

2019

Addressing the Opioid Epidemic: Connecting People to Services

**Best Practices, Examples,
and Tips for Cities and
Towns of All Sizes**

PREPARED FOR THE METROPOLITAN MAYORS COALITION BY THE
METROPOLITAN AREA PLANNING COUNCIL

Table of Contents

Introduction 1

How to Use This Information 2

Best Practices 3

The Chelsea Hub 6

**Providing Access to Addictions
Treatment and Support (PAATHS) 9**

**Arlington Post-Overdose Outreach
and Treatment Placement 11**

**The City of Revere
Substance Abuse Disorder Initiative (SUDI) 13**

**Origins of this Booklet and Potential
for Regional Action 16**

Connecting People to Services



Cities and towns in Greater Boston are on the front line in addressing the impacts of the opioid epidemic. Local police and fire are often first on the scene to revive individuals who have overdosed. Municipal public health, public safety, social work, and recovery professionals are often directly engaged with residents suffering from opioid use disorders (OUD) and their loved ones as they attempt to recover. Because local officials are closest to the challenges raised by the crisis, they are often seen as a resource in helping residents with OUDs to find and access acute and continuing treatment options, harm reduction programs, and long-term recovery services.

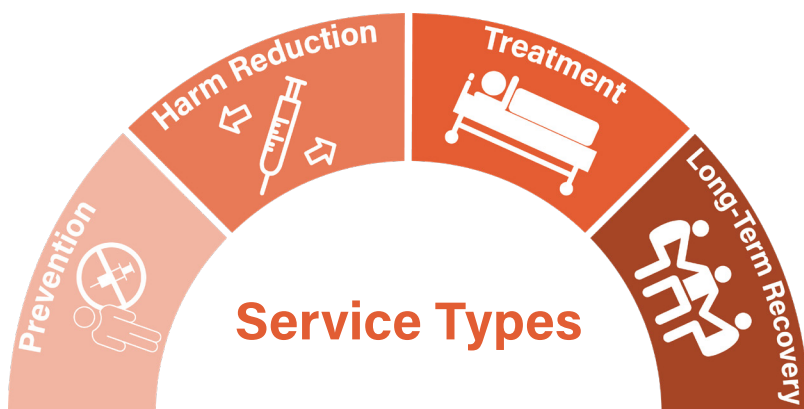
Effectively connecting residents in need to those services is not as simple as it sounds, however. Knowing what services are available, how to get a resident into a program, and which programs are best suited to a resident's needs are all challenges for municipal officials who have limited resources available to develop the knowledge needed to successfully steer residents to services that can help them.

A number of area cities and towns have nevertheless devised strategies and launched programs with the goal of helping to connect opioid users to critical services. Over the course of 2018, staff at the Metropolitan Area Planning Council (MAPC) researched and gathered data on a number of these programs. From that work, and interviews with municipal staff, profiles of four innovative programs and approaches that connect people to services have been developed. This booklet provides tips and best practices from those programs, with the aim of sharing them with other cities and towns that are also trying to figure out the best way to connect their residents to services.

While not every city or town has the same resources or the same problems, there are small steps that even the most resource-strapped community can implement to build the knowledge needed to effectively steer people with OUDs to services they can benefit from.

Thank you to all the municipal officials who gave their time and insight to the development of this booklet.

How to Use this Information



In four case studies, we've identified response strategies that can be scaled depending on a municipality's resources. Throughout this booklet, those are identified as **Tips**.

But key themes emerged throughout our research: steps that every municipality should take to lay the foundation for their opioid response efforts. Those are identified on the **Best Practices** page.

The following examples are just a few of the many efforts underway in Greater Boston to combat the opioid crisis. They represent services along a continuum and each one takes on the problem in a different way. Most identified tips can be scaled based on budget or capability. The programs and strategies highlighted should serve as a starting points – not as exact blueprints – for developing new interventions.

Best Practices

Interviews with local municipal staff and providers revealed that many successful local initiatives to connect people to services had certain practices in common. These are steps that everyone looking to effectively connect people to opioid abuse services can take.



Understand the Local Service Landscape

An important step to effectively connect people to treatment and recovery services is knowing what services are available in your area. A city or town should have someone on staff, or multiple people from key departments like public health, police, and fire/EMS, that have a thorough understanding of the treatment programs, social service supports, and community groups working in their area to help people with OUDs. These staff members should also have a good understanding of the latest practices for reducing harm, providing treatment, and supporting long-term recovery. Having designated municipal officials that are well-informed on the range of services available, from syringe disposal sites to Medication-Assisted Treatment (MAT) options, can save and improve lives in your community.



Communicate

Understanding the local service landscape is important, but if service information isn't shared with community members or residents don't know who they can call if they need assistance, the information is not as helpful as it could be. Cities and towns should make information about services for people with OUDs easily accessible on their websites and in regular communications with residents. They should also have a local point of contact for service assistance listed on the web and in printed materials. Communities can also use or form community coalitions to share this information, including service providers and people who suffer from OUDs (or their families and carers).



Be Proactive, Not Reactive

Communities that want to better connect people to services should be deliberate about it. Developing a plan for how they can achieve this goal is a good first step. The plan should include clear tasks and milestones for how the community will work to connect people and measures to track whether these actions are making a difference for people in need.

Time and funding for carrying out such a program needs to be identified. But don't embark on such an endeavor just because you have a grant that could be used for it. Develop the plan first and then determine how and from where to access resources to undertake it.

Program Profiles

The following four program profiles highlight different approaches taken by Greater Boston communities to connect people to services. The origins of these initiatives and information on budget, staffing, and funding sources are offered as references to other communities seeking to duplicate such programs. Tips drawn from the experience of those running these programs are provided as further guidance.

The Chelsea Hub

Chelsea, Massachusetts

Size: 25 member organizations

15 to 20 regular participants

Budget: The Police Community Engagement Specialist provides their time for this initiative

Funding Sources:

Member organizations dedicate staff participant time; 8-10 hours a week for Community Engagement Specialist

Learn more:

<https://chelseapolice.com/chelsea-hub>

Led by the Chelsea Police Department, the Chelsea Hub is a team of designated staff from health care, community, and governmental agencies. The group meets weekly to identify individuals and families with a high probability of imminent harm and intervenes within 24 to 48 hours. The team develops immediate and integrated responses to situations of elevated risk, collects data on risk patterns and systemic gaps, and generates opportunities for data-driven policy, practice, and system transformations.

The Hub model originated in Scotland and was later implemented in Canada. In 2015, the Chelsea Hub was the first to launch in the United States. Several other Massachusetts communities have piloted similar programs since, including Boston, Worcester, and Springfield.

The Chelsea Hub includes representatives from over 20 agencies and organizations, representing law enforcement, schools, local hospitals, housing, child protection services, and local mental health and addiction services.

The group meets once a week for approximately an hour. All meetings follow a tight script: each participant indicates if they have a situation where an individual or family is at risk and the group determines whether they are at “acutely elevated risk” – meaning they are likely to need intervention within a few days. If they are, the agency provides limited personal details and other agencies note if they’ve worked with the person or family.

The Chelsea Hub



The team determines agencies that should be involved in the situation and who the lead should be and then meet offline to design an appropriate intervention. An individual is identified only when being introduced to the Hub table; afterward, the individual or family is assigned a Hub number, which is how they're subsequently referenced.

All situations conclude when identified cases are connected to services, informed of services, refuse services, or cannot be located. Even when the situation is closed, case management continues outside the Hub by assigned agencies.

The Hub is designed as a communication network between all relevant agencies and a means to identify individuals at extremely high risk. Hub situation introductions typically last two to three minutes and offline meetings to strategize about how to help the individuals take five to seven minutes. Chelsea's Hub team has addressed over 454 cases in this manner.



TIP **Identify Focus Area**

The Chelsea Police identified “hot spots” where individuals with OUDs congregated. The police connect these individuals to mental health, addiction, and housing services. This builds relationships among the police, populations at risk, and service providers in this area.



TIP **Outreach Worker**

In 2014, Chelsea hired its first outreach workers, called Community Navigators, to engage individuals struggling with homelessness, addiction, and other factors. They provide relationship-based linkages to resources in partnership with institutions and organizations around Chelsea.



TIP **Hospital Partnership**

The Chelsea Police Department, North Suffolk Mental Health, and CAPIC established a partnership with the Cambridge Health Alliance (CHA) Everett Hospital in 2016. The partnership provides a consent process which allow partners to co-case-manage individuals that are frequently hospitalized. This has greatly reduced the number of emergency room visits by these individuals.

Providing Access to Addictions Treatment and Support (PAATHS)

Boston, Massachusetts

Staff Size: 14

Budget: \$1,500,000

Funding Sources:

PAATHS is funded by the City of Boston

Learn more:

<https://www.boston.gov/departments/recovery-services/find-your-path-recovery>

PAATHS (Providing Access to Addiction Treatment, Hope and Support) is the City of Boston's one-stop shop for anyone seeking access to, or information about, all types of addiction treatment available in Massachusetts. PAATHS was founded in 2013 by the Boston Public Health Commission to address concerns that navigating the state's fragmented treatment system posed a significant barrier to people struggling with addiction. In 2015, Mayor Martin

J. Walsh created the Mayor's Office of Recovery Services, which has since increased staffing capacity at PAATHS, expanded hours to evenings and weekends, and launched 311 call-in services for recovery resources.

The PAATHS team helps people with OUDs and people with other substance use disorders by assessing their individual needs, working with them to plan the most appropriate treatment path, and guiding them through the process of connecting to care. Anyone in any stage of addiction recovery can access PAATHS services. In addition to treatment referrals, PAATHS public health advocates help people overcome any barriers that are preventing them from accessing treatment, including lack of insurance, lack of identification, and lack of medication. The program operates on a walk-in basis, so no appointment is needed, and it is open seven days a week. PAATHS, through partnership with Boston 311 and the Gavin Foundation, also operates a hotline to remotely provide information, consultations, and resources to Boston residents 24/7. All services provided by PAATHS are free of charge. PAATHS sees anywhere between 30-50 walk ins and successfully places 10-20 people into treatment daily.

Providing Access to Addictions Treatment and Support



TIP

Transportation

Transportation is the final link in connecting individuals to services. Yet many people with OUDs do not have access to reliable or affordable transportation options, creating a barrier to entering treatment, especially since PAATHS refers people to programs across the state. PAATHS procured a van and provides taxi vouchers and MBTA and Commuter Rail passes to make sure that people can get to the care they need. The PAATHS transportation service required an initial investment and is sustained by City funding.



TIP

Resource Center

PAATHS operates a walk-in center and hotline to provide personal support to those struggling with OUDs and other substance use disorders. People at any stage of addiction or recovery can drop in any time to receive support, treatment navigation, and referrals to services. PAATHS chose a central location, instituted an open doors policy, and makes their space comfortable and engaging with hot coffee, a television, and snacks.

Arlington Post-Overdose Outreach and Treatment Placement

Arlington, Massachusetts

Staff Size: 1 mental health clinician to co-respond to calls with the police department and do follow-up with individuals with OUD

Budget: \$45,000

Funding Sources:
Department of Mental Health
jail diversion grant funding

Learn more:
<https://paarius.org/arlington>

Since 2015, the Arlington Police Department (APD) has been reaching out to people in the community who have suffered from an overdose or interacted with law enforcement relating to drug use. Through this work, APD developed a two-pronged approach: proactive outreach to substance users and their families, paired with community education to reduce stigma and encourage treatment and recovery.

Arlington's outreach model is based on comprehensive collaboration between police and a mental health jail diversion clinician embedded in the police department.

The embedded clinician works with the police by joining officers on mental health-related calls, including calls involving individuals with signs of opioid use disorders (OUD). The team assesses whether to divert people into treatment and arranges for continued follow-up. The clinician performs this follow-up to provide ongoing support and connections to services, initiates multiple contacts to build relationships and trust, and works with people to explore and undertake treatment and recovery actions catered to their needs.

The APD was the first police partner in Arlington's Police Assisted Addiction and Recovery Initiative (PAARI) and is also a member of Metro-Boston Project Outreach with seven other Middlesex County communities. Project Outreach holds monthly community education events and regular sessions during which police, health department employees, emergency personnel, and treatment providers from the seven municipalities share information.

Arlington Post-Overdose Outreach and Treatment Placement



TIP

Tailored Post-Overdose Outreach

Post-overdose visits by a jail diversion clinician and police officers to the homes of people that have suffered from a recent overdose can be an effective means of starting a relationship. In Arlington, the clinician begins a relationship by providing Narcan training and doses. Follow-up can include emails, letters, or phone calls to provide important information on contacts, local events, overdose prevention, and treatment options. The goal of this multi-faceted outreach is to introduce individuals with OUDs to the different roles of the officer and clinician and explain how they can help. Not all people will respond immediately or seek the support offered, but the outreach builds a relationship so that when an individual is ready, they know who they can go to for help.



TIP

Know Treatment Providers and Options (Inside and Out)

The clinician in Arlington is familiar with the landscape of treatment and recovery options in the area. This allows the clinician to be able to speak to all the options available and work quickly to place those seeking inpatient treatment for a opioid abuse disorder in a facility best suited to their needs. The clinician also invites treatment providers to speak at community events, strengthening relationships with these providers while encouraging people to talk openly about opiate addiction and breaking down the stigma associated with various forms of treatment, such as medication-assisted treatment (MAT).

The City of Revere Substance Use Disorder Initiatives (SUDI)

Revere, Massachusetts

Budget: \$385,000

Funding Sources:

City of Revere, legislative earmarks, Determination of Needs Funds from Mass General Hospital, Substance Abuse Prevention Collaborative (SAPC), grants

Learn more:

www.revere.org/departments/substance-use-disorder-initiatives

Revere created Substance Use Disorder Initiatives (SUDI) in 2015 in response to the opioid epidemic. The newly-formed department's mission was to keep people alive and promote human dignity. To realize this vision, SUDI had to think holistically about the work Revere was doing to address the epidemic and get creative with funding.

In the past, the short-term requirements of available funding determined the programs the City was able to provide, but SUDI wanted to approach the

work differently. They defined their department strategic goals and plan, aligned all existing programming being done under individual grants to the plan, and changed programs where necessary to better support the community vision.

Today, SUDI's multi-faceted services include a drop-in center, resource coordinator, community outreach worker, overdose outreach program, naloxone and clean needle distribution, community education, peer and family support, and recovery coaching.

SUDI engages individuals suffering from OUDs through several programs aiming to build relationships, increase harm reduction techniques, and ultimately connect those in need to available support services. A community outreach worker visits populations at risk, building rapport and increasing awareness of resources and programs. The Overdose Outreach team, comprised of first responders and an outreach worker, follows up with residences where naloxone has been administered, introducing them to direct service providers and providing them with support.

Substance Use Disorder Initiatives (SUDI)



The SUDI office also hosts a drop-in center with the goal of providing peer and family support. Anyone is welcome to walk in and receive help navigating treatment and service referrals, get trained on administering naloxone, and access harm reduction resources. A Resource Coordinator with a thorough understanding of the local service landscape offers additional support coordinating services for individuals with OUDs and their families.

Substance Use Disorder Initiatives (SUDI)



TIP

Strategic Staffing

SUDI leverages relationships with other programs and subcontractors to support their multi-faceted work plan. Currently, they employ a direct service coordinator (10.5 hours per week), and subcontract a community outreach worker (about six hours per week), and a recovery coach (12 hours per week). SUDI also provides overtime compensation for their overdose outreach team members from other city departments.



TIP

Outreach and Engagement

SUDI realized that establishing trust was important to encouraging people to use their services. Outreach and engagement are the foundation of SUDI's goals and make up the largest proportion of their work. First responders follow up in-person with people who have recently overdosed, and a community outreach worker builds rapport by going to locations known to be hubs for people with OUDs.



TIP

Drop-In Hours

SUDI didn't have the resources to have a 7-day resource center (like PAATHS), but still wanted to provide in-person support. The SUDI drop-in center, staffed by the Direct Service Coordinator, is open Tuesday evenings from 5 p.m. to 8 p.m. and takes advantage of existing space at the SUDI office.

Origins of this Booklet

The Metropolitan Area Planning Council (MAPC) has been working in support of the 15 cities and towns that make up the Metropolitan Mayors Coalition (MMC) as they address the opioid epidemic.

Mayors, managers, and senior public health and public safety officials identified four areas they wanted to work on with MAPC: improving the way their communities connect people to services was one of these.

This booklet was developed to accompany a workshop held on the issue.

Potential for Regional and Local Action

If a community is interested in expanding its efforts to connect people to services, MAPC can help. MAPC can offer technical assistance to communities working to develop programs. When a community is interested in forming partnerships with nearby cities and towns to offer certain services, MAPC can support work to enhance or share resources. MAPC will continue to work with area communities to explore how they can better connect people in need to a range of harm reduction, treatment, and long-term recovery services.

**Learn more about our
Opioid Epidemic Response work:**

www.mapc.org/municipal-response-to-the-opioid-epidemic

METROPOLITAN MAYORS COALITION

a local initiative facilitated by METROPOLITAN AREA PLANNING COUNCIL

