HARVARD

IOP

Involuntary Commitment for Substance Abuse Treatment in Massachusetts

Problems and Proposed Solutions

POLICY BRIEF

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Executive Summary

Rising rates of substance abuse in Massachusetts have created a demand for innovative policies that increase treatment access and further prevention. Working in conjunction with the Committee on Substance Abuse Treatment under Senator John Keenan, we aimed at evaluating the current state of Section 35 and proposing solutions for expanding drug abuse treatment within the state.

Massachusetts currently ranks in the top ten for several categories of drug abuse. The burden of addiction illnesses falls primarily within the 18-25 demographic although rates are rising across the board. Despite ranking in the top 6 nationwide for substance abuse treatment accessibility, there is much improvement to be made. This is evidenced by our research that demonstrates the current abuse of the court system as a means of getting drug abuse treatment. Enacted in 1970 as a mechanism for forcing incompliant individuals to receive addiction help, Section 35 has now become a glaring symptom of healthcare funding and access issues. In this paper, we dissect some these general health trends, provide research on the current initiatives in place to expand treatment, list key issues with the current involuntary commitment system, and then proceed to delineate key steps to be taken by the state.

The four primary problems we identified with the current practice of Section 35 are as follows: 1) overuse of the court system due to lack of alternative treatment options, 2) capacity issues with MATC and FATC and increasing rates of civilly committed individuals at correctional facilities, 3) a lack of rigorous standards for judging long-term effectiveness, 4) and a gaping holes in the data collection process.

In response to these issues, we propose four recommendations that seek to alleviate some of the current burdens being placed upon the court system and also strengthen resources dedicated towards drug abuse prevention:

- Increase funding for initiatives targeting the 18-25 year old demographic
- Expand funding for community-based substance abuse prevention programs
- Match patients to treatment facilities that suit their needs
- Transfer Patients from Correctional Facilities to appropriate treatment centers: It may be more cost effective to set-up a transfer program in which patients can receive more optimal care.
- Expand Data Collection Process and Communications

I. Introduction

Part 1: Purpose of the Law

Section 35 of Chapter 123 of the Massachusetts General Laws, enacted in its current form in 1970, provides a mechanism for a family member, police officer, physician, or court official to petition for a person to be involuntarily committed for substance abuse treatment. If the court approves the petition, the person is sent to the Women's Addiction Treatment Center in New Bedford or the Men's Addiction Treatment Center in Brockton, for a maximum of 90 days. If there are no beds in the treatment centers, the person is sent to complete treatment in a correctional institution. ("Section 35 FAQ," 2014)

Part 2: Court Process Leading to Commitment

Petitions can be filed by a police officer, physician, court official, or relative of the patient. The relative must be a spouse, guardian, or blood relative. After a petition is filed, the court must decide whether to issue an order of commitment. If the court does issue the order, the person will be issued a summons - a written notice delivered to the person - or a warrant of apprehension. A warrant can only be issued during court hours; if it is, the person will be picked up by the police, handcuffed, taken to court, and put in a holding cell to await the hearing. The court will review the results of an examination by a forensic psychiatrist or psychologist, as well as any other evidence pertaining to the case. The person has the right to a lawyer to present her/his case. The court will issue an order of commitment if there is a medical diagnosis of alcohol or substance abuse, and there is a likelihood of serious harm to the patient or others as a result of this addiction. The patient will then be sent to the appropriate treatment facility, where they undergo detoxification and receive subsequent rehabilitation counseling. ("Section 35 FAQ," 2014)

In fiscal year 2013, there were 7,259 new filings under Section 35, with 30.8% for alcohol abuse and 69.2% for drug abuse (Trial Court Testimony, 2014).

II. Treatment Facilities

Part 1: Available Facilities for Women

Women's Addiction Treatment Center, New Bedford (WATC): WATC is a treatment center specifically for women who have been civilly committed for substance abuse treatment; it is the primary treatment center for women committed under Section 35. Available services include a detoxification unit, clinical stabilization services, and transitional support services. The detoxification unit includes 24-hour monitoring by doctors, nurses, counselors, and case managers; treatment during this stage includes counseling, family support and

education, and helping the patient develop plans for her life after treatment. Clinical stabilization at Tranquility Inn also includes 24-hour patient support, as well as a twelve-step education program that consists of individual/group counseling, lectures, and opioid overdose prevention workshops that focus on relapse and coping. This stage of the process can vary in length depending on a patient's needs. The final stage in treatment at WATC is transitional support services. The facility helps patients find housing, if needed, and provide case management to assist with goal development and family unification (Women's Addiction Treatment Center (WATC) Section 35 Facility," 2010)

Massachusetts Correctional Institution (MCI), Framingham: Women who are civilly committed for substance abuse treatment are sent to MCI Framingham if there is no room at WATC. MCI-Framingham is a medium security correctional facility for female offenders, and the Massachusetts Department of Correction's only committing institution for female offenders. The facility houses women at various classification levels, including state sentenced and county offenders, and inmates awaiting trial. ("MCI - Framingham," 2014). There are extensive substance abuse treatment programs available and MCI Framingham. In spite of the diversity of resources available to inmates, however, most of these recovery resources are not available to people who are committed to MCI Framingham under Section 35, as civilly committed individuals are not permitted to interact with criminally committed individuals. (Chisholm, 2013)

Part 2: Available Facilities for Men

Men's Addiction Treatment Center, Brockton (MATC): MATC, formed in 2008, is the substance abuse treatment facility for men, which acts as the equivalent to WATC. The treatment program is very similar, also including detoxification, clinical stabilization, and transitional support. MATC also has a program called Clean And Sober Teens Living Empowered (CASTLE), which provides both short-term services for teens with substance abuse problems and outpatient services in the community. (Men's Addiction Treatment Center (MATC) Section 35 Facility," 2010)

Massachusetts Alcohol and Substance Abuse Center (MASAC): MASAC is a substance abuse treatment facility for men located within MCI Bridgewater. MCI Bridgewater is a minimum-security correctional institution, and it acts as the parallel institution to MCI Framingham for men civilly committed under Section 35. Treatment begins with medical detoxification, and then continues to include case-management services, classes in relapse prevention training, and individual discharge planning for community-based treatment. Programs available at MCI Bridgewater include Christian fellowship-based substance abuse support groups, programs for the education of family and friends of patients, Narcotics Anonymous, and Alcoholics Anonymous. Unlike MCI Framingham, MCI Bridgewater focuses

primarily on substance abuse issues, both for patients who have been civilly committed and those who are in detainment on criminal charges and also have substance abuse problems. ("Massachusetts Alcohol and Substance Abuse Center," 2014)

Part 3: Level 4 Programs

Level 4 Programs exist for patients who are civilly committed for substance abuse treatment, but who have comorbidities that prevent them from being able to receive treatment in a normal facility. Ailments that typically lead someone to receiving Level 4 treatment include CDV, acute liver disease, infectious open sores, or any medical condition that mandates more involved treatment. Patients deemed to be level 4 patients are referred to a more traditional hospital setting where they can receive holistic treatment. Similarly, patients that are simultaneously dealing with mental health problems (e.g. schizophrenia, bipolar disorder, major depressive disorder etc.) are referred to psychiatric units where their co-morbidities can be stabilized.

These comorbidities complicate treatment, making the symptoms generally more severe and resistant to medication. Furthermore, providing adequate care becomes a challenge when facilities are treating patients for illnesses outside of their specialization. ("Section 35 FAQ," 2014). In particular, comorbidities are most common among patients in prison facilities, which have the least comprehensive ability to care for such patients. Comorbidities, particularly mental illnesses, drastically increase the severity of symptoms associated with drug abuse and make providing treatment for these patients much more difficult; thus, it is vitally important that patients who have comorbidities receive treatment at a facility that is prepared to treat them ("Comorbidity: Addiction and Other Mental Illness," 2010)

III. Statewide Trends in Substance Abuse

Part 1: Demographics of People in Substance Abuse Treatment

In fiscal year 2012, there were 105,189 total admissions to substance abuse treatment centers. 2,298 of these cases (2.2%) were adolescents between the ages of twelve and eighteen. 81.2% of people in substance abuse treatment were white, and 7.1% were black, approximately reflecting the relative proportions of these races in the population.

According to a study produced in 2008-2009 by the National Survey on Drug Use and Health, 9.6% of the Massachusetts population had abused drugs or alcohol in the past year or was currently dependent on drugs or alcohol. This percentage was 23.4% among adults between eighteen and twenty-five years old, pointing to a concentration of the problem of drug abuse in that age range. (Treatment Statistics," 2014)

Part 2: Massachusetts Trends in National Context

In 2007-2008, Massachusetts was one of the ten states with the highest rates of drug abuse in several categories. These categories were illicit drug use in the past month among young adults ages 18-25, dependence on illicit drugs among individuals age 12 and over, marijuana use in the past month among adults age 18-25, and dependence on illicit drugs among young adults age 18-25. The rate of drug-related death was also higher than the national average. ("Treatment Statistics," 2014)

IV. Issues with the Current State of the Section 35

Part 1: Overuse of the Court System Due to Lack of Alternative Treatment

Since 2009, more than 23,000 people have been committed for substance abuse treatment in Massachusetts under Section 35, at an average rate of roughly 4,700 commitments per year. Of the 4,700 individuals who are committed each year, around 934 (20%) are self-committed, meaning that they petition the court for their own involuntary commitment. These relatively high rates of voluntary self-commitment are surprising, given that Section 35 was originally intended to provide an involuntary commitment mechanism for patients who were unable or unwilling to seek help on their own. Why so many individuals have chosen to petition the court for their own involuntary commitment is unclear, although a number of plausible motivations have been suggested.

	FY06	FY07	FY08	FY09	FY10	FY11	FY12	FY13
Male	2635	2738	2416	2803	3069	3048	3479	3409
Female	347	1370	1231	1452	1514	1449	1591	1573
Total	2982	4108	3647	4225	4583	4497	5070	4982

Potential Causes First, self-commitment could be a product of a lack of information. Patients who are unaware of the substance abuse treatment opportunities available to them may turn to the court system to find access to treatment. However, it would at seem that information on substance abuse treatment facilities, which is easily searchable online, is easier to find than information about the Section 35 commitment process, which requires both knowledge of the self-commitment "loophole" as well as a potentially lengthy legal process. Since patients who are desperately seeking treatment would be more likely to find information about local treatment facilities than about the Section 35 commitment process, the information shortage hypothesis seems unlikely to fully explain high rates of self-commitment.

Second, high rates of self-commitment could reflect a lack of access to detoxification services. Patients may be aware of nearby substance abuse treatment facilities but may be unable to get access to a bed at one of these facilities, whether as a result of cost issues or simply a shortage of beds. According to the BSAS-funded Massachusetts Substance Abuse Helpline web site, 28 of the 44 non-Section 35 detoxification centers in Massachusetts (64%) accept payments from the Health Safety Net, which pays for medically necessary services for uninsured low-income citizens of Massachusetts, and 35 of the 44 centers (80%) accept MassHealth, now available to all Massachusetts citizens with incomes below 133% of the FPL under the Affordable Care Act. Consequently, it would seem Massachusetts citizens at or near the poverty line should be able to get access to substance abuse treatment at a facility near them. However, while the strong majority of substance abuse facilities in Massachusetts accept either payments from MassHealth, the Health Safety Net, or both, they are often unable to take in an unlimited number of such patients due to both cost issues and a lack of capacity. Therefore, many patients may not be able to find a bed at a treatment facility in their community, and a lack of access to detoxification services seems like a plausible explanation for the rise in rates of self-commitment.

Finally, patients may be pursuing self-commitment voluntarily because they fear they will relapse if they are not legally bound to remain in treatment. Although this explanation could possible explain a few cases each year, it seems unlikely to account for the hundreds of patients participating in the self-commitment process each year.

Policy Concerns Regardless of their underlying cause, rising self-commitment rates represent a policy problem. First, higher numbers of self-commitment petitions have contributed to a backlog in the court system. In FY 2013, there were 7,259 new filings under Section 35, representing an almost 25% increase in petitions over the last three years that an already busy court system was ill equipped to handle. Second, higher rates of self-commitment are a significant factor behind overcrowding at Section 35 facilities. As cases of civil commitment have increased, the MATC, WATC, and DOC facilities have become increasingly over-crowded. At MCI Framingham, for example, the number of commitments related to Section 35 has increased by 131% overall, with a 598% increase for civil-only commitments. Although the facility was designed to have a capacity of 452 beds, MCI Framingham currently houses 672 inmates. Third and finally, patients who commit themselves through Section 35 may not be receiving optimal care. As overcrowding increases, more and more patients are being sent to correctional facilities for treatment. According to a 2004 report from the Criminal Justice Policy Coalition of Massachusetts, the Framingham facility often puts people in jail who have not committed any crimes. According to a program administrator, between July 2002 and July 2003, a total of 50 women past through MCI Framingham before being placed in another detox facility.

Part 2: Civilly Committed Individuals at Correctional Facilities

Because of the increased number of people in Massachusetts who are addicted to opiates, as well as the fact that there are a limited number of beds available at the Addiction Treatment Centers, there has been an increase in the number of civilly committed individuals who are placed into correctional facilities, particularly among women. The number of civilly committed individuals is increasing at a much higher rate than the number of overall Section 35-related individuals (for example, individuals who have been committed for a crime who need accompanying substance abuse treatment). At MCI Framingham, the number of commitments related to Section 35 has increased by 131% overall, with a 598% increase for civil-only commitments. MCI Framingham is generally overcrowded - the design capacity of the facility is 452 beds; as of February 2014, the facility housed 672 inmates. At MCI Bridgewater, there has been a 10% overall increase in commitments related to Section 35, and a 33% increase overall. While MCI Framingham and MASAC provide comprehensive detoxification and substance abuse treatment, it is not ideal that civilly committed individuals are being treated within a correctional facility. (Department of Corrections Testimony, 2014) In addition, MCI Framingham only has programs for rehabilitation after detoxification for women who have been convicted of a crime, and women who are civilly committed cannot participate in these programs because they are not legally allowed to interact with convicted individuals. This occasionally even leads to civilly committed women being charged with minor crimes in order for them to be able to access rehabilitation programs. (Chisholm, 2013)

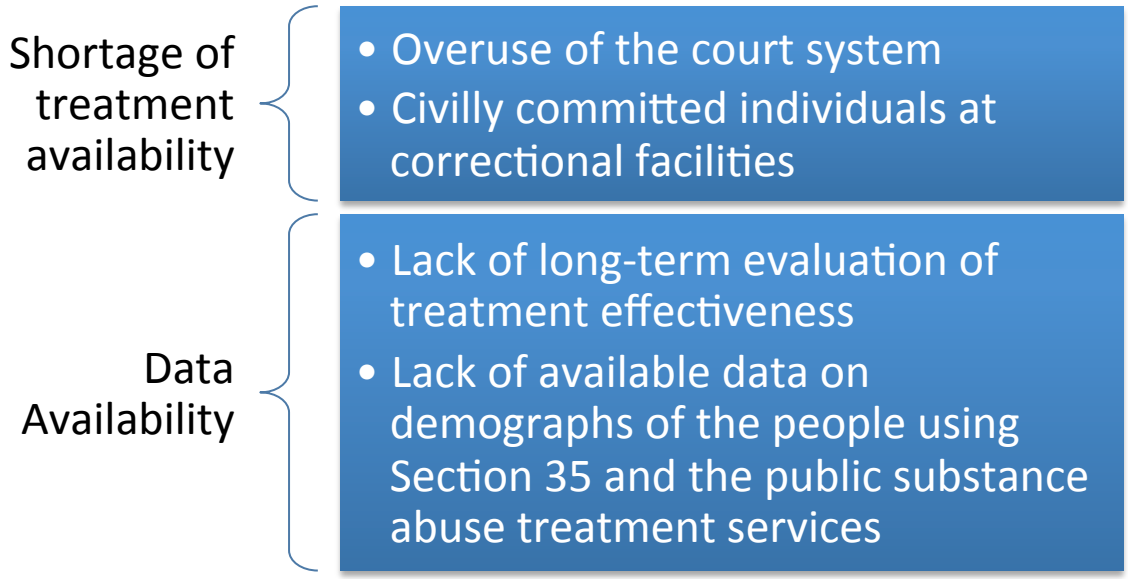
Part 3: Lack of Rigorous Standards for Judging Long-Term Effectiveness

Since patients are not followed individually after detoxification and treatment, there is no way to rigorously determine the effectiveness of the substance abuse treatment that these patients are receiving. Some statistics that are available point to a concerning rate of re-admittance into substance abuse treatment. In fiscal year 2013, there were 1701 admissions to MATC, representing 1570 unduplicated individuals, and 1202 admissions to WATC, representing 1086 unduplicated individuals (Trial Court Testimony, 2014). This means that there were 131 readmissions to MATC and 116 readmissions to WATC, pointing to a need for improvement in the long-term effectiveness of intervention.

Part 4: Data Collection Process and Communications

There seems to be a lack of transparency, or a dearth of valuable data available for evaluating Section 35 and its facilities. From working in conjunction with the committee at the state house, it has become evident that retrieving data from the DPH is a difficult process that often yields unreliable data. For example, according to (Koczela, 2014), opiate addiction in Massachusetts is posited to have been rising, but in reality, the most recent figures date back to

2012. There is also a lack of demographic data about the people using Section 35 and the public substance abuse treatment system, and no way to evaluate whether the long-term outcomes of the patients are related to demographic differences.



V. Existing Programs for Substance Abuse Treatment & Prevention

There are currently several publicly funded programs currently in place to help alleviate the widespread problem of substance abuse in Massachusetts.

BSAS Community Substance Abuse Services

The BSAS (Bureau of Substance Abuse Services) currently funds community substance abuse programs, focusing on community-based prevention programs. They also produce a media campaign that is directed to youth and focuses on prevention of substance abuse and opiate abuse and overdose. There are also publicly funded centers for residential treatment for individuals who have recently stopped using alcohol or drugs and are medically stable, but need assistance recovering from their addiction. These publicly funded centers include Recovery Homes, which provide a structured environment for individuals recovering from addiction; Therapeutic Communities, which also provide structured environment and emphasize allowing residents to take an active role in their own treatment; and Social Model programs, which emphasize a sober living environment, peer counseling, and case management. There are also specialized living centers for women and families, in which a family can remain together while the parent(s) recovers from addiction. ("Substance Abuse Services Descriptions," 2014) These Social Model Recovery Homes are located throughout Massachusetts: there are six total for

men, and seven for women. ("Find a Treatment Center," 2014). There are also Recovery High Schools for youth who are recovering from substance addiction; there are currently four of these high schools, located in Beverly, Brockton, Boston, and Springfield. While Recovery Homes and similar programs are very helpful, they are not suitable for patients who are currently using drugs or alcohol and need medical stabilization during detoxification. ("Substance Abuse Services Descriptions," 2014).

Office of School-Based Health Centers

Introduction The Office of School-Based Health Centers is administered by the Massachusetts Department of Public Health (MDPH) since 1989. School-based health centers (SBHCs) play a critical role in reducing health disparities by providing a consistent source of primary health care in the most accessible environment, the school. It reduces both financial and non-financial barriers to health care, such as lack of insurance, lack of confidentiality, inconvenient office hours and locations, inability of working parents to leave their jobs to get children to care, lack of transportation, and apprehension and discomfort discussing personal problems affecting health. SBHCs are subject to MDPH for licensure. Currently, MDPH funds 17 sponsoring agencies (hospitals, community health centers and local health departments) that operate 34 school-based health centers, which function as satellite outpatient clinics. School-based health centers are staffed by nurse practitioners or physician assistants who are authorized to prescribe medications and are supervised by a medical doctor. They comply with National Standards for Pediatric Preventive Care, such as the American Medical Association's Guidelines for Adolescent Preventive Services (School-Based Health Centers, 2011).

Quality of Standards SBHCs must operate their program every day that the school is in regular session. They must provide mental health and substance abuse prevention and treatment services, either directly through their in-house health care worker or a referral. Behavioral health services include substance use screening, brief interventions, and referral to treatment. If SBHCs refer a student to an outside agency for substance abuse treatment, that agency must be licensed to treat minors for substance abuse. Throughout the process, SBHCs are instructed to cooperate with relevant substance abuse prevention and treatment service providers. In addition to treatment services, SBHCs provide substance abuse prevention services. This includes student assessments of substance abuse prevalence, education regarding prevention and treatment, and counseling (Massachusetts School-Based Health Center Quality Standards, 2014). SBHCs have a vested interest in addressing the issue of substance abuse because the program explicitly aims to decrease dropout rates and disciplinary problems, and it recognizes substance abuse as one of the top risk factors for both (Here for the Kids, 2010).

Drug-Free Community (DFC) Programs

The federal Drug Free Communities Support Program (DFC) was created under the DFC Act of 1997 and offers multi-year (ranging from 5-10 years) grants to fund community-based coalitions dedicated to preventing substance abuse in youths age 18 and under. The DFC program, run by the Substance Abuse and Mental Health Services Administration (SAMHSA), has sponsored around 2,000 coalitions since its inception and currently supports around 9,000 community-based volunteers nationwide. However, the DFC program has specific strategy requirements for coalitions to receive funding -- the group must strive to limit youth substance access, shift consequences associated with youth substance use, and change the cultural context surrounding substance use (Drug Free Communities Support Program, 2014).

Drug-Free Community Programs are excellent resources to leverage upon as policymakers strive towards reducing drug addiction rates in Massachusetts. The main goals of the DFC programs are two-fold:

1) Strengthen ties between communities, agencies and governments for the purpose of drug abuse prevention

2) Reducing rates of substance abuse by directly tackling the societal factors that come into play.

VI. Policy Suggestions and Plans for Investment

Target Funding to Programs that Serve Youth Age 18-25

The Problem The years 18-25 marks a critical period of transition in a person's life. As young adults become independent from their parents and leave secondary school, these years are characterized by uncertainty, sudden changes, and newfound independence. While many move on to college, many do not, and young adults in this age group don't have a sense of community other age groups may have. Consequently, on average this group tends to be risk takers and is skeptical of institutions and cynical about government. For the same reason, this age group is especially vulnerable to alcohol and substance abuse. In fact, this age group consisted 21% of all admissions in 2004, compared to 8% of all admissions for 12-17 year olds (Characteristics of Young Adult and Youth Admissions: 2004, 2006). This age group was also more likely to enter treatment for alcohol abuse than for the abuse of any other substance (Characteristics of Young Adult (Aged 18-25) and Youth (Aged 12-17) Admissions: 2004, 2006). Later data suggests that this trend is continuing: data from year 2008-2009 states that 23.4% of those admitted to substance abuse treatment centers were between the ages of eighteen and twenty-five.

Unfortunately, while this group is especially vulnerable to substance abuse, there is a dearth of resources that target this specific group for treatment. On first glance, the largest factor in this phenomenon is that there is no obvious route to deliver these resources. While for

teenagers, such resources may be delivered via their secondary schools, as not all young adults are enrolled in colleges, college may not seem the most effective way to target these individuals. However, research suggests that admissions based on referrals from schools only accounts for 9% of admissions in the 12-17 year old age group. Rather, the largest source of referral is the criminal justice system (Characteristics of Young Adult and Youth Admissions: 2004, 2006), followed by self-referral. Thus, the school system, including college, may not be the most efficient route to deliver resources, meaning there are many possibilities to consider when devising means of delivery to the 18-25 year old age group.

Programs for Younger Age Groups: Currently, the younger population (12-17) already has some resources allocated for this specific age group. First, Office of School Based Health Centers offer mental health and health care services to students at school. Established in 1989 and administered by the Massachusetts Department of Public Health, the goal of these centers is to keep students healthy and minimize the number of classes missed. Through the program, the disparity in the health care services that children receive can also be minimized. In particular, alcohol abuse in this age group also implicates additional risks such as falling behind in school. Second, the Department of Public Health Substance Abuse Services Directory provides a list of resources that individuals can seek when they deem necessary. However, in its current state, the directory is not very user-friendly and approachable. Thus, making the website more navigable--perhaps even teen-friendly--would appeal to more users. Thirdly, different organizations provide support for teens. For instance, Gavin Foundation provides comprehensive substance abuse treatment services to youth and adults alike. The Gavin Foundation offers both residential programs to assist in recovery and community programs to guide proper immersion. Additionally, through partnerships with schools and through other prevention programs, teens are provided educational resources about avoiding drug and alcohol. Similarly, Inspiration is a teen-only rehabilitation center.

Program Suggestions Additionally, preventative measures that target youth most at risk of developing substance abuse problems must be coupled with curative measures designed to address the unique needs of the most vulnerable demographic, 18-25 year olds. This age group is not only more likely to abuse illicit drugs and alcohol ("The Dasis Report," 2004), they are also at greater "risk for other potentially unhealthy behaviors that frequently co-occur with substance abuse" (Bray, Galvin, & Cluff, 2011).

Moreover, in order to develop initiatives that adequately target 18-25 year olds, it is necessary to describe and address the unique challenges these individuals might face. Specifically, this age group is unique in that individuals are more likely to experience challenges associated with the transition from adolescence to adulthood, which is a period characterized by identity exploration and experimentation (Bray et al., 2011). Emerging adults differ from adolescents and older adults in many ways, including their proclivity to engage in risky behavior (Bray et al., 2011). Other risks unique to this age group include a wider variety and increased intensity of

stressors compared to other periods of life, like low pay, job change, unemployment, and the responsibility of making important life choices (Bray et al., 2011). Research supports the claim that as youth age and encounter more life stressors, they are more likely to initiate illicit drug use (Bray et al., 2011). Therefore, successful interventions for 18-25 year olds should take into account the unique stressors associated with the transition from adolescence to adulthood.

In order to adequately address the specific needs of those in this particular demographic, it is also important to note that young adults encompass a wide range of social groups. Namely, for the purposes of this paper, we shall categorize young adults as belonging to three general groups: those that are employed either full time or part time, those that are unemployed but searching for work, and those attending institutions of higher education.

According to a 2012 national SAMHSA study, 8.0% of full time employed adults above age 18 admitted to using illicit drugs in the past month. 11.6% of adults that are employed part time used illicit drugs. Of those that were unemployed, 18.1% used illicit drugs (US Department of Health and Human Services, 2011). Therefore, we recognize that those that are unemployed are at greater risk of using illicit substances. However, employment does not necessarily eradicate the risk of substance abuse as a significant proportion of employed individuals also admit to drug use. So, it would be feasible and beneficial to design interventions that target employed drug-users, as well as the unemployed.

Furthermore, the same SAMHSA study discussed above reports that the rate of past month alcohol use increased with increasing levels of education. However, the rate of illicit drug use is lowest among college graduates (5.4%) compared to those with some college education (10.4%), high school graduates (8.9%), and those that did not graduate from high school (11.1%) (US Department of Health and Human Services, 2011). In 2011, the rate of current drug use was 22% for full time college students aged 18-22 (US Department of Health and Human Services, 2011). Therefore, interventions designed to curb substance abuse amongst the most vulnerable population, 18-25 year olds, can target those that are employed, those that are unemployed but searching for work, and those that are attending institutions of higher education.

In order to target young adults above age 18, successful interventions should integrate substance abuse prevention programs with places of employment. More generally, successful models of substance abuse prevention amongst working young adults have been shown to share the following characteristics (Bray et al., 2011). Firstly, the intervention should emphasize behavioral modeling and the importance of being self-sufficient. Secondly, the model should address substance abuse prevention in the context of health promotion, as opposed to focusing entirely on the detrimental effects of negative health behaviors. Specifically, instead of emphasizing the dangers of substance use, prevention models should focus on the positive effects of decreasing substance use on overall health. Thirdly, the model should mention that health behaviors are a function of one's level of awareness, personal motivation, and skills. Lastly, the model should illustrate that individuals will avoid substance abuse when the environment provides rewards and social support for positive health behaviors.

Several programs with the above characteristics have been implemented with positive results. PREVENT is a two-day long training program for young workers in the railroad industry, designed to address alcohol and drug abuse, and other challenges facing young adults as they transition to full time work (Bray et al., 2011). The format of the program is founded on the idea that knowledge alone is often unable to modify behavior. Therefore, training is facilitated by group discussions that help participants better understand personal responsibilities, especially regarding alcohol and drug use, stress management, financial management, and more. In addition to substance use, the program also addresses with nutrition and fitness, risky sexual behavior, tobacco use, violence, and financial management (Bray et al., 2011). More generally, the ultimate goal of the program is to "reduce impulsive actions and choices and to act in a way that is more responsible to oneself and others" (Bray et al., 2011). A similar program, Team Resilience, has been implemented for young restaurant workers. Restaurant workers have the highest occupational risk for substance abuse and depression, compared to dozens of other occupations (Bray et al., 2011). Regarding the initial success of these programs,

Investing money in programs similar to PREVENT and Team Resilience might serve to effectively target substance abuse amongst employed young adults by taking into account the unique challenges of emerging adulthood. We recommend that similar programs be designed and implemented in occupations where a significant proportion of employees are adults between 18-25, and the environment or stressors specific to the job place employees at a greater risk of using illicit drugs.

Concerning those that are unemployed but searching for work, there is a dearth of easily accessible resources specific to unemployed drug users. However, we note that those that are searching for work are likely to attend job fairs, seek job search assistance from either privately or publicly funded organizations, or undergo job training. We acknowledge that these spaces might be conducive to putting individuals in contact with easily resources for those that are suffering from substance abuse, but also searching for work. More specifically, we recommend more interaction between such spaces (job training facilities, organizations that provide job search assistance, and job fairs) and organizations that provide resources to deal with substance abuse.

For those that are suffering from drug abuse while attending an institution of higher learning, we recognize that many of these institutions are already equipped with facilities and trained professionals that deal with drug addiction, and any other medical or psychological issues that might accompany it. Therefore, we refrain here from discussing interventions that would address this population.

Expand Programs Focused on Community-Based Interventions

Part 1: Expand Community Funding through Drug Free Communities Programs

Funding local community efforts to fight youth substance abuse has proven to be very successful through the DFC program, as communities funded by DFC have seen significant

reduction in rates of alcohol, marijuana, and tobacco abuse in youth. A 2012 report on the DFC program's progress and outcomes shows a clear decrease in past 30-day substance abuse in high school students, with a 10% decrease in alcohol use, 17% decrease in tobacco abuse, and 4% decrease in marijuana abuse. This noticeable reduction was also observed in middle school students, who saw a 20% decrease in alcohol abuse, 26% decrease in tobacco abuse, and 23% decrease in marijuana abuse. ("National Evaluation of the Drug Free Communities Support Program," 2012)

Since the federal DFC funding program has been so successfully implemented, Massachusetts would do well to encourage and expand this federal program by providing state-level funding for local community coalitions and especially for substance abuse prevention programs (i.e. after-school or mentorship programs), which DFC does not fund. Addressing substance abuse from a grassroots community level may be an effective tool in decreasing its prevalence, since this approach allows for a specific and targeted response to the problem.

Part 2: Use DFC Programs as Educational Platforms

Programs set up with Drug Free Communities funding can also be used as educational platforms to inform patients of the treatment options that are available to them. By being directly involved in the communities that they serve, these programs could reach a wide audience of people who are in need of substance abuse treatment.

Match Patients to Treatment Facilities that Suit Their Needs

If a patient is committed to substance abuse treatment under Section 35, the Bureau of Substance Abuse Services (rather than the judge who committed the patient) should be able to assign the patient to a specific treatment facility that matches the patient's individual needs. For example, a patient who has committed himself or herself and is thus voluntarily seeking treatment likely does not need to be treated in a high-security facility. In addition, this would provide an opportunity for the Bureau of Substance Abuse Services to match patients with either public or non-public treatment facilities based on the patient's location and insurance status. This would allow patients to be treated at facilities that are located closer to the patient's home, as well as allow patients with sufficient health insurance to be treated at facilities that took their insurance. In addition to providing better treatment for patients, this process would reduce the financial strain of caring for patients in publicly run facilities and also reduce the overflow of patients at MATC and WATC.

Transfer Patients Out of Department of Corrections Facilities

Furthermore, patients at Department of Corrections Facilities should be transferred to more appropriate facilities as soon as possible. This is especially true for women, who do not have access to necessary services at MCI Framingham. When the Bureau of Substance Abuse

treatment facilities are at capacity, patients should be transferred to a private facility instead, with the state paying the remainder of the cost of treatment that is not covered by the patient's insurance. While this process would require significant state funding, the state currently pays about 37.53% of the cost of treating a patient committed under Section 35, with insurers paying about 54.15% and the facility picking up the remaining 8.32% (BSAS Data, 2014). The proportion of the cost covered by insurance would be similar if the patient was to be transferred to a private facility, so the state would bear about the same proportion of the cost.

Expand data collection process and communications

A coherent and complete set of data is necessary for research and evaluation of substance abuse treatment facilities. Having data that is easily accessible and publicly available would allow for the government to monitor progress on the issue of substance abuse and provide resources for academic researchers and the general public to conduct their own explorations of the data. The types of data that are needed in cases of Section 35 commitment fall into two categories: demographic information on the people who are committed under Section 35, and treatment outcomes for these patients.

Gathering more information about the demographics of patients who are committed under Section 35 would enable us to analyze who is using the law, and how the Bureau of Substance Abuse Services can better extend access to substance abuse treatment. The following list of information would be helpful for every Section 35 claim that is filed.

- Age, race, and income of the individual being committed
- The relationship of the petitioner to the individual being committed
- A list of medical comorbidities and other concerns (e.g. homelessness, domestic violence)
- The outcome of the court case

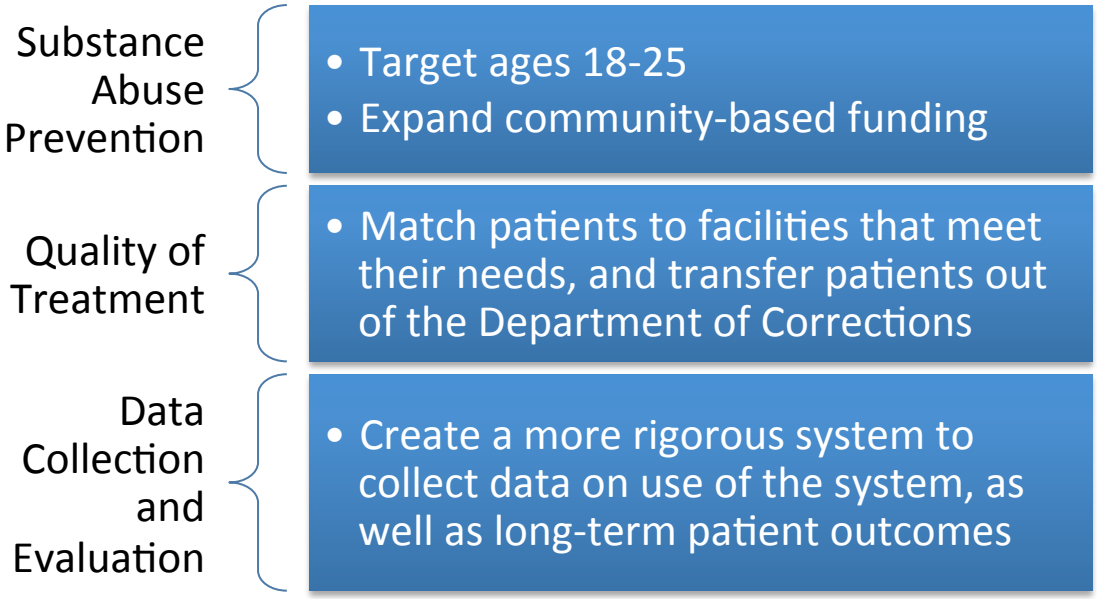
In addition to demographic information about the people using Section 35, it would be useful to have data on the effectiveness of substance abuse treatment for these patients. Upon discharge from the treatment facility, the following information should be collected.

- Whether the patient has stable housing to return to
- The patient's occupation, and whether they will be able to return to their job
- Qualitative data on the individual's perspective on the treatment he/she received
- More importantly, the treatment centers should follow up with the patients after a year, and again after five years, to determine:
- If the patient has relapsed into substance abuse, and whether the patient has had treatment since the initial treatment
- Whether the individual is currently unemployed and/or homeless

Finally, each repeat case of Section 35 petitioning should be carefully documented, and the number of patients who receive treatment multiple times should be noted.

VII. Conclusions

The main issues with the current state of Section 35 implementation is its overuse for cases that do not need to go through the court system at all. This problem reflects a shortage in substance abuse treatment availability, as well as a lack of information among the public about where and how to access substance abuse treatment services. In addition, there is a lack of data available to evaluate the use of the public substance abuse treatment system and the long-term effectiveness of treatment. We present several policy suggestions to help address these issues:



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