious faith. Treatment vendors are required to notify individuals served of this right by including this information in client policy manuals.

IV. REQUIREMENTS RELATED TO ESSENTIAL OPERATIONAL AND ORGANIZATIONAL COMPONENTS

❖ LEADERSHIP AND WORKFORCE DEVELOPMENT:

- ◆ BSAS requires that vendors demonstrate organizational leadership as evidenced by:
 - Clear statement of agency mission and values;
 - Professional development plans for agency management and leadership aimed at supporting capacity to manage change;
 - System for identifying needed organizational changes, and for planning and implementing change, as described in Section II. B of these Standards; and
 - Method for disseminating and supporting best practices.
- ◆ Vendors are required to have in place a Workforce Development plan that is linked to their Quality Improvement plan. For example, workforce development should include understanding of human development so that vendors are able to provide age appropriate services and programs. Licensed programs serving children and youth are required to ensure staff training and education in child development.
- ◆ BSAS requires that
 - Staff training explicitly
 - Include assessment of staff current knowledge, practice skills, beliefs about treatment, their roles, and individuals served; and
 - Address integration of subject matter into practice, and include follow-up to assess skill acquisition and retention;
 - Staff who work directly with individuals served attend at least one training every year covering each of the following topics:
 - HIV/AIDS/Viral Hepatitis, including prevention, etiology and transmission, symptomatology, at-risk populations; confidentiality; and effects on the immune systems;
 - Tobacco use and nicotine addiction, including effects of tobacco use and nicotine addiction, and benefits of cessation;
 - Gambling, including nature of gambling disorder and consequences of problem gambling;
 - Ethics & professional boundaries;

- Pharmacology, including the array of effective medication assisted treatments for substance related disorders; psychopharmacology;
 - Confidentiality, including
 - Requirements of 42 CFR Part 2 and HIPAA; and
 - Provisions for sharing information for the purpose of care coordination and integration;
 - Opioid treatment, including benefits and risks of medication assisted treatment, and benefits and risks of not being treated;
 - Co-occurring Disorders, including importance of care coordination and joint planning;
 - Harm/Risk Reduction, including skill in promoting engagement in treatment;
 - Human Development;
 - Working with families; and
 - Cultural Competency.
- Vendors are required to ensure that professional staff licenses, where applicable, are current and continuing education requirements are met.
 - For programs serving youth and young adults, vendors must ensure staff training and capacity to address:
 - Sexuality and sexual behavior; and
 - Sexual orientation and gender identity; expertise in this area must include capacity to ensure freedom from harassment;
 - ◆ Workforce development efforts linked to cultural competence goals are required to include efforts to recruit and retain a diverse workforce representing the diversity of the community served in terms of race, ethnicity, language, sexual orientation and gender identify, and disability.
 - ◆ Vendors are required to support professional growth for those recovering persons on staff, to augment their expertise.

❖CONFIDENTIALITY:

- ◆ All BSAS-funded programs that are also licensed must comply with the Health Insurance Portability and Accountability Act (HIPAA) and with 42 Code of Federal Regulations Part 2 governing confidentiality of patient information.
- ◆ BSAS requires vendors to review their confidentiality practices so that integration of care may be enhanced while safeguards are maintained.

- ◆ Vendors providing treatment for substance-related disorders must comply with these regulations, which also include information exchanged through technologies such as cell phones, video conferencing, text messaging or other similar technologies. These communications concerning individuals or communications between provider and the individual served are subject to the same regulations that apply to face-to-face communications and releases of information.
- ◆ Vendors are required to ensure that information technology (IT) systems and capabilities meet HIPAA transactions and procedure standards for information transmissions conducted via web interface.
- ◆ Vendors are required to conduct periodic staff training regarding both HIPAA and 42 CFR Part 2, noting that 42 CFR Part 2, is more stringent than the HIPAA privacy regulations (as is the Massachusetts Fair Information Practices Act (FIPA)). HIPAA Privacy training and training on 42 CFR Part 2 is required for all covered entities.

❖ **EIM/ESM:**

- ◆ All BSAS contracted providers are required to use the EIM-ESM application for the submission of client data: Intake, Enrollment, Assessments; and billing data: Cost Reimbursement Invoices, Service Delivery Reports, or Claims.

❖ **ALL-HAZARDS EMERGENCY PLANNING:**

- ◆ BSAS requires vendors to establish a written plan for response to emergencies, based on an 'all-hazards' approach, i.e., a capacity to respond to internal, local, community, state, regional or national emergencies, regardless of cause (natural or man-made).
- ◆ BSAS requires that vendors ensure that:
 - The emergency response plan be developed in consultation with community emergency management and response agencies;
 - The plan establishes a system of internal communication and notifications, specifying responsibility for notification of staff, individuals served and the Department;
 - The plan describes purpose and operation of alarm systems and signals, and procedures for evacuation of the building, including specification of evacuation or relocation locations;
 - Program records are securely stored and can be retrieved; electronic records are securely backed up on a regular schedule;
 - The facility can be secured;

- Provision is made for safe storage of medication as well as continuity of care for individuals served who require continued medication;
- Provision is made for continuity of care for individuals served; this may include cooperative plans with other vendors in the community;
- Periodic training of staff and individuals served is carried out, including drills and reviews of procedures; and
- The plan includes provision for response to community needs related to substance use, arising from emergencies.