MassCALL3 Part B: Strategic Plan

Barnstable County Department of Human Services

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Abstract: Barnstable County Department of Human Services

Barnstable County is made up of 15 towns that are further broken down into four subregions. Those regions include Upper Cape (Sandwich, Bourne, Falmouth, Mashpee); Mid Cape (Barnstable, Dennis, Yarmouth); Lower Cape (Harwich, Chatham, Orleans, Brewster); Outer Cape (Eastham, Wellfleet, Truro, Provincetown). Barnstable County has a unique blend of rural (Lower and Outer Cape) and suburban (Upper and Mid Cape) communities, largely due to its geography which includes the Cape Cod National Seashore on the Outer Cape and other protected lands throughout the region.

Manifestation of Needs Intervening Variables 1 & 2:
IV 1: Need for more awareness around and programs addressing community wellness and how it relates to youth substance misuse prevention, including protective and risk factors.
IV 2: Need for more awareness around and programs addressing community wellness and how it relates to youth substance misuse prevention, including protective and risk factors.

30% of Monomoy High School students (2019 YRBS) report having used alcohol in the past 30 days with 17% of those students reporting binge drinking, which is a higher binge drinking rate than the state and country. 23.8% of Nauset High School students (2021 YRBS) report having used alcohol in the past 30 days, also a higher percentage than the state.

The intervening variables that were chosen by the Core Planning Group are:

1. Lack of awareness around connection between mental health, community wellness, and youth substance use prevention.
2. Parental/caregiver attitudes/perspectives around substance use resulting in younger age of first-time substance use, and multi-generational use.

In Barnstable County, strategies to address youth substance misuse focus on increasing awareness of mental health's role in prevention and fostering supportive family dynamics. For the first intervening variable—lack of awareness around youth mental health and wellness—Youth Mental Health and Wellness Training will be provided across schools and community centers, educating youth on coping and stress management skills to prevent substance misuse. Complementing this, Interactive Wellness Activities will be available through the “My Choice Matters” website and at community events, offering accessible tools to build resilience and healthy behaviors.

For the second intervening variable—parental influence on youth substance use—Parent Education Workshops will take place in schools, community centers, and online to reach families throughout the county, especially in rural areas. These workshops will help caregivers understand substance use prevention and provide strategies for supportive, open discussions with their children. Together, these strategies target both youth and caregivers, creating a stronger, more supportive community foundation to prevent substance misuse.

Strategic Plan Outline

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SPF Step 1: Assessment

Note: Completing SPF Steps 1 and 2 should take approximately 4-6 months. Grantees should not proceed to SPF Step 3 until after submitting these two sections to CSPS and BSAS for approval.

1.1. Assessment Data on Youth Substance Misuse and Other Related Factors

Describe the process you used to collect data on youth substance misuse/substances of first use within your cluster, large individual municipality, or large individual municipality neighborhood cluster:

- **What data sources and techniques for data collection did you use (e.g., focus groups, surveys, key informant interviews)? Include numbers/rates/percentages demonstrating your best source(s) of evidence related to what youth substance misuse use looks like in your catchment area.**

Quantitative Data

In 2022 Barnstable County Department of Human Services (BCDHS) conducted an update to a 2014 baseline assessment on substance use on Cape Cod. This assessment utilized a community engagement assessment approach with ongoing input from the Regional Substance Addiction Council (RSAC) Prevention Work Group (which serves as our Core Planning Group) as well as the full RSAC. BCDHS contracted with Health Resources in Action (HRiA) to conduct the community assessment. BCDHS and HRiA engaged with the Core Planning Group through five meetings over the course of the assessment as well as email communication where the members provided input and feedback on assessment methodology, data collection instruments (e.g., focus group and interview guides), local data sources, and priority stakeholders and population groups to engage in discussions. Members of the RSAC also provided outreach support for BCDHS and HRiA to connect with stakeholders with access to local data sources and connections to specific population groups.

In addition to engagement with the RSAC, two public launch meetings were held in September 2022 to announce the assessment and gather broader community feedback on the approach and goals.

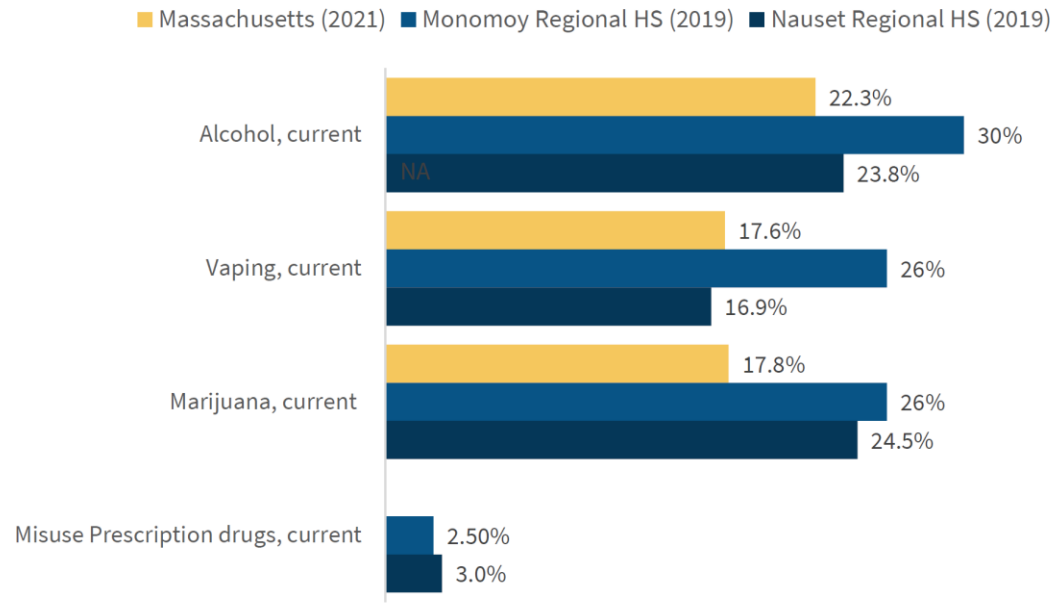
The assessment was conducted using a mixed methods approach to gain a robust understanding of substance use in Barnstable County. This approach included secondary data collection and qualitative data collection through group interviews and discussions with community members.

To inform the assessment, HRiA incorporated school survey data from two schools on Cape Cod as well as annual survey results from the Boys and Girls Club. The hope was to

include data from more than just two of the districts but due to complications with the COVID19 pandemic as well as lack of staff capacity, the schools are slightly outdated with their youth risk behavioral survey data. The two school districts included in the assessment pull students from eight of the fifteen towns in the County so is a more representative dataset than you may expect from just two districts. The Nauset School District also includes a large population of school choice students who could potentially represent other regions of Cape Cod. We do not have information related to the Monomoy School District's school choice population. The plan in the future is to include more than just these two school districts' data- future information is needed to understand the barriers to administering surveys and develop a plan that will support the expansion of this data collection.

In the next section below, you will find some of the survey results explained in narrative form and in graphs. Compared to the state, a higher percentage of high school students in these Barnstable County schools report current alcohol use, marijuana use, and vaping. A small percent reported current prescription drug misuse; however, these data were not available at the state level for comparison.

Figure 20.Self-Reported Current Substance Use Among High School Students, 2019

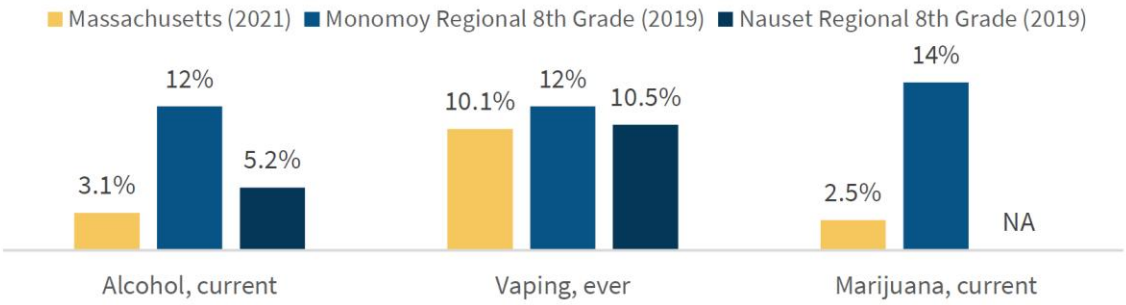


DATA SOURCE: Massachusetts Youth Health Survey 2021; Monomoy Regional High School, Youth Risk Behavior Survey, 2019; Nauset Regional High School, Youth Health Survey, 2019

In addition to the above statistics related to high school aged youth, 8th grade students in Barnstable County (included here are the numbers from Monomoy Regional Middle School

and Nauset Regional Middle School) were also asked about their current substance use (figure below). A higher percent of the 8th graders reported current alcohol use compared to the state. For vaping, these percentages were only slightly higher in Barnstable County schools than in Massachusetts. And only one school asked its 8th graders about current marijuana use; that percent was much higher than in the state (14% compared to 2.5%).

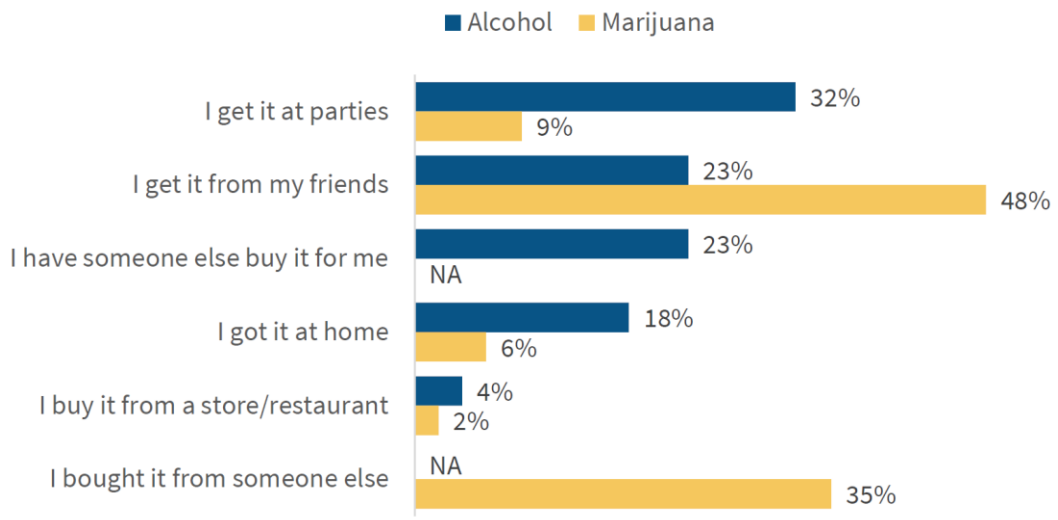
Figure 21. Self-Reported Current Substance Use Among 8th Grade Students, 2019 and 2021



DATA SOURCE: Massachusetts Youth Health Survey 2021; Monomoy Regional Middle School, Youth Risk Behavior Survey, 2019; Nauset Regional Middle School, Youth Health Survey, 2019

One school's survey of students asked for self-reported sources of different substances. Figure 22 presents the sources indicated by high school students for alcohol and marijuana. For alcohol, the most frequently reported sources were getting it at parties (32%), getting it from friends (23%), and having someone else buy it (23%). For marijuana, almost half (48%) get it from their friends and more than a third (35%) get it from someone else.

Figure 22. Self-Reported Source of Substance for High School Students, Monomoy High School, 2019

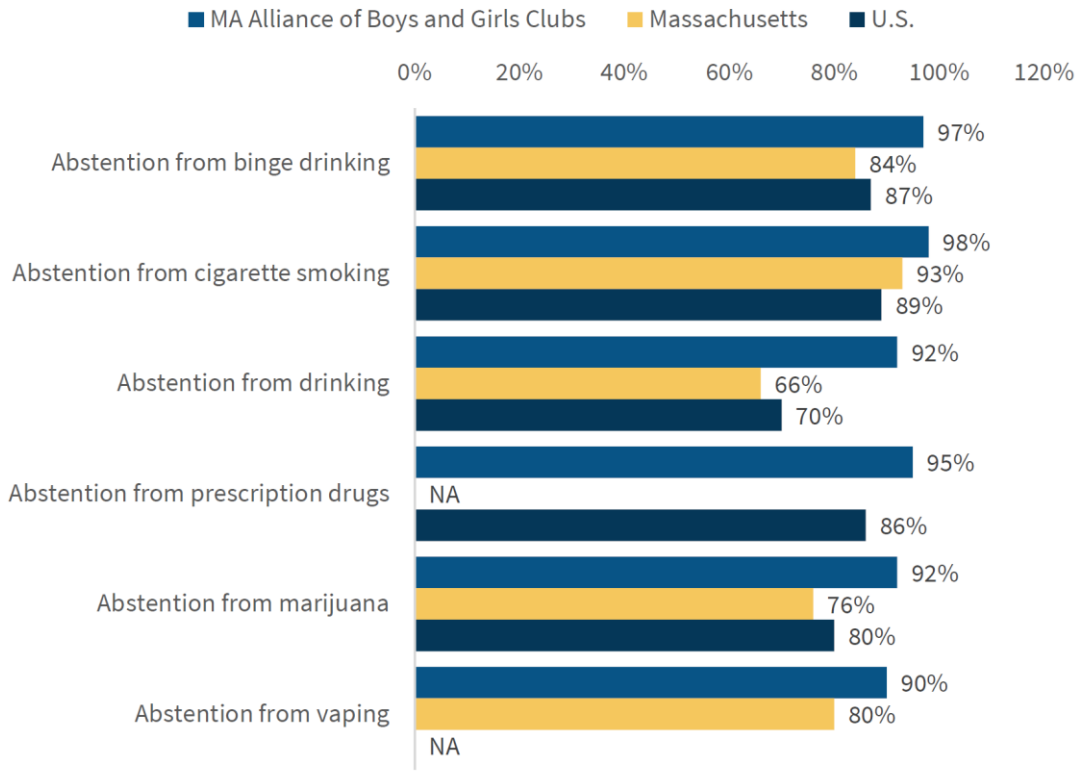


DATA SOURCE: Monomoy Youth Risk Behavior Survey, 2019

Students were also asked about how they accessed vapes and vaping products. Most high school students reported borrowing vaping products from someone else (41%). About 15% of youth accessed vaping products from someone who can legally buy them, another 15% bought them themselves.

While the above-included data focuses on the data about use, the Boys and Girls Club conducted similar self-reported surveys but instead gathered data on youth's abstention from substances. The data available includes responses from youth participants of the Boys and Girls Club across the state of MA so may not be fully representative of the experience of those living in Barnstable County. Higher percentages of young people involved with a Boys and Girls Club in Massachusetts reported abstention from all substances compared to the state overall and the nation.

Figure 24. Self-Reported Abstention from Substance Use, MA Alliance of Boys and Girls Clubs, Massachusetts, and the U.S., 2019



DATA SOURCE: MA Alliance of Boys and Girls Clubs and CDC Youth Risk Behavior Survey, 2019

Qualitative Data

Youth + Young Adult Interviews

In addition to including quantitative data, the assessment collected qualitative data during the interviews. One of these pieces of data included perceptions of youth substance use in your community. Many participants reported that substance use is starting at younger ages, for example as early as 6th grade. They noted that more prevention initiatives within the school system are needed. The topic of intergenerational use was mentioned, noting the importance of recognizing the impacts of youth seeing their older relatives using. Assessment participants also brought up the frequency with which grandparents are raising their grandchildren due to parental substance use. Interviewees perceived tobacco and nicotine, marijuana, and alcohol to be the most used substances among youth. Participants reported that young people use e-cigarettes to consume both nicotine and marijuana. A couple of the youth participants commented that while vaping nicotine is more common in middle school, marijuana and alcohol use are more common in high school.

- **Identify the source(s) of information for any quantitative (numerical) and qualitative (narrative) data.**

Qualitative data collection aimed to gather a range of perspectives from community members related to substance use. The goal of this process was to intentionally include individuals whose voices are typically not heard. The interviewees selected included community members with lived experience as well as people providing direct service in local organizations and service providers with lived experience. Including community members with lived experiences ensured a deeper and unique understanding of the experiences in Barnstable County. Programs will not be as effective if people with no experience with the services are making all the decisions. It is imperative to include people who use drugs, people in recovery, and their family members in all program design and decision-making around substance use. A total of 15 interviews with 27 individuals were conducted in the areas of prevention (4 interviews, 9 interviewees), harm reduction (4 interviews, 6 interviewees), treatment (3 interviews, 4 interviewees), and recovery (4 interviews, 8 interviewees). These interviews ranged from 1-3 participants per group. An additional 4 groups were held with a total of 9 community members with lived experience including youth, individuals engaged with harm reduction services who are actively using substances, individuals engaged in substance use treatment, and individuals who identify as in recovery. There were several individuals who were contacted to participate but were unable to and therefore these findings do not include their perspectives. We did not collect demographic information on the people who participated in the interviews, but this is something to consider moving forward.

Two HRiA staff (a facilitator and a notetaker) were present at each interview. All interviews were conducted via Zoom and lasted approximately 60 minutes. The assessment team used a semi-structured interview guide to ensure consistency in the topics covered across interviews. HRiA staff coded and thematically analyzed notetaker transcripts using NVivo 12 (QSR International Pty Ltd). Key themes were identified based on the frequency and intensity with which they appeared in the transcripts. You may find some quotes from the interviews included in this strategic plan- these quotes reflect the language used by the speaker and therefore may not use person-first language.

In addition to the formal community assessment processes described above, BCDHS staff regularly meet with community members in a variety of groups which include reporting feedback on resources in the community, trends residents are experiencing and witnessing, and gaps/strengths in the community services available. You will also find details on the process and the results of qualitative information collected during school health fairs, in the above section.

Secondary Data

The secondary indicators of interest for this assessment were based on those used for the 2014 assessment. Many of the same indicators were used while some were removed and others recategorized to fit current approaches in substance use as well as based on the expertise of those who provided data. The indicators include those to describe Barnstable County (e.g., demographics, social determinants of health , substance use prevalence data) and those focused on youth focused and school-based prevention activities; harm reduction activities such syringe exchange and disposal, Narcan and fentanyl test strips, and community outreach; inpatient and outpatient treatment at hospitals, community health centers and state-run facilities; and supports for recovery such as sober homes and recovery coaching.

Secondary data were gathered from existing public sources such as the American Community Survey (ACS) from the U.S. Census Bureau, the National Survey on Drug Use and Health (NSDUH) from SAMHSA, and various sources, including the Massachusetts COVID Community Impact Survey (CCIS), from the Massachusetts Department of Public Health. Data from the 2022 Cape Cod Health Care Community Needs Assessment was also included. Additional data were received from local sources to describe the substance use services and programs provided in the county. Local cost data related to service delivery, program implementation, staff, and other relevant costs were requested via email from individuals identified by BCDHS staff as potential resources for data. When necessary, follow-up phone calls and emails were utilized.

As far as gaps in data goes, the Youth Risk Behavioral Surveillance System (YRBS) is only encouraged, not required therefore data availability is subject to the individual school districts' choice to collect it. This in addition to barriers to collecting the data results in an incomplete regional data set.

- **Are any subpopulations of youth disproportionately affected by misuse of substances in your catchment area? If so, please identify these subpopulations, the nature of the disparity, and the data/evidence that were used to make this determination.**

According to the Assessment as well as input from the Core Planning Group the following subpopulations of youth are disproportionately affected by misuse of substances in our catchment area:

1. Teenagers
2. Youth living in rural areas of Cape Cod
3. Youth who do not speak English and/or youth who immigrated to the United States
4. Youth who are parents or other family members using substances

    a. intergenerational use was mentioned widely during the Assessment from both community members and from providers
5. Youth who are just initiating substance use

The following information describes the nature of disparity for the above-mentioned subpopulations:

1. Lack of resources/inequitable distribution of resources
2. Problems accessing resources due to transportation, geographic location
3. Limited awareness and prevention activities within the schools
4. Limited awareness and prevention activities in towns across the Cape
5. Lack of/limited treatment programs servicing Cape Cod, especially the lower/outer Cape
6. Gosnold has had trouble placing clinicians on the Lower/Outer Cape
7. Some of the services listed (e.g. Calmer Choice, Sharing Kindness) while supportive and necessary, have an auxiliary relationship to substance use prevention and may not be sought out or utilized as a primary prevention resource.
8. Schools are limited in their capacity for prevention activities due to curriculum requirements and competing demands within educational institutions
9. Inadequate resources for translation
10. Barriers to accessing non-English speaking and undocumented communities
11. Few opportunities for interaction with peers and older youth with lived experience
12. Socioeconomic factors, especially in rural areas
13. Lack of awareness about existing resources
14. Lack of adequate and robust youth behavioral health resources and supports
15. Not enough places for youth to belong
16. Housing crisis challenges our ability to attract behavioral health professionals

To determine these data points, we looked at the key findings and recommendations from the assessment, we gathered input from community members including our Core Planning Group, and we included ideas and input from all community meetings that BCDHS staff attended. Because many of the towns are holding public discussions with their residents about the use of the opioid settlement funds, these conversations gave us direct information on what Cape Codders think is needed to address substance use and addiction in their community.

- **Note any gaps in the available data on youth substance misuse that may limit your understanding of the issue, and how you plan to address these gaps moving forward.**

1. The impact on the 0-5 population
2. Equity gap in cultures and language of our Cape population (transient and year-round)
3. School surveys annually for all schools in County.

a. The data collected for the assessment only included two school districts. The two school districts that were reviewed are regional districts so included all of the Outer and Lower Cape towns (Monomoy School District and Nauset School District). These surveys are encouraged not required so results in an incomplete regional data set.

4. Information on needs of seasonal residents vs year round residents

- **Add any additional information that you think would help the reader understand how the assessment of youth substance misuse data was conducted.**
  See appendix A for Assessment final report

1.2. Assessing Intervening Variables on Youth Substance Misuse and Other Related Factors

Describe the process you used to collect data on intervening variables related to youth substance misuse:

- **What data sources and techniques for data collection did you use (e.g., focus groups, surveys, key informant interviews)?**

See above section describing data collection sources and techniques. The same techniques apply to collecting data related to intervening variables on Cape Cod.

We received a question in our feedback from MDPH, asking why youth social access to substances wasn't considered as an IV given the quantitative youth survey data illustrating it as a main access point. While the data from two of the school districts on Cape Cod did highlight youth social access to substances, this was not brought up in any community meetings as a concern of community members. It was not mentioned during our regular Core Planning Group, nor was it brought up by youth in any of our school prevention-related activities. Because this has been noted here, we will keep this topic in mind as we make our way through the implementation phase of the grant. If it is something that continues to come up, we will work with the community to figure out if it is a priority and area of concern for them. At this time, we will just continue to monitor it.

- **List all intervening variables related to youth substance misuse (particularly substances of first use) that you investigated, including data (qualitative and qualitative) on each variable and the source(s).**

The following intervening variables related to youth substance misuse were pulled from the Assessment on Substance Use on Cape Cod completed in the winter of 2022. Through

community member and provider interviews and collecting feedback during community meetings, participants commented that early age of onset, family/caregiver environment, access to services, community cohesion, and opportunities for prosocial involvement (both lack of and existence of) are the top variables impacting youth substance use.

The below listed IVs are listed using the language Barnstable County community members used to describe them:

1. Substance use is starting at younger ages than previously
2. Intergenerational use
3. Legalization of marijuana resulted in youth "not seeing it as a drug" and believing that "it's just not a big deal"
4. Geographic inequities in availability of services and supports
5. Widespread stigma against people who use substances resulting in lack of or ineffective education for youth
6. Barnstable County is a "collaborative place" where communities are "invested in the people that live there"
7. Lack of, poorly timed (does not start early enough), or ineffective substance use prevention education
8. There are very few substance use prevention programs and services
9. What services do exist provide safe spaces for youth to connect with eachother
10. What services do exist provide safe spaces for youth to connect with caring adults
11. Parts of Barnstable County are isolated where there are limited activities for youth to participate in, especially in the off season
12. There are prevention and youth organizations that provide youth with positive role models
13. There are prevention and youth organizations that provide youth a safe and fun space to spend time
14. Lack of awareness of services
15. Lack of access to services due to lack of transportation
16. Lack of services in languages other than English

School Health Fair Data

In addition to the data collected during the assessment, during two school health fairs over the past two years we collected feedback from students on a few questions pertaining to youth health and substance use. This information was from Barnstable Intermediate School (collected Fall 2021) and from Monomoy Middle School (collected Spring 2023). Participating students were from 6th through 8th grades. On big pieces of paper laid out on our table, we wrote the following three questions and had students write down their responses for each of them *(See appendix A for responses to the below questions).*

1. What is your biggest health concern?

2. What do you do to make yourself feel better when you are stressed?
3. Why do you think teens your age vape, drink alcohol and/or use drugs?

This information is helpful in prioritizing prevention program activities for youth, being able to tailor it to the unique needs of Cape Cod youth and young adults. Understanding why youth and young adults use substances helps us get to the root cause of their substance use. Students reported stress and anxiety as top reasons for substance use; that tells us what types of programs are needed to provide youth healthier ways of coping with these feelings.

These responses will be categorized and utilized to determine what types of interventions and preventative programs should be implemented, including activities that teens do to de-stress. A few of the intervening variables are related to these questions that were asked of youth, including a lack of awareness around the connection between mental health (and stress) and substance use; a lack of safe spaces for youth to connect with peers and adults; and areas of Cape Cod being isolated from the rest of the County.

- **Note any gaps in the available data on intervening variables related to youth substance misuse that may limit your understanding of the issue, and how you plan to address these gaps moving forward.**

The gaps in data are the same as listed in the above section. The lack of data on the below four subtopics impacts our understanding of the issue of substance use and how/why it impacts different age groups and subpopulations. To address this, we will work to gather more data from different schools and youth organizations' youth surveys. We are also continuing to strengthen our partnership with Cape Cod Children's Place (CCCP), which focuses on the early childhood age group. In addition to partnering with CCCP for early childhood data and programming, the YMCA of Cape Cod is a strong partner within the CPG/Prevention Work Group (PWG). Our CPG/PWG co-chair will be connecting us to the Executive Director at the YMCA for more information on early childhood. To address the lack of data revolving around equity and racism on Cape Cod, we have contracted with a consultant to create a cultural responsiveness and equity/inclusion action plan for the County's Substance Use Programming Department. This consultant just completed a review of printed materials, public-facing resources, the RSAC coalition's materials and membership, as well as several other items. This consultant position will create, with us, an action plan to address the issues that are identified.

1. The impact on the 0-5 population
2. Equity gap in cultures and language of our Cape population (transient and year-round)
3. School surveys annually for all schools in the County- the data collected for the assessment only included two school districts. That being said, the two school

districts that were reviewed are regional districts so included all of the Outer and Lower Cape towns (Monomoy School District-Chatham and Harwich and Nauset School District- Orleans, Brewster, Eastham, Wellfleet, Truro, and Provincetown).

4. Information on needs of seasonal residents vs. year round residents

Lastly, BCDHS plans to conduct this same/similar assessment every 3-5 years to keep up with the changing landscape and to ensure timely data is available for program development. The gaps in data identified here are sections we can build out in the next iteration of the assessment.

- **Add any additional information that you think would help the reader understand how the assessment of the data on intervening variables related to youth substance misuse was conducted.**
  See appendix B for Assessment final report

- **How are you integrating cultural responsiveness and sustainability into the Assessment step of the SPF process (e.g., how will data collection be sustained, how often do you plan to re-assess, what is in place to guarantee ongoing access to data, what are the baselines that progress will be measured against)?**

1. Cultural Responsiveness

This is something we can improve upon for our next assessment as well as our current work. To support this, we have contracted with an Anti-Racism Consultant to review our current projects, printed materials, and other publications. This consultant is a member of the Barnstable County community who does work in anti-racism as well as the prevention field. Once their review is complete, we will work with them to develop an action plan that will address the issues that were identified. Rather than approach this as a "one-and-done" project to check off a box, we plan to keep this consultant on for the lifetime of this grant (and the lifetime of this department) to have continued responsiveness. The goal is to create long-term culture change within the County's substance use work, and potentially within the County as a whole. One way that we could be more culturally responsive during the next assessment is to offer opportunities to share feedback and expertise in multiple languages as well as in person. Due to capacity and time restraints, we were unable to conduct interviews in person. We recognize this resulted in not including as diverse an interview pool as exists on the Cape.

What we did well was to include people with lived experience in this assessment. Our goal was to focus on speaking with the people in our community who are typically not included in community assessments and substance use research. That meant including youth, people who are actively using substances, people in recovery, people receiving treatment for

substance use disorder (SUD), family members of people with substance use disorder, and providers working on the street level directly with people impacted by SUD. This gave us a more accurate depiction of the efficacy of the services that do exist on Cape Cod as well as what may be lacking.

2. Sustainability

We recognize that the Assessment is only as good as how recent the data is. In the substance use field, resources open and close frequently and at times substance use trends change abruptly. We plan to reassess every five years, conducting a similar enough assessment that we would be able to compare results with each update. There was a baseline assessment completed in 2014 and will serve as our starting point. As needed, we would update language and intervening variables as new information becomes available. Data collection at the school level is a current gap and something that we plan to address, first through investigative conversations with the school districts. We would like to better understand which districts conduct regular surveys, how often they are conducted, and what topics are included in their surveys. If there are districts that are unable to conduct regular surveys, we would like to understand what barriers stand in place of accomplishing that. We would use this information to develop a plan that would address and break down these barriers. The data utilized for the 2022 Assessment was mainly public information so continued access to this data is not a concern.

1.3. Equity in Assessment

Describe the steps taken to promote equity during the assessment of youth substance misuse and intervening variables – including, but not limited to, how decisions were made about which data were used (or not used), the individuals involved (or not involved) in the review and interpretation of data, and the extent to which traditionally marginalized populations were represented in these data and involved in interpretation of findings.

- **How were decisions made about which data to use or not use:** The priority was to use as local as possible data that was available. This is an area the County can build upon and support the community: collection of regular data, especially data related to race, ethnicity, culture, language spoken, sexual orientation and gender identity (SOGI), and equity. We would also like to expand upon the assessment next time and include more questions and participants speaking to the topic of equity and anti-racism, especially as it relates to substance use.

- **How were decisions made about which individuals to involve or not involve in the review and interpretation of data?**

- **What extent were traditionally marginalized populations represented in these data and involved in the interpretation of findings:** BCDHS hired Health Resources in Action (HRiA) as the consultant to design the assessment, collect the data, interview community members, and interpret the data. HRiA had just completed the Community Health Needs Assessment for Cape Cod Healthcare, one of the biggest healthcare providers on Cape Cod, so had a lot of local and timely data already collected to build upon. The interview list was created by the Core Planning Group, identifying members of the community with lived experience, providers working directly with people with lived experience, and family members. The Core Planning Group was involved in the writing of the Assessment report from the beginning. As priority areas and initial key findings were identified, this information was presented out to the CPG during meetings. They were asked for their feedback- if anything surprised them, if any information was missing, and what programs should or should not be included in the resource directory. Once a full outline was developed for the Assessment report, CPG members were invited to provide feedback on that with similar questions. And finally when the full report was drafted, a smaller group from the CPG was invited to review the draft and provide thoughts. This draft was finalized and the Assessment report was circulated to the full CPG, the RSAC community, and members of the media and general public. BCDHS offered to report out on the key findings from the Assessment to organizations, health centers, and municipalities, and did report out to a few community stakeholders.

1.4. Technical Assistance Needs Related to Assessment

What assistance do you anticipate needing from BSAS, CSPS, or other sources related to the Assessment step of the SPF once your strategic plan has been approved?

At this time, we do not anticipate needing assistance related to the Assessment step of the SPF. Since writing this section, BCDHS has sought out technical assistance on how to support County school districts in conducting school health surveys on a regular basis and will continue to communicate with BSAS on this topic.

SPF Step 2: Capacity Building

2.1. Community and Key Stakeholder Involvement

1. **List the key sectors (e.g., municipal government, education, prevention, treatment, health care, law enforcement, social service) currently collaborating with you on MassCALL3 and describe their role.**

- Municipal Government
    - Town of Mashpee Human Services: member of the CPG
    - Town of Harwich: member of the CPG
- Health Centers
    - Outer Cape Health Services: member of the CPG
- Parents/Caregivers
    - There are a number of parents/caregivers who are members of the Core Planning Group. We have representation from local parent and grandparent support groups: Parents Supporting Parents; Learn to Cope; Grandparents Supporting Grandparents.
- Schools
    - Town of Barnstable Public Schools: member of the CPG
    - Monomoy School District: member of the CPG
    - Mashpee Public School District: member of the CPG
    - *BCDHS collaborates and partners with other schools and school districts on Cape Cod but not all have active membership on the CPG.
- Young people
    - We currently do not have any young people serving on the Core Planning Group nor the larger Regional Substance Addiction Council. The meeting times have not been convenient for youth/young adults. Regular, sustainable feedback-gathering from youth and young adults is an area for improvement. We are able to receive some feedback from young people through proxies and through school health fairs/presentations.
- Youth- serving agencies
    - Behavioral Health Innovators/ Alternative Peer Group/ PASS Program: member of the CPG
    - Boys and Girls Club: Co-chair of the CPG
- Faith Communities
    - There are no faith leaders as active members of the CPG but there is active participation on the RSAC as well as two of the town substance use coalitions.

- Public safety
    - There are no public safety as active members of the CPG but there is participation on the RSAC and Work Groups as well as a few of the town substance use coalitions.
- Local businesses
    - There are no local business owners on the CPG but there is participation on a few of the town substance use coalitions. The local municipal and regional Chambers of Commerce are active partners with Barnstable County towns.
- Media
    - There are no members of the media on the CPG but BCDHS has positive partnerships with local media, which is utilized to spread messaging around resources, events, town coalition meetings, and other relevant stories.
- Neighborhood and cultural associations
    - Bourne Substance Free Coalition
    - Mashpee Substance Use Task Force
    - Barnstable Substance Use Coalition (in its development phase)
    - Falmouth Commission on Substance Use
    - Non-substance specific neighborhood and cultural associations is an area for growth withing the RSAC and CPG. There are other town associations and cultural associations which are not currently represented.
- Public health agencies
    - House Assistance Corporation (HAC): Co-chair of the CPG
- Other prevention agencies
    - Barnstable County Children's Behavioral Health Consultant: member of the CPG
    - Cape Cod Children's Place: member of CPG and thought partner on the MassCALL3 grant. Recipients of SOR-PEC grant.
    - Calmer Choice: member of the CPG

2. Describe how, if at all, you intend to collaborate with local colleges and/or universities located within your catchment area

Within the RSAC community, there are at least two members who work with or are associated with Cape Cod Community College (4Cs). BCDHS staff collaborate with the teachers leading the Recovery Coach program at the college through guest presentations during their class sessions. Staff also collaborate with professors and staff from 4Cs on community events and speaking engagements with the RSAC. There is room for growth within this partnership, and an opportunity to involve more college students in the work.

3. **Explain how members of the general community are or will be engaged in MassCALL3.**

Members of the general community have been involved in the RSAC work and the MassCALL3 grant since its inception. RSAC meetings are open to the public and new members regularly attend. The MC3 grant process, especially with the assessment phase, has been publicized and community feedback has been incorporated. The assessment started with a community forum, explaining the details of the project and inviting attendees to share their opinions and experience. A similar presentation was shared with the County Commissioners which not only reached county leadership but these meetings are broadcasted on local media and online for members of the public to attend. This level of community engagement is in line with the goal and framework for conducting the assessment as well- we prioritized interviewing community members most impacted by substance use and addiction which included people in recovery, youth and young adults, people receiving treatment, people actively using substances, family members and loved ones of people with substance use disorder, and providers working directly with people who use drugs. The MC3 grant, through the capacity building phase, has funded trainings, support groups, and other awareness-building campaigns. These are all open to the public and include a brief description of the MC3 grant, the assessment, and ways for the community to get involved in substance use programming around the County.

4. **Describe how you will engage key stakeholders and other individuals from sectors not yet represented.**

One important sector that is not directly represented on the CPG nor the RSAC are youth and young adults. From my understanding, there has been an effort in the past to engage with this population but the timing of the meetings were not conducive for young people to attend. Outside of the CPG and RSAC, BCDHS engages with young people through school-based presentations and tabling at school health fairs and through partnerships with youth services providers like the YMCA and the Boys and Girls Club. BCDHS would like to engage with youth in the future through youth health academies that provide students the opportunity to learn about topics important to them and to connect with other youth on Cape Cod. We would also like to find ways to support the County school districts in the administration of youth risk behavior surveys to assess risk as well as collect feedback from young people.

In addition to the CPG members, we have engaged with members of other groups and coalitions to collect feedback and information on what impacts youth and youth substance use on Cape Cod. These additional groups included town substance use coalitions, the Cape Cod School Counselors Group, the Children's Behavioral Health Work Group, the Barnstable

School District Wellness Advisory Council, and other events and community conversations that we were invited to be a part of. These groups included the Barnstable School District, Nauset School District, Children's Cove, JRI, DCF, Bay Cove, NAMI, the Cape Cod Collaborative, Parents Supporting Parents, Learn to Cope, and many others.

5. **Describe the steps taken to promote equity and a restorative prevention framework during community and key stakeholder involvement – with an emphasis on any steps taken to involve traditionally marginalized populations.**

BCDHS contracted with Tara Vargas Wallace of Amplify POC, Inc. to do meaningful anti-racism work to result in culture change at the county level, but specifically within the County's substance use programming. The consultant reviewed BCDHS' current programming and marketing materials and wrote an assessment report of these materials and recommendations which identify areas to be more equitable and inclusive. This report was recently submitted to BCDHS so more review is needed before reporting out. One first step that was identified by the consultant is to offer anti-racism training to county staff, RSAC members, RSAC Work Group members, and town substance use coalitions. The consultant writes, "There is much, and ongoing, internal and reflective work to be done to begin developing a culturally responsive staff and leadership team. Personal assessment is a major part of the process in building culture change within an organization." This report also identifies equity and culturally appropriate principles to incorporate into all the work we are doing. The results of this review will form the equity framework for the next phases of this grant and for future initiatives.

During the assessment phase of the grant, HRiA attempted to include more members of the Mashpee Wampanoag tribe during the interview phase but due to lack of staff capacity in one of the programs, an additional interview was unable to participate. That being said, multiple tribal members were included in the interview process. Moving forward, we would like to have more participation in the development of the interview questions, in the identification of interviewees, and to include more racial equity data. We have recently began to connect with the Cape Verdean Club of Falmouth so are seeing room for partnership within the Cape Verdean community. We recognize that creating partnerships with members of racially marginalized populations can and should take a lot of time to show that the County will not do any harm and is acting genuinely.

2.2. Structure and Functioning

- **Provide an organizational chart of the governing structure of the MassCALL3 Part B project within your catchment area, including any subgroups or workgroups.**
  See Appendix C for organizational Chart

1. **How are the various stakeholders and other representatives within the catchment area functioning together as a team? For example, communication methods, meeting frequency, team-building activities.**

The RSAC and CPG operate as teams with BCDHS providing administrative support. Agendas are set with input from the RSAC and confirmed with the three Co-Chairs. BCDHS staff put the agendas together and circulate them along with the meeting minutes via email. Agenda items and meeting speakers can be proposed by anyone participating in the RSAC community. When the group updated the Governance Document, multiple drafts were distributed to the entire RSAC email contact list allowing the full community to comment on changes to the structure of the group and the governance logistics.

- Communication methods: Email, Microsoft Teams, Virtual Meetings
- Meeting frequency: RSAC meets monthly, CPG meets every other month
- Team Building Activities: The group has not conducted direct team-building activities but there have been some events which have give the group the opportunity to strengthen partnerships. For International Overdose Awareness Day and Month, BCDHS decided to place 86 purple flags on the front lawn of the Superior Courthouse right on Route 6A for the 86 people in Barnstable County who died from an overdose in 2022. The RSAC Work Group members were all invited to be a part of the placing of the flags. It was a powerful moment to see the RSAC community coming together in honor of people who have died and to support each other during this event. And in September, which is Recovery Month, the Pier Recovery Support Center is hosting a Recovery Month event- the Recovery Work Group has dedicated time to spreading the word about the event, will be tabling the event with resources, and generally supporting the Pier Recovery Center in their work.

2. **What is the decision-making process in your catchment area? Include a description of the process, how it is facilitated, who facilitates this process, who is involved in final decision-making, and what communities and sectors decision-makers represent.**

- RSAC: For official voting, there are seven voting members who form the Leadership Committee. Votes typically include approval of minutes, new RSAC leadership, and adjourning meetings. For unofficial decision-making, the RSAC operates fully as a team. RSAC participants are invited to comment on meeting topics to focus on, county-wide priorities, and BCDHS regularly share updates on County initiatives including the MassCall3 grant, the Assessment on Substance Use, spending recommendations for the national opioid settlement funds, and more. The decision-making and the meetings are facilitated by the three RSAC Co-Chairs. All of the sectors

who are members in the RSAC are part of the decision-making (see section on sectors). Input is collected both during meetings as well as via email.

- Core Planning Group: The Core Planning Group operates similarly to the full RSAC but without formal voting processes. The meetings are facilitated by the Prevention Work Group Co-Chairs along with the BCDHS Substance Use Prevention Program Manager, depending on the topics on the agenda. The BCDHS staff person typically leads the conversation around the MassCall3 grant. Decision making has been a collaborative process so far. For example- in the writing of this Strategic Plan, BCDHS drafts the sections based on conversations had during Prevention Work Group/CPG meetings. Each section is sent out in draft form to the full CPG for review with about 10 days to submit feedback. Members can submit feedback via email directly to the BCDHS staff person. After the deadline to submit, the staff person incorporates all feedback into the draft before finalizing that section. This will be repeated with each section of the Strategic Plan. This same process was used when designing the process for completing the Assessment on Substance Use on Cape Cod.

3. **What challenges have you encountered so far related to the functioning of your team and what are you doing to overcome these challenges?**

We have not encountered challenges yet related to the functioning of the team. Leadership and membership on the CPG has been consistent with no real turnover. Solely meeting virtually brings its own challenges and can hinder the group cohesion but this has not been a major issue. We would like to have a meeting in person at some point to further strengthen the group. We would like to involve more youth in the planning process but have encountered difficulty in youth being able to make it to meetings in the past. This is an area that we will continue to ask for TA around, both from CSPS, MDPH, and our peers.

4. **Describe the steps taken to promote equity and a restorative prevention framework within the structure and functioning of your MassCALL3 Part B grant (e.g., involvement of traditionally marginalized populations in decision-making, building and sustaining leadership of people of color).**

We place a major importance on the membership and leadership including people with substance use lived experience which means people who are in recovery, people who are in treatment, and their family members/loved ones. This is done intentionally through creating a community that allows people in recovery and people who are actively using to feel comfortable, welcome, and valued members of the group. There are areas that we can improve upon- making sure that we have folks who are actively using substances and actively in their addiction. In addition, ensuring that the RSAC community is a safe space for people of

color to participate. Through our work with the Anti-Racism Consultant, we are seeking ways to improve upon this. This will include representation on websites, printed materials, language used in the newsletter, and agenda topics. See Section 2.1 question 5 for more information.

2.3. Core Planning Committee

1. **List the membership of the core planning committee responsible for guiding the strategic planning process. Include professional title (where applicable), sector, and community that they are representing.**

See Appendix D for Core Planning Group members

2. **What challenges have you encountered related to the functioning of your core planning committee and what are you doing to overcome these challenges?**

We have not really encountered any challenges. The group includes folks from different sectors as well as different regions on Cape Cod. The level of expertise is varied in a perfect way that gives us a holistic set of knowledge to pull from. There are folks in recovery, family members of people with substance use disorders, school staff, and prevention providers.

3. **Describe the steps taken to promote equity and a restorative prevention framework within the core planning committee (e.g., direct representation, active solicitation of feedback, education on cultural humility and restorative justice).**

See response in section 2.1 question 5.

One additional item to include is the involvement of youth and young people. While it is difficult to find times for youth to be able to attend meetings, many members of the CPG work directly with youth so can lift up their opinions and voices on what works well and areas for improvement. BCDHS staff also works in the schools tabling at health fairs and conducting presentations. This allows staff to speak directly with youth about their experiences with substances, risk factors, and protective factors.

2.4. Capacity-Building Needs Related to Youth Substance Misuse

1. **Describe the strengths within your catchment area to address youth substance misuse (e.g., existing capacity, current prevention efforts, recent prevention efforts, groups already working on this issue).**

A major strength within our catchment area is the expertise within the prevention field. In the RSAC Prevention Work Group alone there is a wealth of knowledge and decades of

experience. When we meet with this group, with the Cape Cod School Counselors group, with the Children's Behavioral Health Work Group, or with the Cape Cod Children's Place SOR PEC grant work group, it is very obvious that we have a lot of the most knowledgeable people on Cape Cod working on implementing and improving prevention services.

Participants from the assessment shared that there are few substance use prevention-specific programs and services available, including resources for youth who may have just started experimenting with or using substances. While more services are needed, participants highlighted many successful youth-serving programs including the Boys & Girls Club, Calmer Choice, Cape Cod Children's Place (including FIRST Steps Together), Herren Project's prevention services, Positive Alternative to School Suspension (PASS), Sharing Kindness, and Youth Villages' Intercept and LifeSet programs. While these were discussed in multiple conversations, other services and programs exist in the county such as the YMCA, other school-based prevention programs through the sheriff's department, Gosnold (Cape Cod Lighthouse Charter, Cape Cod Tech, Falmouth, Mashpee, Provincetown, Truro), and Outer Cape Health Services (Nauset), as well as other individual school or town programming. Several participants described the Boys & Girls Club of Cape Cod as a particularly important resource because it provides youth with positive role models in a safe and fun space to spend time.

In addition to what was mentioned in the assessment, additional services are available through the RecoveryBuild Alternative Peer Group, BFREE Wellness Inc, services and activities through the towns and schools, and anecdotally more prevention and youth services are being developed and added regularly.

One other strength in our area is the implementation of a Children's Behavioral Health Needs Assessment (CBHNA) which will be looking at the behavioral health needs of youth and young people. The research group is in the very early stages of the assessment but they will be rolling out community listening sessions over the next couple of months. The goals of these forums are to elicit input from community members most impacted by the behavioral health needs of children and young people, collect feedback on the needs related to this topic, and understand the barriers that come up when trying to access services. This assessment will provide a more specific set of data that was not fully flushed out in the Assessment on Substance Use that the County completed as part of this grant. BCDHS is contracting with HRiA for the CBHNA as well.

2. **Describe areas in which your group needs additional support to address youth substance misuse more effectively – including the process used to identify these capacity needs and who was involved in the identification process. Indicate whether these needs are specific to the coordinator, core planning committee,**

specific parts of your catchment area, stakeholders, sectors, or the entire coalition.

- Additional support: Vaping; anti-racism trainings as a step one to implementing the restorative prevention principles (this need was identified by the Cultural Responsiveness Consultant during their review); how to better involve youth and young adults in this process
- Process: The Core Planning Group Co-Chairs alongside BCDHS staff check in with the group regularly asking for feedback on capacity needs, including areas for training. BCDHS staff take what the CPG group identifies and attempts to create agendas that respond to those needs. This includes speakers during meetings, trainings open to the public, and educational opportunities for targeted groups. BCDHS staff also reached these conclusions while reviewing the 8 principles of restorative prevention. This draft of section two will be sent to the core Planning Group for review. CPG members will submit feedback and edits to BCDHS staff and will be incorporated into the plan.
- Who was involved: Members of the CPG, with input from additional community groups related to prevention (Cape Cod School Counselors group; Children's Behavioral Health Work Group; Barnstable School District Wellness Advisory Council)
- Who are these needs specific to: The needs were identified by and for the entire coalition.
- For the coordinator: As the BCDHS coordinator is new to the prevention field, training on the Strategic Prevention Framework was needed at the beginning of this process. Identifying intervening variables.

3. **Describe areas of growth in your catchment area that will need to be addressed to promote equity, social and racial justice, and the eight restorative prevention principles – include the process used by the coalition to identify these capacity needs and who was involved. Indicate whether these needs are specific to the coordinator, core planning committee, specific parts of your catchment area, stakeholders, sectors, or the entire coalition.**

Process and who was involved is the same as section 2.4 question 2.

- Areas of growth: lack of local data on social determinants of health and race/ethnicity, primary language spoken; anti-racism trainings; figuring out ways to involve youth and young people, as well as their parents and caregivers, in meaningful ways in this process as well as the prevention service design and delivery; training on gender identify; training on the multiple familial structures; identify gaps in services in the different regions on Cape Cod; building and sustaining the leadership of people of color within the RSAC community. One topic that came up during community

meetings throughout the region is more support and educational opportunities for parents and caregivers. There were multiple intervening variables related to this topic, including a lack of awareness around protective and risk factors and how to implement more protective factors in the home and community. You will see this reflected in the Capacity Building Plan through trainings and workshops on topics related to wellness for caregivers and providers who identify as in recovery (as a way to disrupt generational use).

4. **How are you integrating cultural responsiveness and sustainability into this step of the SPF process?**

This is something that we are actively working on with the hiring a cultural responsiveness consultant. This individual will help identify specific needs and changes to enact, highlighting things that may not stand out to non-POC. Starting with anti-racism trainings for BCDHS staff, the RSAC and RSAC Work Groups, and youth-services providers, will put us all on the right baseline to begin to create needed change.

5. **Include a capacity-building action plan to address your identified areas of growth and capacity needs. The capacity building action plan should include the following elements: area of growth/capacity need, how it will be addressed, who is responsible, timeline and measures of success.**

Area of Growth/ Capacity Need	How It Will Be Addressed	Who Is Responsible	Timeline	Measure of Success
Lack of education and trainings on vaping for all populations	Trainings offered for behavioral health providers, caregivers, and prevention/school-based staff *This was addressed in the Capacity Building phase but will be regularly offered in the implementation phase as well, alongside other wellness and substance use topics.	Contracting with trainers: Becky Fidler, IHR, HRiA	Behavioral health provider trainings completed June 2023. Caregiver trainings completed June 2023 and will repeat late Fall 2023. Prevention and school-based trainings date is TBD.	# of training participants; feedback from participants
Recovery Support for providers	Trainings and groups for providers in recovery in part to help disrupt intergenerational use	Recovery Support + Prevention Capacity Building contract: organization TBD	RFP will go out by 9/29/23	# of participants; # of trainings/groups
More education needed for caregivers on	Trainings and groups for caregivers on how to increase protective factors, the	Recovery Support + Prevention Capacity Building	RFP will go out by 9/29/23	# of participants; # of trainings/groups

self-care, mindfulness, utilizing food and nutrition as a connection to youth	connection between wellness and substance use prevention	contract: organization TBD		
Need to improve racial equity framework Step 1	Cultural Responsiveness review	Cultural Responsiveness Consultant	Review was completed 6/30/2023	Report was submitted on time. See below for more info on next steps
Need to improve racial equity framework Step 2	Create cultural responsiveness action plan, including trainings, action steps to increase equity and inclusion within the RSAC, on the MC3 grant, and County materials/websites	Cultural Responsiveness Consultant	Currently reviewing FY23 consultant proposals. Contract to begin 10/1/2023 and continue throughout lifetime of MC3 grant.	TBD, based on what the consultant develops
Lack of documented data on needs of caregivers	Needs assessments and community conversations with caregivers and with youth	TBD	TBD	TBD
Lack of documented data on needs of youth/students	Student Academy/Listening Sessions	Barnstable County, Core Planning Group, in coordination with schools	TBD	# of student participants

2.5. Proposed Process for Strategic Planning

- **Describe the process the coalition *proposes* to use to facilitate discussions and decision-making related to the prioritization and selection of the final subset of Intervening Variables from the full list identified in Section 1.2—including who will facilitate the process, who will be involved (including the community and sectors they represent), and steps to promote equity and broad representation across your catchment area.**

See Section 3.1 for the full prioritization plan.

The process to prioritize the intervening variables (IVs) will be similar to the processes used during the entire timeline of the grant. The list of IVs included in section 1.2 were sent out to the CPG for review. Feedback on that list and the entire section 1 was submitted to

BCDHS and will be incorporated into the final version. The final process and section 2 will also be reviewed by the CPG. Summaries of sections 1 and 2 will also be reviewed during the CPG's September meeting before submitting to MDPH. During that meeting, BCDHS will review the list of IVs with the group. Members will be invited to share their opinions on whether there are IVs missing from the list and if there are IVs included that should not be.

Once we move onto the next step, we propose to review this list with the full RSAC community and will circulate the agenda for that meeting widely to include a variety of audiences. BCDHS staff and representatives from the CPG will facilitate this conversation. Once the RSAC narrows down the list, the CPG will vote to further prioritize which will be the focus of the implementation phase of the grant.

2.6. Technical Assistance Needs Related to Capacity

- **What assistance do you anticipate needing from BSAS, CSPS, or other sources related to the Capacity Building step of the SPF once your strategic plan has been approved?**

Any tips related to involving more youth in the planning process. We have encountered difficulty in youth being able to make it to meetings in the past.

SPF Step 3: Strategic Planning

Note: SPF Step 3 is expected to take approximately 2-4 months to complete. Grantees should not proceed to SPF Steps 4 and 5 until after submitting this section to CSPS and BSAS for review, feedback, and approval.

3.1. Planning Process

- **Describe the actual process that was followed to facilitate discussions and decision-making related to the prioritization and selection of the final subset of Intervening Variables from the full list identified in Section 1.2 – including who facilitated the process, who was involved (including the community and sectors they represent), and steps taken to promote equity and broad representation across your catchment area.**

The process to prioritize the intervening variables (IVs) was similar to the processes used during the entire timeline of the grant. The list of IVs included in section 1.2 were sent out to the full CPG for review. During the September monthly meeting, BCDHS and the CPG reviewed the list of IVs and staff facilitated a conversation with the group about these. The IVs were also sent out via email so anyone who was not present during the meeting was able to submit feedback as well as to allow for folks in the meeting to process on their own. During this meeting the group decided that in order to meet the December 31st deadline, it would make sense to increase the frequency on meetings to biweekly. Since September BCDHS have held this meeting every other week with many opportunities for input via email and survey.

Once we had revised the IV list slightly from what we originally submitted to MDPH, staff developed a brief survey using SurveyMonkey with 3 questions. The first two questions asked participants to rank the intervening variables by importance and by changeability and the third question gave participants the option to be added to the coalition email contact list. When designing the survey, we decided to keep the survey extremely simple to decrease any barriers that may prevent someone from feeling comfortable participating. If I were to redo this survey though, I would have included an optional question asking participants to identify themselves as (choosing as many as they identify with): parent, guardian/caregiver, school-based staff, counselor, prevention provider, youth services provider, youth/young adult etc… This would have informed the responses that we got and would have provided a little context to the reasoning for each ranking. This also would have given us the information needed to ensure a diverse set of responses. After sending the survey out to the Regional Substance Addiction Council (RSAC) general public and leadership, the Core Planning Group, an email list of youth providers and children's behavioral health providers, a group of parents, and

some youth, we received 30 responses to the surveys and 1 email response during the open survey timeframe. The person who emailed their thoughts had trouble filling out the survey.

We sought out multiple sources of support during the process of interpreting the data through the Logic Model Office Hours, from our TA provider- Adzele Benoit, and from Scott Formica. After discussing the process with everyone, we put all of the results individually into an Excel spreadsheet, calculated the ranking average for each intervening variable (by adding up all of the ranks and divided that total by the total number of surveys submitted), then sorted them low to high by average ranking. When staff met with Scott Formica, they applied a formula to determine how much the 30 responses were in agreement or not. We found that the majority of community members felt similarly about the top and bottom few intervening variables, which made the rest of the process a little simpler (See Appendix E for rankings and agreement formula spreadsheet).

BCDHS staff then utilized Microsoft Whiteboard to create a visual interactive way to present the selected intervening variables (see Appendix F to see full visual). This was presented both during a Core Planning Group meeting as well as via email, and feedback was requested and later incorporated. All of the ten intervening variables which had been included in the survey sent out were typed onto mini post-it notes. Four quadrants were developed, with the following titles: High Importance/High Changeability; High Importance/Low Changeability; Low Importance/High Changeability; Low Importance/Low Changeability. After reviewing where each IV landed within the quadrant, participants had the opportunity to move them if they felt like something was out of place. We did this same activity twice, sending the updated version for feedback the second time. Finally, BCDHS staff took all of the feedback from the Core Planning Group and from the community member survey results and began to draft the logic model. BCDHS staff had a brief meeting with Adzele Benoit, who provided TA on the beginning stages of the logic model. At the next CPG meeting, members who were present reviewed the draft logic model and provided input on each section. It was helpful to go through this process with the CPG members which included members of the Cape Cod Children's Place (CCCP) staff (recipients of the SOR PEC grant) as CCCP has already completed this section of the process. Following this meeting, BCDHS staff incorporated the feedback from the group to develop the final logic model draft. To collect a final set of feedback on the logic model, it was emailed out to the full CPG (to make sure any members who were not at the meeting could provide feedback) and to community members who completed the IV survey (to make sure we were following up with them and letting them know that their opinions are actually being utilized to make real changes in their community).

Who was involved: BCDHS staff facilitated the conversations and developed the IV survey. The survey was sent out to prevention providers, school-based staff (and retired school staff), parents, youth, and members of the Core Planning Group. The Core Planning

Group members were involved in in person and email conversations, providing feedback on the intervening variables selected, the process utilized to prioritize the list, and helped circulate the survey. To ensure equity and broad representation across the County, the survey was circulated to a wide group of folks and encouraged those individuals to forward the survey to anyone they thought may have feedback to include. We have tried to be very transparent about the deadline for this plan, explaining why the survey timeline was fairly short. And finally we tried to ensure equity and a cultural responsive process by following up with everyone who participated in the survey. They were added to the contact list to be aware of the development of the logic model and are continuously being involved in the decision-making process. This follow-up is our attempt at making sure the community knows that their time spent on providing feedback is being valued and that their voices are being heard.

3.2. Planning to Address Youth Substance Misuse

Describe your plan to address youth substance misuse in your catchment area:

- **Using the guidance provided in the MassCALL3 Part B Logic Model Development Guide, list the Local Manifestation of the Issue/Need statements related to youth misuse of substances of first use (e.g., alcohol, nicotine, cannabis) and your group's data-informed rationale for each statement.**

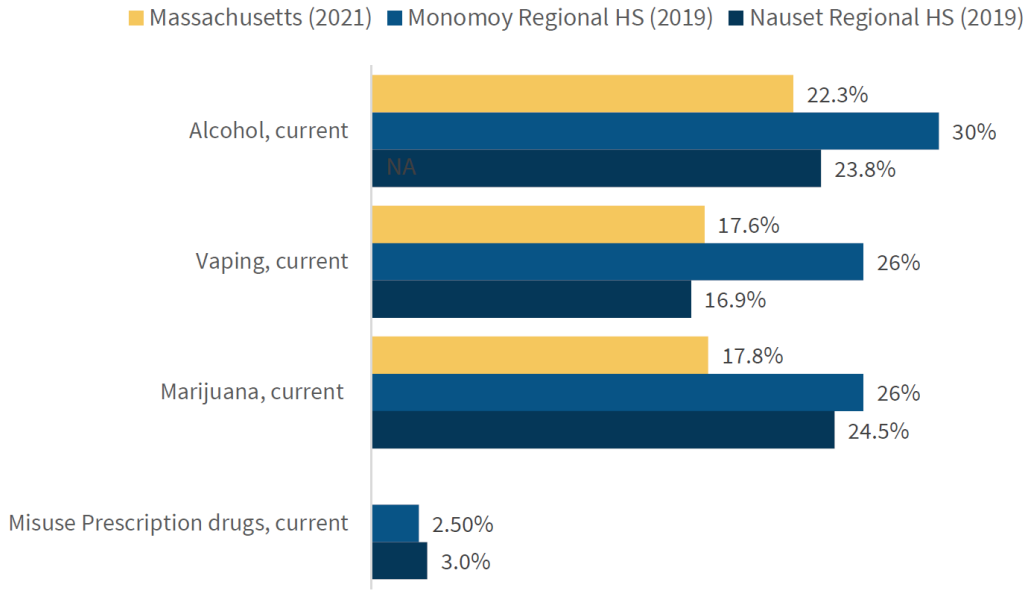
Local Manifestation of Issue/Need Statement: Need for more awareness around and programs addressing community wellness and how it relates to youth substance misuse prevention, including protective and risk factors as measured by 30 day use rates within Monomoy Regional School District (2019 Youth Risk Behavior Survey) and Nauset Regional School District (2021 Youth Risk Behavior Survey). 30% of Monomoy high school students report having used alcohol in the past 30 days with 17% of those students reporting binge drinking, which is a higher binge drinking rate than the state and country. 23.8% of Nauset high school students report having used alcohol in the past 30 days, which is a higher percentage than the state. *The caveat with these data is that they may not be representative of the entire Barnstable County in 2024. While more surveys are being conducted, these data will be utilized.

Throughout the MassCall3 grant process, we have discovered that there is a lack of data available on a local level on student wellness and youth substance use. There is inconsistency across the region in regards to student health surveys in the schools, and you will read in Section 5 about the student health surveys that have been implemented on Cape Cod. We conducted a brief survey of the schools/school districts, inquiring if they have completed a student health survey recently, when and with which grades, and if there are

plans for future surveys. This will give us better insight on which data are being collected from youth and young adults locally, and how the region may need to supplement or enhance what is being done. The below data is what was available at the time of the assessment period and speaks to the need for more awareness around and programs addressing community wellness as it relates to substance misuse prevention.

Figure 20 shows the self-reported current substance use among high school students in Massachusetts and from two Barnstable County high schools, Monomoy and Nauset. As only two schools' data are reported, it is important to note these data do not represent the full county population and should not be interpreted as such. Rather, these data describe the self-report experiences and behaviors of a subset of the youth population in the county. Compared to the state, a higher percentage of high school students in these Barnstable County schools report current alcohol use, marijuana use, and vaping.

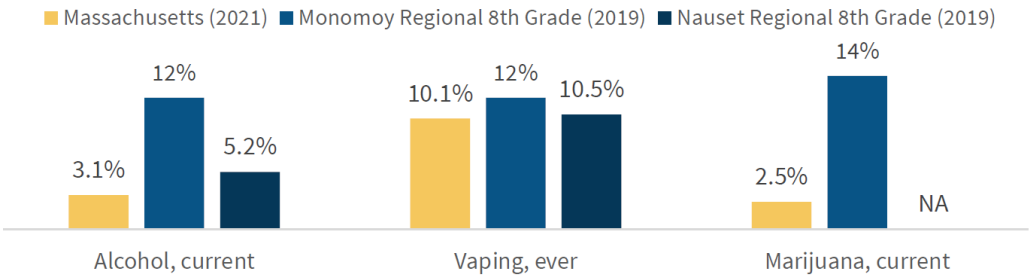
Figure 20.Self-Reported Current Substance Use Among High School Students, 2019



DATA SOURCE: Massachusetts Youth Health Survey 2021; Monomoy Regional High School, Youth Risk Behavior Survey, 2019; Nauset Regional High School, Youth Health Survey, 2019

Middle school students (8th grade) in these Barnstable County schools were also asked about their current substance use (**Figure 21**). A higher percent of the 8th graders reported current alcohol use compared to the state. For vaping, the percentages were only slightly higher in these Barnstable County schools than in Massachusetts. Only one school asked its 8th graders about current marijuana use; that percent was much higher than in the state (14% compared to 2.5%).

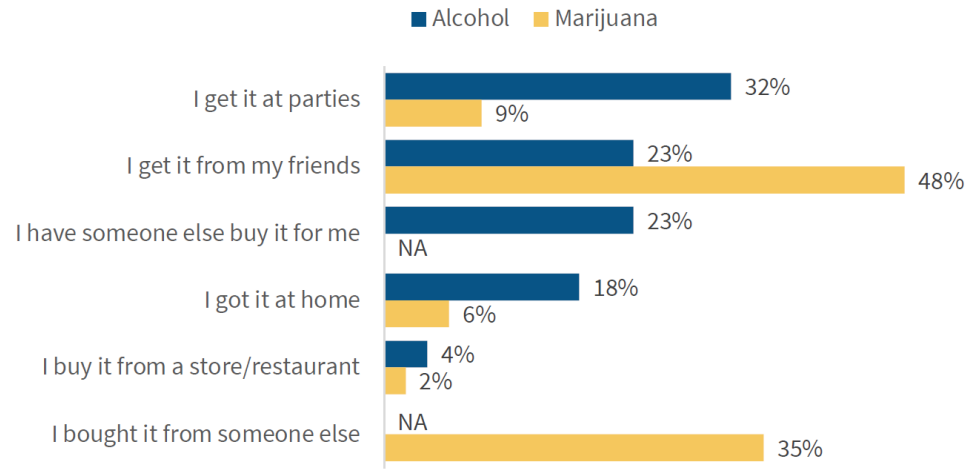
Figure 21. Self-Reported Current Substance Use Among 8th Grade Students, 2019 and 2021



DATA SOURCE: Massachusetts Youth Health Survey 2021; Monomoy Regional Middle School, Youth Risk Behavior Survey, 2019; Nauset Regional Middle School, Youth Health Survey, 2019

One school's survey of students asked for self-reported sources of different substances. **Figure 22** presents the sources indicated by high school students for alcohol and marijuana. For alcohol, the most frequently reported sources were getting it at parties (32%), getting it from friends (23%), and having someone else buy it (23%). For marijuana, almost half (48%) get it from their friends and more than a third (35%) get it from someone else.

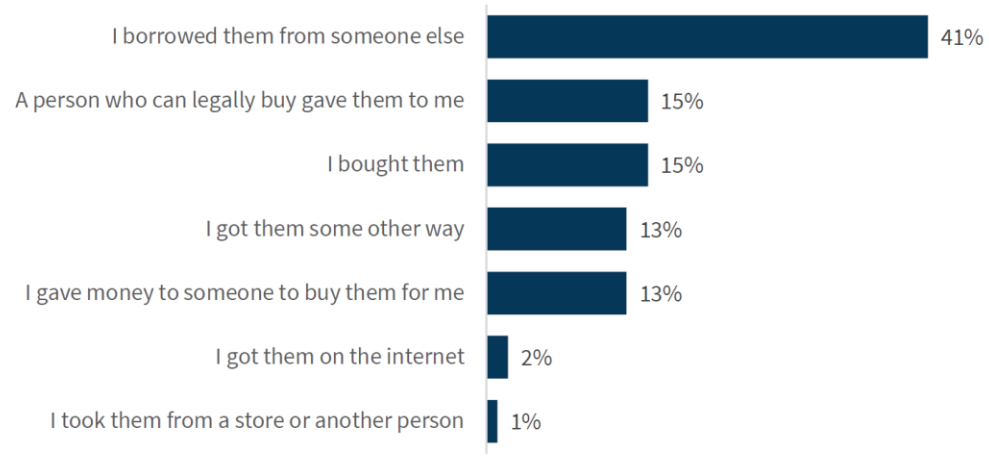
Figure 22. Self-Reported Source of Substance for High School Students, Monomoy High School, 2019



DATA SOURCE: Monomoy Youth Risk Behavior Survey, 2019

Figure 23 presents the self-reported sources for vaping products. Most high school students reported borrowing vaping products form someone else (41%).

Figure 23. Self-Reported Source of Vaping Products for High School Students, Monomoy High School, 2019

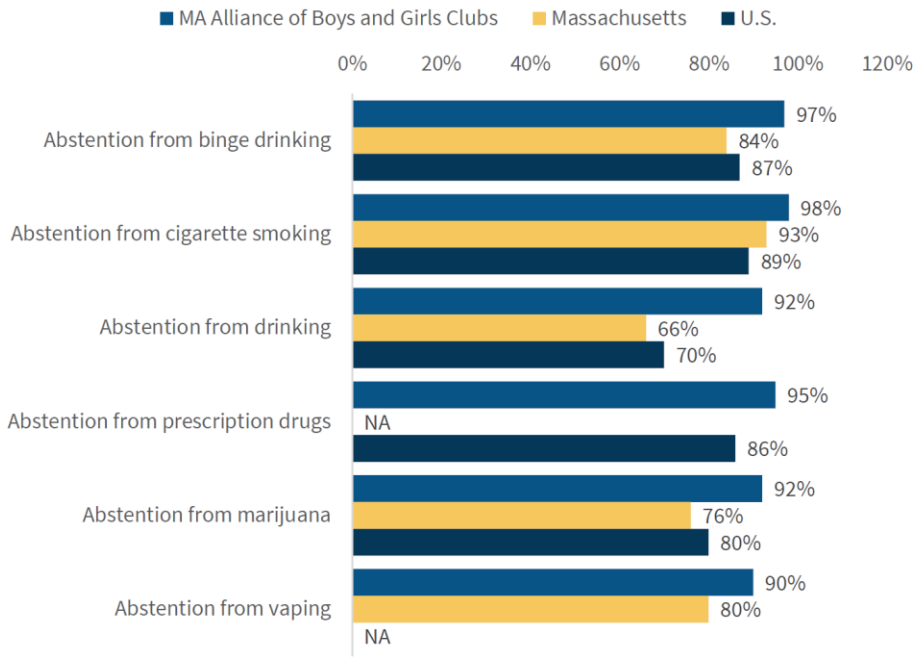


DATA SOURCE: Monomoy Youth Risk Behavior Survey, 2019

The MA Alliance of Boys and Girls Clubs conducted a survey of 40 of its clubs (including its location on Cape Cod) to gather self-reported data on abstention from substances. The Boys & Girls Club of Cape Cod plays an important role in providing young people on the Cape with a safe space to spend their time. It is important to note, these data represent responses from clubs across the state of MA and therefore may not be representative of the experience of those engaged with the club in Barnstable County.

Higher percentages of young people involved with a Boys & Girls Club in Massachusetts reported abstention from all substances compared to the state overall and the nation. These questions about abstention though are not consistently asked of youth not involved in Boys & Girls Club activities, so more data should be collected to fully understand this phenomena.

Figure 24. Self-Reported Abstention from Substance Use, MA Alliance of Boys and Girls Clubs, Massachusetts, and the U.S., 2019



DATA SOURCE: MA Alliance of Boys and Girls Clubs and CDC Youth Risk Behavior Survey, 2019

The COVID Community Impact Survey (CCIS) also reported data on youth and young adults (those less than 25 years of age); however, the sample size of respondents from Barnstable County was not sufficient and cannot be reported. **Figure 25** shows the percent of young people in Massachusetts who reported increased substance use since before the pandemic started. More than a third of those under 18 (44%) and those 18-24 (39%) reported increased use across the state. Although the below numbers do not reflect data in Barnstable County, anecdotal evidence tells us that youth are experiencing more behavioral health needs (anxiety, depression, higher levels of stress) than before the pandemic here on Cape Cod.

Figure 25. Percent of Youth Aged 14-24 Reporting Increased Use Since Before the Pandemic, by Age Group, by State, 2021

DATA SOURCE: Massachusetts COVID-19 Community Impact Survey, 2021

Participants also shared their perceptions specific to youth substance use in their communities. Notably, many participants commented that **substance use is starting at younger ages.** A couple of participants reported seeing substance use beginning as early as 6th grade and emphasized the need for school-based education and services. Several participants also discussed the importance of **recognizing the impacts of intergenerational substance use.** Participants commented on the frequency with which grandparents are raising their grandchildren due to parental substance use and the need to address that this "causes all kinds of things down the road." Participants perceived **tobacco and nicotine, marijuana, and alcohol to be the most used substances among youth.**

Participants shared that young people use e-cigarettes to consume both nicotine and marijuana. A couple of youth participants commented that while vaping nicotine is more common in middle school, marijuana and alcohol use are more common in high school. A couple of participants expressed that the legalization of marijuana resulted in *"kids [not] see[ing] it as a drug"* and believing that *"it's just not a big deal."* One participant shared that the state missed an opportunity to educate youth regarding the potential negative effects of youth marijuana use.

- **The final set of Intervening Variable(s) from Section 1.2 that you selected – including how this list was selected (prioritized) from among the larger list of variables examined by your group.**

The final set of Intervening Variables is included below. This list was prioritized utilizing the process described in section 3.1.

Selected Intervening Variables:

1. Lack of awareness around connection between mental health, community wellness, and youth substance misuse prevention.
2. Parental/ caregivers attitudes/perspectives around substance use resulting in younger age of first time substance use, and multi-generational use.

- **The specific centered population(s) for youth substance misuse (including any centered subpopulations):**

Specific Centered Populations:

1. Elementary, Middle and High School aged youth/students
2. Caregivers/families
3. Prevention providers, including out of school programs and staff

Proposed Strategies:

1. Trainings on youth mental health, wellness, and how it relates to youth substance misuse prevention (IV 1, IV 2).
2. Offer interactive wellness activities on My Choice Matters website and in person, for caregivers and for youth (IV 1, IV 2).

- **For each selected strategy, describe:**
    - **The conceptual and practical fit of the strategy within your catchment area. Why it was chosen. The evidence-base, link to research, or supporting information demonstrating that this is an evidence-based or evidence-informed strategy.**
    - **How, if at all, the strategy promotes equity, social and racial justice, and/or aligns with one or more of the eight restorative prevention principles.**
    - **The primary implementing partner and their relationship to the coalition – including their involvement in the prioritization and decision-making process to select the strategy and their current/future level of commitment to implementation.**
    - **Why you feel this strategy will be sustainable in the catchment area in which it will be implemented.**

Proposed Strategies

1. **Workshops and trainings on youth mental health, wellness, and how it relates to youth substance misuse prevention**

a. <u>The conceptual and practical fit of the strategy within your catchment area. Why it was chosen:</u>

Through conversations with the Core Planning Group, with community members, and incorporating the results from the needs assessment, the following was brought up: a lack of awareness around the intersection of youth mental health and substance use, gap in knowledge around protective and risk factors, and an overall need for more information on youth wellness and its connection to substance use. We would like to train the community on the principles within the restorative prevention framework and offer opportunities for workshop participants to practice how they will incorporate these principles into their home, school, organization, and/or community. While these trainings could be a part of the capacity building phase, implementing regular and consistent opportunities for caregivers, youth, and school/prevention providers to continue to learn more substance misuse prevention should be a sustained program. The full training/workshop curriculum will be developed along with the Core Planning Group and with input from community members to ensure the project is responsive to community needs. In addition to filling the gap in knowledge in the community, it was also chosen as a way of supporting caregivers. Providing them with updated and accurate information will help them have stronger and more honest conversations with their kids.

b. <u>The evidence-base, link to research, or supporting information demonstrating that this is an evidence-based or evidence-informed strategy:</u>

- Dassira, M. School psychologists' current practice, training, and interest in the integration of substance abuse training as part of the mental health profession (2019). Educational Specialist, 2009-2019. 150.
- Riggs, NR, Greenberg, MT, Dvorakova, K. A role for mindfulness and mindfulness training in substance use prevention. 2019 Prevention of Substance Use. Advances in Prevention Science. Springer, Cham. 335-346.
- Marsico, KF, Wang, C, Li Liu, J. Effectiveness of youth mental health first aid training for parents at school. 2022 Psychology in the Schools. 59(8): 1701-1716.
- National Council for Mental Wellbeing. Getting candid: Framing the conversation around youth substance use prevention. A Message guide for providers. 2023. Online access: https://www.thenationalcouncil.org/program/getting-candid/

c. <u>How, if at all, the strategy promotes equity, social and racial justice, and/or aligns with one or more of the eight restorative prevention principles:</u>

These trainings will include topics within the restorative prevention framework, and will directly work to increase caregivers' knowledge on Positive Youth Development and how to increase the self-confidence and self-efficacy of youth in their lives. School-based staff and prevention providers will receive training on how to meaningfully have youth participation in program/community decision-making. The principle of Intersectionality is a part of this activity as well by increasing awareness around the connection between youth mental health and other social determinants of health and substance use. Many of the social determinants of health not only impact young peoples' potential for substance use, but also their mental health and stress levels. It is all interconnected but many times these different fields operate in silos. These trainings aim to make people more aware of this connection.

d. <u>The *primary implementing partner* and their relationship to the coalition:</u>

While BCDHS is the host of this project, we may partner with community agencies, schools, parents groups to implement the caregiver conversations. The details of the assessment activities will be determined once in the implementation phase of this grant.

e. <u>Why you feel this strategy will be sustainable in the catchment area in which it will be implemented:</u>

This activity operates under a growth mindset, acknowledging that knowledge-building is never over but opportunities to increase awareness should be developed in a sustainable and consistent manner. Barnstable County has a strong group of prevention providers and family support organizations which work directly with caregivers as well as education centers and municipalities. There are many partnerships on Cape Cod which will be a part of ensuring the sustainability of this work.

2. Offer interactive wellness activities on My Choice Matters website and in person, for caregivers and youth

a. <u>The conceptual and practical fit of the strategy within your catchment area. Why it was chosen:</u>

Research shows that wellness-related activities can increase overall health, both physical and emotional health, thus can decrease potential for problematic substance use in youth and young adults. These wellness activities can range from physical sports and physical activity to increasing resiliency through mindfulness trainings, journaling, and breathing exercises. For a number of reasons, these wellness activities are not always accessible to all members of communities, including cost, transportation, lack of diversity in language that the activity is offered in, and geographic gaps in service offerings. This strategy aims to break down these barriers and expand access to wellness activities, both in a virtual

setting and in person. The My Choice Matters website is a great platform to offer the virtual options and can be maintained fairly easily through BCDHS. The details of the in person activities will be determined in collaboration with the Core Planning Group and community members.

b. <u>The evidence-base, link to research, or supporting information demonstrating that this is an evidence-based or evidence-informed strategy:</u>

BCDHS will ensure that the selected activities are evidence-informed and/or evidence-based. That being said, the current research does show that wellness activities, like physical activity, resilience education, and social emotional wellness programming, are effective in reducing overall use of most substances in young people.

- Riggs, NR, Greenberg, MT, Dvorakova, K. A role for mindfulness and mindfulness training in substance use prevention. 2019 Prevention of Substance Use. Advances in Prevention Science. Springer, Cham. 335-346.
- Bavarian N, Lewis KM, Holloway S, et al. Mechanisms of influence on youth substance use for a social-emotional and character development program: A theory-based approach. 2022 Substance Use & Misuse; 57(12): 1854-1863.
- Hodder RK, Freund M, Wolfenden L, et al. Systematic review of universal school-based 'resilience' interventions targeting adolescent tobacco, alcohol or illicit substance use: A meta-analysis. 2017 Preventative Medicine; (100): 248-268.
- Brellenthin AG, Lee D. Physical activity and the development of substance use disorders: Current knowledge and future directions. 2018 Prog Prev Med (NY): 3(3):e0018. PMCID: PMC6192057; NIGMSID: NIGMS960425; PMID: 30345414.

c. <u>How, if at all, the strategy promotes equity, social and racial justice, and/or aligns with one or more of the eight restorative prevention principles:</u>

When selecting the wellness activities BCDHS and the Core Planning Group will be mindful of the eight restorative prevention principles. These will be driving factors in the selection of programming.

d. <u>The primary implementing partner and their relationship to the coalition:</u>

The My Choice Matters website is currently hosted by the Barnstable County Department of Human Services, so for the activities housed on the MCM website, BCDHS is the primary implementing partner. BCDHS staff are not experts on social emotional learning

and resilience activities so will identify a community partner(s) to implement the activities. The Core Planning Group will be a part of the identification of community partners.

e. <u>Why you feel this strategy will be sustainable in the catchment area in which it will be implemented:</u>

MCM has been in existence for five years, and will continue to be hosted and maintained by BCDHS. The Substance Use Prevention Program Manager is the lead on this project. An annual review of the MCM website and wellness activities will be implemented to ensure information is up to date and accurate. Cape Cod also has strong wellness and prevention/recovery-related organizations which are strongly invested in being a part of the substance use prevention solution. Many of these organizations are already involved in this project in some way, or at the very least are aware of the MassCall3 grant. These strong partnerships are what will make this and all of these activities sustainable.

3.3. Logic Model

- **Using the MassCALL3 Part B Logic Model Development Guide, attach your logic model. The logic model should cover the period from July 1, 2022, to June 30, 2023 (regardless of your actual implementation start date, which is expected to vary +/- 3 months relative to the needs of each unique community). You are required to review and, if necessary, revise your logic model annually.**
  See Attachment A for Logic Model

3.4. Technical Assistance Needs Related to Strategic Planning and Logic Models

- ***What assistance do you anticipate needing from BSAS, CSPS, or other sources related to the Strategic Planning and Logic Model step of the SPF once your strategic plan has been approved?***

BCDHS will engage with MDPH and CSPS for support on finalizing the logic model, in response to the feedback received from the review.

Deliverable: After your group has written Sections 3.1 to 3.4 of the strategic plan and completed a draft of the logic model, this document must be submitted to CSPS for initial review and feedback. Your BSAS contract manager will not accept any drafts that have not been pre-reviewed by CSPS.

Deliverable: After your group has received and considered the feedback provided by CSPS, you must submit Sections 3.1 to 3.4 (including the logic model) to your BSAS contract manager for final review.

Once your BSAS Contract Manager has determined that Sections 3.1 to 3.4 and the logic model have been successfully completed, you may proceed to the next step of the SPF and begin writing Sections 4.1 to 5.2 of the strategic plan.

SPF Step 4: Implementation

Note: SPF Steps 4 and 5 are expected to take approximately 1-3 months to complete. Grantees must submit to CSPS and BSAS for review, feedback, and approval a full draft of the strategic plan (including the Summary/Abstract) before proceeding to any strategy implementation.

4.1. Implementation of Youth Substance Misuse Strategies

- **For each strategy, describe your youth substance misuse strategy implementation plans in depth, using the format below. Be specific. For example, how many training sessions will be offered, for how many participants, and how long each session will last. When the intervention will begin and end. The scope of implementation (e.g., single municipality, multiple municipalities, sub-municipal units).**

Strategy #1: Trainings on youth mental health, wellness, and how it relates to youth substance misuse prevention

Action Steps	Who Is Responsible	Timeline	Measure of Success
Research curriculum options + identify specific training types (both stand-alone and multiple session format where trainings build off of the previous one)	BCDHS with Core Planning Group	Months 1-2	Curriculum will be purchased (if necessary) and training development needs will be identified.
Identify and contract with an evaluator for all strategies and IVs	BCDHS	Months 1 -3	County procurement process will be completed (if necessary) and evaluator will be selected. Contract will be complete.
Meet with school district administrators to strengthen partnerships and gain an understanding of what is important to their school environment.	BCDHS	Initial outreach: Month 1 Meeting: Months 2-5	Meetings will be scheduled with at least one school in each subregion.
Contract with local providers and trainers and collaborate with them to develop and/or tailor trainings to the needs of the district/school needs	BCDHS	Months 2-5	County procurement process will be completed (if necessary) and trainers will be selected. Contract will be complete.

Collaborate with school district stakeholders (administrators, PTA/PTO members, educators) to implement trainings during established professional development times for school staff. Collaborate to offer trainings during PTA/PTO meetings and other family-focused community events.	BCDHS + school district stakeholders (potentially YSAC due to established relationship with DY Schools)	Following meetings with district administrators	Trainings will be scheduled with at least one school in each subregion.
Create section on BCDHS website to post training videos and resources.	BCDHS Communications Team and staff	Resources posted in months 3-4. Trainings posted following completion of recording.	Trainings will be recorded and posted online for greater accessibility to information. Other resources will be posted as well.
Develop evaluation plan, with multiple options for providing feedback and asking questions (including anonymous options)	Evaluator with input from CPG + BCDHS	Months 3-5	Evaluation plan will be developed.
Market Training Opportunities	BCDHS Communications Team	Once trainings have been scheduled. Anticipate Months 5-6	Information about trainings will be sent out in the RSAC newsletter, Human Services Newsletter and on social media
Table and provide training at already established PTA/PTO meetings, school events, and other family-focused community events throughout the County, ensuring each region receives at least one (1) event.	BCDHS with Core Planning Group	Immediately pending available events, focusing on school year.	Host table at PTA/PTO meetings as well as at student-oriented events (after prom party hosted by school) to promote wellness as it relates to substance use awareness and prevention efforts.
After each event send feedback form out to attendees. Include questions seeing if knowledge and perceptions of awareness around connection between mental health, community wellness, and youth substance misuse prevention changed.	BCDHS and Evaluator	Throughout all events and trainings.	Send feedback from to attendees. Aggregate collected data to identify any knowledge or perception changes among participants.

Strategy #2: Training for parents on substance use and substance use prevention in the home

Action Steps	Who Is Responsible	Timeline	Measure of Success
Research curriculum options + identify specific training types (both stand-alone and multiple session format where trainings build off of the previous one).	BCDHS with Core Planning Group	Months 1-5	Curriculum will be identified and vetted; procurement process followed.
Develop and administer an anonymous survey to gather parent/caregiver perspectives on youth substance use, generational norms/history, and use in the home	BCDHS and evaluator	Months 2-4	Survey will be developed to collect parent/caregiver perceptions on substance use among youth, perceived norms relating to youth substance use. Use this data to inform trainings in that sub region.
Meet with PTA/PTOs to get parent understanding of substance use. Use Parent University to outreach to parents	BCDHS	Immediately pending available events, focused on the school year	Meet with parents/caregivers and get their perspectives on substances of first use.
Use information gathered through survey and meetings with school staff/administrators to tailor programming to be regionally relevant in the 4 sub regions	BCDHS and Coe Planning Group	Months 4-6	Using the information gathered, work with Core Planning Group and evaluator to tailor trainings to be relevant to parent/caregiver and school needs.
Provide trainings at already established PTA/PTO meetings, school events, and other family-focused community events throughout the County, ensuring each region receives at least 1 event. Also have a stationary table set up with printed resources available.	BCDHS with Core Planning Group	Months 5-12, focusing on school year	Host trainings with a focus on topics identified in parent/caregiver initial conversation to make training relevant. Stay after event to answer any questions and hand out printed materials to support further conversations.
Upload programming and materials to BCDHS website for increased access	BCDHS communications team	Months 6-9	Trainings and materials will be posted to BCDHS website.

Strategy #3: Offer interactive wellness activities online and in person, for caregivers and for youth

Action Steps	Who Is Responsible	Timeline	Measure of Success
Identify existing wellness organizations in Barnstable County to partner with to provide monthly in person wellness activities, alternating locations throughout Cape Cod with at least 2 in each region as well as making the activities available online. Wellness activities could include but are not limited to: yoga, mindfulness, breathing exercises, art classes, outdoor activities, and other youth activities.	BCDHS with Core Planning Group	Months 1-3	Meet with local wellness organizations and gather information on wellness activities they offer.
Contract with identified wellness organizations	BCDHS	Month 2-5	County procurement process will be completed (if necessary) and contract will be completed.
Meet with contracted wellness organizations to develop scope of activities and develop wellness activity schedule.	BCDHS, Core Planning Group and organizations	Months 2-5	Scope of activities and activity schedule will be developed.
Develop evaluation plan, with multiple options for providing feedback and asking questions (including anonymous options)	Evaluator with input from CPG + BCDHS	Month 4	Work with evaluator to develop evaluation plan for effectiveness of programs for participants.
Develop marketing plan, including a referral incentive program for youth who bring 1+ friend to the event Market widely with support from full RSAC	BCDHS with Core Planning Group	Month 4-5	Information about trainings will be sent out in the RSAC newsletter, Human Services Newsletter and on social media. Work with collaborating schools from above to market activities.
Provide hybrid interactive wellness activities, alternating locations throughout Cape Cod with at least 2 in each region.	Contracted providers	Months 5-12	Host at least one activity in each region and upload activity materials to website.

Work with contracted wellness organizations to record brief wellness activities that can be accessed on the My Choice Matters website. Develop interactive opportunities.	Contracted providers	Months 5-12	Wellness activities will be recorded and optimized for online learning.
Post recorded hybrid training sessions on My Choice Matters website Include communication information for follow up questions and brief post training evaluation survey	Contracted web designer	Ongoing as trainings occur	Hybrid trainings will be posted on website.

4.2. Technical Assistance Needs Related to Implementation

- **What assistance do you anticipate needing from BSAS, CSPS, or other sources related to the Implementation step of the SPF once your strategic plan has been approved?**

Anticipated technical assistance that may be required includes strategies for effectively engaging youth and their parents or caregivers in workshops, events, and online programming. This support will be crucial for maximizing participation and ensuring that initiatives resonate with the community as well as address potential barriers surrounding engagement. Additionally, guidance in sustainability planning will be essential to ensure that online resources remain accessible beyond the funding period.

SPF Step 5: Evaluation

5.1. Existing and Planned Youth Surveys and Evaluation Support

- **For each municipality in your cluster, large individual municipality, or large individual municipality neighborhood cluster, answer the following:**
    a. **Has there been a student health survey administered since January 2018 among public school students in grades 6–12 that includes questions about youth substance misuse, particularly substances of common first use (alcohol, nicotine, and marijuana)? If so, when was the survey last implemented, when is it expected to be implemented again, and at which grade levels?**

In the Fall of 2019, Monomoy Regional Middle School and Monomoy Regional High School administered the Youth Risk Behavior Survey and Nauset Regional High School administered the Youth Health Survey. Monomoy Regional Middle School covers grades 5-7, Monomoy Regional High School covers grades 5-8 and Nauset Regional High School covers grades 9-12. The three surveys that were administered all covered topics on youth substance use and substances of first use.

    b. **If there has not been a student health survey administered since January 2018 among public school students in grades 6-12, are there plans in place to do so before December 2023? If so, at what grade levels? Is the survey expected to include questions about youth substance misuse, particularly substances of common first use (alcohol, nicotine, and marijuana)? What is the anticipated timing of the next survey implementation?**

Barnstable County Department of Human Services conducted a Children's Behavioral Health Baseline Needs Assessment from March-June 2024. The results of this survey are pending and are expected to inform future survey administration and activities.

    c. **Does your project plan to contract with an evaluator using MassCALL3 Part B funds? If so, include a completed scope of work including evaluation plan from the identified evaluator.**

An evaluator has not yet been identified or contracted with for this work.

5.2. Technical Assistance Needs Related to Strategic Planning and Logic Models

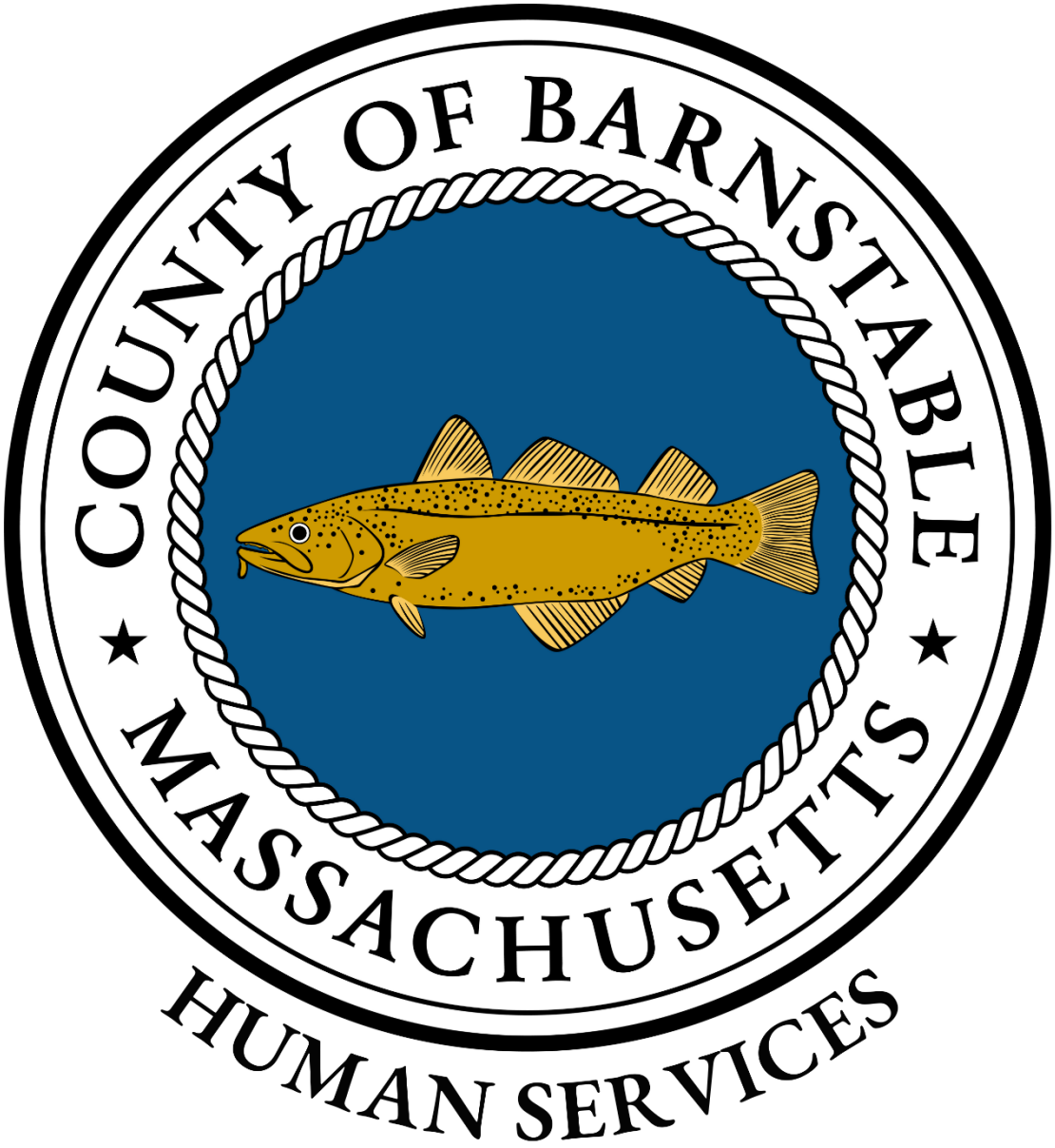
- **What assistance do you anticipate needing from BSAS, CSPS, or other sources related to the Evaluation step of the SPF once your strategic plan has been approved?**

For the Evaluation step of the SPF, we anticipate needing assistance with effectively capturing authentic student perspectives, as traditional paper and digital surveys have proven to be ineffective with this age group. Support will be needed for identifying and implementing alternative, more engaging evaluation tools so to ensure that the input of the target population are captured

Appendix A: Results from School Health Fair Questions

1. **What are your biggest health concerns?**
    a. Body/skin/appearance/body image
    b. Lungs
    c. Mind/mental health
    d. Unhealthy eating
    e. Not being smart enough
    f. Not being perfect
    g. Fitness/not moving
    h. Vapes/cigarettes
    i. Brain development
2. **What do you do to feel better when you are stressed?**
    a. Origami
    b. Text/talk to/hang out with friends
    c. Sleep
    d. Draw
    e. Eat
    f. Talk to a loved one
    g. Read
    h. Music
    i. Workout
    j. Play
    k. Video games
    l. Clean
    m. Play with dog/pets
    n. Push it down
    o. Baseball/basketball/play sports
    p. Take a shower
    q. Take a break and breathe
    r. See my therapist
    s. Go outside
    t. Breathe and talk to someone
    u. Don't get overwhelmed
3. **Why do some teens do drugs, alcohol, or vape?**
    a. Addiction
    b. Looks cool/think it's cool
    c. Environmental trauma
    d. Peer pressure
    e. Coping strategies
    f. Relaxation
    g. Escape
    h. To feel better
    i. Social media
    j. To relieve stress
    k. To fit in with their friends
    l. Anxiety
    m. Family/family issues
    n. To numb pain
    o. To show off
    p. To feel high
    q. It's normalized
    r. Self soothe
    s. Grief

Appendix B: Barnstable County Department of Human Services Substance Use Assessment



Health Resources in Action
Advancing Public Health and Medical Research

Contents

EXECUTIVE SUMMARY

Introduction

Substance use has continued to be a critical community concern in Barnstable County. To examine the current impact of substance use, Barnstable County Department of Human Services (BCDHS) undertook a comprehensive community assessment in 2022 focused on substance use to:

- Describe the mortality, morbidity, and societal costs of substance use
- Understand the community needs related to substance use
- Learn how these needs are and are not being met in the community
- Identify strengths and gaps in available resources

The 2022 assessment builds on a previous assessment in 2014, both conducted in partnership with Health Resources in Action (HRiA), a non-profit public health organization. To reflect changes in the field of substance use since the previous assessment, some changes in approach were made for this 2022 assessment. Specifically, the domains of focus were updated to be prevention, harm reduction, treatment, and recovery. The results in this 2022 report will be used to guide development of a 5-year action plan to direct future programming, policy, and funding priorities related to substance use in Barnstable County.

In doing this assessment work, we acknowledge that Barnstable County is on the lands of the Wampanoag Tribe, including the former Nauset Tribe. We recognize that Indigenous people are the traditional stewards of the land that we now occupy, living here long before Massachusetts was a state and still thriving here today. As we live and work on this land, we have a responsibility to acknowledge the Native people and work together with them to create healthy communities. By taking this small action in making a land acknowledgment, we hope the message will inspire others to stand in solidarity with Native nations.

Methods

This assessment utilized a community engaged assessment approach with ongoing input on assessment approaches and results from the Barnstable County Regional Substance Addiction Council Prevention Workgroup as well as through two public launch meetings held in September 2022 to gather broader community feedback on the assessment approach and goals. The results of the assessment will also be made accessible for the community through presentations by county staff to Barnstable County municipalities and other local entities (e.g., organizations, programs, groups, etc.). The assessment was conducted using a mixed methods approach to gain a robust understanding of substance use in Barnstable County including secondary data collection and qualitative data collection through group interviews and discussions with community members.

Nineteen interviews were conducted with 36 participants in total with perspectives in the areas of substance use prevention, harm reduction, treatment, and recovery. Interviewees included service providers at local organizations, community members, and other local stakeholders working in or with experiences related to substance use. Many of the individuals participating in these discussions brought multiple critical perspectives through sharing their lived experience with substance use.

Prevalence data related to substance use was collected from existing public data sources to describe the issue of substance use in Barnstable County. Indicators related to the cost of substance use services were requested from local service providers, organizations, programs, and other stakeholders to estimate the cost of substance use in Barnstable County. These cost data were analyzed by domain and, where possible, by substance.

Key Findings

The Barnstable County community is primarily White non-Hispanic and older compared to Massachusetts overall. The housing cost burden is higher for those in Barnstable County than in the state and a greater proportion of the county has public health insurance than the state overall. Very few people use public transportation; more renters than homeowners lack access to a vehicle.

In recent years, Barnstable County has had higher rates of opioid-related overdose and alcohol- impaired driving deaths than the state. In 2020, there were higher rates of hospitalization and emergency department visits for drug poisonings compared to the rates in Massachusetts. At state- funded treatment facilities, most of the admissions for those in Barnstable County were for alcohol and fentanyl or heroin. A higher percentage of adults in the county reported using alcohol and marijuana in the past month during the pandemic compared to Massachusetts; more than a third of adults in the county reported increased substance use since the pandemic started. Youth in Barnstable County report more current substance use of alcohol, marijuana, and vaping, than youth in the state overall.

Perceptions of Substance Use

Overall, service providers, community members, and other local stakeholders note that there are major concerns about opioids and overdose in their community; further elaborating that today these substances are different and stronger than in the past. According to their observations and experiences, there are two sides to the perception of substance use. There are those in the county who deny substance use is an issue in the community and pointed out the related issue of stigma related t
perception is the fact that the county is a tourist destination and ca
to have a "look to maintain". On the other side, there are those who work collaboratively to address substance use and who have seen the awareness of substance use and its related issues increase, particularly the co-occurrence of mental health, trauma, and substance use. Those who have seen these positive changes in their community do note that more progress has been made in some communities than others and there are geographic inequities in availability of supports and services.

> ***"I feel that we have grown very much on Cape Cod. It's talked about, I don't feel strange bringing it up to people, it's more of a fluid conversation. I can say I'm a person in recovery. It's not a big shock to anyone and I wouldn't have done that years ago."***
>
> ***-Service Provider with Lived Experience***

> ***"Cape Cod is tourist community [with a] huge income that comes from that for people. There is a look that we need to maintain and I think that there is a lot of stigma around substance use.***
>
> ***You encounter 'not in my back yard' stuff."***
>
> ***-Service Provider***

When thinking about the issue of substance use among youth, people shared that substance use is starting at younger ages and that there is a significant impact of intergenerational substance use.

Substance Use Services and Barriers to Access

Qualitative findings highlighted many impactful services across the domains including early childhood focused prevention programs, expansion of harm reduction services like Narcan distribution, effective treatment facilities with long-standing history in treating substance use in the county, and a supportive and diverse recovery community.

Those who shared their perspectives on prevention services noted there are few available and the primary venue for these is currently schools. They emphasized the importance of doing prevention work early in childhood and consistently through adolescence. There was also discussion of how non-traditional programs, such as those utilizing open conversations with young people, have the potential to impact both substance use and stigma. Another overall theme for prevention was isolation among young people and how having safe spaces where they can spend their time and connect with others could lead to a reduction in youth substance use; these spaces also present an alternative venue for prevention programs to reach young people.

> ***"When we have a guidance counselor do [a] lecture, people listen less. But we did have someone who went through rehab and had [an] incredibly different life; a lot of people [were] saying they really liked it. [It] struck a chord. Hearing it from someone who went through it and struggled through [the] ramifications works a lot better."***
>
> ***-Participant with Lived Experience***

Service providers, community members, and other stakeholders emphasized that harm reduction services are lifesaving and are effective when delivered using an affirming approach. They not only present the opportunity to provide substance use specific harm reduction services, but also to connect individuals to other needed resources such as treatment for substance use and related health concerns (e.g., Hepatitis C). Stigma related to harm reduction from different groups, including some of those in substance use work, was raised as a major contributor to the opposition experienced by those trying to implement and expand these critical services.

> ***"Those [harm reduction] are the first people that talked to me like I was human, they didn't shame or guilt me.... Those were the first people that interacted with me like I mattered. People walk by and judge and shame you, you're already struggling internally. These harm reduction programs provide safety, they kept me alive."***
>
> ***-Participant with Lived Experience***

"Even though [in] our programs we really work hard for same day initiation of treatment, there aren't a lot of opportunities for folks struggling with active use if they walked into [somewhere] using right now at this moment and wanted treatment to start. [We] need a bridge, [an] easy access clinic.

Someone should walk in and be able to find options [and be] referred to whoever is the right choice..."

-Service Provider

The available treatment services are highly regarded by those who shared their perspectives for this assessment; however, they note these services are not able to meet the full extent of these needs, especially for co-occurrence of mental health and substance use. A major concern discussed by many of those interviewed was the beds available for treatment are not enough, particularly those focused on specific populations such as youth, parents of young children, and those transition from correctional institutions.

There is also growing concerns expressed about the number of private facilities opening in the county and the affordability for those with different types of insurance (e.g., public insurance) and the coinciding closings of facilities that were having a positive impact on the community.

Those with perspectives on recovery in Barnstable County shared there is strong community of support and connection among those in recovery and many effective services available. They also lifted up the importance that these services are supportive of each individual's path in recovery and not only one "right path"; different types of services mentioned were focused on wellness, mindfulness, and grief/loss support. Even with these services people shared it is important to expand programming across the municipalities in the county to address barriers (e.g., transportation, availability) as isolation and lack of connection were noted as some of the harder things for someone in recovery to manage.

"[We need] to have places where there are these options and people can choose whether or not it's for them. We're an intelligent group emotionally, which is very much undermined. We talk about feelings all the time, we're very emotionally aware of our needs for each other. It's just being heard and being provided the space. We're told what we need a lot. That's why I appreciate the time to be able to say what we need."

-Participant with Lived Experience

Several cross-cutting barriers to accessing substance use services were ide

- Impacts of individual and community level stigma
- Lack of affordable housing overall and specifically focused on those with substance use disorder (SUD)
- Transportation and insurance related challenges
- Difficulty navigating the existing services and resources
- Geographical inequities in available services

Costs of Substance Use

Using locally provided cost data for substance use services, the estimated cost of substance use in Barnstable County is $48,333,708.77. Below is a table breaking down the total cost by domain as well as by substance were appropriate and data were available. The domain with the highest cost was treatment ($45,073,325.80 or 93.5% of reported estimated costs), and alcohol was the substance with the highest associated cost across the domains.

	Prevention	Harm Reduction	Treatment	Recovery	Total
Alcohol	--	--	$22,492,262.77	$218,988.00	$22,711,250.00
Marijuana	--	--	$730,129.01	--	$730,129.01
Opioids	--	$460,263.12	$14,529,837.56	--	$14,990,100.00
Other Substances	--	--	$2,345,548.32	$444,612.00	$2,790,160.32
Unspecified Substance	--	$176,471.85	$3,062,374.88	$605,960.00	$3,844,806,73
Total	**$1,189,438.00**	**$636,734.97**	**$45,073,325.80**	**$1,323,210.00**	**$ 48,222,708.77**

These data show a large disparity with much of the costs attributed to treatment related services; services in the other domains present critical opportunities to save lives as well as costs. While representing only 2.5% of the total reported estimated costs, prevention activities have the potential to result in over $21 million in savings based on estimates that every $1 spent on school-based prevention programs could save $18.[1] Harm reduction services represent just 1.3% of these costs but investment in these services has immense potential to save both costs and lives. Recovery costs also represent a small percentage of reported costs (2.7%). One study found that a program focused on recovery may have similar costs to traditional clinical approaches to substance use but led to more positive outcomes for individuals to maintain long-term recovery.[2]

Key Recommendations

The results of this assessment highlight the importance of regular, ongoing data collection and assessment to understand the issues related substance use as well as the context in which they are happening. To continue to utilize community perspectives and data to drive decisions regarding substance use services in the county the following should be considered:

- Conduct an assessment of this nature every 3 to 5 years with the goal of understanding both ongoing needs and emerging trends related to substance use.

[1] Miller, T. and Hendrie, D. Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis, DHHS Pub. No. (SMA) 07-4298. Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, 2008.

[2] McCollister, K. E., French, M. T., Freitas, D. M., Dennis, M. L., Scott, C. K., & Rodney, R. F. (2013). Cost- effectiveness analysis of recovery management checkups (RMC) for adults with chronic substance use disorders: evidence from a 4-year randomized trial. Addiction, 108, 2166-2174. https://doi.org/10.1111/add.12335

- Engage with key stakeholders to emphasize the importance of this work, and their contribution to it, to the community to facilitate this type of regular data collection.
- Conduct additional community engaged assessment work, with specific populations and topics of focus, to gain a deeper understanding of needs and trends identified as well as fill any gaps in knowledge.

These assessments should aim to guide decision-making and action planning from an evidence- informed perspective, which includes but is not limited to research as the only form of evidence (i.e., evidence-based practice).[3, 4] With an evidence-informed approach, decision-makers ensure both research and community expertise and experience are integrated to create more equitable and inclusive action.

Participants shared their suggestions and recommendations related to substance use services in Barnstable County specific to each domain as well as those that cut across all domains. Regarding those that should be considered across domains participants identified a need to understand and integrate the impact that social determinants of health – particularly housing, transportation, and insurance – have on accessing resources when developing and implementing substance use services.

Interviewees expressed a desire to see more cross collaboration and coordination between organizations providing substance use services in each of the domains across the county. Individuals shared they thought encouraging and facilitating this collaboration would have far reaching impact including increased awareness, among different providers and in the community in general, of what resources and services are available. Furthermore, interviewees shared that it would be useful to put in place systems to help individuals navigate the existing services; one key piece to this navigation that was identified was a form of person-to-person support, e.g., service navigator, to ensure those in Barnstable County seeking substance use services can get connected.

Based on the input provided during the discussions with these service providers, community members and other stakeholders, the following should be considered when planning future actions to provide substance use services in these domains:

Prevention

- Focus on holistic approaches to prevention as an effective form of substance use prevention, including addressing co-occurring mental health and substance use and providing safe and healthy outlets for youth to spend their time.
    - Provide these holistic services starting in early childhood (0-5 years) and consistently through young adulthood to build and maintain these skills.

[3] Kumah, E. A., McSherry, R., Bettany-Saltikov, J., Hamilton, S., Hogg, J., Whittaker, V., & van Schaik, P. (2019). PROTOCOL: Evidence-informed practice versus evidence-based practice educational interventions for improving knowledge, attitudes, understanding, and behavior toward the application of evidence into practice: A comprehensive systematic review of undergraduate students. *Campbell Systematic Reviews*, 15(1–2). https://doi.org/10.1002/cl2.1015

[4] Bowen, S., & Zwi, A. B. (2005). Pathways to "Evidence-Informed" Policy and Practice: A Framework for Action.

PLoS Medicine, 2(7), e166. https://doi.org/10.1371/journal.pmed.0020166

- Utilize non-traditional approaches to substance use prevention – not only providing education on risks/abstinence, but also using approaches such as open and authentic conversations with young people about what people's experiences have been and engaging parents, families, and other adults connected to youth in these conversations.

Harm Reduction

- Bring resources to where higher risk populations are to make them as low barrier as possible.
- Address individual level and community level stigma impacting both the ability to bring new harm reduction services to a community and access to existing harm reduction services.

Treatment

- Expand and build on existing long-term treatment options with a focus on specific populations: youth, mothers and caregivers with young children, those transitioning from the jail system.
- Create more access to medication-assisted treatment (MAT), specifically those for opioid use disorder such as Methadone.
- Prioritize services for those with cooccurring mental health and substance use disorders.

Recovery

- Establish more sober housing, specifically for those with public or no insurance as well as parents with young children; emphasize integrating some form of regulation or monitoring of the effectiveness of these homes to ensure they are providing the needed safe space for those in recovery.
- Expand support services focused on grief and loss, both for those with SUD and their families, as well as services focused on holistic and diverse approaches to recovery.
- Offer services to help those entering recovery navigate the available services as well as provide support related to challenges such as transportation and insurance.

INTRODUCTION

Substance use has a significant impact on individuals, families, and society. Provisional data from the Centers for Disease Control and Prevention indicate that in 2021 over 107,000 people lost their lives to drug overdose deaths in the United States. The impact of substance use is much greater when taking into account morbidity and hospitalization, lost wages, health care utilization, and costs of prevention, treatment, and recovery services.

Substance use has continued to be a critical community concern in Barnstable County. To examine the current impact of substance use in the County, Barnstable County Department of Human Services (BCDHS) undertook a comprehensive community assessment in 2022 focused on substance use to:

- Describe the mortality, morbidity, and societal costs of substance use
- Understand the community needs related to substance use
- Learn how these needs are and are not being met in the community
- Identify strengths and gaps in available resources

This substance use assessment was funded by a MassCALL3 grant from the Bureau of Substance Addiction Services (BSAS) from the Massachusetts Department of Public Health. To support the assessment's data collection and analysis, Barnstable County Department of Human Services partnered with Health Resources in Action (HRiA), a non-profit public health organization. The 2022 assessment builds on a previous baseline substance use assessment conducted by BCDHS, in partnership with HRiA, in 2014.[1] The results of the 2014 assessment were used to develop an action plan for substance use related efforts in Barnstable County.

The results in this 2022 report have the potential to greatly impact the community members of Barnstable County, including those who have substance use disorder (SUD), their family, friends, and loved ones, and the community as a whole. The information gathered through this assessment will be used to help BCDHS, the Barnstable County Regional Substance Addiction Council (RSAC), and other community leaders and decision-makers, to develop a new 5-year action plan to direct future programming, policy, and funding priorities related to substance use in Barnstable County.

Changes in the Field of Substance Use

One of the important drivers for this updated assessment has been the changing context within the field of substance use over the past eight years. Recently, there has been a strong infusion of funding directed at addressing substance use from multiple sources. This additional funding has highlighted the need even more to conduct an assessment so that decisions on how to utilize these funds could be data informed.

Since the baseline assessment was conducted in 2014, the field of substance use has evolved through its greater recognition of the impact of stigma on individuals who use substances and people with substance use disorder. A major component of this is the shift to approaching substance use as a public health, rather than a criminal issue;[2] coupled with an understanding that individuals respond best to voluntary services rather than mandated services. To reflect this, the domains discussed in this assessment have changed since the baseline study was conducted in 2014. The domains in the 2014 assessment were prevention, harm reduction, treatment and recovery (combined), and law

enforcement. To align with current approaches, the domains used for this assessment **are prevention, harm reduction, treatment, and recovery**. While law enforcement plays a role in responding to substance use in the community, services and programming involving law enforcement can operate within these four domains.

Another change in the field is the understanding of the impact of language and terminology on perception of substance use. The National Institute on Drug Abuse published information on how the language used when talking about those with SUD has the power to reduce stigma and negative bias.[3] In 2017, a memo sent to heads of executive departments and agencies described the impact of terminology that creates and perpetuates stigma related to substance use and misuse and asked these agencies to consider the language used in their internal and external messaging around substance use.[4]

At a state level, there have been recent changes in Massachusetts regarding medications used to treat opioid use disorder (MOUD). In April 2022, the U.S. Attorney's Office, District of Massachusetts, announced that all state and county correctional facilities will be required, under the Americans with Disabilities Act, to maintain all MOUD for people utilizing this treatment prior to entering.[5]

In February 2022, nationwide settlements were reached for all opioid litigation brought against three pharmaceutical distributors and a pharmaceutical manufacturer resulting in a total of $26 billion to be allocated to states.[6] These settlements resulted in more than $525 million funneled to Massachusetts to fund prevention, harm reduction, treatment, and recovery in its communities.[7] Below are the estimated amounts to be received by Barnstable County and its 15 municipalities starting in 2022 through 2038.

Table 1. Allocation Costs from Opioid Settlement Funds, by County and Town, 2022-2038

Municipality	Total Allocation (17 payments)
Barnstable County	$134,456
Barnstable	$1,803,656
Bourne	$795,605
Brewster	$270,070
Chatham	$354,356
Dennis	$203,989
Eastham	$165,455
Falmouth	$1,394,606
Harwich	$602,243
Mashpee	$727,313
Orleans	$196,602
Provincetown	$188,184
Sandwich	$1,039,704
Truro	$127,048
Wellfleet	$140,412
Yarmouth	$275,099
TOTAL	$8,418,798

Data Source: Massachusetts Office of Attorney General Maura Healey website https://www.mass.gov/service-details/learn- about-the-ags-statewide-opioid-settlements-with-opioid-industry-defendants

In May of 2021, the Substance Abuse and Mental Health Services Administration (SAMHSA) announced it was distributing $3 billion to states through the Community Mental Health Services Block Grant (MHBG) Program and Substance Abuse Prevention and Treatment Block Grant Program (SABG) that derived from the American Rescue Plan Act funds for the COVID-19 pandemic.[8] Massachusetts received $28,589,013 in MHBG funds and $32,254,331 in SABG funds.

Land Acknowledgement

We acknowledge that Barnstable County is on the lands of the Wampanoag Tribe, including the former Nauset Tribe. These ancestral lands were the territory of this tribe prior to their forced removal.

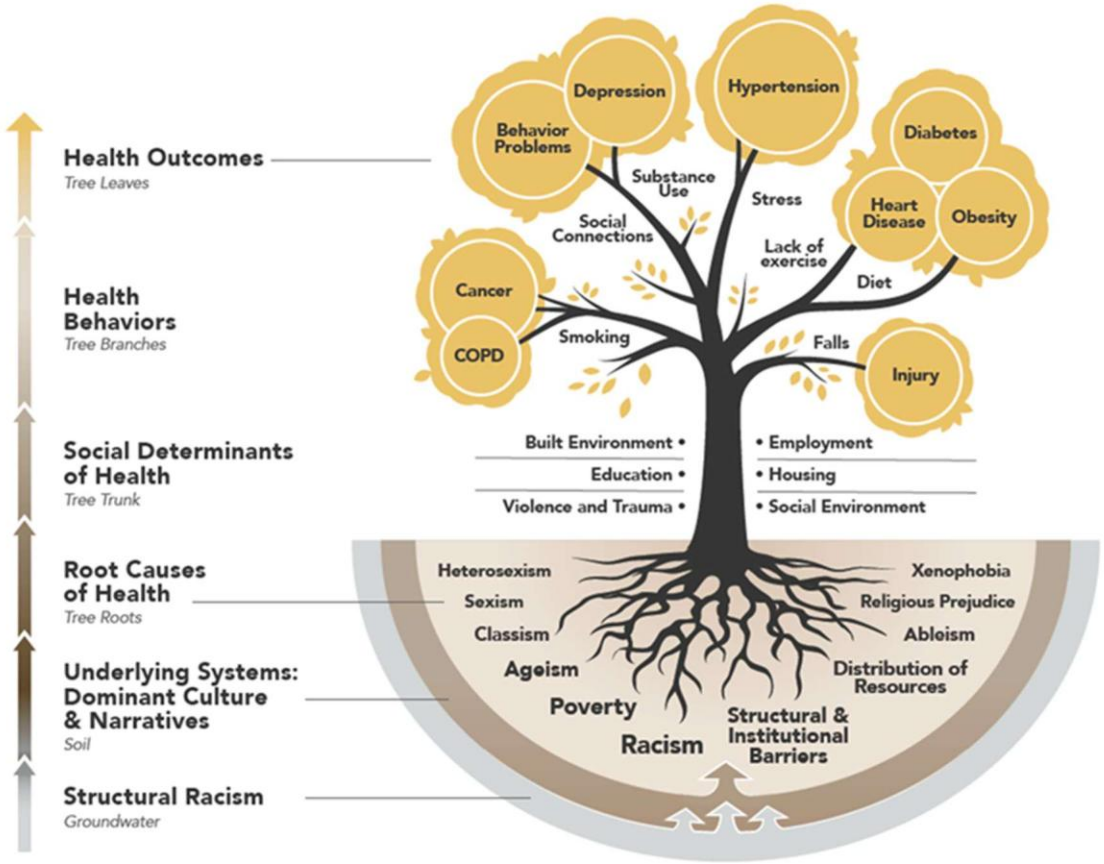
The county is currently home to 3,801 tribal members. We recognize that Indigenous people are the traditional stewards of the land that we now occupy, living here long before Massachusetts was a state and still thriving here today. As we live and work on this land, we have a responsibility to acknowledge the Native people and work together with them to create healthy communities. By taking this small action in making a land acknowledgment, we hope the message will inspire others to stand in solidarity with Native nations.

Social Determinants of Health Framework and Health Equity

This assessment uses a broad definition of health that recognizes and emphasizes numerous factors, beyond individual behaviors, that impact individual, community, and regional health. It is important to recognize that these multiple factors, referred to as the social determinants of health, have a downstream impact on health outcomes and that there is a dynamic relationship between real people and their lived environments. In addition to recognizing and emphasizing these social determinants of health, this assessment was also undertaken with an understanding that health equity (or inequity) precedes these social determinants.

In the United States, social, economic, and political processes ascribe social status based on race and ethnicity, which may influence opportunities for educational and occupational advancement and housing options, which are two social determinants that profoundly affect health. Institutional racism, economic inequality, discriminatory policies, and historical oppression of specific groups are a few of the factors that drive health inequities in the U.S. Understanding the factors (**Figure 1**), their relationship to community health and wellness, and how they contribute to health patterns for these populations can facilitate the identification of data-informed and evidence-based strategies to provide all residents with the opportunity to live a healthy life.

Figure 1. Social Determinants of Health Framework



DATA SOURCE: Health Resources in Action, 2018

METHODS

This assessment utilized a community engaged assessment approach with ongoing input on assessment approaches and results from the Regional Substance Addiction Council (RSAC) Prevention Work Group (Core Planning Group). The RSAC's purpose is to establish a communication infrastructure across towns, providers, organizations, and individuals on Cape Cod to help the region identify and address gaps and disparities in the service system, maximize inter-agency collaboration and to maximize funding and resource opportunities, all with a focus on substance use in Barnstable County. The RSAC membership is comprised of three RSAC Co-Chairs and one Co-Chair from each of the four Work Groups (Prevention, Treatment, Harm Reduction and Recovery), each with a designated alternate. A multi-sector representation from stakeholders and organizations working on the issue of substance use in Barnstable County participate and attend meetings as members of the public.

BCDHS and HRiA engaged with the Core Planning Group through five meetings over the course of the assessment as well as email communication where the members provided input and feedback on assessment methodology, data collection instruments (e.g., focus group and interview guides), local data sources, and priority stakeholders and population groups to engage in discussions. Members of the RSAC also provided outreach support for Barnstable County Department of Human Services

(BCDHS) and Health Resources in Action (HRiA) to connect with stakeholders with access to local data sources and connections to specific population groups. See the Acknowledgements section for a complete list of the RSAC members.

In addition to engagement with the RSAC, two public launch meetings were held in September 2022 to announce the assessment and gather broader community feedback on the approach and goals. The results of the assessment will also be made accessible for the community through presentations by county staff to Barnstable County municipalities and other local entities (e.g., organizations, programs, groups, etc.).

This assessment was conducted using a mixed methods approach to gain a robust understanding of substance use in Barnstable County. This approach included secondary data collection and qualitative data collection through group interviews and discussions with community members.

Qualitative Data

Qualitative data collection aimed to gather a range of perspectives from those in the community related to substance use. The goal of this process was to intentionally include individuals whose voices are typically not heard. The interviewees selected included service providers with lived experience and those providing direct service as well as community members with lived experience. Including these individuals alongside other community stakeholders ensured a deeper and unique understanding of the experiences in Barnstable County. A total of 15 interviews with 27 individuals were conducted in the areas of prevention (4 interviews, 9 interviewees), harm reduction (4 interviews, 6 interviewees), treatment (3 interviews, 4 interviewees), and recovery (4 interviews, 8 interviewees). These interviews ranged from 1-3 participants per group. An additional 4 groups were held with a total of 9 community members with lived experience including youth, individuals engaged with harm reduction services, individuals engaged in substance use treatment, and individuals who identify as in recovery. There were a number of individuals who were contacted to participate but were unable to and therefore these findings do not include their perspectives.

Two HRiA staff, a facilitator and a notetaker, were present at each interview. All interviews were conducted via Zoom and lasted approximately 60 minutes. The assessment team used a semi- structured interview guide to ensure consistency in the topics covered across interviews (see Appendix A for the full interview guide). HRiA staff coded and thematically analyzed notetaker transcripts using NVivo 12 (QSR International Pty Ltd.). Key themes were identified based on the frequency and intensity with which they appeared in the transcripts. It is important to note that quotes reflect the language used by the speaker and therefore may not use person-first language.

Secondary Data

The secondary indicators of interest for this assessment built on the indicators used for the 2014 assessment. Many of the same indicators were used while some were removed and others recategorized to fit current approaches in substance use as well as based on the expertise of those who provided data. The indicators include those to describe Barnstable County (e.g., demographics, social determinants of health , substance use prevalence data) and those focused on youth focused and school-based prevention activities; harm reduction activities such syringe exchange and disposal, Narcan and fentanyl test strips, and community outreach; inpatient and outpatient treatment at

hospitals, community health centers and state-run facilities; and supports for recovery such as sober homes and recovery coaching.

Secondary data were gathered from existing public sources such as the American Community Survey (ACS) from the U.S. Census Bureau, the National Survey on Drug Use and Health (NSDUH) from SAMHSA, and various sources, including the Massachusetts COVID Community Impact Survey (CCIS), from the Massachusetts Department of Public Health. Data from the 2022 Cape Cod Health Care Community Needs Assessment were also included. Additional data were received from local sources to describe the substance use services and programs provided in the county. Local cost data related to service delivery, program implementation, staff, and other relevant costs were requested via email from individuals identified by BCDHS staff as potential resources for data. When necessary, follow up phone calls and emails were utilized.

Limitations

As with all data collection efforts, there are several limitations to note. With many organizations and community members focused on the pandemic and its effects, community engagement and timely response to data collection requests were challenging. While interviews and focus groups provide valuable insights and important in-depth context, due to their non-random sampling methods and small sample sizes, results are not necessarily generalizable. Due to COVID-19, interviews were conducted virtually, and therefore, while both video conference and telephone options were offered, some individuals who lack reliable access to the Internet and/or cell phones may have experienced difficulty participating. Multiple secondary data sources were used to gather data for this assessment each source has its own set of limitations.

Overall, due to data reporting lag as well as additional burden due to the COVID-19 pandemic, the timeframes for these publicly available data may vary. In many cases, prevalence data were not available for all municipalities in the county, either due to data suppression rule – i.e., small percentages not being reported – or due to lack of recent data collection – e.g., the Youth Risk Behavior Survey. Available data from select municipalities are included to represent a local estimate.

The cost data in this report represents the information received from local outreach. While every effort was made to receive data from each contact, not all organizations responded to the request and others were unable to provide all the requested data which is a limitation of these data.

An additional limitation of the secondary cost data is the overall comparability of these data to the findings of the 2014 baseline assessment. Due to the time between assessments, in some cases data available then was not available for this assessment. On the other hand, new data not available for the baseline assessment are included in this report. The structure of data presentation has also been adjusted in this report to align with the current frameworks and approaches to substance use services which limits the ability to do comparison.

Both qualitative and quantitative data are limited in that not all that were contacted were able to participate in interviews or share their local level data. In particular, the lack of tribal participation limits the information provided and should be addressed in future efforts. Furthermore, major treatment providers did not participate in interviews (e.g., Gosnold) or provide data (e.g., Gosnold,

Community Health Center of Cape Cod) and therefore these results to not include their perspectives or cost data.

An exhaustive inventory of substance use treatment programs and other services, public and private, in the county does not currently exist. This assessment provides details of many services and programs; however, the resource inventory will need to be added to and upkept for complete and accurate data on an ongoing basis.

PROFILE OF COMMUNITY

The following sections present the findings detailing the existing and needed substance use services in Barnstable County, as well as barriers to and cost of those services, in the areas of prevention, harm reduction, treatment, and recovery. Additional data are included describing the demographics, social determinants of health, and prevalence and perceptions of substance use to understand the context in which these services are being provided.

To better inform services, overall and those aimed at reaching specific populations, it is important to understand the characteristics of the communities being served. The section presents key demographics for Barnstable County. Barnstable County is made up of 15 municipalities and had a total population of 228,996 people in 2020; a growth of 6.1% from 2010 (**Figure 2**). Almost all municipalities have seen growth in population between 2010 and 2020.

Figure 2. Population Count and Change, 2010 and 2020

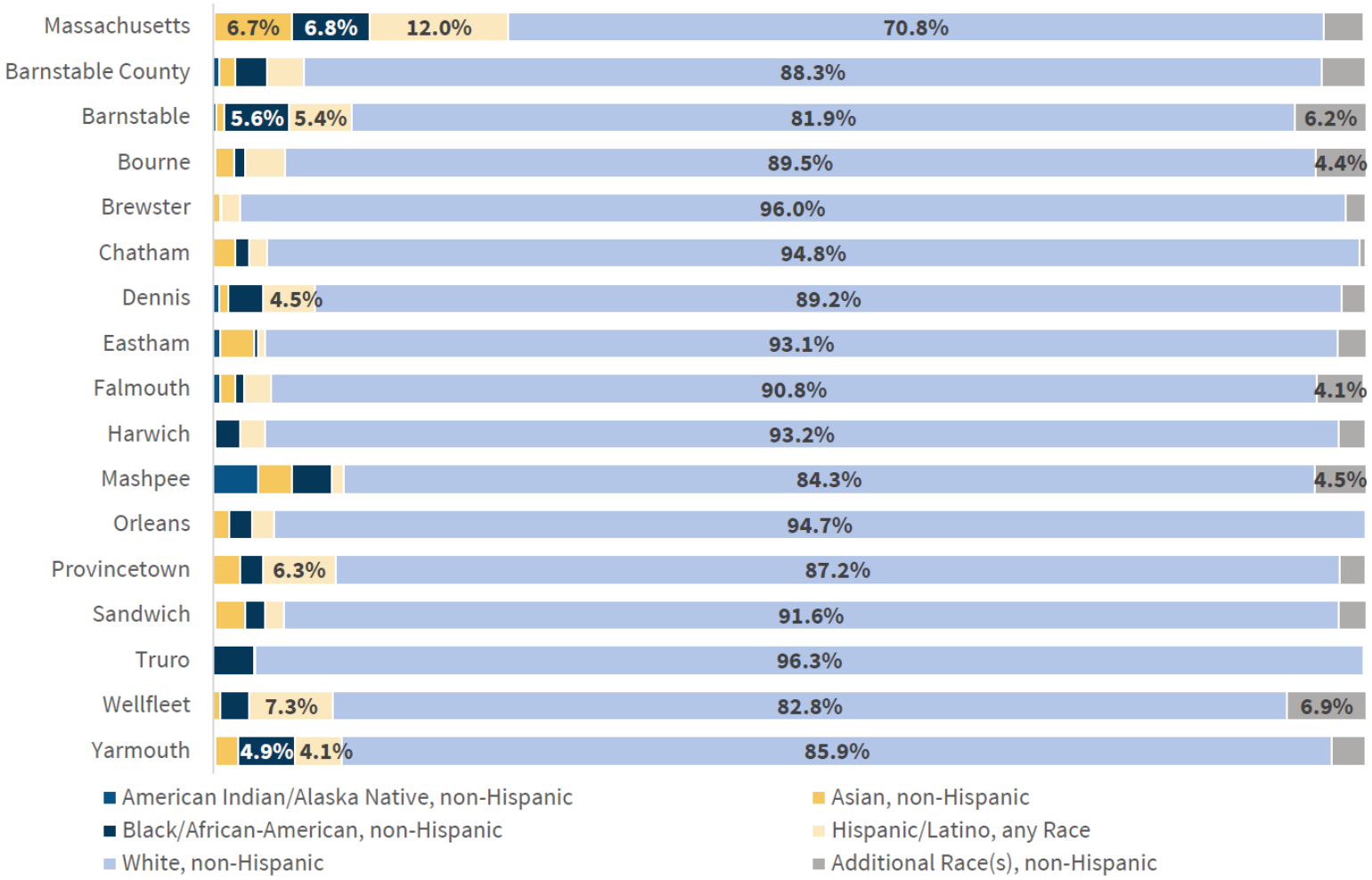
	2010	2020	% Change
Massachusetts	6,547,629	7,029,917	7.4%
Barnstable County	215,888	228,996	6.1%
Wellfleet	2,750	3,566	29.7%
Provincetown	2,942	3,664	24.5%
Truro	2,003	2,454	22.5%
Eastham	4,956	5,752	16.1%
Harwich	12,243	13,440	9.8%
Barnstable	45,193	48,916	8.2%
Chatham	6,125	6,594	7.7%
Mashpee	14,006	15,060	7.5%
Orleans	5,890	6,307	7.1%
Yarmouth	23,793	25,023	5.2%
Brewster	9,820	10,318	5.1%
Bourne	19,754	20,452	3.5%
Dennis	14,207	14,674	3.3%
Falmouth	31,531	32,517	3.1%
Sandwich	20,675	20,259	-2.0%

DATA SOURCE: U.S. Census Bureau, Decennial Census, 2010 and 2020

Figure 3 presents the racial and ethnic breakdown of Massachusetts, Barnstable County, and each of the municipalities. In Barnstable County and its municipalities, the majority of the population (>80%) identify as White non-Hispanic.

Figure 3. Race/Ethnicity Distribution, by State, County, and Town, 2016-2020

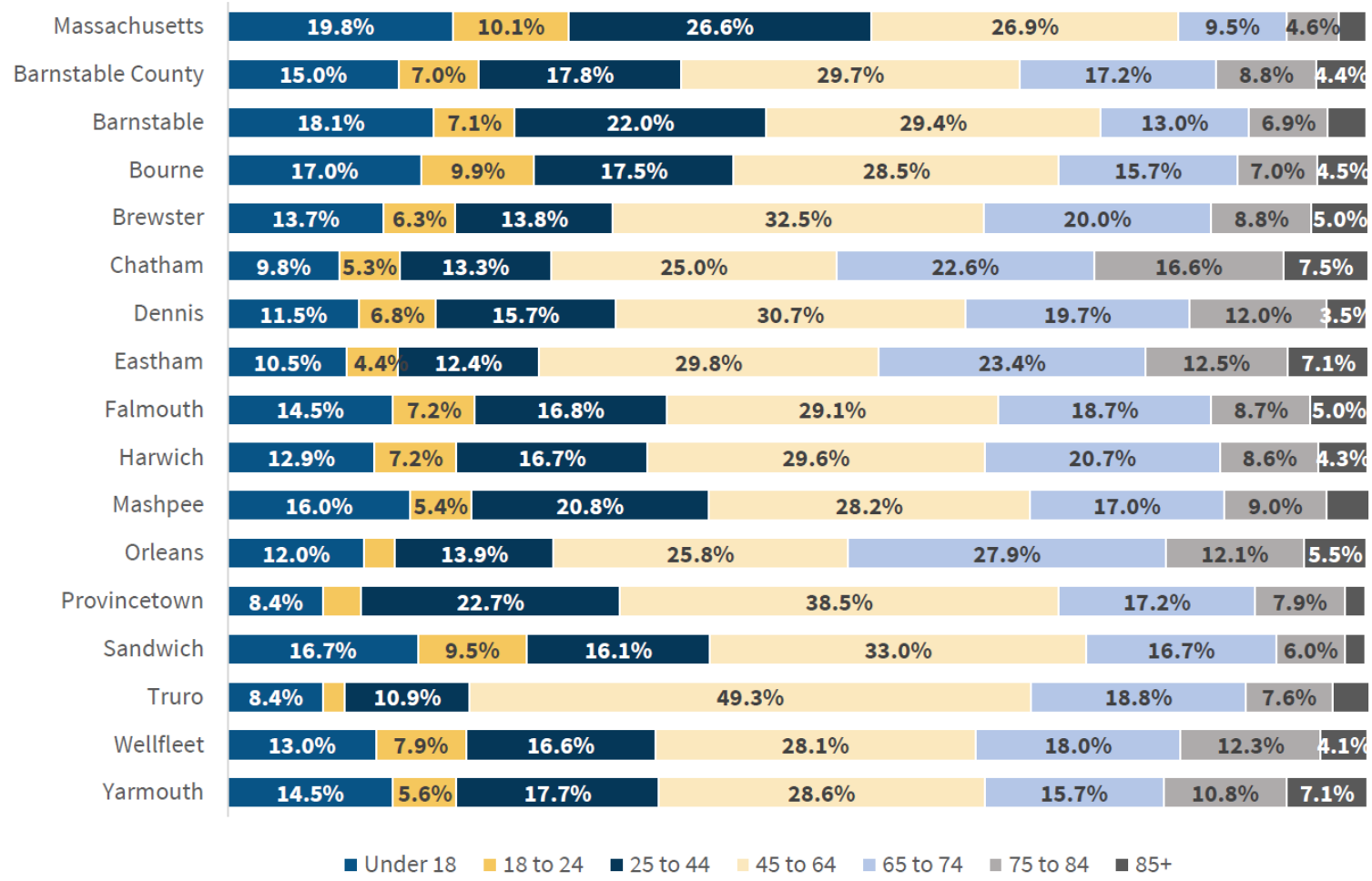
Figure 3. Race/Ethnicity Distribution, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020; NOTE: Additional Race(s), non-Hispanic include residents who identified as Native-Hawaiian/Other Pacific Islander, some other race, or as two or more races. Data labels under 4.0% are not shown.

Figure 4 presents the age distribution in Massachusetts, Barnstable County, and its municipalities. Overall, Barnstable County has a larger percentage of older adults 65 years or older (30.4%) compared to the state (16.5%).

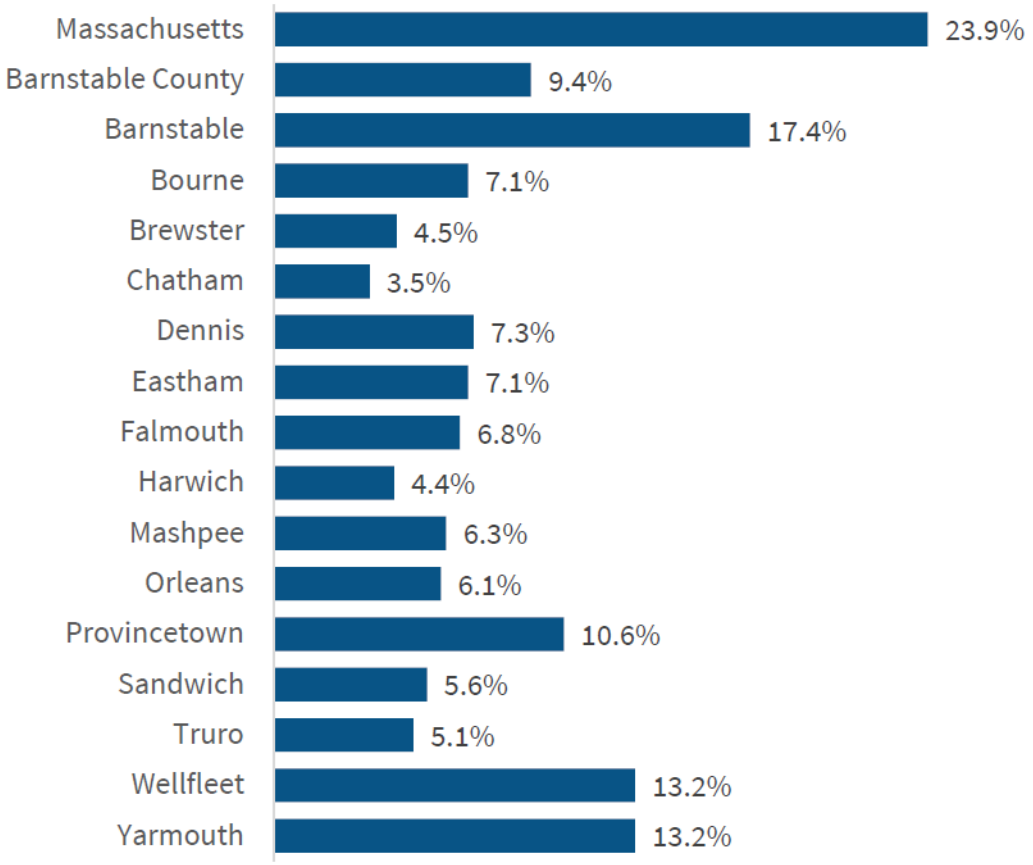
Figure 4. Age Distribution, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020; NOTE: Data labels under 4.0% are not shown.

Less than 10% of Barnstable County population 5 years or older speak a language other than English at home (**Figure 5**). For some municipalities – Barnstable, Provincetown, Wellfleet, and Yarmouth – the percentage is higher, ranging from 10.6% to 17.4% of the population.

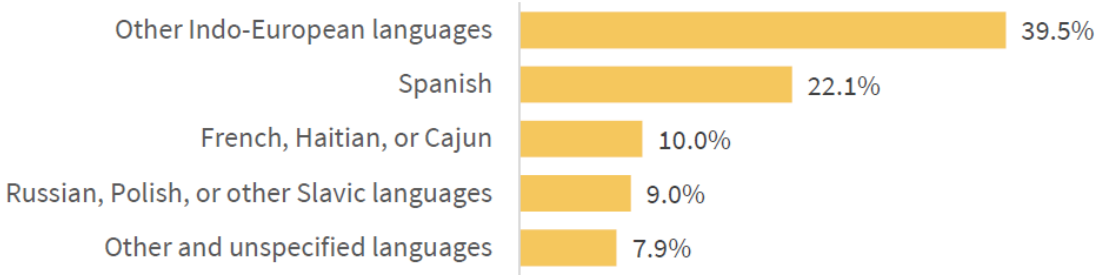
Figure 5. Population Aged 5+ That Speak a Language Other Than English at Home, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

When looking at the top languages other than English spoken in Barnstable County, more than a third (39.5%) of non-English speakers speak Other Indo-European languages, which includes Portuguese. The next most spoken language is Spanish (22.1%).

Figure 6. Top Languages Other Than English Spoken at Home, Barnstable County, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020; NOTE: Other Indo-European languages includes Albanian, Lithuanian, Pashto (Pushto), Romanian, Swedish; Armenian; Bengali; French (incl. Cajun); German; Greek; Gujarati; Haitian; Hindi; Italian; Malayalam, Kannada, or other Dravidian languages; Nepali, Marathi, or other Indic languages; Persian (incl. Farsi, Dari); Polish; Portuguese; Punjabi; Russian; Serbo-Croatian; Tamil; Telugu; Ukrainian or other Slavic languages; Urdu; Yiddish, Pennsylvania Dutch or other West Germanic languages

Impact of Social Determinants of Health

To provide the most effective services to address SUD, it is necessary to understand what additional societal and environmental factors can impact an individual's ability to access these services. This section provides key social determinants of health data that should be integrated into county-wide efforts to address substance use.

In assessment discussions, community members, service providers, and other stakeholders discussed how the impact of the social determinants of health (such as housing, transportation, and unemployment) had on a person's ability to access substance use services was discussed. This section presents data on relevant social determinants of health to provide context for findings presented in later sections of this report. The most commonly discussed determinants were housing, transportation, and insurance. One participant discussed the social and economic challenges that residents face and how services do not seem to keep up with demand:

> *"Cape Cod has a huge housing crisis. Difficulty accessing general medical providers. People may not have health insurance. Transportation is poor, public transportation is really poor. All these barriers exist and affect those who use substances... General lack of resources, support structure in most of the towns on Cape."*

Housing

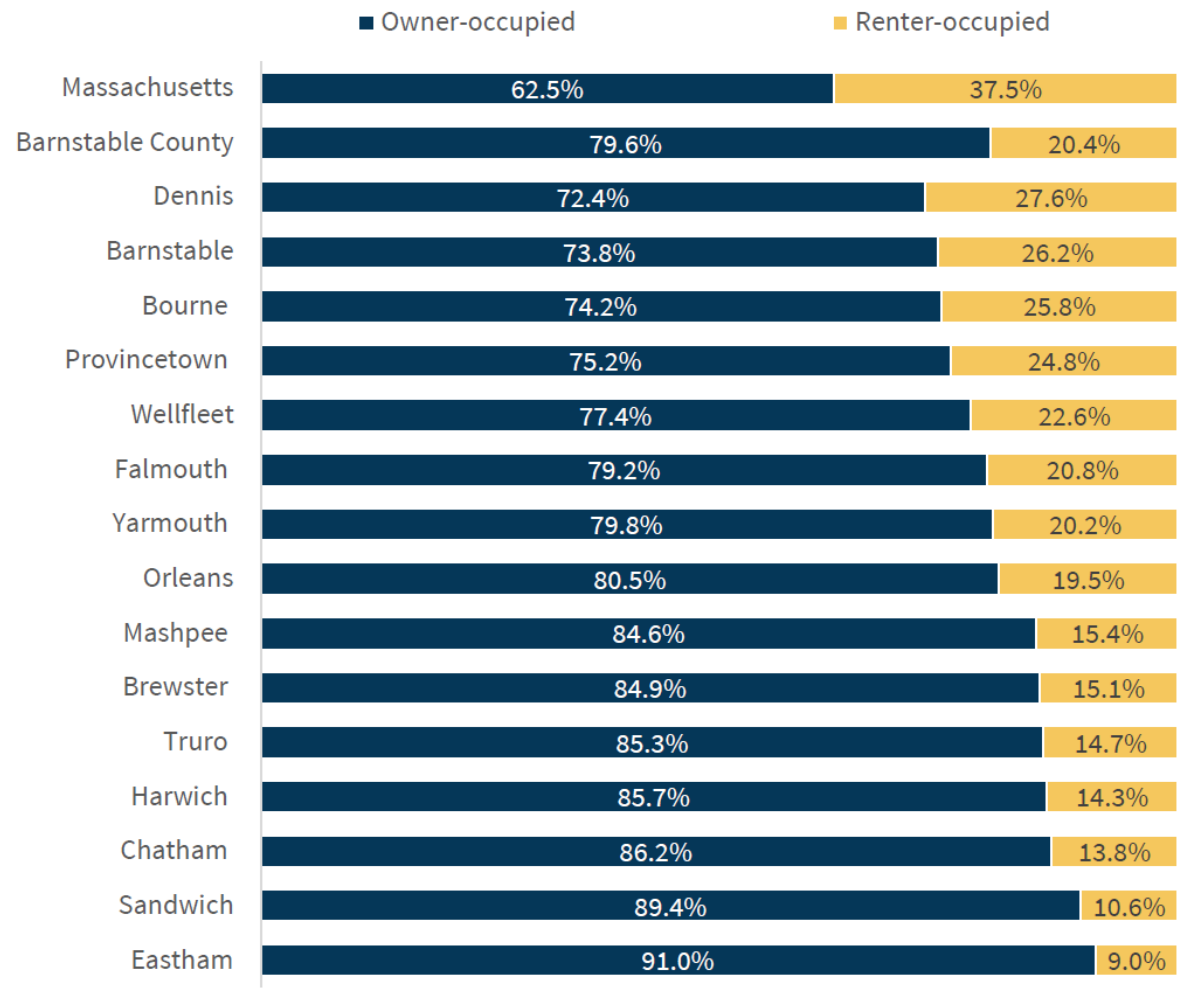
Safe and affordable housing is integral to the daily lives, health, and well-being of a community. Housing can play an important role in an individual's life as safe and affordable housing can reduce a range of negative health outcomes from asthma to poor mental health; housing location also influences an individual's health as easy access to transportation, medical care, good jobs, etc. may help reduce incidence of diseases, including mental health disorders.[9] Experiencing homelessness significantly impacts health behaviors and health outcomes, including increased risk of developing a substance use disorder.[10] It is important to note that some communities in particular, including communities of color and formerly incarcerated individuals, experience homelessness at a much higher rate than other populations.[11,12] An estimated 14.8 per 10,000 people on Cape Cod and the islands are homeless.[13]

> *"[The] housing that is available is very expensive, and there's not a lot of housing here in general. It's not cheap to be on the Cape; a lot of people are either on vacation or retired here. You have the "haves" and "have nots." Housing down here has always been a challenge."*

Many participants in this assessment discussed the lack of affordable housing in Barnstable County and its impact on substance use. Participants explained that there is a **critical need to develop more affordable, transitional, and low-barrier housing**. Participants shared that these **needs are particularly acute for people experiencing homelessness**, **people who are being released from jail**, **and people who are transitioning out of substance use treatment**. Participants explained that without transitional or low-barrier housing options, people may be reincarcerated or forced to live in unsafe conditions where other residents may be actively using substances, which poses major challenges to treatment and recovery. One participant commented that they could not "imagine going through treatment" while living in an unsafe or unstable environment.

Housing in Barnstable County and its municipalities is predominantly owner-occupied with less than a third across the geographies being renter-occupied housing (**Figure 7**).

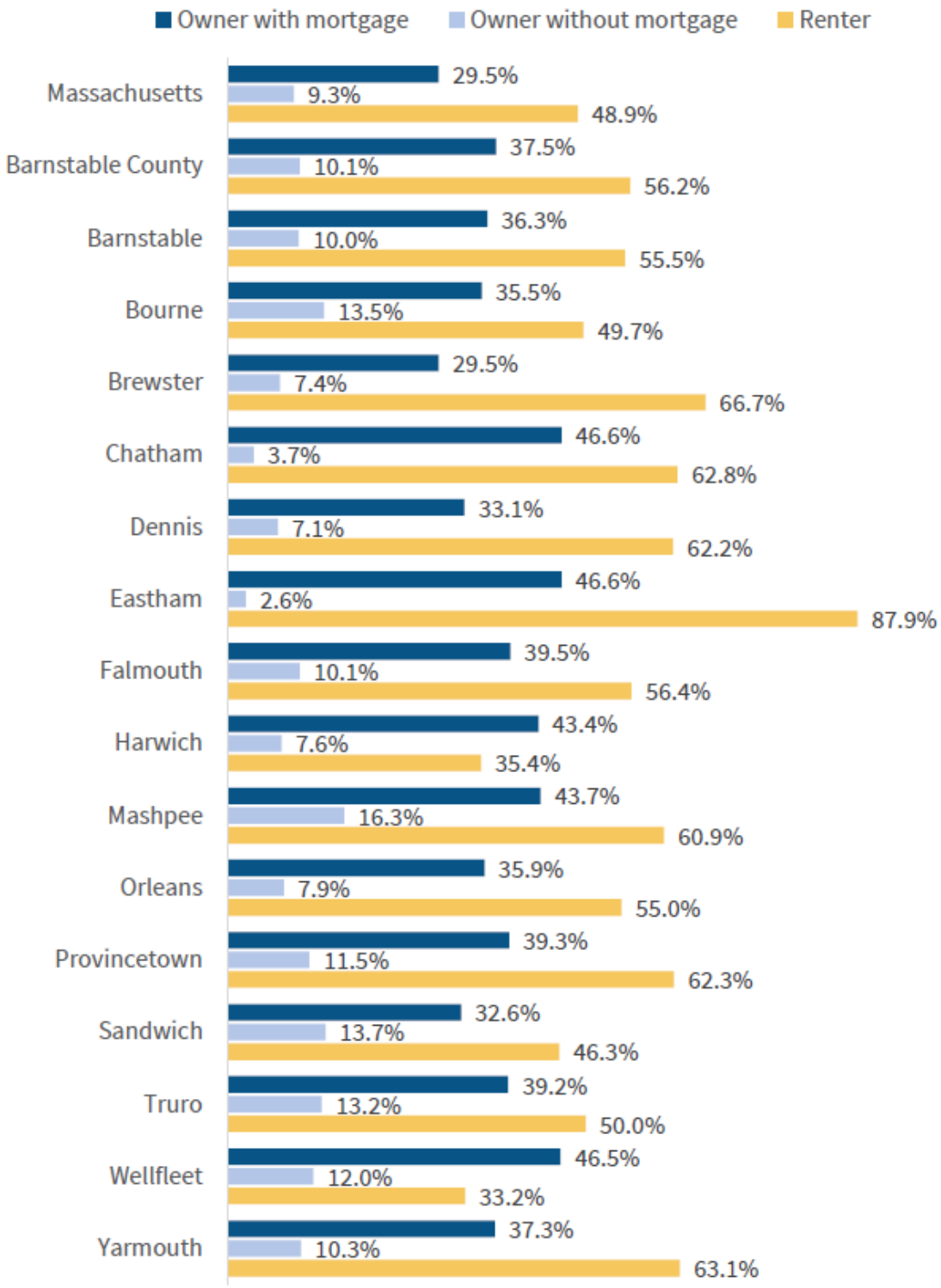
Figure 7. Home Occupancy by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

When considering the burden of housing costs on those living in Barnstable County, high percentages of renters have housing costs that are 30% or more of their household income (**Figure 8**). In almost all towns in the county, with the exception of Harwich and Wellfleet, just about half or more renters are considered housing cost burdened.

Figure 8. Percent Households Whose Housing Costs are 30% or More of Household Income, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Transportation

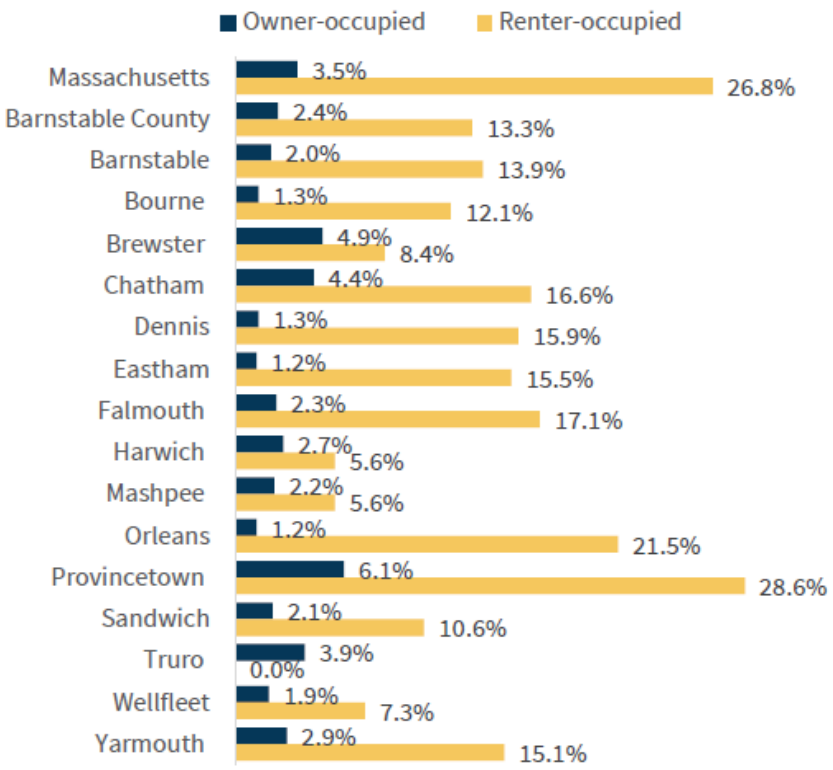
The built environment is designed for people to live, travel, learn, and work. Specifically, transportation is an important connector for communities, and an important part of shaping the infrastructure of communities. Transportation can be a promoter of health by enabling individuals, families, and communities to access resources and opportunities, including employment, health care, education, and other goods and services (e.g., grocery stores, parks).[14] Conversely, without access to cars, particularly in more rural or suburban areas like many places in Barnstable County, people experience limited access to necessities, health care, services, and jobs.[15]

> *"Transportation is huge, [it's] number one. [It] comes down to access [to] services. The Cape is funny—you [have] to travel long distances to get certain services that may be needed."*

Many participants described **transportation as a key barrier to accessing substance use-related programs and resources**. Participants noted that **lack of access to a vehicle** and an **inadequate public transport system** prevent people from accessing needed services. Limited transportation options present additional challenges for people who live farther away from existing services and for people in recovery who may be unable to obtain a driver's license.

In Barnstable County, only 1.5% of workers 16 years or older indicated they used public transportation to get to work. Further exacerbating the transportation barrier is lack of access to a vehicle. Very few owner-occupied households lack access to a vehicle; in most municipalities, 10% or more of renter- occupied households lack access to a vehicle (**Figure 9**).

Figure 9. Percent Households (Renter v. Owner-occupied) Without Access to a Vehicle, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Insurance coverage

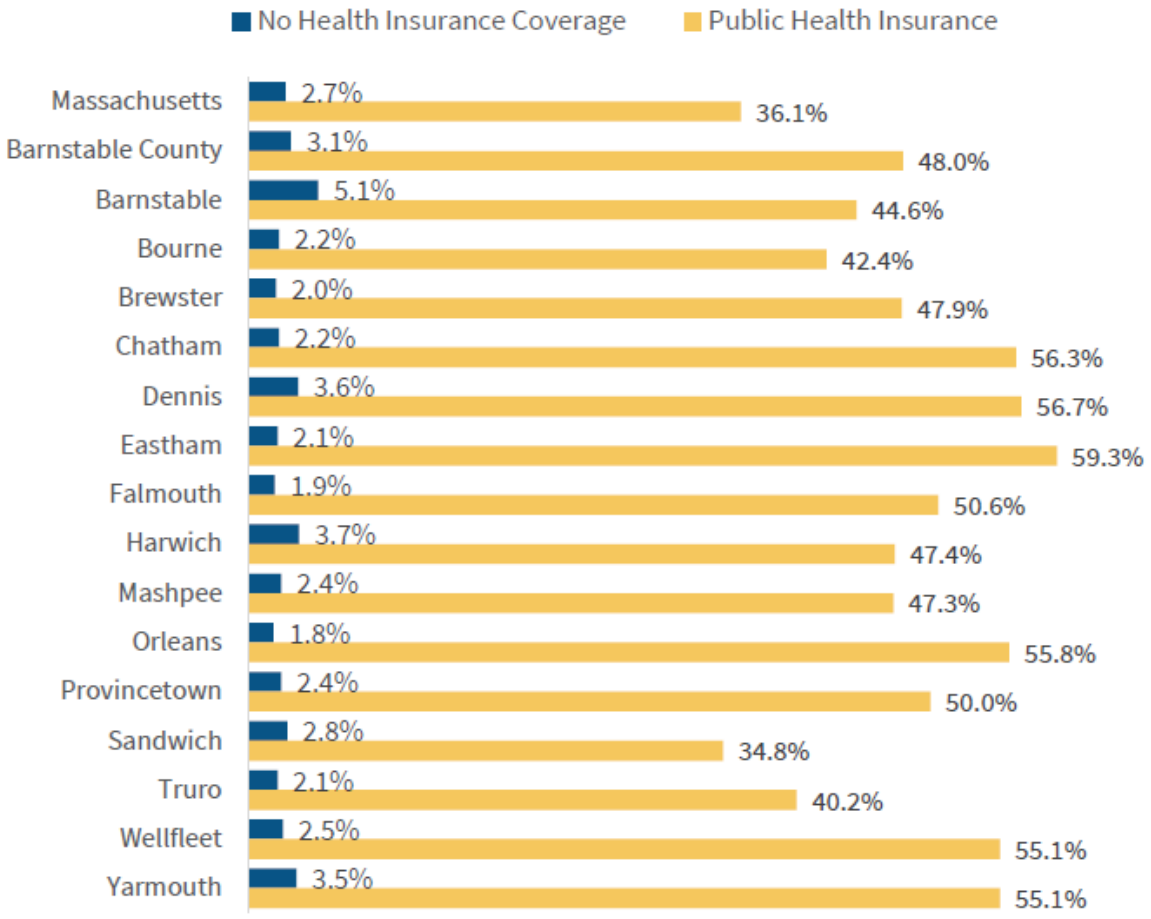
Having health insurance coverage is an important part of accessing comprehensive and quality health care services. Since 2007, prior to the federal level Patient Protection and Affordable Care Act, Massachusetts has required all adults to have medical insurance in 2007.[16] Due to these policies, a high percentage of residents of the state have health insurance. However, inequities exist and not all who need high quality health care are able to access it. Residents who face barriers to access are less likely to receive medical care, more likely to delay care, and less likely to use prevention services, resulting in poorer health status and outcomes.

> *"[If] you are a Medicaid client, your only option is to go to [the] short-term program. [That's the] primary problem. There once was very good treatment and it's gone. On the other hand, if you have [the] right insurance, you can get good long-term, well-fed, well-housed centers that are doing a good job."*

Many participants described **insurance coverage as a barrier to accessing needed substance use- related services**. Participants shared that **insurers are reducing covered benefits** (e.g., decreasing coverage for detoxification services from 30 days to two weeks) and that **some providers are limiting the number of MassHealth-covered patients** they will admit. Several participants explained that there is a **divide or "hierarchy" between people who have private insurance or can pay out of pocket compared to people who have MassHealth**. Participants noted that although a number of private treatment facilities offering longer-term stays have recently opened in Barnstable County, they do not accept MassHealth.

In Barnstable County, almost half (48%) of the population has public health insurance; a much smaller percentage (3.1%) are uninsured (**Figure 10**). These percentages are higher in comparison to Massachusetts overall. In many municipalities in the county, the percent with public insurance is more than half of their community.

Figure 10. Percent of Residents with No Health Insurance or Public Insurance, Barnstable County, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020 NOTE: Coverage may be alone or in combination with another insurance type

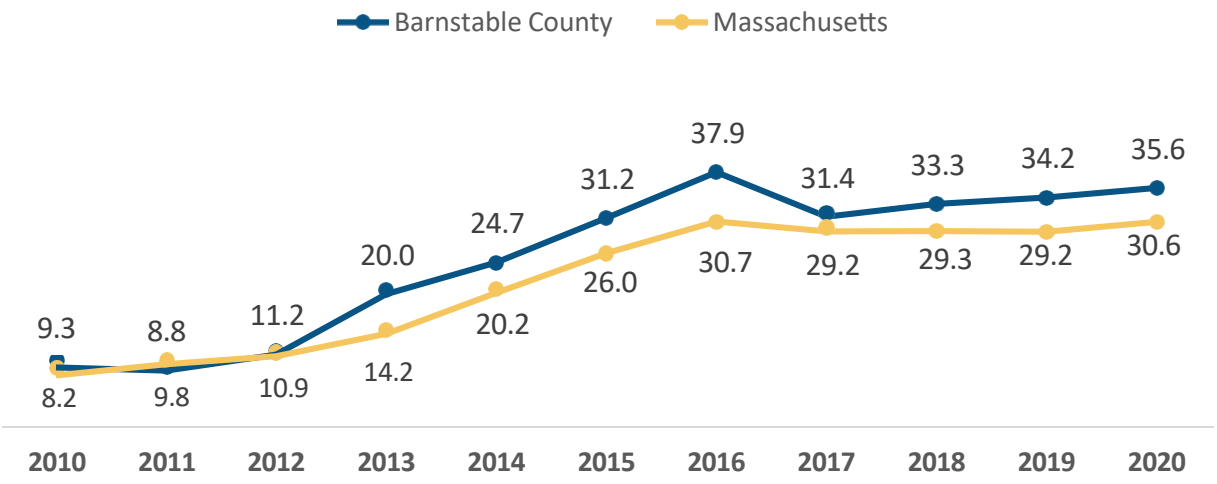
Prevalence and Perceptions of Substance Use in Barnstable County

To understand the scope of substance use in Barnstable County, the following section details prevalence data as well as the perceptions of substance use for both adults and youth.

Mortality&Morbidity

Figure 11 presents the estimated mortality rates related to substance use in Barnstable County from 2010 to 2020. The rate of overall drug-induced causes in 2020 was 35.6 per 100,000; higher than the rate in the state overall (30.6 per 100,000). The mortality rate has been trending upward since 2010, with a drop from 2016-2017, before continuing its upward trend.

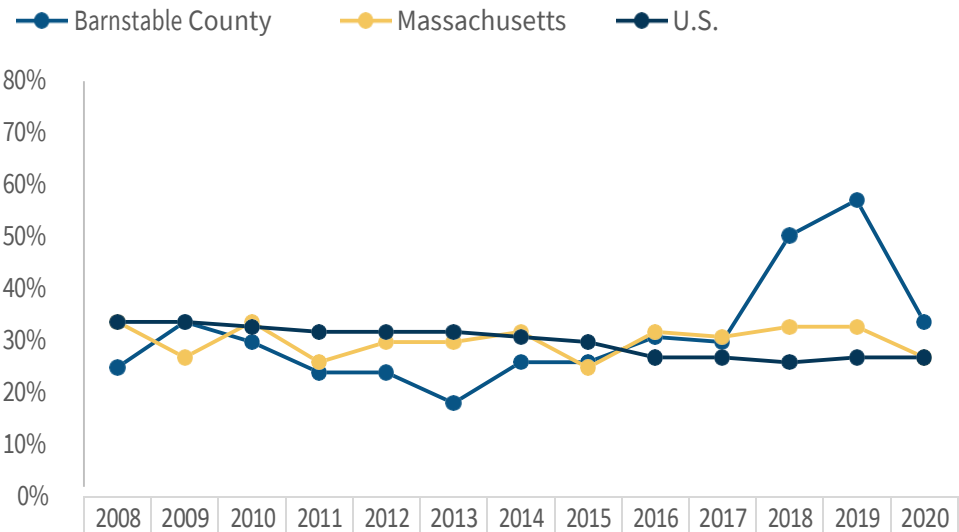
Figure 11. Estimated Opioid-Related Overdose Mortality Rate, 2010-2020



DATA SOURCE: Massachusetts Department of Public Health, Registry of Vital Records and Statistics, Current Opioid Statistics, current data as of November 2021 NOTE: Rates are crude rates; Calculated based on population estimates reported by US Census Bureau, American Community Survey 5-Year data sets (2011-2015 and 2016-2020)

Figure 12 presents the percentage of driving deaths that involved alcohol between 2008 and 2020. In recent years (since 2018), Barnstable County has had higher percentage of driving deaths with alcohol involvement compared to the state and nation; there was a noticeable drop in this percentage between 2019 and 2020 though still higher than Massachusetts and the U.S.

Figure 12. Alcohol-impaired Driving Deaths, by County, State, and Country, 2008-2020



	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Barnstable County	24%	33%	29%	23%	23%	17%	25%	25%	30%	29%	50%	57%	33%
Massachusetts	33%	26%	33%	25%	29%	29%	31%	24%	31%	30%	32%	32%	26%
U.S.	33%	33%	32%	31%	31%	31%	30%	29%	26%	26%	25%	26%	26%

DATA SOURCE: Fatality Analysis Reporting System, County Health Rankings, 2008-2020 NOTE: Alcohol-impaired driving deaths defined as percentage of driving deaths with alcohol involvement.

Table 2 presents the rates of substance use related cancers for Barnstable County, Massachusetts, and the U.S. Barnstable County had higher rates of all cancers (492.0 per 100,000) compared to the state and nation. Rates for specific cancers were higher than both the state and nation for breast, esophageal, and oral cavity and pharynx cancers. Rates were lower than both for liver and bile duct cancers. For colon and rectal cancers Barnstable County rate was higher than the state but lower than in the U.S. overall.

Table 2. Cancer Incidence, Age-Adjusted Rates per 100,000, 2015-2019

	Barnstable County	Massachusetts	U.S.
All Cancer Sites	492.0	454.8	449.4
Breast	154.4	137.6	128.1
Colon & Rectum	34.1	33.5	37.7
Esophagus	6.5	5.3	4.6
Liver & Bile Duct	7.6	8.6	8.6
Oral Cavity & Pharynx	13.7	11.7	12.0

DATA SOURCE: State Cancer Profiles, National Cancer Institute, 2015-2019 NOTE: Breast cancer rate includes females only

Table 3 shows the Massachusetts rates of new HIV diagnoses overall and in those who inject drugs. The diagnoses of HIV among those who inject drugs was 22.4% of all new diagnoses in the state.

Table 3. New HIV Diagnoses Overall and Among People Who Inject Drugs, Massachusetts, 2020

	n	Crude Rate per 100,000 Population
New HIV Diagnoses	437	6.4
New HIV Diagnoses Among People Who Inject Drugs	98	1.4

DATA SOURCE: Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences, HIV/AIDS Surveillance Program, 2020 NOTES: Data are as of 01/01/2022 and are subject to change; Rates are crude rates; Calculated based on population estimates reported by US Census Bureau, American Community Survey 5-Year data (2016-2020); People who inject drugs includes individuals with injection drug use (IDU) or male-to-male sex (MSM)/IDU as their primary exposure mode

The rate of confirmed and probable Hepatitis C cases was lower in Barnstable County than in the state (**Table 4**).

Table 4. Number and Rate of Confirmed and Probable Hepatitis C Cases, State and County, 2021

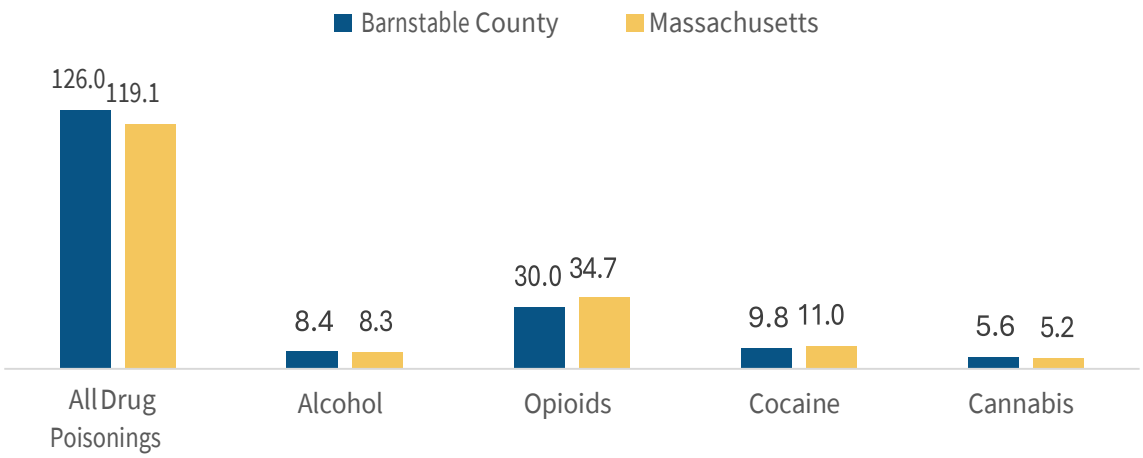
	n	Crude Rate per 100,000
Massachusetts	4,006	57.3
Barnstable County	96	42.1

DATA SOURCE: Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences (BIDLS), 2021 NOTE: Data are current as of 9/30/2022 and are subject to change; Rates are crude rates; Calculated based on population estimates reported by US Census Bureau, American Community Survey 5-Year data (2017-2021)

Hospitalization, Emergency Department Visits, and Treatment Admissions

Figure 13 presents the rate of inpatient hospitalization in Barnstable County and Massachusetts by substance. The rate in Barnstable County for all substances was higher than in the state (126.0 per 100,000).

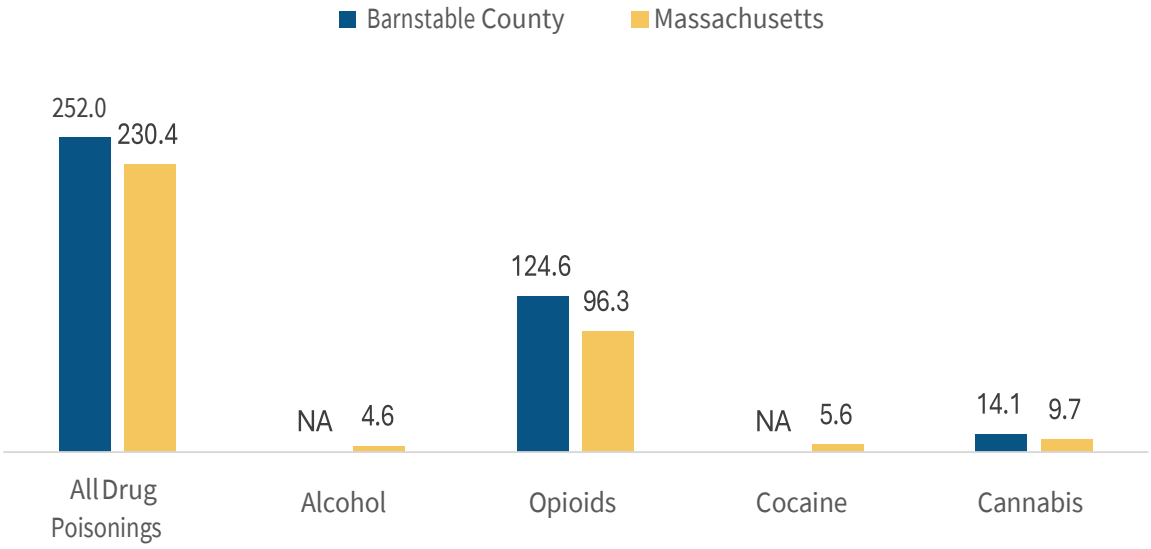
Figure 13. Inpatient Hospital Stays, by Type of Drug Poisoning, 2020



DATA SOURCE: Center for Health Information and Analysis, Massachusetts Inpatient Hospital Discharge Database and Outpatient Observation Stays Database, 2020 NOTE: Rates are crude rates – calculated based on population estimates reported by US Census Bureau, American Community Survey 5-Year data sets (2015-2019 and 2016-2020)

Figure 14 shows the rate of emergency department visits for Barnstable County and Massachusetts by substance. The rate in Barnstable County for all substances was higher than in the state (252.0 per 100,000).

Figure 14. Emergency Department Visits, by Type of Drug Poisoning, 2020

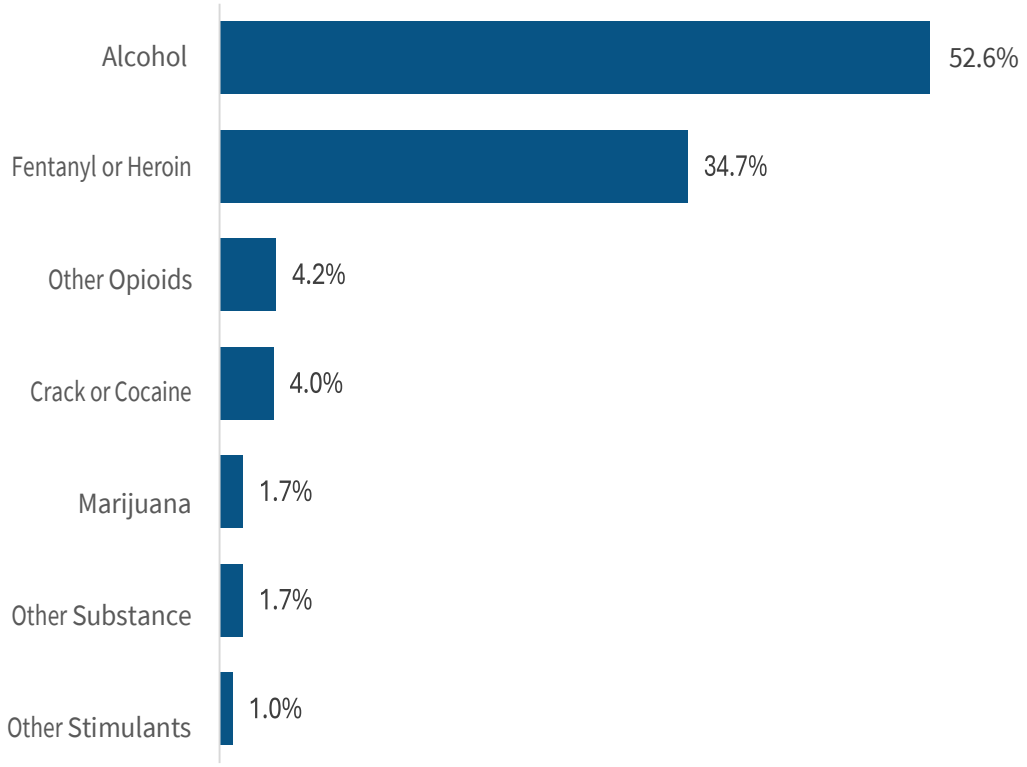


DATA SOURCE: Center for Health Information and Analysis, Massachusetts Outpatient Emergency Department Discharge Database, 2020 NOTE: Rates are crude rates – calculated based on population estimates reported by US Census Bureau,

American Community Survey 5-Year data sets (2015-2019 and 2016-2020); NA indicates that data were suppressed due to a count of fewer than 11 people

Figure 15 presents admissions data for Department of Public Health (DPH)-licensed facilities for Barnstable County. More than half (52.6%) of the admissions for those in Barnstable County were for alcohol and more than a third were for Fentanyl or Heroin (34.7%).

Figure 15. Treatment Admissions to DPH-licensed Substance Use Treatment Programs, by Primary Substance, Barnstable County, 2022

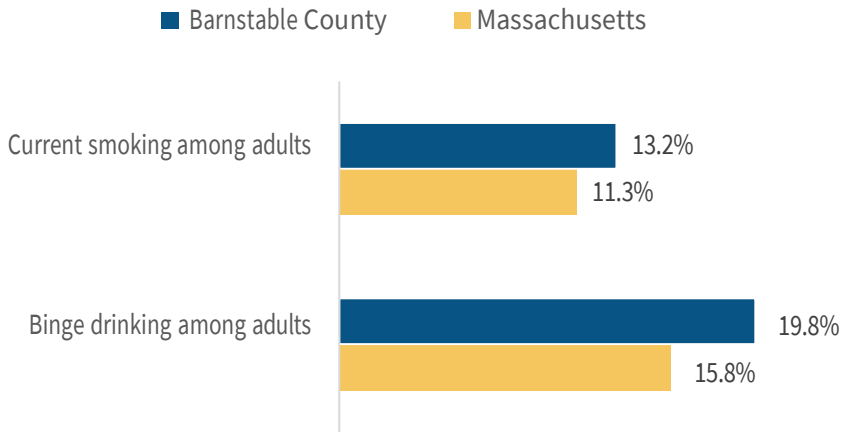


DATA SOURCE: MA Department of Public Health, Bureau of Substance Addiction Services, Office of Data Analytics and Decision Support, 2022

Adult Substance Use

Figure 16 presents substance use-related outcomes for adults in Barnstable County compared to the state. The county had a higher percentage of adults reporting binge drinking (19.8%) compared to Massachusetts; the percentage of adults who are current smokers in the county (13.2%) is also higher than the state.

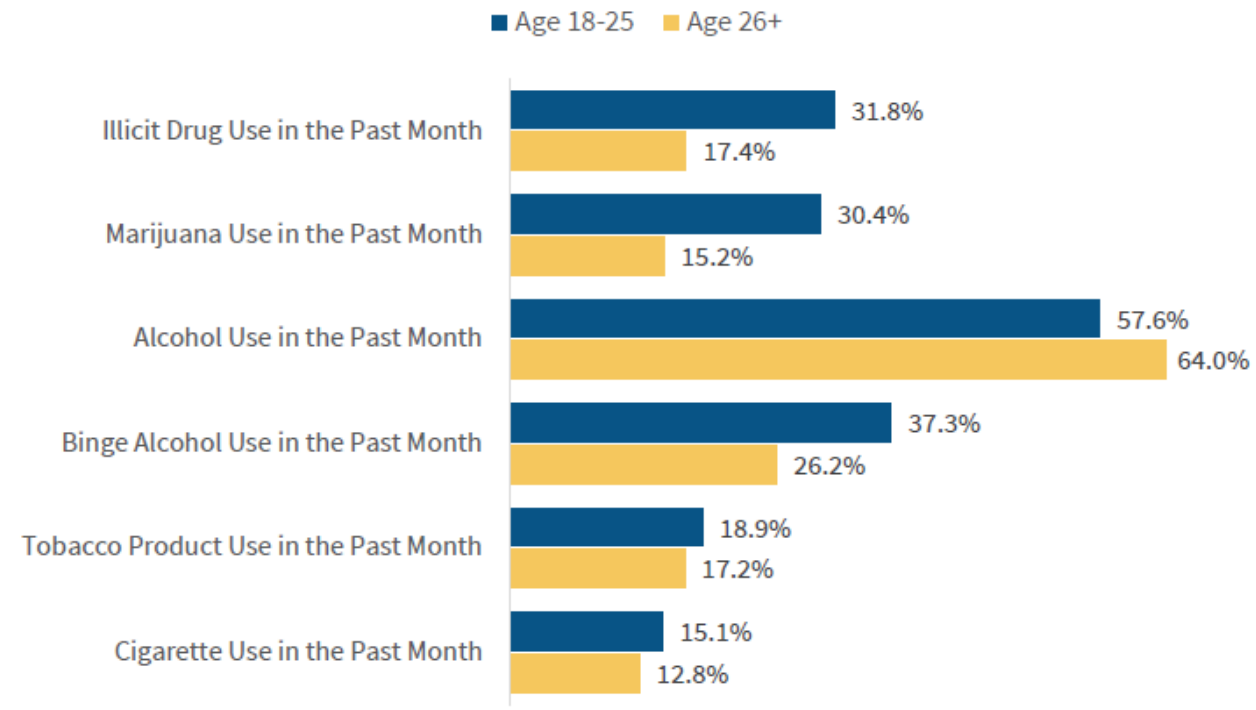
Figure 16. Binge Drinking and Current Smoking among Adults, Barnstable County and Massachusetts, 2020



DATA SOURCE: MA Department of Public Health, Behavioral Risk Factor Surveillance System, Profile of Health Among MA Adults, 2020 (MA estimates); Centers for Disease Control, PLACES Local Data for Better Health, 2020 (county estimate)

Recent data on past month use of different substances are not available at the county level. Below are data describing past month use among adults in the state of Massachusetts by age group (**Figure 17**). Higher percentages of adults 18-24 years old report illicit drug use (31.8%) in the past month compared to adults 25 years or older (17.4%). The percent of 18-24-year-olds reporting past month marijuana use (30.4%) is two times that of adults 25 years or older (15.2%) Adults 25 years or older report somewhat higher alcohol use in the past month; however, binge drinking is reported in a higher percent of the 18-24-year-olds. Lower percentages report cigarette and other tobacco product use in the past month, with slightly higher percentages of 18-24-year-olds reporting use.

Figure 17. Self-Reported Past Month Drug Use Among Adults, by Age Group, Massachusetts

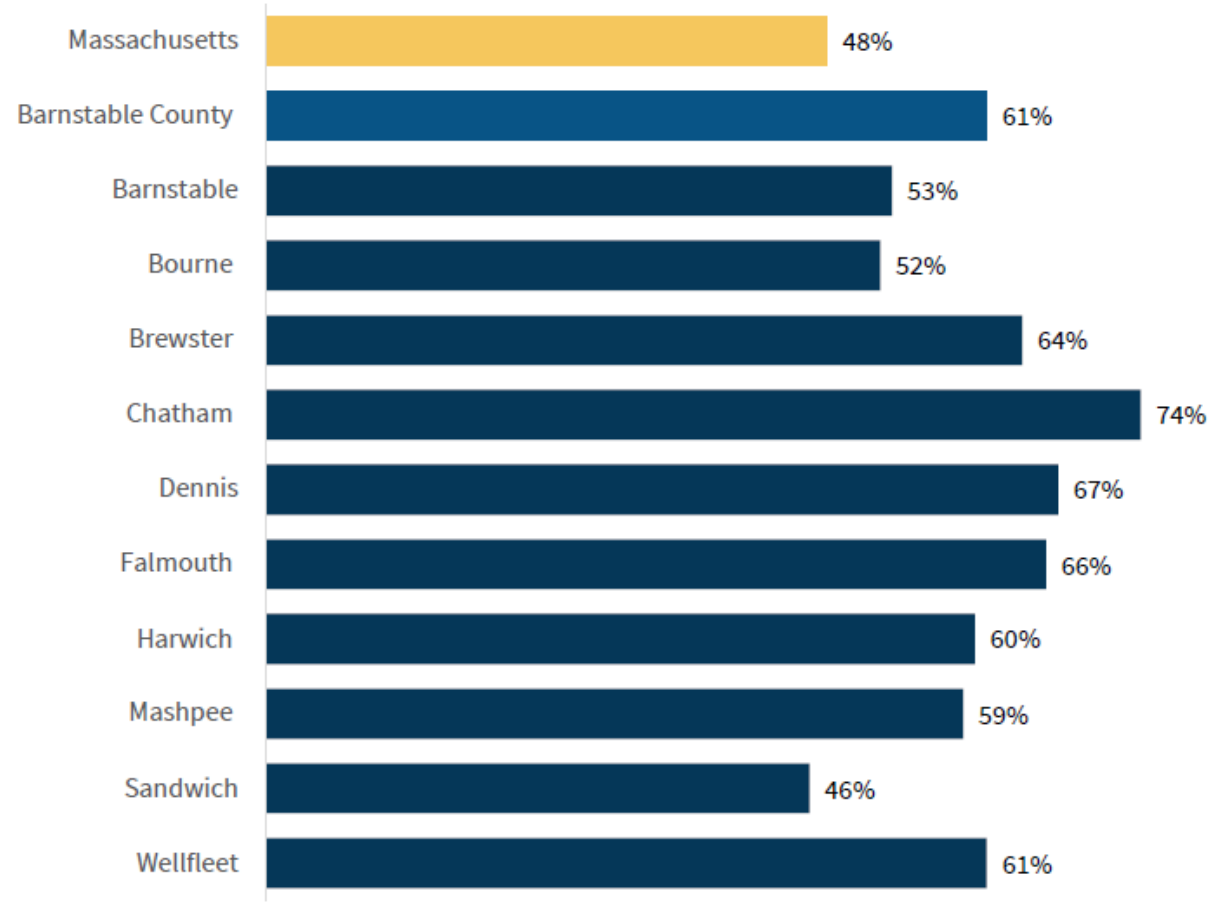


DATA SOURCE: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2018, 2019, and Quarters 1 and 4, 2020. NOTE: Illicit Drug Use includes the misuse of prescription psychotherapeutics or the use of marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine. Misuse of prescription psychotherapeutics is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs. State and census region estimates, along with the 95 percent Bayesian confidence (credible) intervals, are based on a survey-weighted hierarchical Bayes estimation approach and generated by Markov Chain Monte Carlo techniques. For the "Total U.S." row, design-based (direct) estimates and corresponding 95 percent confidence intervals are given.

In Fall of 2020, Massachusetts conducted the COVID-19 Community Impact Survey (CCIS)[17], a statewide survey of over 33,000 residents, to gather information on how communities had been affected by the pandemic. One area of data collection was around substance use in the pandemic. More than a third (35%) of Barnstable County adults reported their substance use had increased since before the pandemic began (data not shown).

Figure 18 and **Figure 19** show the self-reported substance use from the CCIS. Ranging from just about half (46%) up to almost three quarters (74%) of adults in Barnstable County towns reported using alcohol in the last month; the overall percentage in Barnstable County (61%) was greater than the state overall (48%).

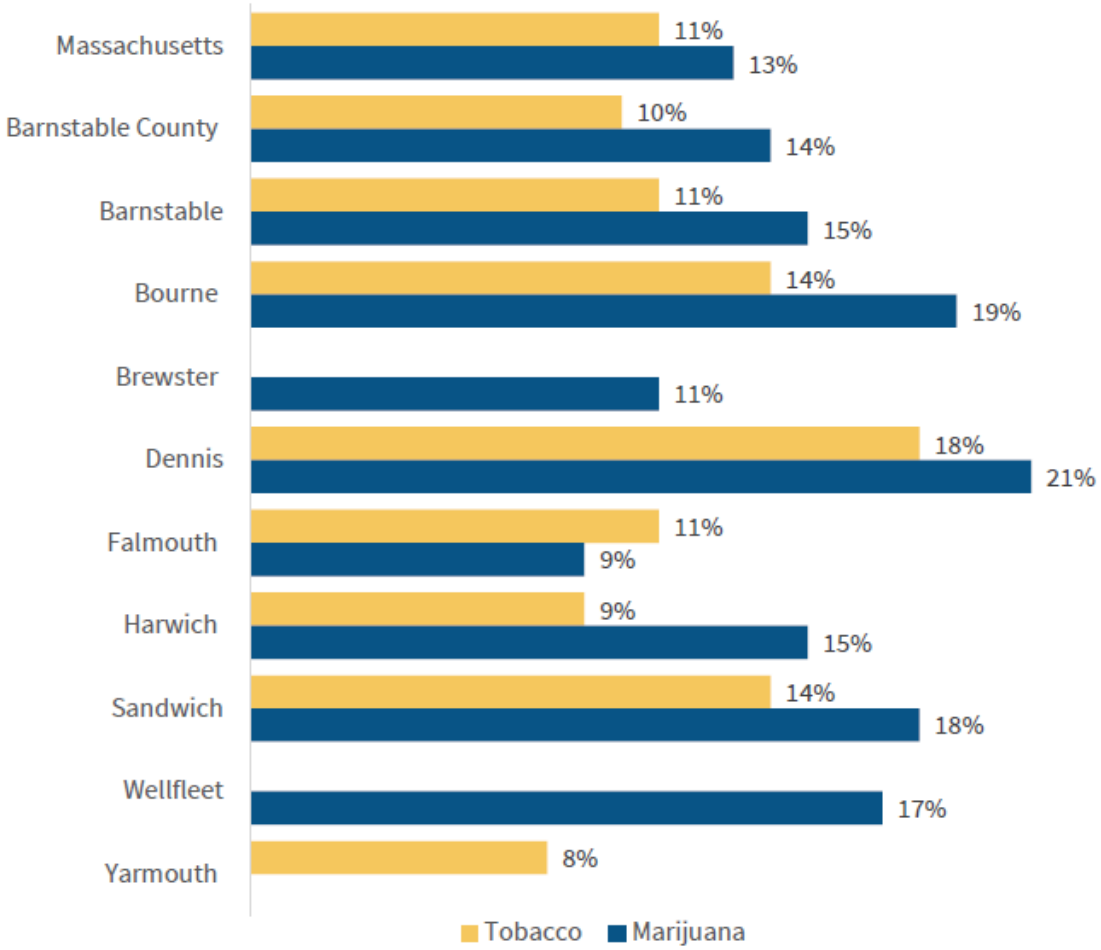
Figure 18. Percent of Adults 25 Years or Older Reporting Using Alcohol in the Past 30 Days, by State, County and Town, 2021



DATA SOURCE: Massachusetts COVID-19 Community Impact Survey, 2021 NOTE: Data for towns of Eastham, Orleans, Provincetown, Truro, and Yarmouth suppressed due to small cell sizes

The percentages using tobacco and marijuana in the past 30 days were lower with Barnstable County and the state having similar rates (**Figure 19**). Looking at these data by age group, a smaller percentage of those 65 years or older in Barnstable County reported marijuana (9%) and tobacco use (6%) than the percentage in the county overall. Data for other substances have not been publicly shared at the state, county, or town levels.

Figure 19. Percent of Adults 25 Years or Older Reporting Using Tobacco or Marijuana in the Past 30 Days, by State, County and Town, 2021



DATA SOURCE: Massachusetts COVID-19 Community Impact Survey, 2021 NOTE: Tobacco data for towns of Brewster, Chatham, Eastham, Mashpee, Orleans, Provincetown, and Truro suppressed due to small cell sizes; Marijuana data for towns of Chatham, Eastham, Mashpee, Orleans, Provincetown, Truro, and Yarmouth suppressed due to small cell sizes

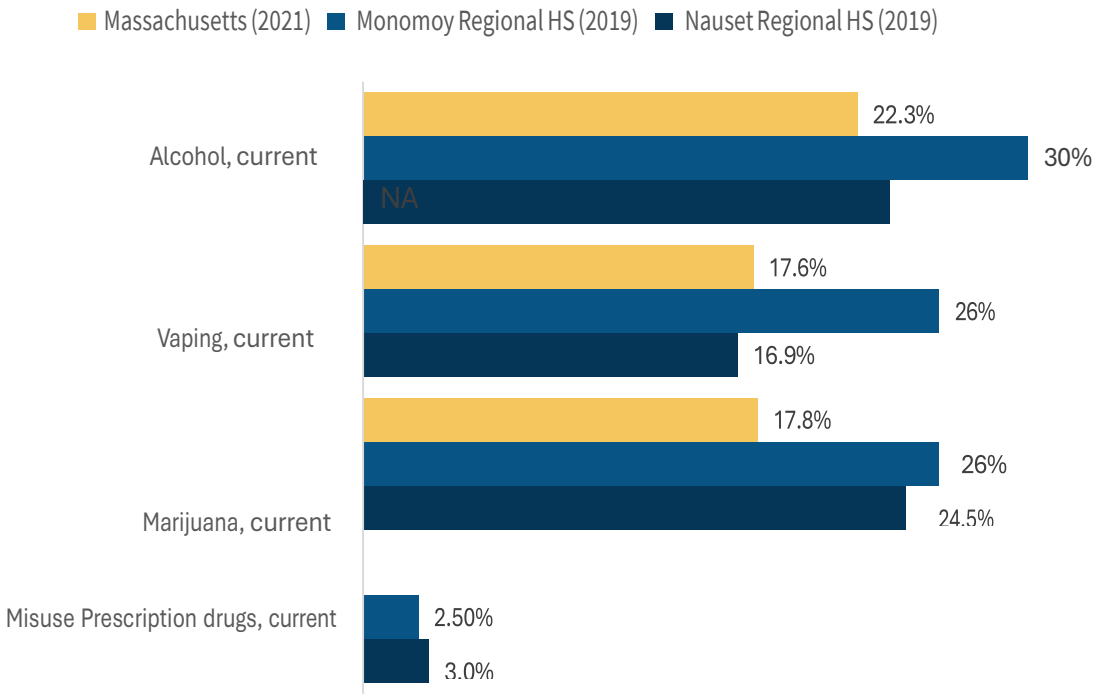
YouthSubstance Use

Figure 20 shows the self-reported current substance use among high school students in Massachusetts and from two Barnstable County high schools, Monomoy and Nauset. As only two schools' data are reported, it is important to note these data do not represent the full county

population and should not be interpreted as such. Rather, these data describe the self-report experiences and behaviors of a subset of the youth population in the county.

Compared to the state, a higher percentage of high school students in these Barnstable County schools report current alcohol use, marijuana use, and vaping. A small percent reported current prescription drug misuse; however, these data were not available at the state level for comparison.

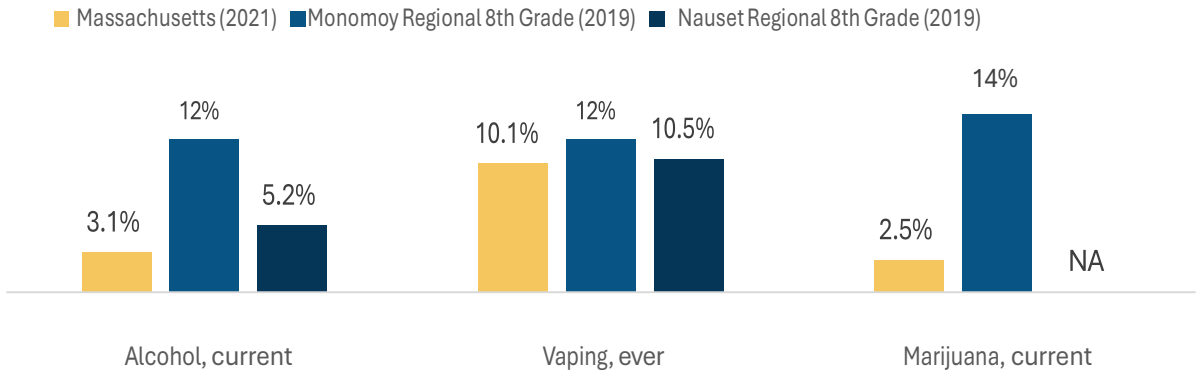
Figure 20.Self-Reported Current Substance Use Among High School Students, 2019



DATA SOURCE: Massachusetts Youth Health Survey 2021; Monomoy Regional High School, Youth Risk Behavior Survey, 2019; Nauset Regional High School, Youth Health Survey, 2019

Middle school students (8th grade) in these Barnstable County schools were also asked about their current substance use (**Figure 21**). A higher percent of the 8th graders reported current alcohol use compared to the state. For vaping, the percentages were only slightly higher in these Barnstable County schools than in Massachusetts. Only one school asked its 8th graders about current marijuana use; that percent was much higher than in the state (14% compared to 2.5%).

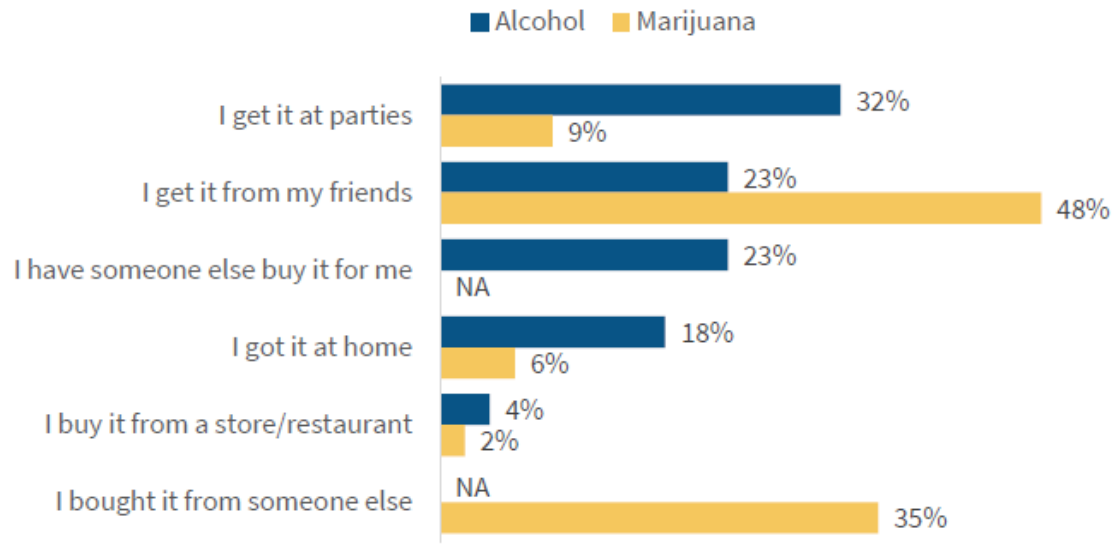
Figure 21. Self-Reported Current Substance Use Among 8th Grade Students, 2019 and 2021



DATA SOURCE: Massachusetts Youth Health Survey 2021; Monomoy Regional Middle School, Youth Risk Behavior Survey, 2019; Nauset Regional Middle School, Youth Health Survey, 2019

One school's survey of students asked for self-reported sources of different substances. **Figure 22** presents the sources indicated by high school students for alcohol and marijuana. For alcohol, the most frequently reported sources were getting it at parties (32%), getting it from friends (23%), and having someone else buy it (23%). For marijuana, almost half (48%) get it from their friends and more than a third (35%) get it from someone else.

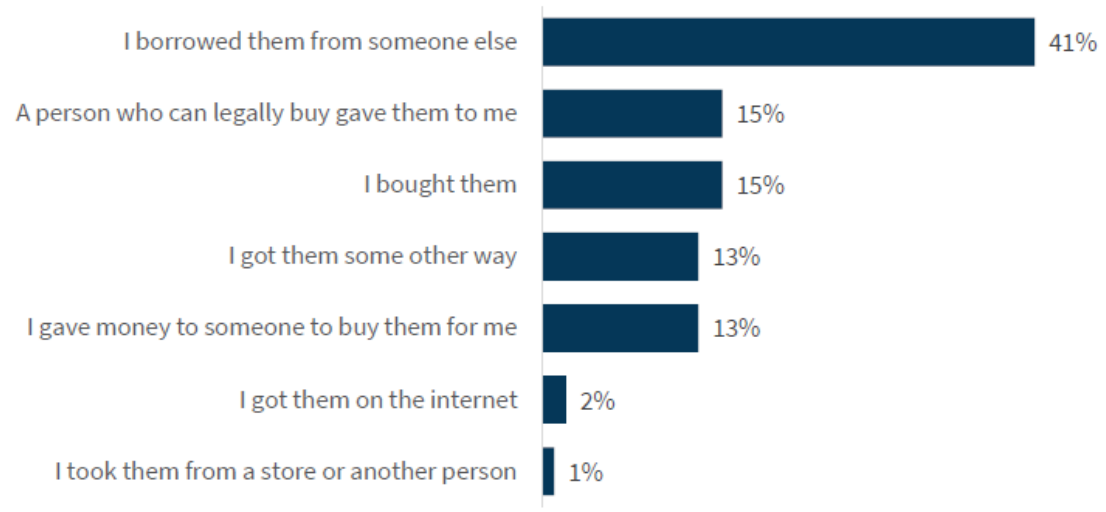
Figure 22. Self-Reported Source of Substance for High School Students, Monomoy High School, 2019



DATA SOURCE: Monomoy Youth Risk Behavior Survey, 2019

Figure 23 presents the self-reported sources for vaping products. Most high school students reported borrowing vaping products form someone else (41%).

Figure 23. Self-Reported Source of Vaping Products for High School Students, Monomoy High School, 2019

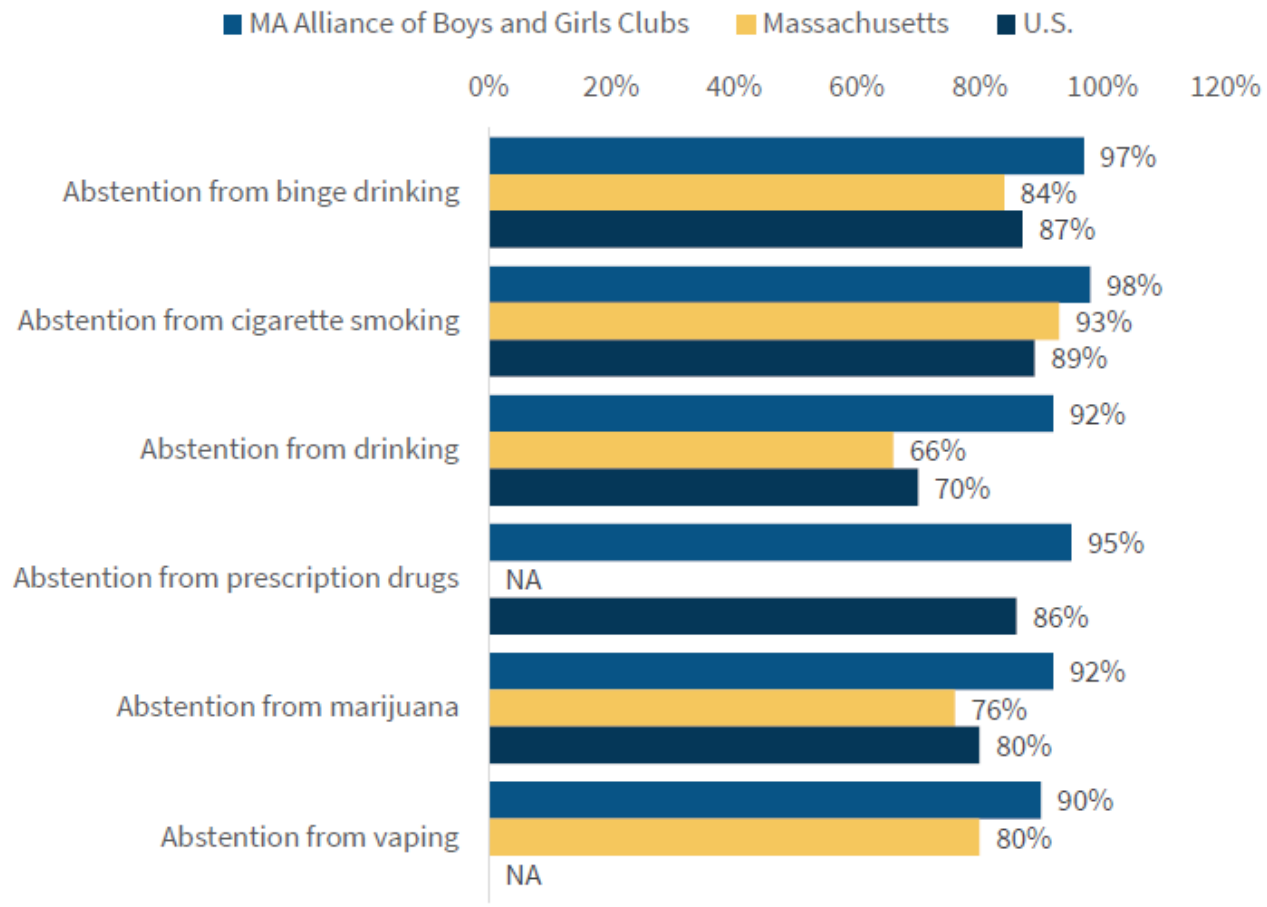


DATA SOURCE: Monomoy Youth Risk Behavior Survey, 2019

The MA Alliance of Boys and Girls Clubs conducted a survey of 40 of its clubs to gather self-reported data on abstention from substances. The Boys & Girls Club of Cape Cod plays an important role in the providing young people in Barnstable County with a safe space to spend their time. It is important to note, these data represent responses from clubs across the state of MA and therefore may not be representative of the experience of those engaged with the club in Barnstable County.

As they are a prevention focused organization, these data are presented as members abstaining from substance use (**Figure 24**). Higher percentages of young people involved with a Boys and Girls Club in Massachusetts reported abstention from all substances compared to the state overall and the nation.

Figure 24. Self-Reported Abstention from Substance Use, MA Alliance of Boys and Girls Clubs, Massachusetts, and the U.S., 2019



DATA SOURCE: MA Alliance of Boys and Girls Clubs and CDC Youth Risk Behavior Survey, 2019

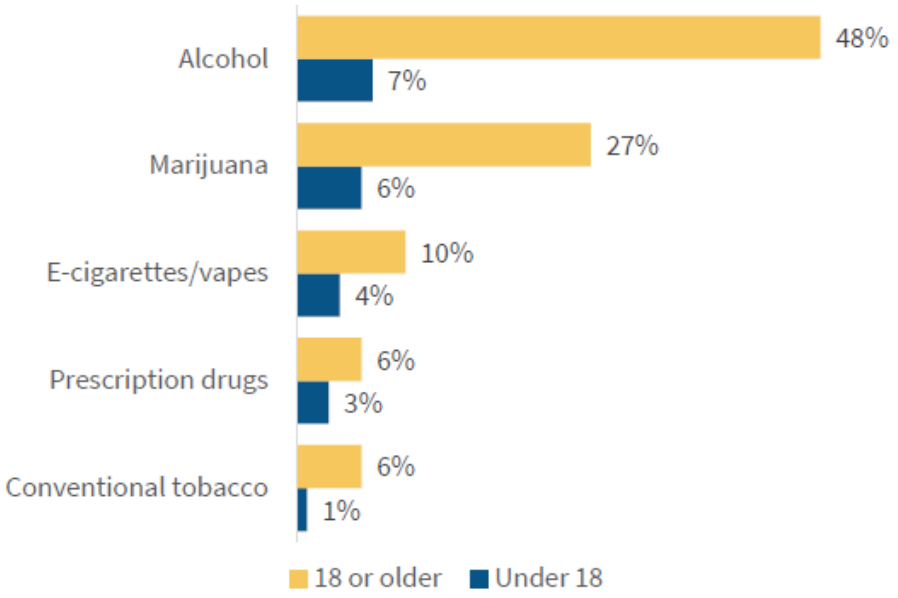
The COVID Community Impact Survey (CCIS) also reported data on youth and young adults (those less than 25 years of age); however, the sample size of respondents from Barnstable County was not sufficient and cannot be reported. **Figure 25** shows the percent of young people in Massachusetts who reported increased substance use since before the pandemic started. More than a third of those under 18 (44%) and those 18-24 (39%) reported increased use across the state.

Figure 25. Percent of Youth Aged 14-24 Reporting Increased Use Since Before the Pandemic, by Age Group, by State, 2021

DATA SOURCE: Massachusetts COVID-19 Community Impact Survey, 2021

Figure 26 presents CCIS data on the types of substances used by youth in the past 30 days in Massachusetts. Less than 10% of those under 18 reported using any of the listed substances in the past 30 days. Use was higher among those over 18, with almost half (48%) reporting alcohol use and more than a quarter (27%) reporting marijuana use.

Figure 26. Types of Substances Used in the Past 30 Days by Youth Aged 14-24, by Age Group, by State, 2021



DATA SOURCE: Massachusetts COVID-19 Community Impact Survey, 2021

Perceptions of Substance Use

In addition to examining the prevalence of substance use and its related issues, it is also critical to understand the perspectives of those in the community regarding substance use.

When participants asked about the most pressing substance use concerns in their community, many participants discussed opioids, including prescription opioids, heroin, and fentanyl. Participants described the prevalence of opioid overdose and the frequency with which they administer Narcan. Several participants also commented that "drugs today" are "different" and "stronger." One participant commented on the prevalence of fentanyl sharing that *"People think they are just using one more time and it's not. I can't tell you how many people I've known [that] have died. It's scary."* Other substances mentioned by a smaller number of participants included alcohol, Adderall, marijuana, MDMA, GHB, benzodiazepines, and xylazine.

When asked to describe perceptions of substance use in their community, many participants reported **widespread stigma against people who use substances**. Participants shared that people who use substances are "looked down on" and that many community members continue to view substance use disorder as a personal choice, rather than a treatable disease. Participants also reported that stigma comes from many sources, including the health care system, the criminal legal system, and from within the substance use community itself. Participants shared that many communities, particularly wealthier ones, **deny that substance use is an issue in their community**, despite

evidence to the contrary. One participant explained that because Barnstable County is a tourist destination, there is a "look to maintain." Many participants **reported significant pushback and Not In My Back Yard "NIMBYism" from communities** who do not want substance use resources or services sited in their communities. Ultimately, the combination of stigma, denial, and "NIMBYism":

- Results in the discrimination and mistreatment of people who use substances
- Limits the availability of evidence-based services (e.g., methadone, syringe exchange, Narcan)
- Prevents people from accessing needed services (e.g., people do not want others to know that they are seeking support for substance use)

Overall, participants **described Barnstable County as a collaborative place** where communities are "invested in the people that live there" and "want things to get better." A few participants also reported that **general awareness of substance use has increased**. As one participant shared:

> *"I feel that we have grown very much on Cape Cod. It's talked about, I don't feel strange bringing it up to people, it's more of a fluid conversation. I can say I'm a person in recovery. It's not a big shock to anyone and I wouldn't have done that years ago."*

Participants also reported that **more progress has been made in some communities than others**. A few participants shared that initially contentious conversations with community members (e.g., regarding the offering of syringe exchange services) became opportunities for education and growth. Still, some communities have remained resistant, which has contributed to **geographic inequities in the availability of services and supports**. One participant shared that "each community has its own personality" while another commented that there are some "towns that feel more supportive" than others. As a result, people have varying degrees of success accessing treatment, harm reduction, or recovery services, particularly in the absence of public transportation.

Finally, participants discussed the importance of recognizing that **substance use is often rooted in experiences of trauma and co-occurring mental health issues**. Participants emphasized the importance of addressing underlying trauma and using trauma-informed practices to break the "constant cycle." A few participants commented on the need for early education and intervention to address childhood trauma before substance use becomes the primary coping tool.

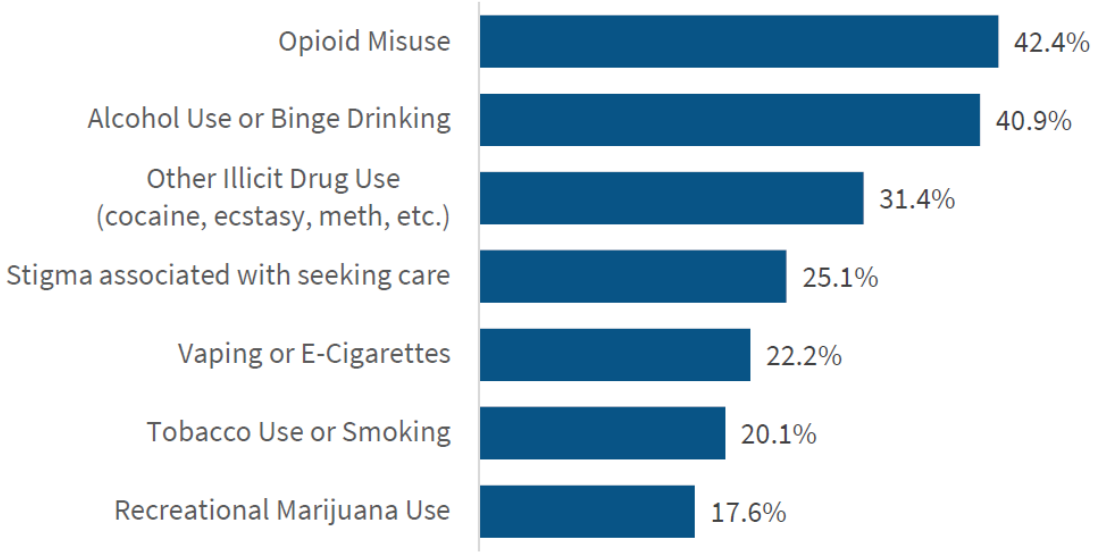
Youth

Participants also shared their perceptions specific to youth substance use in their communities. Notably, many participants commented that **substance use is starting at younger ages**. A couple of participants reported seeing substance use beginning as early as the 6th grade and emphasized the need for school-based education and services. Several participants also discussed the importance of **recognizing the impacts of intergenerational substance use**. Participants commented on the frequency with which grandparents are raising their grandchildren due to parental substance use and the need to address that this *"causes all kinds of things down the road."* Participants perceived **tobacco and nicotine, marijuana, and alcohol to be the most used substances among youth**.

Participants shared that young people use e-cigarettes to consume both nicotine and marijuana. A couple of youth participants commented that while vaping nicotine is more common in middle school, marijuana and alcohol use are more common in high school. A couple of participants expressed that the legalization of marijuana resulted in *"kids [not] see[ing] it as a drug"* and believing that *"it's just not a big deal."* One participant shared that the state missed an opportunity to educate youth regarding the potential negative effects of youth marijuana use.

Results from the 2022 Cape Cod Health Care Community Needs Assessment survey conducted in Barnstable County collected data on the levels of concern community members had about various substances (**Figure 27**). The largest percentages of survey respondents had high concern about opioid misuse (42.4%) and alcohol use or binge drinking (40.9%).

Figure 27. Percent of Community Survey Respondents Reporting "High Concern" for Community, by Substance Use Issue, 2022



DATA SOURCE: CCHC Community Health Survey, 2022 NOTES: Percentages were based on sample size of n=964

FINDINGS

The following sections describe themes discussed by community members and stakeholders around services to address substance use in Barnstable County in each of the four domains – prevention, harm reduction, treatment, and recovery. To present a full picture of the landscape of services, these results highlight successful existing programs, describe challenges with and barriers to accessing these services, and identify opportunities for implementing new and expanded services. Cost data are provided for each domain to serve as an estimate of how much current services cost to provide. While these sections are organized by domain, it is important to recognize these should not be viewed as separate in practice. Similarities and connections across these domains are highlighted to further inform the action plan in including multifaceted efforts to address cross-cutting needs in the community.

The resource inventory section describes different types of resources and services available in the county identified through this assessment; as this is not an exhaustive list, the intent is for the county to use and update this tool on an ongoing basis.

The final section of these findings delves deeper into the cost data presented in each domain, including describing the differences in costs reported by domain and substance as well as highlighting

the cost saving potential of investing more in the domains of prevention, harm reduction, and recovery alongside treatment services.

Prevention

Prevention of substance use is often thought of as an issue of adolescence and one focused primarily on encouraging abstinence and/or highlighting the risks of substance use to teenagers.
However, a large and still growing body of research shows that experiences in early childhood[5] have an impact on later behavioral health. In discussions, service provider participants discussed the connection of early childhood, mental health, and adolescent substance use. For example, one provider noted the importance of reaching children early on:

> *"By the time we get to adolescence [and] high school, we see [young people] again in different areas: detox, court related. To me, I think if we could just put as much effort into our little ones [0-5-year-olds], we'd see a level of foundation our kids could have where mental health is prioritized."*

Prevention is also a cross-cutting aspect to substance use work. It is a primary service aimed at early intervention around substance use and it also is integrated into the other domains – e.g., recovery services for adults providing resources for their children as a form of prevention.

Prevention Programs

B Free Wellness

Boys & Girls Club

Calmer Choice

Cape Cod Children's Place

Herren Project

Positive Alternative to School Suspension (PASS)

Sharing Kindness

Youth Villages
(Intercept and LifeSet)

Existing Programs and Services

Overall, participants shared that **there are very few substance use prevention programs and services available**, including resources for youth who may have just started experimenting with or using substances. While more services are needed, participants highlighted many successful youth- and prevention-focused programs including the Boys & Girls Club, Calmer Choice, Cape Cod Children's Place (including FIRST Steps Together), Herren Project's prevention services, Positive Alternative to School Suspension (PASS), Sharing Kindness, and Youth Villages' Intercept and LifeSet programs.
While these were discussed in multiple conversations, other services and programs exist in the county such as the YMCA, other school-based prevention programs through the sheriff's department, Gosnold (Cape Cod Lighthouse Charter, Cape Cod Tech, Falmouth, Mashpee, Provincetown, Truro), and Outer Cape Health Services (Nauset), as well as other individual school or town programming. Please note this is not an exhaustive list of the prevention programming and services available.

When asked to describe existing resources, participants most frequently discussed the Barnstable County school system. Many participants described schools as an important venue for substance use prevention education and programming, but reported numerous barriers, including teacher and counselor burn out and insufficient pay; lack of dedicated time in the curriculum for

[5] Defined as birth through age 8. https://www.aap.org/en/patient-care/early-childhood/

prevention education; and rules and regulations regarding what can be discussed in the school setting. As one participant shared:

> *"We are so bound by so many rules and regulations about what we can talk about. There is always an opt out. [It is] usually families that have [the] most issues with substance use that opt out… We can get our day in school, [but] we can't get through materials, or we won't be allowed to talk about it."*

Further, several participants explained that conventional prevention programming and messaging (e.g., D.A.R.E. (Drug Abuse Resistance Education), "just say no") does not work. One youth participant shared their perspective on this type of prevention:

> *"We had to do a semester of health where they did a week of substance use. That doesn't do much. In [students'] minds doing drugs is cool; that's how they get in certain crowds. When they weigh benefits and negatives, being part of [a] friend group wins. Health class is just another class to us. We're not going to look back and say health [class] taught me this. It's going to be something more important."*

Several participants described connecting young people to individuals with lived experience as a more effective prevention strategy. One youth participant compared two different approaches to discussing substance use prevention:

> *"When we have a guidance counselor do [a] lecture, people listen less. But we did have someone who went through rehab and had [an] incredibly different life; a lot of people [were] saying they really liked it. [It] struck a chord. Hearing it from someone who went through it and struggled through [the] ramifications works a lot better."*

Several participants, including young people, shared that **parts of Barnstable County are very isolated and that there are limited activities for youth to participate in**, particularly during the off- season for tourism. Participants highlighted the importance of providing young people with "places to belong" where there is a "caring adult they can talk to" and "peers they can commiserate with." There is research to support the positive impact of community and connection, overall and as it relates directly to preventing substance use.[18] Participants highlighted several of these resources that already exist including the Boys & Girls Club of Cape Cod, non-profit organizations like the Herren Project, school clubs, and substance-free athletics. Several participants described the Boys & Girls Club of Cape Cod as a particularly important resource because it provides youth with positive role models in a safe and fun space to spend time.

Barriers to Access

The most frequently described barrier to accessing existing prevention resources, including mental health services, was **a lack of awareness about what resources exist and how to navigate them**. As one participant summarized:

> *"People shouldn't have to seek out these services – it should just come to them."*

Participants suggested increasing communication efforts (e.g., school flyers, RSAC emails) to raise awareness of available resources. There were also calls for an easy-to-use centralized repository of resources available across Barnstable County. One participant commented:

> *"[Awareness] is a big barrier, like, I didn't even know [other services] were there. [Cape Cod] Children's Place created [a] finder and there is something you can plug in… I found it a little bit cumbersome to find where that is. If you make this hard, how do you expect people to find it."*

Another participant described the need for navigators who can support people in accessing needed resources:

> *"In one of our meetings, I think [name] was talking about navigators. I don't know what that position is, but I think that is someone who has good hold on all resources. [With all the services we provide and work we do for families,] there is no time to navigate system. It's easier to say I'll try again tomorrow or forget it."*

Other barriers discussed related to **accessing existing services were transportation**, **lack of services in languages other than English**, and **geographic inequities or "gaps" in available services across communities**. For example, the Boys & Girls Club is an important resource but was noted as not as accessible for those on the lower or outer Cape. Describing the need for culturally and linguistically appropriate services, one participant explained:

> *"There are big [Brazilian and Jamaican] communities here. We haven't figured out how to connect so they can get full access."*

Needed Programs and Services

Participants described three primary prevention-related needs: 1) **developing more robust mental health resources, supports, and interventions**; 2) **starting prevention education, programs, and services at much younger ages**; and 3) **facilitating more open and frank conversations with young people about substance abuse**.

Many participants discussed the need for more robust mental health resources, supports, and interventions for young people and their families, including the need for greater recognition of the links between substance use and mental health. In particular, participants described the importance of teaching young people coping skills, emotional regulation, and resiliency so that they have the tools to manage the challenges they will inevitably encounter as they get older. Participants also discussed the need to cultivate these tools among parents, families, and other adults (e.g., teachers) who play a major role in young people's lives. Participants mentioned several existing resources that provide all or some of these supports, including Calmer Choice and Sharing Kindness. Two other programs, B Free and the Cape Cod Children's Place FIRST Steps Together program, which provide services focused on recovery were noted to have an important role in prevention work.

Participants also discussed specific gaps in mental health and substance use prevention resources for youth who have parents and other family members who are using substances. As one participant shared:

"I work in middle school, but also with high school counselors. There is next to nothing in terms of support for kids who have family members that may be using or on the verge of using. There isn't much of anything. I get calls from school counselors saying, "Do you know any 12 step programs for teenagers?" I don't think it's seen as comprehensively as a youth problem as it needs to be."

Many participants discussed the need to start providing prevention education, programs, and resources, including mental health services, at much younger ages. Participants discussed misperceptions regarding the age at which it is appropriate to start having conversations about substance use and expressed that it is sometimes "too late" once the programming begins. As one participant shared:

"So, to say that 15–16-year-olds don't need to learn about this is incorrect. I think the more we talk about this stuff, [the] less stigma and anxiety. If it's more commonly taught and referred to, it's easier for people to understand what is happening… Ideally, as young as you get, they need to be talking about this stuff."

Several participants discussed the importance of having open and frank conversations with young people about substance use. Participants expressed that open conversations can help reduce stigma surrounding substance use and provide young people with the opportunity to ask the questions that are on their mind. As one participant explained:

"I have frank conversations with kids. 'What made you decide to vape and what made it attractive… Did you know when you tried it that it would be so addictive and dangerous? And did you know it would be hard to quit?' And they said they didn't… nobody had talked to them."

Cost of Substance Use Prevention

To quantify the programs and efforts described above, local programs provided estimates of the costs associated with implementing their prevention programs, including youth focused prevention activities, prevention programs focusing on healthy coping, stress management, and mindfulness, and school suspension diversion.

Table 5 presents the overall estimated cost of prevention. It is estimated that nearly $1.2 million is spent on substance use prevention activities in Barnstable County. The provided estimated costs are about evenly distributed between youth focused prevention activities (51.3%) and school suspension diversion programs (48.7%). Costs for diversion of youth involved with the court system were requested but not received. These costs, alongside the cost of the other domains, are further discussed in a later section of this report; see Appendix C for full details of these estimates.

Table 5. Estimated Costs of Prevention Activities

	TOTAL	% OF TOTAL
Prevention		
Youth-focused prevention activities & engagement	$ 610,438.00	51.3%
School suspension diversion programs	$ 579,000.00	48.7%
PREVENTION TOTAL	$ 1,189,438.00	

Harm Reduction

Harm Reduction Programs

Access HOPE

AIDS Support Group of Cape Cod

Duffy Health Center

Health Imperatives

One Shared Spirit

Yarmouth Comprehensive

Overall, **participants described harm reduction[6] services as critical, life-saving resources** – including methadone[7], Narcan/naloxone, syringe exchange, fentanyl test strips, and supervised consumption. One assessment participant described the importance, and responsiveness, of these services:

"I can literally call or text [name] and say, 'so and so needs this, and make sure you bring Narcan… make sure you don't just bring a couple, bring enough to give out and say here's a couple Narcan or stuff to clean syringes.' It's huge and it saves lives. It saved mine."

Another participant noted these services are not only accessed by those who are at highest risk, but also those around higher risk individuals:

"Narcan has gotten out into the community and a lot of people we see in the office might not be high risk all the time, but they know people who have struggled with this and just want to have Narcan in case – that's been positive."

One participant reflected on the ways in which harm reduction services may reduce overall substance use:

"I think one thing that works is [that] when someone is more careful when they use [and] have [a] clean area, they use less. Slip a little love in… don't use as much."

These benefits of harm reduction have garnered new and growing attention in the field of substance use services. They are recognized as a critical part of addressing those with SUD on its own as well as in coordination with the work in other domains.[19]

Existing Programs and Resources

When asked to share existing harm reduction programs and services, assessment participants most frequently discussed the Narcan and syringe services provided by AIDS Support Group of Cape Cod. Other services mentioned included the harm reduction services provided at Duffy Health Center, Yarmouth Comprehensive Treatment Center, One Shared Spirit, Access HOPE, and newer services offered by Health Imperatives. As one participant shared:

[6] SAMHSA defines harm reduction as "an approach that emphasizes engaging directly with people who use drugs to prevent overdose and infectious disease transmission, improve the physical, mental, and social wellbeing of those served, and offer low-threshold options for accessing substance use disorder treatment and other health care services." https://www.samhsa.gov/find-help/harm-reduction

[7] While methadone is a method of treatment for opioid use disorder interviewees frequently discussed it in relation harm reduction services, emphasizing the overlap of the services provided across these domains.

"AIDS support group is awesome. [It's] all harm reduction. You can go in [and] they can help you navigate treatment systems. You can call them and be like 'Can I [get] 10?' and they can drop off."

Several participants shared that providing harm reduction services also offers an **opportunity to connect with people**, **provide them with support**, and **link them to other needed services**, including Hepatitis C treatment. As one participant shared:

"When you deliver, [you] can give way more [than] Narcan; just make [a] connection so they know they have someone to talk to. [It's a] huge opportunity for all kinds of other services."

Participants also characterized harm reduction services and providers as **non-judgmental, affirming, and respectful**. One participant shared their thoughts based on their lived experience:

"Those [harm reduction] are the first people that talked to me like I was human, they didn't shame or guilt me. They looked me in the eye and showed up even though I didn't want to… Those were the first people that interacted with me like I mattered. People walk by and judge and shame you, you're already struggling internally. These harm reduction programs provide safety, they kept me alive."

Barriers to Accessing Existing Services

While a number of barriers were mentioned, discussions around barriers to harm reduction services primarily focused on stigma.

Stigma

Many participants noted that **significant stigma makes it extremely difficult to access the few resources that do exist**. One participant with lived experience explained how the stigma around harm reduction can prevent people from accessing life-saving services:

"The stigma around methadone was terrible and it would scare you away from trying to get on it, but it was all bullshit and I wish I hadn't heard it because it took me too long to try it."

Another participant shared:

"There's still a lot of people [who] don't support [methadone]. I've always presented it as an option, a choice. It's so nice for people to feel like they have a choice. When you have a choice, you feel like there's hope."

Participants also described experiencing stigma, discrimination, and poor treatment when seeking harm reduction services **from many sources, including police officers, ambulance services, and even people within the substance use community**. A couple participants with lived experience shared the following thoughts:

"When you want to get clean syringes, the pharmacist looks at you like you're a scumbag and follows you around the store. I'm just trying to be healthy… I was spending like a $120 a week or something getting syringes because none of these pharmacies were selling them to me."

"[We've] got these councils that have 'substance use' in their name and [they] look at you with more stigma than someone at the grocery store."

Another participant with lived experience recommended training police officers on how to compassionately interact with people who are using substances, experiencing mental health issues, and/or experiencing homelessness:

> *"The county needs to have a class for the police on how to handle the homeless, drug addicts, alcoholics with mental issues, and not just yell at them and tell them to leave. There needs to be more communication and understanding. I've had cops come up to me at like 3 in the night and tell me you gotta move, and it's like, where do you want me to go? They need to treat people like humans."*

Participants also described how **stigma makes it challenging to discuss harm reduction with young people**, despite its importance. Several participants discussed the need for harm reduction education in schools, even for youth who are not using substances. As one participant shared:

> *"A few years ago, if you bought Adderall, it was Adderall. But now, if you buy it, chances are there is fentanyl. [The] education system tends to be cautious about messaging because these are other people's children. Most people have contradicting views… harm reduction becomes [a] necessary part of prevention. Educating them more on what harm reduction looks like with underage substance use."*

Other Barriers

Participants described several other barriers to accessing and benefiting from harm reduction services, including the **need for low-barrier housing that does not require abstinence**; the **need for more providers of color**; the **provision of services in other languages**; and **transportation**. One participant explained the critical need for low-barrier housing:

> *"The other thing that comes up… is low-threshold housing [for] folks with substance use disorder… If folks have the means and desire to get into sober homes, [they] can access that treatment. If you are actively using or sliding into one of those categories, [there is] no place to hang your hat. Low threshold housing within [the] harm reduction model – that in itself is treatment. Create safety and be available to continue their health and wellness."*

Participants also described the need for more culturally responsive services, including more providers of color and services in other languages.

> *"Right now, [we have] four people on [our] team, two people of color and two white. [It's] super important to bring people to [the] table and [we] can't focus on just white people… men of color [have the] highest rate of deaths."*

Needed Programs and Services

Overall, participants shared that there is a **critical need for more harm reduction services, particularly methadone clinics** and other providers who offer medications for opioid use disorder (MOUD), as well as Narcan distribution, drug checking, syringe exchange, safe consumption sites, and related services like Hepatitis C treatment. As one participant shared:

"If we are looking to target overdose deaths, anything having to do with expanding MOUD, ideally in [Federally Qualified Health Centers], and harm reduction—those are the two areas [that are needed]."

Another participant explained how the stigma discussed above has prevented new harm reduction services from opening:

"They won't allow a methadone clinic here, the closest is 45 minutes away… they were supposed to open [one] a year and a half ago and the town shut it down saying there were too many 'drug addicts' here."

Participants also emphasized the **need to ensure that services are low barrier and as easy to access as possible**. Participants discussed the need for more outreach, service provision, and "boots on the ground" in areas where people who are using substances live and/or use, including homeless camps and public restrooms. One participant shared:

"We go out and deliver [Narcan, fentanyl test kits, and clean/safety syringe kits] no questions asked. I know hangouts and they are all ages, so I just drive to the site [and see if] anyone needs Narcan and clean needles. It's just amazing."

Relatedly, participants described the **importance of maintaining a low profile and protecting the confidentiality of people who are accessing harm reduction services**, in part because of the significant stigma that exists in the larger community. As one participant explained:

"Supervised injection doesn't need to be a huge brick and mortar – no one is going to travel to [a] harm reduction center to use. [We need to] figure out how to have individualized supervision and monitoring of people using drugs and mobile outreach where it's inconspicuous."

Cost of Substance Use Harm Reduction

To understand the costs associated with providing harm reduction services, this assessment collected data related to programming to collect and dispose of excess prescription drugs and syringes/needles as well as outreach activities for resources and harm reduction from local municipal departments and the Cape Cod Cooperative Extension (CCCE) in Barnstable County. Additional costs of providing harm reduction services such as syringe exchange and naloxone distribution were shared by two organizations: AIDS Support Group and ACCESS Hope and a local EMS.

Table 6 presents the overall estimated cost of harm reduction. It is estimated that more than $600,000 is spent on substance use harm reduction activities in Barnstable County. Over one third (38.5%) of the provided estimated costs have gone to naloxone distribution and about a quarter was associated with community outreach in collaboration with PD (27.7%) and needle exchanges (25.0%). These costs, alongside the cost of the other domains, are further discussed in a later section of this report; see Appendix C for full details of these estimates.

Table 6. Estimated Costs of Harm Reduction Activities

	TOTAL	% OF TOTAL
Harm Reduction		
Programming that manages community-based collection and disposal of excess prescription drugs.	$ 3,256.18	0.5%
Programming to manage appropriate community-based syringe and needle disposal.	$ 52,701.84	8.3%
Programming to manage community-based syringe and needle exchange.	$ 158,994.60	25.0%
Programming providing education and naloxone to prevent death from opioid overdose.	$ 245,310.50	38.5%
Collaborative outreach to community, particularly higher risk populations, between behavioral health professionals and law enforcement to provide resources aimed at harm reduction and prevention	$ 176,471.85	27.7%
HARM REDUCTION TOTAL	$ 636,734.97	

Treatment

Treatment Programs

Community Health Center of Cape Cod

Duffy Health Center

Gosnold Behavioral Health

Outer Cape Health Services

Yarmouth Comprehensive Treatment Center

Substance use treatment is a pivotal point in an individual addressing their SUD, and it is vital that the resources be available and accessible for those who are seeking these services. There are multiple entry points to treatment, including through harm reduction services, recovery services in the case of recurrence of SUD, and many in between. The offered programs need to take all potential pathways into consideration.

Existing Programs and Services

Participants discussed a number of existing treatment-related programs and services. Participants spoke particularly highly of the services provided by Duffy Health Center, including its use of an integrated model, incorporation of harm reduction resources, and the Moms Do Care program. Other resources discussed included Gosnold Behavioral Health; Community Health Center of Cape Cod; Yarmouth Comprehensive Treatment Center; Outer Cape Health Services; and mobile clinics (e.g., the previous CHART (Community Harm Reduction and Treatment) team partnership between Duffy Health Center, the Community Health Center of Cape Cod, and the AIDS Support Group of Cape Cod).

Several participants shared that there are private treatment facilities opening in Barnstable County but expressed concerns about access for people who cannot afford to pay for services.

> *"[There are] private facilities who are sprouting up and only taking private insurance and actually pulling some shady business to draw patients into treatment programs and selling the world to individuals. [I'm] hopeful that [their] hearts are in the right place. There is at least one to two in Falmouth, Mashpee, and Bourne areas."*

Barriers to Accessing Existing Services

Participants described a number of barriers to accessing and benefiting from existing treatment resources. The most frequently reported barriers included **lack of transportation; lack of affordable and low-barrier housing while in treatment;** and **challenges navigating insurance coverage**. As one participant shared:

> *"There needs to be some type of transportation when someone is trying to get treatment. I've gotten beds before, but I can't even get there. So maybe some type of program where if you're trying to get a bed, say it's in Fall River or New Bedford, it would probably be huge. Then it's not a huge fight trying to get in - it's already a huge fight with yourself."*

Related to transportation, participants discussed the "huge commitment" required to obtain MOUD from treatment centers on a daily basis and the need to work on "loosening restrictions."

Participants also described the challenges involved in providing treatment to unhoused and unsheltered individuals:

> *"[It's] very hard to treat people not housed [who] are very transient. [The] continuity of care is really challenging."*

Another participant discussed how a lack of affordable housing compelled a client who is in treatment to live in an environment where other people are still actively using substances:

> *"Housing that is available is very expensive, and there's not a lot of housing here in general. It's not cheap to be on the Cape; a lot of people are either on vacation or retired here. You have the haves and have nots. Housing down here has always been a challenge. I can think of a client off the top of my head who's living in a house where they're all using crack, but she has nowhere else to go."*

Participants reported lack of awareness regarding what resources exist and how to navigate them as another barrier to accessing treatment. As one participant expressed:

> *"If people would know… you know, there is help out there instead of putting a needle in your arm. I'm seeing people walk into the clinic just a mess. And within months they're going in the right direction."*

Another participant described the need to compile resources in one place:

> *"[We need] resources in one place. Let's streamline it so parents, loved ones, and addicts can navigate [the] system. Let's think about streamlining resources. Another big thing is navigating insurance companies."*

NeededProgramsandServices

Many participants reported that there are **not enough beds or treatment facilities available**. Participants also shared that there are **not enough long-term treatment options or methadone clinics** and other MOUD treatment options (described in further detail in the harm reduction section above). One participant explained the effect these gaps can have on individuals who are seeking treatment:

> *"Even though [in] our programs we really work hard for same day initiation of treatment, there aren't a lot of opportunities for folks struggling with active use if they walked into [somewhere] using right now at this moment and wanted treatment to start. [We] need a bridge, [an] easy access clinic. Someone should walk in and be able to find options [and be] referred to whoever is the right choice… Even though we desire hospitals to be that linkage if that is where they are at… hopefully they would not get to that level. Can we figure out a way that they don't need to get into [the] hospital system?"*

Another participant echoed the need for more beds, particularly for people who do not have private insurance:

> *"A big thing is getting beds in detox. The sober living is not enough; it seems like if you don't have a private insurance, there's not enough sober houses. [There are] not enough houses and beds and [there are] people with MassHealth coming straight out of holding. I turn down gentlemen every day—at least five people—because there's no beds out here. If you don't have private insurance, it's tough out here."*

Participants also reported that there are **not enough treatment options tailored to the needs of specific populations**, including young people; women with young children; and people who are exiting jail. One participant explained the lack of options for youth under 18, including the need for services that are not provided virtually:

> *"[There are] substance use programs at [the] Outer Cape but not for those under 18. And just because you're 18 you're not an adult. That transitional period, there is absolutely nothing on [the] Outer Cape; [there's] more as you get to [the] Mashpee Falmouth area. I know [Cape Cod Healthcare] is getting ready to launch another [partial hospitalization program] [but it's] still more virtual based. Substance use disorder is already isolating – I find it counterproductive to stick them in their bedroom and have them log onto Zoom for five hours a day."*

Another participant also described the need to address isolation when designing treatment services for youth:

> *"If an adult comes in and they have substance use disorder, I would connect [them] with [a] recovery coach, meet with harm reduction, and refer them to Alcoholics Anonymous. Everyone knows peer models work. We don't have that freedom with teens. So, it's hard due to confidentiality and you want to protect the student. It's isolating for them to think they are the onlyones."*

Several participants described the closure of Emerson House's program for women and children as a major loss:

> *"[I'd] rather see treatment be less money driven and more driven by needs. What happened to Emerson is just a tragedy. [It was] just an amazing program and [it] worked for so many women."*

Many participants also spoke of the **need for more dual diagnosis treatment services** as well as a broader **need to acknowledge and address the intersections between substance use and mental health**. As one participant explained:

> *"Those two things [mental health and substance use] overlap very often. [I'm] not sure [if] it's [the] chicken or egg – just those two things coexisting [is] difficult. [It's] hard to admit that you are dealing with one or both of those things. Add that onto the lack of sober homes and long- term treatment facilities. [There's] not enough of dual diagnosis. When seeing people [in] treatment in Emerson House, that is what people are experiencing. They feel like the only way to feel better is to use drugs and alcohol. It works sometimes but it tends to just make things much worse. [We need to] have the proper dual diagnosis with people."*

Another participant described the consequences of inadequate substance use and mental health services, particularly for young people:

> *"[The] biggest piece is [the] tie between substance use and mental health and access to services for those kids. People [are] talking about we gotta go to McLean or Children's. [There are] just no beds for kids and there never had been. Kids [are] locked up in [a] detention unit [when] they needed a bed. Lock up isn't the place for them. A judge looking at someone saying I have no bed,*

[I] will send them to jail. You see that on [the] adult and juvenile level; there [are] just no beds. Sometimes [jail is] quicker than detox… Now they are back home in [an] environment [that was] not safe for them in [the] first place. [When] kids [are] using substances, there is stuff going on at home and [they] are just self-medicating at that point."

Cost of Substance Use Treatment

The primary cost data for treatment was provided by three health care centers in the county: Duffy Health Center, Cape Cod Health Care (CCHC), and Outer Cape Health Services (OCHS). BSAS provided admissions for Barnstable County that were then combined with the average costs reported by the National Center for Drug Abuse Statistics (NCDAS) for the state of Massachusetts. The Barnstable County Sheriff's Office provided the cost of SUD treatment for incarcerated individuals and those who are in pretrial.

Table 7 presents the overall estimated cost of treatment. It is estimated that more than $45 million is spent on substance use treatment activities in Barnstable County. The majority of cost provided came from DPH-funded BSAS admissions. This cost figure is based on admissions data from BSAS and NCDAS estimates an average cost of $12,500 per 30-day admission for substance use treatment nationally.[20] Not all health care centers in Barnstable County submitted cost data, therefore the cost of inpatient and outpatient care provided by local health care facilities is underestimated. These costs, alongside the cost of the other domains, are further discussed in a later section of this report; see Appendix C for full details of these estimates.

Table 7. Estimated Costs of Treatment Activities

	TOTAL	% OF TOTAL
Treatment		
Local health care facility expenditures (inpatient + outpatient) for substance use treatment services	$ 7,398,325.80	16.3%
DPH-funded substance use treatment programs	$ 37,675,000.00	82.8%
Substance use treatment costs for inmates	$ 432,374.68	1.0%
TREATMENT TOTAL	$ 45,505,700.48	

Recovery

When talking about the recovery, individuals often noted there is no one path, or even only a couple "right" paths, to enter or remain in recovery. Each person's journey will look different and for offered services to be effective for the recovery community, they need to understand the importance of offering a variety of services and resources. One common thread in many people's recovery is the need for a support system who understands their recovery experiences.

Recovery Programs

AA & NA meetings

B Free Wellness

FIRST Steps Together

Foundations Group Recovery Centers

Herren Project

Learn2Cope

Parents Supporting Parents

PIER Recovery Support Center

Recovery Build APG

Recovery Without Walls Refuge

Existing Programs and Services

Overall, participants shared that there is a strong recovery community in Barnstable County but that more services are always needed. Participants discussed several key recovery resources and services, including WellStrong, PIER Recovery Support Center, Recovery Without Walls, Refuge Recovery, Foundations Group Recovery Centers, Herren Project recovery support services, Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) meetings, and sober homes. Other recovery support services discussed in relation to other domains that also provide recovery services include B Free Wellness and Recovery Build Alternative Peer Group (APG). Participants also described the benefits of support services for the parents and families of people using substances, including Parents Support Parents and Learn 2 Cope. One participant shared:

"The recovery community on the Cape is really strong. I think the way all the pieces interact together; treatment centers coordinate well with sober houses. Those are excellent, there are [a] number of them."

Many participants described **community, connection, and support, including peer recovery support services and recovery coaches, as critical components of recovery**. As one participant summarized:

"Isolation is the worst thing for somebody in recovery. It's relapse, it's death, it's the complete opposite of what recovery is, because recovery is connection."

"Coaching has made a huge difference for some people—just having that one person walk alongside you in the beginning. Even making a phone call in the beginning of your recovery, setting up a doctor's appointment, it's scary. I know that maybe doesn't make sense for someone who doesn't understand, but it is. But that's one example of what can happen when the peer-to- peer support is there. People thrive off of community."

Participants also discussed the importance of **physical spaces where people in recovery can be in community** together, have "something to do outside of work", and "feel like they're giving back," especially as they transition out of treatment. A number of participants spoke highly of WellStrong, a fitness and wellness community for people in recovery that "provide[s] [a] safe space for people in recovery to walk in, be themselves, feel comfortable, [and] have a place where, if they're struggling, [they can] ask for help." As one participant shared:

> *"The beautiful thing about WellStrong is [that its] doors are open every day. [You can] come hang out [and] grab a cup of coffee."*

A number of participants described the **importance of wellness services, activities, and programs for people in recovery**, including meditation, yoga and fitness, and art therapy.

> *"[The] wellness portion is huge… Incorporating things that you didn't before. We currently partner with Sharing Kindness and offer [a] grief support 5-week program for young adults. The longer you're in recovery, the more loss you experience because, unfortunately, a lot of people don't grasp [or] hold onto recovery. We don't have coping skills to deal with it."*

Another participant shared:

> *"[We dive] deep into [the] ways we can continue to support [our members] because you never know what that 'aha' moment is for someone – it can be art, music, or walking for different people. [You] never know what someone needs for healing."*

Participants also shared that there are **many "different pathways to recovery,"** that different people will benefit from different approaches, and that abstinence is not the only option; a couple of participants stated that their organizations do not offer or directly work with 12 step programs.

> *"It took me a little while to be like, it's okay if I have a friend who decides she doesn't want to go to meetings, but she wants to go be a yoga instructor and that's what's healing for her. That's her journey, that's her path, we're not all the same and that's okay."*

This participant went on to describe the importance of recognizing that people in recovery know what they need and do not need to be told what is best for them:

> *"[We need] to have places where there are these options and people can choose whether or not it's for them. We're an intelligent group emotionally, which is very much undermined. We talk about feelings all the time, we're very emotionally aware of our needs for each other. It's just being heard and being provided the space. We're told what we need a lot. That's why I appreciate the time to be able to say what we need."*

Barriers to Accessing Existing Services

The most frequently discussed barriers to accessing recovery services included **lack of insurance coverage and difficulty navigating the insurance system**; and **lack of transportation**, especially for the many people in recovery who do not have drivers' licenses. Describing issues with insurance coverage, one participant shared:

> *"It seems like if you don't have private insurance, there's not enough sober houses…if you don't have private insurance, it's tough out here."*

Another participant described the challenges they have faced trying to get insurance to cover needed services for a family member:

> *"Two years later I'm still having a hard time navigating what services are available. [It] took almost 1.5 years to get to therapy. [It's] so hard to navigate [the] system between insurance companies. One system tells you one thing, and another tells you another."*

Transportation was also described as a key barrier to accessing existing services:

> *"A lot of people don't have licenses who are in recovery and transportation is so difficult – a lot of meetings and things [are] so hard for people to get to."*

> *Transportation is really the number one barrier. A lot of people would love to come to WellStrong but they can't get there… WellStrong offers so many amazing things… There's so much interest and [the] number one thing that holds people back is transportation for sure."*

Several participants described additional barriers to accessing services, including a **lack of awareness about existing resources**; and **difficulty navigating existing resources**, including for parents and family members who are supporting their loved ones in seeking recovery services. As one participant shared:

> *"There is just a lack of places for people to access this knowledge… [they] need a platform to look. They don't know about different therapies, [Eye Movement Desensitization and Reprocessing], [Rapid Transformational Therapy]. We're out there but it's getting that information to people in recovery."*

Describing the difficulty of navigating existing resources, another participant shared:

> *"[You] have to jump through hoops to get care. It's a difficult task for anyone; [they're] going through trauma as it is and [then] trying to get… help on top of that."*

Needed Programs and Services

Overall, participants emphasized the need for more of the services described above, including sober homes, peer recovery support services, wellness resources, recovery centers, and support services for the parents and families of people using substances. Many participants shared that there is a **need for more housing for people in recovery, particularly sober homes** for people who do not have private insurance. One participant characterized the housing situation as follows:

> *"[It] always comes back to housing. Unless we correct that, [there is] no point in trying to correct anything else… We should have established links [to] congregate housing that… [there are] no homes there for us."*

While many participants spoke about the need for more sober homes, a couple also shared that there is a need for more regulation to ensure that all sober homes provide high quality services. As one participant shared:

"[I] feel like [sober house managers and owners] should have to check in monthly [and show that] they [are] providing certain services… [Because] anyone [can] open [a] house, a lot turn to flophouses. A lot of people [in recovery] say [that the sober homes] allow you do everything, [but if you] do one thing [they] don't like, they kick you out. There need to be more restrictions on recovery homes [so] not just anyone can open [one]."

Another participant described the need for additional supportive housing as people transition out of sober homes:

"I see so many people relapse in that transition. I'm not sure that people transitioning out of sober living are really ready to go take on apartment. Sometimes they [live with] roommates [who are] not ready to be roommates to someone in recovery. I think grad houses are [an] amazing transition but [there are] not tons of them. I do see that time as a very dangerous time for recovery and [the need for] supports around that."

One participant highlighted how the lack of affordable housing can disrupt the important networks of support that people build while they are in recovery:

"Once people live in sober living [and have an] established network, it's difficult for them to stay on the Cape. Affordable housing is hard to find."

Several participants shared that there are **not enough recovery services for parents of young children, particularly mothers.**

"[There's] a lot of need for women with children. [There are] hardly any services. Even fathers too… a lot of times [parents] have to leave [their] kids in not great situations when they go into recovery, so that's difficult."

As described in the treatment section, the closure of Emerson House's program for women and children was seen as major loss. A couple of participants highlighted that the opportunity for service providers to make more money was behind the closure of this and other programs. One participant shared:

"[We need to] push for nice houses with moms for kids. [The] only thing they had was Emerson House and that's closed now. There [are] no halfway houses anymore. [You can] get one of those beds [at] Emerson TSS or [you're] back on the street. [Halfway houses were] a big thing in this community and that's gone."

Another participant shared their perceptions regarding the financial motives underlying the closure of Emerson House and other programs:

"A lot of reason these six houses were closed [is that organization] wanted to switch to [a] mental health and addiction model. When management… shifted over the years, [the] client became less important; [they] looked at [the] client as [a] cost. Primarily, [they] can get much more money by billing as mental health and CSS [Clinical Stabilization Services]."

Other participants discussed the **need for navigators who can connect individuals in recovery and their loved ones to needed services and supports**. One participant shared that existing resources are not adequate:

> *"[The] state has [the] [Mass]Options program where you can call and get some help. MassOptions [is] mediocre, [and] we have 211… which is too complicated. Where is the person or persons who can walk you through this… That is what we need for this kind of thing. Anyone should be able to access it."*

A couple of participants shared that navigation services should work to break down silos and address all the needs that individuals in recovery have, including insurance, transportation, housing, food assistance, mental health services, and support services for their loved ones.

Cost of Substance Use Recovery

Programs provided costs to support recovery, including those for recovery coaching programs, programs to support sober home placement, and other recovery supports (e.g., peer groups, classes, recovery navigation, etc.). Data were provided from Duffy, WellStrong, Parents Supporting Parents, and Recovery Build APG.

Table 8 presents the overall estimated cost of treatment. It is estimated that more than $1.3 million is spent on substance use recovery activities in Barnstable County. More than half of the reported costs were for other recovery supports (57.1%); over a third (38.9%) were for recovery coaching programs. These costs, alongside the cost of the other domains, are further discussed in a later section of this report; see Appendix C full for details of these estimates.

Table 8. Estimated Costs of Recovery Activities

	TOTAL	% OF TOTAL
Recovery		
Recovery coaching programs	$ 514,267.00	38.9%
Support for sober home placement	$ 53,650.00	4.1%
Other recovery support programs	$ 755,293.00	57.1%
RECOVERY TOTAL	$ 1,323,210.00	

Resource Inventory

A goal of this assessment was to identify the available substance use resources in Barnstable County. Many of the organizations that provide these resources have been mentioned throughout this report; this section further describes the specific services they provide (see Appendix B for further detail).

While this inventory captures many of the services available to Barnstable County communities, it is not an exhaustive list and is intended as a dynamic tool to be updated on an ongoing basis.

Types of Prevention Activities

Holistic, Health Behaviors, Emotional Regulation, Etc.

Substance Use Specific

Within prevention resources, most have a focus on overall prevention through activities around mindfulness, emotional regulation, and health behaviors as a path to prevent substance use, as well as other physical and mental health issues.

Others focus on prevention through recovery work with parents of young people, which focus both specifically on substance use as well as these overall healthy behaviors.

Harm reduction services tend to focus on the following resources: needle/syringe exchanges, Narcan distribution and education, and fentanyl test strip distribution and education. There are also programs in the county that focus on mobile harm reduction bringing resources directly to where the higher risk populations are.

Types of Harm Reduction Activities

Syringe/Needle Exchange

Narcan Distribution & Education Fentanyl

Test Strip Distribution & Education

Types of Treatment Activities

Inpatient

Outpatient

Medically Assisted Treatment (MAT) Detox

The most commonly used treatment services for SUD include inpatient services providing more intensive care, outpatient services, programs offering MAT including MOUD for opioid use disorder, and detox programs.

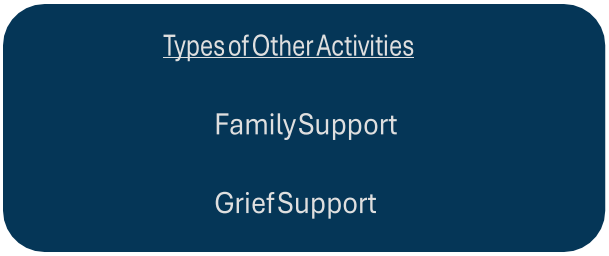
As previously discussed, there is no one path to or in recovery. However, there are some commonly offered services including group meetings and peer support groups, recovery coaching, and holistic health services such as mindfulness.

Types of Recovery Activities

Group Meetings & Peer Support

Recovery Coaching

Holistic Health & Mindfulness



Two types of services that cut across these domains are support services for family, friends, and loved ones of someone with SUD disorder and grief support for individuals who have lost someone to SUD.

As indicated in the resource inventory, many organizations and programs address needs in more than one of the domains discussed. Throughout the conversations with community members and stakeholders, several participants described the **need for more coordination and collaboration across agencies offering similar or related services**. One participant emphasized that the importance of this collaboration is to help the people in their community who need these services:

> *"I feel like finding a way to bridge services together and have a healthy communication system. Professionally and personally, I have seen a competition type thing and that bothers me. It is about the person that needs to [be] served… If there's something we can create, remembering why we're doing this and who we are doing it for."*

Another participant talked about this in the context of their own organization and its leadership:

> *"I don't know if collaborating or championing service with other agencies has been discussed in our leadership, but [I] agree [that we need] to partner to get services [to] everyone."*

Cost of Substance Use in Barnstable County

This section presents a deeper analysis of the cost data discussed in previous sections. In some cases, data from programs were able to be allocated to a certain substance; not all programs were able to provide this level of detail. See Appendix C for full details of these estimates.

Using the cost data provided for this assessment, **the estimated cost of substance use in Barnstable County is $48,333,708.77**. The vast majority of this cost is focused on treatment (93.5%). All other domains represent less than 5% of the reported costs (**Table 9**).

Table 9. Estimated Cost Barnstable County Substance Use Assessments, 2022

	TOTAL COST	% OF TOTAL COST
Domain		
Prevention	$1,189,438.00	2.4%
Harm Reduction	$ 636,734.97	1.3%
Treatment	$ 45,505,700.48	93.5%
Recovery	$ 1,323,210.00	2.7%

A detailed breakdown of the indicators related to specific programs and activities in each domain are presented in **Table 10**. Provided prevention costs were relatively evenly distributed between youth- focused prevention activities (51.3%) and school suspension diversion programs (48.7%). While representing only 2.5% of the total cost, these activities have the potential to result in over $21 million in savings based on estimates that every $1 spent on school-based prevention programs could save $18.[21]

Harm reduction services represent just 1.3% of these costs but investment in these services has immense potential to save both costs and lives. One study found that harm reduction efforts save $100-$1,000 per HIV infection averted[22]; another estimated needle exchange programs save $23-71 dollars per person engaged.[23] Harm reduction efforts, such as naloxone and testing strips, are directly aimed at preventing overdose deaths[24]; in Barnstable County, there were 514 overdose deaths between 2015 and 2021. The largest cost provided for harm reduction was for naloxone distribution and education (38.5%), followed by costs related to outreach efforts conducted in collaboration with law enforcement (27.7%), and managing needle exchange programs (25.0%). Most of the harm reduction cost data collected are aimed at addressing opioid use and its related effects. For the outreach activities, data could not be disaggregated by substance as they aim to reach a wide range of populations in the community.

The treatment provided at state-funded treatment programs comprises the largest percentage of the cost data received (82.8%). Local health care providers contribute the next largest portion (16.3%); it is important to note that multiple local providers did not provide cost data for their treatment services and therefore this number is likely an underestimate. The treatment provided in correctional facilities is a newer indicator developed in response to changes in substance use policy and contributes 1.0% of the estimated treatment costs. Most data for treatment could be disaggregated by substance. Alcohol costs represent almost half (49.4%) of the treatment costs and opioids account for just under a third of the treatment costs (31.9%).

Recovery costs also represent a small percentage of reported costs (2.7%). One study found that a program focused on recovery may have similar costs to traditional clinical approaches to substance use but led to more positive outcomes for individuals to maintain long-term recovery such as more days in recovery and fewer substance used-related problems experienced.[25] Recovery as its own domain allowed for further detail in the cost of different recovery supports. Other recovery support services such as support groups (peer groups, grief and loss groups, AA/NA) account for more than half (57.1%) of the recovery costs. In some cases, these costs could be broken out by alcohol compared to other substances. Alcohol represents 16.5% of the costs; however, almost half (45.8%) could not specify a substance.

Table 10. Full Matrix of Estimated Cost of Substance Use in Barnstable County

			COST BREAKDOWN				
	TOTAL	% OF TOTAL	Alcohol	Marijuana	Opioids	Other Substances	Unspecified Substance
Prevention							
Youth-focused prevention activities & engagement	$ 610,438.00	1.3%	--	--	--	--	--
School suspension diversion programs	$ 579,000.00	1.2%	--	--	--	--	--
PREVENTION SUBTOTAL	*$ 1,189,438.00*	*2.5%*					
Harm Reduction							
Programming that manages community-based collection and disposal of excess prescription drugs	$ 3,256.18	0.01%	--	--	$ 3,256.18	--	--
Programming to manage community-based syringe and needle exchange	$ 158,994.60	0.3%	--	--	$ 158,994.60	--	--
Programming to manage appropriate community-based syringe and needle disposal	$ 52,701.84	0.1%	--	--	$ 52,701.84	--	--
Collaborative outreach to community, particularly higher risk populations, between behavioral health professionals and law enforcement to provide resources aimed at harm reduction and prevention	$ 176,471.85	0.4%	--	--	--	--	$ 176,471.85
Programming providing education and naloxone to prevent death from opioid overdose	$ 245,310.50	0.5%	--	--	$ 245,310.50	--	--
HARM REDUCTION SUBTOTAL	*$ 636,734.97*	1.3%					
Treatment							
Local health care facility expenditures (inpatient + outpatient) for substance use treatment services	$ 7,398,325.80	15.2%	$ 3,242,262.77	$ 92,629.01	$ 304,837.56	$ 1,128,596.46	$ 2,630,000.00
DPH-funded substance use treatment programs	$ 37,675,000.00	77.4%	$ 19,250,000.00	$ 637,500.00	$ 14,225,000.00	$ 3,562,500.00	--
Substance use treatment costs for inmates	$ 432,374.68	0.9%	--	--	--	--	$ 432,374.68
TREATMENT SUBTOTAL	*$ 45,073,325.80*	93.5%					
Recovery							
Other recovery support programs	$755,293	1.6%	$ 63,525.00	--	--	$ 128,975.00	$ 562,793.00
Recovery coaching programs	$514,267	1.1%	$ 155,463.00	--	--	$ 315,637.00	$ 43,167.00
Support for sober home placement	$53,650	0.1%	--	--	--	--	
RECOVERY SUBTOTAL	*$ 1,323,210.00*	2.7%					
TOTAL COST	**$ 48,222,708.77**	**--**	**46.1%**	**1.5%**	**29.9%**	**10.6%**	**7.5%**

Direct comparison of total costs in 2014 and 2022 is not possible due to major methodological changes across assessments, including the splitting of treatment and recovery into separate domains and the removal of law enforcement as a domain. However, after subtracting law enforcement costs from the 2014 total, the 2014 and 2022 totals are similar ($53,184,000 and $48,333,708.77, respectively; **Table *11***). Still, comparisons should be made with caution as the data available and received in each year varies.

Table 11. Estimated Cost Barnstable County Substance Use Assessments, 2014 and 2022

	2022 TOTAL	2014 TOTAL
Domain		
Prevention	$1,189,438.00	$1,010,000.00
Harm Reduction	$ 636,734.97	$707,000.00
Treatment	$ 45,505,700.48	$51,467,000.00[1]
Recovery	$ 1,323,210.00	--
TOTAL	$48,333,708.77	$53,184,000.00

[1]Recovery was not a separate domain in the 2014 assessment and are combined within this number. The regrouping of treatment and recovery is in recognition of the importance of recovery as its own part of the substance use service field. NOTE: Law enforcement cost data from 2014 is not shown in alignment with new domains. The removal of law enforcement – the largest percentage of the 2014 assessment cost estimates, in part due to the inclusion of a large portion of police budgets – is in response to the understanding that there are other more effective ways to address substance use in communities and treating SUD as a public health issue rather than a criminal issue.

KEY FINDINGS AND INITIAL RECOMMENDATIONS

This section summarizes the key findings of this assessment, overall and by domain, including some initial recommendations based on suggestions from assessment participants.

Overall

This assessment is one step in the work to address substance use in Barnstable County; the process highlights the potential impact of regular, ongoing data collection and assessment of the substance use needs and costs in the county to inform and improve the services available and how they are delivered. To continue to utilize community perspectives and data to drive decisions regarding substance use services in the county the following should be considered:

- Conduct an assessment of this nature every 3 to 5 years with the goal of understanding both ongoing needs and emerging trends related to substance use.
    - Timing of assessments should be based on the timeframe of the current action plan, with the aim of having an updated assessment started and/or complete before the action plan is to be revisited.
- Engage with key stakeholders to emphasize the importance of this work, and their contribution to it, to the community to facilitate this type of regular data collection.
    - Some examples include engaging with school systems and leadership about the value of data collection (e.g., YRBS) and substance use prevention programs to the wider community, working with healthcare providers to provide standardized cost data, coordinating with all municipalities to report data on local efforts around substance use services, etc.
- Conduct additional community engaged assessment work, with specific populations and topics of focus, to gain a deeper understanding of needs and trends identified as well as fill any gaps in knowledge.
    - Efforts should be made to explore the impact of, and needs related to, substance use specific to different populations, e.g., geographic areas, different racial and ethnic groups, age groups (e.g., youth, older adults), caregivers, homeless or housing instable, etc.
    - Information should be gathered regarding the intangible costs of substance use (e.g., lost time at work/school, job loss, loss of productivity, etc.). These data are quantified at the national level rather than locally but are often not directly applicable to the unique aspects of regions like Barnstable County.

These assessments should aim to guide decision-making and action planning from an evidence- informed perspective, which includes but is not limited to evidence-based practice or research as the only form of evidence.[26] Evidence-informed approaches consider other information that "affects existing beliefs… about the significant features of the problem under study and how it might be solved or mitigated;" in other words, it takes the perspectives of those with direct and lived experience as valuable contributions to understanding how to approach solutions.[27] SAMHSA also recognizes the challenges faced in implementing evidence-based practices in under-resourced populations.[28] With an evidence-informed approach, decision-makers ensure both research and community expertise and experience are integrated to create more

equitable and inclusive action.

The results quantify that the estimated cost is primarily attributable to treatment services; however, investments in the other domains have great potential to positively impact quality of life and result in cost savings. Perspectives from service providers, community members, and other key stakeholders emphasized the importance of the services in all four domains. Individuals highlighted the effectiveness of services being provided by local organizations; however, they were also clear that there are needed services and supports for each domain as well as those that are cross cutting.
Furthermore, there are two main perceptions of substance use in the county – the growing awareness of the complex impact of substance use and those who deny that substance use is an issue in the community. These perceptions need to be fully understood to effectively address barriers, such as stigma, and effectively deliver services equitably across different geographies and populations.

Based on the perspectives of community members, the following should be considered when planning future actions to address substance use overall:

- There is a need to understand and integrate the impact that social determinants of health – particularly housing, transportation, and insurance – have on accessing resources when developing and implementing substance use services.
- To help ease access to existing resources, it is important to create awareness of these resources – using different avenues of communication – as well as assistance in navigating and selecting appropriate resources.
    - Ideally, this navigation would have a person-to-person component (e.g., navigators) as even resource inventories can be challenging for individuals – including those with SUD and their loved ones – who may not know what services they need.
- Cross collaboration and coordination between organizations and across domains are critical to ensure those with SUD are able to get the needed services at each stage of their journey.
- Ultimately, there needs to be more services across different geographies given some of the barriers to access, such as transportation. Even if these services are available in Barnstable County, they may not be accessible to those living in certain municipalities.

Prevention

Prevention efforts in the county reach far beyond (and in some cases before) prevention of substance use. These efforts contribute a small portion to the cost of substance use in the county and have the potential to save almost half the amount reported by participating programs as being spent in the county on harm reduction, treatment, and recovery. There is a need to expand and build on existing successful programs.

Based on the perspectives of service providers, community members, and other key stakeholders the following should be considered when planning future actions to provide prevention services:

- Focus on holistic approaches to prevention as an effective form of substance use prevention, including addressing co-occurring mental health and substance use and providing safe and healthy outlets for youth to spend their time.
- Provide these holistic services starting in early childhood (0-5 years) and consistently through young adulthood to build and maintain these skills.

- Utilize non-traditional approaches to substance use prevention – not only providing education on risks/abstinence, but also using approaches such as open and authentic conversations about what people's experiences have been and engaging parents, families, and other adults connected to youth in these conversations.

Harm Reduction

These are lifesaving resources in themselves that also present important opportunities to connect with people, provide them with support, and link them to other needed services. Harm reduction is most successful when it is non-judgmental and respectful. Harm reduction contributes the lowest amount to the overall cost of substance use in the county and a focus on these services could save cost related to other domains such as treatment.

Based on the perspectives of service providers, community members, and other key stakeholders, the following should be considered when planning future actions to provide harm reduction services:

- Bring resources to where higher risk populations are to make them as low barrier as possible.
- Address individual level and community level stigma impacting both the ability to bring new harm reduction services to a community and access to existing harm reduction services.
    - This work around reducing stigma will have far reaching impact, including opening up the possibility of integrating harm reduction in work with youth and young adults.

Treatment

The current available treatment services are highly regarded; however, they are not able to meet the full extent of the needs in the community including co-occurring substance use and mental health concerns. Treatment services contribute the vast majority of the cost of substance use in the county; alcohol and opioids are the primary substances driving the cost of treatment. There are growing concerns among service providers and community members with lived experience about the closing of effective programs and the affordability of substance use treatment due to the increasing number of private facilities. Ultimately focusing on prevention, harm reduction, and recovery services while continuing to fund affordable treatment services, could result in cost savings in the treatment domain.

Based on the perspectives of service providers, community members, and other key stakeholders, the following should be considered when planning future actions to provide treatment services:

- Expand and build on existing long-term treatment options with a focus on specific populations: youth, mothers with young children, those transitioning from the jail system.
- Create more access to medication-assisted treatment (MAT), specifically those for opioid use disorder such as Methadone.
- Prioritize services for those with cooccurring mental health and substance use disorders.

Recovery

Barnstable County has a strong recovery community that supports individuals in their own paths of recovery focusing on connection and supports from those with lived experience such as recovery coaches. Recovery costs are a smaller portion of the total county cost and focus on providing diverse support services to those at all points and journeys of recovery.

Based on the perspectives of service providers, community members, and other key stakeholders, the following should be considered when planning future actions to provide recovery services:

- Establish more sober housing, specifically for those with public or no insurance as well as parents with young children; emphasize integrating some form of regulation or monitoring of the effectiveness of these homes to ensure they are providing the needed safe space for those in recovery.
- Expand support services focused on grief and loss, both for those with SUD and their families, as well as services focused on holistic and diverse approaches to recovery.
- Offer services to help those entering recovery navigate the available services as well as provide support related to challenges such as transportation and insurance.

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The members of the Regional Substance Addiction Council (RSAC) Prevention Workgroup served as the Core Planning Group for this assessment providing their perspectives and input on the assessment planning steps, initial and final results, and assessment report as well as connecting the assessment team to key contact for further information (e.g., local level data, interviewee contacts).

- Alicia Bryant
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- Julia Bateman
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- Kathe Medwin
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- Sheila House
- Stacey Schakel
- Stephanie Briody
- Suzanne Hauptmann

Individuals from the following organizations, including community stakeholders, services providers, and those with lived experience, participated in an interview to provide their insights, perspectives, and experiences regarding substance use in Barnstable County.

- ACCESS Hope
- AIDS Support Group of Cape Cod
- Al-Anon
- Barnstable County Sheriff's Department
- Calmer Choice
- Cape Cod Children's Place

- Community Health Center of Cape Cod
- Duffy Health Center
- Gosnold, School-based Counselor Program
- Harwich Youth + Family Services
- Health Imperatives
- Learn 2 Cope
- Monomoy Regional Middle School
- Nauset Schools
- One Shared Spirit
- Parents Supporting Parents
- Pier Recovery Center
- Recovery Build APG
- Recovery Research Institute
- Recovery Without Walls
- Wellstrong Inc.
- Yarmouth Comprehensive Treatment Center
- Yarmouth Police Department, Victim Service

Additionally, nine other community members shared their perspectives. A group of young people focused on substance use prevention, individuals with experience accessing harm reduction services, someone currently accessing treatment for substance use, and individuals who identify as in recovery.

The following organizations provided local level data describing services provided as well as related cost information.

- AIDS Support Group of Cape Cod
- Access HOPE
- Barnstable County Department of Human Services
- Barnstable County Health Department
- Barnstable County Sheriff's Office
- Barnstable Police Department
- Barnstable Police Dept
- Barnstable Public Schools
- Barnstable Town Health Department
- Behavioral Health Innovators, Inc. (including RecoveryBuild Alternative Peer Group (APG) for Teens and Positive Alternative to School Suspension (PASS) programs)
- Boys & Girls Club of Cape Cod
- Calmer Choice
- Cape & Islands District Attorneys Office
- Cape Cod Academy
- Cape Cod Children's Place
- Cape Cod Cooperative Extension | Barnstable County, Regional Government of Cape Cod
- Cape Cod Healthcare
- Cape Cod Parents Supporting Parents (PSP)
- Center for Addiction Medicine, Massachusetts General Hospital

- Chatham Fire Rescue
- Community Planner, Barrett Planning Group, LLC.
- Cotuit Fire Department
- Duffy Health Center
- Harwich Fire Department
- Harwich Health Dept
- Mashpee DPW
- Monomoy Regional Schools
- Orleans Fire-Rescue
- Outer Cape Health Services, Inc.
- Sandwich Fire Department
- Sharing Kindness, Inc.
- Town of Barnstable - Health Division
- Town of Chatham - Health Division
- Wellfleet Police Department
- WellStrong, Inc

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APPENDICES

APPENDIX A: Discussion Guide

Barnstable County Substance Use Assessment

General Key Informant Interview Guide

Goals of the Key Informant Interview

- To understand the perceptions of service providers, community members, and other stakeholders in Barnstable County around substance use
- To determine the challenges to and gaps in related services and programs
- To identify opportunities for addressing community substance use needs more effectively

[NOTE: QUESTIONS FOR THE INTERVIEW GUIDE ARE INTENDED TO SERVE AS A GUIDE, NOT A SCRIPT.]

I. *BACKGROUND*

- Hi, my name is _____and I am with Health Resources in Action (HRiA), a non-profit public health organization working with Barnstable County Department of Human Services. Thank you for taking the time to speak with me today.

- Barnstable County Department of Human Services is partnering with HRiA to conduct an assessment to describe and understand the mortality, morbidity, and societal costs of substance use in the County, the related needs and available resources, and how these needs are currently being addressed and/or can be improved. As part of this process, we are having discussions like these with service providers, community members, and other stakeholders in Barnstable County from a range of different groups including those directly affected by substance use. We are interested in hearing people's feedback on the strengths and needs of the County and suggestions for the future.
- We are conducting interviews and small group discussions with leaders in Barnstable County as well as community members with lived experience to understand different people's perspectives on these issues. We greatly appreciate your feedback, insight, and honesty.
- Our interview will last 60 minutes. After all of the interview and group discussions are completed, we will be writing a summary report of the general themes that have emerged during the discussions. We will not include any names or identifying information in that report. All names and responses will remain confidential. Nothing sensitive nor personal that you say here will be connected to directly to you in our report.

- Any questions before we begin our introductions and discussion?

II. *THEIR AGENCY/ORGANIZATION (5 minutes)*

[FOR SERVICE PROVIDERS & OTHER STAKEHOLDERS – skip for community members]

1. Tell me a bit about your organization. What is your organization's mission/programs/services? What communities do you work in? Who are the main clients/audiences for your programs?

    a. What are some of the biggest challenges your organization faces in providing these programs/services in the community?

III. *COMMUNITY ISSUES (5 minutes)*

2. How would you describe the community [your organization serves/you live in]?

    a. What do you consider to be the community's strongest assets? What are the most positive aspects about the community/Barnstable County?

    b. What are some of its biggest concerns/issues in general in the community? What challenges do residents face day-to-day?

IV. *PERCEPTIONS OF SUBSTANCE USE (10 minutes)*

3. How big of an issue do you think substance use is in your community?

    a. When I say that we are talking about "substance use" as a concern, what does that mean to you? What issues come to mind when you hear that phrase?

    b. What do you think are the most pressing substance use concerns in your community? [IF NEEDED, PROBE ON SPECIFIC ISSUES SUCH AS OPIOID/HEROIN USE, MISUSE OF PRESCRIPTION DRUGS, STIMULANTS, FENTANYL, OTHER DRUGS (COCAINE, ECSTASY), ALCOHOL, TOBACCO.]

4. In what ways has substance use affected your community?

    a. What populations (age, race, ethnicity, gender, income/education, geographical etc.) do you see as being most affected by this issue?

    b. How supportive do you feel the larger community is of people who use substances and/or people living with addiction, etc.? Why/why not? [PROBE ON ADDICTION AS A DISEASE, STIGMA]

V. *SUBSTANCE USE PREVENTION (15-20 minutes for primary domain, 5-7 minutes otherwise)*

5. Let's talk about prevention related to the substance use issues you mentioned. What programs, services, and policies are you aware of in the community that currently focus on prevention of substance use issues? [PROBE ON SPECIFIC SUBSTANCES, TARGET POPULATIONS, ETC.]
    a. Tell me about these programs and services. What do you know about them? Who uses them?
    b. How successful do you think these programs, services, or policies have been? What do you see as the strengths of the substance use prevention programs, services, and policies in your community? What should be changed/improved?
6. How available or accessible are these programs to the people who need them?
    a. What challenges do residents in the community face in accessing substance use prevention services? [PROBE FOR BARRIERS: INSURANCE ISSUES, LACK OF SERVICES, LACK OF TRANSPORTATION, STIGMA, ETC.]
        i. What do you think needs to happen in your community to help residents overcome or address these challenges?
        ii. Do you see opportunities currently out there that can be built upon to strengthen substance use prevention in Barnstable County? For example, are there current prevention-focused collaborations or initiatives that can be strengthened or expanded? [PROBE FOR DETAIL]

7. What's missing? What prevention programs, services or policies are currently not available that you think should be? [PROBE ON SECONDARY AND TERTIARY PREVENTION, i.e., strategies to prevent the negative consequences of substance use e.g., screening for alcoholism or use of Narcan to reverse an opioid overdose?]
    a. What do you think needs to be done to put these programs, services, or policies in place?

VI. *SUBSTANCE USE HARM REDUCTION (15-20 minutes for primary domain, 5-7 minutes otherwise)*

8. Let's talk about harm reduction related to the substance use issues you mentioned. What programs, services, and policies are you aware of in the community that currently focus on harm reduction of substance use issues? [PROBE ON SPECIFIC SUBSTANCES, TARGET POPULATIONS, ETC.]
    a. Tell me about these programs and services. What do you know about them? Who uses them?

    b. How successful do you think these programs, services, or policies have been? What do you see as the strengths of the substance use harm reduction programs, services, and policies in your community? What should be changed/improved?

9. How available or accessible are these programs to the people who need them?

    a. What challenges do residents in the community face in accessing substance use harm reduction services? [PROBE FOR BARRIERS: INSURANCE ISSUES, LACK OF SERVICES, LACK OF TRANSPORTATION, STIGMA, ETC.]

        i. What do you think needs to happen in your community to help residents overcome or address these challenges?

        ii. Do you see opportunities currently out there that can be built upon to strengthen substance use harm reduction in Barnstable County? For example, are there current harm reduction-focused collaborations or initiatives that can be strengthened or expanded? [PROBE FOR DETAIL]

10. What's missing? What harm reduction programs, services or policies are currently not available that you think should be?

    a. What do you think needs to be done to put these programs, services, or policies in place?

VII. *SUBSTANCE USE TREATMENT (15-20 minutes for primary domain, 5-7 minutes otherwise)*

11. Let's talk about treatment regarding a few of the substance use issues you mentioned. What programs, services, and policies are you aware of in the community that currently focus on treating substance use issues? [PROBE ON SPECIFIC SUBSTANCES, TARGET POPULATIONS, ETC.]
    a. Tell me about these programs and services. What do you know about them? Who uses them?
    b. How successful do you think these programs, services, or policies have been? What do you see as the strengths of the substance use treatment programs, services and policies in your community? What should be changed/improved?
12. How available or accessible are these programs to the people who need them?
    a. What challenges do residents in your community face in accessing substance use treatment services? [PROBE ON BARRIERS: INSURANCE ISSUES, LACK OF SERVICES AVAILABLE, LACK OF TRANSPORTATION, STIGMA, ETC.]

        i. What do you think needs to happen in your community to help residents overcome or address these challenges?
        ii. Do you see opportunities currently out there that can be built upon to strengthen Barnstable County's substance use treatment services? For example, are there current collaborations or initiatives that can be strengthened or expanded? [PROBE FOR DETAIL]

13. What's missing? What <u>treatment</u> programs, services or policies are currently not available that you think should be?
    a. What do you think needs to be done to put these programs, services, or policies in place?

VIII. *<u>SUBSTANCE USE RECOVERY</u> (15-20 minutes for primary domain, 5-7 minutes otherwise)*

14. Let's talk about recovery regarding a few of the substance use issues you mentioned. What programs, services, and policies are you aware of in the community that currently focus on helping people in recovery? [PROBE ON SPECIFIC SUBSTANCES, TARGET POPULATIONS, ETC.]
    a. Tell me about these programs and services. What do you know about them? Who uses them?
    b. How successful do you think these programs, services, or policies have been? What do you see as the strengths of the substance use <u>recovery</u> programs, services, and policies in your community? What should be changed/improved?
15. How available or accessible are these programs to the people who need them?
    a. What challenges do residents in your community face in accessing substance use <u>recovery</u> services? [PROBE ON BARRIERS: INSURANCE ISSUES, LACK OF SERVICES AVAILABLE, LACK OF TRANSPORTATION, STIGMA, ETC.]
        i. What do you think needs to happen in your community to help residents overcome or address these challenges?
        ii. Do you see opportunities currently out there that can be built upon to strengthen Barnstable County's substance use recovery services? For example, are there current collaborations or initiatives that can be strengthened or expanded? [PROBE FOR DETAIL]
16. What's missing? What <u>recovery</u> programs, services or policies are currently not available that you think should be?

    a. What do you think needs to be done to put these programs, services, or policies in place?

IX. *<u>CLOSING</u> (5 minutes)*

17. Are you aware of any data sources regarding the impact of substance use in Barnstable County? If so, would you be okay with us reaching out to you to see what we may be able to have access to for this assessment?

18. I'd like you to think ahead about the future of your community. When you think about the community 3-5 years from now, what is your vision specifically related to substance use in the community?

    a. What do you think needs to happen in the community to make this vision a reality?

Thank you so much for your time. That's it for my questions. Is there anything else that you would like to mention that we didn't discuss today?

Just as a reminder, we will be writing a summary report of the general opinions that have come up across all of the discussions we're having with community leaders and residents. In that report, we might provide some general information on what we discussed today, but we will not include any names or identifying information. Your responses will be strictly confidential. In the report, nothing you said here will be connected to your name or any identifying features about you.

Thank you again. Have a good day.

APPENDIX B: Resource Inventory

This is an image of a separate Excel document provided with the final report. This separate spreadsheet is intended to be updated on an ongoing basis as resources shift and expand in the county.

Organization	Town(s) Served	Primary Domain	Prevention	Substance Use Focused	Holistic Approach/Healthy Behavior Focused	Harm Reduction	Fentanyl Test Strips/Education	Mobile Harm Reduction	Narcan Distribution	Needle Exchange/Disposal	Treatment	Inpatient	Outpatient	MAT	Detox	Recovery	Group Meeting	Recovery Coaching	Mindfulness	Other	Family Support	Grief Support
ACCESS Hope	Provincetown, Truro, Wellfleet, Easth	Harm Reduction				x	x	x	x	x												
AIDS Support Group of Cape Cod	Provincetown, Hyannis, Martha's Vine	Harm Reduction				x		x	x	x												
Health Imperatives	Hyannis	Harm Reduction				x			x	x												
One Shared Spirit	Mashpee	Harm Reduction				x		x		x						x	x					
Nathan's Circle	All towns	Other																		x	x	
Boys and Girls Club of Cape Cod	Mashpee	Prevention	x		x															x	x	
Calmer Choice	All towns	Prevention	x		x																	
Cape Cod Children's Place	All towns	Prevention	x	x	x															x	x	
School-based counselors	All towns	Prevention	x																			
Sharing Kindness	All towns	Prevention	x		x															x		x
YMCA	Barnstable	Prevention	x		x																	
Youth Villages (Intercept and LifeSet)	Raynham	Prevention	x																	x	x	
Positive Alternative to School Suspension (P	Barnstable	Prevention	x																			
Alcoholics Anonymous (AA)	All towns	Recovery														x	x					
Al Anon	Provincetown, Dennis, Barnstable, We	Recovery														x	x			x	x	
B FREE Wellness	Hyannis	Recovery	x		x											x		x	x			
FIRST Steps Together	All towns	Recovery	x	x	x											x		x		x	x	
Learn 2 Cope	Yarmouth	Recovery														x	x			x	x	
Massachusetts Organization for Addiction Re	All towns (statewide)	Recovery														x				x		
Narcotics Anonymous (NA)	Barnstable, Brewster, Cataumet, Falm	Recovery														x	x					
Parents Supporting Parents	Sandwich, all towns (virtual)	Recovery														x				x	x	
PIER Recovery Center	Hyannis	Recovery														x	x	x				
Recovery Build APG	South Dennis, Falmouth	Recovery														x	x	x		x	x	
Recovery Research Institute	--	Recovery														x				x		
Recovery Without Walls	West Falmouth	Recovery														x		x	x	x	x	
Refuge Recovery	Falmouth	Recovery														x	x		x			
Wellstrong Inc.	East Falmouth	Recovery														x			x			
Herren Project	All towns	Recovery	x													x						
Foundations Group Recovery Centers	Mashpee	Recovery									x		x	x						x	x	
Cape Cod Comprehensive Treatment Center	Yarmouth	Treatment									x		x	x								
Cape Cod Health Care	Hyannis, Falmouth, Harwich	Treatment									x	x	x									
Clean Slate Centers	Hyannis, Falmouth	Treatment									x		x	x								
Column Health	Hyannis	Treatment									x		x	x	x							
Community Health Center of Cape Cod	Mashpee, Falmouth, Bourne, Sandwic	Treatment									x		x	x								
Duffy Health Center	Hyannis	Treatment				x					x		x	x								
Gosnold	Falmouth, West Falmouth, Centerville	Treatment									x	x	x	x	x							
Outer Cape Health Services	Harwich, Wellfleet, Provincetown	Treatment									x		x	x		x		x				
Recovering Champions	Falmouth	Treatment									x		x	x						x	x	

APPENDIX C: Additional Cost Data Details

Below are further details of the cost data presented in this report, organized by domain.

Prevention

Calmer Choice provided cost information on implementing their programming in one school district which they estimate reaches more than 1,300 students per district. The total estimated cost includes mindfulness coaches, instructors, facilitators, classroom materials, and other costs (e.g., developing curriculum, training, evaluation/assessment, etc.). On average based on previous implementation, the full cost for implementation in one district is **$545,938**.

Sharing Kindness provided an estimated cost for implementing their peer-based family program focusing on youth substance use prevention through grief support. Each family program costs approximately **$10,750** for an academic year. In 2022, they ran two programs and trained eight new clinicians; with these additional resources, they aim to conduct six programs in 2023.

The Cape Cod PASS program provided the cost for operating its program in Centerville which includes personnel expenses, equipment, supplies, and other costs. It costs **$289,500** to operate one PASS program; this will double in 2023-2024 as a second program is implemented.

HarmReduction

For syringe and needle disposal, the majority of cost data was provided by CCCE. These data represent efforts in 14 of the 15 municipalities in Barnstable County (Sandwich does not currently participate in the program). Between January 1, 2022, and November 10, 2022, 348 50-pound boxes of needles and syringes were picked up from 21 sites and 2,960 sharps containers were distributed to county residents free of charge from 20 sites. Cost for this program through CCCE was **$50,064.84** in 2022.

While these services are primarily supported by these CCCE funds, additional costs were provided by two town fire departments (FD)/department of public works (DPW) as well as a police department (PD). Mashpee DPW reported an average additional cost of **$800** annually; Cotuit FD/DPW noted an additional cost of **$430** – these costs were for purchasing of the disposal containers and some staff time. Barnstable PD reported an additional cost of $150 in fiscal year 2022, however they indicated this was low and the costs have ranged up to **$1,407** in the past.

For excess prescription drug disposal, the county funds kiosks at Barnstable County police stations. CCCE had previously funded and managed this initiative and continues to advertise the program and counsel residents on disposal opportunities, which equates to a cost of **$612.18** on average annually. Two PDs also provided their average cost per year: Wellfleet PD estimated **$2,000** and Barnstable PD reported a cost of **$644**.

One local PD, Barnstable, provided cost data related to their collaborative efforts in the community to provide outreach and resources for behavioral health related needs. The department has both a Component Grant for **$51,300.59** to fund their Community Impact Unit (CIU) and provide outreach and resources to the community for mental health and substance use needs; an additional **$14,570.40** funds the CIU's work with the Overdose Response program. This PD also has a Co- response Grant for **$99,994** that embeds a clinician in a PD to address behavioral health needs. Lastly this department provided costs for Section 35 and overdose response calls for a total of **$10,606.86**.

AIDS Support Group estimates it costs about $0.60 to provide one syringe; the 180,316 syringes in a year cost a total **$108,190**. Using this same estimate, the 84,675 syringes distributed by ACCESS Hope between March 2021 and March 2022 cost **$50,805**. Both these organizations as well as the Chatham EMS provided cost for Narcan distribution. AIDS Support Group has a cost of $37 per dose and they distributed 4,615 for a total cost of **$170,755**. Chatham EMS reported a slightly lower cost of $32.50 per dose and administers 8 doses for a total of **$260**. ACCESS Hope did not provide an estimated cost per dose. Using the average of these two costs ($34.75) for the 2,138 kits distributed, ACCESS Hope's cost for March 2021-March 2022 was **$74,296**. These costs are likely underestimates as they do not include staff time for this work.

Treatment

Duffy provided annual cost data for their OBAT program – **$506,000** – as well as the cost of counseling for those with substance use disorders - **$400,000**. CCHC provided the cost of emergency department patient care related to substance use services from May through October 2022 as **$3,862,325.80**; they have an additional cost for a registered nurse to do training and education with a cost of **$94,918** annually. OCHS provided estimated annual costs for outpatient substance use care as **$1,380,000** with additional estimated annual costs for training and community education at **$1,250,000**. Data from some health centers could be categorized by substance and are displayed in a later section of this report.

BSAS reported 3,014 admissions to its programs across Barnstable County in 2022. NCDAS estimates an average cost of $12,500 per 30-day admission for substance use treatment nationally. Based on these, the estimated cost of Barnstable County's admissions to BSAS licensed programs is **$37,675,000**. The Barnstable County Sheriff's Office spent **$432,374.68** on treating SUD in fiscal year 2022.

Recovery

Duffy provided cost data for their recovery coaching program at **$415,100** annually. They also provide other recovery supports through a recovery support navigator program with a cost of **$192,960** annually.

WellStrong also provided recovery coaching costs from November 2021 through October 2022 at **$43,167**. Additional recovery support services cost **$247,793** in that time period and included wellness, meetings, classes, and other related costs.

Parents Supporting Parents provided information on a scholarship program to help support individuals' transition out of treatment and into sober homes. In 2022, they distributed **$53,650** in scholarship funds to community members to find housing after treatment.

RecoveryBuild APG provided the estimated cost of maintaining their program at their Dennis and Falmouth sites providing other recovery support services. These costs include the Family Therapist and Youth Behavioral Health Specialist, peer mentors, and cost of activities, rent, and supplies. For fiscal year 2024, they estimate running these two programs will cost **$315,000**, approximately $157,500 per program.

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Appendix C: Regional Substance Addiction Council Organizational Chart

Appendix D: Barnstable County Core Planning Group/RSAC Prevention Work Group Members

Co-Chairs

Patty Mitrokostas: YMCA, Vice President of Development

Ruth Provost: Boys + Girls Club, CEO

Members

Alicia Bryant: Barnstable Public Schools, Director of Health Services

Barbara Dominic: Barnstable County Children's Behavioral Health Work Group, Consultant

Beth Griffin: Upper Cape Cod Regional Technical School, School Adjustment Counselor/School Counselor

Cindy Horgan: Cape Cod Children's Place, Executive Director

Gail Wilson: Town of Mashpee Human Services, Director

Julia Bateman: Calmer Choice, Director of External Relations

Joy Jordan: Monomoy Regional School District, Community Engagement Coordinator

Kathe Medwin: Cape Cod Children's Place

Melissa Alves: Cape Cod Children's Place, Pediatric Occupational Therapist

Noel Sierra: Massachusetts Organization for Addiction Recovery (MOAR), Southeastern Mass Regional Coordinator

Sheila House: Town of Harwich Youth and Family Services, Licensed Mental Health Counselor (LMHC)

Brianne Smith: Outer Cape Health Services, Community Resource Navigators Program, Program Manager, LICSW, TCTSY-F

Stacey Schakel: Mashpee Public School District/ Mashpee Substance Use Coalition

Stephanie Briody: Behavioral Health Innovators, Inc. Co-founder + CEO

Suzie Hauptmann: Town of Falmouth Human Services, Director

Attachment A: Barnstable County Logic Model

Intervening Variable #1

Local Manifestation of Issue/Need: Need for more awareness around and programs addressing community wellness and how it relates to youth substance misuse prevention, including protective and risk factors. 30% of Monomoy high school students (2019 YRBS) report having used alcohol in the past 30 days with 17% of those students reporting binge drinking, which is a higher binge drinking rate than the state and country. 23.8% of Nauset high school students (2021 YRBS) report having used alcohol in the past 30 days, which is a higher percentage than

Locally identified/prioritized substance of first use for specified populations: Underage use of all substances of first use, including alcohol, tobacco, and marijuana.

				Outcomes		
Intervening Variable	**Strategy**	**Centered Group(s)**	**Outputs**	**Short-Term**	**Intermediate**	**Long-Term**
Lack of awareness around connection between mental health, community wellness, and youth substance misuse prevention	1. Trainings on youth mental health, wellness, and how it relates to youth substance misuse prevention 2. Offer interactive wellness activities on My Choice Matters website and in person, for caregivers and for youth.	Elementary, middle and high school-aged youth/students Families/Caregivers Prevention providers, including out of school programs and program staff School staff + Administrators	# of programs available that address community wellness # of prevention providers and school staff trained # of youth trained # of people who accessed mental health/wellness programs	Increase in referrals to community wellness programs for youth Increase in healthy and safe places for youth to establish a sense of belonging and purpose	Increased knowledge on the connection between substance use and mental health, and wellness-related skills	Increased community wellness, as reflected in youth risk behavior surveys Decrease in use of stigmatizing language related to youth with behavioral health needs

Intervening Variable #2

Locally identified/prioritized substance of first use for specified populations: Underage use of all substances of first use, including alcohol, tobacco, and marijuana.

Local Manifestation of Issue/Need: Need for more awareness around and programs addressing community wellness and how it relates to youth substance misuse prevention, including protective and risk factors. 30% of Monomoy high school students (2019 YRBS) report having used alcohol in the past 30 days with 17% of those students reporting binge drinking, which is a higher binge drinking rate than the state and country. 23.8% of

				Outcomes		
Intervening Variable	**Strategy**	**Centered Group(s)**	**Outputs**	**Short-Term**	**Intermediate**	**Long-Term**
Parental/ caregivers attitudes/perspectives around substance use resulting in younger age of first time substance use, and multi-generational use.	1. Trainings for parents on substance use and substance use prevention in the home 2. Offer interactive wellness activities on My Choice Matters website and in person, for caregivers	Families/Caregivers (primary) Children of the Caregivers (secondary)	# of people trained # of trainings offered # of caregivers attending Parent Academy # of assessment activities completed % increase in folks visiting the My Choice Matters website	Increase in knowledge around substance use prevention and how to talk to your children about substances	Change in parental attitudes and norms around youth substance use	Decrease in multigenerational use Increase in age of first use (data shows delayed first time use results in lesser chance of developing a substance use disorder later in life), as tracked through regional averages from youth health surveys