Commonwealth of Massachusetts
Executive Office of Public Safety and Security
Office of Grants and Research

FISCAL YEAR 2017
RESIDENTIAL SUBSTANCE ABUSE TREATMENT FOR STATE PRISONERS FORMULA GRANT PROGRAM

COMMONWEALTH OF MASSACHUSETTS
APPLICATION FOR FUNDING

SUBMITTED TO THE:
BUREAU OF JUSTICE ASSISTANCE
OFFICE OF JUSTICE PROGRAMS
U.S. DEPARTMENT OF JUSTICE

Charles Baker
Governor

Karyn Polito
Lieutenant Governor

Daniel Bennett
Secretary

Angela F.F. Davis
Executive Director

a. Statement of The Problem

Statistics demonstrate that there is a direct relationship between the use of drugs and the volume of crime committed by drug users. A 2004 report issued by the Bureau of Justice Statistics (BJS) noted that almost a third (32%) of state inmates committed their offense under the influence of drugs. Furthermore, 56% of state inmates report drug use in the month before the offense, and 53% report drug dependence or abuse.[1] The ensuing statistics will demonstrate the need for substance abuse programming for incarcerated individuals as many have experience with drug and alcohol abuse.

The Drug Enforcement Administration (DEA) released a report in November 2016 entitled *National Drug Threat Assessment Summary, 2016*, which provides an in-depth analysis of the specific types of drugs and drug-abuse patterns both nationally and in the New England region. The report identified opioid abuse, and in particular, heroin and controlled prescription medications, as the primary drug concerns for the New England region. Specifically, in Massachusetts, opioid abuse remains a serious public health concern as drug-related overdoses and deaths continue to rise.

Governor Baker continues to champion many initiatives to combat the continuing drug crisis in Massachusetts. In February 2015, Governor Baker established the Opioid Working Group which released 65 recommendations and an action plan less than four months later. Governor Baker's proactive response to the opioid crisis in Massachusetts has remained steadfast. The Governor's Opioid Working Group published *An Action Plan to Address the Opioid Epidemic in the Commonwealth – Update* on January 8, 2016.[2] This highlighted the many actions taken, programs implemented, and guidelines established to enhance prevention, intervention, treatment and recovery around the opioid crisis. An outcome from the Governor's Opioid Working Group was the passage of a bill titled *An Act Relative to Substance Use, Treatment, Education and Prevention (the Act),* and signed into law by Governor Baker on March 14, 2016. This includes "prevention education for students and doctors, and the first law in the nation to establish a seven day limit on first-time opioid prescriptions."[3] The Act establishes three special commissions and underscores the Commonwealth's approach for a multidimensional, collaborative public health and public safety response to the opioid epidemic. Listed below are the three opioid special commissions and their goals.

- *Special Commission to Study the Incorporation of Safe and Effective Pain Treatment Practices into the Professional Training of Students that may Prescribe Controlled Substances*.[4]
    - To develop recommendations to ensure future prescribers have an understanding of certain fundamental issues relative to the opioid epidemic, including: pain

[1] Mumola, Christopher, J., and Jennifer C. Karberg, *"Drug Use and Dependence, State and Federal Prisoners, 2004,"* BJS Special Report, October 2006, NCJ 213530 https://www.bjs.gov/index.cfm?ty=pbdetail&iid=778

[2] Governor's Opioid Working Group, http://www.mass.gov/eohhs/docs/dph/stop-addiction/action-plan-update.pdf Online. Accessed March 15, 2016.

[3] http://www.mass.gov/governor/press-office/press-releases/fy2016/governor-signs-landmark-opioid-legislation-into-law.html. Online. Accessed March 15, 2016.

[4] Online. Accessed April 27, 2017. http://www.mass.gov/eohhs/gov/departments/dph/ch-52-special-commission.html

treatment, pain treatment planning, safe prescribing practices and prescription monitoring.

- *Special Commission to Examine the Feasibility of Establishing a Pain Management Access Program*.[5]
  - To analyze the potential usefulness of the Commonwealth establishing a pain management program in order to increase access to pain management services.
- *Special Commission to Investigate and Study State Licensed Addiction Treatment Centers*.[6]
  - To study the effectiveness of state licensed addiction treatment centers.

The statistics contained in this application highlight the strong association between opioid abuse and violent crime, property crime, and drug-related hospitalizations and deaths.

NUMBER OF PERSONS ARRESTED FOR DRUG ABUSE VIOLATIONS

The Federal Bureau of Investigation (FBI) reports that the number of persons arrested for drug abuse violations in Massachusetts decreased 7% in the one-year period from 2014 to 2015 and 45% in the ten-year period between 2006 and 2015 (Figure 1). This decline in Massachusetts may be attributed to a 2008 Initiative Petition that replaced the criminal penalties for possession of one ounce or less of marijuana with a new system of civil penalties, to be enforced by issuing citations, and would exclude information regarding this civil offense from the state's criminal record information system.[7]

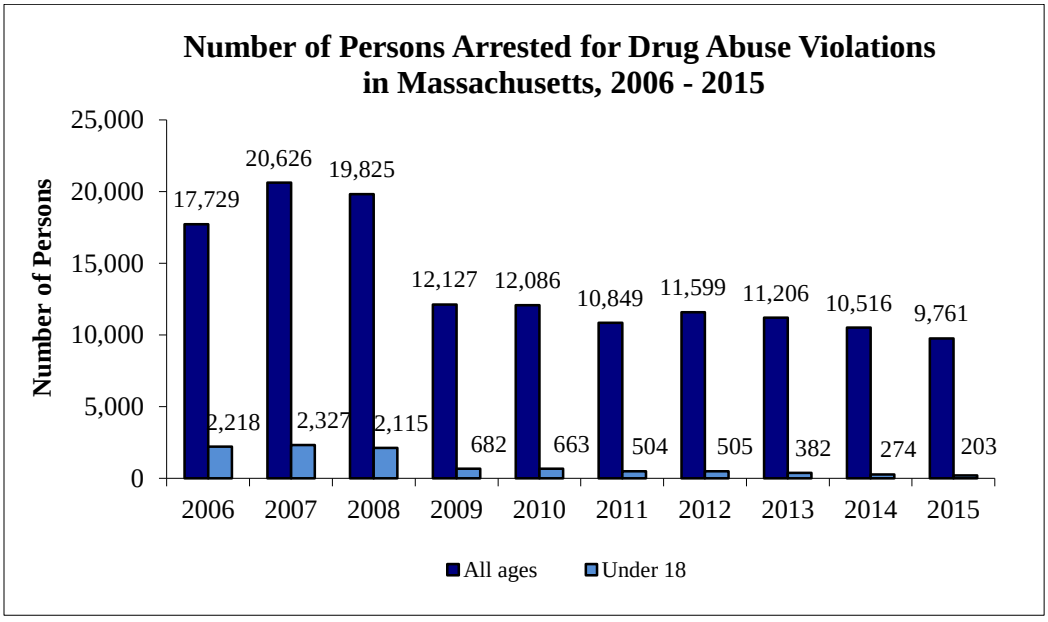

Figure 1. Source: Federal Bureau of Investigation, Uniform Crime Reports, Table 69.

[5] Online. Accessed April 27, 2017. http://www.mass.gov/eohhs/docs/report-commission-on-pain-management.pdf
[6] Online. Accessed April 27, 2017. http://www.mass.gov/eohhs/docs/special-commission-to-investigate-and-study-state-licensed-addiction-tre-.pdf
[7] Question 2: Law Proposed by Initiative Petition *"Possession of Marijuana"* Online. Accessed June 16, 2017 https://www.sec.state.ma.us/ele/ele08/ballot_questions_08/quest_2.htm

Likewise, there has been a dramatic shift in the number of young people arrested for drug offenses during this time period. Peaking at 2,327 in 2007, the number of juveniles under the age of 18 arrested for drug offenses declined 78% by 2011, remained static in 2012, and declined 60% between 2012 and 2015. Despite the downward trend, there is still a critical need to support substance abuse programming in county and state correctional facilities. This is especially true given the lengthy waiting lists for substance abuse programming at many facilities. RSAT funding is needed not only to continue these programs but to accommodate in a timely manner those seeking treatment.

NUMBER OF NEW COURT COMMITMENTS FOR GOVERNING DRUG OFFENSES

The number of new court commitments to Massachusetts state and county correctional facilities fell from 4,401 in 2007 to 2,893 in 2014, a 34% decline (Figure 2).[8] The Department of Correction (DOC) commitments decreased 13% in 2016 from the previous year, and 52% over the ten-year period.

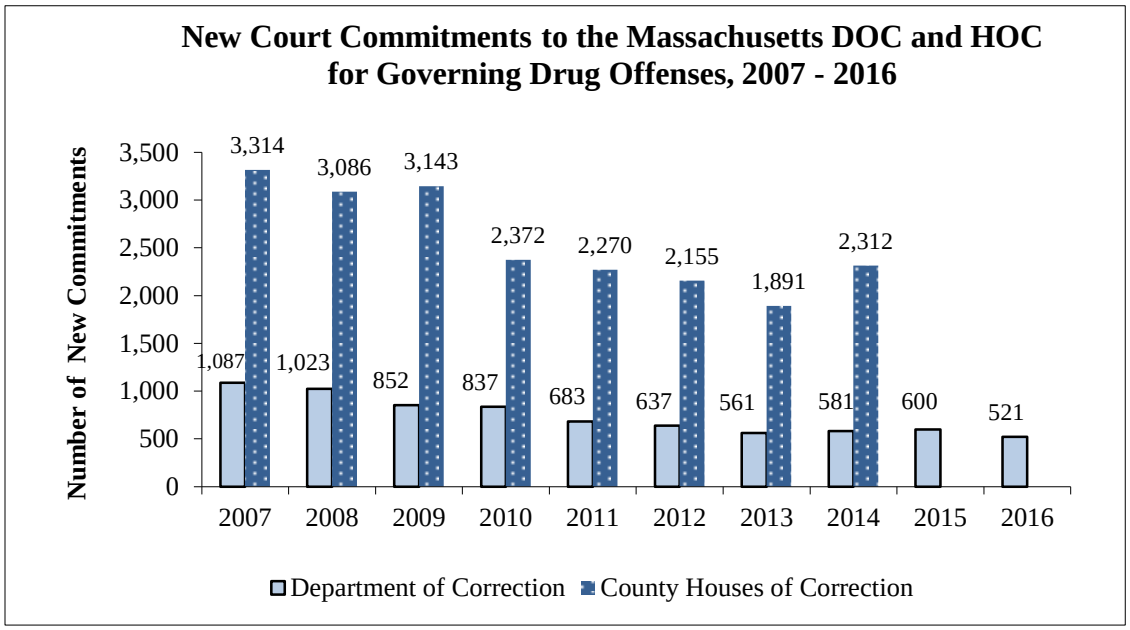

Figure 2. Source: Massachusetts Department of Correction, *Court Commitments to the Massachusetts Department of Correction, 2004 – 2008; New Court Commitments to Massachusetts County Correctional Facilities, 2004 – 2008.* Massachusetts Department of Correction, *Prison Population Trends, 2009 – 2016.* Massachusetts Sentencing Commission, *Survey of Sentencing Practices, SFY 2009 – SFY 2014*.
Note: the Department of Correction data is based on calendar year and the Massachusetts Sentencing Commission is based on state fiscal year.

[8] New commitments for governing drug offenses to the county Houses of Correction are obtained from the Massachusetts Sentencing Commission, *Survey of Sentencing Practices, SFY 2009 – SFY 2014;* however, data are not available for 2015 and 2016. As a result, it is not possible to extend the trend analysis to 2015 and 2016.

MASSACHUSETTS DOC PRISON POPULATION JANUARY 1, 2017

A report published by the Massachusetts DOC in March 2017, *Prison Population Trends, 2016,* identified the following characteristics of the inmate population incarcerated for governing drug offenses:[9]

- On January 1, 2017, 846 males and 22 females were serving a governing mandatory drug sentence;
- On January 1, 2017, drug offenses were the third most prevalent governing offense category for offenders (14%), surpassed by crimes against person offenses (55%) and sex offenses (15%). The remaining governing offense categories were (8%) for both property and other;

ALCOHOL AND SUBSTANCE ABUSE CIVIL COMMITMENTS

One of the three types of civil commitments[10] to the DOC is "Alcohol and Substance Abuse Commitments" to the Massachusetts Alcohol and Substance Abuse Center (MASAC). [11] MASAC provides detoxification and substance abuse treatment for males for a period up to 90 days. On January 1, 2017, there were 118 civil commitments and 28 criminally sentenced inmates.[12] MASAC commitments comprised 79% of the civil commitments to the DOC in 2016; an increase from 71% in 2015. Table 1 below displays the number of Section 35's commitments beginning in 2010, and shows a 16% increase in 2016 over the previous year.[13]

TABLE 1. CIVIL COMMITMENTS TO MASAC, 2010 – 2016

Year	Number	% Change
2010	1,370	
2011	1,381	0.8%
2012	1,679	21.6%
2013	1,503	-10.5%
2014	1,705	13.4%
2015	2,126	24.7%
2016	2,459	16.0%

Source: Massachusetts Department of Correction, *Prison Population Trends, 2010-2016.*

[9] MA DOC define a drug offense as "offenses set forth in Massachusetts General Laws Chapter 94C, including offenses pertaining to the distribution or possession with intent to distribute, trafficking of drugs, and drug violations within proscribed distances from schools and parks". Massachusetts Department of Correction, *Prison Population Trends, 2016,* March 2017.

[10] The other two groups of civil commitments are "Mental Health Commitments" and "Sexually Dangerous Person Commitments".

[11] M.G.L. Chapter 123, Section 35 (i.e., Section 35's). Section 35's provides a mechanism for a family member, police officer, physician, or court official to petition for a person whose alcohol or drug use puts themselves or others at risk to be involuntarily committed for substance abuse treatment. In July 2012, the commitment stay increased from 30 days to 90 days.

[12] Massachusetts Department of Correction, *Prison Population Trends, 2016*, March 2017.

[13] While the number of criminally sentenced jurisdiction admissions have steadily declined from 2014 (3,152); 2015 (2,759); and 2016 (2,578), the civil commitments to MASAC have increased since 2014.

RELEASES TO THE COMMUNITY AND RECIDIVISM TRENDS

The DOC utilizes the COMPAS[14] Risk/Needs assessment to determine inmates' risk for recidivism and their programming needs. The assessment identifies the following areas: criminal history factors, criminal associates/peers, criminal attitudes, social environment, and needs assessment (e.g., substance abuse, financial, vocational/education). Properly assessing the risk and needs of offenders and providing the appropriate programming will help reduce recidivism.

Substance abuse treatment in correctional facilities is crucial to breaking the cycle of drug use and criminal involvement. Comprehensive intervention strategies enable inmates to participate in correctional programs designed to reduce recidivism and help prevent relapse upon release to their community. This is critical as many ex-offenders return to the same community in which they were living prior to incarceration.

According to the DOC, in 2016, Boston had the highest number of criminally sentenced inmates released to the community (448), followed by Springfield (130) (Table 2).

TABLE 2. TOTAL CRIMINALLY SENTENCED RELEASES TO THE STREET BY TOP TEN MASSACHUSETTS CITIES, 2016

City/Town	Number	Percentage
Boston	448	19%
Springfield	130	6%
Worcester	111	5%
Lynn	101	4%
Norfolk	86	4%
New Bedford	74	3%
Brockton	70	3%
Lawrence	68	3%
Fall River	62	3%
Lowell	59	3%

Source: Massachusetts Department of Correction, *Prison Population Trends, 2016*, March 2017.
Note: Release address is self-reported by the inmate prior to release.

Chapter 55 of the Acts of 2015 was passed by the Massachusetts Legislature and signed into law by Governor Charles D. Baker in August 2015. "This new law permits the linkage and analysis of existing data across state government in order to better guide policy development and programmatic decision-making to successfully tackle the current opioid epidemic." Initial findings are addressed in the report *An Assessment of Opioid-Related Deaths in Massachusetts, (2013-2014).*[15] Some of the findings include:

[14] COMPAS [Criminal Offender Management Profiling for Alternative Sanctions] is a statistically based and validated risk assessment tool specifically designed to assess key risk and needs factors in correctional populations and to provide decision support for classification.
[15] Massachusetts Department of Public Health, *An Assessment of Opioid-Related Deaths in Massachusetts (2013-2014)*, September 2016.
http://www.mass.gov/eohhs/gov/departments/dph/stop-addiction/chapter-55-overdose-assessment.html

- 25% of prison inmates received treatment during their incarceration;
- Compared to the general population, individuals recently released from a Massachusetts prison are 56 times as likely to die from an opioid-related overdose;
- The risk of death is highest in the month following release;
- When examining opioid-related overdoses, former inmates had death rates in the first month after release that were up to six times higher than rates at later times;
- Among those released from prison, individuals ages 18 to 24 have almost10 times the risk of death upon release compared to individuals 45 years and older; and
- During 2013 and 2014, 13,918 inmates were released from state correctional facilities. Of these, 287 died during the same time period. Of these deaths, 121 (42%) died from an opioid-related overdose. Comparing with the total population in the state, opioid-related deaths accounted for only 2,192 (2.1%) deaths.

It is imperative that substance abuse treatment services in correctional facilities are provided with fidelity to yield meaningful reductions in drug use and recidivism. Substance abusing offenders who are untreated or receive substandard services have a higher propensity than offenders treated with program fidelity to relapse to substance abuse and criminal behavior. This can result in re-arrest and re-incarceration, jeopardizing public safety and public health.

Massachusetts DOC three-year recidivism rates for 2013 releases to the community revealed:[16]

- After serving time for drug offenses 22% of males and 21% of females re-offended; and
- The recidivism rate for those serving a mandatory minimum drug sentence was lower than those serving a non-mandatory drug sentence (20% vs. 23%).

The report also provided recommendations for reducing inmates' post incarceration risk of substance abuse. The recommendations are:

- Ensuring the availability of treatment within correctional facilities, and improved aftercare planning for inmates prior to release has the potential for life-saving impact and should be prioritized.
- Treatment and overdose prevention services should be expanded in correctional facilities and should be standardized, evidence-based, and monitored.
- Further research is warranted to identify other specific risk factors associated with the increased risk for those released from incarceration.[17]

[16] Source: Massachusetts Department of Correction, *Prison Population Trends, 2016*, March 2017.

[17] Massachusetts Department of Public Health, *An Assessment of Opioid-Related Deaths in Massachusetts (2013-2014)*, September 2016.
http://www.mass.gov/eohhs/gov/departments/dph/stop-addiction/chapter-55-overdose-assessment.html

NATIONAL DRUG THREAT ASSESSMENT

The *2016 National Drug Threat Assessment Summary*, conducted by the DEA, reports that 12% of national law enforcement agencies consider Controlled Prescription Drugs (CPDs) as the ultimate drug threat in their region. This is down substantially from 2014 when 22% reported this concern and a small decline from 2015 (15%). In the New England region, a slightly higher percentage of law enforcement officials reported CPDs as the greatest drug threat (14%); however, this is a decline from 21% in 2015. The number of individuals reporting current use of CPDs is more than those reporting use of cocaine, heroin, and methamphetamine, combined.[18]

Figure 3 demonstrates the availability of CPDs in the New England region as reported by law enforcement officials. In 2010, New England respondents stating there is high CPD availability in their jurisdictions rose 45% from the previous year (80%), remained static in 2011, then declined between 2013 and 2015, before a slight uptick in 2016.

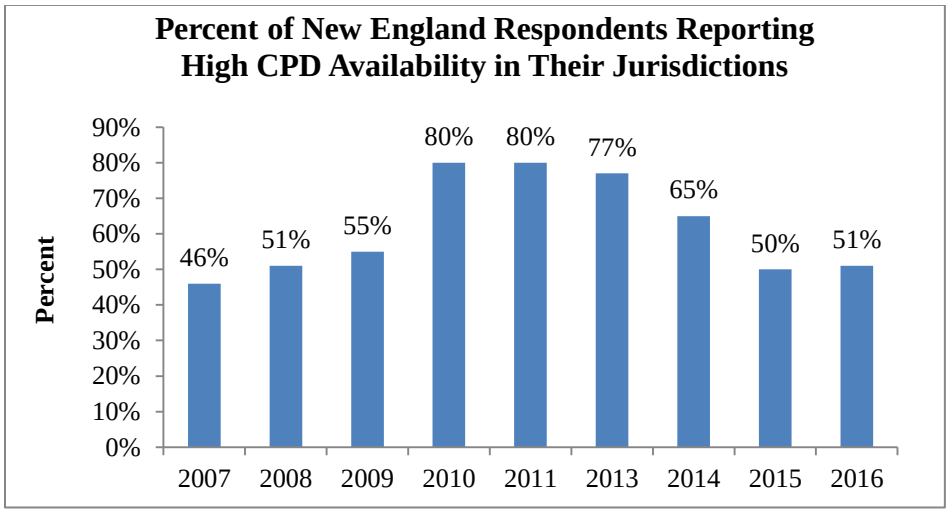

Figure 3. Source: Drug Enforcement Administration, November 2016. *National Drug Threat Assessment Summary, 2016.*
Note: Data is from the National Drug Threat Survey 2007 – 2011, 2013 – 2016. The National Drug Threat Survey was not administered in 2012.

A Department of Justice report details the overall drug threat to the New England High Intensity Drug Trafficking Area (HIDTA) region. Two New England regions are identified as high intensity drug area hubs: Hartford, CT/Springfield, MA and Lowell/Lawrence MA.[19] Furthermore, Boston, Brockton, Cambridge, Lynn, Springfield, and Worcester (MA); are the largest Massachusetts cities in the HIDTA counties. Boston – New England's largest city – is primarily a "consumer drug market" receiving drugs from Lawrence, Lowell, and the New York City metropolitan area. The area between Providence, RI and Fall River, MA is identified as a secondary distribution network that supplies illegal drugs to the Cape Cod area.

[18] Drug Enforcement Administration, November 2016. *National Drug Threat Assessment Summary, 2016* p.30. Online. Available: https://www.dea.gov/resource-center/2016%20NDTA%20Summary.pdf
[19] U.S. Department of Justice, National Drug Intelligence Center, September 2011. *New England High Intensity Drug Trafficking Area Drug Market Analysis, 2011.* Online. Available: https://www.justice.gov/archive/ndic/dmas/New_England_DMA-2011(U).pdf

As a consequence of the severe heroin problems in New England, in 2016, the Director of National Drug Control Policy added Bristol County to the HIDTA list; resulting in half of Massachusetts's 14 counties with this designation. Bristol now joins Essex, Hampden, Middlesex, Plymouth, Suffolk, and Worcester counties as "critical drug trafficking regions".[20] The HIDTA designation means these counties receive federal resources to reduce drug use and overdose deaths, provide treatment services, and serve as a catalyst for coordinating resources among local, state, and federal law enforcement agencies.

As displayed in Figure 4, a high percentage of law enforcement officials responding to the 2016 National Drug Threat Survey report a high availability of heroin in the New England region (67%). The percentage of responders acknowledging high heroin availability increased 68% between 2007 and 2015, and remained static in 2016. Seventy-four percent (74%) of New England respondents stated heroin was the greatest drug threat compared to 45% nationally.

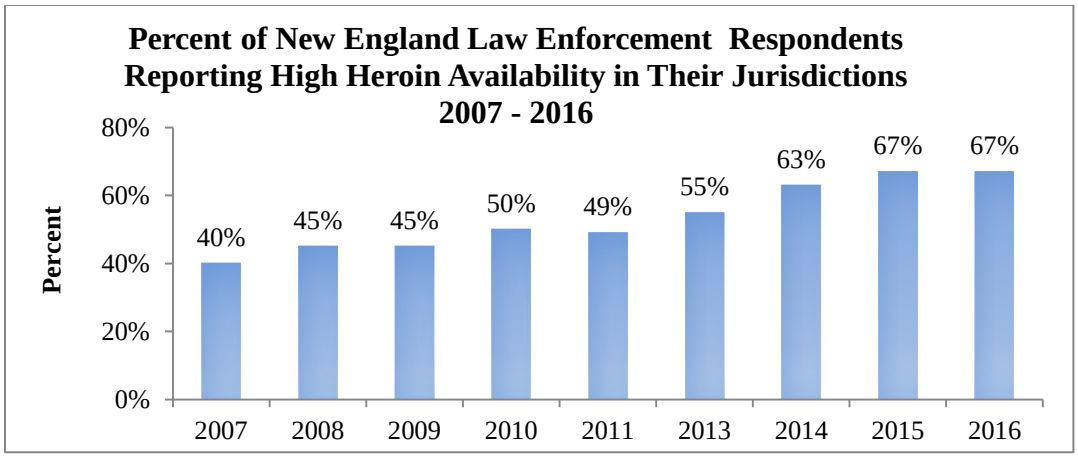

Figure 4. Source: Drug Enforcement Administration, November 2016. *National Drug Threat Assessment Summary, 2016.*
Note: Data is from the National Drug Threat Survey 2007 – 2011; 2013 – 2016. The National Drug Threat Survey was not administered in 2012.

[20] Online. Available: https://obamawhitehouse.archives.gov/the-press-office/2016/01/15/white-house-drug-policy-director-announces-designation-14-counties-high

HEROIN AND OPIOID-RELATED DEATHS IN MASSACHUSETTS

The high heroin and opioid availability continues to impact the Commonwealth of Massachusetts as evidenced by an exponential increase in the number of heroin and opioid deaths in recent years. In 2016, the state's count of opioid-related deaths was 1,979, of which 1,465 have been confirmed (Figure 5). A confirmed death is one in which the state medical examiner has certified a cause of death.

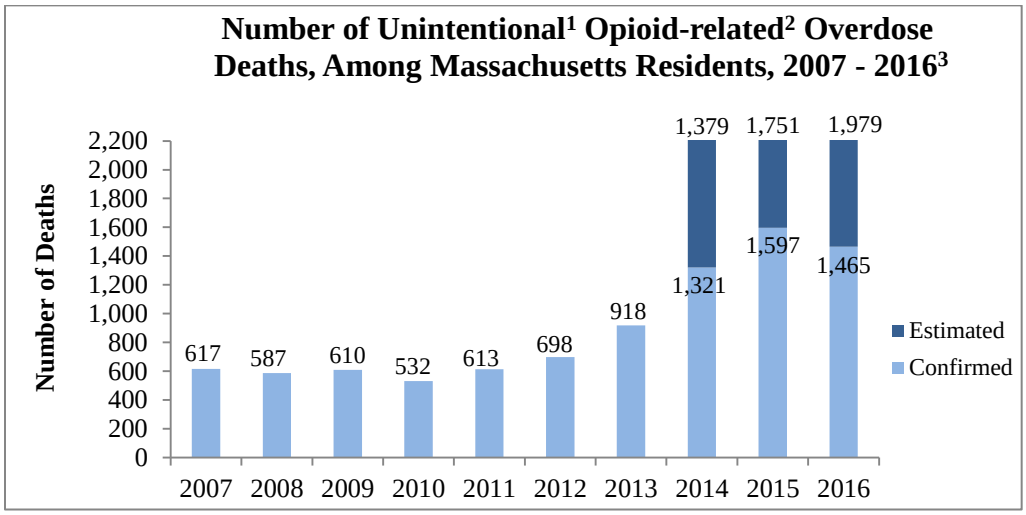

Figure 5. Source: Massachusetts Department of Public Health, Office of Data Management and Outcomes Assessment, *Data Brief: Opioid-related Overdose Deaths among Massachusetts Residents*, February 2017.

[1]Unintentional poisoning/overdose deaths combine unintentional and undetermined intents to account for a change in death coding that occurred in 2005. Suicides are excluded from this analysis.

[2]Opioids include heroin, opioid-based prescription painkillers, and other unspecified opioids. This report tracks opioid-related overdoses due to difficulties in identifying heroin and prescription opioids separately.

[3]The data contains both confirmed and estimated data through December 2016.

In 2015, the estimated rate of unintentional opioid-related overdose deaths was 25.8 deaths per 100,000 residents. This represents a 26% growth from the rate of 20.4 deaths per 100,000 residents in 2014, and a 361% increase from the 2000 rate of 5.6 deaths per 100,000 (Figure 6). In 2014 and 2015, Massachusetts is one of five states that have seen increases in opioid death rates.[21] [22]

[21] Rudd RA, Seth P, David F, Scholl L. *Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–2015*. Centers for Disease Control and Prevention, MMWR Morbidity and Mortality Weekly Report, 2016; 65: 1445–1452. DOI: https://www.cdc.gov/mmwr/volumes/65/wr/mm655051e1.htm

[22] The other four states are New York, North Carolina, Ohio, and Tennessee.

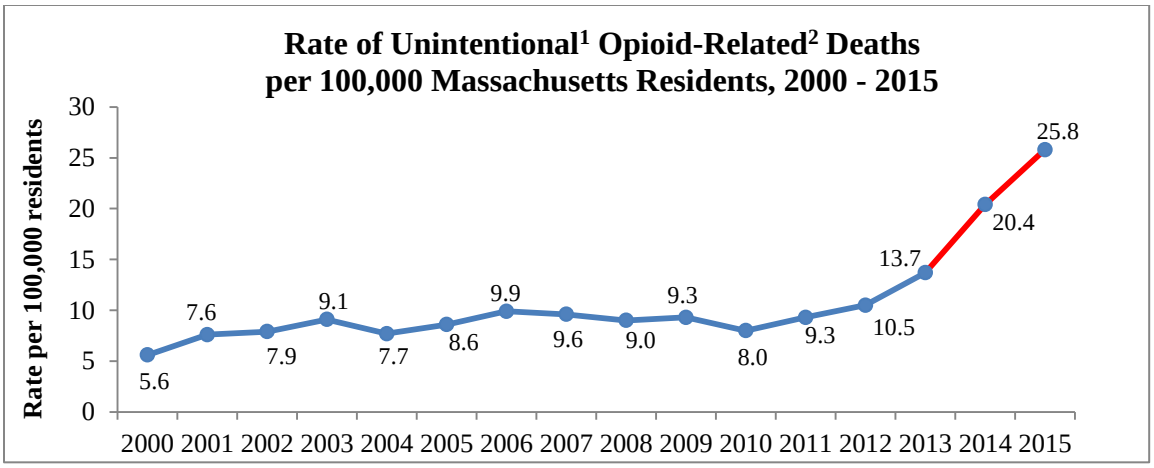

Figure 6. Source: Massachusetts Department of Public Health, Office of Data Management and Outcomes Assessment, *Data Brief: Opioid-related Overdose Deaths among Massachusetts Residents,* February 2017.
[1]Unintentional poisoning/overdose deaths combine unintentional and undetermined intents to account for a change in death coding that occurred in 2005. Suicides are excluded from this analysis.
[2]Opioids include heroin, opioid-based prescription painkillers, and other unspecified opioids. This report tracks opioid-related overdoses due to difficulties in identifying heroin and prescription opioids separately.

Tables 3 through 5 display demographic data from confirmed opioid-related overdose deaths from January 2016 to December 2016.[23] Almost three-quarters (73%) of persons who died from confirmed, opioid-related deaths were male (Table 3).

TABLE 3. CONFIRMED UNINTENTIONAL/UNDETERMINED[1] OPIOID-RELATED DEATHS BY GENDER JANUARY 2016 – DECEMBER 2016

Gender	Number	Percentage
Male	1,070	73%
Female	395	27%
Total	**1,465**	**100%**

Source: Massachusetts Department of Public Health, Office of Data Management and Outcomes Assessment, *Data Brief: Confirmed Unintentional/Undetermined Opioid-related Overdose Deaths Among Massachusetts Residents – Demographic Data Highlights*, February 2017.
[1]Unintentional poisoning/overdose deaths combine unintentional and undetermined intents to account for a change in death coding that occurred in 2005. Suicides are excluded from this analysis.

[23] 2016 death data are preliminary and subject to updates. Case reviews of deaths are evaluated and updated on an ongoing basis. A large number of deaths have yet to be assigned final cause-of-death codes. The information presented in the report only includes confirmed cases. Data updated on 01/12/2017.

Displayed in Table 4, over three-quarters (78%) of opioid-related deaths in 2016 occurred in the 25 – 54 age range. This age group accounts for 10% of all deaths in the Commonwealth.

TABLE 4. CONFIRMED UNINTENTIONAL/UNDETERMINED[1] OPIOID-RELATED DEATHS COMPARED TO ALL DEATHS BY AGE JANUARY 2016 – DECEMBER 2016

Age	0-14	15-24	25-34	35-44	45-54	55-64	65+	Unknown	Total
All Deaths	362	463	1,187	1,393	3,015	5,981	42,947	1,264	**56,612**
Confirmed Unintentional/ Undetermined[1] Opioid Deaths	0	114	458	378	310	183	13	9	**1,465**

Source: Massachusetts Department of Public Health, Office of Data Management and Outcomes Assessment, *Data Brief: Confirmed Unintentional/Undetermined Opioid-related Overdose Deaths among Massachusetts Residents – Demographic Data Highlights*, February 2017.
[1]Unintentional poisoning/overdose deaths combine unintentional and undetermined intents to account for a change in death coding that occurred in 2005. Suicides are excluded from this analysis.

White (non-Hispanic) individuals constituted 82% of the confirmed opioid-related deaths in 2016 (Table 5).

TABLE 5. CONFIRMED UNINTENTIONAL/UNDETERMINED[1] OPIOID-RELATED DEATHS COMPARED TO ALL DEATHS BY RACE/ETHNICITY JANUARY 2016 – DECEMBER 2016

	White non-Hispanic	Black non-Hispanic	Asian non-Hispanic	Hispanic	Other/ Unknown	Total
All Deaths	50,380	2,482	1,024	2,099	627	**56,612**
Unintentional/Undetermined[1] Opioid Deaths	1,194	66	11	172	22	**1,465**

Source: Massachusetts Department of Public Health, Office of Data Management and Outcomes Assessment, *Data Brief: Confirmed Unintentional/Undetermined Opioid-related Overdose Deaths among Massachusetts Residents – Demographic Data Highlights*, February 2017.
[1]Unintentional poisoning/overdose deaths combine unintentional and undetermined intents to account for a change in death coding that occurred in 2005. Suicides are excluded from this analysis.

Nationally, heroin overdose deaths more than tripled between 2010 and 2014, and are predominantly high in the Northeast and Midwest. [24] In 2015, Massachusetts in addition to three other states[25] experienced the largest rate increases in heroin deaths. [26] Heroin is much deadlier as a result of high-purity and mixing with fentanyl; often without the user's knowledge. As previously noted in this analysis, there were 1,597 confirmed and 1,751 estimated opioid-related overdose deaths in 2015 in Massachusetts. While some cities and towns experienced a decline in opioid-related deaths in 2015 compared to 2014: notably Haverhill, Revere, Everett, and Taunton, others saw significant increases. Specifically, the cities of New Bedford (78%), Brockton (88%), and Springfield (105%) had substantial increases from the previous year (Table 6).

[24] Source: Drug Enforcement Administration, November 2016. *National Drug Threat Assessment Summary, 2016.*
[25] The other three states are Connecticut, Ohio, and West Virginia.
[26] Rudd RA, Seth P, David F, Scholl L. *Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–2015*. Centers for Disease Control and Prevention, MMWR Morbidity and Mortality Weekly Report, 2016; 65:1445–1452. DOI: https://www.cdc.gov/mmwr/volumes/65/wr/mm655051e1.htm

TABLE 6. NUMBER OF CONFIRMED UNINTENTIONAL/ UNDETERMINED[1] OPIOID-RELATED[2] OVERDOSE DEATHS BY THE TOP 15 MASSACHUSETTS CITY/TOWN FFY 2011 – FFY 2015

City/Town	Number of Deaths					% Change FFY 14-FFY 15	% of 2015 Total (n=1,574)
	FFY2011	FFY2012	FFY2013	FFY2014[3]	FFY2015[3]		
Boston	63	64	82	105	138	31.4%	8.8%
Worcester	22	28	43	56	75	33.9%	4.8%
Lynn	10	22	25	42	44	4.8%	2.8%
Fall River	26	22	28	34	38	11.8%	2.4%
Lowell	25	9	24	39	54	38.5%	3.4%
Quincy	24	25	26	38	39	2.6%	2.5%
New Bedford	20	26	27	27	48	77.8%	3.0%
Brockton	13	9	27	24	45	87.5%	2.9%
Haverhill	2	11	8	34	29	-14.7%	1.8%
Revere	9	12	15	26	14	-46.2%	0.9%
Everett	8	9	5	27	16	-40.7%	1.0%
Lawrence	7	6	9	25	25	0.0%	1.6%
Malden	4	9	12	18	21	16.7%	1.3%
Springfield	16	22	22	20	41	105.0%	2.6%
Taunton	3	14	13	18	14	-22.2%	0.9%

Source: Massachusetts Department of Public Health, *Number of Confirmed Unintentional/Undetermined Opioid-related Overdose Deaths by City/Town, MA Residents January 2011 – September 2016, November 2016.* Online. Accessed http://www.mass.gov/eohhs/docs/dph/stop-addiction/current-statistics/overdose-deaths-cities-towns-nov-2016.pdf

[1]Unintentional poisoning/overdose deaths combine unintentional and undetermined intents to account for a change in death coding that occurred in 2005. Suicides are excluded from this analysis.

[2]Opioids include heroin, opioid-based prescription painkillers, and other unspecified opioids.

[3]Please note that 2014 and 2015 death data are preliminary and subject to updates. Case reviews of deaths are evaluated and updated on an ongoing basis. A large number of death certificates have yet to be assigned final cause-of-death codes. The information presented in this report only includes confirmed cases. Data updated September 30, 2016.

In 2015, Boston remained unrelenting with the highest number of nonfatal opioid-related overdoses, accounting for almost 10% of the total opioid-related overdoses in the state (Table 7). The 41% increase from the previous year highlights the burgeoning opioid crisis that continues in Boston and several other Massachusetts' cities and towns. For example, Lawrence experienced a 105% increase in FFY 2015 from the previous year in nonfatal opioid-related overdoses, (105 in FFY 2014 to 215 in FFY 2015).

TABLE 7. TOP 15 MASSACHUSETTS CITY/TOWN FOR NONFATAL OPIOID-RELATED OVERDOSES, HOSPITAL EVENTS FFY 2011 – FFY 2015

City/Town	Number of Overdoses					% Change FFY 14-FFY 15	% of 2015 Total (n=11,794)
	FFY2011	FFY2012	FFY2013	FFY2014	FFY2015		
Boston	623	716	802	803	1,132	41.0%	9.6%
Worcester	225	263	334	423	657	55.3%	5.6%
Brockton	136	145	187	300	461	53.7%	3.9%
New Bedford	165	172	215	331	445	34.4%	3.8%
Fall River	170	165	225	269	343	27.5%	2.9%
Lowell	118	124	159	191	278	45.5%	2.4%
Quincy	152	129	197	216	262	21.3%	2.2%
Lynn	116	106	116	168	250	48.8%	2.1%
Taunton	53	96	101	163	221	35.6%	1.9%
Lawrence	55	60	76	105	215	104.8%	1.8%
Haverhill	48	47	74	129	211	63.6%	1.8%
Springfield	106	134	123	153	195	27.5%	1.7%
Weymouth	82	90	115	137	193	40.9%	1.6%
Revere	61	113	95	131	174	32.8%	1.5%
Barnstable	24	46	63	98	170	73.5%	1.4%

Source: Massachusetts Department of Public Health, Inpatient Discharge Database, MA Observation Database, and MA Emergency Department Discharge Database, Center for Health Information and Analysis (CHIA), *Nonfatal Opioid-related Overdoses, Hospital Events, FFY2011-FFY2015*, data obtained May 2, 2017.
Note: Drug poisoning intent categories may be unreliable due to difficulties ascertaining patient's intent and variability in coding across hospitals. Therefore, all intents of nonfatal drug poisonings are included.
Data are submitted by and reported by [federal] fiscal year (October 1st -- September 30th).
Counts represent acute-care hospital episodes which include hospital and emergency department discharges, and observations stays. Opioids include heroin, prescription-based opioid pain killers, and unspecified opioids.
Counts less than 11 are suppressed per confidentiality rules.
In 2015, the Center for Health Information and Analysis added several diagnosis fields to the hospital and ED databases. For consistency, DPH used the same definition as last year (i.e., searched 15 diagnosis fields in hospital, and 6 diagnosis fields in ED).

In FFY 2015, there was a 66% increase in Massachusetts from FFY 2014 in the number of inpatient hospitalizations, observation stays, and emergency department visits for nonfatal heroin-related overdoses (5,320 vs. 8,805), and a 148% increase from FFY 2013 (3,547). Similar to the above statistics for nonfatal opioid-related overdoses, the city of Lawrence had the highest increase for nonfatal heroin-related overdoses in FFY 2015 (108%). This was followed by Haverhill which had the second highest increase at 84% in FFY 2015 (Table 8).

TABLE 8. TOP 11 MASSACHUSETTS CITY/TOWN FOR NONFATAL HEROIN-RELATED OVERDOSES, HOSPITAL EVENTS FFY 2011 – FFY 2015

City/Town	Number of Overdoses					% Change FFY 14-FFY 15	% of 2015 Total (n=8,805)
	FFY2011	FFY2012	FFY2013	FFY2014	FFY2015		
Boston	336	420	517	542	835	54.1%	9.5%
Worcester	86	147	217	309	533	72.5%	6.1%
Brockton	81	80	130	219	376	71.7%	4.3%
New Bedford	95	115	152	264	367	39.0%	4.2%
Fall River	100	101	158	198	267	34.8%	3.0%
Quincy	96	79	134	171	205	19.9%	2.3%
Lynn	77	61	67	132	198	50.0%	2.2%
Lowell	57	63	84	110	189	71.8%	2.1%
Taunton	34	60	69	129	183	41.9%	2.1%
Lawrence	55	60	48	84	175	108.3%	2.0%
Haverhill	48	47	40	93	171	83.9%	1.9%

Source: Massachusetts Department of Public Health, Inpatient Discharge Database, MA Observation Database, and MA Emergency Department Discharge Database, Center for Health Information and Analysis (CHIA), *Nonfatal Heroin-related Overdoses, Hospital Events, FFY2011-FFY2015*, data obtained May 2, 2017.
Note: Drug poisoning intent categories may be unreliable due to difficulties ascertaining patient's intent and variability in coding across hospitals. Therefore, all intents of nonfatal drug poisonings are included.
Data are submitted by and reported by [federal] fiscal year (October 1st -- September 30th).
Counts represent acute-care hospital episodes which include hospital and emergency department discharges, and observations stays. Opioids include heroin, prescription-based opioid pain killers, and unspecified opioids.
Counts less than 11 are suppressed per confidentiality rules.
In 2015, the Center for Health Information and Analysis added several diagnosis fields to the hospital and ED databases. For consistency, DPH used the same definition as last year (i.e., searched 15 diagnosis fields in hospital, and 6 diagnosis fields in ED).

b. Project Design and Implementation

Massachusetts will continue to provide quality residential and jail-based treatment services within its county and state facilities. Massachusetts will ensure applicants provide aftercare services for their participants. The aftercare services must involve coordination between the correctional treatment program and other human service and rehabilitation programs. These include education and job training, parole supervision, access to halfway houses and self-help and peer group programs that aid in rehabilitation. We will also require all sub grantees to provide treatment and services to address opioid abuse reduction. This will be clearly stated in our Application for Grant Funds (AGF) as a requirement in order to be eligible to apply and possibly be awarded funds. No award will be made to an applicant that does not plan to implement these services.

Goals:

- Reduce drug use and crime among offenders;
- Provide effective, science-based substance abuse treatment for offenders;
- Provide quality, coordinated aftercare services in order to prevent recidivism.

Objectives:

- Implement best practice models that utilize uniform standards relative to science-based residential substance abuse treatment;
- Attend and participate in workshops, conferences, and seminars that offer education and assistance in providing offender treatment based on recent, empirically-based research;
- Create and follow up on individualized plans for each program participant;
- Develop and monitor each facility's reintegration plan to ensure compliance with program mandates including counseling, referrals, and the establishment of community and interagency ties; and
- Ensure that aggressive urinalysis continues as part of residential treatment and post-release aftercare plans of the offender.

The RSAT program continues to be administered by the Executive Office of Public Safety and Security (EOPSS), Office of Grants and Research (OGR). OGR serves as the Massachusetts state-administering agency for a variety of federal and state criminal justice grants. The fiscal and programmatic administration of the RSAT program will not exceed 10% of the total grant award. In the past, local facilities (sheriffs' departments) received the majority of the RSAT funds and no more than 10% of the Massachusetts federal award was used for offenders released from state facilities. Depending on the 2017 RSAT federal level of funding to Massachusetts, and as allowed by the solicitation, Massachusetts may utilize more than 10% for offenders in state facilities. Jail-based treatment projects will, when possible, be set aside from the general population and be a minimum of three months in length.

The Massachusetts sheriffs' departments have worked diligently to establish standards specific to county facilities and which accurately reflect the realities of the community to which the offenders will be returning. Assessment tools and treatment plans that focus on matching offenders to the level of resources available in the community have been adopted and supported.

The programs include modalities such as: self-help, group and individual therapy, relapse prevention, peer support/dynamics, basic psycho-educational instruction, and urinalysis testing. The goals of the programs are to reduce substance abuse and recidivism by offering intervention, treatment, and counseling services.

Regularly scheduled training and cross-training are a priority for management, custodial, and treatment staff. The primary responsibilities of the RSAT program managers at state and county facilities are as follows: formulate and monitor each offender's treatment plan to include, but not be limited to individual counseling, group therapy, and referrals to appropriate community agencies; develop a program-tracking system; perform random urinalysis testing or other proven drug testing method for all RSAT participants; and focus on substance abuse related issues.

Revisions to Massachusetts General Laws or Policy. The status of statutes and/or policies is as follows:

G.L. c. 111B--Alcoholism Treatment & Rehabilitation Law: Section 7 was amended to provide that upon a patient's discharge or departure from a facility, the patient may only be referred to alcohol and drug free housing certified by the Bureau of Substance Abuse Services for any appropriate outpatient or residential aftercare treatment. St.2014, c. 165, § 141, eff. June 1, 2015.

G.L. c. 111E--Drug Rehabilitation: Section 12 was amended to require probation officers to refer criminal defendants only to alcohol and drug free housing certified by the Bureau of Substance Abuse Services, where the defendants are ordered to live in alcohol and drug free housing as a condition of probation. Also, section 2 was repealed and sections 3 and 4 were amended to eliminate the drug rehabilitation advisory board. St.2014, c. 165, § 147, eff. June 1, 2015.

G.L. c. 123, § 35—Commitment of Alcoholics or Substance Abusers was amended to eliminate civilly committing females to MCI Framingham under this section. Instead, women who are found to require placement in a secure facility can only be sent to a secure facility approved by the Department of Public Health or the Department of Mental Health. Also, the terms and accompanying definitions of "alcohol use disorder" and "substance use disorder" replaced "alcoholic" and "substance abuser," respectively. Lastly, the legislature inserted the term "qualified" before social worker as one of the experts who can provide an examination of the individual with an alcohol use or substance use disorder. 2016 Mass. Legis. Serv. Ch. 8 (H.B. 4056) approved January 25, 2016.

After 5 years from the date of commitment, a person found to be a person with an alcohol use disorder or substance use disorder and committed pursuant to this section, may file a petition for relief with the court that ordered the commitment, requesting that the court restore the person's ability to possess a firearm, rifle or shotgun. The court may grant the relief sought in accordance with the principles of due process if the circumstances regarding the person's disqualifying condition and the person's record and reputation are determined to be such that: (i) the person is not likely to act in a manner that is dangerous to public safety; and (ii) the granting of relief would not be contrary to the public interest. In making the determination, the court may consider evidence from a licensed physician or clinical psychologist that the person is no longer suffering

from the disease or condition that caused the disability or that the disease or condition has been successfully treated for a period of three consecutive years.

If the court grants a petition for relief pursuant to this section, the clerk shall provide notice immediately by forwarding a certified copy of the order for relief to the Department of Criminal Justice Information Services, which shall transmit the order, pursuant to paragraph (h) of section 167A of chapter 6, to the attorney general of the United States to be included in the National Instant Criminal Background Check System. A person whose petition for relief is denied may appeal to the appellate division of the district court for a de novo review of the denial. (St.2014, c. 284, § 15, eff. Jan. 1, 2015.)

Massachusetts will continue to require urinalysis or other proven reliable forms of testing, including both periodic and random testing. This will be required of an individual before, during, and upon release from a residential substance abuse treatment program if the individual remains in the custody of the state. It is estimated that close to, if not more than 1,000 individuals have been tested for the use of illegal substances during the last calendar year.

Since 1996, EOPSS has worked closely with the DOC and local county sheriffs' departments to coordinate the design and implementation of the RSAT program and ensure aftercare is provided. The programs work collaboratively with the substance abuse treatment services provided by the Department of Public Health (DPH) and the Department of Mental Health (DMH). DPH utilizes approximately $250,000 to fund substance abuse counselors who provide services at each of the eight regional prisoner reentry centers in the Commonwealth.

EOPSS gives preference to applicants who provide aftercare services to program participants. Aftercare services must involve coordination between the correctional treatment program and other social service and rehabilitation programs, such as education and job training, parole supervision, halfway houses, self-help and peer group programs. State correctional and local substance abuse treatment programs are encouraged to work together to place program participants in residential correctional facilities that meet the RSAT Program's primary requirements.

The Bureau of Substance Abuse Services (BSAS) of the Massachusetts DPH has a long history of providing services to the Massachusetts criminal justice system through its continuum of care, which includes outpatient services, medication assisted treatment, and residential services. The criminal justice system includes the courts, probation, parole, DOC, and the county sheriffs' departments. The Governor's Interagency Council on Substance Abuse and Prevention has included criminal justice as one of the focus areas: Focus Area VII - Strengthen Collaborations and Increase the Integration of Substance Use and Addiction Services within the Criminal Justice System.

Correctional facilities continue to work collaboratively with recovery homes to provide aftercare services. The Houses of Correction collaborate with DPH in providing residential substance abuse treatment beds. Through this collaboration, the HOC have access to treatment beds in the community specifically for offenders being released from state and local correctional facilities. Substance abuse treatment, residential, and case management services comprise the continuum

of care, and are designed to address the specialized needs of participants. Several years ago, BSAS awarded residential program contracts for capacity expansion to target post-release criminal offenders, which, over the years, facilitated the enrollment of post-release criminal offenders. As a result of this expansion effort, liaisons from DPH assisted in building relationships between the HOC and residential providers that have resulted in a process at the local level to address communication problems that may arise. Correctional facilities continue to work with recovery homes to simplify the admission screening process.

In addition, training has been provided by BSAS to the sheriffs' departments and treatment providers to maintain and upgrade their skills in serving the target population. The focus of reintegration services is placed on post-release housing needs, employment plans, healthcare, and treatment services, as well as with completing referrals to appropriate agencies and services. Therefore, it is during the reintegration services stage that the out-reach work to community based substance abuse treatment programs occurs. Counselors make referrals and placements to the extent services are available.

The Barnstable County Sheriff's Department treatment staff work with probation and parole to provide aftercare services. Collaborations with off-Cape Cod facilities have been established, allowing more options for reintegration services, including housing and mental health care. Bristol County RSAT staffers conduct reentry groups for RSAT participants that address the many issues associated with returning to the community. The staff members meet with each participant to make appropriate referrals to agencies in the community. The referrals focus on every aspect of reintegration. In addition, a facilitator conducts the eight-week "Success After Prison Job Skills" course.

Essex County's aftercare referrals are an integral part of their RSAT program. Continuing to do outreach and establish relationships within community-based agencies is ongoing, including ties with groups in southern New Hampshire for housing, substance abuse treatment, and counseling for RSAT graduates. Hampshire County provides aftercare assistance with housing, employment, and counseling services. Berkshire County has excellent aftercare services including placement in sober homes and residential programs after release, the tracking of ex-offenders, and collaboration with parole officers. Norfolk County has also placed great emphasis on aftercare services. As part of their discharge planning, inmates are provided assistance with outpatient counseling services and assistance with housing. Plymouth County has strengthened its aftercare component and is continuing to increase relationships within the community, including housing and counseling services.

A Second Chance Act Mentoring grant is being implemented at the Massachusetts DOC by Spectrum Health Systems, the RSAT substance abuse treatment provider for DOC. The Massachusetts DMH applied for Second Chance funding and is implementing the program at the Hampden County Sheriff's Office.

The above described Second Chance projects are coordinated with the substance abuse treatment services for RSAT inmates. They provide resources to support a continuum of care for offenders and include evidenced-based educational programming and substance abuse treatment, enhanced job readiness and work experiences, and individualized transition plans. These projects

complement the RSAT services and support and enhance the coordination of aftercare programming for RSAT offenders returning to the community.

As part of the discharge planning process within DOC, every eligible inmate who is releasing to a city in Massachusetts has a MassHealth application submitted by their assigned Correctional Program Officer, which is currently initiated at 120 days prior to release. Inmates who are considered not eligible include those with immigration issues, are already receiving MassHealth benefits, have coverage under another plan, are ineligible due to high income, are living out of state, or are refusing to participate.

Within the local sheriffs' departments, the sentenced population is screened at intake (within 10 days of booking) to assess whether or not the inmate had insurance prior to incarceration, and if so, the type. For those inmates with longer stays, insurance status is re-assessed 90 days prior to expected release, and staff helps all uninsured inmates submit applications for benefits at that time. For those inmates with shorter stays, the uninsured are offered applications immediately, the privately insured are told to contact reentry staff if there is any change of status, and those who arrive with active MassHealth insurance are tracked by reentry staff weekly through the state Virtual Gateway to check for insurance terminations during their incarceration. If an inmate is terminated prior to release, he or she is offered the opportunity to re-apply for benefits.

Offender needs are multi-faceted; most offenders are in need of substance abuse treatment, vocational and educational programming, and cognitive social skills. In addition to the RSAT Grant, other federally funded programs within the DOC support and complement the RSAT program.

c. Capabilities and Competencies

EOPSS OGR remains committed to supporting quality substance abuse treatment programs in state and local correctional facilities, as well as to appropriately directing available resources to ensure that aftercare priorities are met. Kevin Stanton, Deputy Executive Director for OGR has worked for EOPSS for over 19 years and has an extensive background in grants administration and management of evidence based programs in regards to substance use and abuse and will oversee the administration of the RSAT Grant. Deputy Executive Director Stanton also administered the Governor's Safe and Drug Free Schools and Communities Act Award from the U.S. Department of Education.

Since federal fiscal year 1996, the Commonwealth of Massachusetts has received RSAT funding which has enabled Massachusetts to make available substance abuse treatment services within the State's DOC and twelve local county sheriffs' departments. DOC is responsible for inmates committed to the Massachusetts state correctional system via Massachusetts Correction Institution (MCI)-Cedar Junction or MCI-Framingham. They are also responsible for civil commitments to the MASAC for detoxification and substance abuse treatment for a period up to 30 days.

Local county sheriffs' departments are responsible for the administration and management of persons incarcerated in HOC (inmates who are sentenced mostly through the district courts for

lesser crimes with sentences no more than two-and-one-half years in length). Massachusetts has supported substance abuse treatment programs for offenders in both state and county correctional institutions. For the past several years, DOC has continued operating the majority of its substance abuse treatment programs with state funds provided by the Massachusetts Legislature.

The DOC and the following sheriffs' departments are currently operating with RSAT and Byrne Jag Funds through February 28, 2018: Barnstable, Berkshire, Bristol, Essex, Franklin, Hampshire, Middlesex, Norfolk, Plymouth, and Worcester. Barnstable, Berkshire, Middlesex, and Norfolk counties have been recognized for their innovations in RSAT Programming (Massachusetts Jail Consortium). These four programs were selected collectively as a Mentor Host Site for their evidence-based institutional programming. They are also recognized for their first in the nation adoption of medication assisted treatment as a reentry component to both prevent drug overdose deaths, all too common among recently released inmates, as well as to promote successful long term recovery in the community.

d. Plan for Collecting Required Performance Measure Data

The Massachusetts DOC and the local county sheriffs' departments have complied with the reporting requirements of the Performance Measurement Tool (PMT). Consistently, the subgrantees that have received RSAT funds have successfully reported the data that measures the results of their work in the PMT system. EOPSS will once again provide the RSAT program performance measures link to the subgrantees that is provided in the Federal Grant Announcement (https://bjapmt.ojp.gov/help/RSATPerformanceMeasures.pdf).

In addition to the PMT report, OGR requires all RSAT subgrantees to submit quarterly financial and programmatic progress reports. In order to provide guidance and technical assistance to RSAT subgrantees, OGR will conduct a "Go to Meeting" training and coordinate one RSAT roundtable meeting for subgrantees soon after awards are made. Programmatic monitoring and evaluation will include, but not be limited to: on-site visits; program coordination providing guidance and technical assistance to subgrantees; preparing the quarterly PMT and the Grants Management System (GMS) semi-annual reports, and fulfilling all reporting requirements of the Bureau of Justice Assistance.

e. Time/Task Plan

EOPSS is currently funding RSAT programs with an end date of February 28, 2018. The plan is to not have any interruption in current RSAT programming, so based upon the anticipated federal award notification date of September 30, 2017, EOPSS will make a renewal RSAT AGF available by early November, 2017, with a due date of mid-January, 2018. This will provide ample time for applicants to submit their applications and enable EOPSS to make funding decisions by mid-February, 2018. Sub grantees will be able to continue their current programming on March 1, 2018, upon the expiration of the current award on February 28, 2018, without any interruption.