



RECOMMENDATIONS OF THE GOVERNOR'S OPIOID WORKING GROUP

JUNE 11, 2015

WWW.MASS.GOV/STOPADDICTION





COMMONWEALTH OF MASSACHUSETTS

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.



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

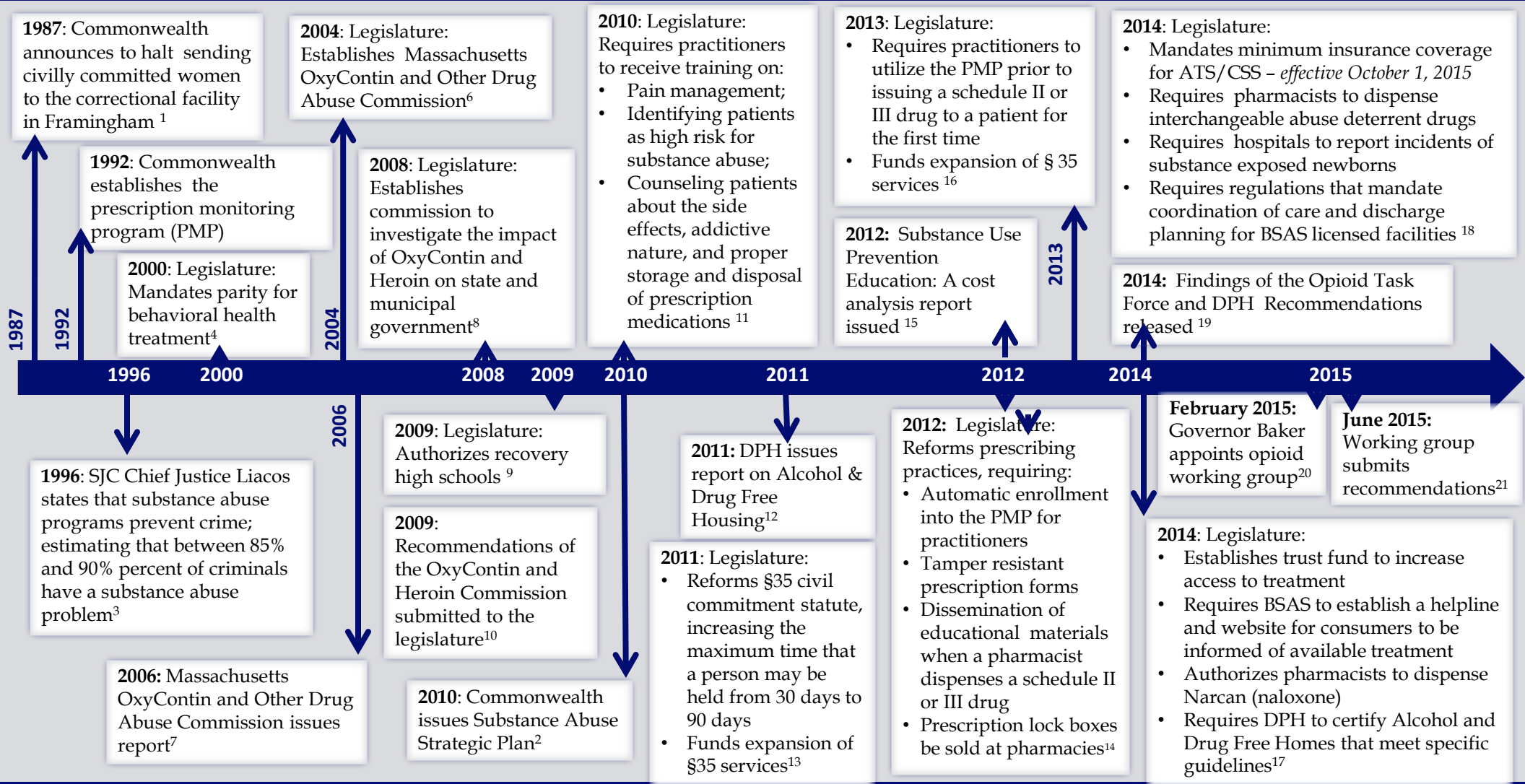


To Meet the Objective the Working Group

- 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



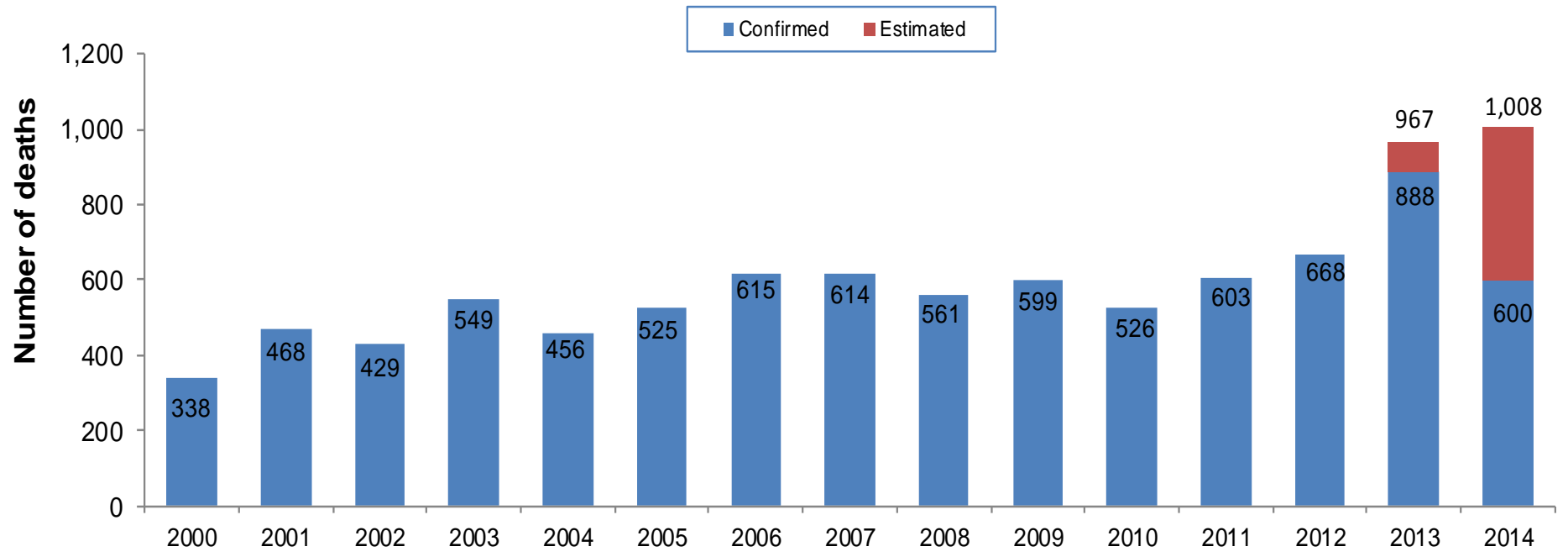
30 Years of Combatting Addiction in the Commonwealth



Sources listed in Appendix A



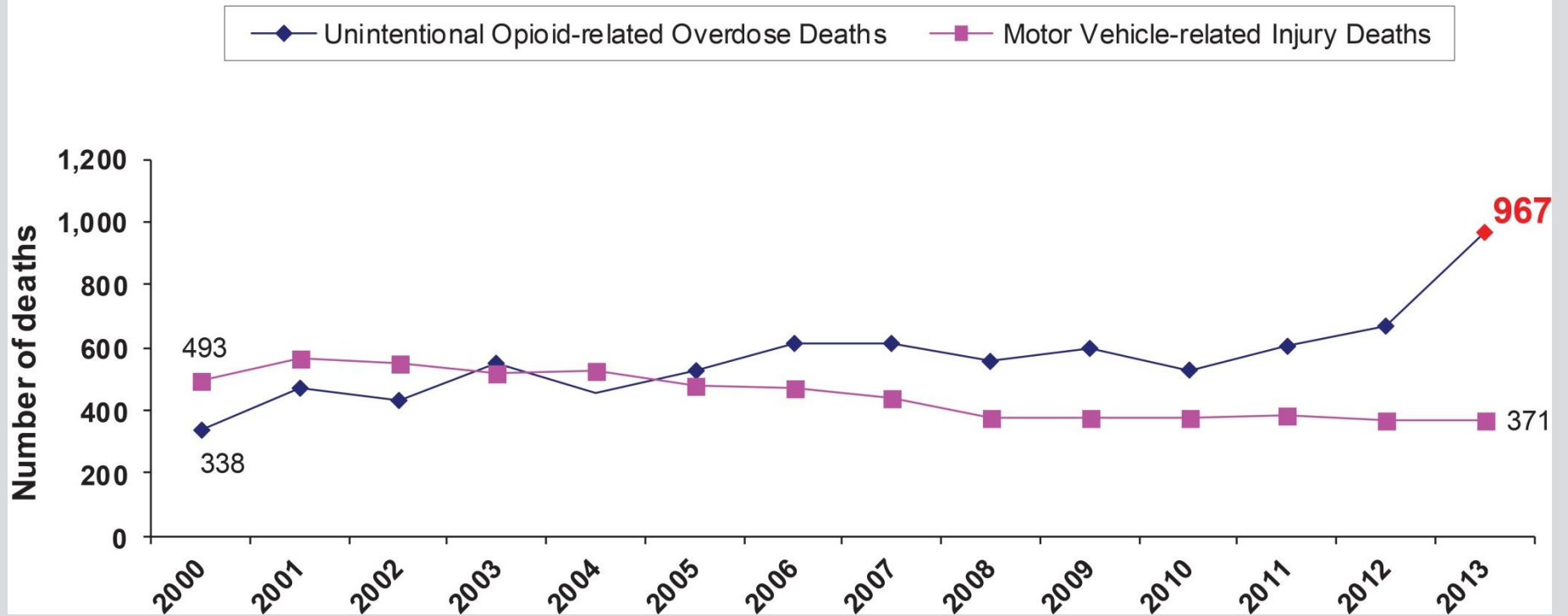
Opioid-Related Deaths, Unintentional/Undetermined Massachusetts: 2000-2014



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>



Unintentional Opioid-related Overdose Deaths vs. Motor Vehicle-related Injury Deaths Massachusetts 2000-2013



MA Department of Public Health Data, February 2015



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.

2. **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.

3. **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.

4. **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.

5. **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.



The Working Group's KEY STRATEGIES:

6. 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.

7. 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.

8. 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.

9. 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.



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

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



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

Recovery Support

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



COMMONWEALTH OF MASSACHUSETTS

FINDINGS AND RECOMMENDATIONS

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

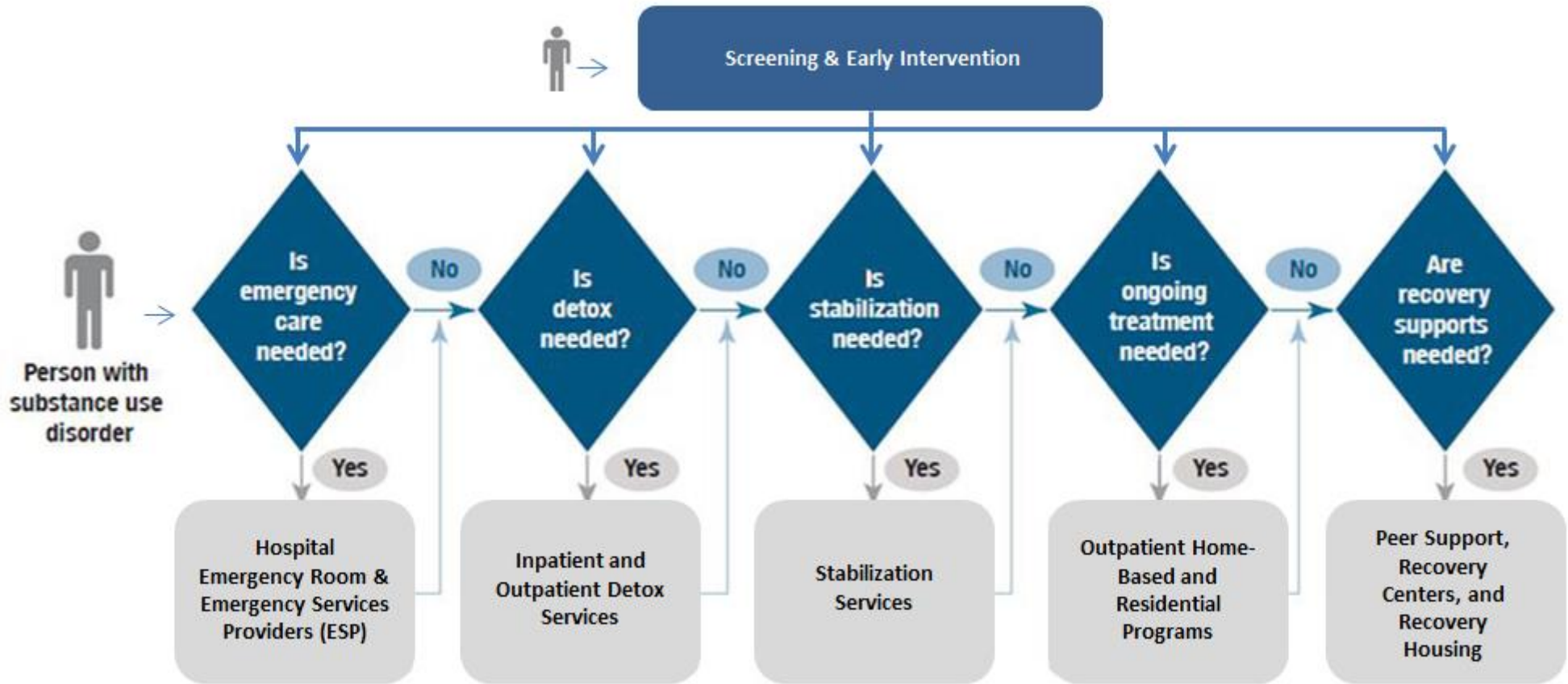


The Working Group's Findings:

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



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

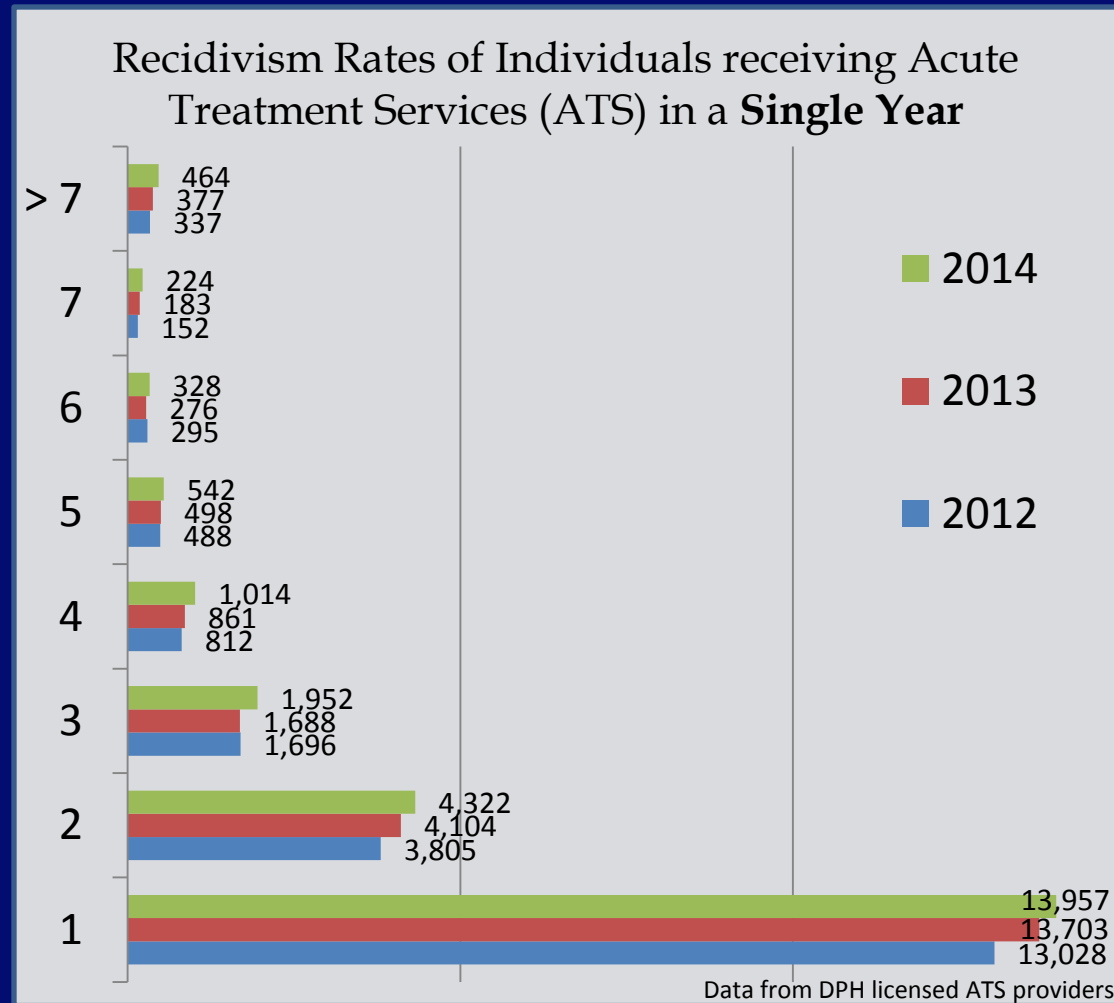


Focusing on patient care can increase access without having to add beds

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 could have received ATS services



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



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

County	Acute Treatment Service Beds (ATS)	Section 35: Acute Treatment Service Beds (ATS)	Clinical Stabilization Service Beds (CSS)	Section 35: Clinical Stabilization Service Beds (CSS)	Transitional Support Service Beds (TSS)	Residential Beds	Outpatient Detox Programs	Opioid Treatment Programs (Methadone)	Outpatient Counseling Programs
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



Number of Licensed Youth & Family Treatment Beds

- 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

County	Family Residential (# of Families Served)	Adolescent Residential Beds (13-17)	Transitional Aged Youth Residential Beds (16-21)	Youth Stabilization Beds (ATS/CSS)
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



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



Recommendations Related to Treatment

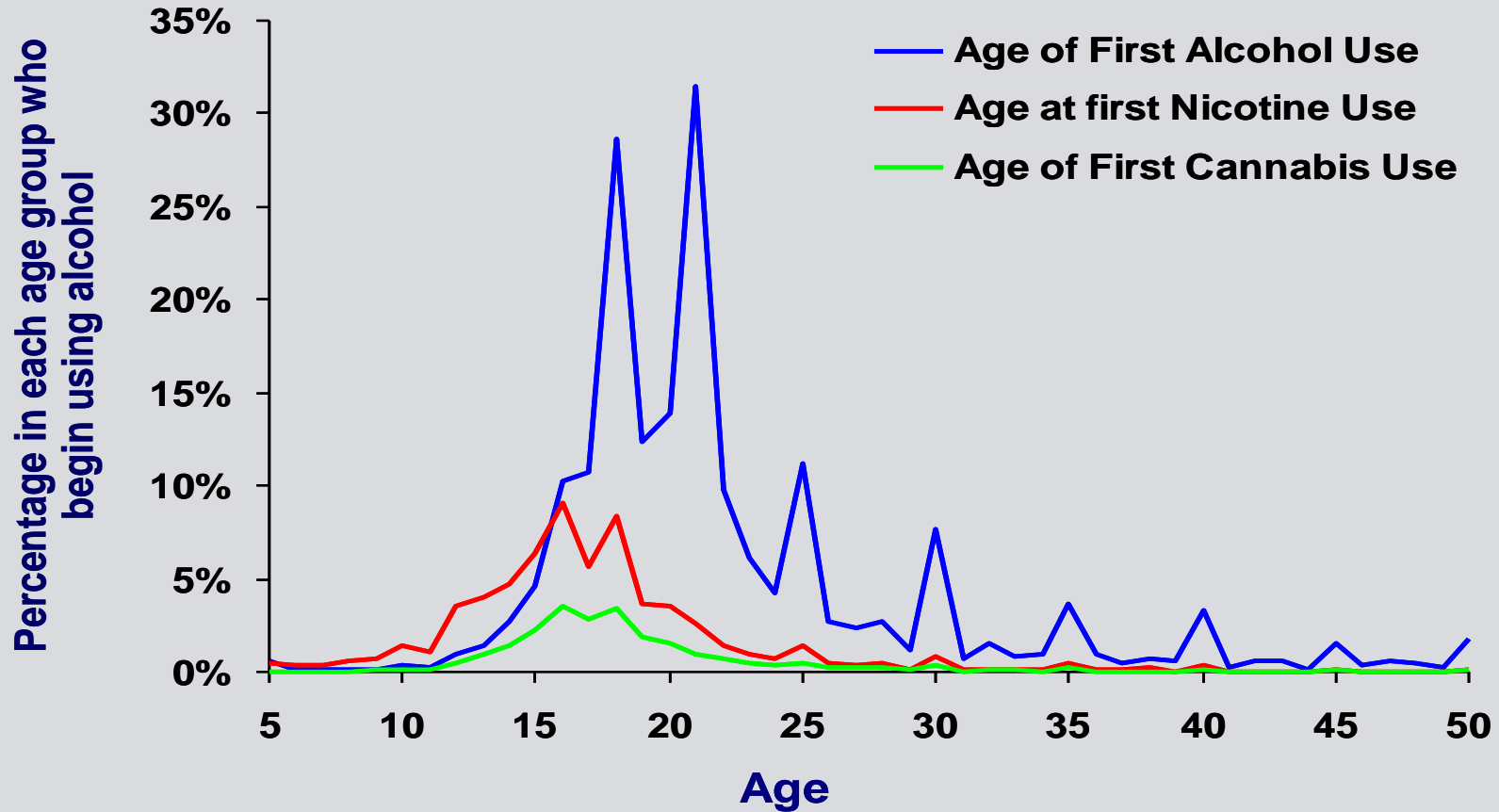
- Increase Access to Evidence-Based Medication-Assisted Treatment
 - Increase the number of office-based opioid treatment programs and the number of practitioners prescribing buprenorphine and naltrexone
 - Enforce and strengthen the requirement that all licensed addiction treatment programs accept patients 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



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

Addiction is a Developmental Disease

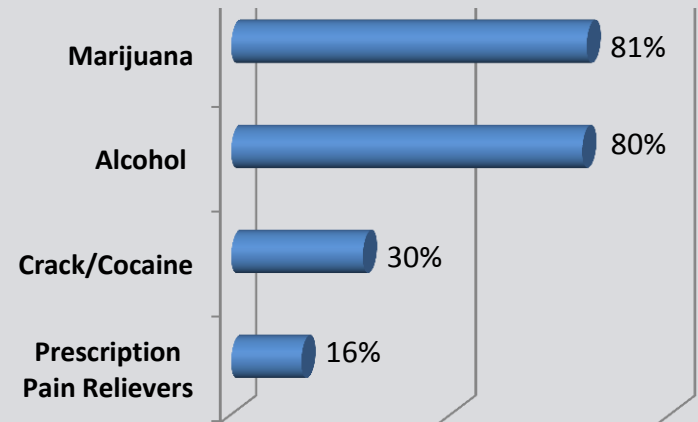


Source: Li, Ting-Kai, *Alcohol Use, Abuse, and Dependence*, National Institute on Alcohol Abuse and Alcoholism, National Institutes of Health, U.S. Department of Health and Human Services, p.30, citing NIAAA National Epidemiologic Survey on Alcohol and Related Conditions, 2003, retrieved from: www.niaaa.nih.gov/publications/monographs/monograph7/25011-26001/25521.ppt

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



2012 National Survey on Parent/Teen Conversations about Substance Misuse²



- 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 younger¹
- 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 substances⁴

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. PMID: 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



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



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



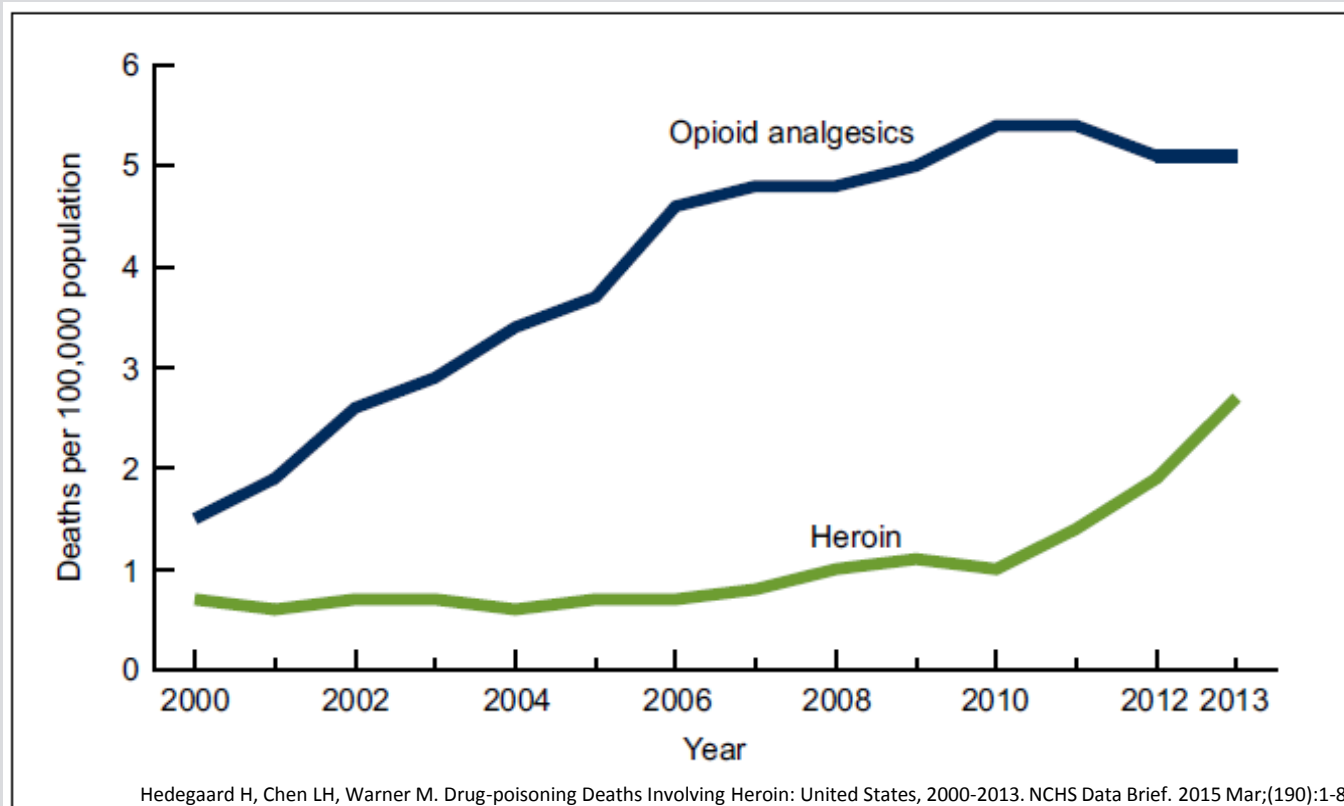
Recommendations Related to Neonatal Abstinence Syndrome, Prenatal Care & Neonatal Care

- 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



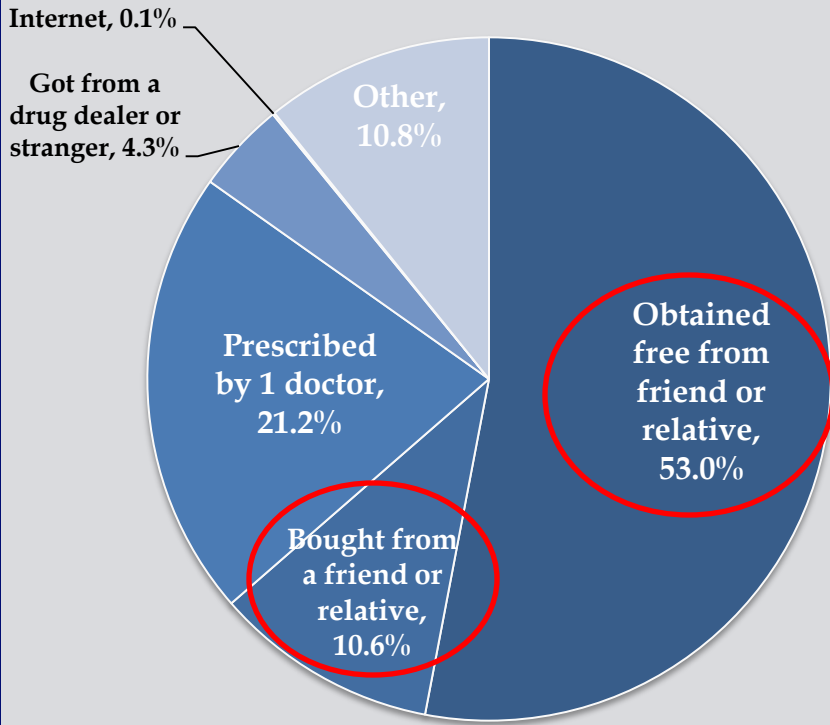
RATES OF OVERDOSE DEATH FROM PRESCRIPTION PAINKILLERS & HEROIN UNITED STATES, 2000-2013



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



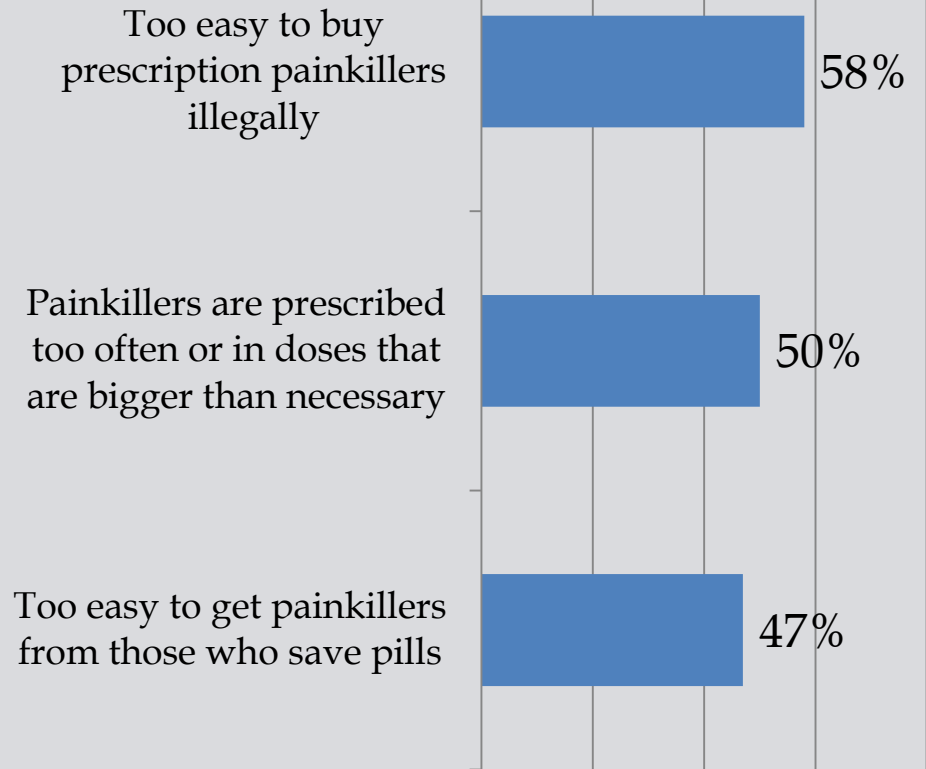
SOURCE, AMONG THOSE AGED 12 OR OLDER, WHO USED PAIN RELIEVERS NONMEDICALLY (2012-2013)



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



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



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

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

* 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



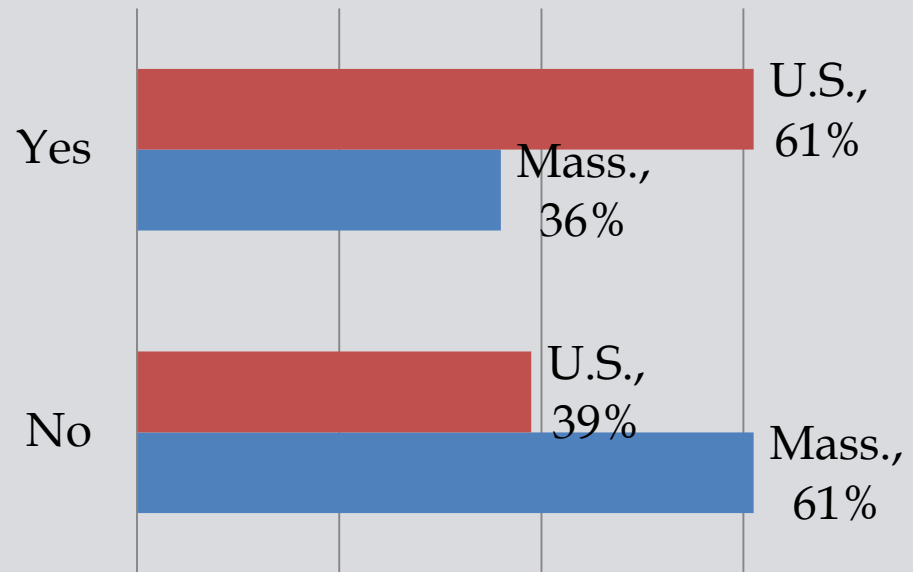
MASSACHUSETTS DOCTORS DISCUSS THE RISKS OF PRESCRIPTION PAINKILLERS WITH PATIENTS LESS THAN DOCTORS IN OTHER PARTS OF THE COUNTRY

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

Did your doctor discuss the risks of addiction with you?



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



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



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 professionals¹

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](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



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



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



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



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

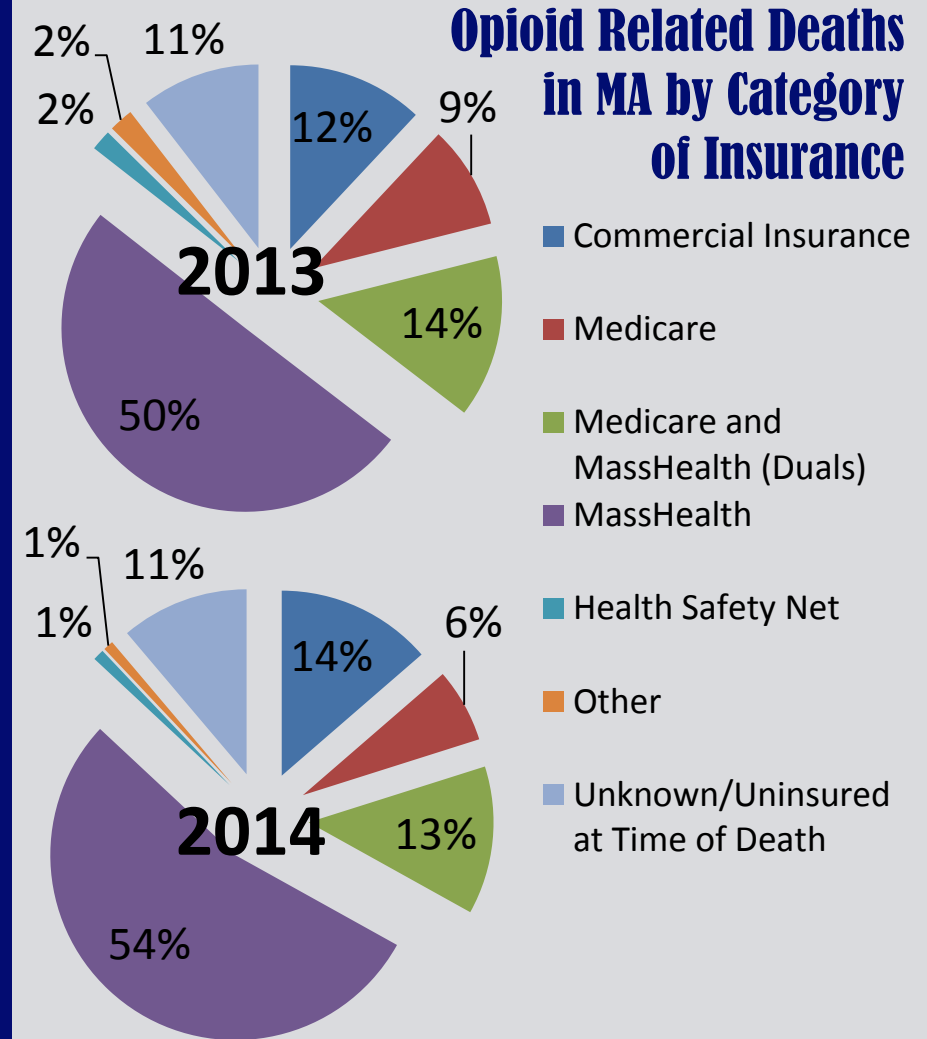
Date	Price Per Naloxone “Kit” 2 Naloxone Doses and 2 Atomizers
November 2007	\$22.98
March 2008	\$31.55
January 2009	\$31.87
September 2009	\$31.49
June 2011	\$31.77
March 2012	\$32.35
May 2012	\$40.56
January 2014	\$42.82
July 2014	\$41.69
November 2014	\$74.06
May 2015	\$74.06

Finding 9: Increasing access to Naloxone will save lives



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 parity laws through enforcement actions to remove inappropriate barriers to treatment
- Encourage insurers to support non-opioid pain therapies
- 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



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



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



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



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

Prevention

- Increase educational offerings for prescribers and patients to promote safe prescriber practices
- Develop targeted educational materials for schools
- Appoint members to the drug formulary commission
- Integrate information about the risks of opioid use and misuse into school athletic programs
- Conduct a public awareness campaign

Intervention

- Improve the PMP
- Outreach to prenatal and postpartum providers to increase screening for women with a substance use disorder
- Improve reporting of overdose death data
- Enhance data transparency, including EMS data
- Encourage naloxone to be co-prescribed with opioids
- Amend civil commitment process
- Identify hot spots for targeted intervention, using EMS, hospital, and police data
- Promote the Good Samaritan law
- Consider mandating testing for in utero exposure to alcohol and drugs at every birth
- Encourage and support alternatives to arrest
- Expand availability of Naloxone

Treatment

- Develop a central statewide database of available treatment services
- Transfer section 35 civil commitment responsibility from DOC to EOHHS
- Increase the number of office based opioid treatment programs
- Require DOI to issue bulletins on chapter 258 of the Acts of 2014 prior to Oct. 2015
- Pilot recovery coaches in emergency rooms and hot spots
- Bulk purchase opioid agonist and naltrexone therapies for correctional facilities
- Add 100 new ATS/CSS beds
- Open Recovery High School in Worcester
- Review capacity in the treatment system for women/families
- Analyze treatment spending in correctional facilities
- Increase the number of stepdown beds and services

Recovery

- 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



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

Prevention

- 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

Intervention

- 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

Treatment

- 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

Recovery

- 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



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

Prevention

- 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

Intervention

- Improve the PMP by interfacing the PMP with electronic health records

Treatment

- Establish and promote a longitudinally based system of addiction care
- Integrate primary care into substance use treatment programs

Recovery

- Reduce stigma among medical and treatment professionals



COMMONWEALTH OF MASSACHUSETTS

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



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



Organizations that Submitted Information to the Working Group

Community Substance Abuse Centers
Cordant Health Solutions
Covectra
Coverys
Education Development Center, Inc.
Emerson Hospital
EvansCutler
Families Against Mandatory Minimums
Family Health Center of Worcester
Franklin County Home Care Corporation
Franklin County House of Corrections - Residents
Franklin County Sheriff's Office
Franklin Regional Council of Governments
Gate House
Gosnold on Cape Cod
Granada House
Greenfield Health Center
Greenfield Public Schools
Hampden County Sheriff's Department
Harvard Pilgrim Health Care
Health Care For All
Health Innovations, Inc.
Healthy Gloucester Collaborative
Healthy Streets Outreach Program
Heroin Education Awareness Task Force

High Point Treatment Center
Holyoke Recovery Support Center
Hope Health / Hope Hospice
Hope House, Inc. - Boston - Residents
Hyde Park Pain Management
Imprivata
Inflexxion
Institute for Health and Recovery
Journal of Opioid Management
Learn to Cope
Locke Lord, LLP
Lowell House, Inc.
Main South Alliance for Public Safety
March of Dimes Massachusetts
Massachusetts Association of Behavioral Health Systems, Inc.
Massachusetts Association of Health Plans
Massachusetts Attorney General's Office
Massachusetts Behavioral Health Partnership
Massachusetts Chiropractic Society, Inc.
Massachusetts Council of Human Service Providers, Inc.
Massachusetts Department of Children and Families
Massachusetts Dept. of Elementary and Secondary Education
Massachusetts Department of Mental Health
Mass. Dept. of Mental Health: Franklin/North Quabbin Area
Massachusetts Department of Public Health



Organizations that Submitted Information to the Working Group

Massachusetts Division of Insurance	North Adams Mayor's Office
Massachusetts Health Council	Northern Berkshire Community Coalition
Massachusetts Hospital Association	Northwestern District Attorney's Office
Massachusetts Medical Society	Number 16
Massachusetts Organization for Addiction Recovery	Opioid Task Force of Franklin County and North Quabbin
Massachusetts Pain Initiative	Ostiguy School
Mass Society for the Prevention of Cruelty to Children	Partnership for Drug-Free Kids
Mass Technical Assistance Partnership for Prevention	Peabody Police Department
Massachusetts Trial Court	Pfizer
MassHealth	Phoenix Multisport
MCI-Norfolk Project Youth Program	Pioneer Valley Regional School District
Medford Substance Abuse Task Force	Plymouth County Correctional Facility
Melrose Substance Abuse Prevention Coalition	Plymouth Fire Department
Meridian House	Plymouth Police Department
Merrimack Valley Prevention and Substance Abuse Project	Plymouth Public Schools
Middlesex County Opioid Task Force	Project Cope
Middlesex District Attorney's Office	Project NESST (Newborns Exposed to Substances: Support and Therapy)
Monson HEARS	Project Youth
Mystic Valley Public Health Coalition's Opioid Abuse Prevention Collaborative	Quaboag Hills Community Coalition
Narcotics Anonymous	Quincy Community Action Programs, Inc.
Never Another Death	Real You Revolution
New Beginnings Peer Recovery Center	Recovery Homes Collaborative
Norfolk County Sheriff's Office	RW Massage Therapy
Norfolk District Attorney's Office	SAS Solutions



Organizations that Submitted Information to the Working Group

Scituate FACTs
SEIU Local 509
Shrewsbury High School
Shilts Chiropractic Offices
Somerville Overcoming Addiction
South Bay Mental Health
South Hadley High School
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

Victory Programs, Inc.
WellCrest
Wellesley College Health Service
Western Mass Recovery Learning Community
Wicked Sober Inc.
Worcester District Attorney's Office
Worcester Sheriff's Office



Additional Resources Reviewed by the Working Group

1. Albert, B. (2015). Analysis of Substance Abuse on Cape Cod: A Baseline Assessment. Barnstable County Human Services, March 2015. Retrieved from: <http://www.bchumanservices.net/library/2015/03/RSAC-Baseline-Report-FULL-REPORT-3-11-15-Final.pdf>.
2. Alford, D. P., LaBelle, C. T., Kretsch, N., Bergeron, A., Winter, M., Botticelli, M., & Samet, J. H. (2011). Five Year Experience with Collaborative Care of Opioid Addicted Patients using Buprenorphine in Primary Care. Archives of Internal Medicine, Vol. 171, No. 5, 425-431. Retrieved from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3059544/pdf/nihms240250.pdf>.
3. Beacon Health Options (June, 2015). Confronting The Crisis Of Opioid Addiction, A Beacon Health Options White Paper. Retrieved from: <http://beaconlens.com/wp-content/uploads/2015/06/Confronting-the-Crisis-of-Opioid-Addiction.pdf>
4. Clark, R. E., Samnaliev, M., Baxter, J. D., & Leung, G. Y. (2011). The Evidence Doesn't Justify Steps By State Medicaid Programs To Restrict Opioid Addiction Treatment With Buprenorphine. Health Affairs, 30, No. 8, 1425-1433. Retrieved from: <http://content.healthaffairs.org/content/30/8/1425.long>.
5. Coffin, P. O., & Sullivan, S. D. (2013). Cost-Effectiveness of Distributing Naloxone to Heroin Users for Lay Overdose Reversal. Annals of Internal Medicine, Vol. 158, Issue 1, 1-9. Retrieved from: <http://annals.org/article.aspx?articleid=1487798>,
6. Connery, H. S. (2015). Medication-Assisted Treatment of Opioid Use Disorder: Review of the Evidence and Future Directions. Harvard Review of Psychiatry, Vol. 23, Issue 2, 63-75. Retrieved from: http://journals.lww.com/hrpjournal/Fulltext/2015/03000/Medication_Assisted_Treatment_of_Opioid_Use.2.aspx#.
7. Cunningham, Courtney (2015). Opioid Addiction Treatment: Evidence-Based Medicine, Policy, and Practice. Massachusetts Association of Health Plans, OnPoint: Health Policy Brief, Vol. II, March 2015. Retrieved from: http://www.maahp.com/unify-files/MAHPOnPoint_March2015_Opioid.pdf.
8. D'Onofrio, G., O'Connor, P. G., Pantalon, M. V., Chawarski, M. C., Busch, S. H., Owens, P. H., Bernstein, S. L., & Fiellin, D. A. (2015). Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence: a randomized clinical trial. The Journal of the American Medical Association, Vol. 313, Issue 16, 1636-1644. Retrieved from: <http://jama.jamanetwork.com/article.aspx?articleid=2279713>.
9. Dart, R. C., Surratt, H. L., Cicero, T. J., Parrino, M. W., Severtson, S. G., Bucher-Bartelson, B., & Green, L. L. (2015). Trends in Opioid Analgesic Abuse and Mortality in the United States. The New England Journal of Medicine, Vol. 372, 241-248. Retrieved from: <http://www.nejm.org/doi/full/10.1056/NEJMsa1406143>.
10. Dennis M., & Scott, C. K. (2007). Managing Addiction as a Chronic Condition. Addiction Science & Clinical Practice, Vol. 4, Issue 1, 45-55. Retrieved from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2797101/pdf/ascp-04-1-45.pdf>.
11. Depew, B., Esiobu, C., Gabrieli, J., Ojeaburu, S., He, C., Moon, J., Chen, E., Agabalogun, T., & Rahman, A. (2014). Involuntary Commitment for Substance Abuse Treatment in Massachusetts: Problems and Proposed Solutions. Harvard Institute of Politics, Policy Brief, May 2014. Retrieved from: http://www.iop.harvard.edu/sites/default/files_new/research-policy-papers/Section35HealthcarePolicyPaper.pdf.
12. Franklin, G., Sabel, J., Jones, C. M., Mai, J., Baumgartner, C., Banta-Green, C. J., Neven, D., & Tauben, D. J. (2015). A comprehensive approach to address the prescription opioid epidemic in Washington State: milestones and lessons learned. American Journal of Public Health, Vol 105, Issue 3, 463-469. Retrieved from: http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2014.302367?url_ver=Z39.88-2003&rft_id=ori%3Arid%3Acrossref.org&rft_dat=cr_pub%3Dpubmed&.
13. Haegerich, T. M., Paulozzi, L. J., Manns, B. J., & Jones, C. M. (2014). What we know, and don't know, about the impact of state policy and systems-level interventions on prescription drug overdose. Drugs and Alcohol Dependence, December 1, 2014, Vol 145, 34-47. Retrieved from: [http://www.drugandalcoholdependence.com/article/S0376-8716\(14\)01846-8/fulltext](http://www.drugandalcoholdependence.com/article/S0376-8716(14)01846-8/fulltext).
14. Hedegaard, H., Chen, L. H., & Warner, M. (2015). Drug-poisoning Deaths Involving Heroin: United States, 2000-2013. NCHS Data Brief, No. 190, March 2015, 1-7. Retrieved from: <http://www.cdc.gov/nchs/data/databriefs/db190.pdf>.
15. 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](http://www.amjmed.com/article/S0002-9343(14)00770-0/pdf).
16. Kolodny, A. K., Courtwright, D. T., Hwang, C. S., Kreiner, P., Eadie, J. L., Clark, T. W., & Alexander, G. C. (2015). The Prescription Opioid and Heroin Crisis: A Public Health Approach to an Epidemic of Addiction. Annual Review of Public Health, Vo. 36, 559-574. Retrieved from: http://www.annualreviews.org/doi/full/10.1146/annurev-publhealth-031914-122957?url_ver=Z39.88-2003&rft_id=ori:rid:crossref.org&rft_dat=cr_pub%3Dpubmed&.
17. Legal Action Center (2015). Confronting an Epidemic: The Case for Eliminating Barriers to Medication-Assisted Treatment of Heroin and Opioid Addiction. Retrieved from: <http://lac.org/wp-content/uploads/2014/07/LAC-The-Case-for-Eliminating-Barriers-to-Medication-Assisted-Treatment.pdf>.



Additional Resources Reviewed by the Working Group

18. Liebschutz, J. M., Crooks, D., Herman, D., Anderson, B., Tsui, J., Meshesha, L. Z., Dossabhoy, S., Stein, M. (2014). Buprenorphine Treatment for Hospitalized, Opioid-Dependent Patients: A Randomized Clinical Trial. *The Journal of the American Medical Association: Internal Medicine* Vol. 174, Issue 8, 1369-1376. Retrieved from: <http://archinte.jamanetwork.com/article.aspx?articleid=1885989>.
19. 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. Retrieved from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3272222/>.
20. Magura, S., Lee, J. D., Hershberger, J., Joseph, H., Marsch, L., Shropshire, C., & Rosenblum, A. (2009). Buprenorphine and methadone maintenance in jail and post-release: a randomized clinical trial. *Drug and Alcohol Dependence*, 99(1-3), 222–230. Retrieved from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2658719/pdf/nihms90814.pdf>.
21. Marshall, B. D. L., Milloy, M. J., Wood, E., Montaner, J. S. G., & Kerr, T. (2011). Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: a retrospective population-based study. *The Lancet*, Volume 377, Issue 9775, 1429-1437. Retrieved from: [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(10\)62353-7/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)62353-7/fulltext).
22. Massachusetts Center for Health Information and Analysis (2015). Access to Substance Use Disorder Treatment in Massachusetts. Retrieved from: <http://chiamass.gov/assets/Uploads/SUD-REPORT.pdf>.
23. Massachusetts Department of Public Health (2015). Data Brief: Fatal Opioid-related Overdose Among MA Residents. Retrieved from: <http://www.mass.gov/eohhs/docs/dph/quality/drugcontrol/county-level-pmp/data-brief-apr-2015-overdose-county.pdf>.
24. Massachusetts Department of Public Health (2014). Findings of the Opioid Task Force and Department of Public Health Recommendations on Priorities for Investments in Prevention, Intervention, Treatment and Recovery. Retrieved from: <http://www.mass.gov/eohhs/docs/dph/substance-abuse/opioid/report-of-the-opioid-task-force-6-10-14.pdf>.
25. Massachusetts Health Council (2015). Local Approaches to the Opioid Overdose Epidemic: How Massachusetts Communities are Responding Today. Retrieved from: http://c.ymcdn.com/sites/www.mahealthcouncil.org/resource/resmgr/Member_Distribution/MHC_Community_Opioid_Coaliti.pdf
26. Massachusetts Hospital Association (2015). MHA Guidelines for Emergency Department Opioid Management. Retrieved from: https://www.mhalink.org/AM/Template.cfm?Section=Substance_Abuse&Template=/CM/ContentDisplay.cfm&ContentID=49021.
27. Massachusetts Joint Policy Working Group (2014). Response to the Massachusetts Opioid Prescription Drug Epidemic. Retrieved from: <http://www.mass.gov/eohhs/docs/dph/quality/drugcontrol/best-practices/best-practices-workgroup-report.pdf>.
28. Massachusetts Medical Society (2015). Massachusetts Medical Society Opioid Therapy and Physician Communication Guidelines. Retrieved from: <http://www.massmed.org/Patient-Care/Health-Topics/Massachusetts-Medical-Society-Opioid-Therapy-and-Physician-Communication-Guidelines/#.VXHIBNJViko>.
29. Massachusetts Office of the Attorney General (2014). Examination of Health Care Cost Trends and Cost Drivers. Retrieved from: <http://www.mass.gov/ago/docs/healthcare/2014-hcctd.pdf>.
30. Massachusetts OxyContin and Heroin Commission (2009). Recommendations of the OxyContin and Heroin Commission. Retrieved from: <http://archives.lib.state.ma.us/bitstream/handle/2452/46748/ocn466141823.pdf?sequence=1&isAllowed=y>.
31. National Association of State Alcohol and Drug Abuse Directors, Inc. (2015). Opioids. Retrieved from: <http://nasadad.wpengine.com/wp-content/uploads/2015/05/Opioids-Final.pdf>.
32. National Institute on Drug Abuse (2014). Drug Facts: Lessons from Prevention Research. Retrieved from: https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/drugfacts_lessonsfromprevention.pdf.
33. Report to the Legislature, Substance Use Prevention Education: A Cost Analysis (2012). Retrieved from: <http://www.mass.gov/edu/docs/eoe/publication-reports/20121001-substance-use-prevention-edu-rpt.pdf>.
34. Saitz, R., Larson, M. J., LaBelle, C., Richardson, J., & Samet, J. H. (2008). The Case for Chronic Disease Management for Addiction. *The Journal of Addiction Medicine*, Vol. 2, Issue 2, 55-65. Retrieved from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2756688/pdf/nihms-123835.pdf>.
35. Schwartz, R. P., Gryczynski, J., O'Grady, K. E., Sharfstein, J. M., Warren, G., Olsen, Y., Mitchell, S. G., & Jaffe, J. H. (2013). Opioid Agonist Treatments and Heroin Overdose Deaths in Baltimore, Maryland, 1995–2009. *American Journal of Public Health*, Vol. 103, Issue 5, 917–922. Retrieved from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3670653/pdf/AJPH.2012.301049.pdf>.
36. Shanahan, C. W., Beers, D., Alford, D. P., Brigandi, E., & Samet, J. H. (2010). A Transitional Opioid Program to Engage Hospitalized Drug Users. *Journal of General Internal Medicine*, Vol. 25, Issue 8, 803-808. Retrieved from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2896583/pdf/11606_2010_Article_1311.pdf.



Additional Resources Reviewed by the Working Group

37. The Boston Globe and Harvard T. H. Chan School of Public Health. Prescription Painkiller Abuse: Attitudes among Adults in Massachusetts and the United States. May 2015. Retrieved from: <https://s3.amazonaws.com/s3.documentcloud.org/documents/2082835/prescription-painkiller-poll-report-the-boston.pdf>.
38. United Nations Office on Drugs and Crime and the World Health Organization. Opioid overdose: preventing and reducing opioid overdose mortality. Discussion paper, UNODC/WHO, 2013. Retrieved from: http://www.who.int/substance_abuse/publications/opioid_overdose.pdf?ua=1.
39. United States Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (2015). Opioid Abuse in the U.S. and HHS Actions to Address Opioid-Drug Related Overdoses and Deaths. ASPE Issue Brief, March 26, 2015. Retrieved from: http://aspe.hhs.gov/sp/reports/2015/OpioidInitiative/ib_OpioidInitiative.pdf.
40. Vermont Agency of Human Services (2012). Integrated Treatment Continuum for Substance Use Dependence "Hub/Spoke" Initiative – Phase 1: Opiate Dependence. Retrieved from: <http://www.healthvermont.gov/adap/documents/HUBSPOKEBriefingDocV122112.pdf>.
41. Vermont Department of Health (2015). Report to the Vermont Legislature: The Effectiveness of Vermont's System of Opioid Addiction Treatment. Retrieved from: <http://legislature.vermont.gov/assets/Legislative-Reports/Opioid-system-effectiveness-1.14.15.pdf>.
42. Volkow, N. D., Frieden, T. R., Hyde, P. S., & Cha, S. S. (2014). Medication-Assisted Therapies – Tackling the Opioid-Overdose Epidemic. The New England Journal of Medicine, Vol. 370, 2063-2066. Retrieved from: <http://www.nejm.org/doi/pdf/10.1056/NEJMp1402780>.
43. Walley, A. Y., Xuan, Z., Hackman, H. H., Quinn, E., Doe-Simkins, M., Sorensen-Alawad, A., Ruiz, S., & Ozonoff, A. (2013). Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis. The Boston Medical Journal, 346: f174, 1-12. Retrieved from: <http://www.bmj.com/content/346/bmj.f174.full.pdf+html>.
44. White House's Office of National Drug Control Policy. 2014 National Drug Control Strategy. Retrieved from: https://www.whitehouse.gov/sites/default/files/ndcs_2014.pdf.



Appendix A

1. Lehr, G. (1987). Program Targets Alcoholic Women Care, Not Jail, Is New Policy. *The Boston Globe*, May 5, 1987, pp. 21.
2. Commonwealth of Massachusetts (2010). Substance Abuse Strategic Plan Update FY 2011 – FY 2016. *July 2010*. Retrieved from: <http://www.dmahealth.com/pdf/ICSAP%20Strategic%20Plan%20Update%20July%202010.pdf>.
3. Unknown (1996). Liacos. State House News Service, June 19, 1996.
4. Chapter 80 of the Acts of 2000.
5. Beardsley, E. J. (2000). New Data Profiles Recipients, Addresses The Success Of Drug Treatment. State House News Service, July 18, 2000.
6. Chapter 189 of the Acts of 2004.
7. Massachusetts OxyContin and Other Drug Abuse Commission (2005). Final Report. Retrieved from: <https://www.ok.gov/odmhsas/documents/MA%20RX.pdf>.
8. Chapter 302 of the Acts of 2008.
9. Chapter 27 of the Acts of 2009.
10. Massachusetts OxyContin and Heroin Commission (2009). Recommendations of the OxyContin and Heroin Commission. Retrieved from: <http://archives.lib.state.ma.us/bitstream/handle/2452/46748/ocn466141823.pdf?sequence=1&isAllowed=y>.
11. Chapter 283 of the Acts of 2010.
12. Massachusetts Department of Public Health (2011). Study Regarding Sober (Alcohol and Drug Free) Housing In response to Chapter 283, Section 10, of the Acts of 2010. Retrieved from: <http://www.mass.gov/eohhs/docs/dph/substance-abuse/adf-housing-study.pdf>
13. Chapter 142 of the Acts of 2011.
14. Chapter 244 of the Acts of 2012.
15. Report to the Legislature, Substance Use Prevention Education: A Cost Analysis (2012). Retrieved from: <http://www.mass.gov/edu/docs/eoe/publication-reports/20121001-substance-use-prevention-edu-rpt.pdf>.
16. Chapter 38 of the Acts of 2013.
17. Chapter 165 of the Acts of 2014.
18. Chapter 258 of the Acts of 2014.
19. Massachusetts Department of Public Health (2014). Findings of the Opioid Task Force and Department of Public Health Recommendations on Priorities for Investments in Prevention, Intervention, Treatment and Recovery. Retrieved from: <http://www.mass.gov/eohhs/docs/dph/substance-abuse/opioid/report-of-the-opioid-task-force-6-10-14.pdf>.