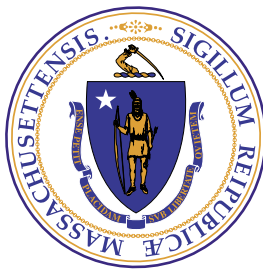




Commonwealth of Massachusetts

*Substance Abuse
Strategic Plan Update
FY 2011 – FY 2016*

July 2010



Commonwealth of Massachusetts
Substance Abuse Strategic Plan
Update: FY 2011 – FY 2016

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Commonwealth of Massachusetts Substance Abuse Strategic Plan Update: FY 2011 – FY 2016

Executive Summary

For the past five years the Commonwealth of Massachusetts has been implementing its 2005 Substance Abuse Strategic Plan.¹ Much has been achieved. Now, in light of that record of accomplishment as well as dramatic changes in the health care, fiscal and policy environments, it is time to update the Plan. This update suggests eight focus areas, including: maximizing interagency collaboration; identifying and addressing disparities throughout the service system; increasing the capacity of communities and other service systems to prevent substance use and addictions while strengthening linkages to needed services; improving access to substance use and addictions screening and services; strengthening the array of recovery oriented services; improving the performance of all components of the substance use and addictions system; strengthening the substance use and addictions workforce and enhancing organizational development; and strengthening collaborations and increasing the integration and availability of substance use and addiction services throughout the criminal justice system. By implementing the strategies outlined within each of these areas, Massachusetts can continue to be a national leader in preventing substance use and addictions and in assuring that individuals with addictions receive coordinated, culturally responsive, recovery oriented prevention, intervention, treatment and support services.

¹ Note on terminology: The term “substance abuse” has been standard in the field for nearly 30 years: federally, the Substance Abuse Block Grant program began in 1982, and the Center for Substance Abuse Treatment was created in 1992. In Massachusetts, the Division of Alcoholism within DPH and the Division of Drug Rehabilitation within DMH merged to become the Bureau of Substance Abuse Services in 1986 and the Governor’s Interagency Council on Substance Abuse and Prevention was created to monitor implementation of the Commonwealth’s 2005 Strategic Plan. The most recent revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) uses the general term “substance-related disorders,” within which it lists “substance dependence” (more severe) and “substance abuse” (less severe). In this report, we will primarily use the phrase “substance use and addictions,” which encompasses the full spectrum of services for unhealthy substance use, substance abuse and addiction – prevention, intervention, treatment and recovery -- and also matches the terminology used in the recently released *Substance Use and Addictions Workforce and Organizational Development Strategic Plan*, DPH, BSAS, Spring 2010.

Message from Lt. Governor Timothy P. Murray, Chair ***Governor's Interagency Council on Substance Abuse and Prevention***

Massachusetts has been implementing a Substance Abuse Strategic Plan originally developed in 2005 by stakeholders representing state and local agencies as well as providers and advocates. Though the Commonwealth has made excellent progress toward many of the goals within that plan, we need to recognize the dramatic changes to our state and national health care systems, fiscal and policy environments, and also the need to readdress strategies outlined in that plan. The Governor's Interagency Council on Substance Abuse and Prevention (ICSAP), which I chair, has partnered with the Massachusetts Department of Public Health's Bureau of Substance Abuse Services (BSAS) to spearhead the work of updating the plan.

Despite improvements made over the past five years, individuals with substance use and addiction problems not only continue to face challenges with treatment and recovery, but also have a major negative impact on the state's health, human service and corrections systems. It is estimated that over 660 thousand individuals of the 1.1 million who are served by state agencies other than the Department of Public Health experience the impact of substance use and addictions.² This includes corrections agencies and courts, as well as agencies concerned with child welfare, mental health, education and others. The Commonwealth must, therefore, find new ways of expanding access to prevention, education, intervention, treatment and recovery support, as well as improving the quality, and enhancing the coordination, of care.

The Substance Abuse Strategic Plan Update is the result of a series of sessions that took place between February 2009 and January 2010. Attendees included stakeholders from all over the state, representing a wide variety of substance use and addictions provider organizations, state agencies, advocates and researchers, as well as stakeholders from the criminal justice system. Additionally, the Governor's ICSAP and the staff of BSAS each met several times to identify needs and potential responses.

On behalf of the Patrick-Murray Administration, we look forward to further addressing the focus areas outlined in the Plan and also developing implementation strategies for each focus area.

Yours truly,



Timothy P. Murray,
Lieutenant Governor

² See Commonwealth of Massachusetts, Substance Abuse Strategic Plan, 2005 at <http://www.mass.gov/Agov3/docs/Substance%20Abuse%20Strategic%20Plan.ppt>

The 2005 Plan has been a Guiding Document

The 2005 Massachusetts Substance Abuse Strategic Plan, which continues to guide the Commonwealth's efforts, put forth a set of six Recommendations, each of which incorporated several specific strategies. The charge of the Governor's Interagency Council on Substance Use and Prevention (ICSAP), under Executive Order 496, is to monitor the implementation of the Plan.

The six Recommendations included:

1. Establishing the Interagency Council on Substance Abuse and Prevention.
2. Enhancing prevention, interdiction, enforcement and intervention.
3. Expanding screening, assessment and referral.
4. Supporting a comprehensive continuum of services for adolescents and adults.
5. Ensuring that services are effective, efficient, well managed and promote recovery.
6. Reducing the high cost of incarceration and recidivism on both the criminal justice and treatment systems by promoting recovery and returning people to productive lives.

Work on each of these recommendations has encouraged further achievements. The ICSAP brings together senior representatives from dozens of state agencies and the Legislature, who have become increasingly aware of the extent to which substance use and addictions impact their work. Through the interagency collaboration the Council facilitates, the Commonwealth has been addressing unmet needs and implementing new prevention and treatment programs. Services are reaching Massachusetts residents of all ages in locations that range from homeless shelters, the streets, community health and resource centers, schools, correctional institutions and doctors' offices to hospital emergency departments and other healthcare settings. Accountability has been increased through implementation of a new data infrastructure and technologies; improvements in licensing and other regulatory processes; and updating of techniques for measuring performance and outcomes. Training and technical assistance are available across the human service, education and criminal justice systems to all those who serve individuals with addictions, including people who are homeless, impoverished, experience mental illness, are in school or are involved with the child welfare or correctional systems. Our collaborative efforts can enable Massachusetts to continue to be a national leader in preventing substance use and addictions and in assuring that individuals with substance use disorders receive coordinated, culturally responsive, recovery oriented prevention, intervention, treatment and support services.

Many of the strategies recommended in the 2005 Strategic Plan have been implemented and are showing positive results:

1. Establishing the Interagency Council on Substance Abuse and Prevention.

The Interagency Council on Substance Abuse and Prevention (ICSAP), created through Executive Order 496 as a result of the 2005 Strategic Plan, is chaired by Lieutenant Governor Timothy P. Murray and staffed by William D. Luzier, Executive Director³. It meets quarterly to provide executive level leadership to implementation of the strategies recommended in the Plan, discussing prioritizing populations and integrating procurement, reporting, planning, and evaluation. The Council's Executive Committee meets between full

³ Members of the Council are listed in Appendix II.

Council meetings. The Council, which consists of the commissioners (or their designees) of the agencies most affected by substance use and addictions, as well as Legislators or their designees, has reviewed and endorsed this Update to the Strategic Plan.

2. Enhancing prevention, enforcement and intervention.

Prevention work has been extensive throughout the past five years. Community needs assessments have identified barriers to behavioral change and led to development of an effective community training model to increase expertise and promote a shared philosophy and approach. Social marketing campaigns conducted through radio spots, theatre and transit ads, 49 town hall meetings, distribution of materials in schools and the Talk about Addiction website (<http://www.talkaboutaddiction.org/>) have reached over three million people in the Commonwealth. The six regional Centers for Healthy Communities have provided training, technical assistance and on-line education and information.

The Investigation and Enforcement Division of the Massachusetts Alcoholic Beverages Control Commission (ABCC) has trained, advised and partnered with several community coalitions in conducting local compliance checks. The Mothers Against Drunk Driving Youth in Action Program and approximately 25 regional community coalitions provide and train the underage individuals who act as decoys. Over the past several years, as the Commission has conducted compliance checks, training and subsequent checks throughout the Commonwealth, focusing on communities with low rates of compliance, the failure rate has consistently declined. In 2009, the Investigation and Enforcement Division conducted Compliance Checks in 125 municipalities across the Commonwealth. They checked 2,044 licensed establishments, of which 109 failed. This represents a success rate of 95 percent, well above the national average of 84 percent, and demonstrates that consistent compliance check enforcement results in a higher success rate.

In 2009, the ABCC's Investigation and Enforcement Division conducted training sessions for 270 Police Departments and 1,081 officers, ensuring that compliance checks are conducted appropriately. In addition, the agency has trained local police departments to educate local and state law enforcement officers in the enforcement of the Massachusetts Liquor Control Act and False Identification and Fraudulent Document detection.

Evidence-based programs such as MassCALL have been expanded and uniform guidelines have been put in place for needs assessment, reporting, outcomes and evaluation of prevention programs. One example of evidence suggesting that ongoing activities are having an impact is that the percentage of youth reporting having had their first drink of alcohol has been reduced from 28 percent in 2001 to 20 percent in 2007.

3. Expanding screening, assessment and referral.

Through the federally funded creation of the Office of Youth and Young Adult Services (OYYAS), a central intake system for youth has been developed that incorporates use of a standard protocol. This system has dramatically reduced hardship for parents and caregivers struggling to find appropriate services. Use of the CRAFFT adolescent screening instrument is being established and all BSAS-funded adolescent providers are being trained in the Global Assessment of Individual Needs (GAIN) tool. Both the CRAFFT and the GAIN are reliable, valid tools that are widely used throughout the country. Screening, Brief Intervention, Referral and Treatment (SBIRT) has been implemented for youth; over 3,000 pediatricians were surveyed regarding current screening practices; and the Pediatric Tool Kit has been developed and distributed to support

screening and referral (http://www.mass.gov/EcoHhs2/docs/dph/substance_abuse/sbirt/crafft_provider_guide.pdf).

A \$2.8 million federal grant has supported SBIRT (MASBIRT) training and implementation in healthcare settings in the Boston area; a Brief Treatment manual has been completed and services were developed at Boston Medical Center and affiliated sites. A total of 32 community health centers and seven emergency departments participated in the BSAS supported SBIRT projects and over 120,000 patients have been screened through Massachusetts' SBIRT initiatives. BSAS has piloted use of the Addiction Severity Index, as well as a Helpline for access to detoxification and other treatment services, and has implemented central intake for Section 35 (involuntary commitment) referrals, and collaborated with DTA on developing family screens.

4. Supporting comprehensive services for adolescents and adults.

A total of 168 new adult clinical stabilization services beds have been procured and opened. Six Recovery Engagement Centers have been implemented, as have 15 Office Based Opioid Treatment (OBOT) programs in Community Health Centers. As of July 2010, OBOT programs have served over 3,000 individuals with opiate addictions. There are also two new secure programs for Section 35 civil commitments; treatment has resulted in the reduction of civil commitments to MCI Framingham and MCI Bridgewater. There has been an expansion of Boston Common Ground for homeless individuals with substance use and addictions problems who are living on the street, as well as expanded case management to help the homeless gain access to residential substance use and addictions treatment. Interdepartmental Service Agreements with Houses of Correction (HoCs) are improving substance use and addictions case management in criminal justice. Through April of 2010, the innovative new Bystander Intra-Nasal Naloxone (Narcan) program enrolled over 6,000 people and led to the reversal of over 650 opioid overdoses. Protocols have been standardized for detoxification and rate increases have been implemented for those programs as well as residential treatment facilities and Transitional Support Services (TSS).

OYYAS, in collaboration with the Interagency Working Group (IWG), has redesigned and re-procured the youth residential system to provide family focused, gender-specific treatment informed by increased mental health clinical expertise. Two new youth detoxification and stabilization centers have been opened, as have three Recovery High Schools. New federal grants and state dollars have funded the development of a family recovery project in Western Massachusetts and eight CASASTART programs, which provide services to keep young teens in school, off drugs and out of trouble with the law. BSAS and the Department of Youth Services (DYS) have collaborated in the development of six CASASTART programs in FY09. Other interagency collaborations include a project with the U.S. Department of Housing and Urban Development to provide housing for homeless 18-24 year olds and expanded services for families living in hotel rooms, funded by the Department of Housing and Community Development.

5. Ensuring that services are effective, efficient, well managed and promote recovery.

Using national performance and evaluation methodologies, including Washington Circle Measures and level of care criteria developed by the American Society of Addiction Medicine (ASAM), the Commonwealth has focused on system improvement through various quality and performance enhancement activities. Massachusetts has been one of only five states in the national Network for Improvement of Addictions Treatment (NIATx) that has emphasized strategies for engaging and retaining people in treatment. Work with

Brandeis University and other experts has involved analyzing integrated data to define outcomes, track progress in treatment, and develop predictive measures. Interagency data sharing efforts (ESM, HMIS) will be dramatically assisted by data system enhancements resulting from single entry of invoices across services and agencies. Outpatient redesign is underway with a focus on training in evidence-based practices and using performance measures in service procurement, supported by active participation in Purchase of Service and Chapter 257 activities. BSAS has achieved a fully staffed licensing unit with revised regulations aimed at improving quality and accountability. Two new physicians are providing medical consultation to the Bureau.

6. Reducing the high cost of incarceration and recidivism on both the criminal justice and treatment systems by promoting recovery and returning people to productive lives.

DYS is engaged in assuring that all youth in the agency's custody are appropriately screened and that those who need treatment receive it. DYS has joined an interagency agreement to increase its residential substance use and addictions treatment capacity.

An interagency review team has standardized Section 35 evaluations and increased Section 35 case management for 18 to 25 year olds. Two new adult drug courts are supported by technical assistance and annual site visits. The corrections system has benefited from funding for substance use and addictions positions in all eight Parole Re-Entry Centers, and funding to 13 Houses of Corrections provides substance use and addictions services to 2,300 admissions per year.

A Substance Abuse Strategic Plan for the Next Five Years

The Changing Environment

The 2005 Plan has altered the state environment by bringing many agencies and disciplines together, reducing the "silos" in which all have typically operated. In addition, the entire health care environment in Massachusetts has changed dramatically over the past few years, and will continue to do so. Health care reform has been implemented in Massachusetts and federal health care legislation has been passed; mental health parity requirements now also cover addiction treatment; an economic downturn has undercut the state's ability to fund services; and the Commonwealth's procurement strategies are in the process of being significantly modified. Together, these dramatic changes are having and will continue to have an impact that will change the role the Commonwealth plays in addressing substance use and addictions among its residents. The now widespread understanding of addiction as a chronic medical condition, along with the evolving healthcare environment, require that careful thought be given to how Massachusetts can best develop a full continuum of prevention, intervention, treatment and recovery supports that are known to be effective.

Health Care Reform and Parity requirements

Massachusetts' landmark 2006 Health Care Reform Law, together with the 2000 Massachusetts Mental Health Parity Act and its recent update, set the stage for numerous changes with regard to how substance use and addictions services are paid for. The 2006 law established a requirement that all residents purchase health insurance, with the result that an estimated 97percent of the population now has some form of coverage.⁴

⁴ "Since the Connector's inception, the state's uninsured rate has dropped from 10.4 percent in 2006 to 2.6 percent in 2008. . ." <http://www.stateline.org/live/details/story?contentId=425028>.

The mental health parity law established, for certain biologically based conditions, coverage without annual or lifetime benefit limits, as well as parity with treatment for physical illnesses with regard to cost sharing. Although the 2000 law only mandated alcoholism and chemical dependency benefits to include 30 days of inpatient treatment and \$500 for outpatient treatment, a revision of the law passed in 2008 expanded coverage so that, as of July 1, 2009, substance use disorders are also parity conditions.

Nationally, private payments for substance abuse treatment fell steadily between 1986 and 2003.⁵ In 1986, public and private payers spent roughly equal amounts, but by 2003 public sources were paying 77 percent of the cost. These payment proportions are expected to shift dramatically in Massachusetts, because individuals are mandated by law to purchase health insurance and many private insurers are required to pay for substance use and addictions treatment on a par with other medical conditions. To cope successfully with these changes, provider organizations and their staffs must be prepared to meet managed care requirements for an increased proportion of the population served.

On the national front, regulations were issued in 2010 for the 2008 Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act. Other changes can also be anticipated, for example: adjustments in the uses of the Substance Abuse Block Grant; the availability of new national insurance plans to Massachusetts residents; mandated coverage of pre-existing conditions; and Medicaid and Medicare benefits that more closely supplement commercial coverage.

Integration with Primary Care

Currently, physical and behavior health care are often provided in separate systems, a situation that may not encourage optimal care for those with behavioral disorders. One key concept receiving much current attention is that of the Medical Home, which better integrates specialty care with physical health care through co-location as well as care coordination. While integration of behavioral health with primary care services will present challenges for behavioral health, it will also offer opportunities. For example it may become increasingly feasible to incorporate SBIRT and Office Based Opioid Treatment (OBOT) into routine care. In June, 2009, the Patrick administration announced that Massachusetts will receive \$500,000 in grant funding to support the transformation of 14 Community Health Centers into patient-centered medical homes over a four-year period. The integration mandate may help to overcome some of the societal stigma against behavioral health clients and those who work with them. Providers face a two-pronged challenge - to provide enough well-trained, skilled practitioners to staff the integrated services; and to adapt business and clinical processes to support integration.

Children's Behavioral Health Initiative (CBHI)

CBHI, an interagency initiative of the Executive Office of Health and Human Services in response to the "Rosie D." class action case, has laid out specific, enforceable standards for the provision of services to youth with mental health diagnoses. Policies, financing, management and delivery of publicly-funded behavioral health services are to be integrated to make it easier for families to find and access appropriate services, and to ensure that families feel welcome and respected and receive fully coordinated services that meet their needs, as the family itself defines them. Substance abuse services must be provided as needed to children who are served under CBHI.

⁵ "Private insurance paying less for substance abuse treatment, according to study of healthcare cost trends," Thomson Healthcare, 2007. http://thomsonreuters.com/content/press_room/tsh/223695.

Changes in the procurement system

On August 5, 2008 Governor Deval Patrick signed *An Act Relative to Rates for Human and Social Service Programs*, which became Chapter 257 of the Acts of 2008. The law requires that the Commonwealth regularly review and adjust rates paid to human service providers and locates the responsibility for setting rates in the Division of Health Care Finance and Policy (DHCFP), instead of the state's purchasing division. The law allows providers to bid on state contracts using rates based upon the actual cost of providing services.

Under the Act, the state will move from a contract-based system to a rate-based system for supporting human services by October, 2011. It is anticipated that these changes will increase reimbursement to providers. It should be noted that even prior to the signing of this bill most BSAS reimbursement was already determined by class rates set by DHCFP. While BSAS is anticipating rate increases for a number of services, the effect on the compensation of individual workers is not certain. Regulations and contracts do not specify how rate increases are to be used.

Budgetary Considerations

In recent years, the nation's economy has suffered an enormous contraction, straining state resources and hindering donations to non-profits (including many substance use and addictions providers), while increasing the population's need for substance use and addictions treatment as well as other services. This situation makes it all the more important that cost-effective ways to support the population be shared and implemented, and that resources be pooled in that effort.

Implications of these environmental changes for substance use and addictions services

It will be critical to continually re-evaluate all these changes from programmatic and fiscal perspectives, and to make adjustments as necessary, in order to assure that a full spectrum of prevention, intervention, treatment and recovery supports for substance use and addictions are available throughout the Commonwealth.

While in recent years expenditures related to substance use and addictions by both BSAS and MassHealth (Medicaid) have increased significantly, further expansion will be contingent on the continuing availability of resources. In times of budgetary uncertainties, some decreases may be anticipated. Regardless of resource availability, however, it will always be important to assure that services are offered in the most efficient and effective manner possible. This Update to the Strategic Plan is intended to initiate a response to the challenges posed by the many environmental changes that have taken place and are still under way.

Principles underlying the Plan

This Update to the Strategic Plan, like the original Plan, is based on a number of key principles:

- ***Addiction is a chronic condition.***

As a chronic illness, addiction requires a continuum of prevention, intervention, treatment and recovery support services extending beyond that which is medically necessary. Filling in the gaps in that continuum requires the involvement of all stakeholders.

- ***Collaboration among all public and private stakeholders, at the state and local levels, is key to the success of this plan.***

Every stakeholder has an important role to play in developing solutions. Stakeholders include not only the state agencies whose clients are impacted by unhealthy substance use and addictions but also the Commonwealth's federal partners, the Legislature, local government partners, service providers, local prevention coalitions, consumers and the correctional and judicial systems.

- ***BSAS by statute is the state entity responsible for substance use and addictions policy and system development.***

Although BSAS is the one agency that focuses exclusively on substance use, addiction, co-occurring disorders and related issues, its success depends upon the engagement and effort of its many federal, state and local partners. Only continuing collaboration will allow the goals of this Strategic Plan to be realized.

- ***Developing the ability to integrate data across agencies and payers is crucial.***

Many of the strategies outlined in the Plan depend on the capacity of state agencies and all payers to integrate their administrative data. Data integration will permit the broader analysis required for evidence-based decisions to be made about resource allocation and program development and to assure that client outcomes and cost effectiveness are being maximized.

- ***Access to care must be equitable and responsive to the needs of all populations.***

The Commonwealth must analyze and address the needs of all its residents for substance use and addictions prevention, intervention, treatment, and recovery supports in order to assure appropriate access.

- ***Agencies and providers should be encouraged to adopt evidence-based practices.***

Evidence supporting specific, effective prevention and treatment strategies has increased exponentially in recent years and will continue to grow. It is incumbent on everyone who works in the field to continue to examine and adopt approaches that have been proven to be effective.

- ***Reducing stigma and involving consumers in the planning and delivery of services will support workforce retention and a more engaged clientele.***

Individuals and families confronting addictions have long been stigmatized, as have those who treat them. Reducing this stigma and seeking the participation of clients in planning, delivering and evaluating services will yield many positive results.

- ***Using SAMHSA's Strategic Prevention Framework will strengthen the system.***

SAMHSA's Strategic Prevention Framework aims to reduce the impact of substance use and addictions through assessment, capacity building, plan development, implementation of evidence-based prevention programs, and monitoring and evaluation of those programs.⁶

⁶ SAMHSA refers to its Strategic Prevention Framework (SPF) program as the "cornerstone" of its prevention efforts. SPF is designed to enable states and communities to build and sustain their own prevention infrastructures, including programs, policies and practices. The underlying principle of SPF is that communities should be knowledgeable about the substance abuse problems that affect them at a local level. This includes being able to identify the cause, provide solutions and provide remediation. The SPF model

- *New technologies offer opportunities for BSAS to extend its work.*

All agencies and stakeholders should routinely examine and consider adopting emerging technologies in order to reach wider audiences and augment capacity. Constantly evolving social media should form one major focus of this work.

has five key components that govern such community prevention services: assessment, capacity, planning, implementation and evaluation. Community prevention efforts should also be sustainable and "culturally competent" to ensure their success.



This Strategic Plan Update is organized into eight Focus Areas, each with its own set of strategies and implementation steps.

FOCUS AREAS

- FOCUS AREA I: MAXIMIZE INTERAGENCY COLLABORATION**
- FOCUS AREA II: IDENTIFY AND ADDRESS DISPARITIES THROUGHOUT THE SERVICE SYSTEM**
- FOCUS AREA III: INCREASE THE CAPACITY OF COMMUNITIES AND OTHER SERVICE SYSTEMS TO PREVENT SUBSTANCE USE AND ADDICTIONS WHILE STRENGTHENING LINKAGES TO NEEDED SERVICES**
- FOCUS AREA IV: IMPROVE ACCESS TO SUBSTANCE USE AND ADDICTIONS SCREENING AND SERVICES**
- FOCUS AREA V: STRENGTHEN THE ARRAY OF RECOVERY ORIENTED SERVICES**
- FOCUS AREA VI: IMPROVE THE PERFORMANCE OF ALL COMPONENTS OF THE SUBSTANCE USE AND ADDICTIONS SYSTEM**
- FOCUS AREA VII: STRENGTHEN THE SUBSTANCE USE AND ADDICTIONS WORKFORCE AND ENHANCE ORGANIZATIONAL DEVELOPMENT**
- FOCUS AREA VIII: STRENGTHEN COLLABORATIONS AND INCREASE THE INTEGRATION OF SUBSTANCE USE AND ADDICTIONS SERVICES WITHIN THE CRIMINAL JUSTICE SYSTEM**

Commonwealth of Massachusetts
Substance Abuse Strategic Plan
Update: FY 2011 – FY 2016

FOCUS AREA I: MAXIMIZE INTERAGENCY COLLABORATION

RATIONALE: Both increasing collaboration and reducing “silos” within and among state agencies are critical to reducing the negative impact of substance use and addictions in the Commonwealth. Effective collaboration with the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Institutes of Health and other Federal agencies, service providers, local prevention coalitions and the correctional and judicial systems is also vital. Every stakeholder has an important role to play in developing and implementing solutions. The 2005 Strategic Plan led to the promulgation of Executive Order 496 which created the Governor’s Interagency Council on Substance Abuse and Prevention (ICSAP). The Council has met regularly for nearly five years and, by bringing agencies to the same table, has supported collaborative relationships and positive results. Over the next five years those relationships will help the Commonwealth realize important new goals. The Council will seek to assure that the needs of individuals who are served by multiple agencies are better met and that the impact of funding related to substance use and addictions is maximized. In addition, the Council can encourage the integration of data from relevant state agencies and from public and private payers. In recent years state agencies have dedicated substantial resources to improving their individual administrative data systems. It has become evident that regular and automated integration of the data obtained through these systems is necessary in order to address cross-agency policy, programming and resource allocation decisions.

Strategy 1: In accordance with Executive Order 496, maximize collaboration among all agencies that serve individuals with addiction problems. These include courts and criminal justice agencies; departments within the Executive Office of Health and Human Services; the Legislature; and agencies whose missions relate to education and housing, among others.

Implementation Team Leader: Executive Director, Interagency Council on Substance Abuse and Prevention⁷

- Monitor funding across agencies and levels of government.
- Increase knowledge, understanding and use of substance use and addictions resources among all state agencies.
- Increase interagency awareness of the needs, cultures and strengths of diverse and special populations.
- Offer technical assistance on substance use and addictions to all relevant agencies.
- Coordinate funding for special initiatives that can meet the needs of shared populations.
- Encourage the use of standardized screening and assessment tools across agencies.

⁷ As a five year plan, this document uses position titles; for names of individuals holding those positions as of July 2010 see Appendix V.

- Encourage a shared vision of the goals of the substance use and addictions system in the Administration and within the Legislature's Mental Health and Substance Abuse Committee.
- Develop agreements and methods for integrating data across state agencies.

Strategy 2: In collaboration with the Youth Interagency Working Group (IWG), continue working to improve services for youth and young adults as well as their families.

Implementation Team Leader: Director, Youth and Young Adult Services

- Use data to identify the unique needs of youth and young adults; continue to develop outpatient services specifically aimed at youth and promulgate standards that are specific to this population.
- Use existing data sets, including the Behavioral Risk Factor Surveillance System (BRFSS), the Youth Risk Behavior Surveillance System (YRBS) and other national survey data, to identify at-risk populations and target prevention programs/resources toward them.
- Expand the use of new technologies, including social media, to reach and engage youth and families.
- Expand the use of the CRAFFT screening tool for youth.
- Develop an on-line information portal for youth and parents, and use other new technologies to increase public awareness of prevention, intervention, and treatment resources including central intake and services for youth.
- Improve interagency communication and services for transition age youth (TAY).
- Support family intervention initiatives to help youth enter treatment and maintain recovery as well as increase families' abilities to work as essential partners with their children, treatment agencies and, often, the criminal justice system.
- Embed evidence-based education about prevention of substance use and abuse more fully in public school curricula statewide.
- Enhance parents' ability to care for themselves and support their children by providing opportunities for peer to peer support groups, parent and professional led trainings and leadership building.

Strategy 3: In collaboration with the Family Recovery Collaborative (FRC), continue to improve services to parents and families involved in the child welfare system.

Implementation Team Leader: Substance Abuse and Special Projects Manager, Department of Children and Families

- Implement technical assistance grant from the National Center on Substance Abuse and Child Welfare; this grant focuses on communication protocols, screening and assessment, and treatment needs for parents involved with child welfare.
- Oversee the joint DPH and Department of Children and Families (DCF) federally funded grant programs that serve the child welfare population; implement lessons learned from them.
- Recognize and respond to the unique needs of substance exposed newborns and their families.
- Seek future federal funding opportunities to develop innovative treatment models serving families involved with the child welfare system.

Strategy 4: Establish a statewide Criminal Justice Collaborative that can pool knowledge in order to increase efficiency, enhance decision making and improve outcomes.

Implementation Team Leader: Executive Director, Interagency Council on Substance Abuse and Prevention

- Bring together BSAS staff, other state agency representatives and additional stakeholders who will meet regularly to share information and develop new strategies.
- Learn from other states how to maximize the value of the Collaborative.
- Encourage use of standardized screening and assessment tools throughout all levels of the criminal justice system.

Strategy 5: Encourage the integration of multi-agency, multi-payer administrative data to inform policy and service delivery decisions for substance use and addictions prevention and treatment services.

Implementation Team Leader: Director, Data Analysis and Decision Support, BSAS

- Promote inter-agency collaboration on data integration through the ICSAP using the expertise of the Massachusetts Epidemiology Work Group.
- Facilitate meetings among all relevant agencies to develop a data integration plan, agreeing on definitions of terms, specifying data security parameters and requirements and assuring privacy and confidentiality protections.
- Perform analyses of data that examine questions of mutual interest; review results in partnership; determine priority populations and allocation of resources; and identify potential cost offsets and cost efficiencies.

Strategy 6: Strengthen relationships both between the Commonwealth and its Federal agency partners and with substance use and addictions agencies in other states.

Implementation Team Leaders: Director, BSAS, and Executive Director, Interagency Council on Substance Abuse and Prevention

- Through direct involvement, maximize relationships with agencies such as the Substance Abuse and Mental Health Services Administration (SAMHSA); the National Institutes of Health (NIH), including the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA); the Office of National Drug Control Policy (ONDCP); the Department of Housing and Urban Development (HUD); the Department of Justice (DOJ); the Bureau of Justice Assistance (BJA); the National Highway Traffic Safety Administration (NHTSA); and the National Association of State Alcohol and Drug Abuse Directors (NASADAD) in order to influence policy and assure funding for infrastructure and services.
- Maintain relationships with substance use and addictions agencies in other states; as appropriate, adopt promising practices they have developed and tested.
- Maximize opportunities for federal funding.

FOCUS AREA II: IDENTIFY AND ADDRESS DISPARITIES THROUGHOUT THE SERVICE SYSTEM

RATIONALE: There are disparities in both need for and access to substance use and addictions services across populations. The Commonwealth should identify groups in need of differentiated services and develop the organizational capabilities and the workforce required to deliver those services. Prevention strategies should be targeted to those at highest risk.

Strategy 1: Use data to identify priority populations whose needs are not being met and develop approaches to address those needs.

Implementation Team Leader: Director, Data Analysis and Decision Support, BSAS, and Deputy Director, BSAS

- Coordinate efforts with the DPH Culturally and Linguistically Appropriate Services (CLAS) initiative to assure that the needs of linguistic and cultural minorities are met throughout the prevention and service systems.
- Routinely examine population based surveillance data and administrative data drawn from an integrated multi-agency, multi-payer data base in order to identify disparities in access to treatment and overlaps in populations served by state agencies, as well as outcomes of services provided.
- Through the use of integrated data, identify populations with co-morbid conditions such as mental health problems and HIV/AIDS/viral hepatitis; and those who are receiving medication assisted treatment to determine whether they have appropriate access to services.
- Use data to help allocate resources appropriately.

Strategy 2: Support Delivery of Culturally Responsive Services.

Implementation Team Leader: Deputy Director, BSAS

- Assess the extent to which providers and other state agencies offer culturally responsive services and meet the needs of underserved groups, using CLAS and other available data.
- Offer training to providers and agencies in developing competence in culturally responsive care and management, as well as recruitment and retention of minority workers.

Strategy 3: Initiate targeted training projects to improve cultural responsiveness throughout the workforce.⁸

Implementation Team Leader: Workforce Development and Training Coordinator, BSAS

- Recruit and retain ethnic/cultural minority students in programs that offer education and training for employment in the substance use and addictions field, to develop a workforce that is more racially, culturally and linguistically aligned with those being served.

⁸ Described further in the Substance Use and Addictions Workforce and Organizational Development Strategic Plan.

- Strengthen culturally responsive curricula in substance use and addictions treatment, prevention and management programs.
- Strengthen and formalize alliances between the addictions field and higher education.
- Replicate programs such as the Latino Counselor Recruitment Project for other populations in order to expand employment of underrepresented groups in the workforce.

FOCUS AREA III: INCREASE THE CAPACITY OF COMMUNITIES AND OTHER SERVICE SYSTEMS TO PREVENT SUBSTANCE USE AND ADDICTIONS WHILE STRENGTHENING LINKAGES TO NEEDED SERVICES

RATIONALE: While addiction is a chronic condition, it is preventable. The Commonwealth should emphasize prevention strategies at both local and state levels. Reaching out to communities, provider groups, the medical system and other public agencies will be critical to this effort. Through the Strategic Prevention Network, strong local coalitions have been built in many areas of the state; these coalitions will be able to link prevention and treatment/recovery work. Massachusetts is ideally positioned to use SAMHSA’s Strategic Prevention Framework to help communities assess, plan and implement prevention efforts.

Strategy 1: Increase support for prevention as a key component of the Recovery-Oriented System of Care.

Implementation Team Leader: Director, Prevention Services, BSAS

- Support and expand the dissemination and implementation of evidence-based prevention strategies/programs and materials in communities throughout the Commonwealth.
- Develop and implement certification standards for prevention professionals and programs in Massachusetts.
- Use existing data sets, including the Behavioral Risk Factor Surveillance System (BRFSS), the Youth Risk Behavior Surveillance System (YRBS) and other national survey data, to identify at-risk populations and target prevention programs and resources toward them.
- Increase distribution of local data (such as YRBS data) back to communities.
- Continue to provide support and leadership encouraging local media to address substance use and addictions.
- Continue to support changes in norms, attitudes and policies by expanding environmental prevention strategies that also limit access to substances; for example, use town hall meetings, alcohol and tobacco compliance checks and local ordinances.

Strategy 2: Implement new models of communication about prevention, using new technologies when appropriate.

Implementation Team Leader: Director, Prevention Services, BSAS

- Expand the use of new technologies, including social media, to reach youth, families, pregnant women, populations at risk and the elderly.

- Continue to frame substance use and addictions as an issue of public health and safety rather than individual illness.
- Incorporate substance use and addictions prevention into wellness programs, Internet resources and curricula.

Strategy 3: Enhance linkages between prevention efforts and the human service and health care systems, including the substance use and addictions treatment system.

Implementation Team Leader: Director, Prevention Services, BSAS

- Expand the distribution of prevention and brief intervention materials to primary care and other providers; evaluate the results.
- Assess, plan and implement prevention efforts to reduce the incidence of Fetal Alcohol Spectrum Disorder.

Strategy 4: Continue and expand efforts to prevent fatal and non-fatal opioid overdoses.

Implementation Team Leader: Assistant Director, Planning and Development, BSAS

- Prevent overdoses from occurring through the continued implementation of community-based strategies, provider and bystander education, and the dissemination of educational materials.
- Improve the management of overdose, if it occurs, with initiatives such as education and training to bystanders and first responders, prescriber Naloxone projects, and the 911 Good Samaritan Bill.
- Reduce the quantity of misused, abused and diverted prescription opioids through community-based strategies as well as collaboration with the Medical Licensure Board and the Prescription Monitoring Program.
- Work with medical schools and physicians on techniques for reducing non-medical use of prescription and psychotherapeutic drugs.

FOCUS AREA IV: IMPROVE ACCESS TO SUBSTANCE USE AND ADDICTIONS SCREENING AND TREATMENT SERVICES

RATIONALE: Increasing access through programs such as Screening, Brief Intervention and Referral to Treatment (SBIRT) saves money and lives.⁹ Bringing SBIRT into the healthcare mainstream can help individuals reduce risky or unhealthy substance use, and those who are identified as having substance use disorders can receive the treatment they need. Research has shown that many of the individuals who use substances in a risky or unhealthy way can benefit from brief intervention, which can reduce adverse alcohol

⁹ Fleming, M.F., et al., “Benefit-Cost Analysis of Brief Physician Advice with Problem Drinkers in Primary Care Settings,” *Medical Care*, 38(1): 7-18, Jan. 2000.

or drug incidents.¹⁰ Individuals who are identified as having misuse, abuse or dependence can be encouraged to get specialty treatment. Although treatment is known to be effective,¹¹ a significant proportion of all those who need addiction services still do not receive them.¹² It is vital that people who need treatment have easy and rapid access to services when they are screened and that transitions between services and levels of care are smooth and effective.

Strategy 1: Integrate substance use and addictions screening, services and skills into health care settings, including primary care, emergency departments, federally qualified health centers and medical homes.

Implementation Team Leader: SBIRT Coordinator, BSAS

- Support health and mental health care settings in sustaining and expanding the use of SBIRT.
- Encourage use of SBIRT as standard operating procedure in schools and colleges.
- Expand the use of the CRAFFT screening tool for youth.
- Encourage standard and routine screening in criminal justice settings.
- Use screening results to provide brief interventions for those using substances in a risky or unhealthy manner and to link to treatment individuals in whom substance use and addictions or dependence is indicated.

Strategy 2: Increase availability of information on substance use and addictions, self-care and treatment options for all stakeholders.

Implementation Team Leader: Assistant Director, Quality Assurance & Licensing

- Enhance and simplify the BSAS website and encourage its use as a key resource that supports access to services and offers “how to” strategies.
- Advertise the Substance Abuse Information and Education Helpline.
- Encourage the use of peer and parent support services where appropriate throughout the service system.
- Develop an on-line information portal for youth and parents that will increase public awareness of prevention resources, central intake and services for youth.
- Help all consumers understand their rights, including their rights to appeal denials or other service problems.
- Provide mechanisms to support communication, networking, technical assistance and quality assurance for providers of new services, as has been done for Office-Based Opioid Treatment.

¹⁰ Babor, T.F. and Higgins, J.C. 2001, *Brief Intervention for Hazardous and Harmful Drinking: A Manual for Use in Primary Care*. World Health Organization, Department of Mental Health and Substance Dependence; L.I. Solberg, M.V. Maciosek, N. M. Edwards, “Primary Care Intervention to Reduce Alcohol Misuse: Ranking Its Health Impact and Cost Effectiveness,” *Am J Prev Med* 2008;34(2):143–152).

¹¹ Simpson, D., et al. “Overview of National Treatment Outcome Studies,” <http://www.datos.org/>.

¹² Whitter, M. “Recovery in the Community: An Emerging Framework – A Recovery oriented Systems Approach,” NASADAD Annual Meeting, June 6, 2008. http://pfr.samhsa.gov/docs/NASADAD_ROSCs_presentation_0608.pdf.

Strategy 3: Facilitate communication among stakeholders.

Implementation Team Leader: Regional Manager, BSAS

- Develop plans for a centralized referral and care coordination system that can be rolled out in high need locations.
- Develop and disseminate communication protocols that enhance communication efforts between state involved (DCF) families and substance use and addictions treatment providers.
- Improve access to substance use and addictions treatment services for families involved with DCF, particularly for families working toward reunification with children in foster care.
- Increase public awareness of the youth central intake system and of the services that are available for youth.

Strategy 4: Improve referrals and transitions.

Implementation Team Leader: Deputy Director, BSAS

- Establish and disseminate protocols for referrals between detoxification and other levels of care. These protocols should delineate responsibilities of the referring and receiving providers, as well as guidelines for shared treatment plans and case histories and other materials.
- Enhance existing Care Coordination and Case Management positions in Commonwealth agencies to offer motivational interviewing and to provide help with navigating the health and behavioral health care systems, with specific approaches tailored to families receiving DCF services.
- Improve interagency communication and services for transition age youth.
- Collaborate across agencies and use advanced technology to help youth and families navigate the system so that they know what services are available and help them negotiate with their insurers – assure “the right information at the right time, to get to the right provider.”

FOCUS AREA V: STRENGTHEN THE ARRAY OF RECOVERY ORIENTED SERVICES

RATIONALE: Service providers and policy makers have become increasingly aware that a linear “continuum of care” does not support individuals who experience a chronic illness such as addiction. Non-medical services need to be expanded to supplement the existing array of medically based services that support recovery and resilience in the community. A recovery oriented system of care includes a comprehensive menu of services and supports that can be combined and readily adjusted to meet the individual’s needs and chosen pathway to recovery; an ongoing process of systems improvement that incorporates the experiences of those in recovery and their family members; and the coordination of multiple systems to provide responsive, accountable, outcomes-driven approaches to care.¹³

¹³ M. Whitter, op. cit., p. 8.

Strategy 1: Review the current services against an ideal strength based and recovery oriented array of services to identify service gaps and services that need an increased focus on recovery.

Implementation Team Leader: Director, BSAS

- Analyze the entire system of outreach, prevention, engagement, peer supports, outpatient services, medication-assisted treatment, aftercare, and community supports across the state; determine where the gaps are; and develop strategies to fill them.
- Use the Block Grant and state funding to develop access to “care beyond coverage” - community based services that support maintenance of recovery following the medically necessary acute treatment services that are covered by health insurance.
- Help providers, particularly small specialized ones, adapt to new administrative and regulatory requirements, gain access to insurance panels, and maximize their ability to bill third parties.
- Use licensing authority to reduce unnecessary access barriers to recovery oriented services, e.g., ensure that programs treat individuals who also have mental illness or are receiving medication assisted therapy.
- Ensure that there is a spectrum of accessible substance use and addictions services available in the community that can help prevent entry into the criminal justice and child welfare systems.
- Ensure that client- and family-centered intervention, treatment and recovery services for addictions are available.
- Provide support and intervention services for the children of parents with substance use disorders.
- Expand support for recovery centers in additional parts of the Commonwealth.
- Increase the involvement in planning efforts of consumers who represent a wide range of needs and populations.
- Increase the availability of information and other materials that can be used for peer support (e.g., the Talk about Addiction website, <http://www.talkaboutaddiction.org/>).
- Integrate tobacco cessation and gambling efforts more fully with other BSAS work.

Strategy 2: Leverage funding for recovery oriented services by encouraging all state agencies to intervene earlier to prevent and treat addiction; this will ultimately enable the most effective use of resources.

Implementation Team Leader: Executive Director, Interagency Council on Substance Abuse and Prevention

- Limited resources can be maximized through collaborative investment in substance use and addictions screening, brief intervention, referral to treatment, and integration of treatment across agencies.
- Use interagency collaborations to develop jointly planned and/or funded initiatives aimed at special populations served by multiple agencies, for example, substance abusing parents of children who are in the care of DCF or individuals with co-occurring addictions and mental illness.

FOCUS AREA VI: IMPROVE THE PERFORMANCE OF ALL COMPONENTS OF THE SUBSTANCE USE AND ADDICTIONS SYSTEM

RATIONALE: The Commonwealth supports continuous performance improvement in all that it does. It has been investing significantly in the collection and use of data on the treatment system and treatment outcomes. The system has also benefited significantly from involvement with the Network for Improvement of Addiction Treatment (NIATx) and other national performance improvement efforts. While data exist on many aspects of the system, they are not always available in ways that make them useful within BSAS or to other stakeholders. Data that BSAS and other agencies are required to gather can be used to help support system change and improve performance.

Strategy 1: Use data, licensing and credentialing authority, and funding to disseminate standards of care for all services and encourage innovation.

Implementation Team Leader: Deputy Director, BSAS

- Develop and disseminate data driven standards of care for all substance use and addictions services.
- Disseminate practice-based evidence gained from pilots and grants.
- Support pilot projects as well as transitions from pilots to established services.

Strategy 2: Provide data analysis and decision support to regulators, providers and payers.

Implementation Team Leader: Director, Data Analysis and Decision Support, BSAS

- Establish methods to integrate and use multi-agency and multi-payer administrative data, as described in Focus Area I, Strategy 5.
- Enable web-based communication among appropriate stakeholders.
- Invest in and support the effective use of Electronic Health Records.
- Drive the development of performance metrics for substance use and addictions treatment services.
- Monitor payers' fulfillment of their obligations under new parity requirements.

Strategy 3: Design and procure a system of care that optimizes client engagement and utilizes resources efficiently.

Implementation Team Leader: Director, BSAS

- Coordinate purchasing of substance use and addictions services among all payers in the Commonwealth.
- Examine a variety of purchasing models, including those used by other states; coordinate performance improvement initiatives with agencies in other states.
- Work with other payers, including MassHealth, to optimize outcomes by aligning performance measures and quality improvement initiatives.
- Use contracting to reward performance.

Strategy 4: Encourage state agencies and providers to adopt evidence-based practices.

Implementation Team Leader: Workforce Development and Training Coordinator, BSAS

- Encourage providers to better understand the relationship between organizational practices and client outcomes, and to modify their practices to improve outcomes.
- Include key quality and performance requirements in Requests for Response (RFRs) and contracts.
- Continue involvement with and participation in NIATx.

Strategy 5: Assess, redesign and re-procure the adult and youth outpatient systems to improve community supports for recovery.

Implementation Team Leader: Regional Manager, BSAS

- Map levels and types of care across the service system.
- Assess the needs of youth and young adults and identify needs that differ from those of the adult population; continue to develop outpatient services specifically aimed at youth.
- Increase the focus on the family when assessing and treating youth.
- Support family intervention initiatives to help both adults and youth enter treatment and maintain recovery.
- Support use of American Society for Addiction Medicine (ASAM) criteria in level of care determinations.
- For youth, integrate engagement strategies, wraparound and care coordination, family support, home-based interventions, parenting training, mentoring, and the use of natural support systems into outpatient services.
- Utilize new technologies to engage individuals and families and support recovery in the community.
- Support training in and the use of promising practices, data and performance incentives to improve quality of care.
- Integrate into the system redesign standards and training for developmentally appropriate and culturally responsive services in diversion, engagement, assessment and treatment.
- Encourage the use of peer supports in engagement and aftercare.

FOCUS AREA VII: STRENGTHEN THE SUBSTANCE USE AND ADDICTIONS WORKFORCE AND ENHANCE ORGANIZATIONAL DEVELOPMENT

RATIONALE: The Commonwealth's *Substance Use and Addictions Workforce and Organizational Development Plan*¹⁴ was created to address a variety of issues related to developing and sustaining services that are scientifically based as well as viable, culturally responsive and accessible. A wide variety of stakeholders from within and

¹⁴ The Substance Use and Addictions Workforce and Organizational Development Strategic Plan: Year 1 Results and Update; Spring 2010.

outside state government have been involved in developing the Workforce Plan and will participate in its execution. Implementation of the Workforce Plan will take place in conjunction with the implementation of this Plan. The following outlines the approach, which is further detailed in the Workforce Plan itself:

Strategy 1: Identify and create structures for communication and collaboration among stakeholders.

Implementation Team Leader: Workforce Development and Training Coordinator, BSAS

- Support collaboration among stakeholders.
- Promote communication opportunities among stakeholders.
- Strengthen and formalize alliances between the substance use and addictions field and higher education.
- Unify and coordinate diverse evidence-based marketing messages and effective social marketing approaches.

Strategy 2: Support effective and continuous learning opportunities for individual workers and organizations that include critical clinical and administrative topics.

Implementation Team Leader: Workforce Development and Training Coordinator, BSAS

- Replicate Work-Based Learning initiatives.
- Enhance organizational training and development.
- Improve the effectiveness of training and education.
- Support quality improvement at all levels.
- Increase technical and administrative program support.

Strategy 3: Increase the reward and value of work in the field.

Implementation Team Leader: Workforce Development and Training Coordinator, BSAS

- Advocate for enhanced funding for education, training of workers, and utilization of interns.
- Advocate for improved salaries, career ladders, reimbursement and benefits.

Strategy 4: Improve recruitment and retention strategies at provider organizations.

Implementation Team Leader: Workforce Development and Training Coordinator, BSAS

- Improve providers' skills in recruiting and retaining staff.
- Learn more about current workers and organizations and their specific needs and successes.
- Identify and learn more about potential workers, particularly those who reflect the populations being served.

FOCUS AREA VIII: STRENGTHEN COLLABORATIONS AND INCREASE THE INTEGRATION OF SUBSTANCE USE AND ADDICTIONS SERVICES WITHIN THE CRIMINAL JUSTICE SYSTEM

RATIONALE: Substance use and addictions continues to have a significant impact on the criminal justice and corrections systems. For example, the Probation Commissioner's office has data indicating that 85 percent of their population is addicted, or a substance precipitated their crime, and 45 percent need treatment. Furthermore, in 2009, 50 percent of the individuals admitted into BSAS supported residential programs were on Probation (45.6 percent) or Parole (5.0 percent) and 39 percent of all those admitted to ambulatory programs were on Probation. Seven percent (614) of residential admissions entered directly from incarcerated status at Houses of Correction (HoC) or Department of Correction (DoC) facilities. In FY 09 BSAS expanded its treatment system by 104 beds to serve civilly committed individuals who had previously gone to MCI-Bridgewater (MASAC). Because data indicated that a large number of overdoses were experienced by individuals who had recently been released from correctional institutions, BSAS began to provide training on overdose prevention to all the HoCs, DoC, and civil commitment programs. Since 2005, considerable progress has been made toward assuring that treatment is available within HoCs and that individuals leaving HoCs are helped to enroll in Medicaid and to receive prescriptions and/or medications. In FY 09, approximately 1,550 parolees received case management services through a program funded collaboratively by BSAS and the Parole Board. There is room for improvement, however, in all of these areas. Several HoCs have done small studies of their populations; for example, Plymouth County found that recidivism was significantly higher (34 percent) for those who did not receive treatment while incarcerated than for those who did (18 percent).

Strategy 1: Expand planning and coordination of drug courts.

Implementation Team Leader: Criminal Justice Service Coordinator, BSAS

- Identify a statewide drug court coordinator.
- Bring together representatives of all currently functioning adult and youth drug courts for regular meetings.
- Use meetings to share information on sources of funding, on best practices and on how to encourage development of additional drug courts throughout the Commonwealth.

Strategy 2: Support correctional facilities in adopting medication assisted treatment.

Implementation Team Leader: Deputy Director, BSAS

- Develop informational materials to be shared with the correctional system.
- Encourage small pilot efforts to introduce medication assisted treatment in a few settings.
- Encourage further development of medication assisted treatment programs based on the results of the pilot efforts.

Strategy 3: Continue to expand diversion and treatment options in the criminal justice system.

Implementation Team Leader: Criminal Justice Service Coordinator, BSAS

- Expand diversionary services.
- Promote treatment and support services for individuals in jail and prison.
- Facilitate reentry into the community.

Appendix I

SAMHSA's 10 Strategic Initiatives

The Substance Abuse and Mental Health Services Administration's (SAMHSA) mission is to reduce the impact of substance use and addictions and mental illness on America's communities. Over the years SAMHSA, in collaboration with other Federal agencies, States, local organizations, and individuals including consumers and the recovery community, has demonstrated that - prevention works, treatment is effective, and people recover from mental and substance use disorders. Behavioral health is a component of service systems and community-wide strategies that improve health status and contain health care and other costs to society. Continued improvement in the delivery and financing of prevention, treatment, and recovery support services provides a cost effective opportunity to advance and protect the Nation's health. To continue to improve the delivery and financing of prevention, treatment, and recovery support services SAMHSA has identified 10 Strategic Initiatives to focus the Agency's work on people and emerging opportunities. The 10 Initiatives are described below with the Agency lead identified.

1. Prevention of Substance Abuse and Mental Illness

(Fran Harding, Director, Center for Substance Abuse Prevention)

Create prevention prepared communities where individuals, families, schools, workplaces, and communities take action to prevent and reduce mental illness and substance abuse across the lifespan.

2. Violence and Trauma

(Kana Enomoto, Principal Senior Advisor to the Administrator)

Reduce the behavioral health impacts of violence and trauma and integrate trauma-informed services in prevention and treatment programs in States and communities, and throughout the health service delivery system to address root causes of pervasive, harmful, and costly public health problems. Divert youth and adults with substance use and mental disorders from criminal and juvenile justice systems into trauma-informed treatment and recovery.

3. Military Families - Active, Guard and Veteran

(Kathryn Power, Director, Center for Mental Health Services)

Support of our service men and women and their families and communities by leading efforts to ensure needed behavioral health services are accessible and outcomes are successful.

4. Housing and Homelessness

(Kathryn Power, Director, Center for Mental Health Services)

Provide housing and reduce the barriers that homeless persons with mental and substance use disorders and their families experience when accessing programs that sustain recovery.

5. Jobs and Economy

(Larke Huang, Senior Advisor to the Administrator)

Promote the behavioral health of individuals, families, and communities affected by the economic downturn; the employment of people with mental and substance use disorders, and policies for employers that support behavioral health in the workplace.

6. Health Insurance Reform Implementation

(Ric Broderick, Deputy Administrator)

Broaden health coverage to increase access to care and reduce disparities that currently exist between service for substance use and mental disorders and other medical conditions.

7. Health Information Technology for Behavioral Health Providers

(Westley Clark, Director, Center for Substance Abuse Treatment)

Ensure the behavioral health provider network, including prevention specialists and consumer providers, fully participates with the general health care delivery system in the adoption of health information technology.

8. Behavioral Health Workforce - In Primary and Specialty Care Settings

(Westley Clark, Director, Center for Substance Abuse Treatment)

Provide a coordinated approach to address workforce development issues affecting the behavioral health service delivery community and promote the training and use of behavioral health screening, brief intervention and referral for treatment in primary care settings.

9. Data and Outcomes - Getting Results

(Pete Delaney, Director, Office of Applied Studies)

Realize an integrated data strategy that informs policy and measures program impact leading to improved outcomes for individuals, families, and communities.

10. Public Awareness and Support

(Mark Weber, Director, Office of Communications)

Increase understanding of mental and substance use disorder prevention and treatment services to achieve the full potential of prevention and help people recognize and seek assistance for these health conditions with the same urgency as any other health condition.



NATIONAL DRUG CONTROL STRATEGY

A New, Balanced
Approach

Highlights

2010



2010 National Drug Control Strategy

Highlights

To the Congress of the United States

I am committed to restoring balance in our efforts to combat the drug problems that plague our communities. Drug use endangers the health and safety of every American, depletes financial and human resources, and deadens the spirit of many of our communities. While I am proud of the new direction described here, a well-crafted strategy is only as successful as its implementation. To succeed, we will need to rely on the hard work, dedication, and perseverance of every concerned American.

Barack Obama
The White House

Preface from Director Kerlikowske

The Obama Administration's strategy is unique because it takes advantage of what we now know about how to more effectively prevent drug use, provide addiction treatment, and enforce the law against illegal drugs. The balanced approach of evidence-based prevention, treatment, and enforcement presented in this *Strategy* will effectively address the serious drug problem faced by our Nation today.



R. Gil Kerlikowske
Director, Office of National Drug Control Policy

Key Strategy Objectives

President Obama's 2010 *National Drug Control Strategy* ("Strategy") reflects a comprehensive approach to reducing drug use and its consequences. Endorsing a balance of prevention, treatment, and law enforcement, the *Strategy* calls for a 15 percent reduction in the rate of youth drug use over 5 years and similar reductions in chronic drug use and drug-related consequences, such as drug deaths and drugged driving.

Below is a summary of the *Strategy's* key objectives:

Strengthen Efforts to Prevent Drug Use in Our Communities

Preventing drug use before it begins is a cost-effective, common-sense way to build safe and healthy communities. Instead of a system in which communities must adapt to the ways and conveniences of Federal and State agencies, it is vital for these agencies and departments to adapt and remain sensitive to the needs of local communities. This new system must help communities become prepared for prevention and support states in their efforts to expand upon the number of such communities.

Seek Early Intervention Opportunities in Health Care

Only a fraction of the money spent on health-related drug abuse costs is spent on identifying and intervening early in emerging cases of drug abuse or treating those with the disease of addiction. Research has clearly established that a brief intervention by a primary care provider can help people who abuse substances, but are not yet addicted, cut back or eliminate their substance use. It is both more humane and less costly to intervene when a case of addiction is just emerging than to wait until the disease is well-established. The *Strategy* calls for increasing screening and early intervention for substance use in all healthcare settings and expanding prescription drug monitoring programs.

Integrate Treatment for Substance Use Disorders into Health Care, and Expand Support for Recovery

For millions of Americans, substance use progresses to a point where brief interventions are not sufficient to promote recovery. Addiction treatment can be a critical—even lifesaving—resource in such situations, but only if it is readily available and of high quality. Among other measures, the *Strategy* calls for expanding addiction treatment in Community Health Centers and the Indian Health Service.

Break the Cycle of Drug Use, Crime, Delinquency, and Incarceration

Drug use is often interwoven with criminal and delinquent behavior that disrupts family, neighborhood, and community life in fundamental and long-lasting ways. Actions described in the *Strategy* include supporting law enforcement efforts to reduce drug availability, promoting alternatives to incarceration, and mandating treatment and court monitoring for chronic drug-using offenders.

Disrupt Domestic Drug Trafficking and Production

Drug trafficking organizations move large quantities of illicit drugs into the United States. These same groups, at times working through street and prison gangs, employ criminal networks that return the illicit proceeds of the drug trade—along with an array of weapons—across our borders. Specific steps in the *Strategy* include maximizing Federal support for law enforcement drug task forces, assisting tribal authorities in combating drug trafficking, and interdicting the southbound flow of currency and weapons.

Strengthen International Partnerships

The United States is one of the world's most lucrative markets for illegal drugs. It is in our interest to work collaboratively with international partners to reduce the global drug trade. Actions described in the *Strategy* include conducting joint counterdrug law enforcement operations with international partners, promoting alternative livelihoods for coca and opium farmers, and targeting the illicit finances of drug-trafficking organizations.

Improve Information Systems for Analysis, Assessment, and Local Management

Science should help inform policy and rigorously evaluate its effects. This can be possible only with near real-time information on drug use patterns, associated problems, and the results of previously implemented policies. The *Strategy* focuses on enhancing current data systems and assessing the availability, price, and purity of illicit drugs on the street so that it is known when our programs have a measurable impact on drug markets.

A New Approach to America's Drug Problem

The Obama Administration's *National Drug Control Strategy* relies on a comprehensive approach, informed by experience and evidence, to reducing drug use and its consequences in the United States. The *Strategy* is a collaborative effort by dozens of departments, agencies, Members of Congress, and the American people, and its implementation is a shared responsibility guided by the Office of National Drug Control Policy and its interagency partners.

This vision for United States drug policy is responsible, realistic, and informed by experience. We will implement a balanced public health and public safety strategy that recognizes that the demand for drugs and, increasingly, their production are within our own borders. We will foster collaboration and coordination at every level of government to create a drug policy that keeps our communities safe, supports the healthy development of our Nation's youth, and offers treatment and the hope of recovery to every addicted American.

ONDCP Mission Statement

ONDCP seeks to foster healthy individuals and safe communities by effectively leading the Nation's effort to reduce drug use and its consequences.

National Drug Control Strategy Goals to be Attained by 2015

Goal 1: Curtail illicit drug consumption in America

- 1a. Decrease the 30-day prevalence of drug use among 12–17 year olds by 15%
- 1b. Decrease the lifetime prevalence of 8th graders who have used drugs, alcohol, or tobacco by 15%
- 1c. Decrease the 30-day prevalence of drug use among young adults aged 18–25 by 10%
- 1d. Reduce the number of chronic drug users by 15%

Goal 2: Improve the public health and public safety of the American people by reducing the consequences of drug abuse

- 2a. Reduce drug-induced deaths by 15%
- 2b. Reduce drug-related morbidity by 15%
- 2c. Reduce the prevalence of drugged driving by 10%

Data Sources: SAMHSA's National Survey on Drug Use and Health (1a, 1c); Monitoring the Future (1b); What Americans Spend on Illegal Drugs (1d); Centers for Disease Control and Prevention (CDC) National Vital Statistics System (2a); SAMHSA's Drug Abuse Warning Network drug-related emergency room visits, and CDC data on HIV infections attributable to drug use (2b); National Survey on Drug Use and Health and National Highway Traffic Safety Administration (NHTSA) roadside survey (2c).



Contact ONDCP

**For more information about the
Office of National Drug Control Policy,
or to view the full text of the
2010 National Drug Control Strategy, visit:**

www.WhiteHouseDrugPolicy.gov

Appendix III

Timeline for updating the Substance Abuse Strategic Plan

January 26, 2009	Distribution of the Treatment Inventory Surveys to members of the Governor's Interagency Council on Substance Abuse and Prevention (ICSAP).
February 20, 2009	ICSAP Executive Committee reviews 2005 Strategic Plan.
March 20, 2009	ICSAP Executive Committee reviews Treatment Inventory Surveys.
April 22, 2009	Discussion of the Strategic Plan Update with the entire Council
June 24, 2009	Stakeholder retreat at Boston Public Library.
September 17, 2009	ICSAP Executive Committee meeting.
September 17, 2009	Meeting of BSAS senior staff, including regional staff.
September 25, 2009	Meeting of Criminal Justice stakeholders at MA Emergency Management Agency, Framingham.
October 19, 2009	Meeting of Western MA stakeholders at Holyoke Community College.
October 22, 2009	ICSAP meeting.
November – December, 2009	Meetings of BSAS staff.
January 4, 2010	Draft Plan transmitted to ICSAP for review.
January 21, 2010	ICSAP meeting.
Spring, 2010	Develop final version of Plan.

Appendix IV

Participants in Strategic Planning meetings

Lt. Governor Timothy P. Murray, chair of the Governor's Interagency Council on Substance Abuse and Prevention, convenes quarterly meetings of the Council. As part of the development of the Substance Abuse Strategic Plan Update, presentations and discussions relative to the Plan were addressed during these meetings.

Per Executive Order # 496, below is a complete list of Council Members:

Lt. Governor Timothy P. Murray, Chair
William D. Luzier, Executive Director

John Auerbach	Department of Public Health
JudyAnn Bigby	Executive Office of Health and Human Services
Kim Bishop-Stevens	Department of Children and Families
Michael Botticelli	Department of Public Health
Charles Carr,	Massachusetts Rehabilitation Commission
Seena Carrington (HCF)	Health Care Finance and Policy
Mitchell Chester	Department of Elementary and Secondary Education
Christopher Bulger	Probation
Harold Clarke	Department of Correction
John O'Brien	Commissioner of Probation
Mark Conrad	Parole Board
Terry Dougherty	MassHealth
Dr. Robert T. Kinscherff, Esq.	Juvenile Court
Ellen S. Shapiro	District Court
Jennifer Flanagan	Legislature (Senate)
Francis Wall	Probation
Mary Elizabeth Heffernan	Executive Office of Public Safety
David Hoffman	Department of Mental Health
Elin Howe	Department of Developmental Services
Bradley Jones	Legislature (House)
Lauren Jones	Office of the Lt. Governor
Julia Kehoe	Department of Transitional Assistance
Tom Kelley	Department of Veterans' Services
Sherri Killins	Early Education and Care
Peter J Kosciusko	Department of Youth Services
Barbara Leadholm	Department of Mental Health
Veronica Madden	Department of Correction
Liz Malia	Legislature (House)
Maria Pena	Superior Court
Maryanne Frangules	MOAR
Angelo McClain	Department of Children and Families
David Morales	Health Care Finance and Policy
Janice O'Keefe	Department of Developmental Services
Pat Horne	Community Corrections
Paul McDevitt	Modern Assistance Programs
Heidi Reed	Commission for the Deaf and Hard of Hearing
Ellen Sandler	Health Care Finance and Policy
Jane E. Tewksbury	Department of Youth Services
Richard Tisei	Legislature (Senate)
Robert M. Turillo	Department of Youth Services

Participants in June 24, 2009, stakeholder retreat, Boston

William D. Luzier	Executive Director, ICSAP
Laura Ames	Spectrum Health Systems
Allison F. Bauer	The Boston Foundation
Emily Bharagava	Regional Center for Healthy Communities
Fred Blake	Hurley House
Barry P. Callis	Bureau of Infectious Disease, DPH
David F. Capeless	Berkshire County DA
Nicole Charon-Schmitt	Boston Public Health Commission
Vic DiGravio	Association for Behavioral Healthcare
Deborah Ekstrom	Community Healthlink, Inc.
Norma Finkelstein, Ph.D.	Institute for Health and Recovery
Lorraine Franciose	Victory Programs
Mary Anne Frangules	Massachusetts Organization for Addiction Recovery
Sheridan Haines	Governor's Council to Address Sexual & Domestic Violence
Jeff Harness	Western Massachusetts Center for Healthy Communities
Margie Henderson	Greater Boston Center for Healthy Communities
Matt Hoffman	Answer House
Constance Horgan	Heller School for Social Policy & Management, Brandeis University
A. Jay Horowitz	ValueOptions
Michael Jackman	Norfolk District Attorney's Office
Peter Lee	MA Partnership for Healthy Communities and Local Public Health
Fran Markle	High Point Treatment Center
Bob Monahan	South Shore Recovery Home
Stephanie M. Patton	Southeast Center for Healthy Communities
Constance Peters	Association for Behavioral Healthcare
Rick Quiroga	Casa Esperanza, Inc.
Ximena Sanchez-Samper	Adolescent Substance Abuse Program (ASAP)
Ronnie Springer	Bay Cove Human Services, Inc.
Shari Sprong	Greater Boston Center for Healthy Communities
Emily Stewart	Casa Esperanza, Inc.
Gerry Stewart	Suffolk County D.A.'s Office
Michael Botticelli	Massachusetts Department of Public Health, BSAS
Carolyn Castro-Donlan	Massachusetts Department of Public Health, BSAS
Richard Dougherty	DMA Health Strategies
Carol Girard	Massachusetts Department of Public Health, BSAS
Drew Hanchett	Massachusetts Department of Public Health, BSAS
Frank Holt	Massachusetts Department of Public Health, BSAS
Hilary Jacobs	Massachusetts Department of Public Health, BSAS
Stefano Keel	Massachusetts Department of Public Health, BSAS
Russell Lyman	DMA Health Strategies
Jen Parks	Massachusetts Department of Public Health, BSAS
Sylvia Perlman	DMA Health Strategies
Karen Pressman	Massachusetts Department of Public Health, BSAS
Deborah Strod	DMA Health Strategies
Jennifer Tracey	Massachusetts Department of Public Health, BSAS

Participants in September 25, 2009 meeting of criminal justice stakeholders, Framingham

William D. Luzier	Executive Director, ICSAP
Carole Cafferty	Suffolk County Sheriff's Office
Paul Chiano	Plymouth County Sheriff's Office
Nancy Coffee	New England Field Division
Christopher Dawley	Norfolk County Sheriff's Office
Michael Fabbri	Middlesex District Attorney's Office
Christine Gorgizian	Plymouth County Sheriff's Office
William M. Hughes	Worcester County House of Correction
Pamerson Ifill	Office of Community Corrections
Gary Larareo	Massachusetts Department of Public Health, BSAS
Rui Lima	Bristol County Sheriff's Office
Daniela Lopes	Office of Community Correction
Veronica Madden	Department of Correction
Peter Maguire	Plymouth County Sheriff's Office
Terre Marshall	Department of Correction
Philip McCue	District Court, Boston
Anne Nee	Suffolk County House of Correction
Cecelia Porche	Bristol County District Attorney's Office
James Rioux	Bristol County Sheriff's Office
Cynthia Robinson-Markey	Boston Municipal Court Department
Dan Ryan	Office of the Commissioner of Probation
Gerald Stewart	Suffolk County Sheriff's Office
Laura Waskiewicz	Franklin County Sheriff's Office

Participants in October 19, 2009 meeting of Western MA stakeholders, Holyoke

William D. Luzier	Executive Director, ICSAP
Kat Allen	Community Coalition for Teens
Rene Andersen	Andersen Healing
Judy Atkin	Providence Prenatal and MeryCare Forest Park
Jen Babich	Habit OPCO, Inc.
Debra Bercuvitz	FRESH Start
Christopher Bernier	Phoenix House
Karen Cole	Pittsfield Prevention Partnership/Berkshire United Way
Peter Crumb	MHAJAC
Mariluz Davila	Baystate Brightwood and High Street Health Center
Phil Day	ADS, Baystate Medical Center
Paul Gitterman	The Brien Center for Mental Health and Substance Abuse Services
Janet Grant	Western Massachusetts Center for Healthy Communities
Karen Harrigan	Gandara Residential Services for Women
Kim Harris	Partners for Community
Ruth Jacobson-Hardy	MDPH Western Regional Office
Mali Jeffries	Institute for Health and Recovery
Jim Leyden	Providence Hospital, Substance Abuse Service
Dan McCarthy	Hairston House
Richard McKeown	Western MA Substance Abuse Providers' Association
Jennifer Michaels	The Brien Center
Lorraine Montalto	Corporation for Justice Management
Joanne Morelock	The Brien Center for Mental Health and Substance Abuse Services
Mary Pfister	DCF, Western MA, Substance Abuse Services
Polly Prunuske	Community Action of Franklin, Hampshire & N. Quabbin Regions
Millie Rivas	Gandara Center
Maria Rodman	Western Massachusetts Training Consortium
Jay Sacchetti	ServiceNet, Inc.
Betsy Sanchez	Project RISE, Institute for Health and Recovery
Estelle Santiago	Gandara Center
Linda Sarage	The RECOVER Project
Valerie Soules	Berkshire County Sheriff's Office
Timothy Stanton	AdCare Outpatient – West Springfield, MA
Nancy Stoll	Berkshire United Way
Matthew Tirrell	Berkshire County Sheriff's Office
Janice Tortoriello	River Valley Counseling Center
Joyce Toth	Behavioral Health Network
Melissa Young	Phoenix House Springfield Center

Appendix V

Names of individuals whose positions are identified in this document, as of July 2010

TITLE	NAME
Director, Bureau of Substance Abuse Services	Michael Botticelli
Executive Director, Interagency Council on Substance Abuse & Prevention	William Luzier
Assistant Director, Administration and Finance, BSAS	Joel Acker
Substance Abuse and Special Projects Manager, Department of Children and Families	Kim Bishop-Stevens
Regional Manager, BSAS	Jim Cremer
SBIRT Coordinator, BSAS	Carol Girard
Director, Data Analysis & Decision Support, BSAS	Andrew (Drew) Hanchett
Human Service Program Planner, BSAS	Kathleen Herr-Zaya
Deputy Director, Bureau of Substance Abuse Services	Hilary Jacobs
Regional Manager, BSAS	Ruth Jacobson-Hardy
Program Coordinator, BSAS	Alexandra Kearns
Director, Prevention Services, BSAS	Stefano (Steve) Keel
Regional Manager, BSAS	Ray Kosinski
Criminal Justice Service Coordinator, BSAS	Gary Larareo
Assistant Director, Youth & Young Adult Services, BSAS	Brian Miller
Program Coordinator, BSAS	Rodrigo Monterrey
Assistant Director, Prevention Services, BSAS	Jose Morales
Regional Manager, BSAS	Mayra Morales
Workforce Development and Training Coordinator, BSAS	Jennifer Parks
Licensing Inspector, BSAS	Erica Piedade
Director, Planning & Development, BSAS	Karen Pressman
Assistant Director, Planning & Development, BSAS	Sarah Ruiz
Assistant Director, Quality Assurance & Licensing	Eileen Rush
Director, Youth & Young Adult Services, BSAS	Jennifer Tracey
Director, Administration and Finance, BSAS	Charles (Chuck) Whiteman