Commonwealth of Massachusetts

Substance Abuse Strategic Plan

May 16, 2005

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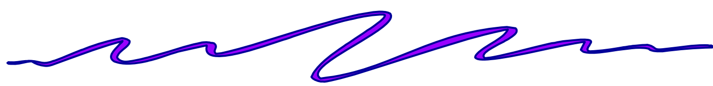
Overview



In August 2004, the Lieutenant Governor held a series of roundtable discussions with federal, state and local government officials on substance use. As a result, MDPH embarked on an <u>interagency, inter-secretariat and inter-branch</u> effort designed to:

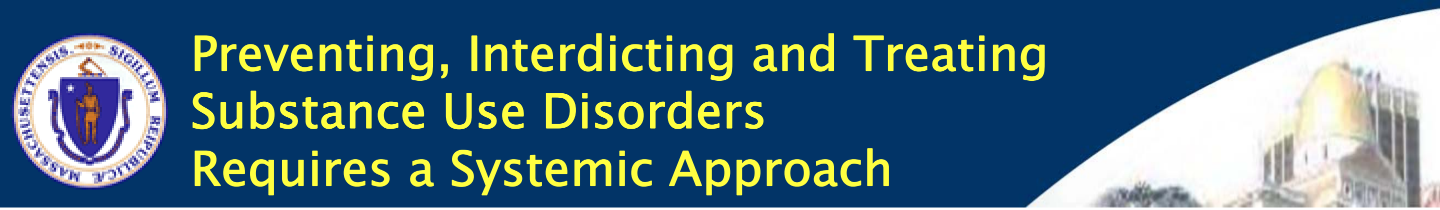
- Integrate the needs, concerns and ideas of key stakeholders across government agencies
- Incorporate the involvement and feedback of providers, communities, advocacy groups and others
- Generate a strategic plan for the Commonwealth that aligns prevention, interdiction, enforcement, treatment and recovery support efforts across agencies
- *Increase our collective ability to reduce the scope and consequences of this systemic problem across the state*

** Within this report we will use the term "substance abuse" at times, although the preferred term today is "substance use disorder "or "addictive disorder."*

A Partnership Effort

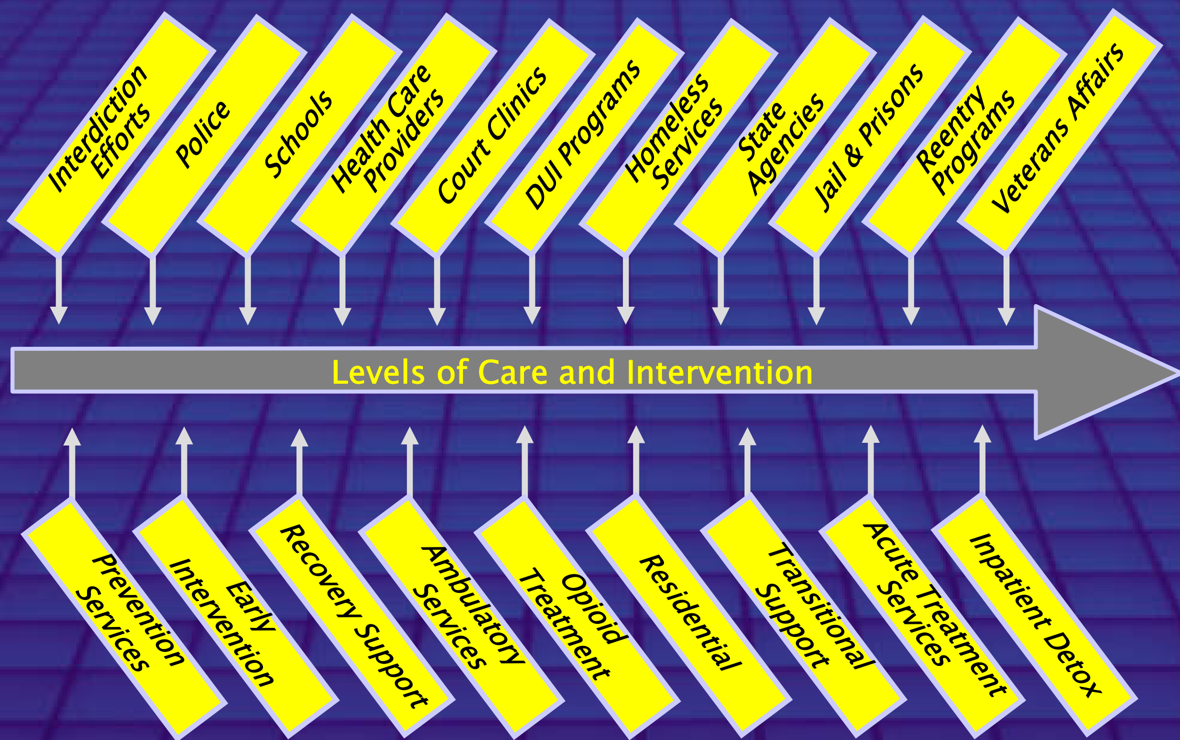
Partners in this effort have included:

- A Broad Spectrum of Providers, Advocacy Organizations, Social Service Agencies and other Experts
- Governor’s Office
- Administrative Office of the Trial Court, including the Juvenile Court
- Executive Office for Administration & Finance
- Executive Office of Elder Affairs
- Executive Office of Health & Human Services
- Executive Office of Public Safety
- Massachusetts Parole Board
- Massachusetts Behavioral Health Partnership
- Massachusetts Office of Long Term Care
- Massachusetts Rehabilitation Commission
- Department of Correction
- Department of Education
- Department of Mental Health
- Department of Mental Retardation
- Department of Public Health
- Department of Social Services
- Department of Transition Assistance
- Department of Youth Services
- Division of Healthcare Finance & Policy
- Middlesex County District Attorney’s Office
- Office of the Attorney General Office of Medicaid/MassHealth
- Office of Child Care Services
- Office of the District Attorney
- Office of Community Corrections
- Office of the Commissioner of Probation
- Office of Veterans’ Affairs
- Commission for the Blind
- Commission for the Deaf & Hard of Hearing
- Clinical Effectiveness Advisory Group
- Drug Enforcement Agency
- Governor’s Commission
- Governor’s Advisory Council
- Representative of the Departments of the Army and the Air Force
- The National Guard
- The Soldiers’ Home
- Cambridge, Fitchburg, Framingham and Methuen Police Departments



Preventing, Interdicting and Treating Substance Use Disorders Requires a Systemic Approach

The system in Massachusetts for preventing, interdicting, and treating substance use disorders consists of levels of care and intervention that include the traditional substance abuse treatment system as well as law enforcement, the courts, corrections, probation, parole, schools, programs for the homeless, health care providers, and programs run by other state agencies. Any successful strategy must account for the interactions between each of these system components and the individuals, families, communities affected by substance use disorders.



The Vision

We envision a system in which individuals, families, communities and service agencies work cooperatively to prevent and treat substance abuse and addiction. Through the work of the Interagency Council on Substance Abuse and Prevention, the Commonwealth will make strategic investments for individuals, families and communities most affected by substance abuse.

Through prevention, early identification, intervention, interdiction/enforcement, treatment and recovery support we expect that individuals at risk for and diagnosed with a substance use disorder can lead healthier, more productive lives in safer and more livable communities.

Principles for Success

- Addiction is recognized and dealt with as *a chronic disease*.
- Potential users receive *prevention* services before they ever use.
- Effective *interdiction and enforcement* efforts reduce the availability and the pervasive impact of drugs.
- People needing treatment and/or other interventions are *identified* early, effectively and efficiently.
- Individuals receive effective *assessments* and are consistently *placed* in the most appropriate levels of care.
- A *continuum* of services, with supply corresponding to appropriate demand, is available and is well managed.
- Prevention, treatment and support services are *timely, appropriate* and *effectively delivered.*
- Reducing substance abuse and addiction is *a government and community-wide* fight. Successful strategies involve both levels.

The Case for Change

- Addiction is a chronic, relapsing disease.
- Left untreated, its consequences take a significant human toll and have an enormous impact on multiple systems.
  - Its physical consequences range from illness and disability to death
  - Its social consequences include traffic accidents, crime, job loss, homelessness, domestic violence, and child abuse and neglect, among innumerable others.
    - Alcohol was involved in 45% of fatal automobile crashes in 2003.
    - People with drinking problems use healthcare services at twice the rate of others.
    - 83% of those arrested were using alcohol or other drugs at the time of their offense.
- Most aspects of our society, and every aspect of our social service and criminal justice systems, bear a significant impact from substance use disorders.
  - The impact on all our public systems and professionals is extraordinary – from the court system to corrections, emergency rooms to homeless shelters, and from police officers to school teachers.

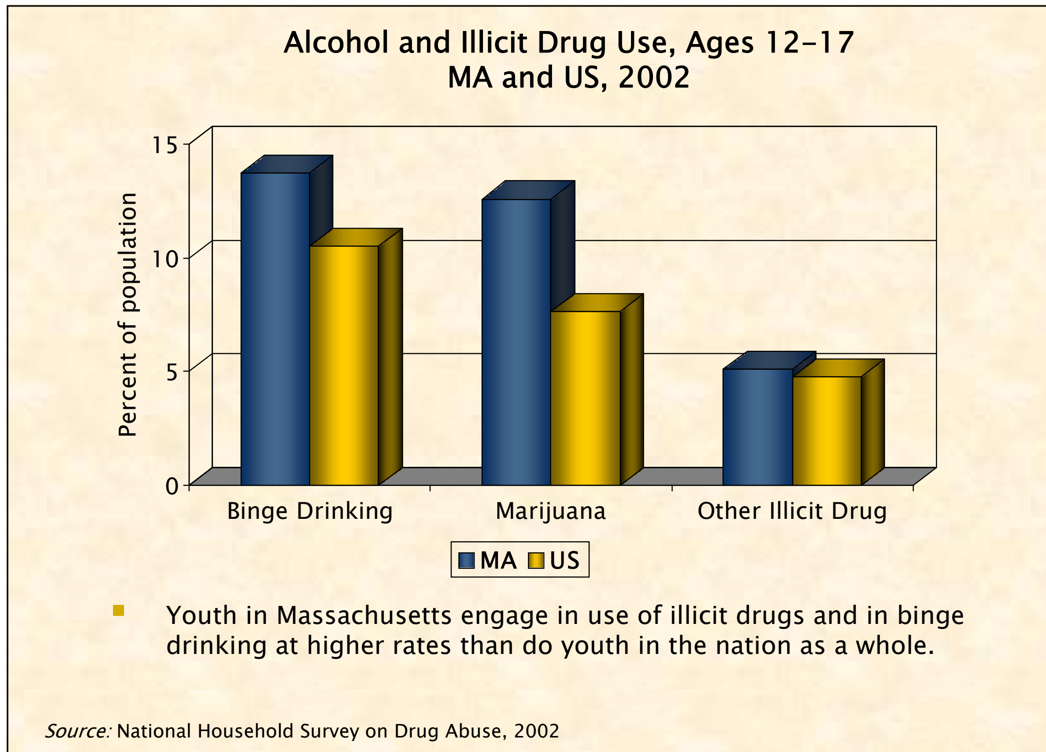
The Case for Change:
Our current approach isn't working

- Massachusetts' approach to the issue of substance abuse and addiction is not yet sufficiently comprehensive, well organized or systemic when dealing with the many facets of substance use disorders. In the past we have generally funded services, not strategies.
- Some population groups, left untreated, impose significant costs on the Commonwealth, especially those who rely upon programs and services of multiple state agencies.
- We must coordinate all of our efforts related to prevention, interdiction, enforcement, screening, assessment, treatment and support.
- As other states have discovered, better coordinated services will reduce recidivism, increase retention in treatment and provide the long term supports needed by people in recovery.

The Case for Change:
Massachusetts has high levels of alcohol and drug use

- Massachusetts residents use alcohol and drugs at high levels, generally at higher levels than do residents of the nation as a whole.
  - Both youth and adults are affected.
  - Adults at all income and education levels are affected.

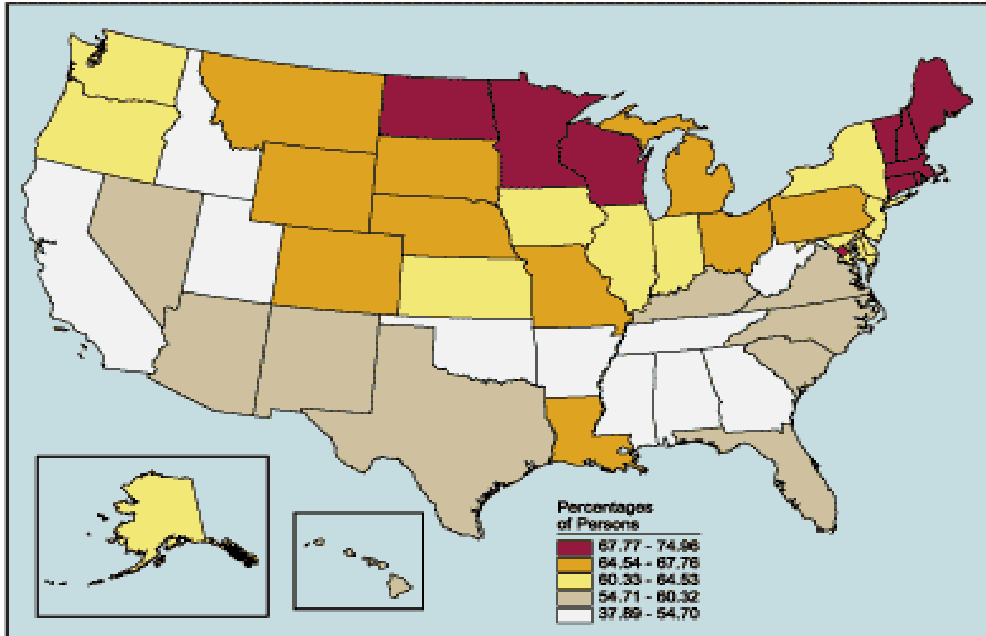
Youth



- We use statistics on "binge drinking," defined as "having five or more drinks on one occasion," because of the high risks associated with this behavior.
- Illicit drugs include marijuana, cocaine, crack, heroin, hallucinogens and LSD.

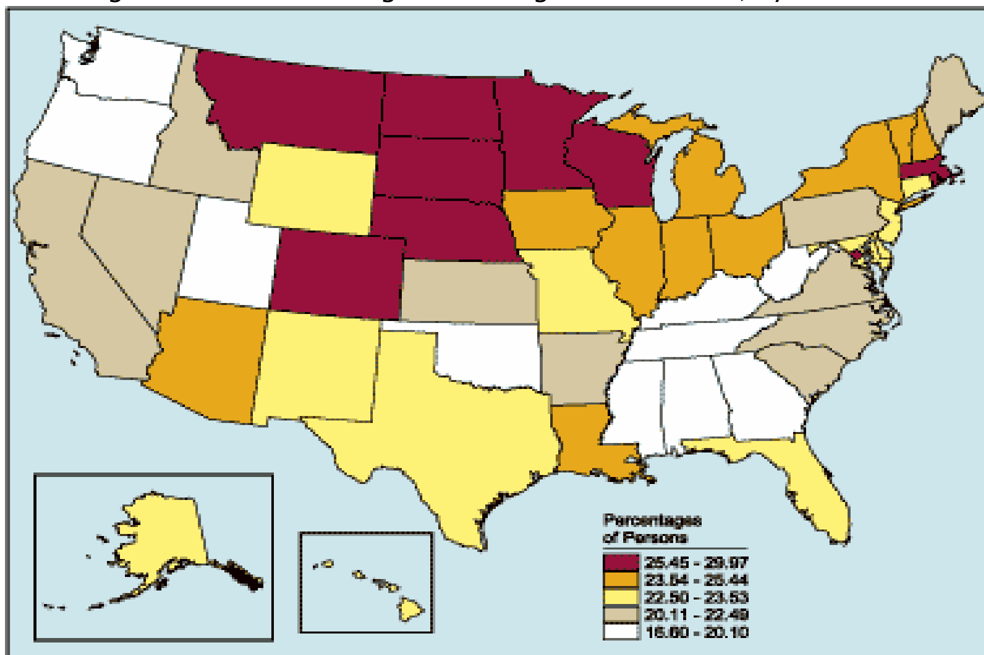
The Case for Change:
Massachusetts has high levels of alcohol and drug use

Use of *Alcohol among Persons Aged* ***18 to 25****,* by State: 2002



Percentages of telephone survey respondents who reported past-month alcohol usage

Binge Alcohol Use among Persons Aged **12 or Older**, by State: 2002

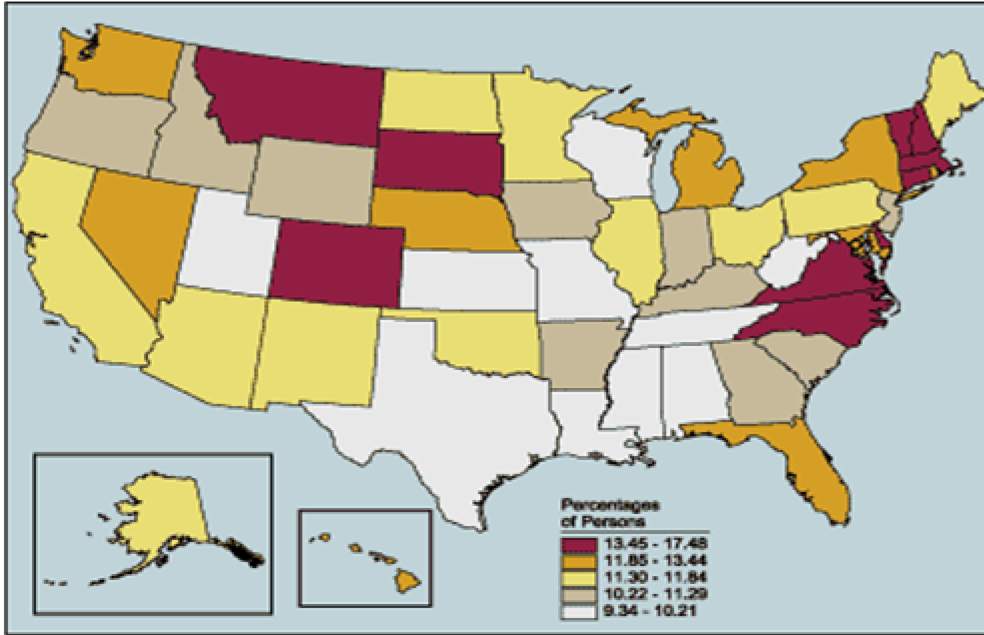


Percentages of telephone survey respondents who reported past-month binge drinking episode(s)

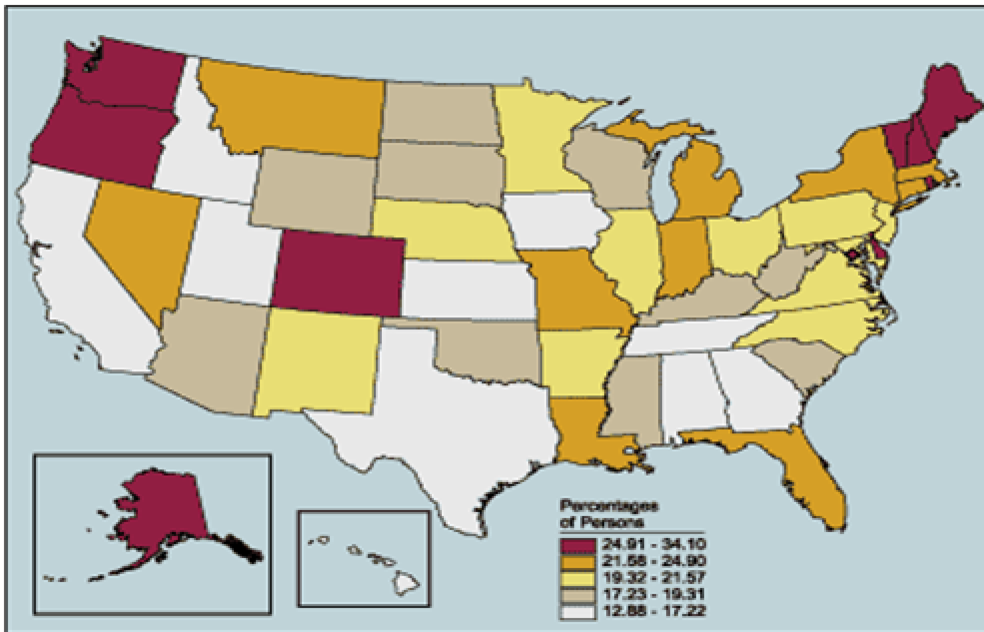
Source: National Household Survey on Drug Abuse (NHSDA)

The Case for Change:
Massachusetts has high levels of alcohol and drug use

Past Month Use of *Any Illicit Drug among Youths Aged **12 to 17**,* by State: 2002



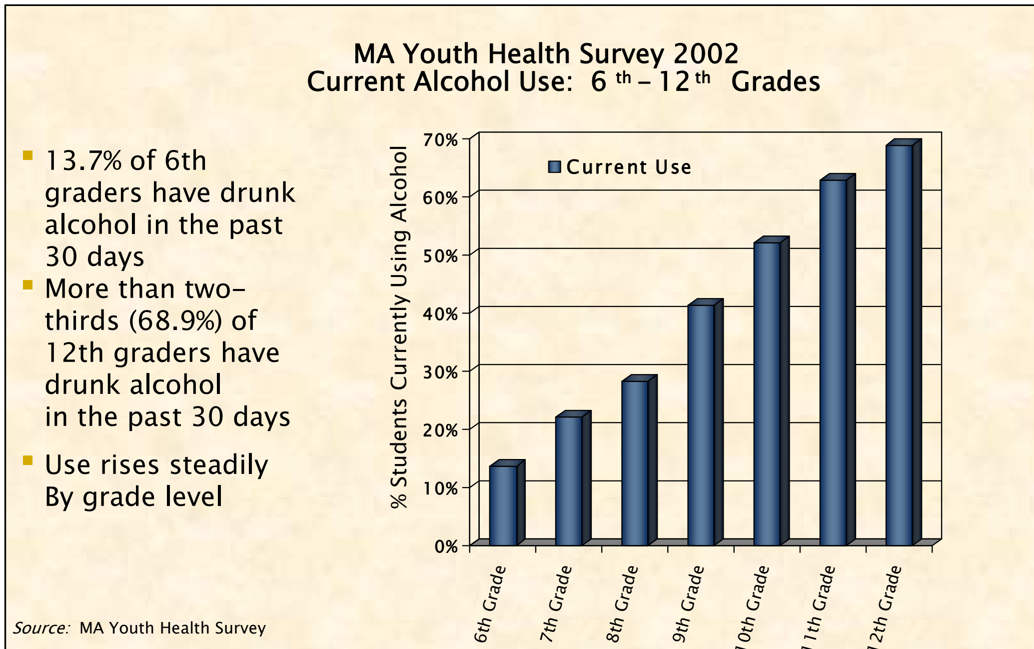
Past Month Use of *Any Illicit Drug among Persons Aged **18 to 25**,* by State: 2002



The Case for Change:
The earlier kids begin using alcohol the worse the impact.

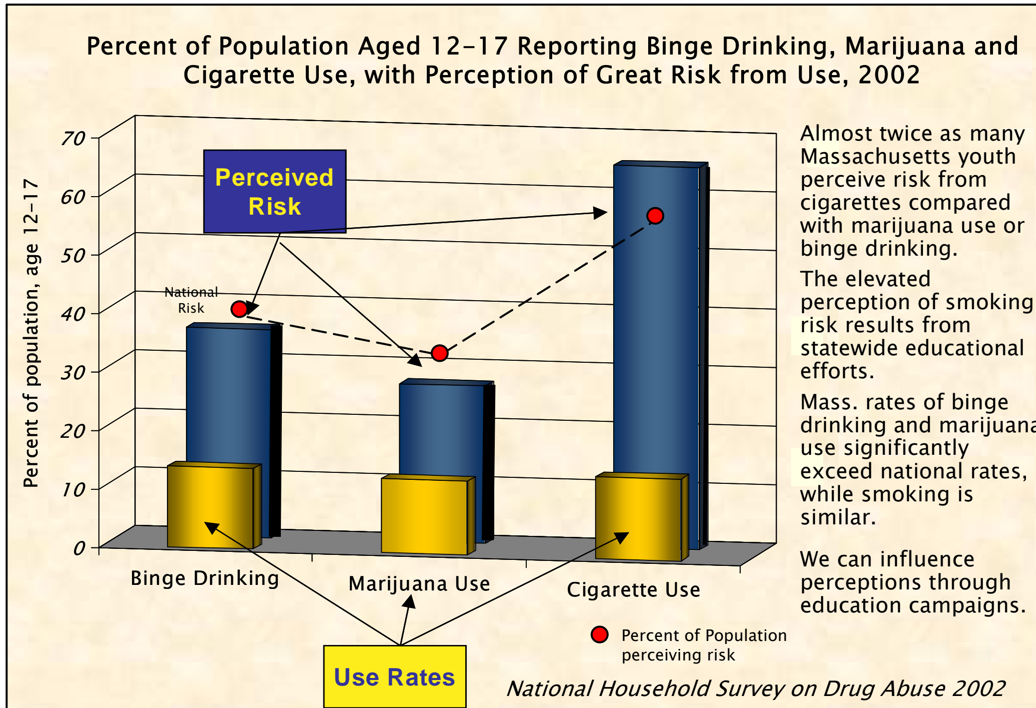
Youth

Youth

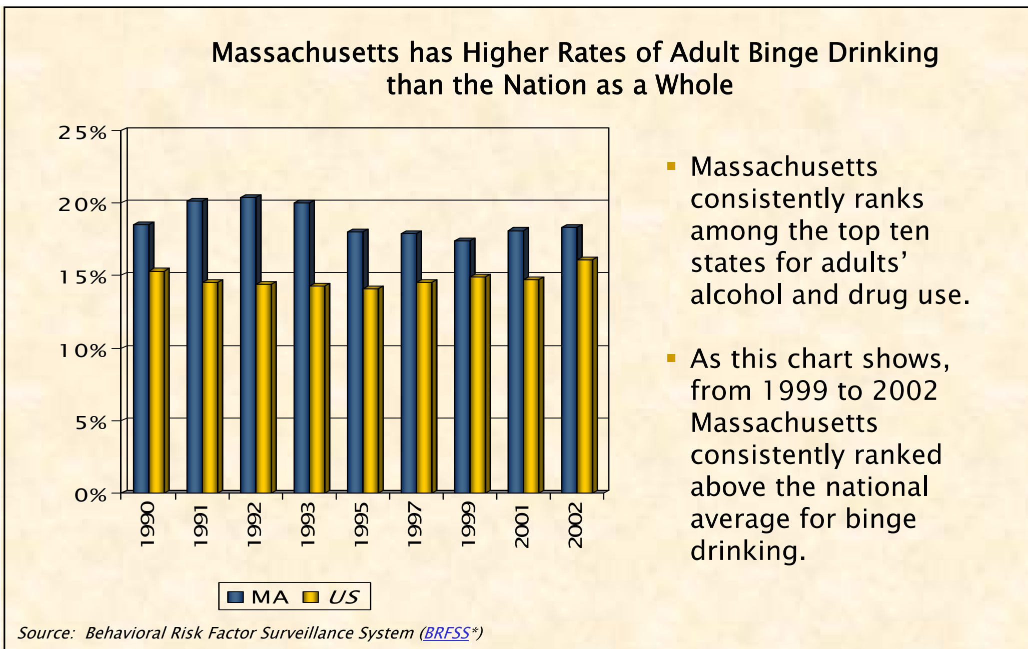


The Case for Change:
Youth misperceive the relative risks

Youth



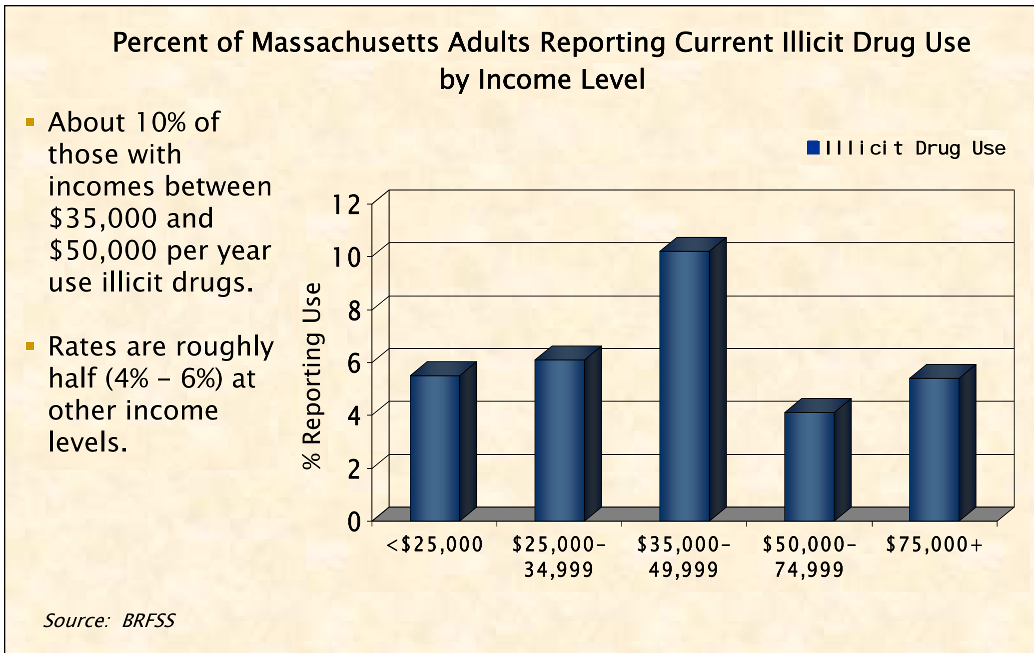
Adults



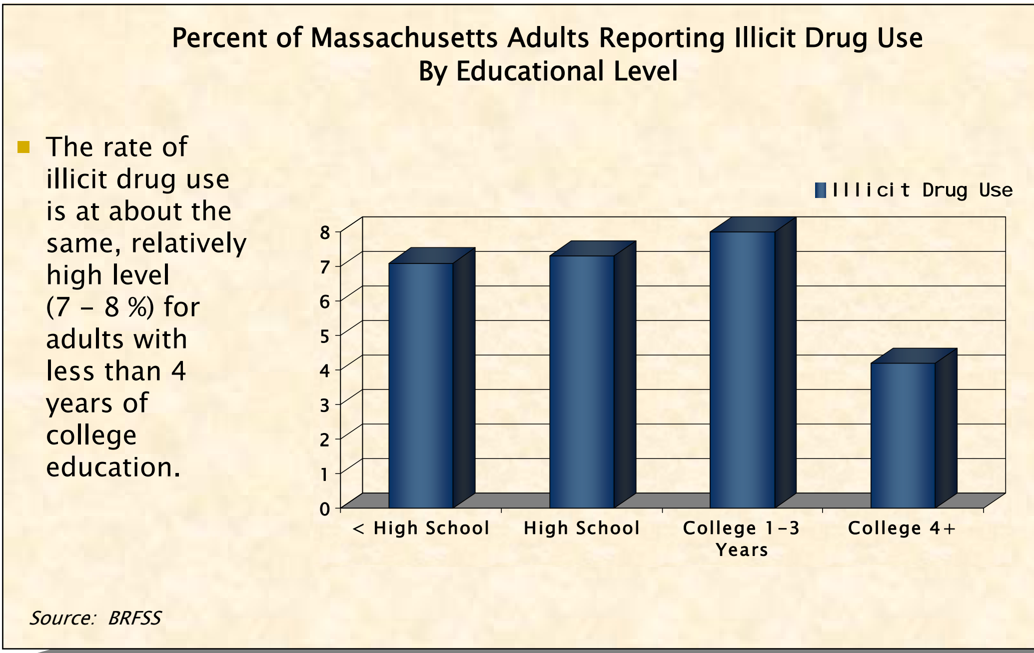
* Words identified by this formatting are included in the glossary available at the end of this document

The Case for Change:
The middle class has high rates of alcohol and drug use

Adults

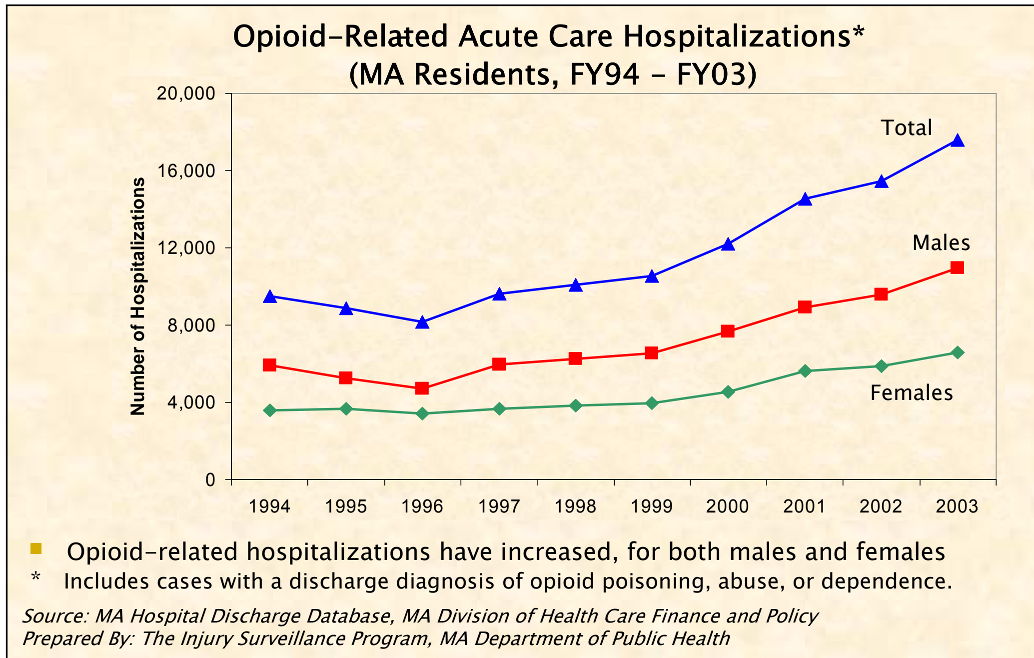


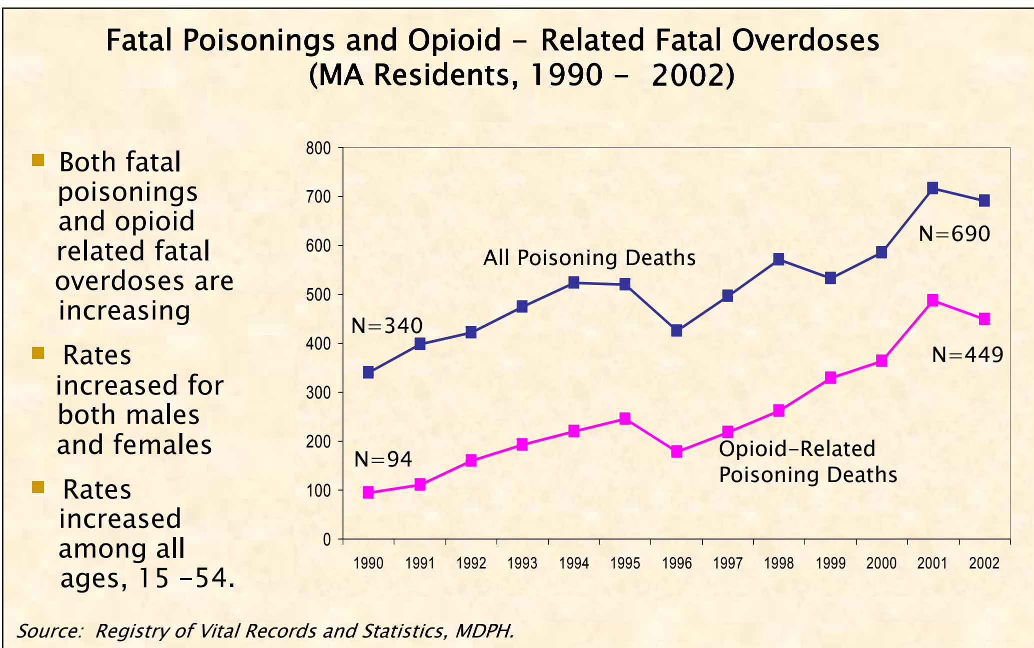
Adults



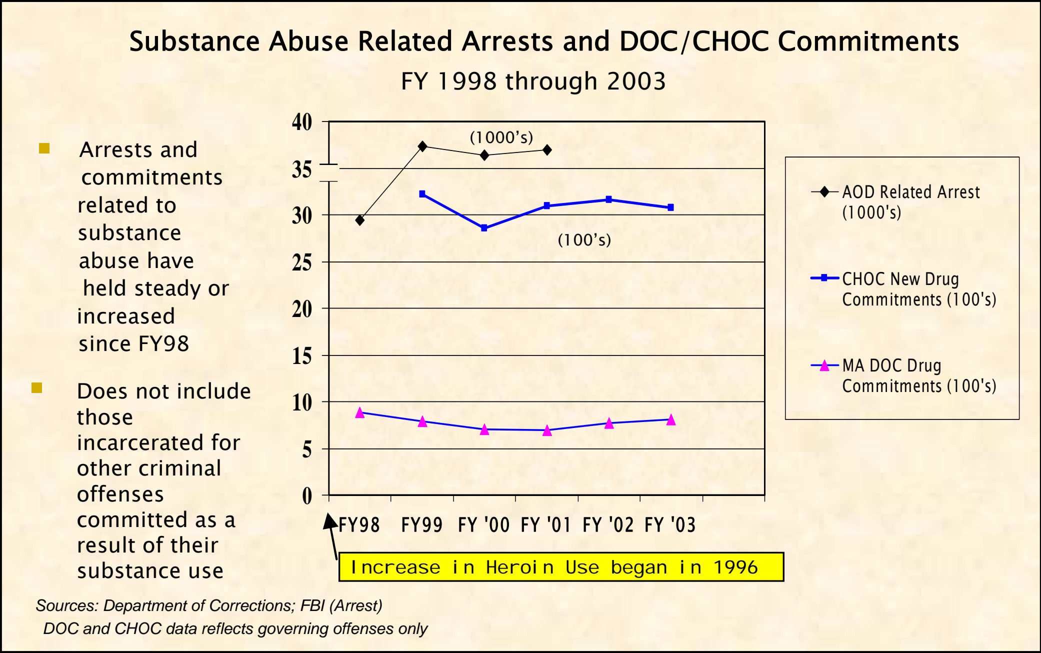
The Case for Change:

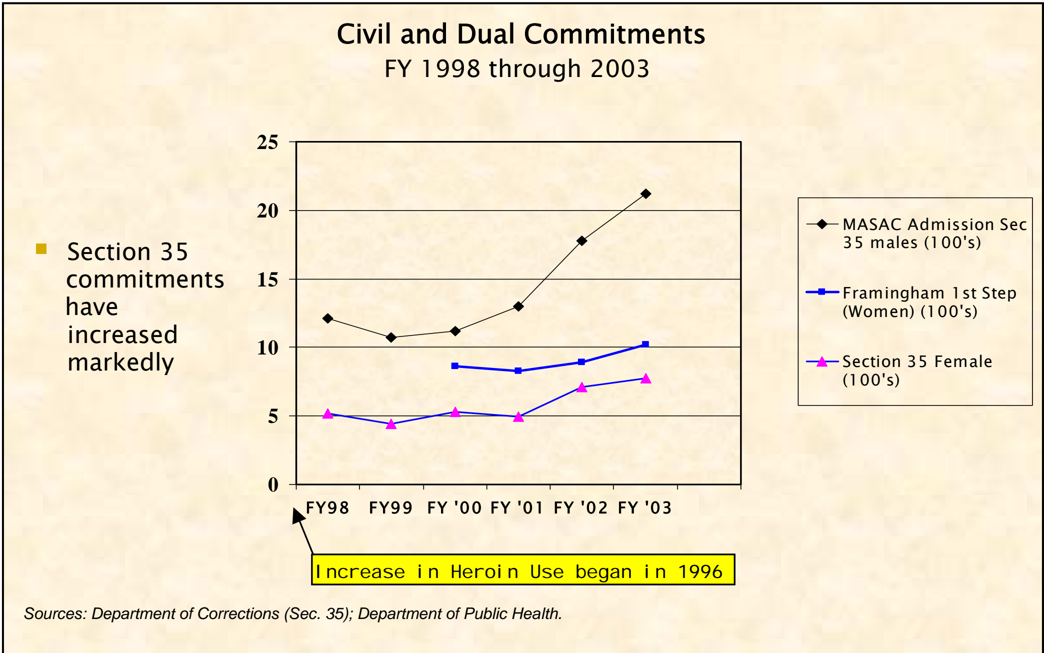
Opioid related hospitalizations & fatal overdoses are increasing





The Case for Change:
Trends in Substance Use related Arrests and commitments



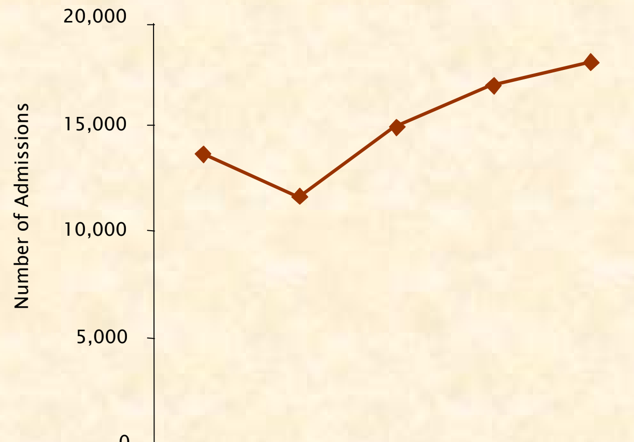


The Case for Change:

Substance abuse imposes high costs on the healthcare system

Substance Abuse Related Emergency Room Admissions
1998 – 2002

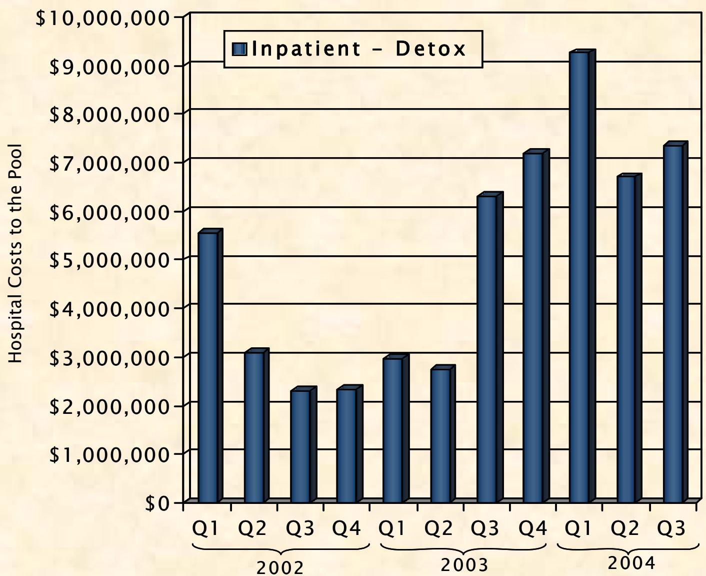
- Mean charge per Emergency Department discharge, FY'02, was $667
- Therefore total charges for substance abuse related ER admissions that year approximated $12M.



	1998	1999	2000	2001	2002
ER Admissions	13656	11668	14901	16853	17965

Source: Massachusetts Division of Health Care Finance and Policy

Substance Abuse Costs to the Uncompensated Care Pool



- The cost of inpatient detoxification to the Uncompensated Care Pool increased from $2.7 million in the second quarter to $6.3 million in the third quarter of FY03, and was at $7.3 million in the most recent quarter.

Totals

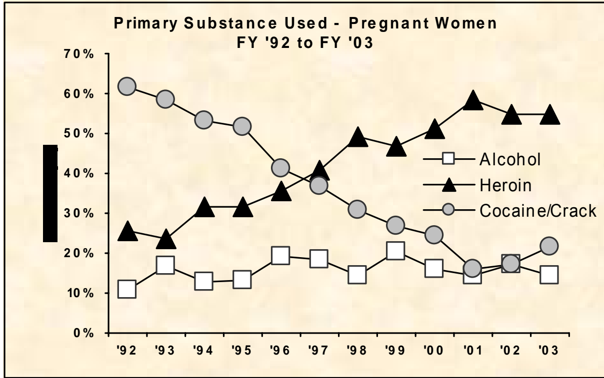
2002 -$13,303m

2003 -$19.224m

2004 -$23,909m (3 quarters only)

Case for Change:
Different populations have different drug use patterns

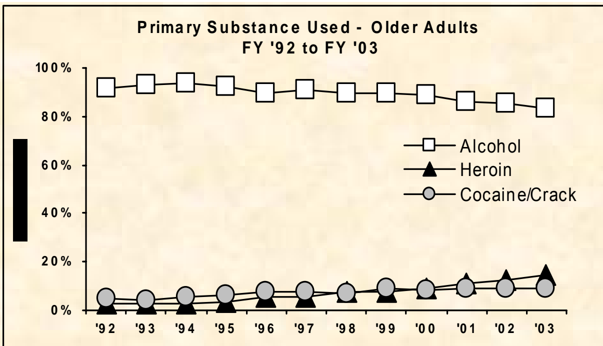
Pregnant Women



Of 30,922 adult women admitted to SA treatment (2003):

- 504 were pregnant when admitted;
- 5,077 were homeless;
- 466 were Section 35 commitments
- 75.3% were White, 12.0% were Black, 9.3% were Latino

Older Adults



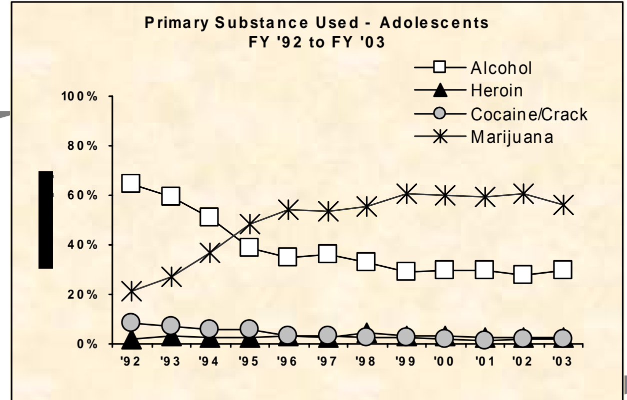
(3.1% reported *other* drugs as primary substance of use.)

- 81.3% male; 18.7% female;
- 75.7 were white

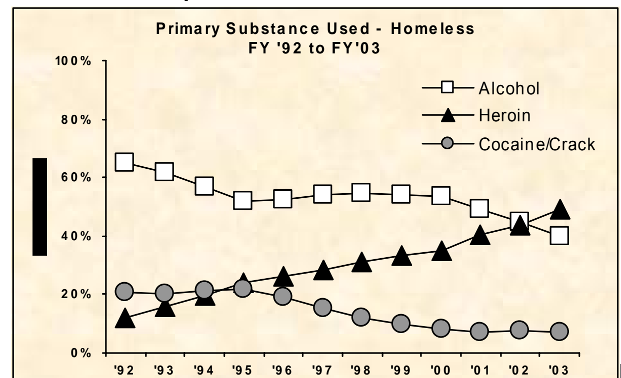
Of adolescent SA admissions:

- 72.3% (2,197) were male;
- 66.1% were White; (12% were Black, 16.9% were Latino, 5% were other);
- 39.7% reported prior mental health treatment.

Adolescents



Homeless Population



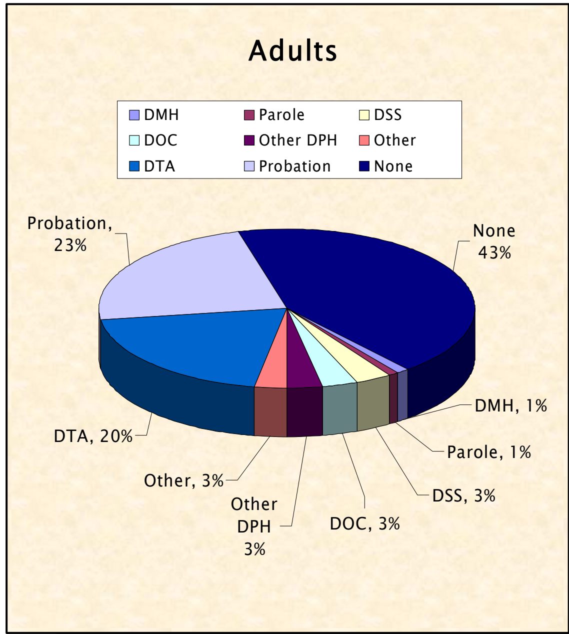
- 78.2% (18,249) were male and 21.8% (5,077) were female.
- 64.2% (14,980) were White
- 96.0% were currently unemployed
- 24.0% reported prior mental health treatment

These (sometimes overlapping) groups include:

- Individuals involved in the criminal justice system
- Youth
- Pregnant and parenting women
- Injection drug users
- Homeless individuals
- Individuals without health insurance
- Individuals diagnosed with mental illness as well as substance use disorders
- Multiple-drug users
- High frequency “repeat clients” (e.g., detox)

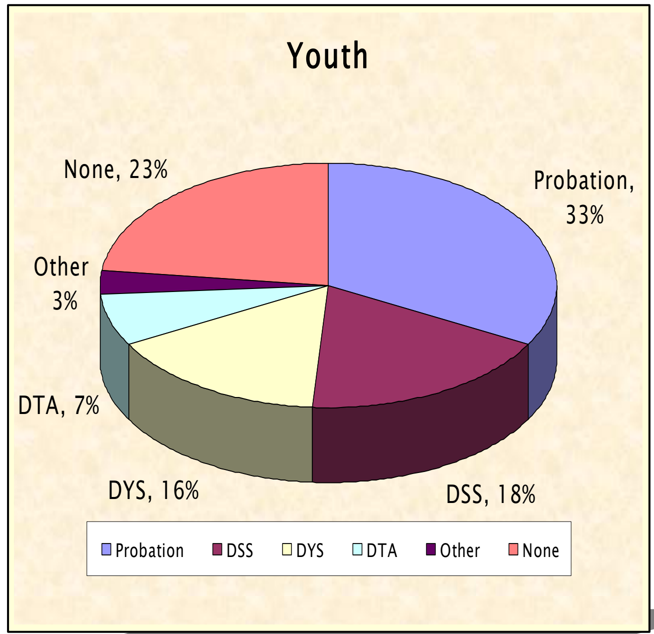
Source: These charts based on Substance Abuse Admissions information (2003) – Massachusetts

The Case for Change:
Reported involvement with Massachusetts state agencies by individuals receiving treatment



- Nearly three in five adults, and more than three in four young people, who receive substance abuse treatment also report involvement with other state agencies.
- We minimize costs when we serve each individual at the most appropriate, least restrictive, level of care.

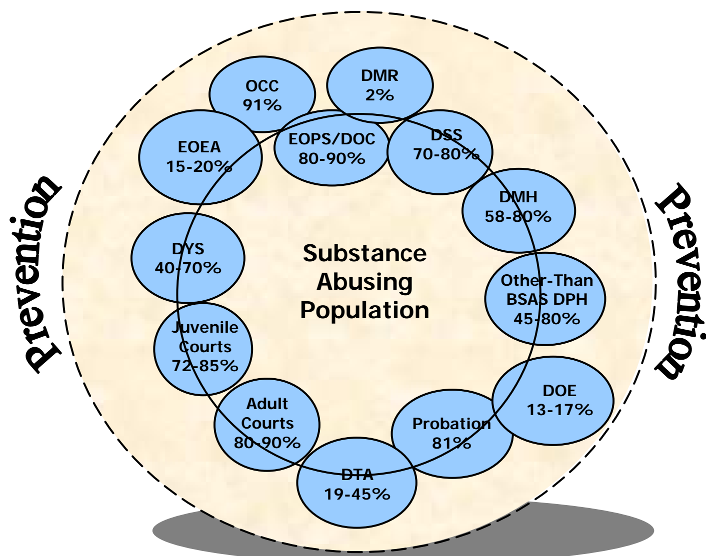
- Doing so requires individualized treatment plans, standardized assessments and a continuum of services where the supply of service types is consistent with assessed needs (demand).
- Left untreated, individuals in some population groups impose high costs on multiple systems



Source: SAMIS – Self report at time of admission

The Case for Change:

Many state agencies are disproportionately affected by Substance Abuse

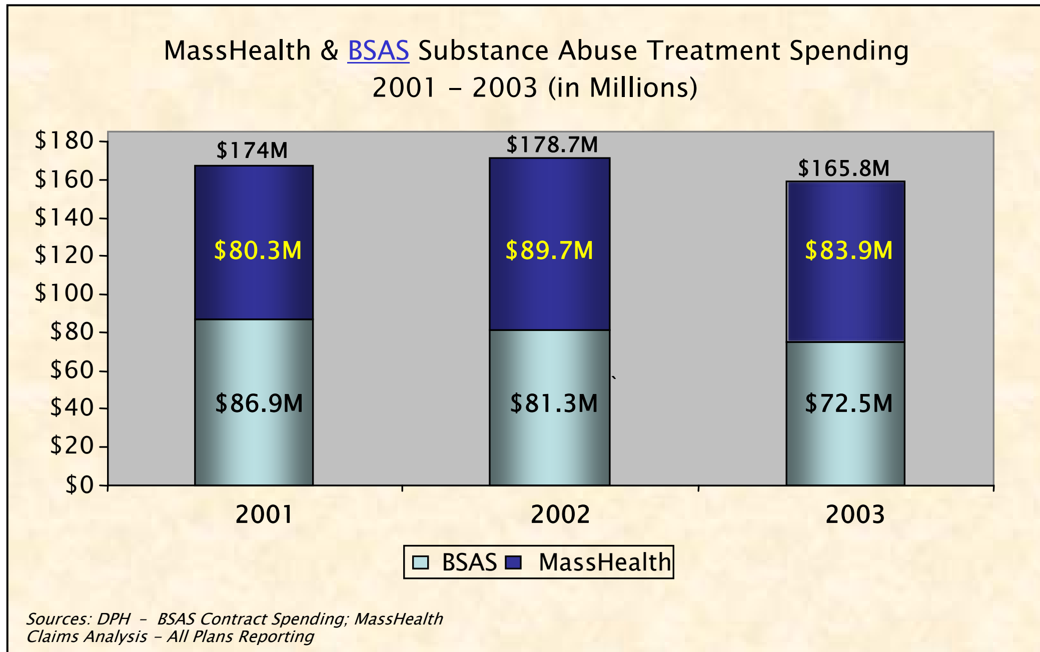


State Agencies	Total Agency Consumers	Percent with Substance Use Disorder *	Number with Substance Use Disorder **(est.)
Office of Community Corrections (OCC)	250,000	91%	227,500
Probation	160,000	81%	129,600
Adult Courts	148,000	81%	119,880
EOPS/DOC	85,000	81%	68,850
Juvenile Court	18,000	72%	12,960
DSS	30,000	70%	21,000
DMH	24,500	58%	14,210
DYS	18,000	40%	7,200
DTA	300,000	19%	57,000
EOEA	2,944	15%	442
DOE	73,732	13%	9,585
DMR	32,000	2%	640
	1,142,176	n/a	668,867

**Sources: "Shoveling Up: The Impact of Substance Abuse on State Budgets" (2001); National Center for Addiction and Substance Abuse (CASA) at Columbia University; Massachusetts Agency Statistics; and Self-Report*

*** not unduplicated count – many people receive services from multiple agencies*

The Case for Change:
Numerous state agencies fund or provide substance abuse services



Substance Abuse Services: Funding Sources

	InPatient Detox	Acute Treatment Svcs.	Residential <30 Trans. Support (IIIB)	Residential >30	Ambulatory Svcs	Opioid Tx	Aftercare/ Recovery Support	Court/ Corrections	Homeless	DUI	Early Intervention	Screening/ Assess/ Refer	Statewide Support	Prevention & Interdiction Services	Total
BSAS		$7,274,834	$8,622,112	$29,727,766	$4,979,162	$4,540,694	$3,576,156		$2,079,672	$733,837			$3,860,646	$7,090,000	$72,484,879
Mass Health	$1,478,001	$28,899,640	$4,859,771	$4,846,510	$3,514,449	$40,281,050									$83,879,421
Other EOHHS*				$8,900,000	$265,000				$200,000		$100,000	$150,000			$9,615,000
Uncompensated Care Pool **	$19,224,000				$18,564,000										$37,788,000
Federal Direct Funding			$623,000	$743,526	$2,537,261		$943,780	$500,000			$1,092,273	$4,514,840		$5,715,311	$16,669,991
EOPS														$3,680,551	$3,680,551
Department of Correction ***								$3,206,240							$3,206,240
Office of Community Correction					$12,100,000										$12,100,000
Department of Education														$6,063,795	$6,063,795
Self Pay - SAMIS Only	$925,322			$4,746,658	$2,480,738										$8,152,718
	$21,627,323	**$36,174,474**	**$14,104,883**	**$48,964,460**	**$44,440,610**	**$44,821,744**	**$4,519,936**	**$3,706,240**	**$2,279,672**	**$733,837**	**$1,192,273**	**$4,664,840**	**$3,860,646**	**$22,549,657**	**$253,640,595**

* *Other EOHHS includes expenditures by DYS, DSS, MCDHH, Veterans' Affairs, DMR, DTA*

** *Ambulatory Services for the Uncompensated Care Pool includes both MH and SA claims*

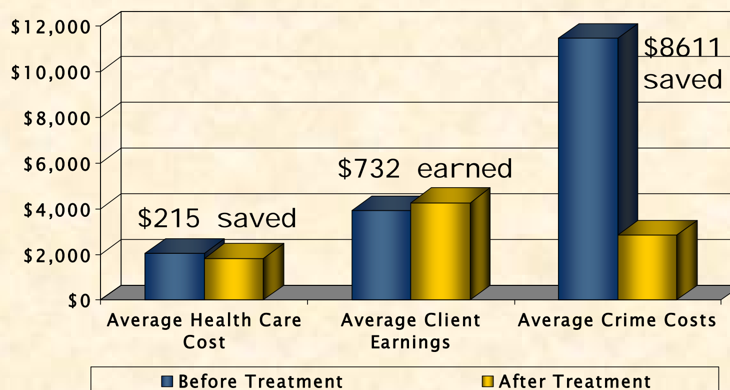
*** *DOC funding for Residential <30 days is for 2004 – SAMIS Only*

The Case for Change:
Treatment works and is cost effective

- The cost of substance abuse treatment is recouped within two to three years of treatment through reductions in other healthcare costs (Center for Substance Abuse Treatment).
- Average annual crime-related costs to society fell by $8,600 per client following treatment (Koenig et al., 1999).
- A major study done in California reported that the economic benefit of treatment outweighed the cost of treatment by seven to one (CALDATA, 1997). In this study,
    - Treatment costs were $209 million.
    - The more than $1.49B in savings resulted from, among other things, reductions in hospitalization and ER admissions by one-third and crime reductions.

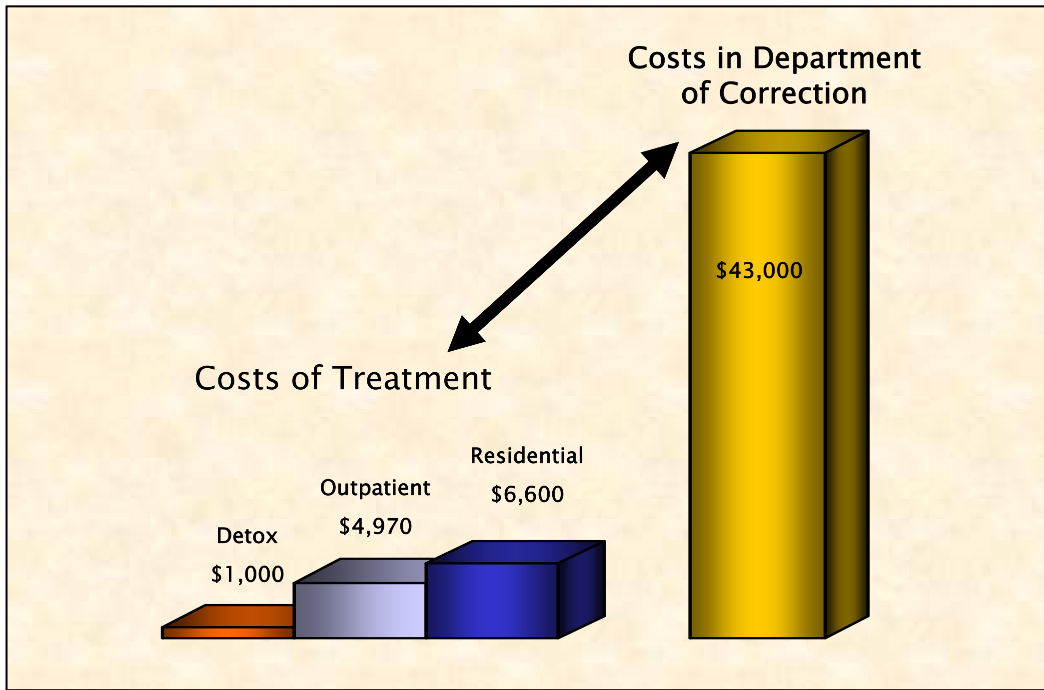
Average Per Client Costs & Benefits of Substance Abuse Treatment
Lewin Group, 2002

- The literature shows that, following treatment for substance use disorders, costs of healthcare and crime go down, while earnings go up.



National Evaluation Data Set

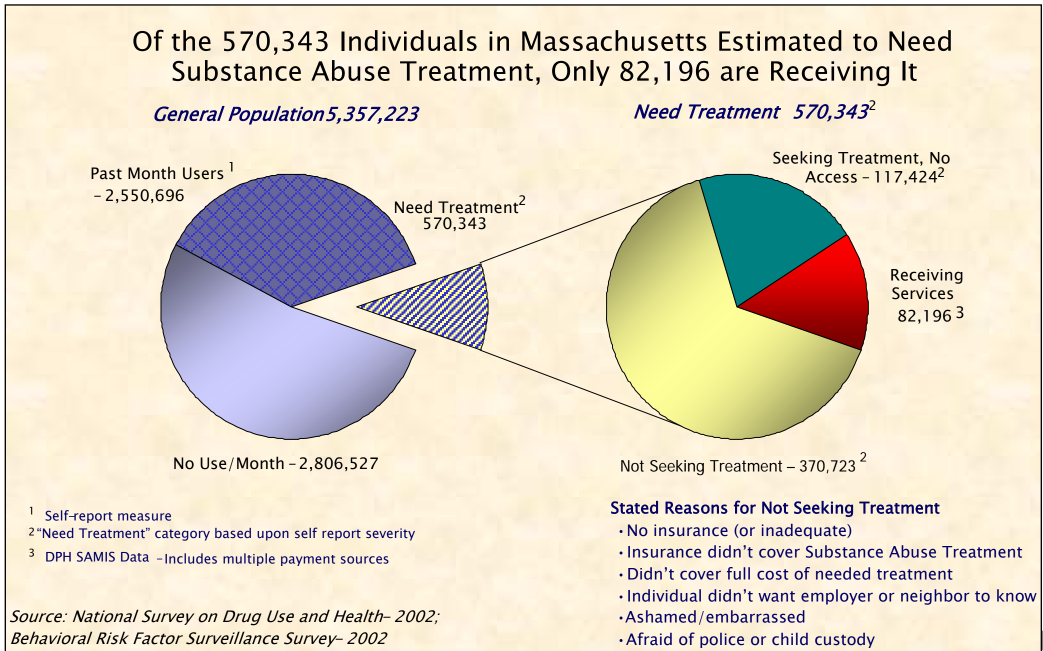
The Case for Change:
Treatment costs much less than incarceration



- *ATS, Acute Treatment Service* (Community-based Detox) costs $1,000 per 5-day treatment episode. (A five-day in-hospital detox costs $4-5,000 per episode)
- OTS, *Outpatient Treatment Services*, cost $4,970 per year
- RRH, *Residential Rehab Services* cost $55/day, or $6,600 for 120 days per year
- DOC, *Department of Corrections*, bed, costs $43,000 per year

The Case for Change:

There is a gap between the number who need treatment and the number receiving it



A study by researchers at Brandeis University estimated that of the 117,424 individuals seeking treatment but with no access, 39,450 require treatment at a specialty facility with an estimated total cost of $109M (approximately two-thirds of which requires public funding).

Using targeted interventions for high risk and high cost individuals, expanding key services, emphasizing prevention, developing recovery supports and improving the coordination between services, we believe that we can increase access and begin to meet the need of individuals in the Commonwealth for substance abuse services.

Savings from increased treatment access should accrue to various public agencies, employers and communities. Only a coordinated policy and planning effort will enable us to realize these savings and reinvest them to address unmet need.

The Case for Change:
Conclusions

- This strategic plan lays out a direction and set of critical steps needed to stabilize and maximize the impact of the system. It is a beginning. The data we have collected and the messages we have heard from stakeholders are clear.
- We need more data to monitor our success and make the case for future changes.
- Our prevention and treatment services need to function as a system – now they tend to be isolated and lack coordination between levels of care.
- We need to intervene early to prevent irresponsible drinking and drug use.
- We need to prevent alcohol and drug dependence before they start. This requires broad based screening, standardized assessments, but also new cultural norms for drinking behavior and more proactive interventions by peers.
- We need to develop a system of recovery supports to individuals and families throughout our communities.
- Finally, we need better coordination among public agencies and among purchasers, providers and consumers. Coordination is essential to the redesign of our system.

The Plan

The Vision

We envision a system in which individuals, families, communities and service agencies work cooperatively to prevent and treat substance abuse and addiction. Through the work of the Interagency Council on Substance Abuse and Prevention, the Commonwealth will make strategic investments for individuals, families and communities most affected by substance abuse.

Through prevention, early identification, intervention, interdiction/enforcement, treatment and recovery support we expect that individuals at risk for and diagnosed with a substance use disorder can lead healthier, more productive lives in safer and more livable communities.

Principles for Success

- Addiction is recognized and dealt with as *a chronic disease*.
- Potential users receive *prevention* services before they ever use.
- Effective *interdiction and enforcement* efforts reduce the availability and the pervasive impact of drugs.
- People needing treatment and/or other interventions are *identified* early, effectively and efficiently.
- Individuals receive effective *assessments* and are consistently *placed* in the most appropriate levels of care.
- A *continuum* of services, with supply corresponding to appropriate demand, is available and is well managed.
- Prevention, treatment and support services are *timely, appropriate* and *effectively delivered.*
- Reducing substance abuse and addiction is *a government and community-wide fight*. Each has an important role to play.

See Appendices C and D for Standards for Treatment and Prevention

Proposed Areas of Focus

The following six priority areas will help us achieve the vision.

- **Establish a formal, Governor's Interagency Council on Substance Abuse and Prevention to provide executive level leadership to**:
  - *Maximize and align available resources;*
  - *Develop unified statewide strategies to drive changes in the substance abuse prevention and treatment systems.*
- **Expand prevention programs targeting at-risk youth; expand community-based prevention efforts**
  - *Implement pilot prevention programs focusing on youth in elementary, middle and high school to prevent alcohol and other drug use*
- **Expand screening,* assessment and referral activities:**
  - *Effectively and efficiently identify people needing intervention and treatment services in primary care systems, school, state agencies and other community settings;*
  - *Conduct immediate brief interventions to deter harmful behavior, when appropriate; and*
  - *Refer individuals needing more comprehensive services for standardized assessments and appropriate treatment.*
- **Support a comprehensive continuum of services, matched to demand, to:**
  - *Focus on the whole person;*
  - *Include the treatment and rehabilitation/recovery services and modalities we know to be most effective; and*
  - *Support treatment for priority populations.*
- **Develop a system of accountable prevention, treatment and recovery support services that are:**
  - *Evidenced-based or based on best practice*
  - *Cost Efficient*
  - *Well managed, and*
  - *Outcomes-based.*
- **Reduce the high cost of incarceration and recidivism on both the criminal justice and treatment systems, ensure the public safety, promote recovery and return people to productive lives:**
  - *Expand diversionary services,*
  - *Promote treatment and other support services for individuals in prison, and*
  - *Facilitate reentry from secure facilities without losing recovery support.*

* Refer to Glossary for how these terms are defined.

Leadership, Oversight and Alignment of Resources

Recommendation 1:

Establish a Governor's Interagency Council on Substance Abuse and Prevention to provide executive level leadership to:

- **Maximize and align available resources for addressing substance use issues**
- **Develop unified strategies to drive changes in the substance abuse prevention and treatment systems**
- **Unify the authority of the Governor's separate alcohol and drug advisory councils**

Rationale:

Currently the Commonwealth has two statutory advisory councils, one for alcohol and one for drug rehabilitation, which meet jointly and have a limited focus and membership. Present statutes do not provide for one integrated, executive level leadership body with the authority to establish and/or coordinate implementation of a statewide drug and alcohol strategy, agree on priorities for resource allocation and/or align efforts across agencies and secretariats. Absent such an ongoing body, our ability to address the systemic impacts of substance trafficking and use, and effectively and efficiently implement prevention, intervention, enforcement and treatment strategies, is thwarted.

Strategies:

1.1 By Executive Order, create an Interagency Council on Substance Abuse and Prevention. The goals of the Council will be to:

   a. Prioritize target populations and assemble resources in order to maximize outcomes.
   b. Oversee implementation of the initiatives detailed in this strategic plan.
   c. Integrate procurement, reporting, planning, and evaluation.

   Working toward those goals, the Council will:

   a. Submit a unified annual state substance abuse spending plan based on strategic priorities.
   b. Develop an annual report that justifies spending amounts and priorities.

   The Council will meet quarterly and will be chaired by the Lieutenant Governors and include: The Secretaries of Health and Human Services, Public Safety, and Elder Affairs; The Commissioners of Public Health, Correction, Education, Parole, Youth Services, Mental Health, Mental Retardation, Transitional Assistance, Social Services, Public Health, Health Care Finance and Policy, Office of Medicaid, Deaf and Hard of Hearing, Early Education and Care, Chief Judges of the Juvenile, Superior, and Trial Court, Chair of the Governor's Commission on Homelessness and other members as appropriate.

   An Executive Committee composed of at least 11 members of the Council will be created and will meet on a bi-monthly basis to provide guidance based on the recommendations of the Council.

Recommendation 2:

Expand prevention, interdiction and enforcement efforts. Leverage and build upon existing statewide, regional and local community efforts to create and promote a common framework for prevention, interdiction, enforcement and intervention to prevent underage alcohol and other drug use in youth and prevent alcohol and other drug abuse in adults.

Rationale:

- 32% of Massachusetts youth report having been offered, sold or given an illegal drug on school property. Youth who have used alcohol before age 12 are five times more likely to become dependent or abuse drugs.
- An estimated 147,000, or 12.5% of youth aged 12-17 in New England, are lifetime users of psychotherapeutic drugs taken non-medically.
- An estimated 2.5 million people in New England, or 21.4% of the population, are lifetime non-medical users of psychotherapeutic drugs. (2003 National Survey on Drug Use and Health (NSDUH))
- Emergency room visits in Boston associated with narcotic pain relievers increased 153% from 1995 to 2002. (Drug Abuse Warning Network (DAWN))

Strategies:

2.1 Increase the age of first use, reduce underage alcohol and other drug use and reduce binge drinking in youth and young adults.

2.2. Expand evidenced-based prevention efforts, focused on youth in communities and schools, to reduce risk factors and enhance protective factors affecting alcohol and other drug use.

2.3. Prevent the misuse of alcohol and other drugs (including prescription drugs) among adults, with particular emphasis on vulnerable populations.

2.4 Curtail access to alcohol and other drugs, reduce exposure to drug sales and distribution, and enhance enforcement efforts.

2.5 Coordinate efforts to detect and identify non-medical use of prescription psychotherapeutic drugs and develop methods for prevention and early intervention.

2.6 Coordinate, monitor, support and evaluate evidence-based prevention, interdiction and enforcement programs and activities across state agencies and communities. Allow the flexibility to meet unique community needs and to adjust to new, innovative approaches

2.7 Assess community needs and resources to identify barriers to behavior change, such as stigma, and to target prevention and interdiction resources to those regions, communities and neighborhoods most impacted by drug sales, drug use and crime.

2.8 Use cross-training and technical assistance capabilities to build shared expertise on evidence-based prevention practices across multiple disciplines

Prevention, Interdiction & Enforcement

Strategy 2.1 – Increase the age of first use, reduce underage alcohol and other drug use and reduce binge drinking in youth and young adults.

Implementation Plan:

1. Review and develop standards for alcohol advertising in state operated venues, such as the MBTA, state colleges and universities, etc.
2. In collaboration with local boards of health and law enforcement, implement compliance checks in communities throughout the Commonwealth.
3. In conjunction with the Massachusetts Restaurant Association and other key stakeholders, develop a plan to have universal server training for all retailers and vendors of alcohol.
4. Implement a social marketing plan directed at parents of pre-teens to educate about the importance of appropriate modeling behavior.
5. Expand the use of brief intervention strategies to reduce alcohol use and binge drinking among young adults.
6. Develop state wide educational efforts that increase the perceived risk of alcohol and other drug use among youth.

Strategy 2.2 – Expand evidenced-based prevention efforts, focused on youth in communities and schools, to reduce risk factors and enhance protective factors affecting alcohol and other drug use.

Implementation Plan:

1. Provide funding for selected school districts to implement pilot comprehensive substance abuse prevention, intervention services, including screening, assessment, drug testing and referral, in order to guide the development of the most effective programs at the local and state level.
2. Expand BSAS-funded, community-based, evidence-based prevention programs from 28 to 35.
3. Distribute evidence-based materials in every town and city of the Commonwealth that increases parent/child communication on alcohol and drug use.
4. EOHHS in partnership with EOPS, continue to support the Heroin and other Opioid Prevention Community Grants to plan and implement community and evidence-based prevention strategies. Expand to targeted communities.
5. Through the Inhalant Abuse Task Force and the Emerging Drug Task force, develop targeted educational campaigns for emerging drugs of abuse.

Strategy # 2.3 – Prevent the misuse of alcohol and other drugs (including prescription drugs) among adults, with particular emphasis on vulnerable populations.

Implementation Plan:

1. Through the establishment of a an epidemiological work group, enhance data sharing capabilities for tracking emerging drug trends, measuring capacity and focusing and coordinating all substance abuse prevention resources on those communities and people most in need and most vulnerable. Produce and release an annual report.
2. Working with the Massachusetts Retailers Association seek voluntary compliance from vendors to store pseudoephedrine behind counters that are not accessible to the public, limits the amount that can be purchased and requires a photo ID of the purchaser.
3. Introduce legislation that would criminalize the possession of chemicals where the intent is to manufacture, distribute, dispense or posses methamphetamine.
4. With the BSAS Federal Club Drug grant, expand regional training efforts to human service providers and local law enforcement on effective prevention and intervention strategies for methamphetamine.
5. Through the efforts of the Massachusetts Elder Substance Abuse Task Force, continue to work with elder providers, physicians and caretakers to prevent the misuse of alcohol and other drugs in this population and promote screening, assessment and intervention efforts.

Strategy # 2.4 – Curtail access to alcohol and other drugs, reduce exposure to drug sales and distribution, and enhance enforcement efforts.

Implementation Plan:

1. Provide training to local coalitions, including law enforcement, to conduct compliance checks and other strategies to change community norms on alcohol use.

2. Coordinate efforts with the Governor's Safe and Drug-free Schools and Communities, Byrne Law Enforcement Grants and Governor's Highway Safety Bureau to provide comprehensive, integrated community-based, evidence-based prevention and intervention efforts

3. EOPS will convene a series of implementation team meetings at a central and regional level. Attendees will include, at a minimum, DOE, EOPS, DPH, State Police, local law enforcement, National Guard, High Intensity Drug Trafficking Area representatives, Alcohol Beverage Control Commission and others. The goals will be:

    a. Review and inventory the current level of services provided in the system and identify any needs and gaps. Identify any duplication or overlap where similar populations are being served.

    b. Review and identify the existing regional prevention and interdiction efforts.

    c. In conjunction with Lieutenant Governor's Office, convene meetings with municipal government to discuss local strategies.

    d. Monitor progress on the EOPS, DOE, DPH Heroin and Other Opioid prevention initiatives.

Prevention, Interdiction & Enforcement

Strategy # 2.5 – Coordinate efforts to detect and identify non-medical use of prescription psychotherapeutic drugs and develop methods for prevention and early intervention.

Implementation Plan:

1. Improve the capacity of the Massachusetts Prescription Monitoring Program (PMP) to detect and identify individuals at risk for or involved in non-medical use of prescription psychotherapeutic drugs. Facilitate the use of PMP data to guide coordinated resource allocation among all MA cities and towns.
2. Develop methods and systems to provide health care providers with access to substance use data.
3. Use existing and develop new intervention best practices to ensure that those identified at risk for or involved in non-medical use of prescription drugs can be referred to appropriate treatment and/or intervention/enforcement.
4. Develop an epidemiological tracking system, utilizing PMP data, to provide needed information on the prevalence of medical and non-medical opioid use.
5. In collaboration with the Massachusetts Medical Society and the Board of Registration of Pharmacy, develop warning materials for all prescription narcotic and other dangerous drugs.

Strategy # 2.6. Coordinate, monitor, support and evaluate evidence-based prevention, interdiction and enforcement programs and activities across state agencies and communities. Allow the flexibility to meet unique community needs and to adjust to new, innovative approaches

Rationale:

Although we spend more than $23M on prevention, enforcement and interdiction efforts across the state (primarily federal funds), program planning, resource allocation, training and technical assistance are not yet sufficiently strategically aligned at either the state or local level. State and regional teams need training and technical assistance to faithfully replicate the model prevention programs that have already demonstrated effectiveness.

A lack of common data and needs assessments inhibits collaboration among prevention, enforcement and interdiction efforts. SAMHSA and Center for Substance Abuse Prevention (CSAP) support comprehensive models of prevention. Distribution of services is limited and often not based on areas of highest need, capacity and readiness. Barriers to program effectiveness include stigma, community readiness and peer culture.

Implementation Plan:

1. Develop uniform criteria, guidelines, and tools to assist communities in: conducting needs/resource assessments; selecting evidence-based programs and programs with promising approaches; leveraging and directing resources; creating systems for continuous professional development; developing uniform reporting mechanisms; adopting common outcome measures; and developing common evaluation processes.
2. Build shared expertise on evidence-based prevention practices across multiple disciplines (e.g., municipal government, law enforcement, educational organizations, medical providers, social service agencies); coordinate planning efforts to bridge differences in philosophy, resources and approach.
3. Develop a pilot effort of one or two regional collaborative to expand local networks that address prevention, intervention, enforcement and interdiction and treatment; these collaboratives must be coordinated with existing community-based treatment services, regional re-entry sites, school departments, social services, mental health and other agencies.

Prevention, Interdiction & Enforcement

Strategy # 2.7 – Assess community needs and resources to identify barriers to behavior change, such as stigma, and to target prevention and interdiction resources to those regions, communities and neighborhoods most impacted by drug sales, drug use and crime.

Implementation Plan:

1. Develop and provide tools to support use of a common Needs and Resource Assessment.
2. Form an data work group made up of personnel from each agency to reach consensus on common data elements and share data for *common* planning purposes
3. Conduct a statewide, regional and local assessment and gap analysis.
4. Update resource assessments and need indicators on a yearly basis. (Develop capacity and train regional staff in order to maintain regional data and keep plans up-to-date.)
5. On an annual basis, develop and maintain a resource directory of prevention and intervention programs.
6. Geo-map areas of need, area resources and capacity and other efforts.
7. Provide training and technical assistance and support to *all* state funded substance abuse prevention programs including a resource library system.

Strategy # 2.8 – Use cross-training and technical assistance capabilities to build shared expertise on evidence-based prevention practices across multiple disciplines

Implementation Plan:

1. Task the proposed Governor's Interagency Council to drive evidenced-based efforts by aligning state, regional and local planning and evaluation.
2. Develop a cross-training plan with a common calendar of trainings, grant opportunities, etc.
3. Develop a pilot effort of one or two regional collaborative to expand local networks that address prevention, intervention, enforcement and interdiction and treatment. These collaboratives must be coordinated with existing community based treatment services, regional reentry sites, school departments, social services, mental health and other agencies.
4. Use the Regional Center Prevention System to provide technical assistance, support and training to all State providers of substance abuse prevention services
5. On an annual basis, develop and maintain a resource directory of prevention and intervention programs.
6. Maintain the Resource Library system, part of the Regional Prevention Center System, to make substance abuse prevention and related materials available in each Region.
7. Develop a tool kit, made up of the best state and national educational materials, which can be used at the local level and coordinated with statewide media efforts
8. Develop guidelines, based on research of effectiveness, to be used in the development of any education related activity

Early Identification, Intervention, Assessment and Referral

Recommendation 3:

Expand screening and assessment activities:

- Use culturally competent tools to effectively and efficiently identify people needing intervention and treatment services in primary care, emergency departments, schools, state agencies and other community settings.
- Conduct brief interventions when appropriate.
- Refer individuals needing more comprehensive services for standardized assessments and appropriate treatment.

Rationale:

The Boston University School of Public Health[1] says "screenings and brief interventions save thousands of dollars in medical and social costs each year." More specifically, screening, brief intervention, referral and treatment in primary care have been shown to save $6 for every dollar spent.

SAMIS data reveal that only five percent of Massachusetts' admissions are referred from primary care, suggesting we miss this opportunity to identify substance use problems early, offer appropriate brief interventions to address problems, and match patients to treatment. As a consequence, individuals tend to be seen in the later stages of their disease by which time they are likely to have more complex medical, social service and/or criminal justice involvement, require more costly interventions and have triggered more human suffering and societal impact.

We also lack a centralized intake process to expedite treatment admissions, leaving individuals seeking care to find their own services.

Strategies:

3.1 Create and deploy uniform, culturally competent, screening processes, giving priority to essential community providers, police, emergency rooms, schools and other state agencies.

3.2 Increase use of brief interventions and brief treatment for appropriate individuals based on screening.

3.3 Implement for all appropriate individuals a culturally competent, standardized assessment process. Give priority in roll out to homeless shelters, courts, emergency rooms and essential community providers.

3.4 Implement real-time referral and wait list management tools.

[1] Source: "10 Drug and Alcohol Policies that Will Save Lives"

Strategy #3.1: Create and deploy uniform, culturally competent, screening processes. Prioritize community providers, police, emergency rooms, schools and other state agencies.

Rationale:

Massachusetts lacks any standard protocol for determining who should be screened for substance use disorders. Therefore, neither healthcare providers nor state agencies screen consistently, and when they do they use a variety of processes and instruments, many of which are not evidence based. Absent standard methods, state agencies are not making needed referrals. As a result, by the time problems are identified, they require more costly interventions.

Implementation Plan:

1. Assemble an implementation team.
2. Agree on screening tools to be used in different settings and populations (adults and youth).
3. Develop procedures for screening, recommendations for follow up and referral for assessment.
4. Identify initial sites to include, at a minimum, schools, state agencies, police, emergency rooms, and primary health care settings.
5. Secure training vendor to develop and train sites (train trainers) for initial and subsequent implementation.
6. Implement and collect data on outcomes of screens, follow up actions and disposition.
7. Modify guidelines and training materials as necessary for full roll-out.
8. Train trainers and other local professionals and implement plan. Sites to include primary care, hospitals, police stations, school, other state agencies, etc.

Strategy #3.2 – Increase use of brief interventions and brief treatment at "teachable moments" for facilitating changes in at-risk behaviors with appropriate individuals identified through screening.

Rationale:

Both brief intervention and brief treatment are known to be clinically effective and to save money when they are used to treat individuals who have not previously been identified as having alcohol and other drug (AOD) problems.

Implementation Plan:

1. Agree on best practices for brief intervention and brief treatment and select models tailored to population served (i.e., youth, adults, elders, etc.).
2. Develop procedures for brief intervention and brief treatment.
3. Secure training vendor to develop and train sites (training of trainers) for initial and subsequent implementation.
4. Identify other payer sources and joint funding opportunities.
5. Identify initial selected sites from among essential community providers, schools, state agencies, police, emergency rooms, courts, and primary care settings; formulate implementation schedule.
6. Train sites in brief intervention and brief treatment process.
7. Implement and collect data on outcomes of Brief Intervention and Brief Treatment, follow-up actions, and disposition.
8. Modify guidelines and training materials as necessary for full roll-out.
9. Train trainers and other professionals and implement plan.
10. Continue to monitor federal funding opportunities for screening and brief intervention.

Early Identification, Intervention, Assessment and Referral

Strategy # 3.3: Implement a culturally competent, standardized assessment process that enables clinicians across the Commonwealth to similarly match each client to the appropriate level of care.

Rationale:

Matching each individual to the most appropriate level of care promotes a cost effective system that is capable of achieving optimal client outcomes, but Massachusetts does not have either uniform assessment processes or standardized tools to guide clinicians in their decision making. Providers cannot therefore determine whether they are recommending the most appropriate level of care for each client or a level commensurate with recommendations of other referrers.

Implementation Plan:

1. Develop consensus of appropriate assessment instruments, including instruments for special populations.
2. Secure licensing agreement for instruments.
3. Determine priority areas for deployment, including:
4. Courts – Juvenile and Adult: Build on existing capabilities of Forensic Court Clinicians;
    a. Emergency Service Programs (ESPs): Enhance substance abuse assessment capabilities through training and collaboration with DMH;
    b. Homeless shelters;
    c. Hospital Emergency Departments; and
    d. Community providers and other community based programs (Community Health Centers, behavioral health providers, etc.).
5. Identify sites within priority areas.
6. Identify other payer sources and joint funding opportunities.
7. Secure training vendor for curriculum development, trainings, and support materials.
8. Conduct initial training in selected sites in priority areas.
9. Modify training as necessary for full implementation.
10. Monitor outcomes and case finding implications.

Strategy # 3.4 – Implement real-time referral and wait list management tools.

Rationale:

Because each service program currently maintains its own wait list, there is no coordinated mechanism allowing those in need to access information about available slots. It is extremely difficult for "referrers" (including court clinicians, emergency room staff and youth-serving agencies) to identify the range of resources available or find appropriate placements. Without a "real time" list of open program slots, consumers, family members, and professionals have no single point of entry into the system.

Implementation Plan:

1. Work with the DPH/DHCFP IT Business Steering Committee and ITS to begin requirements development to incorporate a capacity and diversion system into the Virtual Gateway architecture.
2. Formulate plan for application development.
3. Review design with detox and other providers and consumers in requirements development and business process re-engineering.
4. Modify as necessary.
5. Procure IT consultant to write program code, test, and modify as needed.
6. Develop guidelines for appropriate authorized user role to ensure security and clinical judgment for referral system.
7. Develop training plan, communications, and change-management plan to deploy system in field.
8. Train users.

Comprehensive Continuum

Recommendation 4:

Support a comprehensive continuum of services, matched to demand, to:

- **Focus on the whole person;**
- **Include the treatment and rehabilitation/recovery services and modalities we know to be most effective; and**
- **Support treatment for priority populations.**

Rationale:

- A recent Brandeis University study conservatively estimates that 39,450 residents with severe substance use disorders need treatment but are unable to access it. The current system is not sufficient, or sufficiently well coordinated, to meet their needs or the needs of those with less severe problems.
- Massachusetts consistently ranks among those states with the highest rates of alcohol and illicit drug use among both youth and adults.
- Massachusetts has some of the highest heroin use rates in the country; over half of all clients in the SAMIS database report heroin as their drug of choice.
- A fall 2003 survey conducted by Mental Health and Substance Abuse Corporations of Massachusetts found that detox programs were turning away as many as 30 to 80 uninsured people per day.
- Hospitals report a two-fold increase in drug mentions in Emergency Departments (DAWN Data). Hospitalizations of those with drug dependency/drug poisonings increased by 25% (HCFP, Hospital Discharge data).
- The number of women civilly committed to treatment doubled, as did the number of admissions to MASAC. Among these admissions, there was an 80% increase in patients needing hospitalization at the Shattuck Hospital, a 120% increase in hospital days and a 151% increase in ICU days. The cost of care in a prison setting is far higher than it would be in a community program.
- Even as rates of use have been increasing, knowledge about treatment of substance use disorders has grown, so that we now have a consensus about promising practices. Indeed, a comprehensive review of the literature indicates that a continuum of effective services pays for itself. The Commonwealth, however, does not offer a fully integrated continuum of high quality, cost effective services, and there is a significant supply/demand gap between the number of individuals who need and seek treatment and the number who actually receive it.

Strategies:

4.1 Develop a comprehensive continuum of care for children, youth and families coordinated with the mental health, health care, education, training and law enforcement systems, courts and other youth serving agencies.

4.2 Stabilize, expand and redevelop the adult system to assure the availability of a comprehensive continuum of care.

4.3 Develop targeted initiatives to meet the needs of identified special populations.

Strategy # 4.1– Develop a comprehensive continuum of care for children, youth and families that coordinates with the mental health, health care, education, training and law enforcement systems, courts and other youth serving agencies.

Rationale:

Rates of substance use and abuse among Massachusetts youth significantly exceed the national average. While alcohol use declined from 1999-2002, marijuana and crack cocaine use showed significant increases. Other state agencies report high levels of substance use issues among children, youth and families within their care. Services for youth across agencies and programs are fragmented, lack coordination across state systems and are structured around an adult continuum of care rather than a developmentally appropriate model. The State Treatment Needs Assessment suggests that 9.1% of residents aged 12-17 have unmet Alcohol and Other Drug (AOD) needs. Left untreated, youth tend to go on the develop more serious substance abuse problems and represent substantial costs in other health care and social arenas, especially the criminal justice system.

Strategies

4.1.1 – Develop a comprehensive continuum of care for adolescents age 13-17

4.1.2 – Expand services for youth and families particularly homeless families and those involved in the child welfare system

Comprehensive Continuum

Strategy 4.1.1 – Develop a comprehensive continuum of care for adolescents ages 13-27.

Implementation Plan:

1. Build on the work of the Interagency Work Group and Kids Core Team
2. Improve access to substance abuse screening, assessment and treatment services for youth in detention and custody and for families (DYS, DSS, DPH)
3. Define the Youth Continuum of Care for AOD services in the Commonwealth.
4. Identify funding resources to support the Youth AOD Continuum of Care including the most appropriate purchaser(s) and mechanisms for each element of service to be delivered maximizing federal revenue
5. Develop service specifications (identifying clinical models and outcome measures based on the best available evidence
6. Procure Youth services for multiple levels of care (DPH, MassHealth)
7. Coordinate and conduct cross-training and skill-based trainings among state agencies
8. Standardize treatment curricula with SAMHSA/CSAT
9. Develop capacity (within the work of Virtual Gateway) for collection and analysis of uniform data systems to track and monitor this population and the system of care

Comprehensive Continuum

Strategy 4.1.2 – In conjunction with DYS, DSS and DTA, expand services for youth and families particularly homeless families and those involved in the child welfare system.

Implementation Plan:

1. Building on the work of the DSS substance abuse strategic plan, DSS will:
   - Hire 6 new substance abuse regional coordinators to focus on Regional/ Area Office needs on substance use issues;
   - Enhance the capacity for integrated mental health, substance use and domestic violence practice within the child welfare system;
   - Develop an ongoing substance use training curriculum for DSS field staff through the recently developed Child Welfare Training Institute;
   - Implement technical assistance grant with DPH and the courts to the National Center on Substance Abuse and Child Welfare. The grant focuses on training and staff development, client screening and assessment, improving services to children of substance users.
   - Expand substance abuse services to homeless families through restructuring of DTA-funded family shelters for homeless families.

Strategy # 4.2 – Stabilize, expand and redevelop the adult system to assure the availability of a comprehensive continuum of care.

Rationale:

In FY03 there were 950 publicly-funded detox beds in the Commonwealth, and half of those who needed care were able to access it on their initial attempt; in FY04 there are 420 detox beds. There is no evidence of a decrease in need.

Current community-based detoxification programs have an average length of stay of about four days because of payers' requirements. Although detox should represent a gateway to longer term treatment, both Massachusetts and national discharge data reveal that only eight percent of individuals leaving detox programs are transferred for further treatment. The lack of adequate step down services from acute detox results in high rates of relapse and recidivism. BSAS data show that in FY04 over 20 percent of clients had three or more admissions to detox.

Outcomes studies demonstrate that the longer the client remains in treatment, the better the outcomes. In order to sustain recovery many clients need ongoing support services to help them deal with the variety of issues (legal, housing, medical care) they face. These services need to be incorporated within community based case management and relapse prevention programs.

Strategies

4.2.1 Increase community-based acute detoxification capacity, particularly for the uninsured

4.2.2 Expand secure acute treatment and transitional support services, especially for women

4.2.3 Create step down and transitional services from acute detox

4.2.4 Expand access to office-based opioid treatment

4.2.5 Increase the availability of disease management approaches and recovery support services

Comprehensive Continuum

Strategy #4.2.1 – Increase community-based acute detoxification capacity, particularly for the uninsured.

Implementation Plan:

1. Using BSAS supplemental dollars, immediately increase the purchase for acute detoxification services for the uninsured by 3 beds per program.
2. Identify opportunities, detail the costs and revenue maximization possibilities for expanded coverage of detoxification services by MassHealth.
3. In conjunction with MassHealth, develop standardized detoxification protocols.
4. Continue to monitor IMD (Institutions for Mental Disease) exclusionary language for community-based acute detox programs.

Strategy # 4.2.2 – Expand secure acute treatment and transitional support services, especially for women.

Implementation Plan:

1. Develop scope of specialized services to address the primary care and mental health needs of civilly committed women and other targeted clients referred from the courts/criminal justice system.
2. Continue DPH work with Court system and DMH forensic mental health to expand treatment and step down options under the Section 35 statute.
3. Review regional and statewide data to identify any continuing treatment gaps.

Comprehensive Continuum

Strategy # 4.2.3 – Create step down and transitional services from acute detox

Implementation Plan:

1. Create implementation team to examine current models and develop clinically appropriate models for step down programs.
2. Identify number of people who might be served and determine program costs.
3. Identify potential payers and revenue maximization opportunities.
4. Identify and train clinical staff in best practices (i.e., Motivational Interviewing, Contingency Management).
5. Use EOHHS web applications to monitor outcomes by instituting performance measures:
   a. Train approved providers regarding scope of services and data requirements
   b. Develop regulatory language that defines scope of services utilizing ASAM criteria for transitional services level of care.

Comprehensive Continuum

Strategy #4.2.4 – Expand access to office-based opioid treatment (OBOT)[2]

Implementation Plan:

1. Expand current Boston Medical Center pilot program to provide statewide training and clinical consultation services for OBOT providers.
2. In DPH/MassHealth partnership, develop targeted capacity expansion plan for CHCs and hospitals.
3. Develop best practice guidelines for OBOT provider, utilizing CSAT Treatment Improvement Protocol (TIP) Guidelines
4. Develop and distribute consumer information on OBOT.
5. Convene currently approved providers to discuss barriers to beginning OBOT and devise strategies to address
6. Develop and implement an evaluation program to ensure appropriate treatment.
7. Reconvene Interagency Work Group with Board of Pharmacy, DEA, Massachusetts Drug Control Program, AIDS Bureau, etc.

Strategy # 4.2.5 – Increase the availability of disease management approaches and recovery support services

Implementation Plan:

1. Assess current models of care and determine those to be procured, cost of services and number of people to be served.
2. Examine regional distribution of services along with those already in place.
3. To the extent feasible, identify areas for MassHealth/MBHP reimbursement and co-purchase.
4. Procure services based on available resources.
5. Identify opportunities through MBHP Performance Incentive to establish Recovery Learning Center(s).

[2] OBOT provides a way for buprenorphine and methadone to be dispensed by authorized physicians through their own offices rather than via centralized clinics

Comprehensive Continuum

Strategy #4.3 – Develop targeted initiatives to meet the needs of identified special populations, including women, with significant unmet need.

Rationale:

Because we know from both national and Massachusetts data that, left untreated, people in certain population groups are likely to impose significant costs on multiple systems, we need to consider giving high priority to treating these individuals. While Massachusetts has developed initiatives for some of these populations, the efforts have been fragmented and limited in scope.

- Approximately 30,000 homeless individuals were served in the State's emergency shelters, and many of them have complex mental health, substance abuse and other health issues. Over 25% report substance abuse as the reason for their homelessness and up to 70% (depending on the study) report significant involvement with alcohol and/or other drugs. The chronically homeless utilize medical services at significantly higher rates than do other populations.
- As many as 50% of people requiring substance abuse services may have co-occurring mental illnesses, although they may not meet DMH eligibility criteria. While lack of integrated treatment is often cited as a primary reason for diminished retention rates and relapse, Massachusetts also lacks standard clinical criteria and adequate reimbursement mechanisms for providing this care.
- As many as 60-80% of those requiring mental health services may have co-occurring substance use disorders.
- Substance abuse among older adults is often invisible. Alcohol and abuse of prescription drugs affect up to 17% of older Americans. (Center for Substance Abuse Treatment) Treatment admissions among older adults has risen over 30% since 1992. (DPH-SAMHSA data)

Implementation Plan:

4.3.1 Develop consensus on high priority special populations (proposed Governor's Interagency Council).

4.3.2 Expand the capacity for dual-diagnosis services.

4.3.3 Implement the DTA/DMH work plan on Housing and Homelessness based on the work of of the Governor's Executive Commission on Homelessness, the Interagency Council on Homelessness and Housing, and the Massachusetts Policy Academy on the Chronically Homeless.

4.3.4 Implement initiatives based on the work of the Massachusetts Elder Substance Abuse Task Force.

Comprehensive Continuum

Strategy 4.3.1 – Develop consensus on high priority special populations (Interagency Council)

Implementation Plan:

1. Review potential and existing target populations and determine which have greatest need for special focus/attention.
2. Determine if/how state attention is required; develop policies, programs, plans as needed.
3. Examine best practices to identify effective program models.
4. Identify possible funding sources and areas for revenue maximization.

Comprehensive Continuum

Strategy #4.3.2 – Expand the capacity for dual-diagnosis services

Implementation Plan:

1. Building on the work of the Consensus Panel for Co-Occurring Treatment, reconvene Dual-Diagnosis Workgroup to:
   - Assess current system capacity and constraints for dual-diagnosis services.
   - Identify key service areas for expansion/revision of dual-diagnosis services.
   - Develop implementation plans, where funded, to address identified needs.
2. DMH, DPH, MassHealth, MBHP and managed care organizations partner to establish clinical treatment guidelines, best practices and core competencies for treatment services for the dually-diagnosed.
3. Review and re-write current BSAS regulations to include dual-diagnosis services.
4. Examine and adjust rate structure for dual-diagnosis services.
5. Cross-train substance abuse/addiction and mental health service providers on integrated service provision.

Strategy 4.3.3 – Implement DTA/DMH work plan on Housing and Homelessness.[3]

Implementation Plan:

1. Expand substance abuse services to homeless families through restructuring of DTA-funded family shelters for homeless families.
2. Redesign and reprocure (January 2005) specialized residential services for women/families with children, family shelters and transitional sober housing for parents.
3. Monitor treatment outcomes from newly re-designed HUD-funded residential demonstration projects for the chronically homeless to determine possible need for expansion.
4. Complete analysis of mental health, substance abuse and health care expenditures for Boston's chronically homeless population.
5. Strengthen linkages between outpatient substance abuse services and the DTA shelter.
6. Examine and implement other evidence-based program models for serving homeless people with substance use issues.

[3] Based on the work of the Governor's Executive Commission on Homelessness, the Interagency Council on Homelessness and Housing, and the Massachusetts Policy Academy on the Chronically Homeless

Recommendation 5:

Ensure that treatment and recovery support services are clinically effective, efficient and well managed and that they promote recovery.

Rationale:

Effective clinical and administrative oversight requires data-driven decision making. New standards for clinical efficacy and treatment outcomes provide the opportunity to procure, monitor and reward programs based on data. Multiple barriers often constrain sharing of data across agencies. Absent a strong interagency commitment, comprehensive cross-system analysis, state and regional planning and the evaluation of effectiveness are limited. SAMHSA's Performance Partnership grants will require new outcome reporting. "Retention in Treatment" has been recommended as the first or primary outcome to measure by Join Together's "Rewarding Results" report and the substance abuse Clinical Effectiveness team. Perhaps most importantly, consumers should have access to performance information when choosing their providers.

Strategies:

5.1 Expand internal and cross-agency data resources to track program outcomes, promote shared regional and local resource allocation and ensure program effectiveness and efficiency.

5.2 Increase expertise and training in evidence-based/best practice across systems and services.

5.3 Establish a performance-based monitoring system which promotes quality and accountability for clear outcomes.

5.4 Establish financial incentives to support and reward key outcomes.

5.5 Establish within the Department of Public Health's Substance Abuse (BSAS) program a strong clinical/medical oversight unit.

5.6 Review and redesign purchasing mechanisms, rates and regulations to reflect redesign of programs and new modalities.

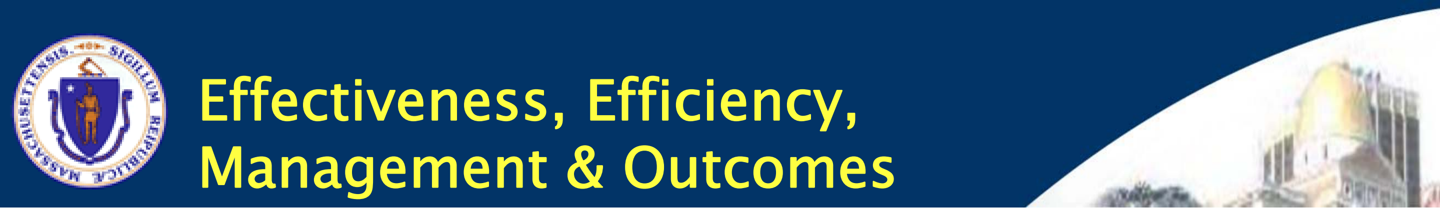
5.7 Staff and support the implementation of this Substance Abuse Strategic Plan.

Effectiveness, Efficiency, Management & Outcomes

Strategy # 5.1 – Expand internal and cross-agency data resources to track program outcomes, promote shared regional and local resource allocation and ensure program effectiveness and efficiency.

Implementation Plan:

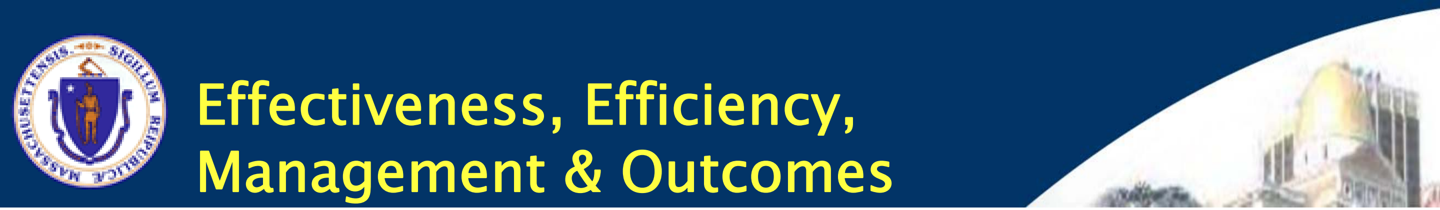
1. Refine treatment need estimates
   a. Develop statewide and regional estimates of need for and cost of treatment by ASAM level of care. Develop estimates of the treatment gap between supply of treatment slots and demand. (Brandeis' Schneider Institute.)
   b. Use social indicator methodology with existing administrative data sets: death data, hospital discharge data, treatment data and F.B.I. crime data.
   c. Develop a data system based upon unique client identifiers that will allow the identification of treatment patterns and history, while preserving individual privacy per HIPAA, etc.
2. In conjunction with the Boston University School of Social Work, submit a request for technical assistance to the Center for Substance Abuse Treatment. This request will provide resources to identify treatment patterns of clients in Methadone programs from 1992-2004, including an analysis of racial disparities.
3. Produce annual analysis of admissions to detoxification programs. Examine analyses over three fiscal years.
4. Examine clients' treatment patterns using administrative data from 1992-2004. Identify commonly occurring patterns in use of treatment services over time (in conjunction with Brandeis University Schneider Institute).
5. Advance work with the national Washington Circle Performance Measurement Group to develop performance measures for providers and health plans.



Strategy # 5.2 – Increase expertise and training in evidence-based/best practices across systems and services.

Implementation Plan:

1. Based on agreed upon outcomes and best practices, develop a training plan in evidence-based techniques and best practices leveraging the training resources of various state and federal agencies.
2. Cross-train human service agencies' staffs, providers' workforces and individuals in related disciplines to enhance treatment skills for fidelity to established evidence-based methods.
3. Set priorities for training curriculum with Adcare Educational Institute and the New England Institute for Addiction Studies on workforce development efforts.
4. Build on current 111J regulations (Substance Abuse Counselor Credentialing) to set standards for core competencies and continuing education.



Strategy # 5.3 – Establish a performance-based monitoring system which promotes quality and accountability for desired outcomes.

Implementation Plan:

1. Examine performance measures currently being tracked by payers for each treatment modality to identify those most closely correlated with successful treatment outcomes.
2. Convene Clinical Effectiveness Group, as an advisory board, to help determine other metrics to be monitored. Include National Outcomes Measures.
3. Determine any needed systems modifications necessary to collect data (MIS, Virtual Gateway).
4. Complete necessary SAS programming.
5. Convene providers to solicit feedback and plan.
6. Develop and communicate implementation plan.
7. Develop and distribute provider level reports for feedback.
8. Implement sample and compile in-process and post-process results; produce and disseminate reports.
9. With providers, identify lessons learned and performance improvement opportunities. Revise and implement agreed modifications.

Effectiveness, Efficiency, Management & Outcomes

Strategy # 5.4 – Establish financial incentives to support and reward key outcomes

Implementation Plan:

1. Identify Implementation Team.
2. Reach consensus with key stakeholders and the clinical effectiveness team on priority outcomes to target for purchase.
3. Determine reimbursement models, incentive structures and performance expectations, and draft contract terms.
4. Identify funding for incentives.
5. Develop final implementation plan.
6. Continue to investigate contract reimbursement models.
7. With the Governor's Interagency Council and EOHHS Purchasing Council, create joint procurement template.
8. Establish feedback mechanisms for ongoing interchange of ideas between providers and implementation team.
9. Develop evaluation component and data collection capacity.
10. Implement additional measures as necessary and/or appropriate.

Strategy # 5.5 – Establish within the Department of Public Health's Substance Abuse (BSAS) program a strong clinical/medical oversight unit to support the work of the proposed Governor's Interagency Council.

Implementation Plan:

1. Convene the Clinical Effectiveness Group on a quarterly basis to advise public purchasers on best practice, treatment outcomes, etc.
2. Enhance clinical capacity within DPH, directly or perhaps by contract with the University of Massachusetts, to assist other state agencies with substance abuse program planning, development and management.

Strategy # 5.6 – Review and redesign purchasing mechanisms, rates and regulations to reflect redesign of programs and new modalities.

Implementation Plan:

1. Task a subgroup of the Governor's Interagency Council on Substance Abuse and Prevetnion to develop and implement a workplan to ensure that state (substance abuse) policies and purchasing mechanisms remain coordinated.

Strategy # 5.7 – Staff and support the implementation of this Substance Abuse Strategic Plan

Implementation Plan:

1. The DPH 2004 Supplemental Budget request included funding for technical assistance on the implementation of the Strategic Plan. Additional funds are proposed for 2006 and 2007.
2. Staff shall be assigned from DPH and other agencies as necessary to conduct and report on research; coordinate data collection, assimilation and reporting; support implementation of initiatives; coordinate Council meetings; and implement the various projects of the Governor's Interagency Council.

Recommendation 6:

Reduce the high cost of incarceration and recidivism on both the criminal justice and treatment systems, ensure the public safety, promote recovery and return people to productive lives:

- **Expand diversionary services**
- **Promote treatment and other support services for individuals in prison**
- **Facilitate reentry from secure facilities**

Rationale:

Our correctional system is being overwhelmed by the problem of substance abuse:

- Nearly 25,000 men and women are incarcerated in Massachusetts' state and county facilities; 20% of them for specific drug use related offenses. (Governor's Commission on Corrections Reform)
- Another 20.9% of inmates committed other offenses (robbery, fraud, assault) to obtain money for their drug use. (Study of State Inmates, 1997)
- 70 to 90 percent of those incarcerated have extensive histories of alcohol and substance use problems. (Massachusetts Department of Corrections report)
- The number of men and woman committed to MCI Framingham and Bridgewater for substance abuse treatment has doubled over the past 3 years.
- Over 700 women were treated under civil commitment in FY 2004.

National studies demonstrate that treating those with substance use problems reduces criminal behavior by 60 to 80 percent, recidivism by 80 percent, and the cost of incarceration by $3,500 per offender. But:

- Because law enforcement and judicial systems currently have limited options regarding the disposition of individuals with substance use disorders many individuals are committed to prison for substance abuse treatment, either civilly or criminally.
- Treatment services within and across state and county houses of correction are not standardized.
- The majority of prisoners leaving are not linked into community based services prior to or at the time of discharge.
- Nineteen percent of all those who were released in 1997 were reconvicted within one year; 48% were reconvicted within 3 years.

Strategies:

6.1 Expand the capacity of courts to perform standardized screening and assessment of individuals who have substance use disorders.

6.2 Expand the treatment options available to law enforcement and courts to reduce the number of women and men committed to prison for substance use problems.

6.3 Expand treatment options for individuals during incarceration and provide enhanced transition and referral services prior to release.

6.4 Build an integrated substance abuse component into the Parole reentry sites to increase support and services for discharged individuals.

Strategy # 6.1: Expand the capacity of courts to perform standardized screening and assessment of individuals who have substance use disorders.

Rationale:

Eighty percent of those arrested and/or incarcerated in the Commonwealth had used illegal drugs, abused alcohol, were arrested for driving under the influence, or were under the influence at the time of their crime or committed a crime to support their addiction. In 2002, a Harvard University/MDPH study of two District Courts found that 48% of offenders needed treatment services.

A lack of staff, tools, and expertise in providing consistent substance abuse and mental health assessment for those entering the criminal justice system is having costly consequences. Currently, Forensic Mental Health clinicians are not systematically trained or required to have addictions expertise. Not all of the 68 Courts have a clinician readily available and court clinics are not consistent in the level of services provided across the system. Diversion options are often not clear to judges who would like to use them, and services are difficult to find.

Implementation Plan:

1. Staff adult courts sufficiently to conduct integrated Substance Abuse/Mental Health assessments.
2. Enhance capacity of Forensic Court Clinicians to conduct integrated Substance Abuse/Mental Health assessments.
3. Provide training on utilizing a standardized assessment tool.
4. Establish review teams to examine the quantity and quality of substance abuse services provided within court clinics and assess capacity impact.
5. Monitor federal funding opportunities.

Strategy # 6.2 – Expand the treatment options available to law enforcement and courts to reduce the number of women and men committed to prison for substance use problems

Rationale:

Approximately a third of all admissions to community programs in FY 02 were from the criminal justice system. The DOC, Parole, the Office of Community Corrections, the courts, the DPH and the DMH have historically provided some level of service for individuals with substance use issues involved with the criminal justice system. These efforts have not been undertaken within the context of any formal or coordinated interagency planning. This has resulted in lost opportunities to maximize and align resources for more comprehensive planning and effective service delivery.

Implementation Plan:

1. DPH and DOC will convene a series of implementation team meetings at a statewide and regional level. Attendees will include Probation, Parole, EOPS, Corrections (DOC, Houses of Correction (HOC)), Trial Court, Provider representatives, and DMH
2. The goals will be to:
    a. review and identify the existing services,
    b. review and inventory the current level of services provided in the criminal justice system and identify any needs and gaps. Identify any duplication or overlap (i.e. Drug Courts and Office of Community Corrections Centers) where similar populations are being served,
    c. explore the development of diversion programs based on experience of previous pilots and models (drug courts), and
    d. continue to enhance the relationship between community-based providers and the Criminal Justice system to better serve clients with criminal histories.

Strategy # 6.4– Expand the treatment options for individuals during incarceration and enhance transition and referral services offered prior to release.

Rationale:

Currently more than 24,800 people are incarcerated in State and County facilities. About 80 percent, or nearly 20,000 of them self-report a substance abuse problem (a figure that is consistent with national data), 4,873 or almost 20% of them have a governing offense that is drug related, and another 21% are incarcerated for offenses committed to support their drug use. Left untreated, and without an integrated transition or reentry plan, many of those released from custody will return to alcohol and drug use and recidivate. While a variety of programs are available in correctional facilities, "these programs are not delivered in sufficient numbers or organized so that inmates experience activities targeted to their particular criminal risks." (Governor's Commission on Corrections Reform)

Implementation Plan:

1. Conduct an inventory of the current level of substance use disorder services provided in state and county facilities.

2. Determine areas needing expanded/improved services, including methadone and buprenorphine services within the institutions.

3. Identify barriers to and develop strategies ensuring that discharged offenders have immediate access to necessary medical and psychopharmacologic medications upon release.

4. Financially support and expand transition planning services at the County Houses of Correction to provide integrated primary care and behavioral health services for ex-offenders.

Strategy # 6.5 – Build an integrated substance abuse component into the Parole reentry sites to increase support and services for discharged individuals

Rationale:

Over 10,000 parolees are released annually from DOC. We know that the first 72 hours are critical to preventing re-arrest and re-incarceration. Since a majority of prisoners have substance abuse issues, it is vital that we provide a seamless transition to both medical and behavioral health services as they leave custody. Lt. Governor Healey and the Department of Corrections have recently announced a major reentry effort designed to ease the transition from Corrections facilities to the community.

Implementation Plan:

1. Parole, DMH, DPH and MassHealth to work together on the reentry initiative to implement substance abuse services at Regional Parole Reentry Sites.
   a. Determine core components of substance abuse services to be offered including facilitated referral, care coordination and brief interventions as needed.
   b. Provide substance abuse staff support to Regional Reentry Sites.
   c. Establish preferred provider network to effectively provide services for parolees.
   d. Collect data on reentry referrals and subsequent retention in treatment.
2. Build on existing programs working with County Houses of Correction to facilitate reentry.
3. Collect data on reentry referrals, recidivism and retention in treatment.

A Phased Approach

Phase I	Phase II	Phase III
FY 2005 – 2006 Make Targeted Investments	FY 2007 – 2008/9 Realign Supply to Correspond to Demand	FY 2009 – 2010 Maintain Levels of Support
Selectively Invest in Keeping with Strategy Develop Targeted Initiatives for High Risk Populations Begin Immediate Support of Court System to Reduce Recidivism and Linked Costs in the Court, Corrections, Child Welfare & Other Systems*	▪ Grow Prevention ▪ Strengthen Early Identification ▪ Strengthen Assessment ▪ Stabilize Detox/Transition ▪ Strengthen/Shift to Out-Patient, Medical, Residential Recovery ▪ Enhance work with special populations	Flexibility in Matching Supply to Demand Strategic Reductions Once Strategy Takes Hold

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- Judge Jay Blitzman
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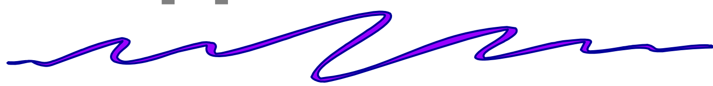
Appendices



Cost Effectiveness Studies:
Overall

Shoveling Up: Shouldering the Burden of Substance Abuse, Columbia University, 2001

Analysis of Massachusetts governmental spending (in 1998) indicates:

- 17.4% of the state budget (in 1998 spending) was for the substance abuse related costs in the criminal justice, public safety, human services and educational systems.
- For every dollar spent in these areas, one 4 cents was spent on treatment and only one cent was spent on prevention efforts.

Ensuring Solutions to Alcohol Problems, George Washington University: Identifying and Treating Alcohol Problems, 2003

- People with drinking problems use healthcare services at 2x the rate as those without drinking problems
- Treatment reduces healthcare cost as soon as it is initiated
- Higher savings over the lifetime for younger drinkers who receive treatment

Cost Effectiveness and Cost Benefit Analysis of Substance Abuse Treatment: A Literature Review, The Lewin Group, June 2002

A comprehensive review of studies examining the cost effectives of treatment show strong evidence that substance abuse treatment pays for itself. Improved outcomes in the areas of reduced alcohol and drug use, criminal behavior and social functioning

Types of Treatment

No conclusive evidence to suggest that certain kinds of treatment of more effective or more economical than others. What works for some people doesn't work for others.

Specific Populations

<u>Women</u>

Newborns of women who receives treatment were less likely to require NICU admissions and, of those admitted to NICU had substantially lower costs – $900 v.12,000 per admission.

<u>Prisoners/Offenders</u>

- Lower rates of incarceration for those receiving treatment – Savings of $3,500 per offender treated
- Women mandated into treatment rather than incarceration saved about $3,000 per woman treated.
- Crime related behavior decreased 60-75% post treatment with costs savings of about $8,600

Cost Effectiveness Studies:
Overall

Methadone

One additional life year saved for each $5,900 spent on methadone treatment. Most healthcare studies indicated that any intervention cost less than $50,000 per life year saved is cost effective.

US Department of Health and Human Services, National Treatment Improvement Evaluation Study, 2001

- Following treatment, 19% more people received income from a job
- 11% fewer people receive welfare income

State of California, Evaluating Recover Services, California Drug and Alcohol Treatment Assessment (CALDATA), 1997

- $7 saved for every $1 invested in treatment
- Cost of treating 150,000 people was $200 million.
- First year after treatment saving was $1.5 billion.
- The largest saving area were reductions in crime
- One-third reductions in hospitalizations and ER admissions

Reentry:
US Department of Labor, US Department of Health and Human Services

Over 650,000 people released annually from prison
About 2 of every 3 are re-arrested within the first year of release

A Study on the Habilitation of Chronic Offenders in a Massachusetts House of Correction, December 2003.

- From January 1999, through June 2001, those inmates who completed a residential program had a lower rate (15.5%) of recidivism
- $490,000 in reduced re-incarceration costs
- $285,000 reduction in victim-associated costs

Reentry
"After Prison: Roadblocks to Reentry. A Report on State Legal Barriers Facing People with Criminal Records". Legal Action Center, 2004. State Housing, Welfare, and other roadblocks

Cost Effectiveness Studies:
Overall

Treatment Alternatives

DTAP targets residential (Therapeutic Community) treatment to drug addicted, non-violent repeat felony offenders. DTAP Defers sentencing rather than prosecution; individuals plead guilty to the offense and are subject to a mandatory sentence if they do not complete treatment.

- DTAP costs half as much as incarceration.
- DTAP graduates are 3½ times more likely to be employed after treatment than before.
- DTAP graduates are 67% less likely to return to prison 5% to 15%.
- DTAP Graduates' rearrest rates are 33% lower and reconviction rates are 36% lower two years after the program.

(National Center on Addiction and Substance Abuse at Columbia University. "Crossing the Bridge: An Evaluation of the Drug Treatment Alternative to Prison (DTAP) Program" March 2003.)

80% of all adults incarcerated for felonies had regularly used illegal drugs, abused alcohol, been convicted of a drug or alcohol violation, were under the influence of a drug or alcohol at the time of their crime, committed a crime to support their habit, or some combination. (Belenko, S. and Peugh, J. "Behind Bars: Substance Abuse and America's Prison Population – Technical Report" The National Center on Addiction and Substance Abuse at Columbia University: New York, 1999.)

Marlowe, D.B. "Integrating Substance Abuse Treatment and Criminal Justice Supervision"; Treatment Research Institute, University of Pennsylvania, August 2003.

Detoxification

In 2000 12.6M Americans were heavy drinkers (5 or more drinks in one sitting) and 14M Americans were using illicit drugs (Office of Applied Studies, Summary of Findings from the 2000 National Household Survey on Drug Abuse. Substance Abuse and Mental Health Services Administrations, 2001.)

Fewer than ¼ of those needing treatment receive it. (Schneider Institute for Health Policy, Brandeis University. " Substance Abuse: the Nation's Number One Health Problem". Princeton, NJ. The Robert Wood Johnson Foundation.)

Detox offers a gateway to a substance abuse treatment Program. Detox alone will not lead to lasting improvements (Institute of Medicine. "Broadening the Base of Treatment for Alcohol Problems". Washington DC, National Academy Press, 1990.)

Cost Effectiveness Studies:
Overall

Detoxification (continued)

Only half of people who were admitted to detox received treatment in any [other] setting, in one national study using private insurance claims. Another study of Medicaid claims in Washington, Delaware and Oklahoma showed that only ⅓ of the people receiving detox services received any form of inpatient, residential, or outpatient services following their brief detox stay. (Mark, T.L., Dilonardo, J.D., Chalk, M., Coffey, R.M. "Substance Abuse Detoxification: Improvements Needed in Linkage to Treatment"; SAMHSA Publication No. SMA-02-3728, Rockville, MD. Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, September 2002.)

Emergency Room and Health Offset

Alcohol and drug treatment reduced hospitalizations by 36% for physical health problems; 58% for drug overdoses and 44% for mental health problems.

Net savings in the National Treatment Improvement Evaluation Study from reduced hospital and ER encounters was $1.45M (Gerstein, D.R. et. al., "Evaluating Recovery Services: The California Drug and Alcohol Treatment Assessment. General Report". Sacramento, CA California Department of Alcohol and Drug Programs, 1994.)

A state health services utilization rate decreased from 41% before treatment to 7% after treatment among adults in outpatient treatment. (Albert, D.H., "Tobacco, Alcohol and Other Drug Abuse Trends in Washington State". Olympia, WA. Washington State Department of Social and Health Services, 2000.)

Cost of treatment is recouped within two to three years of treatment through reductions in other health care costs. (Center for Substance Abuse Treatment.)

Cost Effectiveness Studies:
Criminal Justice Programs

Hughey and Klemke (1996) – offenders completing in-jail programs had significantly lower rates of recidivism. Savings after treatment costs, from lower rates of re-incarceration alone, were about $3,500 per offender.

Berkowitz et al. (1996) – mandating women into treatment saved about $3,000 compared to the nearly $17,000 in expense to incarcerate and treat them in prison for six months

Koenig, Demead, Nguyen, Harrison and Harwood (1999) – cost offsets for correctional treatment. The average annual crime related costs to society fell by $8,611 per client

California Department of Alcohol and Drug Programs (1994) – study estimates that the $209 million spent in California on substance abuse treatment generated $1.5 billion in savings as a result of reduced crime and healthcare costs.

State of Oregon – Finigan (1996) – Every tax dollar spent on treatment produced $5.60 in avoided costs to the taxpayer.

Rajkumar and French (1996) – Total costs of crime averaged $47,971 per patient in the year prior to treatment; that figure dropped to an average of $28,657 per patient in the year following treatment. The drop of $19,314 was more than the cost of treatment.

State of California (CALDATA) (1994) – The cost/benefit averages a $7 return for every dollar invested. Criminal activities significantly declined after treatment. The largest savings were due to reductions in crime. Emergency room admissions were also reduced by one-third following treatment.

Washington, D.C., Arizona, California, and Hawaii have enacted treatment instead of incarceration initiatives:

- Arizona's initiative saved taxpayers approximately $2.56 million its first year and $6 million in prison costs its second year
- California estimates that Proposition 36 will save taxpayers approximately $1.5 billion over 5 years

  (McColl, W. & Opio, S., March-April 2003, "Treatment Instead of Incarceration", Behavioral Health Management 23(2), 21-24)

State of CA (1994), "Evaluating Recovery Services: The California Drug and Alcohol Treatment Assessment (CALDATA) Executive Summary", (ADP) 94-4628

- Cost/Benefit for taxpayers averages $7.50 return for every dollar invested in treatment
- In 1992, cost of treating 150,000 individuals was $200 million. Benefits generated during treatment and first year afterwards – approximately $1.5 billion.
  - Largest savings due to reduction in crime (criminal activities significantly declined after treatment)
  - Significant improvements in health and reductions in hospitalization found during and after treatment. Emergency room admissions were reduced by ⅓ following treatment.

Cost Effectiveness Studies:
Screening & Assessment Practices

Fleming and colleagues were able to demonstrate that a system of screening, brief intervention, referral and treatment (SBIRT) in the primary care setting saved $6 for every dollar spent.

BSAS Admissions data – only 5% of admissions referred from primary care, suggesting screening and referrals not a standard practice in Massachusetts; consistent with national studies.

Studies show that physicians speak to patients about alcohol use less frequently than about any other health-related behaviors.

Studies suggest that physicians assume that substance use disorders are not prevalent among their patients.

Many managed care organizations have not implemented screening protocols by primary care physicians.

National Center on Addiction and Substance Abuse at Columbia University in "Missed Opportunities: National Survey of Primary Care Physicians and Patients on Substance Abuse," – primary care physicians, as gatekeepers to the health system, fail to detect, diagnose, intervene, and treat or refer for substance abuse and addictions, especially in the early stages, when potential success is high and the medical and social costs are relatively low.

Screening and Assessment Tools: A number of studies confirm screening tools are reliable and valid and help to screen broad populations for Alcohol and Other Drugs (AOD).

Massachusetts has identified the following screening instruments:

Screening
CRAFFT for youth
CAGE-AID for adults
MAST -G for elders
4Ps+ for women (which is in the process of being validated) and TWEAK for pregnant women

Assessment
ASAM PPC 2-R Assessment Software – the most studied assessment instrument is the ASI, which has been consistently shown to work well with a wide variety of populations, including homeless, opioid dependent and non-opioid dependent populations, and Hispanic and African American men and women.

Cost Effectiveness Studies:
Prevention Efforts

The benefits of preventing illicit substance use and/or the development of a substance use disorder show considerable savings. E.g., every $1 spent on selected programs yielded the following results:

Project Northland – $10.39 saved for every $1
Life Skills Training – $25.61 saved for every $1
All Stars – $ 3.43 saved for every $1

(Benefits and Costs of Prevention and Early Intervention Programs for Youth , Technical Appendix, Washington State Institute for Public Policy, Olympia, Washington, 2004).

A Risk and Protective Factor approach is central to SAMHSA's programming. Research has identified risk factors that are reliable predictors of substance use disorders, etc. and protective factors that can buffer youth from such disorders. A youth development approach lessens the effects of risk factors and promotes the development of protective factors by fostering the development of strong family, school and community bonds.
(CSAP/NPN Prevention Backgrounder–SAMHSA www.prevlink.org/training/pdf/NPN_CSAP.pdf).

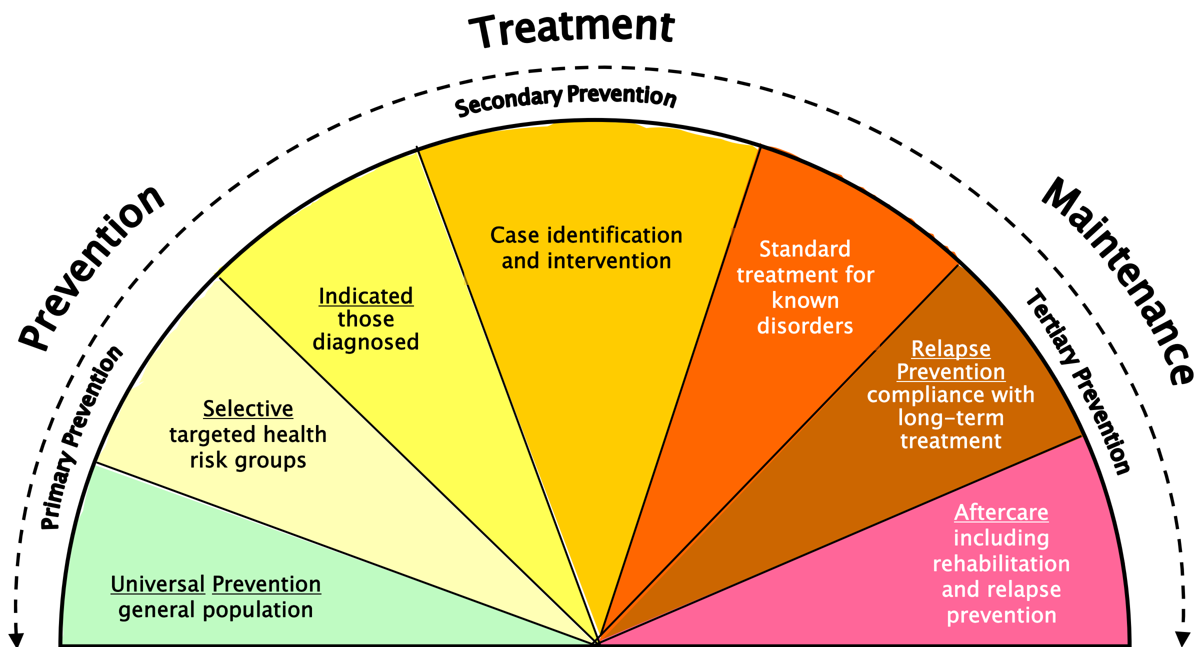
Studies have shown that advertising can help lower the rate of use among youth (*Anti-Drug Ads Work,* Partnership for a Drug-Free America, March, 2004); paid ads are associated with changes in the behavior of parents (*A paid Radio Advertising Campaign to Promote Parent-Child Communication about alcohol,* Journal of Health Comm., 2003.)

Studies have shown that paid ads can work with adults and youth (*Anti-Drug Ads Work,* Partnership for a Drug-Free America, March, 2004).

SAMHSA is advocating that all entities it funds start using the Strategic Prevention Framework (see www.SAMHSA.gov). Many communities will not have the capacity to implement such a framework unless they receive technical support. We have a regional system, though, in need of further development which has the level of expertise necessary to support the communities. Most other states do not have such a system.

SAMHSA/CSAP support comprehensive models of prevention, in terms of domains– individual, peer, family, school, community, and society – and in terms of a public health model, activities that impact the host – individual user, agent – substance, and environment – the physical context in which the activity occurs. (CSAP/NPN Substance Abuse Prevention Backgrounder – SAMHSA)

Components of a Prevention Oriented Continuum of Care



Primary Prevention – The reduction or control of causative and risk factors for a health problem

Secondary Prevention – The early detection, intervention and treatment of health problems

Tertiary Prevention – The Provision of appropriate, supportive and rehabilitative services to maximize the quality of life

Principles of Effective Treatment

- No single treatment approach is appropriate for all individuals
- Treatment needs to be readily available
- Effective treatment attends to the multiple needs of the individual, not just drug use
- Remaining in treatment for an adequate period of time is critical for treatment effectiveness. Most studies indicate a minimum of 90 days
- Counseling (individual, family and/or group) and other behavior therapies are critical components of effective treatment
- Medications are an important element of treatment for many people, especially when combined with counseling and other behavior therapies
- Addicted individuals with co-existing mental disorders should be treated in an integrated way
- Medical detoxification is only the first stage and by itself does little to change long term use
- Treatment does not need to be voluntary to be effective
- Treatment programs should provide assessments and counseling to prevent and treat HIV, Hepatitis B and C
- Recovery is a long term process that frequently requires multiple episodes of treatment

Principles of Drug Treatment Addiction: A Research Based Guide. National Institute on Drug Abuse, 1999. Consensus of Clinical Effectiveness Group

Principles of Effective Prevention

1. Prevention programs should enhance protective factors and reverse or reduce risk factors (Hawkins et al. 2002).
2. Prevention programs should address all forms of drug abuse, alone or in combination, including the underage use of legal drugs (e.g., tobacco or alcohol); the use of illegal drugs (e.g., marijuana or heroin); and the inappropriate use of legally obtained substances (e.g., inhalants), prescription medications, or over-the-counter drugs (Johnston et al. 2002).
3. Prevention programs should address the type of drug abuse problem in the local community, target modifiable risk factors, and strengthen identified protective factors (Hawkins et al. 2002).
4. Prevention programs should be tailored to address risks specific to population or audience characteristics, such as age, gender, and ethnicity, to improve program effectiveness (Oetting et al. 1997).
5. Family-based prevention programs should enhance family bonding and relationships and include parenting skills; practice in developing, discussing, and enforcing family policies on substance abuse; and training in drug education and information (Ashery et al. 1998).
6. Prevention programs can be designed to intervene as early as preschool to address risk factors for drug abuse, such as aggressive behavior, poor social skills, and academic difficulties (Webster-Stratton 1998; Webster-Stratton et al. 2001).
7. Prevention programs for elementary school children should target improving academic and social-emotional learning to address risk factors for drug abuse, such as early aggression, academic failure, and school dropout. (Ialongo et al. 2001; Conduct Problems Prevention Work Group 2002b).
8. Prevention programs for middle or junior high and high school students should increase academic and social competence… (Botvin et al. 1995; Scheier et al. 1999):
9. Prevention programs aimed at general populations at key transition points, such as the transition to middle school, can produce beneficial effects even among high-risk families and children. Such interventions do not single out risk populations and, therefore, reduce labeling and promote bonding to school and community (Botvin et al. 1995; Dishion et al. 2002).

Principles of Effective Prevention

10. Community prevention programs that combine two or more effective programs, such as family-based and school-based programs, can be more effective than a single program alone (Battistich et al. 1997).
11. Community prevention programs reaching populations in multiple settings—for example, schools, clubs, faith-based organizations, and the media- are most effective when they present consistent, community-wide messages in each setting (Chou et al. 1998).
12. When communities adapt programs to match their needs, community norms or differing cultural requirements, they should retain core elements of the original research-based intervention (Spoth et al. 2002b).
13. Prevention programs should be long-term with repeated interventions (i.e., booster programs) to reinforce the original prevention goals. Research shows that the benefits from middle school prevention programs diminish without follow-up programs in high school (Scheier et al. 1999).
14. Prevention programs should include teacher training on good classroom management practices, such as rewarding appropriate student behavior. Such techniques help to foster students' positive behavior, achievement, academic motivation, and school bonding (Lalongo et al. 2001).
15. Prevention programs are most effective when they employ interactive techniques, such as peer discussion groups and parent role-playing, that allow for active involvement in learning about drug abuse and reinforcing skills (Botvin et al. 1995).
16. Research-based prevention programs can be cost-effective. Similar to earlier research, recent research shows that for each dollar invested in prevention, a savings of up to $10 in treatment for alcohol or other substance abuse can be seen (Pentz 1998; Hawkins 1999; Aos et al. 2001; Spoth et al. 2002a).

Preventing Drug Use among Children and Adolescents: A Research-Based Guide for Parents, Educators, and Community Leaders; Second Edition, National Institute on Drug Abuse, October, 2003

The SAMHSA[4] Strategic Prevention Framework

Principles of a Strategic Prevention Framework

1. Prevention is an ordered set of steps along a continuum to promote individual, family and community health, prevent mental and behavioral disorders, support resilience and recovery, and prevent relapse.
2. Prevention is prevention is prevention –that is, the common components of effective prevention for the individual, family or community within a public health model are the same – whether the focus is on preventing or reducing the effects of cancer, cardiovascular disease, diabetes, substance abuse or mental illness.
3. Common risk and protective factors exist for many mental health and substance abuse problems. Good prevention focuses on these common risk factors that can be altered.
4. Resilience is built by developing assets in individuals, families, and communities through evidence-based health promotion and prevention strategies.
5. Systems of prevention services work better than service silos.
6. Baseline data, common assessment tools, and outcomes shared across service systems can promote accountability and effectiveness of prevention efforts.

The Strategic Prevention Framework of SAMHSA

1. Profile population needs , resources, and readiness to address the problems and gaps in service delivery.
2. Mobilize and/or build capacity to address needs.
3. Develop a comprehensive strategic plan.
4. Implement evidence-based resilience building prevention programs.
5. Monitor process, evaluate effectiveness, sustain effective programs, and improve or replace those that fail.

[4] The Substance Abuse Mental Health Services Administration, U.S. Department of Health and Human Services

SAMHSA Matrix: Program Priorities

SAMHSA Priorities: Programs & Principles	Cross-Cutting Principles									
Programs/Issues	Science to Services/ Evidence-based Practices	Data for Performance Measurement & Management	Collaboration with Public & Private Partners	Recovery: Reducing Stigma & Barriers to Services	Cultural Competency/ Eliminating Disparities	Community and Faith-Based Approaches	Trauma & Violence (e.g., Physical & Sexual Abuse)	Financing Strategies & Cost-effectiveness	Rural & Other Specific Settings	Workforce Development
Co-Occurring Disorders										
Substance Abuse Treatment Capacity										
Seclusion & Restraint										
Strategic Prevention Framework										
Children & Families										
Mental Health System Transformation										
Disaster Readiness & Response										
Homelessness										
Aging										
HIV/AIDS and Hepatitis										
Criminal Justice										

SAMHSA's budget, programs and policies have been aligned to match a series of **core priority issues and cross-cutting principles**, consistent with the goals and objectives of the U.S. Department of Health & Human Services and the Administration. These priorities are represented on the SAMHSA matrix—an evolving tool that keeps the Agency's work focused on the most critical issues in behavioral health.

SAMHSA links these core priority issues to cross-cutting principles that help ensure that all of the Agency's work supports activities that—

- Are data driven and evidence based
- Recognize and respond to racial, cultural and geographic diversity
- Foster public-private partnerships
- Lift the discrimination and stigma of substance abuse and mental illness
- Place a high priority on community-based services, including faith-based initiatives
- Develop a highly qualified workforce
- Focus on recovery.

The matrix has guided SAMHSA's program, policy and budget decisions for the past 2 years. By constantly monitoring and evaluating the programs and principles against emerging issues and the changing needs of the people it serves, SAMHSA will ensure that it remains focused on priorities that improve lives.

Glossary

AOD Alcohol and Other Drugs

ASAM American Society of Addiction Medicine

Assessment A more extensive process than screening; it involves a broad analysis of the factors contributing to and maintaining a client's substance abuse, the severity of the problem, and the variety of consequences associated with it.

BSAS (Massachusetts) Bureau of Substance Abuse Services, Department of Public Health. The agency charged with funding and monitoring services for individuals with substance abuse disorders.

BRFSS Behavioral Risk Factor Surveillance System, the world's largest telephone survey, tracks health risks in the United States. Information from the survey is used to improve the health of the American people. The Department of Public Health implements this CDC survey for Massachusetts.

CHC Community Health Center

CSAP Center for Substance Abuse Prevention, part of the (Federal) Substance Abuse and Mental Health Services Administration (see also SAMHSA)

CSAT Center for Substance Abuse Treatment, part of the (Federal) Substance Abuse and Mental Health Services Administration (see also SAMHSA)

Brief intervention Practice that aims to investigate a potential problem and motivate an individual to begin to do something about his substance abuse

Brief interventions/treatment Screening and brief intervention are two separate skills that can be used together to reduce risky substance use. Screening involves asking questions about use; a "brief intervention" is a negotiated conversation between a health professional and a patient designed to reduce use. Not everyone who is screened will need a brief intervention, and not everyone who needs a brief intervention requires treatment. The goals of screening and brief intervention are to reduce risky substance use *before* people become dependent or addicted.

DAWN Drug Abuse Warning Network, a national public health surveillance system that monitors drug-related emergency department visits and deaths

IMD Institutions for Mental Disease (IMDs): inpatient facilities of more than 16 beds whose patient roster is more than 51% severe brain disorders by primary admitting diagnosis. Federal Medicaid matching payments are prohibited for IMDs with a population between the ages of 22 and 64.

MASAC Massachusetts Alcohol and Substance Abuse Center, a treatment center located within Bridgewater State Hospital (a facility of the MA Department of Correction). MASAC houses individuals who are committed under MGL 123, Section 35 who are participating in a 30-day detoxification program.

Glossary

MassHealth	The Medicaid program in Massachusetts.
MBHP	Massachusetts Behavioral Health Partnership, the private company that manages mental health and substance abuse services for MassHealth (Medicaid) members in the Primary Care Clinician Plan.
MHSACM	Mental Health and Substance Abuse Corporations of Massachusetts; it is the statewide provider association.
MOAR	Massachusetts Organization for Addiction Recovery, an advocacy organization for those in recovery from alcohol and other drug addictions
NAMI	A nonprofit, grassroots, self-help, support and advocacy organization of consumers, families, and friends of people with severe mental illnesses. Founded as the National Alliance for the Mentally Ill.
NPN	National Prevention Network
NSDUH	National Survey on Drug Use and Health; a SAMHSA survey providing yearly national and state level estimates of alcohol, tobacco, illicit drug, and non-medical prescription drug use. Other health-related questions also appear from year to year, including questions about mental health.
SAMHSA	Substance Abuse and Mental Health Services Administration, the Federal agency charged with focusing attention, programs, and funding on improving the lives of people with or at risk for mental and substance abuse disorders. SAMHSA includes three Centers that engage in program activities focusing on substance abuse treatment (CSAT), mental health service (CMHS), and substance abuse prevention (CSAP). The Office of Applied Studies collects, analyzes and disseminates national data on practices and issues related to substance abuse and mental disorders.
SAMIS	The Substance Abuse Management Information System
Screening	A process in which clients are identified according to characteristics that indicate they are possibly abusing substances. Screening identifies the need for more in-depth assessment but is not an adequate substitute for complete assessment.
Section 35	The section of the Massachusetts General Laws that enables 30 day civil commitment of an individual who constitutes a risk to him or her self or others as a result of drug or alcohol abuse.
TIP	Treatment Improvement Protocol, developed and made available by CSAT (see above). Guidelines for providing care.
Virtual Gateway	A web-based tool that serves as a single access point for a wide variety of state-sponsored programs