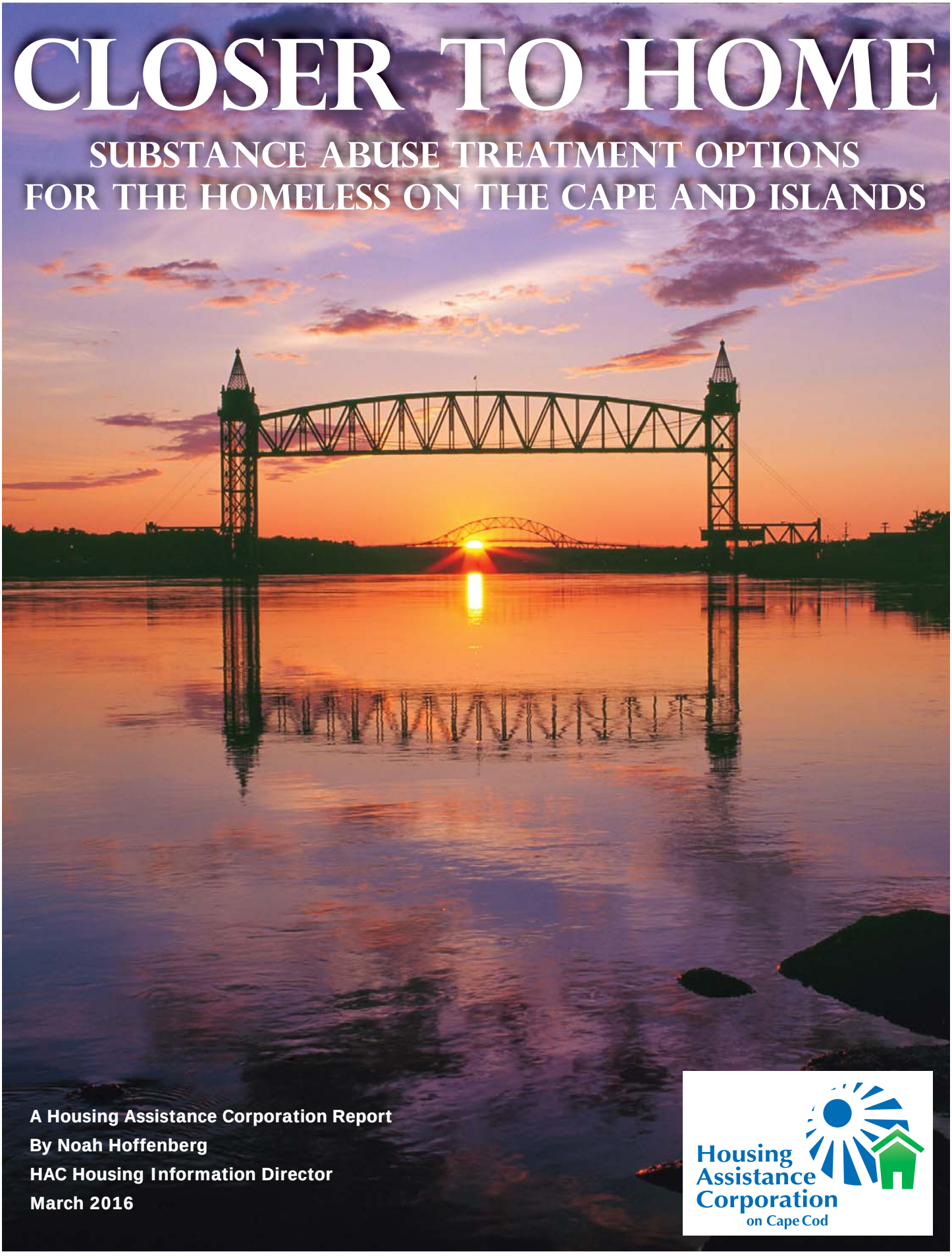
CLOSER TO HOME

SUBSTANCE ABUSE TREATMENT OPTIONS FOR THE HOMELESS ON THE CAPE AND ISLANDS



A Housing Assistance Corporation Report

By Noah Hoffenberg

HAC Housing Information Director

March 2016

Housing Assistance Corporation on Cape Cod

Pictured above are: the Cape and Islands (NASA photo); Sharon, a NOAH Shelter guest who lost her housing when a roommate was arrested for drugs (Alan Belanich photo); and Nantucket Cottage Hospital (Nantucket Cottage Hospital photo).

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ACKNOWLEDGMENTS

The author would like to thank all of the medical, housing and substance abuse treatment experts who contributed to this report. Also, thanks go to those Housing Assistance Corporation staffers and others who aided with suggestions, proofreading, document production and design.

ON THE COVER

The Cape Cod Canal Railroad Bridge with the Bourne Bridge in the distance. Photo by Alan Belanich for Housing Assistance Corporation

Housing Assistance Corporation on Cape Cod

FOREWORD

A new beginning

By Rick Presbrey

At the start of this fiscal year in June, we decided to begin a new initiative to develop white papers on a variety of subjects related to housing and our clients on the Cape and Islands. This decision was made when we thought of our 40-plus-year history and the next 40 years.

Over the past four decades we have accomplished a lot in serving more than 160,000 people with a wide variety of services related to housing. In many ways our efforts have helped change attitudes and create new organizations to aid in accomplishing our mission or related ones, and we may have precipitated an environment that is more welcoming to the idea of public involvement in creating housing that is "affordable."

RICK PRESBREY
Housing Assistance Corporation CEO

The fundamental problem in our region, as I have said many times, consists of several components: 1) that seasonal demand drives up housing prices; 2) our service-based economy provides low-paying jobs; 3) the cost of building rental housing for year-round tenants is too high to provide a return on investment with the rents local people can afford to pay; 4) lack of multifamily zoning districts leaves appropriate land to build multifamily rentals in short supply; 5) lack of public wastewater systems makes it difficult to build rental developments of a size that provides efficiencies of scale.

I appreciate that we, at HAC, have won many battles to provide decent housing for people, but we have lost the war so far in that housing problems are worse now than they were when we started in 1974. One result of this conclusion is that we have started to research and publish white papers to help add to the information we need as civic leaders and citizens so we can make the most informed decisions possible to improve the future availability of housing for an economically diverse population in our region.

We hope to write four papers a year. Some of the topics under consideration now are:

1) The shortage of rental housing for young professionals, seniors and people with lower incomes. Presently, demand exceeds supply.

2) A report card on how town-based Community Preservation Act (CPA) funds are being used.

3) The relationship between housing insecurity to children's health, education, and the general well-being and prospects for their future.

4) The relationship between trauma in early life and homelessness.

5) Regulatory barriers to providing housing for those on the autism spectrum.

6) Housing Court for Barnstable, Dukes and Nantucket Counties: Do we need one and will it happen?

In "Closer to Home: Substance Abuse Treatment Options for the Homeless on the Cape and Islands," the report highlights the substance abuse treatment services available to all Cape Codders, with special attention to people simultaneously experiencing homelessness and substance use disorders.

It finds that treatment for all people with substance use disorder is limited in the region; most sites are far away; and that wait times for a treatment bed can drag into months. While these difficulties pose problems for Cape Codders at all income levels, the dangerousness for the homeless is magnified, as they have no shelter, few resources and little in the way of support systems once they emerge from treatment. Relapse and treatment dropout rates for the homeless are high, given the heavy substance use by people living on the streets, but this can be mitigated by stable housing during and after treatment, studies cited in the report show.

I hope you find our first white paper to be an informative and eye-opening read.

Housing Assistance Corporation on Cape Cod

EXECUTIVE SUMMARY

The supply of substance abuse treatment in Massachusetts is being outpaced by demand, resulting in bottlenecking at all levels of care. The problem is worse in rural areas, such as Cape Cod and the Islands, where services are limited by capacity, scope, payment methods and the travel distances needed to get help. While these problems pose difficulties for the average resident, they are greatly exacerbated for people experiencing homelessness.

Housing Assistance Corporation is highlighting the problem because substance use disorder is pervasive among our clients – a disease that has affected most of our shelter guests and many of the other people we help with housing issues. Nothing in this report should be construed as HAC seeking to get into the substance abuse recovery business; our continuing mission is to provide safe, decent, affordable housing in the region, and housing plays a significant role in recovery. HAC, however, is committed to developing partnerships whereby we together can begin addressing problems highlighted herein and delivering solutions for our homeless neighbors. The following report, "Closer to Home: Substance Abuse Treatment Options for the Homeless on the Cape and Islands," examines what's available here for services, as well as what's missing.

Homeless Cape and Islanders are an at-risk population. The lives of people experiencing homelessness often are plagued by extreme stressors and trauma, such as violence, sexual abuse, drug and alcohol use, and incidences of homelessness itself. According to the U.S. Substance Abuse and Mental Health Services Administration, 20 percent of homeless people were also homeless as children, and another 25 percent report childhood physical or sexual abuse. A study of people homeless on the Cape found that 86 percent have health problems or injuries; 78 percent have mental health disorders; and 80 percent have had current or past problems with substance use. SAMHSA says about 50 percent of chronic homeless individuals have co-occurring substance use and mental health problems. Many homeless people seek substance abuse treatment every year in the commonwealth, but the demographic has difficulty accessing services on Cape Cod, and services here and statewide are not tailored to meet the special needs of this population, which require trauma-informed care and stable housing during and after treatment to heal and reintegrate.

Key details in the report include:

- Drug and alcohol detoxification bed occupancy hovers between 91 and 100 percent daily, often translating in waits of three to five days for patient admittance. Experts say this time is crucial to capitalize on someone's willingness to enter treatment. Also, because of the systemwide shortage, only about 17 percent of the people emerging from detox can find a readily available rehab bed. Waits for the homeless to get a long-term recovery bed can be as long as 10 weeks;

- About 40 percent of the Cape's treatment beds are occupied by people from outside the region, sending many Cape Codders and Islanders to the mainland for help; studies show – and experts concur – that treatment away from home is about 50 percent less effective;

- The most common kind of inpatient treatment for the homeless is hospital detox. Over the past five years, the Cape Cod Hospital Emergency Center has experienced a 78 percent increase in care hours related to mental health and substance use patients. About 80 percent of the visits by the homeless could've been treated with preventative care, and housing options reduce these visits by some 61 percent, according to experts;

- Studies show that stable housing initiatives, such as Housing First programs combined with community-based treatment, deliver better outcomes for housing retention and recovery, while also greatly reducing societal costs. On Cape Cod, it costs anywhere from $8,000 to $13,000 less per person per year with a Housing First apartment than a year in an emergency shelter, according to HAC figures.

People experiencing homelessness and addiction on the Cape and Islands are suffering because of the current system's inability to accommodate demand for services; the revolving door of detox, treatment and relapse; difficulty in paying for services; and a lack of transportation and housing. Simultaneously, our region pays for the profound expense of substance abuse – tagged at more than $100 million annually – and an additional perception problem (whether true or not) that our area, a tourism haven that relies on the appearance of carefree beach living, is being overrun by the homeless.

But there is hope, for both those in dire need of help and for our Cape and Islands community as a whole. Alternative substance abuse and housing programs here and elsewhere in the nation have shown that there are successful paths to recovery; that the societal costs of homelessness can be cut dramatically with rapid re-housing programs; and that by bolstering the substance abuse treatment infrastructure here at home, more Cape Codders and Islanders who suffer from addiction have a much better chance at leading healthier and more productive lives.

-- Please email your comments and suggestions for future subjects to report author Noah Hoffenberg at nhoffenberg@hacon-capecod.org.

Housing Assistance Corporation on Cape Cod

INTRODUCTION

Earlier this year, "Wilma," a 61-year-old Hyannis woman in recovery from addiction, watched her grown son overdose on heroin.

Wilma – who asked that her real name not be used in this report – has been an alcoholic for most of her life, as well as homeless at various intervals; her son, now also homeless but in treatment, was exposed from birth to rampant alcohol and drug use. Her husband, his father, died of complications from AIDS, and her brother died at 21 from substance abuse-related health problems.

Her son's opiate habit was as bad as any of his family members' addictions, perhaps worse: He had taken to carrying three doses of the anti-overdose drug Narcan on him shortly before his most recent OD, one of three that led up to him wanting to get into treatment.

It took nearly four weeks to get Wilma's son into a detox and rehab program, and the facility ended up being out of state.

For Wilma's part, she said she's been in and out of detox so many times that she jokes she has a wing in the clinic named after her.

Theirs is a commonplace story for the Cape and Islands homeless: addiction treatment that's hard to get, far away from home and not tailored for the needs of people who live on the streets.

A NATIONWIDE EPIDEMIC

The commonwealth of Massachusetts, like the rest of the nation, is in the midst of an opioid abuse epidemic. And Cape Cod, Nantucket and Martha's Vineyard, rural outlying areas, are lacking critical substance abuse treatment infrastructure for area residents, according to experts, as most treatment sites – from detoxification to recovery homes – are located off-Cape and off-island. And yet, the state notes that the Cape and Islands have one of the greatest concentrations of detox beds in the commonwealth, per 100,000 people. Meanwhile, about 40 percent of the treatment beds here are occupied by people from outside the area.

On any day of the week, hundreds of people with substance use disorders are waiting for a treatment bed in the Bay State, according to 2015 statistics from the Center for Health Information and Analysis, a state agency. This poses a particular danger to individuals already considered at-risk: people living on the streets or in emergency shelters. They have piecemeal services, little informational help online and some of the longest wait times for beds in the commonwealth.

Massachusetts touts itself as having one of the strongest substance abuse treatment systems in the U.S., according to published material from the state. And yet there are holes in the public safety net, in so far as more people emerge from detox than there are available clinical rehab beds. Waits of up to a month for long-term recovery beds are common for treatment seekers who live near the coast.

HOMELESSNESS NUMBERS ON THE RISE

Moreover, homelessness numbers are rising in the commonwealth, up some 40 percent from 2007 to 2015, according to U.S. Department of Housing and Urban Development statistics. The number of the state's homeless families

CAPE AND ISLANDS SUBSTANCE ABUSE AND HOMELESSNESS SNAPSHOT

43 **percent of people experiencing homelessness attribute their homelessness to alcohol or drugs**

80 **percent of homeless reported either a current or past alcohol and/or substance use problem**

78 **percent had a mental health issue**

12 **percent were actively involved in some kind of substance abuse treatment program**

557 **discharges from Cape and Islands hospitals for substance abuse emergencies**

Sources: Massachusetts Department of Public Health; "Costs of Homelessness: A Study of Current and Formerly Chronically Homeless Individuals on Cape Cod, Massachusetts," by Lee M. Hamilton, 2009

increased by 116 percent from 2007 to 2015. Cape homeless numbers are trending downward over the past decade, but the point in time count in January 2015 still showed 362 people living in shelters or places not suited for human habitation, such as cars and unheated outbuildings. In 2015, 33 people died while homeless or while housed after experiencing homelessness on Cape Cod; the year before, it was 34, according to reports in the Cape Cod Times.

For families and individuals, substance use is a housing destabilizer. It's well-documented that substance use can lead to homelessness, and vice versa, and studies show that without some kind of housing, relapse after a period of sobriety is far more likely.

Unlike treatment-seeking Cape residents with homes and/or a support structure of family and friends, homeless people in recovery require housing, so outpatient treatment would only address one of a homeless individual's concurrent problems, which often include mental illness and other long-term health issues. On the Cape and Islands, there's limited, year-round rental housing, and very little for those residents who lack financial resources.

Thus, it must be asked: Is the Cape and Islands substance abuse treatment system good enough as it is, or does it need shoring up?

METHODOLOGY

This white paper began with a simple version of that aforementioned question: "If you're homeless and addicted on the Cape and Islands, what's available to you for substance abuse treatment?"

Research began with a survey of Mass.gov, the official website of the commonwealth of Massachusetts, as well as other non-governmental substance abuse treatment websites, and the state's Bureau of Substance Abuse Services site, which yielded lists of regional services from the Massachusetts Substance Abuse Helpline (http://helpline-online.com), and statistics from the bureau. A year-over-year comparison of attendance by Cape and Islanders at state-licensed substance abuse treatment facilities was not possible in this report, because of limited information available from the state. The white paper's section on "Homelessness and Addiction: The Bay State in General and Cape Cod in particular" is meant to provide some snapshots of general costs, treatment admissions and the numbers of people experiencing homelessness over the last several years.

Instrumental to this paper was research gleaned from a 2015 report by the Center for Health Information and Analysis, called "Access to Substance Use Disorder Treatment in Massachusetts." This state report clearly outlines the kinds of treatment available in the Bay State, and also highlights the obstacles. Key points from that report are included within.

Questions were designed to extrapolate the spectrum of services available for the homeless on the Cape and Islands, as well as to identify trends in experiences across the continuum of care.

Additionally, this report includes information from dozens of studies, reports and policy briefs on important aspects of substance abuse, homelessness and treatment, such as the limited offerings in rural areas, the relationship of distance to treatment efficacy, the effects of rapid re-housing on substance use and home retention, as well as the best practices for aiding the homeless population to get off the streets, out of hospitals and jails, and into housing and treatment. Local studies on substance abuse and homelessness – such as those by the Barnstable County Department of Human Services and the Cape and Islands Regional Network on Homelessness – also proved vital to this paper. In this report and others, programs were deemed successful if they saved lives while also saving money.

Lengthy interviews were conducted with regional experts in the fields of substance abuse treatment, housing, and medical and shelter care. Interviewees were queried in person, via phone and by email. Questions were designed to extrapolate the spectrum of services available for the homeless on the Cape and Islands, as well as to identify trends in experiences across the continuum of care.

Interviewees included:

Greg Bar, NOAH shelter director, Hyannis

Caroline Corrigan, manager at Homeless Not Hopeless, Hyannis

Robert Davis, Falmouth Hospital emergency department director, Falmouth

Geoff Gagnon, NOAH shelter recovery advocate, Hyannis

Katie Geissler, director of the Carriage House shelter, North Falmouth

Jason Graziadei, Nantucket Cottage Hospital spokesman, Nantucket

Matthew Liber, legislative aide to state Rep. Randy Hunt, R-Sandwich

Paula Mallard, director of the Village at Cataumet, Bourne

Robert Monahan, president of the Recovery Homes Collaborative of Massachusetts, Quincy

Daniel Mumbauer, president of High Point Treatment Center, Plymouth

Heidi Nelson, executive director of Duffy Health Center, Hyannis

Ann Marie Peters, supportive housing and client services program manager for HAC, Hyannis

Lin Rohr, director of Angel House, Hyannis

Nate Rudman, Cape Cod Hospital Emergency Center physician, Hyannis

Paula Schnepp, Cape and Islands Regional Network on Homelessness coordinator

Raymond Tamasi, Gosnold on Cape Cod CEO, Falmouth

Rachel Vanderhoop, Martha's Vineyard Hospital spokeswoman, Oak Bluffs

Elizabeth Wade, CHAMP Homes director, Hyannis

"Wilma," a homeless woman who was living in a Hyannis transitional site

Questions included:

- What kind of role does your organization/program play with the regional homeless population?
- How many detox or shelter beds does your organization have, over how many sites? How many supportive housing beds?
- How many people are on your waiting list, and how long is the average wait before placement?
- What is the breakdown of how beds are paid for (i.e., private pay, Medicaid, private health insurance, MassHealth, state-sponsored)?
- To which detox sites are patients/clients being referred?
- Of those homeless people who are seeking detox, how long does it take to get them situated in a bed in a treatment facility?
- Are there enough detox and aftercare options for your patients/clients?
- What do you see as the positive aspects of undergoing treatment off Cape? What are the detriments?
- What are the impediments and/or apparent holes in the system/process to getting homeless Cape and Islanders into treatment?
- What's needed to best treat homeless people suffering from addiction on the Cape and Islands?

The information from these sources has been compiled and organized in such a way to describe the Cape and Islands' regional substance abuse treatment infrastructure for the homeless as it stood in late 2015 and early 2016; to share the thoughts of experts who work in that world daily; to show the challenges faced by a rural area in fighting substance abuse; to convey the state's own assessments of the system; and to present possible solutions to identified deficiencies in the region.

THE STATE'S SUBSTANCE ABUSE TREATMENT INFRASTRUCTURE

Here in Massachusetts, many drug and alcohol treatment services are provided through the Bureau of Substance Abuse Services. The bureau is the commonwealth's sole authority on substance abuse and offers services across the care spectrum. State budget figures show an increase in appropriations to the bureau from $74.8 million in 2012 to $98.2 million for 2016, demonstrating a financial commitment to the problem.

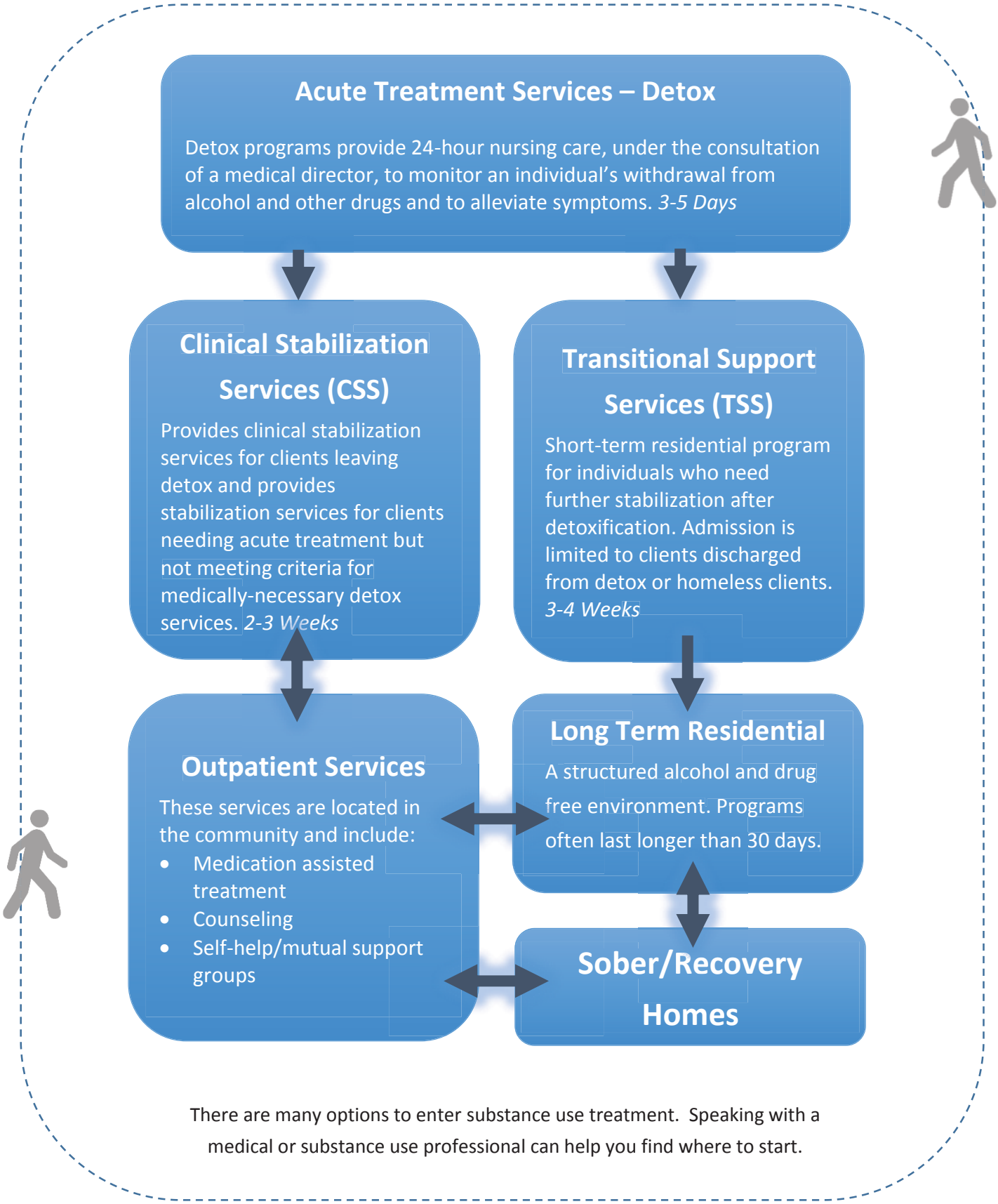
The bureau licenses addiction treatment programs, addiction counselors and pays for a mix of prevention, intervention, treatment and recovery support services. A policy-setting agency, the bureau also serves as the payer of last resort for treatment for the un- and underinsured, the numbers of which have plummeted since the state adopted mandatory health care for all residents.

THE PRINCIPLES

According to the bureau, the principles that guide its mission on substance abuse treatment are:

- No single treatment approach is appropriate for all individuals;
- Treatment needs to be readily available;
- Effective treatment attends to the multiple needs of the individual, not just substance use;
- Remaining in treatment for an adequate period of time is critical for treatment effectiveness. Most studies indicate a minimum of 90 days;
- Counseling (individual, family and/or group) and other behavior therapies are critical components of effective treatment;
- And medications are an important element of treatment for many people, especially when combined with counseling and other behavior therapies.

SUBSTANCE USE TREATMENT SYSTEM



There are many options to enter substance use treatment. Speaking with a medical or substance use professional can help you find where to start.

Graphic courtesy of the Barnstable County Department of Human Services

ANNUAL PROGRAM ENROLLMENTS

In a recent presentation, the bureau cited 2014 enrollments of 107,358 in state-licensed substance abuse treatment programs (85,823 individuals were served, with some enrolling in more than one program within a year); 17.6 percent identified themselves as homeless.

Substance abuse treatment tends to follow a track of detoxification, followed by inpatient or outpatient rehabilitation treatment and relapse prevention, according to the National Institute on Drug Abuse. Entering and staying in a continuum of care, including a customized treatment regimen with medical and mental health components, can be crucial to staying substance-free, according to the institute.

On Cape Cod, people who are homeless and addicted often begin a path to recovery and societal reintegration when they first enter shelters, community health centers or hospitals. At these sites, they will meet with an intake, health care admissions or case worker, who can help with substance abuse assessment and placement in a treatment facility if it's warranted.

Descriptions of state-certified, -sponsored and -reimbursed treatment options follow here (details come from the Center for Health Information and Analysis):

DETOXIFICATION AND SECTION 35s

After intake and assessment, medically supervised detoxification – or acute treatment service – is often the next stop for people seeking substance abuse treatment. These inpatient programs most often last for four to six days, with the patient's withdrawal monitored 24 hours a day by medical staff.

For some people, detox might not be a choice. Under a provision in state law called Section 35, people who pose a danger to themselves or others because of substance use can be involuntarily committed to treatment. Petitions to local courts can be made by police officers, doctors, family members, guardians or a court official. After weighing the evidence, a judge has the ability to commit a person to treatment for up to 90 days, although commitments of that length tend to be the exception.

In the commonwealth, there are four hospital-based programs with 150 detox beds and 20 freestanding programs with 710 such beds, which can serve about 3,500 individuals a month, and two Section 35 programs with 56 acute treatment beds. The fees and costs of detox programs are typically paid for by commercial insurers, state-sponsored MassHealth insurance, other public payers and with bureau subsidies. Section 35 costs are paid for entirely by the state.

REHABILITATION

"Step-down" rehab treatment is recommended for addicted Bay State residents to help them maintain sobriety. These are clinical stabilization service programs, which provide a combination of housing, nursing care, education and counseling on addiction and its consequences, relapse prevention and aftercare planning. The usual length of stay in a stabilization program is seven to 14 days. In the commonwealth, there are 11 programs with 297 beds that serve about 600 people per month; and there are two Section 35 programs with 142 beds. These programs are paid for by MassHealth, the bureau and some commercial insurers.

Three of the principles that guide the state in its mission to fight substance abuse:

- **No single treatment approach is appropriate for all individuals;**
- **Treatment needs to be readily available;**
- **Effective treatment attends to the multiple needs of the individual, not just substance use.**

TRANSITIONAL SUPPORT SERVICES

Transitional support service programs are another type of a short-term residential "step-down," often used by people experiencing homelessness in addition to substance use disorders. The stay in these structured programs is up to 30 days, prepping clients who are leaving detox for longer-term residential rehab or a return to the community. These programs are paid for by the bureau. The bureau pays for nine such programs with 339 beds, which can serve about 331 residents per month (some clients stay for slightly longer periods while waiting for a recovery home slot to open, hence the difference in numbers). People in Section 35 civil commitments can graduate to two transitional support programs with 80 beds.

RECOVERY HOMES

Recovery homes, or residential rehabilitation treatment, offer regimented substance abuse treatment, 24 hours a day, in a community setting; these are not "sober homes," group homes for people in recovery from substance use disorders that are not regulated by the state. Recovery homes offer a safe and stabilized living environment for six to 12 months for adults. This kind of treatment is paid for by the bureau, organizational fundraising and private payers. The state reimburses 79 adult residential programs with 2,281 beds; eight family residential programs that serve about 110 families; as well as some offerings for youth in transition.

OUTPATIENT SERVICES

Outpatient substance abuse services include individual, group and family counseling, intensive day treatment and educational services. Costs are paid by commercial insurers, MassHealth, other public payers and the state bureau.

For those in need of medication-assisted treatment, addicted residents can use outpatient services that include methadone, in combination with related counseling, drug screening and case management, to address opioid cravings and withdrawal symptoms. Suboxone and Vivitrol are two additional types of medications used to help patients manage their urge to use opioids or alcohol during recovery. Methadone treatment is primarily paid for by MassHealth and the bureau, while Suboxone and Vivitrol are paid for by MassHealth and the majority of commercial insurers.

Bringing up the tail end of bureau-funded treatment programs are recovery support centers, seven of which can be found across the commonwealth, including a new site in Hyannis. These use a peers-in-recovery model and offer classes, activities and support group meetings. Case management services are provided to support participants as they move toward healthier living.

Median time from first treatment to one substance-free year is nine years, and includes three to four treatment episodes, according to the state bureau. Studies show that relapse is an integral and expected part of recovery.

WHAT'S BEST?

What kind of treatment works best for a person with substance use disorder? Often-repeated by studies and experts is the call to address the needs of the individual patient. Studies also show that most treatment platforms tend to have the same level of effectiveness. For example, mandatory treatment – such as ordered by a court – is reported to have the same level of effectiveness as voluntary treatment, according to a National Institute on Drug Abuse and Department of Veterans Affairs analysis.

Meantime, a study called "Substance Abuse Intensive Outpatient Programs: Assessing the Evidence," reported in 2014 that intensive outpatient treatment is as effective as inpatient treatment for people with substance use disorders.

However, to best treat the people experiencing homelessness, the National Health Care for the Homeless Council says that clients have better results within a program that focuses on harm reduction rather than abstinence; without judgment, harm reduction measures use techniques negotiated with clients that focus on reducing the negative consequences and behaviors of substance use.

Within harm reduction, abstinence can be an eventual goal. Stable housing also leads to better outcomes for homeless people in treatment and recovery, as it decreases the risk of relapse, according to the National Coalition for the Homeless.

On Jan. 20, 2016, when photographed for this report, Helen Lewis, 50, of Dennis, had been homeless for a month; previously, she had been homeless from 2003-2007. Lewis said she's been in substance abuse treatment 33 times, and sober for the last nine years. When she was using heroin, Lewis said she didn't care about anything else. Her biggest struggle now is finding warm places to go when it is cold, she said. Photo by Alan Belanich for Housing Assistance Corporation

Studies also show, as detailed later in this report, that treatment closer to home is more effective than treatment away.

HOMELESSNESS AND ADDICTION: THE BAY STATE IN GENERAL AND CAPE COD IN PARTICULAR

There's a clear link between substance abuse and homelessness; not only can substance use be the cause of homelessness, but it can also be caused by homelessness, studies show. About 80 percent of homeless people surveyed by the U.S. Substance Abuse and Mental Health Services Administration reported having long-time substance use problems; about 50 percent of these people reported concurrent mental health problems.

Even though substance use, mental health disorders and homelessness are linked, finding a treatment center that deals with the dual diagnosis of addiction and mental illness can add to the difficulty for someone living at the fringes of

Sharon heads into the NOAH Shelter on Winter Street in Hyannis on Jan. 20. She's been homeless for one month. She lost her home when a roommate was arrested for drugs; Sharon was caught up in the sweep and was arrested, too, she said. Photo by Alan Belanich for Housing Assistance Corporation

society.

Tracking the numbers of the homeless in Massachusetts and elsewhere comes with obvious challenges, as it's a segment of the population without physical addresses. People "double up" with friends or family in lieu of permanent housing and sometimes live off the grid.

This report aggregates some of the latest statistics and numbers available, from the state's Bureau of Substance Abuse Services, the federal Substance Abuse and Mental Health Services Administration and others. Much of the substance abuse treatment data from the state that follows within this report is from 2011, and the latest study of people experiencing homelessness on Cape Cod was completed in 2009. The cost statistics from the Barnstable County Department of Human Services are also from 2013, and are in the process of being updated. The lack of immediate state and county data makes year-over-year comparisons impossible, but the following details and statistics do paint a picture of the demands placed on the Cape and Islands by substance abuse and homelessness in recent years.

There were 21,135 people in Massachusetts tallied as homeless during the January 2015 point-in-time counts, according to numbers from the U.S. Department of Housing and Urban Development's Annual Homeless Assessment Report to Congress. In Barnstable County's homeless census for the same year, counters tallied 362 people without permanent housing, including 263 in emergency shelters, 52 in transitional shelters and another 47 unsheltered in any way.

On Martha's Vineyard, there were 15 homeless counted in 2015, 29 in 2014, and 119 the year before that, according to the Vineyard Gazette.

On Nantucket, point in time counts have yielded no results; however, a 2015 article in N Magazine noted how there are islanders living out of their cars and in other places not fit for habitation.

COSTS TO THE REGION

The total cost of substance abuse on Cape Cod in 2013 was $110 million according to the "Regional Substance Abuse Council Analysis of Substance Abuse on Cape Cod:

A Baseline Assessment," a Barnstable County Department of Human Services report issued in 2015. The treatment and recovery portion was about $51 million (representing 47 percent of the total spent on substance abuse-related services); the money accounts for costs associated with Gosnold on Cape Cod, Cape Cod Healthcare, community health centers, emergency medical services, private health providers, self-help meetings and sober living facilities, according to the county report. Fifty-two percent of the cost of addiction on the Cape was for law enforcement and corrections, totaling $57 million. The remaining 1 percent went to prevention and harm reduction efforts.

According to bureau statistics from 2011, in Barnstable, Dukes and Nantucket counties, there were about 5,585 admissions into bureau-contracted or licensed substance abuse treatment programs.

During the same year, the homeless point-in-time count for the region was 493; homeless people from the Cape and Islands who were admitted to substance abuse treatment facilities in 2014 totaled about 7.2 percent of all treated patients from the region (Bureau of Substance Abuse Services data was not specific for towns that had fewer than 100 enrollments, so actual enrollments and the percents of people identified as homeless were likely higher).

HIGH RATES OF SUBSTANCE USE

According to a 2009 study of the homeless population on Cape Cod, 43 percent attributed being homeless to alcohol and/or drugs; 80 percent of homeless participants reported either a current or past alcohol and/or substance use problem; 78 percent had a mental health issue; and 12 percent were actively involved in some kind of substance abuse treatment program. That year (the latest information available), there were 557 discharges from Cape and Islands hospitals for substance abuse emergencies, according to the state Department of Public Health.

Treatment dropout rates are high among the homeless population, more than 66 percent, according to the report "Substance Abuse Treatment: What Works for Homeless People? A Review of Literature," by Suzanne Zerger (other studies cite substance abuse treatment dropout rates as high as 90 percent for people experiencing homelessness, according to "Behavioral Health Services for People Who Are Homeless," a 2013 guide from Substance Abuse and Mental Health Services Administration); treatment dropout rates for the general population are at about 56 percent, according to 2011 statistics from SAMHSA.

Another study featured in the Journal of Substance Abuse Treatment states clearly the dire straits that homeless people can fall into if they drop out of treatment without housing: "When homeless clients do leave treatment prematurely, they do not merely fail in a treatment episode, but tend also to return to the highly precarious circumstances that precipitated their homelessness. Once homeless and using again, they are at high risk of HIV and a host of other serious health problems as well as violence and ultimately death. They also exact high societal costs through resumed utilization of expensive and inappropriate services."

STATE-FUNDED SERVICES: WHAT'S HERE AND WHAT'S NOT?

The Bureau of Substance Abuse Services budget for 2016 is about $98.2 million; a portion of that sum was allocated for the Cape and Islands in grants and reimbursements in four areas: prevention, intervention, treatment and recovery, according to information provided by Matthew Liber, legislative aide to state Rep. Randy Hunt, R-Sandwich.

For prevention, the state is giving $200,000, half in the form of a grant from the Massachusetts Opioid Abuse Prevention Collaborative to Barnstable County to support local opioid abuse prevention efforts and half in the form of a Substance Abuse Prevention Collaborative Grant to support prevention of underage drinking and substance use.

For intervention, a total of $167,440 is coming to the Cape via a First Responder Naloxone (Narcan) Grant ($32,440) for the training and purchase of naloxone for

police and through a grant ($135,000) to the AIDS Support Group of Cape Cod for naloxone distribution and overdose prevention education within the HIV/viral hepatitis/high-risk opioid user population.

There's an additional $2.3 million in state grants designated for treatment, with $1.5 million in combined funding for Gosnold inpatient beds; $821,000 for family residential treatment for HAC's Angel House in Hyannis; and $52,000 for office-based opioid treatment at Duffy Health Center.

For recovery, the state is providing $350,000 for the fledgling Hyannis Recovery Support Center, which is being run by the Gandara Center.

Using the state's Web search engine and specifying the Cape and Islands as a destination for services will often result in off-Cape sites being listed as the predominant options for many key services, such as acute treatment, rehab, transitional and long-term recovery sites.

The state's Massachusetts Substance Abuse Helpline (http://helpline-online.com) yields a comprehensive list of all state-contracted/licensed programs for the region. Using the site's search engine and specifying the Cape and Islands as a destination for services, however, will often result in off-Cape locations being listed as the predominant options for many key services, such as acute treatment, rehab, transitional and long-term recovery sites. This highlights the lack of services east of the Cape Cod Canal.

For instance, those needing a Section 35 civil commitment, there's a site for women in New Bedford and a site for men in Brockton.

Access to Recovery, a federally funded program, provides a variety of substance abuse recovery support services through a voucher payment system, but it is available in only Hampden and Suffolk counties.

For transitional support services, there's Angel House in Hyannis, a Housing Assistance Corporation shelter focused on a specific demographic: women in recovery and their children.

For medication-assisted treatment, such as Suboxone, methadone and Vivitrol, there are sites in Hyannis, Mashpee, Yarmouth, Falmouth, Buzzards Bay, Wellfleet and others.

For state funded and private substance abuse counseling and outpatient services, there are a number of providers across the Cape and Islands.

MEDICATION-ASSISTED TREATMENT

In combination with counseling and support from friends and family, substance use disorder treatment that includes medication is an option for people who are addicted to opioids, according to the Substance Abuse and Mental Health Services Administration.

Medication-assisted treatment increases patient survival rates, boosts length of time in treatment, decreases illegal drug use and criminal activity, helps the patient get and keep employment, and also improves birth outcomes for pregnant women with substance use disorders, said Heidi Nelson, executive director of Duffy Health Center in Hyannis.

METHADONE, BUPRENORPHINE, NALTREXONE

Medications for treating opioid addiction – such as methadone, buprenorphine (Suboxone) or naltrexone (Vivitrol) – are used to manage withdrawal symptoms, addictive cravings, feelings and behaviors to maintain a state of recovery, according to SAMHSA.

Drugs that activate receptors in the brain are called agonists, and methadone is a full opioid agonist, according to SAMHSA. When taken, it tells the brain that it's still receiving the opioid of choice, such as heroin, but the person with substance use disorder instead feels normal and without painful withdrawal symptoms.

Buprenorphine is a partial agonist and also reduces cravings, but it has a lower dosage ceiling than methadone, and is believed to be less effective, according to SAMHSA.

Naltrexone, an opiate antagonist, blocks the receptors in the brain from opioid drugs; it is also used to treat alcohol addiction. People taking naltrexone who then use opiates will not feel the effects of the drug over the medication and as such it's helpful in preventing relapse, according to SAMHSA. It can't be taken with opioids already in the system, otherwise withdrawal symptoms can break through, according to the FDA.

Methadone is provided to people at specially licensed treatment centers. Buprenorphine and naltrexone can be dispensed at treatment centers or prescribed by doctors, according to SAMHSA.

"The right medication has been found when the person feels normal, has minor or no side effects, does not feel withdrawal, and has cravings under control," SAMHSA says on its website.

Doctors at Duffy Health Center in Hyannis prescribe Suboxone and Vivitrol; people who aren't successful with those medications are referred to HabitOpco in Yarmouth

for methadone treatment.

"It's a pathway we endorse, but don't provide simply because we are a primary care practice. A person can overdose from methadone and it therefore has to be administered in a highly regulated way," said Nelson.

Duffy believes that medication-assisted treatment programs are an important part of resolving heroin and opiate use on Cape Cod. Nelson said that Duffy contracts with its patients to insure their active participation in recovery, and also conducts regular screenings to make sure patients are taking their proper medications and not using other drugs.

Nelson said the program – having served 800 people over the past 10 years – has led many patients back to stable jobs, relationships and housing. She said health center data show that Duffy's treatment program has reduced homelessness and dependence on public benefits, too.

"What we are beginning to discover is that we can bypass the entire system – heavy on infrastructure with beds and facilities – by treating people with these options on an outpatient basis," said Nelson.

People experiencing homelessness still need housing, but outpatient care for a successfully housed and formerly homeless person can be a much less expensive intervention than placement in a treatment facility.

GOSNOLD ON CAPE COD

Gosnold on Cape Cod is the sole stand-alone detox provider on the Cape and Islands and the region's largest provider of substance abuse treatment, offering inpatient and outpatient addiction and related outpatient mental health services at a number of regional sites.

Gosnold CEO Raymond Tamasi said his organization serves people from all socioeconomic groups. However, because of the kinds of payments accepted by Gosnold, not all homeless people can make use of the organization's services. Gosnold does accept dually diagnosed clients at its detox, rehab and recovery home sites, Tamasi said; according to SAMHSA, about 50 percent of homeless people have co-occurring substance abuse and mental health illnesses.

About 60 percent of Gosnold's clients hail from the Cape and Islands, and Tamasi said that homeless people – already a minute portion of the population – represent a small segment of clients. A state report from May 2015 shows that from July 1, 2014, to March 31, 2015, Gosnold served 2,489 people with detox services; 4.5 percent, or about 112 people, identified as homeless during the three fiscal quarters described in the report.

Based in Falmouth, Gosnold's infrastructure consists of a detox site, a rehab site, two recovery homes, six sober homes, as well as an array of outpatient services at its main locations and elsewhere in the region. About 36 percent of

Based in Falmouth, Gosnold's infrastructure consists of a detox site, a rehab site, two recovery homes, six sober homes, as well as an array of outpatient services across the region. About 60 percent of Gosnold's clients hail from the Cape and Islands, and homeless people – already a minute portion of the region's population – represent a small segment of clients. Housing Assistance Corporation photo

RAYMOND TAMASI
Gosnold CEO

Gosnold's detox clients are private pay, 22 percent private insurance, 3 percent Medicare and 25 percent Medicaid; 7 percent of patients have no insurance, according to the Bureau of Substance Abuse Services.

Very few of Gosnold's referrals come from medical providers, about 1 percent, and the vast majority are self, family or others, at about 96 percent. Also, very few of Gosnold's clients are recipients of other state services, such as from the Departments of Children and Families or Transitional Assistance; about 97 percent of patients use no such services.

About 70 percent of Gosnold detox patients have had no prior mental health treatment history; about 25 percent have received prior mental health counseling, and about 3 percent have received one or more psychiatric hospitalizations.

From July 1, 2014, to March 31, 2015, the drug of choice for Gosnold detox patients was heroin (46 percent) with alcohol close behind (41 percent).

Recidivism is high: Only 23 percent have had no prior detox experiences, while about 77 percent had between one and five prior detox experiences.

In Gosnold's residential program, 59 percent had no such prior treatments; 41 percent had been in treatment between one and five or more times.

Opioid treatment at Gosnold is experiencing a sizable

wave of people who have never needed treatment before, at 70 percent.

DETOX

At the Gosnold Treatment Center near Falmouth Hospital, there are 50 beds used for both acute treatment and clinical stabilization services (detox and rehab), Tamasi said. The beds used for rehab usually total 15 at this site. Beds here are paid for by all payer types: insurance, state reimbursements and self-pay. An average of 70 patients move through Gosnold's detox program in a week. Those who specifically choose Gosnold might have a wait of three to five days, depending on demand, said Tamasi.

REHAB

At Gosnold at Cataumet, on Route 28A in Bourne, the organization operates 40 state-licensed inpatient rehab beds. Tamasi said methods of payment include public and private insurance, and self pay. However, Medicare and four of eight MassHealth products don't pay for this site, but Medicaid Managed Care will. Tamasi said there are a number of homeless or near-homeless people who use this service. Patients stay an average of about 24 days. Tamasi said this part of Gosnold's business carries much of the financial weight, as the self-pay aspect generates revenue while other aspects of the business lose money (the state reimburses for less than the actual cost of care for treatment beds).

RECOVERY HOMES

At the Emerson House on West Falmouth Highway, Gosnold has 38 recovery home (long-term rehab) beds for women. Since these are largely funded with state reimbursements per day of service (about 75 percent of total use), Tamasi said this site often plays host to the homeless in recovery. The average stay is about 50 days.

The Miller House for men on Woods Hole Road is set up in the same way, serving 23 men with long-term residential rehabilitation, and the average length of stay is about the same as the Emerson House. As such, about 75 percent of its users pay for the program through Bureau of Substance Abuse Services money.

SOBER HOMES

Gosnold also owns four sober homes (two for men and two for women), plus manages two others, the Flynn House (owned by the Falmouth Housing Trust) and the Canal House in Orleans (owned by the Community Development Partnership). The latter two make use of federal Housing Choice vouchers for payment.

The company also provides a wide-range of outpatient treatment, including counseling and medication-assisted therapy.

If there's no room at Gosnold, homeless people with substance use disorders would then need to seek services at other Bureau of Substance Abuse Services-approved sites in the Southeastern part of the state, such as in Fall River, Middleboro, Plymouth and Brockton. Tamasi said his staff assists with referrals, either by distributing phone numbers to callers or by making the call on behalf of the treatment seeker, depending on need.

A new Gosnold program is yielding dividends: Re-admissions to detox in the study group (67 young men and women) dropped by 72 percent; hospital admissions declined by 46 percent; and residential rehab re-admissions dropped by 56 percent.

For most Cape and Islands homeless who need treatment after detox but are waiting for a recovery home bed to open up, their main option tends to be a transitional support service site off-Cape, Tamasi said. These sites house clients for a month. Gosnold did offer this kind of service until about 2006 but discontinued the program after a building fire spurred the organization to restructure without it. Reimbursements were poor (falling short by about $200,000 annually), and the program was housed in a building with other programs to which it was unrelated, Tamasi said.

NEW PILOT PROGRAM

Tamasi also said that Gosnold has been using a philanthropic donation to pay for a pilot effort called the Young Adult Opiate Program that has set up nine recovery managers to work directly with patients at their homes. The program was in response to some disheartening relapse statistics: using traditional methods of treatment, Gosnold researchers found that of 75 patients treated, 17 percent relapsed within two weeks of discharge; 93 percent of the 75 patients had successfully completed detox, and 90 percent had a continuing care plan and family support.

Targeting the 18- to 28-year-old demographic, this community-based model offers a combination of personalized home-based recovery management, Vivitrol treatments, a smartphone app and traditional counseling. The program is yielding dividends, Tamasi said, such that re-admissions to detox in the study group (67 young men and women) dropped by 72 percent; hospital admissions declined by 46 percent; and residential rehab re-admissions dropped by 56 percent. The recovery managers work with the patient, as well as their friends, family and significant

Cape Cod Hospital in Hyannis often acts as a receiver of homeless people in the midst of a substance abuse crisis. "We struggle when we act as a virtual funnel, where we have a wide open front door and a narrow back door. This is the current situation where we board patients for very long periods of time because there are no resources available to move them to the next step in their care," said Emergency Center Dr. Nate Rudman. "It overwhelms our ability to care for new patients of any type." Housing Assistance Corporation photo

others, to make sure that they're stably housed, and doing OK with day-to-day activities and appointments.

With this new program, participation in 12-step programs increased by more than 30 percent, and participants increased their sobriety rates from 17 percent in the year before the new program to 77 percent with program participation. This group also became more productive in the workforce, doubling the number of days employed annually (from 6,739 to 12,999).

Tamasi hopes that the model catches the attention of the state and insurance industry, so that the work can be sustained and expanded.

Gosnold is also now teaming up with Cape police departments by having its recovery management supervisor visit recent overdose victims to see if they're ready for treatment. According to an article from The Barnstable Patriot, the recovery supervisor will be pursuing all overdose victims for possible treatment, including the homeless and those living in encampments.

THE HOSPITALS

Hospitals are frequently used by the homeless; on average, homeless individuals visit hospital emergency departments about five times per year, according to the Green Doors community partnership, a Texas-based nonprofit group that aids the homeless; as such, the homeless are the most frequent users of emergency services annually. About 80 percent of the visits by the homeless could've been treated with preventative care, and housing options reduce these visits by some 61 percent, Green Doors states on its website. According to the National Health Care for the Homeless Council, the most common kind of inpatient treatment for the homeless is hospital detox.

CAPE COD HOSPITAL

Cape Cod Hospital is a nonprofit community hospital in Hyannis, and the primary charge of its emergency center is to care for and stabilize any patient with medical, surgical or psychiatric needs, emergency or perceived emergency, regardless of ability to pay.

"We are and should be the medical safety net for the community," said Dr. Nate Rudman, a Cape Cod Hospital Emergency Center physician as well as board member for both Cape Cod Healthcare, the hospital parent, and Housing Assistance Corporation.

The emergency center has 52 beds in its main sec-

tion, 12 set aside for urgent care and an additional six in its Purple Zone, a section for psychiatric and substance abuse emergencies that's away from the hustle of the main EC. Rudman said another 10 to 15 beds can be set up in hallways if such a situation presents itself.

Rudman said the hospital does not track homeless individuals by themselves, but rather has their numbers tied to mental health and substance abuse visits to the EC.

DR. NATE RUDMAN
Cape Cod Hospital Emergency Center physician

The hospital's EC team assesses and treats homeless patients, determining a course of treatment to stabilize them; the nature of their addiction might result in discharge within a few hours (for a heroin overdose) or could require admittance to the hospital (for alcohol or benzodiazepines) because of the health dangers during withdrawal.

Once the patient is treated medically, a social worker assists with detox placements and related casework. Meanwhile, a state Department of Mental Health evaluator works with DMH clients, and a psychiatric nurse practitioner deals with the non-DMH clients. Rudman said the Purple Zone is inundated by people other than for whom it was originally intended, as the emergency psychiatric beds once occupied by mental health patients are now filled with people with substance use disorders who have become depressed or suicidal, or overdosed.

Some might end up in the emergency center for a day or two, as they wait for a treatment bed to open up. Others might be admitted to the hospital; admission to the hospital is at a lower threshold for homeless individuals, said Rudman, as they have nowhere to convalesce safely upon discharge.

Meanwhile, the wait for beds goes on, with dual diagnosis beds (for patients who suffer mental illness and substance use disorders) being the most difficult to find, Rudman said, which echoes the situation statewide.

It's a "front door, back door" problem, Rudman said, in which the hospital can handle the inflow of patients through the front door, but a lack of substance abuse and mental health beds across the commonwealth is keeping these at-risk groups from heading out the back door to the next level of care: detox, rehab and other inpatient treatments.

"We struggle when we act as a virtual funnel, where we have a wide open front door and a narrow back door. This is the current situation where we board patients for very long periods of time because there are no resources available to move them to the next step in their care," said Rudman. "It overwhelms our ability to care for new patients of any type."

From 2011 to 2015, the Cape Cod Hospital Emergency Department has seen a 78 percent increase in care hours for staff dealing with people with mental illness and substance abuse disorders.

What Cape Cod Hospital EC statistics show over the past five years is a marked increase in the number of hours in care provided for the mentally ill and substance abusing populations, which includes homeless individuals. In fiscal year 2015, Cape Cod Hospital EC staff cared for these groups for 91,062 hours, dealing with an average of 10.5 patients for every 24 hours, with an average stay of just shy of a day. This level of EC demand for these demographics has risen dramatically since 2011, when the hospital spent 51,255 care hours on medical, behavioral and social services for people with mental illness and substance abuse emergencies; that's a 78 percent increase over five years. (The hospital does not track patient care hours for visits that are less than six hours, however, which results in an underestimation of total hours spent with these patients. Six hours is the rough average for a patent to be admitted.)

Incidentally, a heroin overdose patient could be released in as few as two to three hours, and they're not included in the statistics above. The sickest patients – such as those suffering cardiac failure – are often out of the EC in less than six hours, moved on to the next level of care; on the other hand, people with substance abuse and mental health illnesses spend much more time in the EC waiting for treatment beds.

"Based on hours, it appears to be getting worse," he said.

By comparison, Rudman said bottlenecking like this doesn't happen with cardiology patients, as there's infrastructure to move these patients along typically in under three hours.

Rudman believes there are two major deficits in the system: There are not enough treatment beds for post-emergency department care and stabilization, and that the next steps are not effective enough. The "revolving-door" of detox, treatment and relapse does not support a notion of effectiveness, Rudman said.

Change is needed in the treatment system, he said.

NANTUCKET COTTAGE HOSPITAL

On the island of Nantucket, there's little infrastructure for substance abuse treatment and the homeless, except

At Nantucket Cottage Hospital, its emergency department is licensed for six beds but can accommodate nine. No beds are dedicated to any specific demographic, such as the homeless or people with mental illness. Photo by Nicole Harnishfeger/The Inquirer and Mirror

Martha's Vineyard Hospital is offering space for the island's first crisis stabilization center. Photo by Ivy Ashe/Courtesy of the Vineyard Gazette

At Falmouth Hospital, the average stay for behavioral health or opioid patients in the emergency department is 19 hours. Housing Assistance Corporation photo

for outpatient counseling and support groups. The majority of the community's health care and medical needs are addressed at Nantucket Cottage Hospital, in operation since 1911. The small hospital's emergency department is licensed for six beds but can accommodate nine. No beds are dedicated to any specific demographic.

Unlike Cape Cod Hospital, the Nantucket hospital does not track its care hours as they relate to behavioral health patients in its emergency department. However, the department recorded 29 visits by substance abuse and mental health patients in November 2015, according to hospital staff.

Beyond the lack of island substance abuse treatment infrastructure, the existing hurdles of getting an islander off-island addiction help include a lack of beds, insurance problems and ability to pay, travel considerations such as ferries and weather, and coordinating bed availability with the ability to get patients to the treatment site.

The hospital recognizes the need for improved resources and support for behavioral health patients, and is committed to working with patients, families, providers and the community at large to ensure it is able to meet the specific needs of the homeless and behavioral health populations, according to a hospital spokesman.

FALMOUTH HOSPITAL

At the Falmouth Hospital emergency department, there are 33 beds, with four dedicated to behavioral health patients, said Dr. Robert Davis, director of emergency medicine at the hospital. He said Falmouth Hospital does not have a large number of homeless patients, likely because of a lack of programs in town. The hospital does, however, have a considerable amount of patients with substance use disorders, he said.

From Jan. 1, 2015, to Aug. 31, 2015, Falmouth's emergency department had behavioral and opioid-related visits that totaled more than 14,188 hours, with an average length of stay at over 19 hours.

Davis said the demand for substance abuse and mental health beds regularly exceeds supply, and that more beds would be welcome, especially for those patients with a dual diagnosis.

MARTHA'S VINEYARD HOSPITAL

On Martha's Vineyard, treatment services largely mirror Nantucket. There are few homeless people who pass through the emergency department at Martha's Vineyard Hospital, said spokeswoman Rachel Vanderhoop. The organization doesn't track their numbers, she said.

The emergency department has 16 beds, with no set-asides for behavioral health patients. When patients with substance use disorders land in the emergency department, it usually takes 48 hours to complete their transfer to an off-island treatment site, about double the length of an emergency center stay at Cape Cod Hospital.

Vanderhoop also said that the hospital has entered into an agreement with Martha's Vineyard Community Services to provide a small hospital outbuilding, free of charge, to become the island's first crisis stabilization center. The center, which will have two beds, should be open sometime in 2016, said Vanderhoop.

NON-STATE-FUNDED SERVICES FOR THE HOMELESS ON CAPE COD AND THE ISLANDS

In addition to private and state-contracted services, there are some additional options on Cape Cod for shelter with substance abuse treatment coordination; these include federal programs administered by Duffy Health Center, housing authorities and Housing Assistance Corporation, as well as others. These housing options have no treatment services on-site, but are worth noting because they offer the homeless some shelter, which experts say is key to successful outcomes for sobriety. Most of these sites offer housing to residents of the Cape and Islands as well as those from off-Cape.

Duffy Health Center in Hyannis manages a number of Housing First slots, which combine rapid re-housing efforts with case management. Photo by Alan Belanich for Housing Assistance Corporation

DUFFY HEALTH CENTER

Duffy Health Center in Hyannis administers 45 Housing First case management slots; with a Housing First voucher, people are housed immediately in area apartments and services are made available to them without stringent conditions. Some of these vouchers are subsidized through HUD, and the rest use other subsidies. The case management services are funded through MassHealth reimbursements, and are also part of the Home and Healthy for Good program through the Massachusetts Housing and Shelter Alliance. (Some clustered Housing First sites offer services onsite; others do not offer direct clinical help, and instead facilitate outpatient services through a caseworker. Either way, results from Housing First programs have yielded human and capital dividends. For instance, the Journal of the American Medical Association reported that in Seattle in 2009, the city saved taxpayers $4 million-plus during its program's first year; emergency room visits, hospitalizations and stays in sobering facilities and shelters all declined.)

Meanwhile, HAC manages some 52 scattered site beds through its federally subsidized Cape Homes III, IV and V programs, as well as the Home and Healthy for Good program. These too are operated under a Housing First model.

BARNSTABLE HOUSING AUTHORITY

The Barnstable Housing Authority administers a number of Housing First sites. Some 35 beds are federally subsidized for the chronically homeless with HIV (10 of whom reported ongoing drug or alcohol abuse) as well as four rooms at two properties, also federally subsidized, for the chronically homeless with a dual diagnosis. They receive case management from the AIDS Support Group of Cape Cod and Duffy Health Center respectively. The Barnstable Housing Authority also administers federal subsidies for five beds managed by CHAMP Homes in Hyannis at its Pilot II site.

CHAMP Homes in Hyannis offers a mix of substance-free housing. Tenants pay a portion of their income to live there. Photo by Alan Belanich for Housing Assistance Corporation

OTHER TRANSITIONAL LIVING SITES

There are other Cape shelters and transitional living sites, such as HAC's Chase House (six units), HAC's Village at Cataumet (18 units serving families) and the Carriage House (nine young mothers and their children), the Homeless Not Hopeless transitional homes (serving 40 formerly homeless women and men at four sites), CHAMP Homes (69 beds), and St. Clare's shelter (six beds for recently incarcerated women), but these all lack a direct substance abuse treatment component onsite. They coordinate such services for clients and encourage sobriety, but clinical supports are not part of the regimen.

CHAMP Homes, for example, is for those who have already taken the first steps toward sobriety. CHAMP Homes – which offers a mix of substance-free housing, from permanent to transitional – includes a main campus with 25 beds for those men and women who are at least six months sober; Pilot House I and II, which house a total of 23 newly sober men; six more beds at the Jamie Ready House; 10 at the Lyndon Lorusso House; and the Bayside Cottage, which is run in partnership with the Cape Cod Council of Churches and houses five women who've just emerged from incarceration.

The organization receives and sends out referrals for those exiting treatment or needing to enter treatment, and also partners with Duffy Health Center as its medical go-to site for its spectrum of services, which include general health, mental health and substance abuse treatment, medication-assisted and otherwise. Funding for CHAMP Homes comes through a mix of federal funding, fundraising, grants, donations and fees.

There are also sober houses in various locations across the Cape, with a concentration in Falmouth. These are unregulated and do not offer substance abuse treatment services.

With the exception of support group meetings, sober homes and counseling, there are no such services on the islands, as well as no shelters.

HOUSING FIRST

The Housing First model of homelessness reduction gets people off the streets and into safe, stable and affordable housing, without stringent requirements or conditions on the tenants. It's a movement based on the principle that housing is a basic human right, including for those who suffer from substance use and mental health disorders. Abstinence-only housing programs require sobriety for admittance; Housing First advocates do not set that requirement, although abstinence might eventually become part of clients' treatment regimen if they wish.

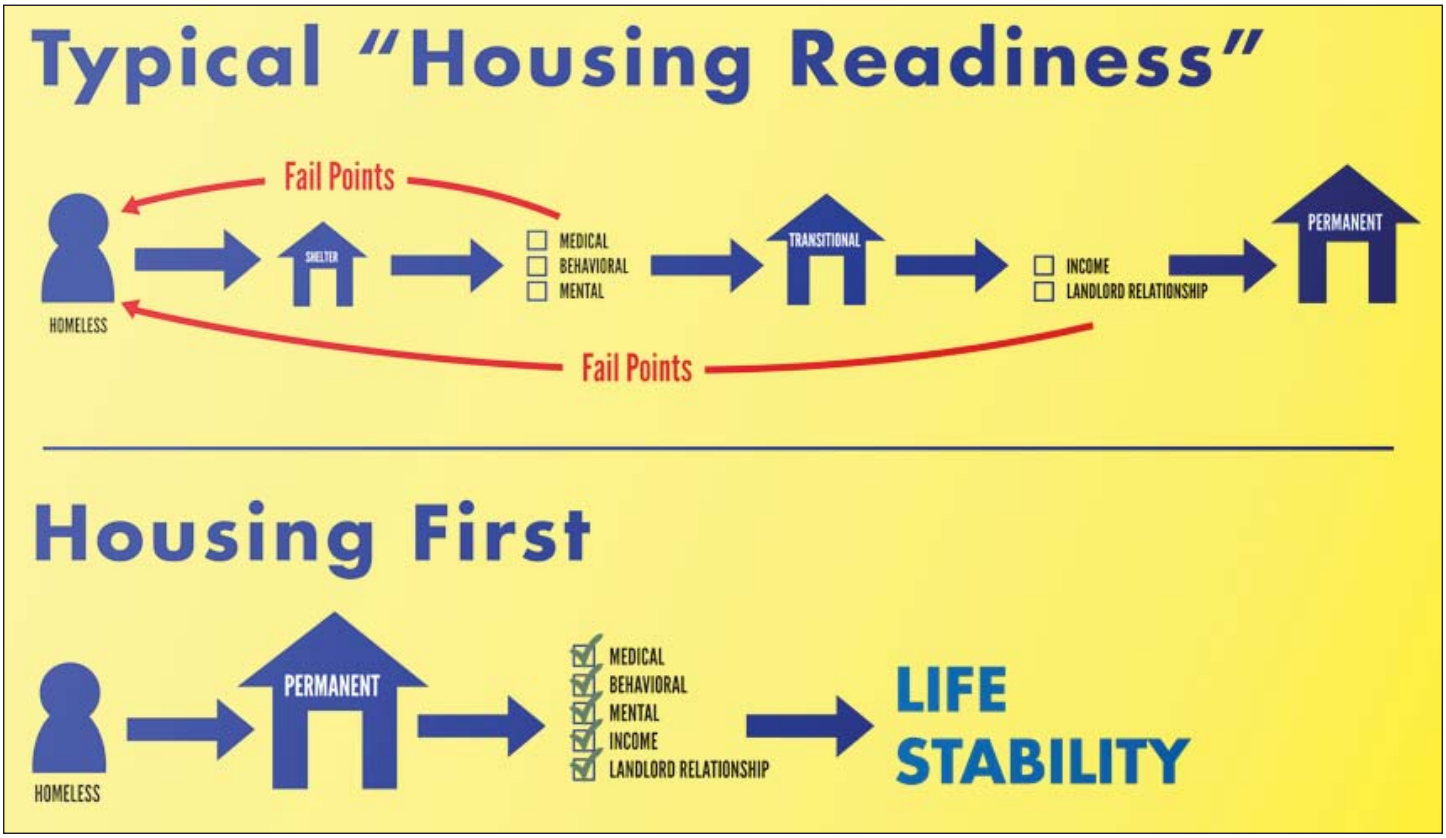
The first efforts sprang up in 1988 in Los Angeles with PATH Beyond Shelter, founded by Tanya Tull, to get homeless families into permanent housing as rapidly as possible, according to a 2004 study on the Housing First Model, called "Housing First for Families: Research to Support the Development of a Housing First for Families Training Curriculum." Once housed, families received home-based services, including life skills education, physical and mental health care, child care, employment aid, benefits advocacy, financial assistance, proactive landlord outreach and housing search help. The combined services are designed to help families overcome financial barriers, to gain economic security, and to foster housing stability and family health and well-being, according to the organization.

The work in Los Angeles was followed a few years later in New York by Dr. Sam Tsemberis, who began Pathways to Housing in 1992; his Housing First model focused on homeless people with psychiatric and addiction disorders. At scattered site apartments, clients are rapidly re-housed from the streets or shelters, and provided with services for mental and physical health, substance abuse, education and employment.

'THE IMPORTANCE OF HOUSING ...'

"The importance of housing (as well as employment) in successfully treating individuals cannot be understated," writes Suzanne Zerger in her 2002 paper, "Substance Abuse Treatment: What Works for Homeless People? A Review of Literature." "Indeed, the evidence shows that dropout rates are consistently much higher for clients enrolled in nonresidential programs than in residential programs."

A 2007 review by SAMHSA found that 80 percent of Housing First clients remained housed, while only 30 percent remained housed in an abstinence-based model, according to "Housing First and Harm Reduction: Effective Models For Substance Abuse Treatment with Individuals Who Are Homeless," a paper by Amanda Russell.



Graphic by Abode Services

Further, another study – "The Applicability of Housing First Models to Homeless Persons with Serious Mental Illness," by HUD in 2007 – states that, "Some Housing First programs can ameliorate some of the worst social effects of persistent drug abuse through close and proactive contact with the client and steady commitment on the part of an interdisciplinary team to meet the needs of landlords as well as clients."

Housing has the greatest single effect on client retention in treatment programs, according to the U.S. Substance Abuse and Mental Health Services Administration.

A study published by the National Institutes of Health found that "Housing First participants were significantly more likely to have low/no substance use during the study year than the treatment first participants."

Critics of Housing First endeavors, meanwhile, decry the lack of longitudinal and blind studies on the programs, even as they cite the efficacy of existing programs.

Today, there are Housing First sites – both scattered and in organized developments – all across the country. The Corporation for Supportive Housing, an advocacy and technical assistance group, cites three documented results from Housing First programs: Housing First models lead to higher rates of housing retention compared to other anti-homelessness models; Housing First models do not increase substance use habits among tenants, even with the model's lack of an abstinence policy; and that participation in services is high in Housing First programs, but not as high as programs where attendance is a requirement.

HIGH RETENTION NUMBERS

Home retention is high among Housing First tenants; the Closer to Home Initiative, a program in California and New York, had 83 percent retention in its first year, and 77 percent after two years, according to a 2004 study by the Corporation for Supportive Housing.

The model is also cited as being cost-effective. The National Alliance to End Homelessness says that permanent supportive housing models, such as Housing First, reduce inpatient mental health care and hospitalizations; these tenants "increase their incomes, work more, get arrested less, make more progress toward recovery, and become more active and productive members of their communities."

The alliance cites several examples where cities saved money while diverting people from the traditional track of staying in homeless shelters. For instance, the Denver Housing First Collaborative reduced public costs (health, mental health, substance abuse, shelter and incarceration) by $15,773 per person per year, offsetting the $13,400 annual

cost of the supportive housing. Meanwhile, Portland, Oregon's Community Engagement Program reduced the cost of health care and incarcerations from $42,075 to $17,199 per client once enrolled and housed; the average cost per client for housing and substance abuse treatment was $9,870 annually. Meanwhile, another study of 100 homeless people in Denver showed considerable savings when the city implemented a Housing First program there: Emergency service costs dropped by 72.95 percent, or nearly $600,000, over a period of two years, as compared to the prior two years; related cost savings averaged $31,545 per person.

Ann Marie Peters, HAC supportive housing specialist, said about 95 percent of her Housing First residents have substance use disorders (72 percent use alcohol and 42 percent use drugs); and 98 percent have a mental health diagnosis.

On Cape Cod, costs range from $5,526 to $11,196 a year (for leasing, services and administration) to get a chronically homeless individual into permanent supportive housing; meanwhile, it costs $19,027.45 to house an individual for a year at the NOAH Shelter, according to HAC figures. Additional savings from supportive housing come from the formerly homeless individual no longer being a heavy user of public emergency, health and substance abuse services.

In "Costs of Homelessness: A Study of Current and Formerly Chronically Homeless Individuals on Cape Cod, Massachusetts" from 2009, the author followed 51 people, some recently homeless in permanent supportive housing and others who were totally homeless. The group in permanent supportive housing cost $992,369 over a year's time for all services, while the homeless group cost $1.3 million.

ENDING HOMELESSNESS

Housing First programs have been credited with putting a giant dent in homelessness. Utah began a 10-year plan to end chronic homelessness in 2005, focusing on a Housing First model that provides a mix of housing with supportive treatment services, such as physical and mental health care, education and employment. The state reports that since efforts began there in 2005, the numbers of chronically homeless dropped from 1,932 to 178 in 2015. Utah housing workers know the remaining homeless people by name, according to a Utah.gov factsheet on homelessness.

Utah's 10-year plan relied on deep partnerships among state, county and local organizations, with no fewer than 38 community groups, associations and service providers teaming up to tackle the problem. It resulted a 91 percent reduction of the chronically homeless population and an average savings of $8,000 for every person moved from the streets into supportive housing.

ANN MARIE PETERS
Supportive housing and client services program manager for HAC

Supportive housing developments that include a myriad of services that address the diverse needs of the recently homeless are cited as being effective for preventing and ending homelessness, according to SAMHSA's "Behavioral Health Services for People Who Are Homeless" from 2013. Programs with housing have consistently lower substance abuse treatment dropout rates, according to the National Health Care for the Homeless Council, as it stated in a report from 2002.

SAMHSA goes as far as saying that housing has the greatest single effect on client retention in treatment programs.

Cape Cod has a number of scattered site Housing First apartments, largely paid for by federal funds through HUD's Continuum of Care Program. These Housing First sites are managed by the Falmouth Housing Authority, HAC, the Barnstable Housing Authority, the Department of Mental Health and Duffy Health Center; the tenants are helped by caseworkers and receive outpatient services. There are no cluster developments with wraparound services on the Cape and Islands.

Ann Marie Peters, supportive housing and client services program manager for HAC, oversees dozens of federally subsidized Housing First rooms for chronically homeless individuals as part of the federally funded Cape Homes program.

THEY PAY TO STAY, PLUS GET HELP

Of the scattered site apartments she manages, Peters said these are all occupied by chronically homeless individuals; these clients receive case management through HAC or a partner agency. Residents pay a portion of their income – about 30 percent – toward the rent, with most money sources being Social Security, welfare or disability payments; HAC pays for the rest of leased room costs through a federal subsidy.

Based on her data, Peters said about 95 percent of her Housing First residents have substance use disorders (72 percent use alcohol and 42 percent use drugs); and 98 percent have a mental health diagnosis. Those who experience severe substance use problems are referred to detox, and

their apartment is held for them while they're away. Peters said she's only had two people leave the housing program during the nine years she's overseen it.

Peters said that even the most challenging members of the homeless population can be successful in using the Housing First model.

"The more people who are housed and can remain housed, reduces the number of people on the streets and in shelter," she said.

Daniel Mumbauer, CEO of High Point, said Housing First sites "have a huge impact on discharges and admissions" to substance abuse treatment facilities.

Making use of Housing First scattered site apartments can reduce the "footprint" that homelessness can have on a place like Hyannis.

"Homelessness is a Capewide problem, yet because there is a large cluster of programs in the downtown area, Hyannis bears the burden and the majority of the cost to deal with this issue. Using the scattered site model could alleviate some of the problems," she said.

Moreover, the model delivers many personal benefits to the people who use it.

"The primary benefit is safe, stable, affordable housing, which is the ultimate goal for people experiencing homelessness," said Peters. "It is a huge relief to no longer worry about being on the streets or getting a bed at a shelter."

The case management that comes with Housing First programs gives the clients a single point of contact for health and social services, which makes navigating the system much easier for them. It's played a key role in housing retention, Peters said. It also gives the client a greater sense of self-determination, as they make informed decisions about their health and well-being.

With 52 scattered site beds through various non-state programs, Peters said occupancy is always full, and there's a constant waitlist of 50, with little to no movement. That waitlist is shared with Duffy Health Center.

Daniel Mumbauer, CEO of High Point, said Housing First sites "have a huge impact on discharges and admissions" to substance abuse treatment facilities. "They have the supports and they can do outpatient (treatment). It reduces the reliance on longer stays in detox and rehab," he said.

The clients entering and staying in Housing First sites are "folks people thought could never make it. We've had people go back to school, work and become (High Point) staff," said Mumbauer.

The Cape and Islands Regional Network on Homelessness is a coalition of public, private, business and faith-based groups, all working toward a goal of preventing and ending homelessness. The network isn't specifically involved in substance use issues or treatment for people experiencing homelessness, said network coordinator Paula Schnepp. The network is, however, deeply involved in getting federal grants through the Continuum of Care program, the HUD effort whose mission mirrors that of the regional network. Barnstable County Department of Human Services is the "Collaborative Applicant" for Continuum of Care grants, and has taken the lead on applying to HUD. Grantees also need to complete renewal applications for funding along with the main proposal.

$1.7 MILLION SOUGHT FOR REGION

Through the Continuum of Care grant application process, the regional network helps direct funding to meet both HUD's priorities and the community's greatest needs. Money is disbursed directly from HUD to grantees, most often going toward ongoing and new Housing First endeavors in the region. For the latest round of funding sought, the region is hoping to get $1.7 million, largely for continued operation of existing programs. New efforts include the Mashpee Wampanoag Tribe seeking to get 10 Housing First beds and rental assistance money, as well as the county asking for $60,000 to begin its coordinated entry system for homeless people.

"Housing First is so popular because it's a low-cost response," said Schnepp, noting how people experiencing homelessness are often cost drivers in hospital emergency departments, and that housing them costs less. With rapid re-housing, "... we're in a much better situation," she said. Schnepp said that agencies administering Housing First programs, cite an 85 percent retention rate of keeping Housing First tenants stably housed. (HAC's retention rate is 90 percent.)

"Sobriety is harder to maintain when you're in a tent and cold. The ones who get into some form of housing, at least there's a place to come back to (after detox or rehab). The more people we can get into Housing First with the subsidies we have, that's good," said Schnepp.

Schnepp did say, though, that the remaining 15 percent who drop out of Housing First programs are often the most challenging to get housed again, and might require more supervised types of housing. She also said the tight real estate market is creating difficulties in getting people housed. Sometimes the cost of a rental unit is the problem; other times, it's the tenant history of the person seeking housing.

"That's why models that are able to apply a little more grace for people are helpful," said Schnepp. "A person who's chronically homeless, it's likely they've had housing at vari-

Village at Cataumet shelter Director Paula Mallard, right, speaks with a staffer. She said finding a treatment bed for a client often can be a challenge. Housing Assistance Corporation photo

ous points in their life, but it invariably falls apart. How do you find that right blend of services that really, effectively keeps people in housing?"

For people experiencing homelessness, "little things" can become a barrier to client success, such as "not being able to fully assist someone to visit a landlord. … On the Cape, one's ability to get to housing and get to appointments is a big feature in whether someone is successful in getting housing."

The network has been having discussions on how to make Housing First agreements more palatable for landlords, as well as taking a close look at the available housing versus the current needs.

The difficulty with Housing First tenants and with getting landlords to accept them resulted in one HUD grantee on the Cape not pursuing renewal of four federally funded Housing First units. According to advocates, the tight real estate market has made it difficult to house chronically homeless individuals with vouchers made available through the state's Social Innovation Fund program. Another 10 vouchers from the Massachusetts Rental Voucher Program for chronically homeless individuals will soon be available, and HAC is working with network members to issue these vouchers and try to house individuals by June 30. Schnepp also said that this year there was an opportunity to get some bonus HUD funding, but no agencies applied. "I strongly support the Housing First model, but we need more housing resources to make it work in our region."

"If you're not willing to get clean, we could offer you a million bucks and a McMansion, and you still wouldn't do it," said Paula Mallard, director of the Village at Cataumet family shelter in Bourne.

IS THERE THE CAPACITY?

If there were to be a Housing First push on the Cape, Duffy Health Center CEO Heidi Nelson said her organization's capacity could withstand an increase in delivery of medical and mental health care services. For substance abuse treatment, Duffy could help with outpatient care, as well.

Case management, which is instrumental in Housing First efforts, would need to be bolstered in the area. Duffy is the only Cape provider currently being reimbursed by MassHealth for case management services for the chronically homeless, she said.

CAPE COD EXPERIENCES

The majority of the 14 medical, housing and substance abuse treatment experts interviewed for this report cited the Cape's lack of treatment beds, outpatient treatment options and supportive housing units as obstacles for the region's homeless population.

A few of the experts also cited the Cape's need for more trauma-informed care, more transportation for at-risk groups and more affordable housing.

THE VILLAGE AT CATAUMET

Paula Mallard, director of the Village at Cataumet, a HAC shelter for homeless families in the town of Bourne, said finding a treatment bed for a client often can be a challenge. She mentioned a husband and wife in particular: The wife was able to get into a detox treatment bed within 24 hours back in May, while her husband waited for 72 hours in August.

For the husband, who was from the Cape, things ended tragically: He died from a heroin overdose on Dec. 4, mere months after emerging from detox. Mallard said after detox, the man – a 35-year-old father of three young children – never followed up with any treatment.

Mallard said the man died about a week before his 36th

NOAH Shelter Director Greg Bar talks about people experiencing homelessness recently. He says it's the alcohol and drug abuse that's claiming lives of homeless people on Cape Cod, not the elements themselves. Housing Assistance Corporation photo

birthday. "He actually was a really good dad. He was very connected with his kids," Mallard said.

Mallard said all three children saw their father's body that morning, after he died in a Village at Cataumet bathroom with a needle by his side.

"My heart breaks for the kids," said Mallard, who feared that their mother, also in her early 30s, is using again. "If she doesn't stop what she's doing, (they) are going to lose their mother."

Mallard said this man would've been a prime candidate for a residential treatment site that welcomes families, such as Sage House's Residential Family Treatment Program in Framingham; no one wants to be separated from their children, and yet long-term treatment doesn't account for it enough. Most family components in modern treatment include counseling, training and at-home support for the relatives of the person in recovery during and after their stay in rehab.

"He could have used some kind of aftercare. But I don't think he would do it without his family," said Mallard.

However, foremost in her mind regarding addiction is the personal responsibility of the individual with a substance use disorder.

"If you're not willing to get clean, we could offer you a million bucks and a McMansion, and you still wouldn't do it," said Mallard.

Accordingly, treatment can't be delivered in a cookie-cutter fashion, as there are too many individualized needs, she said.

For those receiving outpatient care, Mallard also cited concerns about the overprescribing of non-opiate drugs, such as benzodiazepines like Ativan and Klonopin, which are reducing clients' ability to work or be trained.

"There needs to be more treatment on the Cape," said "Wilma," a lifelong and sometimes homeless Cape resident who's battled addiction for most of her life. "They have no other choices. Go to the hospital or NOAH or nothing."

Success for shelter clients, Mallard said, is if they can maintain their temporary housing and not lose their children to the state. Mallard spoke of needing to plant the seeds of change into the minds of those in her care.

Inadequate transportation for clients to get to and from medical appointments or jobs is also a problem, said Mallard.

Mallard echoed other shelter directors' complaints about the pervasiveness of drug use by her clients, all of whom are referred to the shelter by the state. Like most shelters and supportive housing on the Cape, off-site substance abuse treatment is coordinated by staff, but is not at the site itself.

She also highlighted how traumatized her clients are, in most cases dating back to long before they arrived at the shelter. She said upward of 80 percent of clients have experienced trauma, and that close to half have been through the foster care system and experienced abuse.

"Most families are in survival mode, and they've been in survival mode since they were this big," said Mallard, motioning to the height of a toddler.

Their problems are cyclical, stemming from little-to-no education or job skills, and few life skills, and many suffer from situational depression because of their homelessness. Some counselors from the state's Healthy Families program do meet with clients and their families, Mallard said, teaching them basic child-rearing skills. And there is a peer recovery group that convenes every other week.

THE NOAH SHELTER

In Hyannis, the NOAH Shelter serves homeless Cape Codders and a smaller transient population who are seeking sanctuary from the elements. Cape and Islanders can stay at the shelter for an undetermined amount of time, while the transients are provided shelter for one night unless they are due to be housed imminently.

The numbers of homeless guests who stay at the shelter have been holding steady over the past few years, with 417 in fiscal year 2013, 422 in FY 2014 and 417 in FY 2015.

All guests at NOAH are required to meet with a recovery advocate, who works at the shelter from 4 to 7 p.m. five nights a week to conduct both mandatory and random drug and alcohol testing, and to assist guests with referrals, rides to services and information about sobriety meetings, treatment centers and other related programs.

Prior to the shelter becoming dry in September 2015, NOAH recovery advocate Geoff Gagnon checked the admissions criteria for drug and alcohol treatment centers, largely from Central Massachusetts eastward. He aggregated a list of about 29 such places; most of these facilities are located off-Cape, and services vary widely.

What he found was "there wasn't very much here or on the South Shore," said Gagnon. "There (are) no beds."

In September, NOAH had eight clients who entered treatment or hospitalization to address their substance use problems. Of the clients Gagnon assists in getting into treatment, waits of a week are the norm. Gagnon said the interim period between a client saying they want help and the time they're cleared for a bed can be precarious, if not deadly. During the waits, homeless people with substance use disorders lose the urge to get treatment, relapse, get exposed to the elements, sometimes fall into crime and risk their lives. Substance abuse is often accompanied by other health problems, which magnifies the risk.

Moreover, with the NOAH Shelter now dry, a detox-waitlisted client won't get access to a NOAH shelter bed if they test positive during entry, Gagnon and shelter Director Greg Bar noted. That means the homeless person's only options are the streets or the hospital; Bar said this circumstance has not yet occurred at the shelter.

"There needs to be more treatment on the Cape," said Wilma, a lifelong and sometimes homeless Cape resident who's battled addiction for most of her life. "They have no other choices. Go to the hospital or NOAH or nothing."

She recalls treatment waits of a week from her several detox stays. "That's a scary week," she said of homeless people like herself. "They can die."

Citing the homeless deaths over the past few years, Bar said it's the alcohol and drug use that's claiming lives of homeless people on Cape Cod, not the elements themselves.

Wilma, now sober for the past eight years and recently living in transitional housing in the Mid-Cape area, said substance use disorder needs to be seen as a "progressive fatal illness," and that treatment needs to be available on demand.

Proactive harm reduction services at NOAH are ongoing, according to Bar. Offerings for guests there are wide-ranging, including: recovery and AA meetings; a women's support group, led by Independence House, a regional domestic violence prevention organization; visits from a Vinfen mental health outreach team, and Department of Transitional Assistance and Social Security representatives; meetings with the shelter's transition team (housing, employment and health specialists) to help guests move toward independent living; a day center where guests can rest and regroup, or participate in programs (i.e., stress management, goal-setting, finances and budgeting); a trauma-informed yoga group; psychotherapy group meetings, as well as visits and discussion groups led by local psychiatrists; a recovery advocate; and information sharing on treatment centers, sober houses, meetings and shelters. NOAH's housing specialist works five days a week helping people into housing – including sober houses and transitional living, most often providing move-in funds; another housing search specialist helps those who are not yet, but are imminently, homeless; and a stabilization volunteer makes weekly visits to those who do get housing.

A HAC client recently overdosed twice, a crisis-intervention team convened, and the team was able to get that client to both recognize his problem and agree to go to detox. "He was willing to go to treatment, but we could not find a bed for him. It was a huge letdown for that individual," said Ann Marie Peters of HAC.

HAC SUPPORTIVE HOUSING

Ann Marie Peters, supportive housing and client services program manager for HAC, sees a high rate of substance use at the scattered site apartments she manages and helps facilitate treatment for those who seek it. "It's difficult getting anyone in anywhere," said Peters of treatment beds, echoing concerns of her peers.

She said wait times vary for getting a detox, sober house or rehab bed, and during these waits a number of problems might arise for clients. For example, a client recently overdosed twice, a crisis-intervention team convened, and the team was able to get that client to both recognize his problem and agree to go to detox. "He was willing to go to treatment, but we could not find a bed for him. It was a huge letdown for that individual," said Peters.

At the time of this writing, the client still had not entered rehab, although he had been evaluated and said he was open to following through.

Peters also makes use of a network of sober homes, largely located in the Upper Cape. These can be very suc-

Angel House Director Lin Rohr keeps a little one snug during warmer days at the Hyannis-based shelter. Rohr would like to see more safety net infrastructure for those residents with the dual diagnosis of mental health and substance abuse disorders. Housing Assistance Corporation photo

cessful for getting unstably housed or homeless clients back on the right track. However, sober homes are unregulated, and are not allowed to offer substance abuse services to residents, thus the client must be able to handle their treatment independently.

Costs for temporary stays at sober homes for HAC clients are paid through income (wages, Social Security and disability payments), as well as prevention money from HAC or Team M25, an independent Cape anti-homelessness group.

Peters said there are palpable gaps in the substance abuse treatment system: The region needs more detox beds, more housing with a substance abuse treatment component and more affordable properties.

ANGEL HOUSE

HAC's Angel House is the Cape's sole state-contracted transitional support shelter, located in Hyannis and serving 13 women in recovery and their children. Angel House is a long-term (nine to 12 month) trauma-informed care treatment program. Residents of Angel House are referred by the Institute for Health and Recovery, a Massachusetts nonprofit agency.

Residents come to Angel House from a variety of circumstances, including detox, living with friends or family, the streets or incarceration. With state Bureau of Substance Abuse Services funding and HAC fundraising, clients receive the full gamut of services, plus behavioral health learning and growth experiences. Shelter Director Lin Rohr said the waiting list to get into Angel House averages between six weeks to three or four months.

At Angel House, harm reduction measures include: nine mandatory weekly groups for guests, including relapse prevention, housing (with a staff housing specialist), anger management, nurturing/parenting, nutrition, life skills (budgeting, job applications, time management, job interviewing skills and communication), health and wellness (dental care and pediatric appointments), a house meeting to help residents to work cooperatively while in a communal living arrangement, and yoga. On a rotating basis there are: speakers on domestic violence from Independence House; mandatory weekly therapy sessions onsite with a clinical director; mandatory weekly therapy offsite; weekly case management meetings; a minimum of five AA or NA meetings a week (three must be offsite); community service one hour a week to Angel House to increase connection to community and competency; treatment from Habit OpCo for those who choose maintenance methadone; and joint meetings with clients and their Department of Children and Families workers, probation officers and others. At Angel House, guests are supported in getting food stamps, Social Security, Department of Transitional Assistance aid, government IDs and programs, as well as achieving their own personal goals in recovery, said Rohr.

Rohr said she would like to see more such shelters in the commonwealth to fill the need, to provide the kinds of transitional supports that Angel House offers to more people. The program functions well, based on comparisons to similar programs elsewhere in Massachusetts: Retention at Angel House is strong (7.1 percent of clients drop out and 14.3 are released for administrative reasons), and 64.3 percent complete treatment, compared to the statewide 34 percent. Upon completion/graduation or within 3 months of it, 92 percent of Angel House clients have secured housing. In her yearlong tenure, Rohr hasn't had any clients needing to go to rehab in the midst of their stay at Angel House; some clients have relapsed into drug or alcohol use, but they instead are given services in-house and from local service providers.

For gaps in the system, Rohr said there's a need for more safety net infrastructure for those residents with the dual diagnosis of mental health and substance use disorders.

HOMELESS NOT HOPELESS

Homeless Not Hopeless is an organization in Hyannis that operates four transitional homes for formerly homeless men and women where they can rebuild their lives. The group receives no state funding for substance abuse services, but manager Caroline Corrigan said staff monitors guest sobriety and points them to the correct resources. She said sometimes a case manager might assist, but very rarely.

She said the biggest impediment to getting substance abuse treatment is the wait for a bed, as well as the medical clearances required to get the bed. For those Homeless Not Hopeless guests needing detox, they are sent to Gosnold on Cape Cod if there is a bed available. Usually, though, there

isn't one open, as the wait is often four to five days. For those with dual diagnosis, clients are sent off-Cape to High Point Treatment Center in Plymouth.

DUFFY HEALTH CENTER

Duffy Health Center is a community-based medical center in Hyannis that serves homeless and at-risk people from the Cape. Duffy's Executive Director Heidi Nelson said nearly half of all Duffy Health Center clients in 2014 (about 1,500 homeless or at-risk individuals) had substance use disorders. And even with state health insurance, getting a bed in a detox facility for an at-risk Cape Codder can be a challenge, she said. High Point – located off-Cape – has become a "go-to" detox provider for Duffy, in part because of the availability of beds and its ability to serve those with a dual diagnosis. She said detox placement for Duffy clients occurs about three or four times a month.

HEIDI NELSON Duffy Health Center CEO

Duffy also offers intensive outpatient medication-assisted treatment, and individual and group counseling. Meanwhile, Duffy case managers work with clients on receiving outside treatment and state or federal benefits, such as Social Security or food stamps, and the center also gets clients signed up for health benefits from appropriate agencies.

And while housing isn't part of Duffy's core mission, it's still a related offering there, with 45 Housing First case management slots. At Housing First scattered site apartments, chronically homeless clients receive coordination for services for substance abuse, as well as for mental and physical health, education and employment.

Nelson believes there aren't enough treatment resources on the Cape.

CHAMP HOMES

Beth Wade, executive director of CHAMP Homes in Hyannis, said her organization is often the receiver of calls for homeless Cape Codders emerging from detox or other rehab sites. Conversely, CHAMP oftentimes throughout the span of a year will need to make rehab or detox placement calls for residents who are dismissed from the program for substance use, a breach of the agreement for residents at the group's many sites.

Formerly, CHAMP Homes would immediately dismiss a resident if he was found to be under the influence. Now, however, Wade said CHAMP Homes is taking a more compassionate and problem-solving approach, such that residents who relapse are given seven days' notice before they need to vacate. By then, in most cases, shelter and/or treatment – such as NOAH, Gosnold or High Point – have been found for their exiting clients.

Carriage House Shelter Director Katie Geissler gives a lift to her daughter, outside the shelter this fall. She says when clients want to go to detox, they go wherever a bed is available, which most often is off-Cape. Housing Assistance Corporation photo

Wade said she would like to see longer periods of rehab for people in substance abuse treatment, citing the oft-repeated metaphor of a revolving door for those in treatment: an endless circle of substance use, detox, rehab, sobriety and relapse.

She said she'd love to have a version of the Pilot House for women only (it currently serves men), but lack of funding keeps any imminent plans at bay.

CARRIAGE HOUSE

Katie Geissler is shelter director at HAC's Carriage House, which serves nine young homeless women who are either pregnant or with a young child. Clients are referred to her site from the state. There are no substance abuse treatment services onsite, although Carriage House case managers will aid with facilitating supports.

That said, Geissler said about half her clients are struggling with substance use at any given time; some are aware of their problem and are in recovery, while others haven't acknowledged the abuse and are actively using alcohol, marijuana, opiates and benzodiazepines.

"They self-medicate," said Geissler.

When clients want to go to detox, Geissler said they go wherever a bed is available, which most often is off-Cape. This happened on two occasions in 2015, she said.

Almost uniformly, the reason for the self-medication, said Geissler, is trauma. The women at Carriage House have either been traumatized through early home life, or more recently through domestic violence, as well as from poverty and being raised in foster care.

"It's all about healing," she said, and self-medicating is the opposite of that.

Accordingly, she said a major gap in the existing shelter system is the lack of services and treatment beds for people suffering the effects of trauma, as well as more services across the spectrum for people with a dual diagnosis of substance use and mental health disorders; she cited waits of three to four months for her clients who were seeking outpatient psychiatric treatment. All of these groups need more therapeutic structure in their daily programs, but are not getting it now.

Like her peer Mallard, Geissler said a huge component to recovery rests with the individual who has the substance use problem.

"It's not how much we want people to get sober; it's how much they want to be sober," said Geissler.

GOSNOLD ON CAPE COD

Gosnold on Cape Cod CEO Raymond Tamasi said the current model of acute treatment, followed by clinical and transitional services, just isn't working, as evidenced by the high percentage of people who return for the same kinds of treatment within a year's time. "We treat a chronic condition with an acute care model," said Tamasi.

Tamasi has advocated for a redesign of the state's addiction treatment system from the current "bed-driven" system to one that treats addiction as a chronic disease. He said the commonwealth needs to invest more heavily in community-based recovery services and early intervention.

"One of the DPH principles suggests that, 'Remaining in treatment for an adequate period of time is critical for treatment effectiveness. Most studies indicate a minimum of 90 days.' I would revise that statement. It is misleading because most experts today agree that care, in some form, should be provided over the life of the illness," Tamasi said. "We recognize that, just as with other chronic illnesses, remissions without occasional setbacks are unlikely for most patients. 'Success' then needs to be measured, yes by sobriety, but also by how well the patient is functioning in the core areas of life – relationships, family, work, school, etc."

The solution, Tamasi said, isn't more beds, as the people who cycle through them will continue to do so.

"Patients with chronic addictive disease should never be 'discharged,'" he said.

Rather, they should be ushered into an outpatient recovery care plan with supervision. If someone is emerging from treatment and re-entering the community, they need comprehensive, locally based wraparound services coupled with stable housing, such as long-term assisted sober living residences. Some residents with extreme needs might end up living out their days at such a site.

"They need a care manager to help them negotiate and navigate what it means to live independently," he said. "People want to be in a house, not a treatment center for the rest of their lives."

The reason for self-medication, said Katie Geissler, Carriage House shelter director, is trauma. The women at Carriage House have either been traumatized through early home life, or more recently through domestic violence, as well as from poverty and being raised in foster care.

A better practice would be to keep people out of treatment beds in the first place through strong early intervention, said Tamasi. This means integration with medical care, screening to identify patients at high risk, and much more aggressive and sustained prevention services.

Tamasi said he expected detox and rehab bed funding to be redirected by the state to other needs in the near future, as most clients now have state-sponsored insurance at minimum.

Tamasi hopes that his pilot program of deploying recovery managers into communities will catch on with the industry, the state and insurers, as it's a results-oriented practice. Furthermore, he said the future of insurance payments for services will likely soon be tied directly to patient outcomes.

CAPE AND ISLANDS REGIONAL NETWORK ON HOMELESSNESS

Paula Schnepp, coordinator for the Cape and Islands Regional Network on Homelessness, said it was imperative to make sure that there's equal access to substance abuse treatment services, whether they're people experiencing homelessness or the general public.

She also pointed out how treatment is primarily a voluntary endeavor, with the exception of Section 35s, but, "You want to make sure that the options are there; it should be available," said Schnepp.

Schnepp said that longer-term treatment might be best for the homeless, but the person's level of commitment is also critical. "Their decisions contribute to the course," she said.

Traditional treatment models could be infused with cutting-edge treatment programs, she suggested.

THOUGHTS FROM OFF-CAPE

Other than Gosnold in Falmouth, High Point Treat-

ment Center operates two of the closest treatment sites for Cape Codders, one in Middleboro and another in Plymouth. High Point is one of the largest providers of addiction beds in the state, and also serves as the operator of the state's Section 35 civil commitment sites.

Daniel Mumbauer, longtime president and CEO of the organization, said High Point has some 667 treatment beds and an additional 213 shelter and permanent housing beds. Need of services is grounds for admittance, not ability to pay.

Robert Monahan, president of the Recovery Homes Collaborative of Massachusetts and director of the South Shore Recovery Home in Quincy, said most recovery homes have wait times for beds of three weeks to four or five months, depending on the house and its location.

While the state offers money to High Point to cover the cost of many detox beds, he said the money isn't used to the degree it once was, as MassHealth insurance takes care of the expense. Uninsured usage for these beds hovers at between 10.5 and 11.5 percent, and this cost is covered by reimbursement from the Bureau of Substance Abuse Services.

Entry into the High Point system is on a first-come, first-served basis. The majority of beds open up in the morning, but others open as the day progresses with off-cycle discharges. Mumbauer said High Point turns over about 120 detox beds every four or five days, with a couple dozen clients waiting anywhere from not at all to up to a week, depending on demand. Most people would get a bed in 48 hours; going beyond a week is not acceptable, Mumbauer said.

The next step for homeless people seeking ongoing treatment would be a clinical stabilization service program, or rehab. High Point has 214 of these beds. For the uninsured and those with MassHealth, clients are guaranteed a 14-day stay. Commercially insured clients are typically covered for only seven days.

After rehab, homeless High Point clients can get either transitional support service living arrangements, for up to 30 days, or be sent directly to a supportive housing site. High Point uses an affiliate for most of these services, the Southeast Massachusetts Council on Addiction. These long-term recovery homes are located in New Bedford, and stays range from a minimum of three months to years, depending on the individual needs.

NEVER ENOUGH BEDS

Generally, Mumbauer said there's never enough resources or beds, something that his organization always wrestles with. He said he has five detox centers open at the moment, with another on the way for civil commitments at Lemuel Shattuck Hospital in Jamaica Plain. He said more Section 35 sites are needed in the state – only two exist now, and he also called upon health care organizations to offer more services to improve regional access to treatment.

He noted the shortage of clinical stabilization beds in the state, and pointed to how beds decrease in number as a person traverses the treatment continuum, which spurs longer wait times.

Mumbauer recommended developing more Housing First sites on the Cape; such projects could be easily supported by an organization like High Point.

Mumbauer also echoed complaints of the state recovery home association, citing inadequate reimbursement for the actual cost of supplying detox beds to those in need. However, he noted that Gov. Charlie Baker recently increased the reimbursement rate.

WAIT TIMES OF UP TO FIVE MONTHS

Robert Monahan is the president of the Recovery Homes Collaborative of Massachusetts and director of the South Shore Recovery Home in Quincy. Because of the lack of capacity, most recovery homes have wait times for beds of three weeks to four or five months, depending on the house and its location, he said.

Most recovery homes are fed from sites that precede them in the continuum of substance abuse care and are not admitting people directly off the street, he said, "because you don't know what you're getting." Rather than risking upheaval in a house full of people weeks or months into recovery with someone who is freshly sober, not sober or mentally ill, recovery homes tend to take referrals from either shelters or clinical stabilization rehab sites.

"If they've been through the system, all of those issues have been clarified," said Monahan.

Monahan estimated that about 60 to 70 percent of his clients are homeless, either having been on the streets or otherwise unstably housed.

Business didn't start out that way, said Monahan. His recovery home set out to be a site solely for substance abuse treatment and recovery. Over time, however, the recovery home's clientele – like many across the nation – began to be filled by people with concurrent problems, such as mental illness, recent incarceration, domestic violence and homelessness, above and beyond alcohol and/or drug use.

"We don't have the beds to treat the people with sub-

Regarding the differences between treatment at home versus treatment afar, there are two trains of thought by local and regional experts: 1) that it's best to get addicted people away from their home to avoid triggers, habits, and friends or family that might instigate negative behavior; and 2) that community-based treatment is best for a person with an addiction illness to stay close to their existing support and health network to better prepare for societal re-entry in the place that they live. Wikimedia Commons illustration

stance abuse issues as it is," said Monahan. If a person is using a bed for housing, it's pushing out someone who needs it for substance abuse treatment, he said.

Monahan echoed what some studies call for, namely supportive housing tailored for each demographic to best address their individual needs.

The collaborative president was somewhat doubtful of the Housing First model, because "it could be a problem for those who don't see their problem as a problem." In his many decades in the recovery home field, Monahan said the pendulum in the industry swings back and forth between housing and treatment as the best solutions.

What he is certain about is trauma and substance abuse being at the core of many of society's woes; for instance, he cited that the vast majority of cases in Quincy District Court involve substance abuse, everything from drunk driving and burglaries, to theft and drug trafficking.

Looking ahead, Monahan was hopeful that the insurance industry would begin paying for long-term residential recovery.

'IT MIGHT BE COST-EFFECTIVE'

"It's a chronic health problem, and it might be cost-effective," he said. If someone is in long-term care, they're staying on psychiatric medication, not committing crimes, not getting arrested and staying out of hospitals. "Maybe if we do pay for some of this (recovery home service), our other costs would drop," he said.

State-contracted recovery homes are now paid about $100 per day of service by the Bureau of Substance Abuse Services, up from $75 a day last year, Monahan said. But with actual costs much closer to $200 a day, recovery homes like his are forced to adhere to austere budgeting: Staffing is cut, as are services, and food is often procured from a local food pantry. "We have to fundraise, and we have to go without," said Monahan.

Of the Cape's existing substance abuse infrastructure, Monahan said more transportation is needed.

"On the Cape, the problem always was one of transportation. Even if you have treatment centers on the Cape, people can't get to them," Monahan said.

TREATMENT AT HOME OR AWAY?

When it comes to substance abuse treatment, does it matter if the care is provided near your hometown or in the next county or two over? And how far is far?

Regarding the differences between treatment at home versus treatment afar, there are two trains of thought by local and regional experts: 1) that it's best to get addicted people away from their home to avoid triggers, habits, and friends or family that might instigate negative behavior; and 2) that community-based treatment is best for a person with an addiction illness to stay close to their existing support and health network to better prepare for societal re-entry in the place that they live.

Researchers also point to proximity as a factor in successful substance abuse treatment.

'A BENEFIT DERIVED FROM CLOSER PROXIMITY TO A PROGRAM'

"Among inpatient clients, a benefit derived from closer proximity to a program suggests that staying within one's cultural domain, being in a social environment with others who share similar beliefs and experiences, or being near family and other adjunctive community resources may enhance recovery efforts," researchers write in "Effects of Distance to Treatment and Treatment Type on Subsequent Alcohol Consumption," a 2016 study from the Public Health Institute in Emeryville, California.

The study of about 713 participants from 10 public and private substance abuse treatment programs in Northern California showed that clients traveling more than 10 miles from their home to inpatient treatment consumed significantly more alcohol than those who traveled less than 10 miles for inpatient treatment, and that longer distances to treatment related to increased subsequent consumption.

Further, longer durations of treatment also reduced subsequent alcohol consumption, the study said, and outpatient clients report longer duration of treatment than inpatient clients. Inpatient clients tended to travel nomi-

nally farther to treatment sites than outpatient clients, the study found.

A 2003 study published in the Journal of Substance Abuse Treatment, for instance, did note that people undergoing treatment near their home were 50 percent more likely to complete their treatment. In "Distance Traveled to Outpatient Drug Treatment and Client Retention," University of Maryland researchers studied treatment in Baltimore City. Patients traveling more than a mile for treatment were half as likely to complete treatment as those who traveled less than a mile; other patients who traveled 4 miles or more had significantly shorter treatment stays than patients traveling a mile or less (treatment days were 13 fewer with the former).

Researchers further state that while their study focused on an urban area, they expected their findings to hold true for rural areas, as distance correlates to cost and ability to travel, which are barriers for vulnerable demographics such as the homeless. The report recommends communication about transportation between client and provider, as well as to create satellite treatment centers closely located to where patients live.

TRAVEL TIME AFFECTS OUTCOMES

In "Geographic Barriers to Community-Based Psychiatric Treatment for Drug-Dependent Patients," researchers found that longer travel time relates directly to disruptions in treatment. They say that even when treatment is available, patients are often victims of other forces, such as affordability, eligibility, waits, hours of operation and access to transportation. Studying 294 patients with co-occurring mental health and substance use illnesses, researchers found that the longer it takes to drive to an outpatient program from point of discharge, the less likely it is for that patient to attend treatment one month out from inpatient release. With every extra 10 minutes of travel time, likelihood of attendance drops by half.

The report further notes how patient travel time isn't taken into account during discharges, and that it should be a key element in care planning and in the siting of new facilities. Many patients experiencing poverty do not drive, but rather walk or use public transportation. Some sheltered Cape-area homeless can get rides to treatment through their shelter provider; others can get a taxi voucher, such as through Duffy Health Center.

Gosnold's CEO, Raymond Tamasi, said those seeking treatment should always be treated in their community; it allows family, friends and other supporters to be involved. Staying local also makes for more facile coordination and continuity of care for the patient.

Greg Bar, NOAH Shelter director, Geoff Gagnon, shelter recovery advocate, and Wilma, the homeless mom cited in this report, all expressed the value of treatment closer to home, family, friends and other supports.

Gosnold's CEO, Raymond Tamasi, said those seeking treatment should always be treated in their community; it allows family, friends and other supporters to be involved. Staying local also makes for more facile coordination and continuity of care for the patient.

"If they want to be clean and sober, they have to learn how to be clean and sober in their community," said Gagnon. But he said the Cape is a "crater in services. They're not going to get the treatment they need here."

Daniel Mumbauer, the High Point CEO, sees both problems and benefits for those who have to travel to a treatment site far from home, a situation faced by many Cape Codders entering the system. Those who don't end up in Gosnold or at one of the few supportive housing sites on Cape Cod are looking at travel. On the positive side, that keeps people in recovery from encounters with friends who continue to use. By the same turn, it also separates them from their friends, family and other community supports, he said.

To that end, Mumbauer would like to see a better network of substance treatment supports near people's homes, in part to help stop the cycle of entering rehab, leaving and then coming back for the same treatment after relapse. Also, for people who have little-to-no access to transportation, it can be harder to get to a far-flung detox site, as well as to return home once they complete a phase of their substance use re-education.

Similarly, Mumbauer believes it's important to have the various programmatic steps of treatment to be close to one another – such as a clinical site located adjacent to a transitional site – as it aids with client retention. He said you can lose clients if they're too far away from familiar turf, but you can also lose clients if they're too close to old stomping grounds. However, he noted he had not seen data pointing to the benefits or negatives of seeking treatment close to home.

He also noted how the Cape has few recovery homes, and with a lack of these and related services comes greater risk of relapse.

Robert Monahan, the president of the Recovery Homes Collaborative of Massachusetts, illustrated the dichotomy of the issue: Client A might say he wants to be near his support system, but what he really means is he wants to stay near his

dealer; conversely, client B might actually have strong supports at home, such as a significant other, children and friends. "It has to be individual," Monahan said.

At Homeless Not Hopeless, manager Caroline Corrigan said she saw it as a positive that her clients receive treatment off-Cape, as "the resident does not see their friends that they used with." Gosnold detox and subsequent programs are often "flooded with people who have used together."

A 2003 study published in the Journal of Substance Abuse Treatment, for instance, did note that people undergoing treatment near their home were 50 percent more likely to complete their treatment.

Paula Schnepp, coordinator for the Cape and Islands Regional Network on Homelessness, said with a lack of treatment beds locally, "The creative solution is that people are sent off-Cape."

ACCESS IN RURAL AREAS

The Rural Health Information Hub cites some of the substance abuse treatment challenges faced by rural areas, a geographic category that the Cape and Islands fall under. Detox services are not as readily available in rural communities and, when they are available, the spectrum of services might be limited; rural patients often have to travel long distances to get treatment; and rural patients might be reluctant to access local services because of privacy concerns in a tight-knit community.

Of the 14 counties in the state, Barnstable (214,914 population, according to the U.S. Census) ranks ninth in size, behind Plymouth County but larger than Hampshire, Berkshire, Franklin, Dukes and Nantucket counties. According to the state Executive Office of Health and Human Services, 13 of the 15 Cape towns are identified as rural, accounting for 86.7 percent of the county's land mass (the state agency considers towns rural if they have fewer than 500 people per square mile). In Dukes County five of seven towns are considered rural, accounting for 71.4 percent of Martha's Vineyard land, and in Nantucket County, 100 percent of the island is considered rural.

Studies have looked at the particular challenges that are faced by people with substance use disorders who live in rural areas. Most detox centers serve a radius of at least 50 miles and often greater than 100 miles, according to "Few and Far Away: Detoxification Services in Rural Areas," a policy brief by the Muskie School of Public Service at the University of Maine from 2009. In rural areas across the country, 95 percent of detox providers serve patients who live more than 51 miles from the facility.

The brief also pointed out that rural areas don't often have the full complement of services; most rural detox centers – 85 percent – offer only one level of service based on the criteria from the American Society for Addiction Medicine. In the "Regional Substance Abuse Council Analysis of Substance Abuse on Cape Cod: A Baseline Assessment," there's a resource inventory list that shows a mix of services, with a notable lack of detox and inpatient treatment centers.

THE SOLE PROVIDER: GOSNOLD

Like most rural detox facilities, Gosnold is the sole standalone provider of detox services in the region, mirroring 90 percent of providers in the nation. These isolated providers are less likely to offer specialized programs for demographic sub-populations, such as adolescents and people with co-occurring disorders. Gosnold does have two demographic-specific recovery homes – one for men and one for women – but there is only one transitional shelter on the Cape with a substance abuse treatment component.

Rural patients also struggle with a lack of variety of payment methods for services, with limited acceptance of public coverage and few sites that offer sliding fees, according to the university brief. This oftentimes serves as a major obstacle for those people with limited finances.

Wait lists and admissions denials all point to inadequate capacity in rural areas, according to the policy brief.

Rural areas rely heavily on an informal network of community-based organizations and resources to get people placed into and out of detox. The Cape is no different, using a patchwork of social, medical and emergency services to coordinate care for people seeking or in need of treatment.

DISPROPORTIONATELY DISADVANTAGED

In a report published in 2014 called "Barriers to Substance Abuse Treatment in Rural and Urban Communities: A Counselor Perspective," a University of Kentucky paper, it says that urban treatment centers are more likely to have positive outcomes for clients, and that rural centers are disproportionately disadvantaged when it comes to basic services.

"As research indicates that shorter travel distances are associated with longer stays and greater completion rates in substance abuse treatment, this has unfortunate implications for rural counselors and clients," the paper states. Rural areas often lack options for specialty substance abuse treatment programs – such as those tailored to the homeless – which can discourage treatment participation, it states.

Additionally, residents have fewer public transportation options in rural areas; many people experiencing homelessness also lack their own of transportation. In "Developing

an Integrated Health Care Model for Homeless and Other Vulnerable Populations in Colorado," a 2013 report from the Colorado Coalition for the Homeless, authors detail how vast distances from available services exacerbate the transportation problem. Severe weather and the physical disabilities of clients also pose problems of access.

The Cape does have public transportation, and the Cape Cod Regional Transit Authority provides rides for very little money, with prices ranging from $1.50 to $3 for most routes. Further, the CCRTA provides contracted rides for free to certain MassHealth clients.

With a doctor's approval, MassHealth clients can get a "prescription for transportation," or PT1, to get rides to methadone treatments and counseling up to nine times a week at no cost, said CCRTA Administrator Thomas Cahir. Clients only need to call 24-hours ahead of time to schedule.

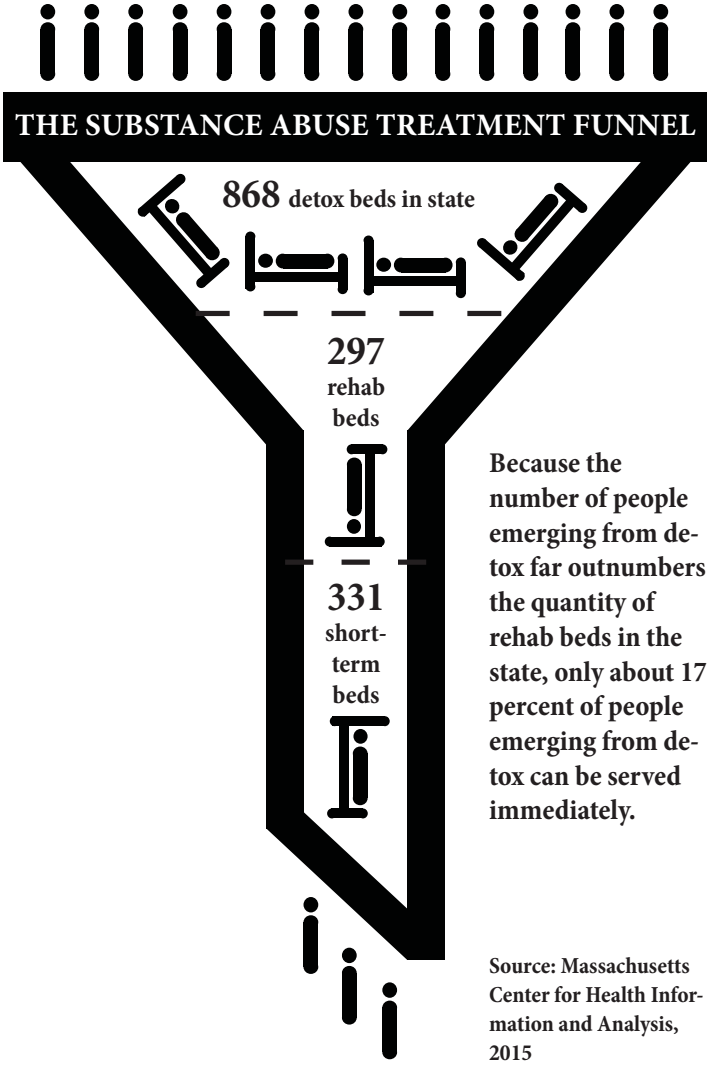
In fiscal year 2015, the CCRTA provided 120,586 trips for 845 MassHealth clients with PT1s; 26,400 of these rides were for medication-assisted treatment. The Cape agency was reimbursed $4.3 million for the work. The CCRTA takes clients to Yarmouth and Wareham for methadone, and a subcontractor does rides to Fall River and New Bedford clinics. "We take anybody, everywhere, every time. Nobody gets turned down," said Cahir. "We'll get you there."

Treatment programs can maximize attendance and retention by minimizing obstacles to access, such as lack of transportation, as recommended in "Community Based Treatment: Good Practice," from the U.N. Office on Drugs and Crime in 2008. The document also recommended that programs manage staff properly to avoid waiting lists.

The report from the University of Kentucky also noted the lack of client anonymity in rural areas can dissuade someone from treatment. It also said that many addiction counselors report trouble for clients who receive treatment located too close to home, if their family subverts their attempts at recovery. Substance abuse often originates in the family unit, the report notes.

ASSESSMENTS OF THE SYSTEM AND PLANS FOR THE FUTURE

The "Findings of the Opioid Task Force and Department of Public Health Recommendations on Priorities for Investments in Prevention, Intervention, Treatment and Recovery," a 2014 state study and subsequent recommendations to deal with the burgeoning opioid epidemic, highlighted the need to centralize treatment resources. The study's contributors found obstacles to accessing services in a timely manner, noting the slim window of opportunity when a person with addiction illness is ready for treatment.



Because the number of people emerging from detox far outnumbers the quantity of rehab beds in the state, only about 17 percent of people emerging from detox can be served immediately.

Source: Massachusetts Center for Health Information and Analysis, 2015

A NARROWING PIPELINE OF OPTIONS

A separate study from the Center for Health Information and Analysis in 2015 showed that, with a statewide total of 868 detox beds for non-Section 35 patients, the daily occupancy rate landed between 91 and 100 percent. And there were nearly three times the number of detox beds (868) as rehab (297) or short-term residential beds (331). Because the average stay of one week of detox is less than the average two week stay in a rehab site, or the four weeks at a short-term residential site, the number of patients leaving detox on a weekly basis is much greater than the number of rehab or short-term residential beds being vacated. In other words, if the clinical stabilization beds serve about 600 people each month, they can serve only 17 percent of the people emerging from detox, according to the Center for Health Information and Analysis.

Those seeking longer-term residential treatment waited about 19 days from the time of first contact with a desired program to their time of admission, according to the center. Waits in Western and Central Massachusetts averaged about two weeks, while waits along coastal Massachusetts were

closer to a month. For those seeking specialized treatment, such as the homeless, waits can be as long as 10 weeks.

PRIORITY PLACEMENTS

Further, some bureau-funded programs agree to give priority placement to certain segments of the population, which means longer waits for those not of that population group. For instance, some residential programs might avoid methadone patients, while others do not permit entry to those with pending criminal cases or who have a dual diagnosis of mental illness and a substance use disorder.

CHARLIE BAKER
Governor
of Massachusetts

In state focus groups, the study found another major hurdle, in that there was no clear understanding of how to access the treatment network in the commonwealth, which for many participants involved making multiple dead-end calls to find services. As a result the state is rolling out a central navigation system for adult services that can be accessed through a toll-free number and website. The system would maintain a real-time inventory of all available substance abuse services; identify appropriate resources for the afflicted and their families, first responders, schools and providers; have available intake staff to work with the treatment seeker on program placement; start regional walk-in centers that can aid a client with navigation, as well as provide assessments, daily clinically run group therapy sessions, and emergency one-on-one counseling; and to create a user-friendly menu of services and offerings within the system.

The state began tackling widespread opioid addiction head-on in 2014 when former Gov. Deval Patrick declared a public health emergency. The mantle was carried and put into action by the current governor, Charlie Baker, who convened an opioid crisis working group in early 2015 that had compiled an action plan by mid-November.

ACTIONS TAKEN IN MASSACHUSETTS

The action plan includes the following measures that expand substance abuse treatment options, many of which will help people experiencing homelessness:

- Baker secured $27.8 million to address the opioid crisis, $14 million of which will be used to increase reimbursement rates paid to recovery homes (these serve all kinds of addicted people, not just opioid users). The rate will increase from $75 per day to $100.08 per day, retroactively to July 1, 2015;
- In June 2015, 10 new adult residential recovery home beds were added in Westboro, and two additional clinical stabilization service beds were added in Fall River;

WAIT TIMES FOR LONG-TERM TREATMENT BEDS IN THE BAY STATE

14 days for residents of Western and Central Massachusetts

19 days for most commonwealth residents

30 days near the coast

70 days for specialized treatment

Sources: Massachusetts Center for Health Information and Analysis, 2015

- In July 2015, MassHealth established rules to enroll eligible people being released from incarceration;
- Also in July 2015, MassHealth instituted protocols at four sites to speed up MassHealth enrollment of uninsured Department of Public Health clients receiving detox services;
- In August 2015, MassHealth and the DPH announced the development and implementation of a statewide database of available treatment services, available via a helpline and website. This project is due to be fully phased in by February 2016;
- In September 2015, 11 additional detox and eight clinical stabilization service beds were added in Plymouth;
- Also in September 2015, 23 adult residential recovery home beds were added in Westboro;
- In October 2015, 15 adult residential recovery home beds were added in Lowell, and 22 adult residential recovery home beds were added in Boston;
- The Bureau of Substance Abuse Services on Oct. 23, 2015, began seeking proposals to create a pilot program for walk-in emergency/urgent addiction assessment and direct referral to the appropriate level of care;
- Also in October, MassHealth issued policy guidance to reduce barriers to substance use disorder treatment and to ensure access to medication-assisted treatment;
- In November 2015, the Bureau of Substance Abuse Services began seeking proposals to boost the number of office-based opioid treatment programs in community health centers;
- In January 2016, 32 detox and 32 rehab beds were scheduled to open in Greenfield;
- In the winter of 2016, 30 new Section 35 treatment beds for women will open up for use;
- By spring 2016, MassHealth will ensure that outpa-

tient treatment programs that dispense methadone can also bill for buprenorphine and naltrexone;

- And by March 1, 2016, MassHealth is expected to boost the capacity of its emergency services programs to help more people with addiction.

The work of Barnstable County Regional Substance Abuse Council has culminated in a report it updated on Nov. 1, 2015, called "Addressing Substance Use on Cape Cod: Action Plan."

The county report recommends a move to centralize substance abuse treatment referrals, as well as conducting a review of existing treatment resources available to Cape residents. Similarly, the Cape and Islands Regional Network to Address Homelessness has issued a call for centralizing entry for homeless people into the federal Continuum of Care program.

Also, in a House conference committee is Senate bill S. 2022, "An Act Relative to Substance Abuse Prevention," which will mandate annual insurance carrier reporting on addiction service denials; a universal intake form; state reporting of treatment capacity, including wait times and other obstacles to treatment; Bureau of Substance Abuse Services referrals through collaborations with police departments; and the creation of a special state commission to oversee licensed addiction treatment centers and recommend legislation, with a first report due in January 2017.

LOCAL PERSPECTIVES

Both Duffy Health Center's Heidi Nelson and Gosnold's Raymond Tamasi agreed that if there were more state support for outpatient treatment and aftercare, more beds would open up for those people who truly need them, such as the homeless. "The more pathways we open up, the more choices and avenues people have, (and) the strain on the existing 'capital assets' for treatment decreases," said Nelson. "More support for people in the community would mean better success in recovery and less need for beds."

Nelson also said, "That if more services were available while people are incarcerated, the more we open up access to existing treatment beds." The criminal justice system often feeds directly into the shelter and substance abuse housing system.

Tamasi said one reason that relapses occur is because "there are not enough substantial community support systems that have proactive, personalized management plans with navigators/coaches who know their patients." He hoped for an environment like that of the 1960s, when the Kennedy and Johnson administrations and Congress saw through legislation that paid for a whole generation of social workers who effected change at a community level.

▫▫▫

Georgie, 59, of Hyannis, has lived on the Cape for 50 years. For three of those years, she's been homeless. Georgie's been in substance abuse treatment three times: first detox, then a dual-diagnosis treatment center and finally at Gosnold's Emerson House. Photo by Alan Belanich for Housing Assistance Corporation

Housing Assistance Corporation on Cape Cod

CONCLUSIONS

The lack of Cape and Islands substance abuse infrastructure for the homeless is in opposition to three of the state's core principles that guide its Bureau of Substance Abuse Services, in that government-sponsored treatment is supposed to be readily available (there are long waits); it's supposed to recognize that no single treatment approach is appropriate for all individuals (homeless addicts need housing as part of their treatment); and it's supposed to address the multiple needs of the individual, not just substance use (people experiencing homelessness also require other simultaneous services, such as trauma counseling).

Cape residents, including the homeless, must frequently wait after they decide to enter treatment because of a lack of beds in the region and statewide. One mainstream solution, which the state already is doing, is to add facilities and beds at each level of care to respond to the demand, ensuring an end to the bottlenecking and waitlists that exist now. Another solution, says Gosnold on Cape Cod CEO Raymond Tamasi, is for the state to recognize that substance use disorder is a chronic illness, to be mitigated with strong early inventions and to be managed with outpatient supervision for the life of the illness. For the homeless in substance use recovery, Tamasi notes how stabilized housing and ongoing care management are key.

Studies say the same thing: that stable housing is at the core of recovery for homeless people. Meeting the housing needs of homeless people with addiction illnesses is achieved in a variety of ways, from supportive living sites with services onsite, to scattered sites with case management and outpatient supports, to long-term assisted sober living facilities or outreach once the individual is stabilized. Some successful sites accept abstinence and harm reduction philosophies under the same roof to help different kinds of clients, such as in the Albuquerque Health Care for the Homeless program in New Mexico. This program is guided by doing "whatever works for the client." Because the homeless are often a treatment-averse population, studies suggest low-impact and less stringent offerings, to make the prospect of treatment more palatable.

The Housing First model has been cited as a proven way to prevent homelessness, to get people experiencing homelessness and addiction on the path to recovery and to save taxpayer dollars. On the Cape, Housing First apartments cost about $8,000 to $13,000 less annually than to house someone at a shelter for a year. These rapid-rehousing sites result in large drops in emergency department visits, hospitalizations, arrests and shelter stays. Locally, the "Cost of Homelessness" study on the Cape found that people living in permanent supportive housing were less likely to use the emergency room at Cape Cod Hospital, more likely to have their own primary care doctor and cost about 12 percent less to care for than their unsheltered counterparts. A larger scale study, "The Cost of Long-Term Homelessness in Central Florida" found in 2014 that each homeless person cost taxpayers about $31,000 per year; implementing a Housing First option knocked that figure down to about $10,000 a year. The same study also pointed out that Housing First and other permanent supportive housing models had client retention rates of between 80 and 90 percent.

With a renewed focus on outpatient support, the need for more treatment beds and related infrastructure will decrease, leaving the existing beds available for people experiencing homelessness and others who have no bed of their own, according to Cape experts.

Another related solution to prevent recidivism for the stably housed and recently homeless would be an adaptation of Gosnold's pilot program that puts recovery managers in the community. Results for the program have been dramatic for young opioid users, according to Gosnold's statistics, with detox re-admissions dropping by 72 percent. Tailoring such a program for the recently homeless and its sub-demographics could yield considerable human and economic dividends.

Based on demand, best practices and outcomes, the Cape and Islands could be doing far better in addressing the needs of all addicted residents, but especially the homeless and the related subset of people with no homes and a dual diagnosis of substance use and mental health disorders. If implemented and/or expanded here, local and national recommendations such as permanent supportive housing and community-based intervention and treatment could result in a reduced homeless population, a wider spectrum of services that address multiple population groups and needs, more available treatment beds, less churn and recidivism, and a major reduction in emergency, medical and legal costs for public and private entities.

Ultimately, it will be up to Cape and Islands residents, its health and social service network, and its political and business communities to decide if it's acceptable to continue sending many people out of the area to receive treatment because of the lack of local infrastructure. However, with local and national studies showing that community-based treatment can have better results than treatment away and with addiction on Beacon Hill's radar, the Cape and Islands are now presented with a very real opportunity to care for all residents much closer to home.

Housing Assistance Corporation on Cape Cod

GLOSSARY

Abstinence: The practice of not doing or having something that is wanted or enjoyable.

Acute treatment services: Also called detoxification or detox, an inpatient substance abuse treatment program that most often lasts about five days, with the patient's withdrawal monitored 24 hours a day by medical staff.

Benzodiazepines: A family of medications sometimes prescribed to treat anxiety, acute stress reactions and panic attacks.

Buprenorphine: A medication used to help people reduce or quit their use of heroin or other opiates. It is the first medication to treat opiate dependency that is permitted to be prescribed or dispensed in doctors' offices, significantly increasing treatment access. Called Suboxone as a brand name, it is a partial opiate agonist.

Case management: A collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for services to meet an individual's comprehensive health needs.

CCRTA: Cape Cod Regional Transit Authority

Clinical support services: Also called rehabilitation or rehab, these inpatient programs provide a combination of housing, nursing care, education and counseling on addiction and its consequences, relapse prevention and aftercare planning. The usual length of stay is seven to 14 days.

Community-based treatment: Inpatient or outpatient treatment near one's home, in which a person with substance use disorder relies on a network of local partner agencies across the continuum of care, as well as the support of family and friends.

Detoxification, or detox: See acute treatment services

Dual diagnosis: When a person has more than one documented condition, such as substance abuse disorder and bipolar disorder.

Gosnold on Cape Cod: The sole standalone detox provider on the Cape and Islands and the region's largest provider of substance abuse treatment, offering inpatient and outpatient addiction and outpatient mental health services at a number of sites.

HAC: Housing Assistance Corporation, a nonprofit agency that delivers housing, housing information, services and advocacy to the Cape and Islands region of Massachusetts.

Harm reduction: Harm reduction refers to a public health philosophy and intervention that seeks to reduce the harms associated with drug use and drug policies, e.g. free needle distribution. Harm reduction can also mean substance use treatment that involves reducing the negative consequences and risky behaviors of substance use, without judgment. Abstinence can be an eventual goal.

Heroin: An illegal, highly addictive drug processed from morphine, a naturally occurring substance extracted from certain poppy plants. It can be snorted, smoked or injected.

HIV: Human immunodeficiency virus. It attacks the immune system, and if untreated can develop into AIDS, or acquired immunodeficiency syndrome. Transmitted through IV drug use and unprotected sex.

Homeless: Lacking a fixed, regular and adequate residence.

Housing First: An approach to quickly connect people experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment or service participation requirements. Supportive services are offered to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to housing.

HUD: U.S. Department of Housing and Urban Development

MassHealth: State-sponsored health insurance for the residents of the commonwealth of Massachusetts.

Medicaid: A joint federal and state program that helps low-income people pay for long-term medical and custodial care. Although largely funded by the federal government, Medicaid is administered by each state, and programs may vary.

Medicare: The federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with end-stage renal disease.

Medication-assisted treatment: Medications are used to treat addiction by controlling addictive cravings, feelings and behaviors to maintain a state of recovery.

Methadone: A long-acting synthetic opioid used in the treatment of opiate dependence and detoxification and for patients having chronic, severe pain. See opiate agonist.

Naloxone: An anti-overdose drug, which goes by the brand name Narcan.

Naltrexone: An opioid antagonist used to manage addiction. The brand name is Vivitrol.

Narcan: Naltrexone, an overdose reversal medication.

Opiate: Relating to opium-like drugs, such as heroin and morphine. They reduce the intensity of pain signals reaching the brain and affect those brain areas controlling emotion, which diminishes the effect of a painful stimulus.

Opiate agonist: A medication that occupies the receptors in the brain where an opiate would be attached, reducing the symptoms of addiction and withdrawal. Methadone

is an agonist.

Opiate antagonist: A non-addictive medication that blocks opiate receptors so they cannot be activated. Vivitrol is one of these.

Opioid: Often used interchangeably with opiate, it refers to pharmaceutical versions of opium-like drugs.

Outpatient services: Treatment that occurs on repeat visits to medical offices, in one's home or other care center.

Overdose: Taking more than the recommended dose of a drug or medication; with opioids, it slows the breathing and heart rate, and can lead to death.

Partial opiate agonist: These medications can block or attach to opiate receptors, taking the place of opiates like heroin. Suboxone is one.

Rapid re-housing: Moving people experiencing homelessness into permanent housing as quickly as possible, ideally within 30 days of becoming homeless. While originally aimed at people experiencing homelessness because of short-term financial crises, programs across the country have begun to assist survivors of domestic violence and those with substance abuse issues.

Recovery: A process of emerging from substance abuse to a period improved health, wellness and quality of life. Abstinence is a goal, and relapse is a recognized part of recovery. Also called remission.

Recovery homes: This form of long-term residential rehabilitation provides regimented substance abuse treatment, 24 hours a day, in a community setting; these are not "sober homes." Recovery homes offer a safe and stabilized living environment for six to 12 months, or longer.

Rehabilitation or rehab: See clinical support services

Relapse: Returning to substance use

Retention: Referring to housing or behavioral health programs and their ability to keep clients housed and/or participating.

SAMHSA: U.S. Substance Abuse and Mental Health Services Administration

Scattered-site apartments: Individual or small groups of subsidized apartments not concentrated in a single area.

Section 35, or civil commitment: A Massachusetts law in which people who pose a danger to themselves or others because of substance use can be involuntarily committed to treatment.

Sober homes: Unregulated congregate living sites for people in recovery from substance use.

Sobriety: No use of alcohol or drugs

Stable housing: Regular access to safe, decent and affordable housing.

Suboxone: The brand name for buprenorphine, a partial opiate agonist.

Subsidy: Money paid by the state or federal government to keep the price of a product or service low.

Substance abuse treatment: Clinical help to get addicted individuals to stop compulsive drug and alcohol seeking and use. Treatment can occur in a variety of settings, take many different forms and last for different lengths of time. For many, treatment is a long-term process that involves multiple interventions and regular monitoring.

Substance use disorder: The recurrent use of alcohol and/or drugs, which causes significant impairment, including health problems, disability and failure to meet major responsibilities at work, school or home.

Supportive housing: Combines and links permanent, affordable housing with flexible, voluntary support services designed to help tenants stay housed and build the necessary skills to live as independently as possible.

Transitional support service: A step-down short-term treatment (about 30 days) that includes services and housing, which a client might use after rehab but before returning to the community or moving to a longer-term recovery home.

Treatment first: An approach in which people experiencing homeless are placed in emergency services and must address personal issues – such as addiction and mental health – prior to being deemed ready for housing, having received access to health care or treatment.

Unstable housing: Irregular or lack of access to safe, decent and affordable housing. A step before homelessness.

Vinfen: A regional provider of behavioral health services in Southeastern Massachusetts.

Vivitrol: The name brand of naltrexone, an opioid antagonist used to manage addiction.

Wraparound services: A matrix of intensive, individualized care planning and management, such as physical health, mental health, job training and financial management, for at-risk clients, often facilitated by a case manager.

Sources: merriam-webster.com; National Institute on Drug Abuse; U.S. Substance Abuse and Mental Health Services Administration; Case Management Society of America; Drug Policy Alliance; aids.gov; National Health Care for the Homeless Council; Medicaid.gov; UCLA; opiate.com; whitehouse.gov; National Alliance to End Homelessness; Corporation for Supportive Housing; The Homeless Hub; National Wraparound Initiative

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