



Overview

The Commonwealth has a long history of trying to combat addiction. We began to address the harm of opioids in 2004, when 456 individuals died of an opioid overdose. Since 2004, more than 6,600 members of our community have died, and behind those deaths are thousands of hospital stays, emergency department visits, and unquantifiable human suffering.

We are in the midst of an epidemic. Our response requires a strong partnership between the medical community, law enforcement, the judiciary, insurers, providers, health and human services agencies, elected officials, and the public. Our law enforcement agencies are a critical part of the opioid solution; however, we cannot arrest our way out of this epidemic. These recommendations aim to ensure access to pain medication for individuals with chronic pain while reducing opportunities for individuals to access and use opioids for nonmedical purposes.

The Commonwealth must **build upon** and **accelerate** the prevention, intervention, treatment, and recovery support strategies recommended by prior task forces and commissions and acted upon by the legislature. Equally important, we must implement **BOLD NEW STRATEGIES**. To that end, the working group developed more than 65 actionable recommendations for the administration to consider for implementation.

The challenge is great. Addiction is a complex disease. There are no easy or quick solutions, nothing short of a comprehensive approach to this opioid epidemic will turn the tide of overdose deaths and reduce the harms that opioids are inflicting upon individuals, families and our communities.

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Objective

Produce actionable recommendations to address the opioid epidemic in the Commonwealth

Goals

* Reduce the magnitude and severity of harm related to opioid misuse and addiction
* Decrease opioid overdose deaths in the Commonwealth

To Meet the Objective the

Working Group

* Hosted 4 listening sessions in Boston, Worcester, Greenfield, and Plymouth
* Held 11 in person meetings
* Received and examined documents and recommendations from more than 150 organizations
* Heard from more than 1,100 individuals from across the Commonwealth
* Reviewed academic research, government reports, and reports of previous task forces and commissions

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30 Years of Combatting Addiction in the Commonwealth

**1987**: Commonwealthannounces to halt sending civilly committed women to the correctional facility in Framingham 1

**2004**: Legislature:

Establishes Massachusetts

OxyContin and Other Drug

Abuse Commission6

**2010**: Legislature:Requires practitioners to receive training on:

• Pain management;

• Identifying patients

as high risk for

**2013**: Legislature:

• Requires practitioners to

utilize the PMP prior to

issuing a schedule II or

III drug to a patient for

the first time

**2014**: Legislature:

|  |
| --- |
| • Mandates minimum insurance coverage |
|  | for ATS/CSS – *effective October 1, 2015* |
| • | Requires | pharmacists to dispense |
|  | interchangeable abuse deterrent drugs |
| • | Requires | hospitals to report incidents of |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | **1992**: Commonwealth |  | **2008**: Legislature: |  |
|  |  | establishes the |  | Establishes |  |
|  |  | prescription monitoring |  | commission to |  |
|  |  | program (PMP) |  | investigate the impact |  |
|  |  | **2000**: Legislature: |  | of OxyContin and |  |
|  |  |  | Heroin on state and |  |
|  |  | Mandates parity for |  |  |
| ***1987*** | ***1992*** | ***2004*** | municipal |  |
| behavioral health |  |
| government8 |  |
| treatment4 |  |
|  |  |

substance abuse;

• Counseling patients

about the side

effects, addictive

nature, and proper

storage and disposal

of prescription

medications 11

• Funds expansion of § 35

services 16

|  |  |  |
| --- | --- | --- |
| **2012:** Substance Use | ***2013*** |  |
| Prevention |  |
| Education: A cost |  |
|  |  |

analysis report issued 15

substance exposed newborns

• Requires regulations that mandate

coordination of care and discharge

planning for BSAS licensed facilities 18

**2014:** Findings of the Opioid TaskForce and DPH Recommendations released 19

**1996** **2000**

**2008** **2009 2010** **2011**

**2012** **2014**

**2015**

|  |
| --- |
| ***2006*** |

**1996**: SJC Chief Justice Liacosstates that substance abuse programs prevent crime; estimating that between 85% and 90% percent of criminals have a substance abuse problem3

**2006:** MassachusettsOxyContin and Other Drug Abuse Commission issues report7

**2009**: Legislature:Authorizes recovery high schools 9

**2009**:Recommendations of the OxyContin and Heroin Commission submitted to the legislature10

**2010**: Commonwealthissues Substance Abuse Strategic Plan2

**2011:** DPH issuesreport on Alcohol & Drug Free Housing12

**2011**: Legislature:

* Reforms §35 civil commitment statute, increasing the maximum time that a person may be held from 30 days to 90 days
* Funds expansion of §35 services13

**2012:** Legislature:Reforms prescribing practices, requiring:

* Automatic enrollment into the PMP for practitioners
* Tamper resistant prescription forms
* Dissemination of educational materials when a pharmacist dispenses a schedule II or III drug
* Prescription lock boxes be sold at pharmacies14

|  |  |  |
| --- | --- | --- |
| **February 2015:** | **June 2015:** |  |
| Governor Baker |  |
| Working group |  |
| appoints opioid |  |
| submits |  |
| working group20 |  |
| recommendations21 |  |
|  |  |

**2014**: Legislature:

* Establishes trust fund to increase access to treatment
* Requires BSAS to establish a helpline and website for consumers to be informed of available treatment
* Authorizes pharmacists to dispense Narcan (naloxone)
* Requires DPH to certify Alcohol and Drug Free Homes that meet specific guidelines17

*Sources listed in Appendix A*

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|  |
| --- |
| ***Number of deaths*** |

**Opioid-Related Deaths, Unintentional/Undetermined**

**Massachusetts: 2000-2014**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 1,200 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Confirmed |  |  | Estimated |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 1,000 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 800 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 668 |  |  | 888 |  |  |  |  |  |  |  |
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| 600 |  |  |  |  |  |  |  |  |  |  |  |  |  | 615 | 614 |  |  |  |  | 599 |  |  | 603 |  |  |  |  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  | 549 |  |  |  |  |  |  |  |  |  |  | 561 |  |  |  |  |  |  |  |  |  |  | 600 |  |  |  |
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|  |  |  | 468 |  |  |  |  | 456 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 400 |  |  | 429 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 200 |  | 338 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 2000 | 2001 | 2002 | 2003 | 2004 | 2005 |  | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |  |  | 2013 |  |  | 2014 |  |  |

MA Department of Public Health Data Brief, April 2015 http://www.mass.gov/eohhs/docs/dph/quality/drugcontrol/county-level-pmp/data-brief-apr-2015-overdose-county.pdf

5



MA Department of Public Health Data, February 2015

6



The Working Group’s KEY STRATEGIES:

1. Create new pathways to treatment

Too many individuals seeking treatment utilize acute treatment services (ATS) as their entry point, even when a less acute level of treatment may be appropriate. By creating new entry points to treatment and directing individuals to the appropriate level of care, capacity will be managed more efficiently and the Commonwealth will be better able to meet the demand for treatment.

1. Increase access to medication-assisted treatment

Medication-assisted treatment for opioid use disorder (e.g. methadone, buprenorphine, naltrexone) has been shown to reduce illicit opioid use, criminal activity, and opioid overdose death. Increasing capacity for long-term outpatient treatment using medications as well as incorporating their use into the correctional health system, can be a life-saving intervention.

1. Utilize data to identify hot spots and deploy appropriate resources

By the time DPH receives overdose death data from the medical examiner, the data is stale. The Commonwealth should partner with law enforcement and emergency medical services to obtain up-to-date overdose data, which can be used to identify hot spots in a timely manner and allocate resources accordingly.

1. Acknowledge addiction as a chronic medical condition

Primary care practitioners must screen for and treat addiction in the same way they screen for and treat diabetes or high blood pressure. This will expedite the process for timely interventions and referrals to treatment.

1. Reduce the stigma of substance use disorders

The stigma associated with a substance use disorder (SUD) is a barrier to individuals seeking help and contributes to: the poor mental and physical health of individuals with a SUD; non-completion of substance use treatment; higher rates of recidivism; delayed recovery and reintegration processes; and increased involvement in risky behavior.

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The Working Group’s KEY STRATEGIES:

1. Support substance use prevention education in schools

Early use of drugs increases a youth’s chances of developing addiction. Investing in the prevention of youth’s first use is critical to reducing opioid overdose deaths and rates of addiction.

1. Require all practitioners to receive training about addiction and safe prescribing practices

Opioids are medications with significant risks; however, safer opioid prescribing practices can be accomplished through education.

1. Improve the prescription monitoring program

The Commonwealth’s prescription monitoring program (PMP) is an essential tool to identify sources of prescription drug diversion. By improving the ease of use of the PMP and enhancing its capabilities, it will no longer be an underutilized resource.

1. Require manufacturers and pharmacies to dispose of unused prescription medication

Reducing access to opioids that are no longer needed for a medical purpose will reduce opportunities for misuse.

10. Acknowledge that punishment is not the appropriate response to a substance use disorder

Arrest and incarceration is not the solution to a substance use disorder. When substance use is an underlying factor for

criminal behavior, the use of specialty drug courts are effective in reducing crime, saving money, and promoting retention in drug treatment. It is important that treatment occur in a clinical environment, not a correctional setting, especially for patients committed civilly under section 35 of chapter 123 of the General Laws.

11. Increase distribution of Naloxone to prevent overdose deaths

Naloxone saves lives. It should be widely distributed to individuals who use opioids as well as individuals who are likely to witness an overdose.

12. Eliminate insurance barriers to treatment

Removing fail first requirements and certain prior authorization practices will improve access to treatment. By enforcing parity laws, the Commonwealth can ensure individuals have access to behavioral health services.

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In order to reduce opioid deaths, the Commonwealth must use all the tools in the toolkit

 Prevention

* School based prevention education
* Parent education about signs of addiction
* Community coalition initiatives
* Local drug-free school initiatives
* Prescriber and patient education
* Drug take-back programs
* Public awareness

 Treatment

* Continuum of treatment from acute inpatient services to outpatient services
* Civil commitment: court-ordered SUD treatment
* Medication assisted treatment
* Outpatient counseling
* Emergency services
* Central database of treatment resources

 Intervention

* Evidence-based screening for risk behaviors and appropriate intervention methods
* Prescription monitoring program
* Civil commitment
* Utilization of data to identify hot spots
* Access to naloxone
* Recovery coaches in Emergency Departments

 Recovery Support

* Residential rehabilitation programs
* Alcohol and drug free housing
* Family and peer support
* Recovery high schools
* Resource navigators and case management

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FINDINGS AND

RECOMMENDATIONS

\*\*Recommendations appearing in red are included in the Governor’s action plan

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The Working Group’s Findings:

|  |  |  |
| --- | --- | --- |
| 1. | Individuals in crisis cannot access the right level of treatment at the right time | 12 |
| 2. | Youth drug use and addiction trends must be addressed through prevention education | 18 |
| 3. | Pregnant women and mothers with a substance use disorder need specialized care | 21 |
| 4. | Opioid medications must be safely managed by prescribers, pharmacists, and patients | 23 |
| 5. | The stigma associated with a substance use disorder is a barrier to treatment and recovery | 28 |
| 6. | Lack of transparency and accountability hinder our ability to respond to the opioid crisis | 29 |
| 7. | Courts and Jails should not be the primary mode of accessing long-term treatment | 30 |
| 8. | Recovery resources are insufficient and difficult to access | 31 |
| 9. | Increasing access to Naloxone will save lives | 32 |
| 10. | Insurance barriers prevent individuals from receiving treatment | 33 |
| 11. | The opioid crisis is a national issue that requires both state and federal solutions | 34 |
|  |  |  |

11



**The Commonwealth must realign the treatment system to reflect the nature of opioid use disorder as a chronic disease to allow for multiple entry points to treatment**

*Revised figure from Center for Health Information and Analysis, Report: Access to substance use disorder treatment in Massachusetts, 2015*

*Finding 1: Individuals in crisis cannot access the right level of treatment at the right time*

12

Focusing on patient care can increase access without having to

Recidivism Rates of Individuals receiving Acute Treatment Services (ATS) in a **Single Year**



add beds

In 2014, **4,524 individuals** utilized

ATS services 3 or more times

Two individuals utilized ATS services

**23 times**

In 2014, if these individuals had received ongoing treatment, at least

**16,000 additional** individuals couldhave received ATS services

* 7

7

6

5

4

3

2

1

464

377

337

224

183

152

328

276

295

542

498

488

1,014

861

812

1,952

1,688

1,696

 2014

 2013

 2012

4,322

4,104

3,805

13,957

13,703

13,028

Data from DPH licensed ATS providers

*Finding 1: Individuals in crisis cannot access the right level of treatment at the right time*

13



Number of Adult Treatment Beds & Licensed Programs for a Substance Use Disorder

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Acute | Section 35: | Clinical | Section 35: | Transitional |  |  | Opioid |  |  |
|  | Acute | Clinical |  | Outpatient | Outpatient |  |
| County | Treatment | Stabilization | Support | Residential | Treatment |  |
| Service Beds | Treatment | Service Beds | Stabilization | Service Beds | Beds | Detox | Programs | Counseling |  |
|  | Service Beds | Service Beds | Programs | Programs |  |
|  | (ATS) | (ATS) | (CSS) | (CSS) | (TSS) |  |  | (Methadone) |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| Barnstable | 35 | 0 | 55 | 0 | 0 | 61 | 1 | 1 | 2 |  |
| Berkshire | 21 | 0 | 13 | 0 | 0 | 24 | 0 | 2 | 2 |  |
| Bristol | 52 | 24 | 30 | 66 | 80 | 333 | 0 | 5 | 8 |  |
| Dukes | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |  |
| Essex | 86 | 0 | 23 | 0 | 25 | 137 | 0 | 7 | 15 |  |
| Franklin | 0 | 0 | 0 | 0 | 0 | 70 | 0 | 1 | 2 |  |
| Hampden | 60 | 0 | 30 | 0 | 27 | 224 | 0 | 4 | 11 |  |
| Hampshire | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 |  |
| Middlesex | 79 | 40\* | 0 | 0 | 0 | 347 | 0 | 5 | 23 |  |
| Nantucket | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |  |
| Norfolk | 75 | 0 | 62 | 0 | 60 | 52 | 0 | 0 | 5 |  |
| Plymouth | 89 | 132\*\* | 64 | 76 | 0 | 43 | 0 | 3 | 6 |  |
| Suffolk | 188 | 0 | 22 | 0 | 80 | 690 | 0 | 6 | 30 |  |
| Worcester | 207 | 0 | 30 | 0 | 72 | 377 | 1 | 5 | 15 |  |
| Total | **892** | **196** | **329** | **142** | **344** | **2358** | **2** | **40** | **122** |  |

Bed & Program data, May 2015 \*MCI Framingham has 40 infirmary beds, 12 designated as detoxification beds, for its entire population \*\*Department of Correction beds included

*Finding 1: Individuals in crisis cannot access the right level of treatment at the right time*

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* 61 of the 122 adult outpatient counseling programs in the Commonwealth treat adolescent patients
* There are 4 recovery high schools in the Commonwealth, with 1 additional planned in Worcester

Number of Licensed Youth & Family Treatment Beds



|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Family | Adolescent | Transitional | Youth |  |
|  | Aged Youth |  |
|  | Residential | Residential | Stabilization |  |
| County | Residential |  |
| (# of Families | Beds | Beds |  |
|  | Beds |  |
|  | Served) | (13-17) | (ATS/CSS) |  |
|  | (16-21) |  |
|  |  |  |  |  |
| Barnstable | **13** | 0 | 0 | 0 |  |
| Berkshire | 0 | 0 | 0 | 0 |  |
| Bristol | 0 | 0 | 0 | 0 |  |
| Dukes | 0 | 0 | 0 | 0 |  |
| Essex | 0 | **15** | 0 | 0 |  |
| Franklin | 0 | 0 | 0 | 0 |  |
| Hampden | 0 | **16** | 0 | 0 |  |
| Hampshire | **14** | 0 | 0 | 0 |  |
| Middlesex | **37** | **26** | 0 | 0 |  |
| Nantucket | 0 | 0 | 0 | 0 |  |
| Norfolk | 0 | 0 | 0 | 0 |  |
| Plymouth | 0 | 0 | 0 | **24** |  |
| Suffolk | **34** | **15** | **30** | 0 |  |
| Worcester | **12** | **33** | 0 | **24** |  |
| Total | **110** | **105** | **30** | **48** |  |
|  |  |  | Bed & Program data from May, 2015 |  |

*Finding 1: Individuals in crisis cannot access the right level of treatment at the right time*

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Recommendations Related to Treatment

* Realign Treatment System to Reflect Nature of Opioid Use Disorder as a Chronic Disease with Periods of Acute Needs and Periods of Stability
	+ Increase points of entry to treatment, eliminating the need for individuals to access other levels of care only through acute treatment services (ATS) and clinical stabilization services (CSS)
	+ Establish and promote a longitudinally based treatment system and continuum of care
* Increase Treatment Access by Matching Demand and Capacity
	+ Develop a real-time, statewide database of available treatment services, making information available via phone and the internet
	+ Increase the number of post-ATS/CSS beds (transitional support service, residential recovery homes)
	+ Fund patient navigators and case managers to ensure a continuum of care
	+ Pilot a program that provides patients with access to an emergent or urgent addiction assessment by a trained clinician and provides direct referral to the appropriate level of care
	+ Establish revised rates for recovery homes, effective July 1, 2015

*Finding 1: Individuals in crisis cannot access the right level of treatment at the right time*

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Recommendations Related to Treatment

* Increase Access to Evidence-Based Medication-Assisted Treatment
	+ Increase the number of office-based opioid treatment programs and the number of practitioners prescribing buprenorphine and naltrexone
	+ Enforce and strengthen the requirement that all licensed addiction treatment programs accept patients on an opioid agonist therapy
* Promote Integration of Mental Health, Primary Care, and Opioid Treatment
	+ Create a consistent public behavioral health policy by conducting a full review of all DPH and DMH licensing regulations for outpatient primary care clinics, outpatient mental health clinics, and BSAS programs removing all access barriers
	+ Explore state mechanisms to establish opioid treatment programs as Health Homes
	+ Conduct a review of the license renewal process for programs accredited by The Joint Commission or Commission on Accreditation of Rehabilitation Facilities (CARF) and evaluate whether Massachusetts should implement a “deemed status” for BSAS license renewals
	+ Permit clinicians to hold an individual with a substance use disorder involuntarily in order to conduct an assessment of whether release poses a likelihood of serious harm

*Finding 1: Individuals in crisis cannot access the right level of treatment at the right time*

17



Studies demonstrate that youth begin to use alcohol and drugs as early as 10 years old

Addiction is a Developmental Disease

|  |  |
| --- | --- |
| ***age group who*** | ***alcohol*** |
| ***Percentage in each*** | ***begin using*** |

**35%**

**30%**

**25%**

**20%**

**15%**

**10%**

**5%**

**0%**

**Age of First Alcohol Use**

**Age at first Nicotine Use**

**Age of First Cannabis Use**

**5** **10** **15** **20** **25** **30** **35** **40** **45** **50**

**Age**

Source: Li, Ting-Kai, *Alcohol Use, Abuse, and Dependence* , National Institute on Alcohol Abuse and Alcoholism, National Institutes of Health, U.S. Department of Health and Human Services, p.30, *citing* NIAAA National Epidemiologic Survey on Alcohol and Related Conditions, 2003, retrieved from: Retrieved from: www.pitt.edu/~super7/25011-26001/25521.ppt

*Finding 2: Youth drug use and addiction trends must be addressed through prevention education*

18



* Universal evidence-based preventive interventions can effectively and efficiently reduce nonmedical prescription opioid use1
* According to a 2012 National Survey, parents generally do not discuss the dangers of prescription pain relievers with their teens2
* 74% of individuals with a substance use disorder began substance use at the age of 17 or younger; 10.2% initiated use at the age of 11 or younger 1

**2012 National Survey on Parent/Teen Conversations about Substance Misuse2**

|  |  |  |
| --- | --- | --- |
| **Marijuana** | 81% |  |
|  |  |  |  |
| **Alcohol** | 80% |  |
|  |  |  |
|  |  |  |  |
| **Crack/Cocaine** | 30% |  |
|  |  |  |  |
| **Prescription** | 16% |  |
| **Pain Relievers** |  |  |  |
|  |  |  |  |

* 40% of kids who begin drinking at age 15 will become alcoholics, while only 7% of those who begin drinking at age 21 become alcoholics3
* Adolescent males who participate in sports may have greater access to opioid medication, which puts them at greater risk to misuse these controlled substances 4
1. Crowley, D. M., Jones, D. E., Coffman, D. L., & Greenberg, M. T. (2014). Can we build an efficient response to the prescription drug abuse epidemic? Assessing the cost effectiveness of universal prevention. Preventive Medicine, 62, 71-77. doi: 10.1016/j.ypmed.2014.01.029. PMCID: PMC4131945 .
2. 2012 Partnership Attitude Tracking Study (2013). MetLife Foundation. Retrieved from: http://www.drugfree.org/newsroom/full-report-and-key-findings-the-2012-partnership-attitude-tracking-study-sponsored-by-metlife-foundation/
3. Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (July 17, 2014). The TEDS Report: Age of Substance Use Initiation among Treatment Admissions Aged 18 to 30. Rockville, MD. Retrieved from: http://www.samhsa.gov/data/sites/default/files/WebFiles\_TEDS\_SR142\_AgeatInit\_07-10-14/TEDS-SR142-AgeatInit-2014.htm
4. Veliz, P, Epstein-Ngo, Q.M., Meier, E., Ross-Durow, P.L., McCabe, S.E., Boyd, C.J., (2014). Painfully obvious: a longitudinal examination of medical use and misuse of opioid medication among adolescent sports participants. J Adolescent Health, 2014 Mar;54(3), 333-40.

*Finding 2: Youth drug use and addiction trends must be addressed through prevention education*

19



Recommendations Related to Youth & Parent Education & Interventions

* Support the implementation of substance use prevention curricula in schools. School districts should have the autonomy to choose the evidence-based curricula and the grade level that it is implemented in their district. Programs must be proven to reduce nonmedical opioid use. Examples of programs include: LifeSkills and All Stars
* Integrate information about the risks of opioid use and misuse into mandatory athletic meetings and trainings for parents, students, and faculty
* Increase the use of screenings in schools to identify at-risk youth for behavioral health issues
* Develop targeted educational materials for school personnel to provide to parents about closely monitoring opioid use if their child is prescribed opioids after an injury, as well as, signs and symptoms of drug and alcohol use
* Partner with state universities that have strong education programs to develop substance use prevention curricula for school districts throughout the Commonwealth
* Require state universities that educate teachers to integrate screening and intervention techniques as well as substance use prevention education into the curriculum

*Finding 2: Youth drug use and addiction trends must be addressed through prevention education*

20



**The Department of Children and Families (DCF) received 2,376 reports of a substance exposed newborn (SEN) between March, 2014 and March, 2015**

A SEN designation is given when 1 or more of the following occurs:

* A positive toxic screen on the newborn;
* A positive toxic screen on the mother during her pregnancy or at delivery;
* A newborn has been diagnosed with Neonatal Abstinence Syndrome (NAS);
* Evidence of withdrawal symptoms from alcohol or drugs on the mother or the baby;
* A newborn shows signs of Fetal Alcohol Syndrome (FAS);
* A newborn tests positive for methadone, buprenorphine (Subutex), or buprenorphine with naloxone (Suboxone); or
* A self report by the mother or a verifiable report from a treatment provider that during pregnancy the mother used illicit drugs.

**SEN reports to DCF**

|  |  |  |
| --- | --- | --- |
| **Mar, 2014** | **133** |  |
| **Apr, 2014** | **142** |  |
| **May, 2014** | **157** |  |
| **Jun, 2014** | **159** |  |
| **Jul, 2014** | **168** |  |
| **Aug, 2014** | **206** |  |
| **Sep, 2014** | **244** |  |
| **Oct, 2014** | **219** |  |
| **Nov, 2014** | **160** |  |
| **Dec, 2014** | **200** |  |
| **Jan, 2015** | **177** |  |
| **Feb, 2015** | **203** |  |
| **Mar, 2015** | **208** |  |
| **Total** | **2,376** |  |

*Finding 3: Pregnant women and mothers with a substance use disorder need specialized care*

21



Recommendations Related to Neonatal Abstinence

Syndrome, Prenatal Care & Neonatal Care

* Outreach to prenatal and postpartum providers to increase training about: screening, intervention, and care for women with a substance use disorder
* Promote early identification and proper treatment, raise awareness of NAS within the public health and medical communities
* Review the costs and benefits of mandating testing for in utero exposure to alcohol and drugs at every birth
* Ensure adequate capacity for pregnant women in the treatment system
* Develop and institute a training program focused on NAS and addiction for Department of Children and Families staff
* Work with health care providers to ensure all infants with NAS are referred to early intervention by the time of hospital discharge
* Partner with early intervention (EI) leadership and developmental experts to study the value of increasing automatic EI eligibility for infants with NAS from one year to two years

*Finding 3: Pregnant women and mothers with a substance use disorder need specialized care*

22



RATES OF OVERDOSE DEATH FROM PRESCRIPTION PAINKILLERS & HEROIN

UNITED STATES, 2000-2013

Hedegaard H, Chen LH, Warner M. Drug-poisoning Deaths Involving Heroin: United States, 2000-2013. NCHS Data Brief. 2015 Mar;(190):1-8.

*Finding 4: Opioid medications must be safely managed by prescribers, pharmacists, and patients*

23

SOURCE, AMONG THOSE AGED 12 OR OLDER, WHO USED PAIN RELIEVERS NONMEDICALLY (2012-2013)

|  |  |  |
| --- | --- | --- |
| **Internet, 0.1%** |  |  |
| **Got from a** | **Other,** |  |
| **drug dealer or** |  |
| **10.8%** |  |
| **stranger, 4.3%** |  |
|  |  |

|  |  |  |
| --- | --- | --- |
| **Prescribed** | **Obtained** |  |
| **free from** |  |
| **by 1 doctor,** | **friend or** |  |
| **21.2%** | **relative,** |  |
|  | **53.0%** |  |

**Bought from a friend or relative, 10.6%**

Source: Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality

SURVEY: REASON FOR PRESCRIPTION



PAINKILLER MISUSE

*% of Massachusetts residents who say each of the following is a* ***major cause*** *of prescription painkiller misuse*

Too easy to buy

prescription painkillers 58% illegally

Painkillers are prescribed

too often or in doses that 50% are bigger than necessary

|  |  |  |
| --- | --- | --- |
| Too easy to get painkillers | 47% |  |
| from those who save pills |  |
|  |  |

Source: Boston Globe and Harvard T.H. Chan School of Public Health, Prescription Painkiller Abuse: Attitudes among Adults in Massachusetts and the United States

*Finding 4: Opioid medications must be safely managed by prescribers, pharmacists, and patients*

24



Enrollment of Providers and Delegates in the MA Online PMP (March, 2015)

* 25% of enrolled prescribers have logged into the PMP and searched for a patient at least 1 time in the past year
* Over 50% of enrolled prescribers have never logged into the system
* 58% of prescribers enrolled in the PMP issued more than 10 Schedule II-V prescriptions during 2014

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | **Estimated** |  | **Total** |  |
|  |  | **Percentage** |  |
|  | **Total** | **Number** |  |
|  | **Enrolled** |  |
|  | **Enrolled** | **Practicing** |  |
|  | **(of** | **Eligible** |  |
|  |  | **in MA** |  |
|  |  | **Providers)** |  |
|  |  |  |  |
| **Practitioners** |  |  |  |  |  |
| **(MD / DO / Dentist** | **25,977** | **34,173** |  | **76%** |  |
| **/ Podiatrist)** |  |  |  |  |  |
| **Mid-Levels** | **2,671** | **8,626** |  | **31%** |  |
| **(APRN / PA)** |  |  |
|  |  |  |  |  |
| **Pharmacists** | **3,521** | **12,000\*** |  | **29%** |  |
| **Total Provider** | **32,169** | **54,799** |  | **51%** |  |
| **Enrollment** |  |  |
|  |  |  |  |  |
| **Delegates** | **139** | **N/A** |  | **N/A** |  |
| **(New Entry)** |  |  |
|  |  |  |  |  |

\* This number represents an estimate of all registered pharmacists that are licensed in MA. Many licensed pharmacists do not work in retail pharmacy settings and are not dispensing controlled substances; therefore, the percentage enrolled for this provider category will be biased on the low side.

*Finding 4: Opioid medications must be safely managed by prescribers, pharmacists, and patients*

25



MASSACHUSETTS DOCTORS DISCUSS THE RISKS OF PRESCRIPTION PAINKILLERS WITH PATIENTS LESS THAN DOCTORS IN OTHER PARTS OF THE COUNTRY

In a 2015 survey, individuals who, in the past 2 years, **HAD** taken a strong prescription painkiller, such as Percocet, OxyContin, or Vicodin that was prescribed by a doctor for more than a few days, were asked the following question:

“Before or while you were taking these strong prescription painkillers, did you and your doctor talk about the risk of prescription painkiller addiction, or haven’t you talked about that?”

Only 36% of Massachusetts residents said “yes”, compared to 61% nationally

Yes

No

*Did your doctor discuss the risks of addiction with you?*

U.S., Mass., 61%

36%

U.S.,

39% Mass.,

61%

Source: Boston Globe and Harvard T.H. Chan School of Public Health, Prescription Painkiller Abuse: Attitudes among Adults in Massachusetts and the United States

*Finding 4: Opioid medications must be safely managed by prescribers, pharmacists, and patients*

26



Recommendations Related to Prescriber & Safe Disposal Practices

* Mandate pain management, safe prescribing training, and addiction training for all prescribers as a condition of licensure (physician assistants, nurses, physicians, dentists, oral surgeons, and veterinarians)
* Allow partial refills across all payers with a one-time co-payment
* Eliminate prescription refills by mail for schedule II medications
* Improve the Prescription Monitoring Program (PMP):
	+ Increase utilization by improving ease of use and expanding abuse alerts from the PMP to prescribers
	+ Ensure data compatibility of the PMP with other states & interface the PMP with electronic health records
	+ Enforce mandatory use of the PMP
	+ Require PMP data to be submitted within 24 hours by pharmacies
	+ Improve data analytics and educate prescribers about how to utilize the information
* Implement electronic prescribing for opioids
* Partner with the medical and provider community to improve and increase educational offerings for prescribers and patients to promote safe prescribing
* Promote awareness and support for alternate pain therapies
* Appoint individuals with expertise in addiction to the medical profession licensing boards
* Develop universal distribution of easy to read materials at pharmacies on the safe use of medications
* Expand and promote drug take-back days and permanent drug take-back locations, financed by pharmacies and manufacturers
* Require practitioners, including dentists, to educate patients on the risks and side effects associated with opioids and document such discussions at the point of prescribing
* Increase screening for substance use at all points of contact in the medical system
* Appoint members to the drug formulary commission established under Chapter 258 of the Acts of 2014

*Finding 4: Opioid medications must be safely managed by prescribers, pharmacists, and patients*

27



The Harms of Stigma Associated with a Substance Use Disorder:

* Stigma is a barrier to individuals seeking help1
* Stigma contributes to the poor mental and physical health of individuals with a SUD2
* Stigma contributes to non-completion of substance use treatment2
* Stigma delays recovery and reintegration processes2
* Stigma increases involvement in risky behavior (e.g. needle sharing) 2

Recommendations Related to Reframing Addiction as a Disease

* Create a public awareness campaign, with messaging that targets various ages, focused on:
	+ Reframing addiction as a medical disease
	+ Promoting medication safety practices
* Promote the Good Samaritan law
* Reduce stigma among medical and treatment professionals 1
1. Kelly, J. F., Wakeman, S. E., & Saitz, R. (2015). Stop Talking ‘Dirty’: Clinicians, Language, and Quality of Care for the Leading Cause of Preventable Death in the United States. The American Journal of Medicine, Vol. 128, Issue 1, 8-9. Retrieved from: http://www.amjmed.com/article/S0002-9343(14)00770-0/pdf.
2. Livingston, J. D., Milne, T., Fang, M. L., & Amari, E. (2012). The effectiveness of interventions for reducing stigma related to substance use disorders: a systematic review. Addiction (Abingdon, England), 107(1), 39–50.

*Finding 5: The stigma associated with a substance use disorder is a barrier to treatment and recovery*

28



Recommendations Related to Enhancing the Utilization of Data to Improve Transparency

* Require and support universal and timely reporting of overdose deaths, through a partnership between the

Department of Public Health, the Attorney General’s Office, the Massachusetts State Police, the District Attorneys, local police departments, emergency medical services, hospitals, and others

* Make EMS overdose data available
* Utilize overdose reports to identify geographical hot spots for targeted intervention and to alert law enforcement, public health entities, community coalitions, and the public
* Create a unified EOHHS privacy policy and implement a process for sharing confidential data

Recommendations Related to Government & Provider Accountability

* Establish a single point of accountability for the Commonwealth, *Director of Addiction and Recovery Policy*
* Enhance provider accountability by requiring treatment programs at all levels (inpatient and outpatient) to report on outcomes
* Incentivize and support providers to develop and test innovative treatment approaches
* Create provider accountability for the successful transition from one level of care to the next and incentivize providers to reduce re-admissions; the current "system" inadvertently "rewards" providers for repeat detoxes and rehabs
* Require the Department of Public Health to advance standards of care by establishing industry benchmarks

*Finding 6: Lack of transparency and accountability hinder our ability to respond to the opioid crisis*

29



Recommendations Related to the Courts

* Increase drug and specialty court capacity
* Increase access to beds for patients who are civilly committed under section 35 of chapter 123 of the General Laws and provide a roster of currently available beds to judges for section 35 commitments
* Review and revise discharge policies for section 35 patients; facilities must be required to follow the law and issue a written determination that release will not result in a likelihood of serious harm when individuals are discharged from the facility
* Improve the continuum of care for patients committed under section 35
* Ensure notification to the Court when a section 35 patient escapes from treatment

Recommendations Related to Policing & Correctional Institutions

* Transfer responsibility for civil commitments from the Department of Corrections to the Executive Office of Health and Human Services
* Suspend, rather than terminate, MassHealth coverage during incarceration
* Partner correctional facilities with community health centers to ensure individuals can access treatment upon release
* Analyze treatment spending in correctional facilities
	+ Inmates should be able to continue medication-assisted treatment while incarcerated
	+ Inmates should be able to begin treatment while incarcerated and be connected to treatment upon release
* Encourage and support alternatives to arrest, making police a partner in obtaining treatment for individuals
* Bulk purchase opioid agonist and naltrexone therapies for county corrections

*Finding 7: Courts and Jails should not be the primary mode of accessing long-term treatment*

30



Recommendations Related to Recovery & Support

* Leverage and increase support for community coalitions to address the opioid crisis
	+ Create an online repository of resources and best practices for community coalitions
	+ Improve statewide coordination and information sharing among coalitions
* Expand peer and family support organizations such as *Learn to Cope*
* Pilot recovery coaches in emergency rooms and hot spots
* Implement a process to certify alcohol and drug free housing to bring accountability and credibility to this recovery support system
* Partner with businesses to remove employment barriers that recovering individuals experience, specifically review regulations related to CORI checks
* Incentivize employers to hire individuals in early recovery
* To improve outcomes for recovery, explore the benefits and costs associated with issuing certificates of recovery

*Finding 8: Recovery resources are insufficient and difficult to access*

31



Recommendations Related to Naloxone

* Investigate the feasibility of having Naloxone in public spaces
* Improve affordability of Naloxone
	+ Through bulk purchasing agreements
	+ By eliminating all copayment requirements
* Encourage Naloxone to be co-prescribed with opioids

|  |  |
| --- | --- |
|  | **Price Per Naloxone “Kit”** |
| **Date** | **2 Naloxone Doses and 2** |
|  | **Atomizers** |
|  |  |
| **November 2007** | $22.98 |
| **March 2008** | $31.55 |
| **January 2009** | $31.87 |
| **September 2009** | $31.49 |
| **June 2011** | $31.77 |
| **March 2012** | $32.35 |
| **May 2012** | $40.56 |
| **January 2014** | $42.82 |
| **July 2014** | $41.69 |
| **November 2014** | $74.06 |
| **May 2015** | $74.06 |
|  |  |

*Finding 9: Increasing access to Naloxone will save lives*

32



Recommendations Related to Insurance

• Require the Division of Insurance to implement

guidance for commercial insurers about the

implementation of chapter 258 of the acts of 2014

prior to October 1, 2015

• Eliminate insurance barriers that impede integration

of addiction and mental health care into the primary

care setting

• Require consistent coverage and prior authorization

practices and policies throughout all MassHealth

programs

• Bring meaning to federal and state behavioral health

2% 11%

2% 12%

**2013**

50%

1% 11%

Opioid Related Deaths

9% in MA by Category of Insurance

 Commercial Insurance

|  |  |  |  |
| --- | --- | --- | --- |
| 14% |  | Medicare |  |
|  |  |
|  |  |
|  |  | Medicare and |  |
|  |  |  |
|  |  |  |
|  |  | MassHealth (Duals) |  |
|  |  | MassHealth |  |
|  |  |  |
|  |  |  |

parity laws through enforcement actions to remove

inappropriate barriers to treatment

• Encourage insurers to support non-opioid pain

therapies

1%

14%

|  |  |  |  |
| --- | --- | --- | --- |
| 6% |  | Health Safety Net |  |
|  |  |
|  |  |
|  |  |  |
|  |  | Other |  |
|  |  |  |
|  |  |  |
|  |  | Unknown/Uninsured |  |

• Prepare a public report on what non-

pharmacological treatments for pain are covered by

all private and public insurers

• Encourage insurers to support recovery coaches for

individuals with a substance use disorder

• Encourage insurers to support new pathways to

treatment

**2014**

54%

|  |  |
| --- | --- |
| 13% | at Time of Death |

Data provided by the Center for Health Information and

Analysis, the Department of Public Health, and MassHealth

*Finding 10: Insurance barriers prevent individuals from receiving treatment*

33



Recommendations Related to Federal-State Partnerships

* Partner with federal leaders to recommend that the American College of Graduate Medical Education adopt requirements for pain management and substance use disorder education for all medical and residency programs (i.e. surgical, pediatrics, internal medicine, family medicine, obstetrics, and gynecology)
* Partner with federal leaders to recommend that the Commission on Dental Accreditation adopt requirements for education on safe opioid prescribing practices for all dental programs
* Partner with federal leaders to recommend that the American Veterinary Medical Association adopt requirements for education on safe opioid prescribing practices for all veterinary programs
* Partner with federal leaders to increase support for substance use prevention, intervention, treatment, and recovery efforts uniquely tailored for our Veterans

*Finding 11: The opioid crisis is a national issue that requires both state and federal solutions*

34



Recommendations Related to Federal-State Partnerships

* Request the Drug Enforcement Agency (DEA) to permit medical residents to prescribe buprenorphine under an institutional DEA registration number, thus allowing residents to learn how to manage patients with an opioid addiction
* Implement nationwide standards for pharmaceutical take back programs
	+ Require manufacturers and pharmacies nationwide to finance the disposal of unused prescription medication
* Change the laws and regulations related to prescribing buprenorphine
	+ Increase the cap - the number of patients a physician can treat - or remove it entirely
	+ Permit nurse practitioners and physician assistants to prescribe buprenorphine
* Facilitate the interoperability of prescription monitoring programs nationwide
* Review 42 CFR Part II to ensure that it facilitates integrated care and the use of electronic health records and does not exacerbate the stigma associated with a substance use disorder
* Request that the Pain Management Question from the HCAHPS not be linked to hospital reimbursement

*Finding 11: The opioid crisis is a national issue that requires both state and federal solutions*

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Summary of Short-Term Action Items (6 months to 1 year)

Prevention Intervention Treatment Recovery

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| • | **Increase educational offerings** | • | **Improve the PMP** | • **Develop a central statewide** |
|  | **for prescribers and patients to** | • | **Outreach to prenatal and** | **database of available treatment** |
|  | **promote safe prescriber** |  | **postpartum providers to** | **services** |
|  | **practices** |  | **increase screening for women** | • **Transfer section 35 civil** |
| • | **Develop targeted educational** |  | **with a substance use disorder** | **commitment responsibility** |
|  | **materials for schools** | • | **Improve reporting of overdose** | **from DOC to EOHHS** |
| • **Appoint members to the drug** |  | **death data** | • **Increase the number of office** |
|  | **formulary commission** | • | **Enhance data transparency,** | **based opioid treatment** |
| • **Integrate information about the** |  | **including EMS data** | **programs** |
|  | **risks of opioid use and misuse** | • | **Encourage naloxone to be co-** | • **Require DOI to issue bulletins** |
|  | **into school athletic programs** |  | **prescribed with opioids** | **on chapter 258 of the Acts of** |
| • | **Conduct a public awareness** | • | **Amend civil commitment** | **2014 prior to Oct. 2015** |
|  | **campaign** |  | **process** | • **Pilot recovery coaches in** |
|  |  | • **Identify hot spots for targeted** | **emergency rooms and hot spots** |
|  |  |  | **intervention, using EMS,** | • **Bulk purchase opioid agonist** |
|  |  |  | **hospital, and police data** | **and naltrexone therapies for** |
|  |  | • **Promote the Good Samaritan** | **correctional facilities** |
|  |  |  | **law** | • **Add 100 new ATS/CSS beds** |
|  |  | • Consider mandating testing for | • **Open Recovery High School in** |
|  |  |  | in utero exposure to alcohol and | **Worcester** |
|  |  |  | drugs at every birth | • Review capacity in the treatment |
|  |  | • | Encourage and support | system for women/families |
|  |  |  | alternatives to arrest | • Analyze treatment spending in |
|  |  | • | Expand availability of Naloxone | correctional facilities |
|  |  |  |  | • Increase the number of |
|  |  |  |  | stepdown beds and services |

* **Promulgate chapter 257 rates for recovery homes effective July 2015**
* **Establish a single point of accountability for addiction and recovery policy at EOHHS**
* **Suspend rather than terminate MassHealth coverage during incarceration**
* **Certify alcohol and drug free housing**
* **Enforce the requirement that BSAS treatment programs accept patients on an opioid agonist therapy**
* Strengthen connections between law enforcement and community providers for individuals upon release
* Explore issuing certificates of recovery
* Review and revise discharge/court notification policies for section 35

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Summary of Mid-Term Action Items (1 year to 3 years)

Prevention

Intervention Treatment Recovery

* **Support substance use prevention curricula in schools**
* **Mandate pain management, safe prescribing and addiction training for all prescribers**
* **Partner with federal government regarding graduate medical education**
* Require manufacturers and pharmacies to dispose of unused prescription medication
* Require prescribers to discuss opioid side effects at point of prescription
* Allow partial refills across all payers
* Eliminate prescription refills by mail for schedule II medications
* Amend the curriculum for teachers as state universities to include training on screening and intervention techniques
* Have state universities develop substance use prevention curricula for schools
* **Improve the PMP to ensure data compatibility with other states**
* **Develop training on neonatal abstinence syndrome and addiction for DCF staff**
* **Improve affordability of Naloxone**
* **Increase access to beds for section 35 patients**
* Implement electronic prescribing for opioids
* Increase screening for substance use at all points of contact in the medical system
* Increase the use of screenings in schools to identify at-risk youth for behavioral health issues
* **Create a consistent public behavioral health policy through licensing reforms**
* **Pilot providing patients with access to an emergent/urgent addiction assessment by a trained clinician and direct referral to the appropriate level of care**
* **Increase points of entry to treatment**
* **Ensure section 35 patients receive a continuum of care**
* Enhance provider accountability by requiring treatment programs to report on outcomes
* Reform purchasing of substance use disorder treatment services
* Require DPH to advance standards of care by establishing industry benchmarks
* Add new non-ATS/CSS treatment beds
* **Fund patient navigators and case managers**
* **Leverage community coalitions to address opioids**
* Ensure all infants with NAS are referred to early intervention by time of hospital discharge
* Increase drug and specialty court capacity
* Expand peer/family support
* Partner with businesses to remove employment barriers that recovering individuals experience

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Summary of Long-Term Action Items (3+ years)

Prevention Intervention Treatment Recovery

* Support alternate pain therapies through commercial and public insurers & prepare a public report on what non-pharmacological treatments for pain are covered by all private and public insurers
* Improve the PMP by interfacing the PMP with electronic health records
* Establish and promote a longitudinally based system of addiction care
* Integrate primary care into substance use treatment programs
* Reduce stigma among medical and treatment professionals

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Opioid Working Group Members

**Marylou Sudders,** Chair, Secretary of the Executive Office of Health and Human Services **Maura Healey,** Attorney General

**George Bell,** General Catalyst Partners

**Monica Bharel, MD, MPH,** Commissioner of the Department of Public Health **Hon. Paula M. Carey,** Chief Justice of the Trial Court

**Bill Carpenter,** Mayor of Brockton

**Alan Ingram, Ed.D.,** Deputy Commissioner of the Department of Elementary and Secondary Education

**Colleen Labelle BSN, RN-BC, CARN,** Boston Medical Center

**Judy Lawler,** Chelsea District Drug Court **Joseph D. McDonald,** Sheriff, Plymouth County **John McGahan,** The Gavin Foundation

**Hon. Rosemary B. Minehan,** Plymouth District Court

**Fred Newton,** Hope House, Inc.

**Robert Roose, MD, MPH,** Sisters of Providence Health System **Cindy Steinberg,** Massachusetts Pain Initiative, U.S. Pain Foundation

**Raymond V. Tamasi,** Gosnold on Cape Cod

**Steve Tolman,** Massachusetts AFL-CIO

**Sarah Wakeman, MD,** Massachusetts General Hospital

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Organizations that Submitted Information to the Working Group

**AdCare Hospital of Worcester, Inc.**

**AIDS Action Committee of Massachusetts, Inc. AIDS Project Worcester**

**Alkermes, Inc. Alosa Foundation**

**American Academy of Addiction Psychiatry American Academy of Pain Management American Round Table to Abolish Homelessness**

**Associated Industries of Massachusetts Mutual Insurance Company**

**Association for Behavioral Healthcare Barnstable County Human Services**

**Barnstable County Sheriff’s Office**

**Baystate Mary Lane Hospital Baystate Wing Hospital**

**Berkshire District Attorney’s Office**

**Berkshire Opioid Abuse Prevention Collaborative Berkshire Public Health Alliance**

**Berkshire Regional Planning Commission**

**Beth Israel Deaconess Hospital – Plymouth Blake Works**

**Blue Cross Blue Shield of Massachusetts**

**Boston Homeless Solidarity Committee Boston Medical Center**

**Boston Municipal Court**

**Boston Public Health Commission**

**Boston University School of Medicine: Continuing Medical Education Program**

**Boston University School of Public Health Boston Warm**

**Boys and Girls Club Massachusetts Alliance**

**Brockton Area Multi-Services, Inc. (BAMSI) Brook Retreat**

**Cambridge Health Alliance**

**Cambridge Needle Exchange**

**Cape and Islands District Attorney’s Office**

**Carlson Recovery Center Casa Esperanza, Inc.**

**Center for Early Relationship Support at Jewish Family &**

**Children’s Service**

**Center for Human Development, Inc.**

**Children’s Mental Health Campaign**

**Christian Service and Outreach Committee Clean Slate Centers**

**Collaborative for Educational Services Commission on the Status of Grandparents Raising**

**Grandchildren**

**Committee for Public Counsel Services Communities United For A Drug Free Environment Community Catalyst**

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Organizations that Submitted Information to the Working Group

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Community Substance Abuse Centers** | **High Point Treatment Center** |  |
|  | **Cordant Health Solutions** | **Holyoke Recovery Support Center** |  |
|  | **Covectra** | **Hope Health / Hope Hospice** |  |
|  | **Coverys** | **Hope House, Inc. – Boston - Residents** |  |
|  | **Education Development Center, Inc.** | **Hyde Park Pain Management** |  |
|  | **Emerson Hospital** | **Imprivata** |  |
|  | **EvansCutler** | **Inflexxion** |  |
|  | **Families Against Mandatory Minimums** | **Institute for Health and Recovery** |  |
|  | **Family Health Center of Worcester** | **Journal of Opioid Management** |  |
|  | **Franklin County Home Care Corporation** | **Learn to Cope** |  |
|  | **Franklin County House of Corrections – Residents** | **Locke Lord, LLP** |  |
|  | **Franklin County Sheriff’s Office** | **Lowell House, Inc.** |  |
|  | **Franklin Regional Council of Governments** | **Main South Alliance for Public Safety** |  |
|  | **Gate House** | **March of Dimes Massachusetts** |  |
|  | **Gosnold on Cape Cod** | **Massachusetts Association of Behavioral Health Systems, Inc.** |  |
|  | **Granada House** | **Massachusetts Association of Health Plans** |  |
|  | **Greenfield Health Center** | **Massachusetts Attorney General’s Office** |  |
|  | **Greenfield Public Schools** | **Massachusetts Behavioral Health Partnership** |  |
|  | **Hampden County Sheriff’s Department** | **Massachusetts Chiropractic Society, Inc.** |  |
|  | **Harvard Pilgrim Health Care** | **Massachusetts Council of Human Service Providers, Inc.** |  |
|  | **Health Care For All** | **Massachusetts Department of Children and Families** |  |
|  | **Health Innovations, Inc.** | **Massachusetts Dept. of Elementary and Secondary Education** |  |
|  | **Healthy Gloucester Collaborative** | **Massachusetts Department of Mental Health** |  |
|  | **Healthy Streets Outreach Program** | **Mass. Dept. of Mental Health: Franklin/North Quabbin Area** |  |
|  | **Heroin Education Awareness Task Force** | **Massachusetts Department of Public Health** |  |
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Organizations that Submitted Information to the Working Group

**Massachusetts Division of Insurance Massachusetts Health Council Massachusetts Hospital Association Massachusetts Medical Society**

**Massachusetts Organization for Addiction Recovery Massachusetts Pain Initiative**

**Mass Society for the Prevention of Cruelty to Children Mass Technical Assistance Partnership for Prevention Massachusetts Trial Court**

**MassHealth**

**MCI-Norfolk Project Youth Program**

**Medford Substance Abuse Task Force**

**Melrose Substance Abuse Prevention Coalition Meridian House**

**Merrimack Valley Prevention and Substance Abuse Project Middlesex County Opioid Task Force**

**Middlesex District Attorney’s Office**

**Monson HEARS**

**Mystic Valley Public Health Coalition’s Opioid Abuse**

**Prevention Collaborative Narcotics Anonymous Never Another Death**

**New Beginnings Peer Recovery Center**

**Norfolk County Sheriff’s Office**

**Norfolk District Attorney’s Office**

**North Adams Mayor’s Office**

**Northern Berkshire Community Coalition**

**Northwestern District Attorney’s Office**

**Number 16**

**Opioid Task Force of Franklin County and North Quabbin Ostiguy School**

**Partnership for Drug-Free Kids Peabody Police Department Pfizer**

**Phoenix Multisport**

**Pioneer Valley Regional School District**

**Plymouth County Correctional Facility Plymouth Fire Department**

**Plymouth Police Department Plymouth Public Schools Project Cope**

**Project NESST (Newborns Exposed to Substances: Support and Therapy)**

**Project Youth**

**Quaboag Hills Community Coalition Quincy Community Action Programs, Inc. Real You Revolution**

**Recovery Homes Collaborative RW Massage Therapy**

**SAS Solutions**

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Organizations that Submitted Information to the Working Group

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|  | **Scituate FACTs** | **Victory Programs, Inc.** |
|  | **SEIU Local 509** | **WellCrest** |
|  | **Shrewsbury High School** | **Wellesley College Health Service** |
|  | **Shilts Chiropractic Offices** | **Western Mass Recovery Learning Community** |
|  | **Somerville Overcoming Addiction** | **Wicked Sober Inc.** |
|  | **South Bay Mental Health** | **Worcester District Attorney’s Office** |
|  | **South Hadley High School** | **Worcester Sheriff’s Office** |
|  | **Spectrum Health Systems, Inc.** |  |
|  | **Square Medical Group** |  |
|  | **State Representative Joseph McKenna, 18th Worcester District** |  |
|  | **State Representative Kay Khan, 11th Middlesex District** |  |
|  | **State Senator Eric Lesser** |  |
|  | **Suffolk County Sheriff’s Office** |  |
|  | **Team Morrison** |  |
|  | **The Alex Foster Foundation** |  |
|  | **The Alliance of Massachusetts YMCA’s** |  |
|  | **The Brien Center** |  |
|  | **The Carson Center for Human Services, Inc.** |  |
|  | **The Herren Project** |  |
|  | **The New Testament Church, Plymouth** |  |
|  | **The Social-Emotional Learning Alliance for Massachusetts** |  |
|  | **(SAM), Inc.** |  |
|  | **Town of Greenfield** |  |
|  | **Tufts Medical Center** |  |
|  | **U.S. Pain Foundation** |  |
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