

**APPLICATION OF ROOT CENTER FOR ADVANCED
RECOVERY FOR MAP AMENDMENT AND SPECIAL
EXCEPTION WITH SITE PLAN REVIEW FOR
392 WASHINGTON STREET, MIDDLETOWN, CT**

**Responses to PCD Comments and Public Comments
From September 9, 2020 Public Hearing**

– Submitted September 18, 2020 –



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SUBMITTED SEPARATELY

SUBMITTED SEPARATELY

Six Full-size Revised Site Plan / Layout Plan Sheets CS-101, LP-101, L-1, September 16, 2020, prepared by Fuss & O'Neill, showing addition of two parking spaces; elimination of monument and rear building sign; mitigation / elimination of light spillage onto adjacent properties.

Dropbox link of all supplemental materials.

MEMORANDUM

TO: Stephen Devoto, Chair, and Members, Middletown Planning and Zoning Commission
Marek Kozikowski, City Planner, City of Middletown

FROM: Root Center for Advanced Recovery Applicant Team / Shipman & Goodwin LLP

DATE: September 18, 2020

RE: Applicant's Responses to September 9, 2020 Public Hearing

During the September 9, 2020 public hearing, the Commission heard claims from a handful of people who operate a small business or reside near 392 Washington Street, that Root Center's proposal to establish a methadone clinic will decrease property values and increase criminal activity in the area. While acknowledging the need for treatment of substance use disorders, these opponents asserted that 392 Washington Street is “not an appropriate location” for a methadone clinic. Opponents also asked why the proposed methadone clinic cannot operate at the Root Center's facility at 520 Saybrook Road in Middletown (or at least, somewhere else). In addition, in a memo, City Planner Kozikowski stated a variety of comments and questions about impacts of the proposed facility on Washington Street.

In this package, Root Center, as applicant, has responded to the City staff's and public hearing comments and questions, thoroughly and definitively. In summary, as described in detail below and in the attached materials, *the Commission has already determined that the MX Zone, including Washington Street, is an appropriate location for a methadone clinic*; the Root Center's application complies with all applicable regulations; and not only will there be no adverse impacts on property values or crime, *but the clinic will help stabilize the lives of the individuals who will receive treatment, which will benefit the City and the neighborhood, and most likely improve property values and decrease crime*. As a result, this Commission should

approve the application. We suggest the Commission consult with the City Attorney to verify what Root Center has provided here as responses.

This conclusion is based on the following:

1. When this Commission, in its hearings held February – April 2020, reviewed and discussed designating a methadone clinic as a special exception use, it reviewed maps (*see* Tab 5 of this package) identifying the locations within the City where a methadone clinic could be established. In particular, the Commission focused on the MX Zone and Washington Street. Having amended its zoning regulations to designate MX zoned parcels on Washington Street as an appropriate location for a methadone clinic as a special exception use, the Commission may not now assert that 392 Washington Street is not an appropriate location.

By designating a methadone clinic in April 2020 as a special exception use in the MX Zone, the Commission legally determined that such a use is "generally compatible with the zoning district, but requires review and approval by a land use agency under standards in the zoning regulations to determine that it is consistent with uses permitted as-of-right in the district." If the use meets the regulations, then the Commission's only remaining question is whether the "mode of operation must be regulated [through conditions of approval] because of topography, traffic problems, neighboring uses, etc. of the site." *See* R. Fuller, *Connecticut Land Use Law and Practice*, § 3.8 (4th ed. 2019) (copy attached / yellow highlighting added).

2. The City's Planning staff agrees at this point that Root Center's application complies with all aspects of the applicable Zoning Regulations such as setbacks, building height, storm drainage, etc. The City's Design Review and Preservation Board approved the architecture, appearance, floor plan, and amenities on September 9, and the City's various departments have signed off on the site plan. *Thus, the only remaining question is whether the clinic's operations will cause impacts that need to be controlled by approval conditions.*

3. At Tabs 6 and 7 of this package, we have provided definitive academic studies demonstrating that methadone clinics do not decrease property values or increase crime. Evaluation of such impacts requires specialized expertise, which the authors of these studies have, and those who spoke in opposition at the September 9 public hearing do not. On subjects requiring expert testimony, our courts have held that a zoning commission may not reject or ignore unchallenged expert testimony and instead choose to accept unsupported claims.

4. As to the operation of the clinic: (a) all treatment will be inside the facility; (b) the client entrance is purposely located at the rear of the facility and the exit on the side, so as to move all activity away from Washington Street, while also preserving client privacy; (c) Root Center's medical staff is obligated to work with those receiving treatment to ensure they do not engage in conduct at the clinic or off-site that could put them or others at risk; and (d) Root Center will regularly monitor activity in its own parking lot and around its building.

In summary, the facility meets all regulatory requirements; the facility will benefit those receiving treatment, the area, the City, and the region; and the assertions of adverse impacts -- on property values, crime, and client conduct -- are not only unsupported, but incorrect.

9 Conn. Prac., Land Use Law & Prac. § 3:8 (4th ed.)

Connecticut Practice Series TM October 2019 Update

Land Use Law & Prac.
Robert A. Fuller

Part I. Land Use Agencies and Their Powers and Duties

Chapter 3. The Zoning Commission and Types of Zoning Controls

§ 3:8. Zoning controls—Special permits

The authority to issue special permits or special exceptions is allowed by an amendment in 1959 to General Statutes § 8-2.¹ The amendment added a provision to the statute allowing zoning commissions to adopt regulations which would allow a use subject to standards contained in the zoning regulations and under special conditions after the obtaining of a special permit. In *Summ v. Zoning Commission of Ridgefield*,² the supreme court stated that this amendment was in response to a problem with the statute discussed in an earlier case.³ General Statutes § 8-2 now provides that the zoning regulations “may provide that certain classes or kinds of buildings, structures or uses of land are permitted only after obtaining a special permit or special exception from a zoning commission, planning commission, combined planning and zoning commission or zoning board of appeals, whichever commission or board the regulations may, notwithstanding any special act to the contrary, designate, subject to standards set forth in the regulations and to conditions necessary to protect the public health, safety, convenience and property values.” As recognized in *Summ v. Zoning Commission of Ridgefield*,⁴ the amendment to the statute gives local zoning authorities the power to impose certain standards and conditions on the use of property when the public interest requires it. The zoning commission can also reserve to itself or delegate to any of the other specified agencies in the zoning regulations the power to grant a special permit or special exception.

The zoning commission has retained for itself the authority to issue special permits (or special exceptions) in a majority of Connecticut towns, and the procedures are then governed by General Statutes § 8-3c. In a significant number of towns, the zoning commission has delegated special permits to the zoning board of appeals. There is no material difference in the statutory procedures, but the zoning board of appeals proceeds under General Statutes §§ 8-6(a)(2), 8-7. A few towns allow special permits to be issued by the planning commission, and its procedures on special permits (or special exceptions) are covered by General Statutes § 8-26e. No matter which agency acts upon special permits, the test for approving them is identical.⁵

The terms special permit and special exception mean the same thing and are used interchangeably.⁶ While the terms “special permit” and “special exception” come from the enabling statute, General Statutes § 8-2, occasionally, other terms such as “special use” or “special cases” are used.⁷

A special permit is a use which the zoning regulations expressly permit under conditions specified in the regulations.⁸ The special permit has become a popular means of zoning control by municipalities as an alternative to having the zoning regulations structured so that only particular, specified uses are allowed in a particular zoning district under traditional Euclidian zoning. If a particular use is allowed in a zone as a permitted use, the property owner is entitled to it as a matter of right, which results in uses which the commission finds to be undesirable in some cases. On the other hand, if the use is not permitted or is prohibited but is desirable for a particular property, it cannot be obtained except with a variance from the zoning board of appeals, which generally cannot be granted because of the hardship requirement. Many zoning commissioners and most planners would like to control land use on a case by case basis, but this could lead to favoritism and corruption and violate concepts of fairness and due

process and the uniformity provision in General Statutes § 8-2.⁹ Special permits overcome these problems while giving some individual treatment of applications, by allowing particular types of uses only after a special permit has been obtained from the agency, guided by standards contained in the zoning regulations. The special permit also gives some flexibility in regulating the use of a particular parcel as an alternative to regulating all parcels in the same zoning district identically.

A special permit differs from a variance because a special permit allows a use specified in the regulations subject to conditions contained in them while a variance allows a use which is otherwise not allowed by the zoning ordinance.¹⁰ A special permit is considered generally compatible with the zoning district but requires review and approval by a land use agency under standards in the zoning regulations to determine that it is consistent with uses permitted as of right in the district.¹¹ In recent years, zoning commissions have often required the submission of a site plan application as part of a request for a special permit in accordance with zoning regulations. This then results in the option of more individualized treatment of a particular parcel or structure but within the legal limits of regulation through zoning.

The rationale for a special permit (or special exception) is that while certain specially permitted uses are generally compatible with uses permitted as of right in particular zoning districts, their precise location and mode of operation must be regulated because of topography, traffic problems, neighboring uses, etc. of the site.¹²

A special permit or special exception does not require any showing of hardship like a variance because a variance permits the owner to use the property in a manner forbidden by the zoning regulations while a special permit or special exception allows uses that are expressly permitted under conditions stated in the regulations.¹³

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Footnotes

- 1 1959 Public Act 59-614 § 2.
Campion v. Board of Alderman of City of New Haven, 85 Conn. App. 820, 836, 837, 859 A.2d 586, 596 (2004), judgment rev'd on other grounds, 278 Conn. 500, 899 A.2d 542 (2006).
- 2 *Summ v. Zoning Commission of Town of Ridgefield*, 150 Conn. 79, 86, 186 A.2d 160, 164 (1962).
- 3 *Pecora v. Zoning Commission of Town of Trumbull*, 145 Conn. 435, 144 A.2d 48 (1958).
- 4 *Summ v. Zoning Commission of Town of Ridgefield*, 150 Conn. 79, 86, 186 A.2d 160, 164 (1962).
- 5 See §§ 5:1, 33:3.
- 6 *A. P. & W. Holding Corp. v. Planning and Zoning Bd. of City of Milford*, 167 Conn. 182, 185, 355 A.2d 91, 93 (1974); *Summ v. Zoning Commission of Town of Ridgefield*, 150 Conn. 79, 87, 186 A.2d 160, 164 (1962).
- 7 *Maher v. Town Planning and Zoning Commission of Town of Stratford*, 154 Conn. 420, 422, 226 A.2d 397, 399 (1967).
- 8 *W A T R, Inc. v. Zoning Bd. of Appeals of Town of Bethany*, 158 Conn. 196, 200, 257 A.2d 818, 821 (1969); General Statutes § 8-2.
- 9 See §§ 4:5, § 22:16.
- 10 *Town of Burlington v. Jencik*, 168 Conn. 506, 509, 362 A.2d 1338, 1340 (1975); *Lurie v. Planning and Zoning Commission of Town of Westport*, 160 Conn. 295, 304, 278 A.2d 799, 804, 49 A.L.R.3d 476 (1971); *Parish of St. Andrew's Protestant Episcopal Church v. Zoning Bd. of Appeals of City of Stamford*, 155 Conn. 350, 353, 232 A.2d 916, 918 (1967); *Service Realty Corp. v. Planning and Zoning Bd. of Appeals of Town of Greenwich*, 141 Conn. 632, 636, 109 A.2d 256, 259 (1954).
- 11 *Barberino Realty and Development Corp. v. Planning and Zoning Com'n of Town of Farmington*, 222 Conn. 607, 612, 610 A.2d 1205, 1208 (1992).
- 12 *Zoning Com'n of Town of Farmington*, 222 Conn. at 612, 610 A.2d at 1208; *Municipal Funding, LLC v. Zoning Bd. of Appeals of City of Waterbury*, 270 Conn. 447, 456, 457, 853 A.2d 511, 517 (2004); *Smith-Groh, Inc. v. Planning and Zoning Com'n of Town of Greenwich*, 78 Conn. App. 216, 228, 826 A.2d 249

(2003); Yagemann v. Planning and Zoning Com'n of Town of Greenwich, 92 Conn. App. 355, 361, 886 A.2d 437 (2005).

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Grasso v. Zoning Bd. of Appeals of Groton Long Point Ass'n, Inc., 69 Conn. App. 230, 242–244, 794 A.2d 1016, 1024–1026 (2002).

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**RESPONSES OF APPLICANT HARTFORD DISPENSARY
d/b/a ROOT CENTER FOR ADVANCED RECOVERY
TO PCD COMMENTS OF SEPTEMBER 8, 2020**

– September 18, 2020 –

Below, the PCD's comments are in regular type and the Root Center for Advanced Recovery's responses are in *bold italics*. (PCD comments are excerpted here only if a Response is provided.)

Existing Site Conditions

The property is bound by a commercial property with a restaurant use to the south, a mixed use building and an automotive repair facility to the north, a railroad right-of-way with single family dwellings beyond to the west and Route 66 with a cemetery beyond to the east. All abutting property is in the MX zone.

APPLICANT'S RESPONSE: *It is important to note that, in name and substance, the MX Zone is not a residential zone, but one that allows commercial and retail areas along with multi-family and single-family residential. See Tab 8.*

The property comprises of a single parcel containing of 1.115 acres in the MX zone. It has 100 ft of frontage on Washington Street. The property has conforming frontage and lot area. It is improved with a 7,200 SF, one story commercial building with associated utilities, driveways, parking area and green spaces. The building is currently divided into two tenant spaces. One space is occupied by an automobile repair facility and the other space is vacant retail space. The building has conforming, height, stories, setbacks and a nonconforming use. The site has a lawn area and parking in front of the building, and parking, greenspace and some down sloped area in the back of the property. There are no inland wetlands.

APPLICANT'S RESPONSE: *Because the existing auto repair use is nonconforming in the MX Zone, by law it should be terminated in favor of an allowed, conforming use.*

REZONING

The property is currently in the MX zone and abuts only properties located in the MX Zone. The cemetery across Washington Street is in the M zone. The applicant proposes to change the zone of the property to the Substance Abuse/Mental Health Floating (SMH) Zone and the MX zone will remain the underlying zone.

APPLICANT'S RESPONSE: *It is important that that not only is 392 Washington Street zoned MX, but so are all abutting parcels.*

The intent of the zone, is to minimize the impact of such development on neighbors within the floating zone and abutters in adjacent, more restrictive zones while recognizing the important service which these facilities provide to the residents of Middletown.

APPLICANT'S RESPONSE: Agreed; this underscores the accuracy and importance of the Commission's April 2020 decision to make methadone clinics a special exception use in the MX Zone.

Applicability (39C.02)

The property lays within the section of Washington Street of which the SMH zone could be applied.

APPLICANT'S RESPONSE: Agreed.

Permitted Use (39C.03)

The proposal is for a substance abuse/mental health diagnosis and treatment facility providing methadone treatment, which appears to fall under the allowed uses in the zone (39C.03).

APPLICANT'S RESPONSE: Agreed.

Changes in Use/ Enlargement/ Expansion (39C.04)

The proposal includes review for the use for initial approval. The use would occupy the entire 7,200 SF of the existing building with no proposal to expand the building footprint or square footage. The remaining portions of the site will be utilized as driveways, parking, loading, sidewalks, green spaces, a staff patio and other improvements associated with the proposed use.

APPLICANT'S RESPONSE: Agreed.

Yards and Height Requirements (39C.03)

Both the existing and proposed conditions meets the yard and height requirements for the underlying MX zone.

APPLICANT'S RESPONSE: Agreed.

- 2) The Design Review and Preservation Board (DRPB) reviewed the initial submission and provided feedback to the applicant on August 12, 2020. The applicant submitted revised plans which is scheduled for review by the DRPB on September 9, 2020.

APPLICANT'S RESPONSE: *Design Review / Preservation Board approved the building design on September 9, 2020.*

- 3) The average building size of the five closest buildings is estimated at 7,208 SF based on information from the property field cards.

APPLICANT'S RESPONSE: *Agreed. The proposed building rehabilitation is consistent with buildings on neighboring parcels.*

- 4) The most restrictive abutting zone is the MX zone. The proposal meets the required height and bulk requirements of that zone.

APPLICANT'S RESPONSE: *Agreed.*

- 5) The compatibility with the neighborhood in terms of traffic, noise, illumination and number of patients/clients is evaluated later in this report.

APPLICANT'S RESPONSE: *And the applicant's responses address this specific issue.*

- 6) Due to the proximity of existing buildings and driveways to property lines, there is little opportunity for adequate evergreen screening, fences and earthen berms to screen the facility from adjacent properties.

APPLICANT'S RESPONSE: *The applicant has proposed, and Design Review has approved, a fence along the entire eastern boundary of the site, separating the proposed use from the salon property. In addition, in the Site Plan revision filed September 3, 2020, several trees and other landscape screening were added.*

- 7) The Commission is given authority based on reasonable and minimum standards to impose additional conditions and modifications as necessary to protect the public health, safety and welfare.

APPLICANT'S RESPONSE: *Correct. The Commission cannot at this point assert that the proposed location is not appropriate to the proposed use. See Tab 1 discussion. The Commission may impose conditions to control impacts.*

Illumination

The proposed lumen plan does show light spilling onto adjacent properties. This is evaluated later in this report. The proposed signs are not internally illuminated.

APPLICANT'S RESPONSE: *Light spillage has been addressed in a Site Plan revision, see Sheet L-1.*

SPECIAL EXCEPTION/SITE PLAN

On April 22, 2020 the Planning and Zoning Commission approved a text amendment removing methadone clinics from the prohibitive use category and made clinics for mental health and/or substance use diagnosis and treatment uses special exception uses in the SMH zone.

APPLICANT'S RESPONSE: *Correct. See Tabs 4 and 8.*

A site plan is required for the special exception use (44.03.1). The proposal qualifies as a Category 4 site plan review.

APPLICANT'S RESPONSE: *Agreed.*

Proposed Conditions

The applicant proposes to maintain the existing building and curb cut and constructed façade improvements, expansion of the parking lot to the rear of the property, install a new generator construct a new staff patio area, construct privacy walls, retaining wall, drainage system, landscaping and other associated improvements.

APPLICANT'S RESPONSE: *Agreed.*

Buildings and Uses

The existing building will obtain façade improvements. The front façade will be cladded with a mixture of materials including grey and white hardie plank artisan lap siding, painted grey block wood siding with a wood trellis. The front windows will be glazed and the door into the building is limited to employees. The company sign and logo is visible from the front façade.

APPLICANT'S RESPONSE: *As noted, Design Review approved a revised site and building design on September 9, 2020.*

The main entrance to the building will be located at the rear of the building. This façade includes a main front door and canopy over the entrance and sidewalks. The cladding will be the grey and white hardie plank artisan lap siding. The company name and logo will be installed over wood cedar siding.

APPLICANT'S RESPONSE: *Agreed. As to the rear entrance, see cover memo, Tab 1, and supplemental memo from Tecton Architects, Tab 10.*

The side facades will include planted brick. The southern wall will have a screening wall that provide privacy for patients as they exist the building after treatment.

APPLICANT'S RESPONSE: *Agreed. Approved by Design Review.*

The floor plans show the entry vestibule and check in areas, common space at the rear of the building. The floor plans include 13 counseling rooms, three group counseling rooms, dosing areas, medical supply area, pharmacy, conference room, exam room, lab and other support spaces. The rooms along the front façade including a staff conference room, three counseling rooms and an employee breakroom.

APPLICANT'S RESPONSE: *Agreed.*

Parking, Loading and Circulation

The site will utilize the existing curb cut. A 24 ft wide driveway will provide two way access to the rear of the property where all the onsite parking is provided. The proposed conditions show a parking lot containing 44 parking spaces at the rear of the building which includes two ADA accessible spaces. There is a loading space located at the front of the building.

APPLICANT'S RESPONSE: *Revised plan submitted with this package shows two additional parking spaces.*

The proposed medical clinic use demands 45 parking spaces as presented by the applicant (40.04.03). The use will utilize all 7,200 SF of the building as well as provide one space for the one doctor on site and one space for each three employees.

APPLICANT'S RESPONSE: *Site Plan now shows 46 spaces.*

The proposal is deficient by one parking space.

APPLICANT'S RESPONSE: *Deficiency addressed.*

No electric charging stations are proposed when two charging space are required (40.02.01).

APPLICANT'S RESPONSE: *Site Plan shows two electric charging stations. See Sheet C-101.*

Drainage

The proposed drainage system consists of collecting stormwater from the driveways and parking area and directing it into an underground detention system. Overflow will be directed to a scour hole proposed in the northwest corner of the lot and adjacent to the railroad right-of-way. A stormwater management report was provided and notes that peak flows will be reduced for all storms measure up to a 100 year storm under proposed conditions.

APPLICANT'S RESPONSE: *Agreed; approved by City Water and Sewer Department.*

Utilities

The building will utilize existing underground utilities that service the building. An emergency generator with concrete pad is proposed to the rear of the building.

APPLICANT'S RESPONSE: *Agreed.*

Lighting

All site lighting for the site includes three lights on the building and four light poles along the driveway and within landscape islands in the parking lot. The lumen plan shows light spillover of up to 0.6 foot candles onto adjacent properties. There is no light spilling onto properties with residential uses but all properties are in the MX zone which is classified as a residential zone (Section 60).

APPLICANT'S RESPONSE: *Light spillage addressed, see Sheet L-1 as revised.*

Signage

The applicant proposes two building signs with one on each the front and the back facades. The signage includes the company name "Root Center for Advanced Recovery" and company logo. A freestanding sign is proposed in the front lawn. No dimensions for the signage to demonstrate compliance with the regulations. There are no specific sign standards for the SMH zone but the underlying MX zone allows a maximum one building sign (48.03.06).

APPLICANT'S RESPONSE: *The freestanding / monument sign has been eliminated from the Site Plan. See Sheet LP-101 and Tab 10.*

Landscaping

The landscaping plan shows a mix of planning of trees, shrubs and perennial flowers and grasses.

APPLICANT'S RESPONSE: *Agreed, and enhanced on the Site Plan as revised, see Sheet LP-101.*

The front of the building will include a front lawn area with plantings around the freestanding sign. A street tree (Bloodgood London Planetree) is proposed behind the sidewalk in the front yard of the property. Adjacent to the building will be a patio area that will be screened with a cedar fence and landscape planting.

APPLICANT'S RESPONSE: Monument / freestanding sign eliminated. Landscaping enhanced on Site Plan as revised.

The rear parking lot will have landscaping within landscaping island and along the periphery of the paved area. The parking lot trees includes four red oaks, four flowering dogwoods and one honeylocust. Additional shrubs and grasses are proposed.

APPLICANT'S RESPONSE: Additional landscaping proposal on September 3 revision.

Erosion & Sediment Controls

The proposal includes erosion & sedimentation controls that consist of a row of silt fencing along the perimeter of the rear of the property around the disturbed area. An anti-tracking pad is located at the construction entrance that utilizes an existing curb cut.

APPLICANT'S RESPONSE: Agreed.

Special Exception Findings (44.04)

The Commission may grant a special exception when making a finding on the following criteria below:

Compliance with the City Plan

The 2010 Plan of Conservation and Development does list expanding and building upon the medical sector as a regional draw as one of the guiding principles of the Plan. The plan describes the Saybrook Road Medical Corridor that details the significant investment in the medical sector in this area. Portions of Saybrook Road are eligible for rezoning to the SMH Zone.

APPLICANT'S RESPONSE: Agreed. Also, see response at Tab 3 as to Saybrook Road.

Furthermore, the Plan lists protecting the unique character of neighborhoods and improve the quality of development by adopting form-based design standards. The Planning and Zoning Commission has not adopted form-based design standards for this section of Washington Street but any current or potential form-based design standards would likely discourage, if not prohibit, orienting front building facades away from the public way.

APPLICANT'S RESPONSE: As noted, the City has not adopted a form-based code for Washington Street. Moreover, there is no reason that a form-based code would or could prohibit a methadone / medical

clinic having a rear or side entrance for the purpose of protecting client / patient / visitor privacy.

Adverse Effects

Side effects of methadone treatment may include impaired cognition or confusion, forgetfulness, impaired balance or coordination, fatigue, nausea or vomiting, and stupor among other effects. It is unclear how the facility will control for these side effects, which if displayed out among the community could have detrimental adverse effects to the health and safety of resident, workers in the area or adjacent properties.

APPLICANT'S RESPONSE: *As discussed at Tabs 1 and 3, Root Center will monitor all client / patient conduct in its parking lot and around the facility. Medication-assisted treatment is intended to stabilize individuals with substance use disorders, so the clinic will actually improve health and safety in the City of Middletown.*

There has been significant amount of written public comment submitted to date expressing concerns on how the facility could impact their property values and the community.

APPLICANT'S RESPONSE: *All recent, credible studies, performed by experts, have concluded that methadone clinics do not decrease property values. Several such studies are at Tab 6.*

Visibility and Accessibility Not applicable.

APPLICANT'S RESPONSE: *The building and parking areas will be adequately lit to provide visibility, but also screened from adjacent parcels, and accessible in compliance with legal requirements.*

Traffic Movement

The proposal will use the existing curb cut for ingress and egress onto the site for vehicular travel. The applicant provided a traffic impact study for the proposed site activity. The analysis generalizes the use as a "clinic" and does not discuss any potential changes in trip generation for the proposed substance use treatment use.

APPLICANT'S RESPONSE: *See supplemental memo at Tab 9.*

The plan notes that the level of service entering the site will not change from the existing LOS A. The plan notes that the level of service exiting the site will not change from the current LOS F. A LOS F is classification for the most dangerous intersections in the Highway Capacity Manual, 6th Edition.

APPLICANT'S RESPONSE: *Level of Service / LOS is not a measure of vehicular or pedestrian danger. See memo at Tab 9.*

The analysis does not discuss how the effects of treatment could further impact a driver's ability to navigate this challenging intersection. The study notes that there were 7 car crashes in front of the proposed site. It is not discussed how the proposed use can further impact drivers and ability to avoid incidents.

APPLICANT'S RESPONSE: *First, the Root Center, as applicant, is entitled to a presumption that its clients and patients will exercise appropriate care of their own safety and not drive when under the influence of impairing medication. Conversely, the Commission may not make the opposite assumption. There is nothing unsafe about the site's driveway. See Tab 9.*

Orderly Development

The proposed use will utilize the existing building and existing curb cut. The parking lot to the rear of the site will be expanded.

APPLICANT'S RESPONSE: *Agreed.*

The site is located in the middle of the MX zone which is primarily a residential zone that allows for a select amount of commercial uses. Many of the current uses in the MX zone were established prior to the creation of the zone. Medical and dental offices and clinics are the most similar use which are allowed under special exception (61.01.54 & 61.02.35). For the purpose of a comparison, a medical clinic would fail to meet specific special exception standards at this location (44.08.06)

APPLICANT'S RESPONSE: *This comment is inaccurate, as well as difficult to understand. The MX Zone, in name and substance, allows mixed uses. Washington Street is a prime example. Since medical offices are allowed by special exception, and the Commission in April 2020 voted that methadone clinics are a special exception use in the MX Zone, the applicant is hard-pressed to understand this comment. The Commission determined that methadone clinics are compatible with other MX Zone uses.*

Property Values and Character

It is unclear how the proposed use can affect property values. There is public input that does express concern about property values. Any change in property values will likely be a result from general upkeep of the property and management of outpatients.

APPLICANT'S RESPONSE: *See Tab 6.*

The Washington Street corridor would be impacted by the proposed development. While the corridor could be greatly benefited with building façade and landscaping improvements, there are some fundamental flaws to the proposal that negatively impact the character of the corridor. First the building is orientated backwards. While placing the parking behind the building is encouraged and desirable, the clinic façade is on the back of the property. The front façade with the entrance and canopy should face the public way. Basically the back of the building faces Washington Street. Furthermore the proposal includes a semi private staff area that is screened by fence. The fence will be the most visible improvement from the public street. Furthermore, the use of the door that faces the street is limited to employees only and the windows facing the street will be glazed/tinted, which will eliminate the opportunity let the internal use of the building contribute activity of the streetscape.

APPLICANT'S RESPONSE: *The proposal (1) will replace a nonconforming use; (2) complies with all objective criteria in the Zoning Code; (3) has a rear entrance and site exit, and a rear parking lot, so all activity will be separated from Washington Street.*

Parking and Loading

The plan proposes off-street parking totaling 44 spaces when 45 would be required under Section 40 of the Zoning code. The Commission may modify the parking requirement under Section 40.08.

APPLICANT'S RESPONSE: *Revised plan shows 46 spaces.*

Compliance with Standards

There are no additional specific standards for special exception use under Section 44.08.

APPLICANT'S RESPONSE: *Agreed.*

Issues remaining to be addressed

1. The applicant should discuss how potential side effects of methadone treatment will be mitigated for and offer no detrimental impacts to the public health and safety of the neighborhood.

APPLICANT'S RESPONSE: *See Tabs 1 and 3. Methadone treatment stabilizes the conduct of individuals with substance use disorders. Root*

Center's treatment obligation is to ensure that clients are aware of, and able to control, any impacts of receiving medication.

2. The applicant should provide any empirical data available on the impacts of methadone treatment clinics have on property values.

APPLICANT'S RESPONSE: See Tab 6.

3. The applicant should explain why the proposed location along the Washington Street corridor is a preferential location for the proposed use as opposed to clustering closer to other medical uses in the Saybrook Road area.

APPLICANT'S RESPONSE: See Tabs 1 and 3.

4. The traffic analysis should be modified to address the following:
 - a. The report should distinguish differences as they relate to traffic patterns for substance abuse treatment clinics and general medical clinics.

APPLICANT'S RESPONSE: See Tab 9.

- b. The report should address opportunities to improve the LOS F of when existing the site. Furthermore the report should address how driver's ability to navigate this challenging intersection.

APPLICANT'S RESPONSE: See Tab 9.

- c. The report should address how the proposed use can further impact drivers and the ability to avoid crashes.

APPLICANT'S RESPONSE: See Tab 9.

5. The entrance and "front" façade of the building should be reoriented to the façade facing the public-way.

APPLICANT'S RESPONSE: See Tab 10.

6. Windows, at least at the street side façade should be clear and visible from the street.

APPLICANT'S RESPONSE: *Windows are clear and visible.*

7. The interior floor plan should be reoriented to that the main public active uses are located at the front of the building.

APPLICANT'S RESPONSE: *The floor plan, designed for treatment optimization, is not a land use / zoning issue.*

8. Only one building sign is allowed. It is recommended that the rear building sign be removed.

APPLICANT'S RESPONSE: *Monument sign removed. See Tab 10 as to signage.*

9. Dimensions for the signage should be provided to verify compliance.

APPLICANT'S RESPONSE: *Provided, see Tab 10.*

10. The cedar screening fence for the patio area should be removed to expose more of the front of the building.

APPLICANT'S RESPONSE: *See Sheets CS-101 and LP-101.*

11. The Commission requires a report from the DRPB before an approval can be issued.

APPLICANT'S RESPONSE: *Approved September 9, 2020.*

12. The lighting plan should be modified to eliminate light spillover onto adjacent properties.

APPLICANT'S RESPONSE: *Revised, see Sheet L-1.*

13. The Commission may consider modifying the parking requirement from 45 spaces to 44 spaces pursuant to Section 40.08.

APPLICANT'S RESPONSE: *Unnecessary.*

14. A minimum of two electronic vehicle charging stations should be provided.

APPLICANT'S RESPONSE: Provided.

15. Comments from Public works and the Water and Sewer Department on the revised plans dated September 2, 2020 are unavailable at this time. The plans were revised to address earlier comments.

APPLICANT'S RESPONSE: Public Works and Water and Sewer has signed off.

**RESPONSES OF APPLICANT ROOT CENTER TO
PUBLIC COMMENTS AND QUESTIONS AT SEPTEMBER 9, 2020
PUBLIC HEARING**

– September 18, 2020 –

1. Why not dispense methadone at Root Center’s facility at 520 Saybrook Road? Methadone needs to be dispensed at a facility expressly designed for client dosing, queuing, and medical evaluation. The confines of the space that “houses” the methadone also needs to be specifically designed for enhanced safety and security as dictated by the Drug Enforcement Administration (DEA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Department of Public Health (DPH). The floor plan for 392 Washington Street will meet this goal. 520 Saybrook Road, however, is rented office space and too small for methadone treatment, and thus cannot be renovated to anything resembling the proposed rehab of the building at 392 Washington Street. In addition, 392 Washington Street is accessible by public transportation, and a sidewalk.

2. How many clients per day will the facility serve? Root Center’s methadone treatment census will be approximately 500 patients when at full capacity. Where a particular client is in their recovery will determine how many patients come each day to the clinic. About 20-25 percent will be Middletown residents and the rest will come from other parts of Middlesex County.

3. Will this facility be overtaxed when free educational / information programs are presented? No. Such programs -- when permitted to resume under COVID-19 rules -- will be held when client use is at its lowest levels, during off hours, or via a “Zoom” equivalent technology.

4. What is the grade of the site and why is a retaining wall needed at the rear? In order to construct the parking lot, the majority of the property to the rear needs to be raised between 1 and 3 feet over what is existing today. Retaining walls are needed along the north and west property lines as the existing grade currently drops significantly along the property line to the neighboring properties. The height of the retaining wall along the westerly property line varies from 13 feet to 17 feet in height while the majority of the wall along the north property line is approximately 6 feet in height.

5. Was this application required to be submitted to the Inland / Wetlands & Watercourses Agency? No. There are no wetlands on the site.

6. Who will monitor the outside of the building and parking lot? The facility staff will regularly monitor the building, parking area, and client use of these areas.



**REGULAR MEETING OF THE PLANNING AND ZONING COMMISSION
MIDDLETOWN CONNECTICUT
FEBRUARY 12, 2020**

1. Pledge of Allegiance

Chairman Devoto called the meeting to order at 7:03 PM with the Pledge of Allegiance.

2. Roll Taking

Present: Commissioner Stephen Devoto
Commissioner Nicholas Fazzino
Commissioner Richard Pelletier
Commissioner Thom Pattavina
Commissioner Marcus Fazzino (arrived at 7:04 PM)
Commissioner Catherine Johnson
Commissioner Kellin Atherton (seated for Commissioner Brown)
Commissioner Shanay Fulton
Commissioner James O'Connell

Absent: Commissioner Tyrell Brown

Staff: Marek Kozikowski, AICP, City Planner

3. Items removed from the agenda and why

6.1 is postponed per applicant's request

6.2 is postponed per applicant's request

4. Public comment on items on agenda which are not currently scheduled for a public hearing

None

5. ZEO Certification that all public hearing signs have been properly noticed (when scheduled)

No signs required.

6. Public Hearings (when scheduled)

- 1. Continued: Proposed three (3) lot subdivision at 584 Atkins Street (Atkins Ridge) between Brechlin Road and Timber Ridge Road in the R-60 Residential**

Zone. Applicant/agent Cocomo II, LLC S2019-3 (To be rescheduled to March 11, 2020 per applicant)

Rescheduled to the February 26, 2020 per applicant's request.

- 2. Special Exception application proposing a 17 Unit Multi-Family Development at 0 & 61 West Street in the MX Zone. Applicant/agent DelFavero Associates, Inc. SE2019-9 (Postponed by applicant to February 26, 2020)**

Rescheduled to the March 11, 2020 per applicant's request.

7. Old Business

None

8. New Business

- 1. Proposed amended site plan (SPR2017-72) to modify the footprint of Building 1 to accommodate Retail and Automotive Use for the property of Washington West, LLC located at 804 Washington Street. Applicant/agent Washington West, LLC / Abe Kaoud SPR2020-2 (Date of receipt 2/12/20)**

Commissioner Richard Pelletier moved, seconded by Commissioner Thom Pattavina to waive Roberts Rules of Order to allow public testimony. The chair calls for the vote. It is unanimous to approve as amended with 7 aye votes. The chair states the matter passes unanimously with 7 affirmative votes.

Amy Souchons, attorney at Herwitz Sagarin Slossberg & Knuff representing Bridgestone Retail Operation, LLC spoke on behalf of the proposal. Mark Grocki, Project Manager with VHB gave a summary of what was approved in 2017 and the current proposal with a much smaller footprint. Because some of the site has already been constructed, the storm water improvements has also already been constructed for the larger impervious footprint.

Commissioner Atherton said it seems that the applicant took a lot of effort in insuring everything that was brought up to where they are now and asked if there were any follow up measures for any foreseeable issues in the future. Mark said the DEEP and Army Corps approvals were strictly for the culverting of the stream. The follow-up would be to ensure that all work has been completed and the stabilized.

Commissioner Fazzino asked if the Water Sewer requirement been satisfied. Mark said the revised plan was submitted last Friday and the W/S comments were submitted this week. They have no issues with complying with the W/S comments so if the approval is with the condition of the comments, they would have no issue.

Commissioner Johnson questioned the amount of parking in the plans with 22 extra spaces. Mark explained that they don't know what the adjacent use next to the Firestone building will be. It could be a restaurant, urgent care or some type of division between those which are more intensive uses. Having more spaces on site is a benefit should the use having to change for a different type of tenant.

Commission Devoto said that electric vehicle charging stations is a requirement with the Zoning Code. Mark said he wasn't aware of that requirement. Marek said the Zoning Code calls for 3% of the total spaces which would be 5-6 charging stations for this proposal. The applicant may ask

for a waiver or reduction at the time of the site plan approval. Mark asked for a few minutes to confer with the applicant. Attorney Souchons said that they would be willing to put in 2 charging stations but would have to look at the locations of the utilities to see where they can go.

Commissioner Devoto also asked about sidewalks on Plaza Drive. Mark explained that it wasn't compatible with their side of the street because of the steepness of the slope and their proposal for a guardrail next to the curb.

Commissioner Johnson would like the dumpster moved to another location. Mark Grocki explained that the IWWA were adamant not to put the dumpster in the upland review area.

Attorney Rich Carella said that he represents a number of people in the area that have many concerns about the project including the traffic flow and the totally different type of use that was originally approved. He asks for a public hearing.

Beth Emery who is on the Complete Streets Committee and the Commission's representative to RiverCog is concerned about the walkability in that area. She would like to ask the state why there aren't more crosswalks put in so the public can go from one shopping center to the next. The guardrail that is proposed is for the safety of the cars. Where is the proposal for the safety of the pedestrians?

Commissioner Fulton said she would also like to have more public input regarding the walkability. She feels the entryways are congested.

A discussion ensued about whether a public hearing is needed.

A motion to waive the number of charging stations from 5 to 3 was moved by Commissioner Devoto and seconded by Commissioner Fazzino. The chair calls for the vote. It is unanimous to waive the number of charging stations with 7 aye votes. The chair states the matter passes unanimously with 7 affirmative votes.

Commissioner Nicholas Fazzino moves for approval for an amended site plan to modify the footprint of Building 1 to accommodate Retail and Automotive Use for the property located at 804 Washington Street with the following conditions: 1) Install 3 charging stations; 2) Install sidewalks along Plaza Drive; and 3) The excess 22 parking spaces should be pervious to reduce runoff; 4) adhere to all staff and departmental comments. Commissioner Thom Pattavina seconds the motion. The chair calls for the vote. It is unanimous to approve with 7 aye votes. The chair states the matter passes unanimously with 7 affirmative votes.

2. Request for a five (5) year extension for Permit #SE2015-4 and Site Plan Approval for the South Cove Residential Development located at 225 River Road and 35 Eastern Drive. Applicant/agent Turkey Hill LLC/ Martin Smith SE2015-4 (Date of receipt 1/22/20)

Marek Kozikowski gave a review of the application. Commissioner Pelletier said there has been a significant change in Middletown since they gave this approval in 2015. He recommends not extending it. Marek said there is still a lot of discussion regarding the riverfront and moving River Road but there are no plans yet. Commissioner Johnson agrees with Commissioner Pelletier. She said the road needs to be moved.

The applicant, Martin Smith said it has been a long drawn-out process. The water treatment plant was supposed to be closed years ago and that is why this project has been delayed. He would

be happy to work with the City regarding moving the road but is not confident that it would ever happen. He needs to get more from the City than he is getting.

Commissioner Devoto suggests tabling the application so that they can get more input from staff and perhaps the mayor's office with respect to the master plan for the riverfront.

Commissioner Richard Pelletier moves to table until March 11, 2020. Commissioner Nicholas Fazzino seconds the motion. The chair calls for the vote. It is unanimous to table with 7 aye votes. The chair states the matter passes unanimously with 7 affirmative votes.

- 3. Schedule a Public Hearing for a Special Exception for a Home Day Care for children at 72 Pond Place in the R-1 Zone. Applicant/agent Valerie Demeze SE2020-1 (Date of receipt 1/22/20) (Suggested date February 26, 2020)**

Commissioner Thom Pattavina moves to schedule a Public Hearing for February 26, 2020 for a Special Exception for a Home Day Care for children at 72 Pond Place in the R-1 Zone. Commissioner Richard Pelletier seconds the motion. The chair calls for the vote. It is unanimous to schedule a public hearing with 7 aye votes. The chair states the matter passes unanimously with 7 affirmative votes.

- 4. Schedule a public hearing for a re-subdivision to convert parcel (30-0201) Brown Street into a building lot. Applicant/agent Brad Baker S2020-1 (Suggested date February 26, 2020)**

Commissioner Richard Pelletier moves to schedule a public hearing on February 26, 2020 for a re-subdivision to convert parcel (30-0201) Brown Street into a building lot. Commissioner Thom Pattavina seconds the motion. The chair calls for the vote. It is unanimous to schedule a public hearing with 7 aye votes. The chair states the matter passes unanimously with 7 affirmative votes.

- 5. Schedule a public hearing for a text amendment to Section 71 (Amendment Procedure) of the Middletown Zoning Code. Applicant/agent City of Middletown PCD Dept. Z2020-1**

Commissioner Thom Pattavina moves to schedule a public hearing on March 11, 2020 for a text amendment to Section 71 (Amendment Procedure) of the Middletown Zoning Code. Commissioner Nicholas Fazzino seconds the motion. The chair calls for the vote. It is unanimous to schedule a public hearing with 7 aye votes. The chair states the matter passes unanimously with 7 affirmative votes.

- 6. Schedule a public hearing for text amendments to Sections 61 and 40 to modify language related to prohibited uses, rooming houses and clinics in the Middletown Zoning Code. Applicant/agent City of Middletown PCD Dept. Z2020-2 (Suggested date of public hearing March 11, 2020)**

Commissioner Thom Pattavina moves to schedule a public hearing on March 11, 2020 for text amendments to Sections 61 and 40 to modify language related to prohibited uses, rooming houses and clinics in the Middletown Zoning Code. Commissioner Nicholas Fazzino seconds the motion. The chair calls for the vote. It is unanimous to schedule a public hearing with 7 aye votes. The chair states the matter passes unanimously with 7 affirmative votes.

7. Schedule a public hearing for a text amendment to Section 61 of the Middletown Zoning Codes to allow motor vehicle uses in the Transitional Development Zone. Applicant/agent John Sheil Z2020-3

Commissioner Richard Pelletier moves to schedule a public hearing on March 11, 2020 for a text amendment to Section 61 of the Middletown Zoning Codes to allow motor vehicle uses in the Transitional Development Zone. Commissioner Nicholas Fazzino seconds the motion. The chair calls for the vote. It is unanimous to schedule a public hearing with 7 aye votes. The chair states the matter passes unanimously with 7 affirmative votes.

9. Public comment on topics which are not or have not been the subject of a public hearing

None

10. Minutes of the Regular Meeting, Transcripts, Staff Reports and Commission Affairs

10.1 Minutes of January 8, 2020 Meeting

Commissioner Nicholas Fazzino moves for approval of the minutes of January 8, 2020 Meeting. Commissioner Richard Pelletier seconds the motion. The chair calls for the vote. It is 6 aye votes and 1 abstention by Commissioner Devoto. The Chair states the matter carried with 6 affirmative votes.

Commissioner Devoto left the meeting at 8:44 PM

10.2 Other Commission Affairs

a. River-Cog Report

Commissioner Kellin Atherton gave a report.

10.3 Report from by-laws subcommittee

Marek said they met on Monday and will continue working through the text.

10.4 POCD subcommittee

Marek said that the sub-committee was formed by previous members of the Commission and they will need to form a new POCD subcommittee. Commissioner Johnson said that the whole committee should be participating.

The Committee is working on amending the draft to incorporate comments made. Draft to come soon. The next sub-committee meeting to be determined. All commissioners encouraged to attend the next sub-committee meeting.

11. Adjournment

Commissioner Richard Pelletier moves for adjournment at 8:53 PM. Commissioner Kellin Atherton seconds the motion. The vice-chair states the matter passes unanimously with 6 affirmative votes.

Respectfully submitted,

Marek Kozikowski, AICP
City Planner



**REGULAR MEETING OF THE PLANNING AND ZONING COMMISSION
MIDDLETOWN CONNECTICUT
MARCH 11, 2020**

1. Pledge of Allegiance

2. Roll Taking

Present: Commissioner Stephen Devoto
Commissioner Nicholas Fazzino
Commissioner Thom Pattavina
Commissioner Richard Pelletier,
Commissioner Catherine Johnson
Commissioner Marcus Fazzino
Commissioner Kellin Atherton
Commissioner James O'Connell (seated for Commissioner Brown)
Commissioner Shanay Fulton (arrived at 7:05 PM)

Absent: Commissioner Tyrell Brown

Staff: Marek Kozikowski, City Planner

Public: 9 members

3. Items removed from the agenda and why

None

4. Public comment on items on agenda which are not currently scheduled for a public hearing

None

5. ZEO Certification that all public hearing signs have been properly noticed (when scheduled)

All public hearing signs were properly posted.

6. Public Hearings (when scheduled)

- 1. Proposed three (3) lot subdivision at 584 Atkins Street (Atkins Ridge) between Brechlin Road and Timber Ridge Road in the R-60 Residential Zone. Applicant/agent Cocco II, LLC S2019-3**

No one representing the application was present. Marek said that based on the statutory timeline, the Commission has to open the public hearing because the maximum amount of extensions has been granted. Marek described the proposal. He said the applicant is proposing a non-conforming frontage. 200 feet is needed in an R-60 zone and applicant is asking for 122 feet. The applicant has an application with the Zoning Board of Appeals and is scheduled for the first week of April.

Commissioner Pelletier moves to continue the public hearing to the April 8th meeting for a three (3) lot subdivision at 584 Atkins Street (Atkins Ridge) between Brechlin Road and Timber Ridge Road in the R-60 Residential Zone. Commissioner Fazzino seconds the motion. The chair calls for the vote. It is unanimous to table with 7 aye votes. The chair states the matter passes unanimously with 7 affirmative votes.

- 2. Proposed Special Exception for a Home Day Care for children at 72 Pond Place in the R-1 Zone. Applicant/agent Valerie Demeze SE2020-1**

Valerie Demeze represented the application. She said she has a finished basement and is going to put up a fence in the rear of her property. He spoke about the traffic and noise from the proposed use.

87 Pond Place spoke for a number of other residents who could not come tonight that lives on their street. They are concerned about the safety of the residents. The lots are very small and the neighborhood is residential with many older residents.

Commissioner Atherton spoke but the tape was not working right and it was inaudible.

Commissioner Fazzino moves to close the public hearing. Commissioner Pattavina seconds the motion. The chair calls for the vote. It is unanimous to close public hearing with 7 aye votes. The chair states the matter passes unanimously with 7 affirmative votes.

Commissioner Pelletier moves for approval for a Special Exception for a Home Day Care for children at 72 Pond Place with the following conditions: 1) Limit to 6 children; 2) Fence around rear yard to be installed and 3) Limit to no more than one employee. Commissioner Pattavina seconds the motion. The chair calls for the vote. It is unanimous to approve with conditions with 7 aye votes. The chair states the matter passes unanimously with 7 affirmative votes.

- 3. Petition for a text amendment to Section 71 (Amendment Procedure) of the Middletown Zoning Code. Applicant/agent City of Middletown PCD Dept. Z2020-1**

Commissioner Pattavina moves to close the public hearing. Commissioner Fazzino seconds the motion. The chair calls for the vote. It is unanimous to close public hearing with 7 aye votes. The chair states the matter passes unanimously with 7 affirmative votes.

Commissioner Fazzino moves to approve as amended for a petition for a text amendment to Section 71 (Amendment Procedure) of the Middletown Zoning Code. Commissioner Pattavina

seconds the motion. The chair calls for the vote. It is unanimous to approve as amended with 7 aye votes. The chair states the matter passes unanimously with 7 affirmative votes.

4. **Petition for text amendments to Sections 61 and 40 to modify language related to prohibited uses, rooming houses and clinics in the Middletown Zoning Code. Applicant/agent City of Middletown PCD Dept. Z2020-2**

Commissioner Fazzino moves to continue the public hearing for a future meeting Commissioner Johnson seconds the motion. The chair calls for the vote. It is unanimous to table with 7 aye votes. The chair states the matter passes unanimously with 7 affirmative votes.

5. **Petition for a text amendment to Section 61 of the Middletown Zoning Code to allow motor vehicle uses in the Transitional Development zone (TD). Applicant Agent/John Sheil. Z2020-3**

Commissioner Fazzino moves to close the public hearing Commissioner Pattavina seconds the motion. The chair calls for the vote. It is unanimous to close public hearing with 7 aye votes. The chair states the matter passes unanimously with 7 affirmative votes.

Commissioner Fazzino moves to approve a text amendment to Section 61 of the Middletown Zoning Code to allow motor vehicle uses in the Transitional Development zone (TD). Commissioner Pattavina seconds the motion. The chair calls for the vote. It is unanimous to approve with 7 aye votes. The chair states the matter passes unanimously with 7 affirmative votes.

7. Old Business

None

8. New Business

1. **Request for a five (5) year extension of the site plan approval SPR2015-50 for property at 823 & 833 Newfield Street (behind Tractor Supply Co.) Applicant/agent Hallisey, Pearson & Cassidy Engineering Assoc. SPR2015-50**

Commissioner Pelletier moves for approval for a five (5) year extension of the site plan approval SPR2015-50 for property at 823 & 833 Newfield Street. Commissioner Fazzino seconds the motion. The chair calls for the vote. It is unanimous to approve with 7 aye votes. The chair states the matter passes unanimously with 7 affirmative votes.

2. **Schedule a public hearing for a proposed twelve (12) lot re-subdivision of the property of Old Colony of Wallingford located at Ridgewood Road and Mile Lane. Applicant/agent Sunwood Development Corp/Bob Weidenmann S2020-2**

Commissioner Pelletier moves to schedule a public hearing for April 22, 2020. Commissioner Pattavina seconds the motion. The chair calls for the vote. It is unanimous to schedule a public hearing with 7 aye votes. The chair states the matter passes unanimously with 7 affirmative votes.

3. **Schedule a public hearing for a new medical clinic use in a portion of an existing building located at 211 South Main Street in the MX zone. Applicant /agent 211 South Main Street LLC/Robert Kempenaar II SE2020-2**

Commissioner Pelletier moves to schedule a public hearing on March 25, 2020 for a new medical clinic use in a portion of an existing building located at 211 South Main Street in the MX zone. Commissioner Pattavina seconds the motion. The chair calls for the vote. It is unanimous to schedule a public hearing with 7 aye votes. The chair states the matter passes unanimously with 7 affirmative votes.

9. Public comment on topics which are not or have not been the subject of a public hearing

10. Minutes of the Regular Meeting, Transcripts, Staff Reports and Commission Affairs

10.1 Minutes of February 26, 2020 Meeting

Commissioner Pelletier moves for the approval for the minutes of February 26, 2020 meeting. Commissioner Fazzino seconds the motion. The chair calls for the vote. It is unanimous to adjourn with 7 aye votes. The chair states the matter passes unanimously with 7 affirmative votes.

10.2 Other Commission Affairs

a. River-Cog Report

10.3 Report from by-laws subcommittee

10.4 Staff Reports

11. Adjournment

Commissioner Richard Pelletier moves for adjournment. Commissioner Nicholas Fazzino seconds the motion. The chair calls for the vote. It is unanimous to adjourn with 7 aye votes. The chair states the matter passes unanimously with 7 affirmative votes.

Respectfully submitted

Marek Kozikowski
Middletown City Planner



**REGULAR MEETING OF THE PLANNING AND ZONING COMMISSION
MIDDLETOWN CONNECTICUT
APRIL 22, 2020**

1. Roll Taking

Present: Chairman Stephen Devoto
Vice-Chairman Nicholas Fazzino
Commissioner Thom Pattavina
Commissioner Richard Pelletier
Commissioner Catherine Johnson
Commissioner Shanay Fulton (seated for M. Fazzino)
Commissioner Kellin Atherton (seated for Tyrell Brown)
Commissioner James O'Connell

Absent: Commissioner Tyrell Brown
Commissioner Marcus Fazzino

Staff/Host: Marek Kozikowski, AICP, City Planner

2. Items removed from the agenda and why

None

3. Public comment on items on agenda which are not currently scheduled for a public hearing

None

4. ZEO Certification that all public hearing signs have been properly noticed (when scheduled)

All public hearing signs have been properly noted

5. Public Hearings (when scheduled)

- 1. Proposed Special Exception for a new medical clinic use in a portion of an existing building located at 211 South Main Street in the MX zone.
Applicant/agent 211 South Main Street LLC/Robert Kempenaar II SE2020-2**

Nicholas Fazzino moves to close the public hearing. Thom Pattavina seconds the motion. The chair calls for the vote. The chair states the matter passes unanimously with 7 affirmative votes.

Nicholas Fazzino moves for approval with conditions for a Special Exception for a new medical clinic use in a portion of an existing building located at 211 South Main Street in the MX

zone. Applicant/agent 211 South Main Street LLC/Robert Kempenaar II SE2020-2. Thom Pattavina seconds the motion. The chair calls for the vote. The chair states the matter passes unanimously with 7 affirmative votes.

The conditions of approval are:

1. If there is a change in the type of medical office from orthopedist to another type of medical office or service, there will need to be a new application for special exception.
2. The front of the building will remain active, open and transparent. The glass of the offices and waiting area MUST remain clear and transparent, so as to enable a view into the building. The windows may not be obscured with film or any other means.
3. Floor plans for the medical clinic space should be submitted for review prior to the issuance of permits.
4. The medical clinic use should be limited to 5 practitioners and 9 employees.
5. The medical clinic use specifically excludes clinics whose principal service is mental health and/or substance abuse diagnosis and treatment.
6. The applicant should get final CT DOT approval for the improvements in the state Right of Way prior to the issuance of a certificate of occupancy.

2. **Continuation of public hearing of a Petition for text amendments to Sections 61 and 40 to modify language related to prohibited uses, rooming houses and clinics in the Middletown Zoning Code. Applicant/agent City of Middletown PCD Dept. Z2020-2**

Kellin Atherton moves to close the public hearing. Thom Pattavina seconds the motion. The chair calls for the vote. The chair states the matter passes unanimously with 7 affirmative votes.

Richard Pelletier moves for approval for text amendments to Sections 61 and 40 to modify language related to prohibited uses, rooming houses and clinics in the Middletown Zoning Code. . Kellin Atherton seconds the motion. The chair calls for the vote. The chair states the matter passes unanimously with 7 affirmative votes.

6. Old Business

None

7. New Business

1. **Request for an affirmative G.S. 8-24 for a 5 year lease agreement between the City of Middletown and Fidelux Lighting, LLC (an existing tenant) for 23,500 sq. ft. at 180 Johnson Street. Applicant/agent City of Middletown/PCD Dept. G.S. 8-24 2020-1**

Richard Pelletier moves for an affirmative G.S. 8-24 for a 5 year lease agreement between the City of Middletown and Fidelux Lighting, LLC (an existing tenant) for 23,500 sq. ft. at 180 Johnson Street. Thom Pattavina seconds the motion. The chair calls for the vote. The chair states the matter passes unanimously with 7 affirmative votes.

2. **Schedule public hearing for a proposed Special Exception regarding Section 55.03 for construction of a high tunnel greenhouse at 1044 River Road. Applicant/agent Forest City Farms/Gabe Russo SE2020-3**

Nicholas Fazzino moves to schedule a public hearing for May 27, 2020 for a Special Exception regarding Section 55.03 for construction of a high tunnel greenhouse at 1044 River Road. Thom Pattavina seconds the motion. The chair calls for the vote. The chair states the matter passes unanimously with 7 affirmative votes.

8. Public comment on topics which are not or have not been the subject of a public hearing

9. Minutes of the Regular Meeting, Transcripts, Staff Reports and Commission Affairs

a. Minutes of the March 11, 2020 Meeting

Thom Pattavina moves for approval of the minutes of the March 11, 2020 meeting. Nicholas Fazzino seconds the motion. The chair calls for the vote. The chair states the matter passes unanimously with 7 affirmative votes.

b. Minutes of the April 1, 2020 Meeting

Thom Pattavina moves for approval of the minutes of the April 1, 2020 meeting. Nicholas Fazzino seconds the motion. The chair calls for the vote. It is unanimous to approve with 7 aye votes. The chair states the matter passes unanimously with 7 affirmative votes.

2. Other Commission Affairs

a. River-Cog Report

Kellin Atherton and Beth Emery provided a report of the March 23rd and April 14th RiverCOG meetings.

3. Staff Reports

Staff provided an update on the closure of City Hall.

10. Adjournment

Thom Pattavina moves for adjournment. Nicholas Fazzino seconds the motion. The chair calls for the vote. The chair states the matter passes unanimously with 7 affirmative votes.

Respectfully submitted,

Marek Kozikowski, AICP
City Planner

Application: Zoning Text Amendment
Z2020-2
Applicant: PCD Staff
Owner: N/A
Address: N/A
Zone: N/A
Description: Clinics for Mental Health & Rooming Houses

UPDATE

The Planning and Zoning Commission continued the public hearing from the March 11th meeting so that Staff can address comments from the Planning and Zoning Commission.

The Commission made two requests. The first request was for Staff to prepare a map showing the eligible properties for the Substance Abuse/ Mental Health Floating Zone (SMH Zone). The maps attached indicate the major corridors of the City that are eligible for rezoning to the SMH floating zone (39C.02). See attached.

Lastly, the Commission asked for Staff to explore modifying the parking demand for urban living units (44.04.18). Staff determined that such a text amendment requires an independent analysis separate from this proposal. Therefore, no changes to the parking demand for urban living units are made at this time.

Proposal

PCD Staff submitted a petition for a text amendment to modify Section 40 and 61 to remove methadone clinics and rooming houses from prohibited uses and make them special exception uses pursuant to Section 71 of the Middletown Zoning Code. The proposed amendments are as follows:

~~Strikethrough~~ Text: Deleted

Bold Text: Added

xx: Denotes section number to be determined

61.05 PROHIBITED USES

Any use which can be reasonably considered to cause, despite existing environmental safeguards, hazardous or noxious conditions or which would violate Section 15.01, Performance Standards. Further any use not specified as a permitted use, special exception use, accessory use, permitted home occupation use or use by temporary permit are prohibited uses including but not limited to the incineration of solid waste, correctional facilities, alternate incarceration centers, ~~methadone clinics~~, half way houses, ~~rooming houses~~, pawn shops, check cashing establishments, and asphalt/batch plants.

ZONES: ALL

Section 61 BUSINESS ZONES, INDUSTRIAL ZONES AND OTHER NON-RESIDENTIAL ZONES USE
SCHEDULE

61.02 SPECIAL EXCEPTION USES

61.02.xx Rooming Houses
ZONES: MX, ID

61.02.xx Clinics for Mental health and/or substance abuse diagnosis and treatment
ZONE: SMH

Section 40 OFF-STREET LOADING REGULATIONS

	USE	REQUIREMENT
40.04.03	CLINIC, MEDICAL OR DENTAL	One (1) parking space for each two hundred (200) sq. ft. of floor area plus one (1) space for each doctor plus one (1) space for each three (3) employees.
40.04.18	<u>URBAN CORE LIVING UNIT</u> (Including former category of Rooming House)	One or no bedrooms 1 space Two or more bedrooms 2 spaces
40.04.20	<u>ROOMING HOUSES</u> Included in Urban Core Living Unit	DELETED Same as a Same a Urban Core Living Unit

Clinics for Mental health and/or substance abuse diagnosis and treatment

Methadone clinics are currently listed in the list of prohibited uses and proposal includes a modification to Section 61.05 to remove them from the list of prohibited uses.

Definition

Methadone clinics is considered a clinic for substance abuse. Clinics which is already defined as a place used for the care, diagnosis and treatment of sick, ailing, infirm and injured persons and those who are in need of medical or surgical attention, but who are not provided with board or room nor kept overnight on the premises (16.03.05).

Schedule of Uses

The Middletown Zoning Code has a Substance Abuse/Mental Health (SMH) Floating Zone that allows for clinics for mental health and substance abuse and other similar uses. The floating zone, can be applied in various sections of the city including portions of: Saybrook Road, Main Street Extension, South Main Street, Washington Street and Silver Street (39C.02).

The proposal includes modifications to Section 61.02 to include these clinics in the schedule of uses. The proposal would list clinics for mental health and/or substance abuse diagnosis and treatment as a special exception use so that the Planning & Zoning Commission has the opportunity to assess a new proposal with regards to the special exception standards in Section 44.

Parking Requirement

Clinics, for medical and dental have a parking requirement of One (1) parking space for each two hundred (200) sq. ft. of floor area plus one (1) space for each doctor plus one (1) space for each three (3) employees (40.04.03).

The proposal eliminated the terms medical and dental and opens up the parking requirement for all types of clinics.

Rooming Houses

Rooming houses are currently listed as a prohibited use in all zone although there are many in the city.

The Health Department records 33 rooming houses in the City. (See list attached). The department performs regular inspections to ensure compliance with the housing code. The houses include homes for health housing services, hotels, university housing and fraternity/sorority housing.

Definition

They are defined in the Zoning Code as a structure licensed by the Middletown Health Department as a rooming house per Housing Code Regulations (16.18.02). The Housing Code defines rooming houses as any dwelling or that part of any dwelling containing one or more rooming units in which space is occupied by six or more persons who are not members of a single family (Sec 178-2).

Schedule of Uses

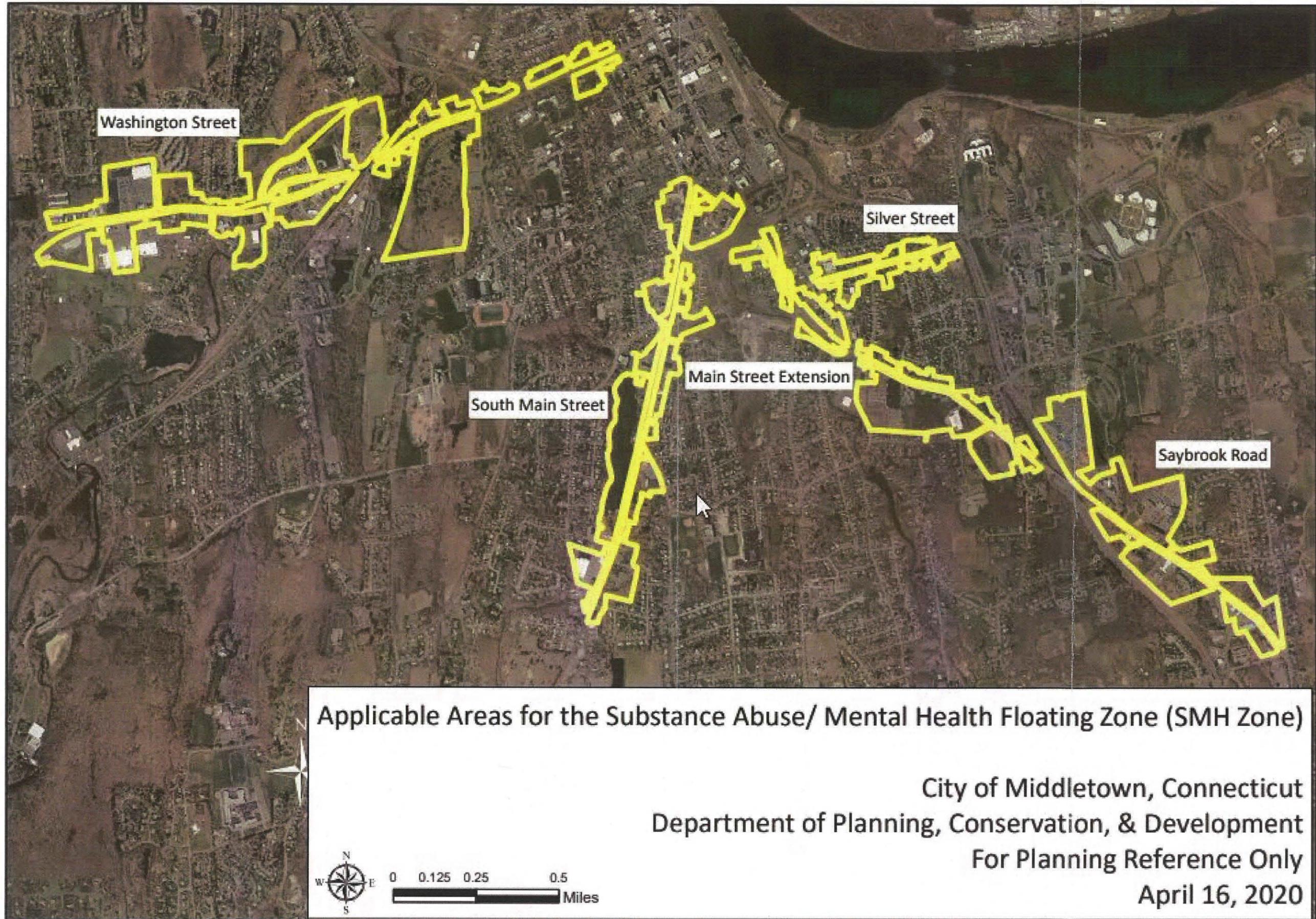
The proposal would list rooming houses as a special exception use so that the Planning & Zoning Commission has the opportunity to assess a new proposal with regards to the special exception standards in Section 44.

Rooming houses are located in many different zones but majority of the existing houses are in the MX and ID zones. The proposal puts rooming houses in the MX and ID zones. The MX zone allows for a variety of uses that include multi-family housings. The ID zone allows for a variety of institutional uses which includes housing for students.

Parking Requirement

Section 40 already lists a parking requirement for rooming houses by way of reference to the parking requirement for urban core living units. The requirement is one space one or no bedroom units and 2 spaces for two or more bedroom units.

The proposed modifications to clean up the language and references in the Zoning Code without modifying the requirement.



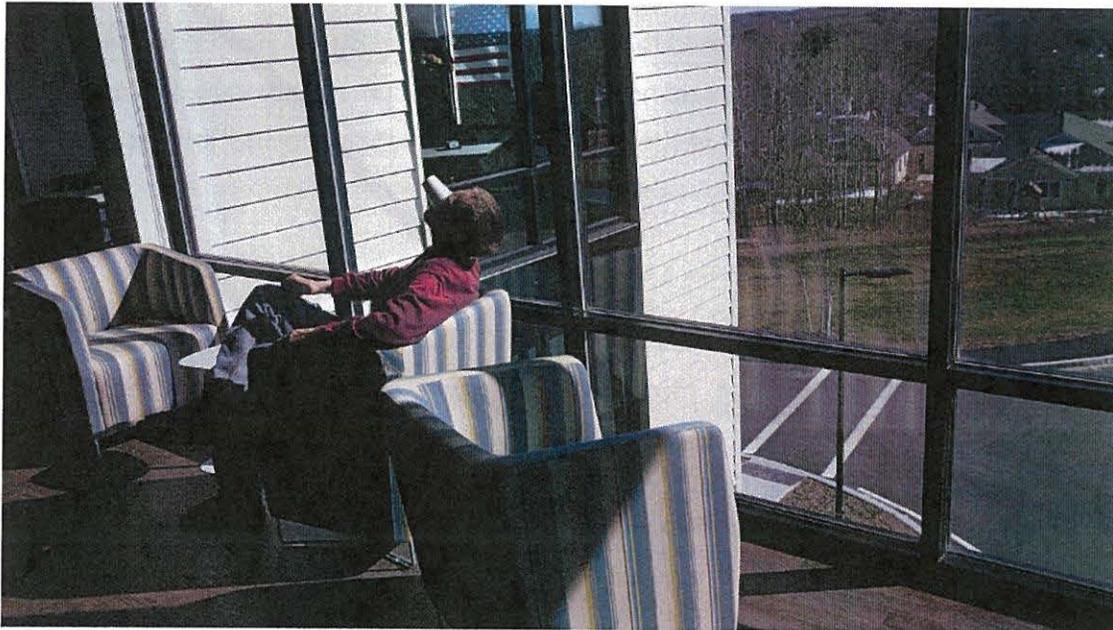
Do drug treatment facilities really lower property values? Finally, an answer

Published: Jan. 11, 2019 at 5:42 a.m. ET

By Kari Paul

When it comes to rehab centers, many people think 'not in my backyard'

4



A drug addict in recovery drains the last drops of a yogurt drink at a substance abuse treatment center in Westborough, Mass.

GETTY IMAGES

As the opioid crisis rages on, those affected struggle to find treatment. One potential reason? People don't want rehab centers in their backyards.

The arrival of a substance-abuse treatment center in a new neighborhood can spark protests, heated city hall meetings, and other attempts to block developments. Some homeowners believe the introduction of substance-abuse treatment centers into a neighborhood will also bring crime and other problems that will decrease property value.

But opposition may be unfounded, a study distributed this week by National Bureau for Economic Research found: Substance-abuse disorder centers do not negatively affect property values in areas where they set up shop, the report by researchers at the University of New Mexico and Temple University concluded.

The model created for this paper showed that when adjusted for issues like benefits to surrounding businesses, there is no measurable difference.

“For most people purchasing a home is the largest financial investment they are going to make in their lives and the most important financial asset they have,” Catherine MacLean, a lead researcher on the paper, said. “So we believe people’s concerns about decreasing property values are valid, but we wanted to test that.”

Past economic models have shown the construction of such centers may decrease values by 3.4% to 4.6%, but the model created for this most recent paper showed that when adjusted for factors like value prior to the center’s introduction and benefits for surrounding businesses, there is no measurable difference. The researchers examined property value between the years of 2003 and 2016 using data from Seattle.

Past economic models have shown the construction of such centers may decrease values by 3.4% to 4.6%.

“Suburban residents tend to be very risk averse when it comes to changes in their neighborhoods,” said Igor Popov, chief economist at apartment-search platform [ApartmentList](#). “It’s not unheard of for neighborhood groups to try to block local development of substance-abuse treatment centers, so these residents must feel that these centers negatively affect the local quality of life.”

The opioid crisis costs the U.S. more than \$500 billion per year. Inpatient facilities have been proven an effective means of treating substance abuse disorders, but often cannot find locations to build, Maclean said. Only one in 10 patients with drug addiction are able to get treatment, and a commonly stated barrier is not being able to locate a treatment center.

“If ‘not in my backyard’ concerns prevent centers from locating in convenient settings, this sub-optimal location may make it harder for patients to get into treatment and remain in treatment, which will limit our ability as a society to reduce substance abuse disorders,” she said. **MW**

NBER WORKING PAPER SERIES

SUBSTANCE USE DISORDER TREATMENT CENTERS AND PROPERTY VALUES

Brady P. Horn
Aakrit Joshi
Johanna Catherine Maclean

Working Paper 25427
<http://www.nber.org/papers/w25427>

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Substance Use Disorder Treatment Centers and Property Values
Brady P. Horn, Aakrit Joshi, and Johanna Catherine Maclean
NBER Working Paper No. 25427
January 2019
JEL No. H0,I1,R3

ABSTRACT

Substance use disorders (SUDs) are a major social concern in the United States and other developed countries. There is an extensive economic literature estimating the social costs associated with SUDs in terms of healthcare, labor market outcomes, crime, traffic accidents, and so forth. However, beyond anecdotal claims that SUD treatment centers (SUDTCs), settings in which patients receive care for their SUDs, have a negative effect on property values, there is scant empirical work on this question. In this paper, we investigate the effect of SUDTCs on residential property values using data from Seattle, Washington, and SUDTC location, entry, and exit information. To mitigate bias from the potential endogeneity of SUDTC location choices, we apply a spatial differences-in-differences (SDD) model, which uses property and SUDTC location to construct treatment and comparison groups. Our findings suggest that SUDTCs endogenously locate in lower value areas, and naïve models imply that the entry of an SUDTC leads to a 3.4% to 4.6% reduction in property values. When an SDD model is applied, we find no evidence that SUDTCs affect property values. Overall, our findings suggest anecdotal claims that SUDTCs reduce property values are potentially overstated.

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1. Introduction

Substance use disorders (SUDs) are chronic health conditions that impose substantial costs, both costs fully internalized by the affected individual and costs externalized to society. For the affected individual, SUDs hinder overall health, employment, financial stability, and relationships, and can lead to incarceration and other legal consequences, and for some, death. In terms of negative externalities, SUDs are incredibly costly to society in terms of direct addiction treatment costs which have historically been financed by public payers within the U.S., increased costs of general healthcare, increased reliance on social services, traffic accidents, and crime and violence (Carpenter 2005; Balsa et al. 2009; French, Fang, and Balsa 2011; Jayakody, Danziger, and Pollack 2000; Anderson, Hansen, and Rees 2013; Markowitz and Grossman 2000; Popovici, Maclean, and French 2017; Terza 2002).

Overall, the annual costs of SUDs to the U.S. are estimated to be very high: \$544B (Caulkins, Kasunic, and Lee 2014).¹ For comparison, government estimates suggest that heart disease and stroke, which are leading causes of mortality and morbidity, are associated with \$359B each year in terms of healthcare costs and lost productivity in the U.S. (Department of Health and Human Services 2018).² Given these high costs, both private and public agents allocate substantial financial resources to curtail SUDs. For instance, the U.S. spends approximately \$28B annually on direct SUD treatment, with 71% of this treatment financed by public payers (Substance Abuse and Mental Health Services Administration 2014).³ While treatment programs are obviously heterogeneous, there is compelling evidence that numerous treatment modalities are clinically effective and cost-effective in reducing SUDs and associated

¹ This estimate is inflated by the authors from the original estimate of \$481B (with \$255B attributable to alcohol and \$226B attributable to psychoactive drugs) in 2011 dollars to 2018 dollars using the Consumer Price Index (CPI).

² Inflated from the original estimate (\$317B in 2011 dollars) to 2018 dollars using the CPI.

³ Inflated by the authors from the original estimate of \$23.4B in 2009 dollars to 2018 dollars using the CPI.

social costs (Collins et al. 2010; Doran 2008; French and Drummond 2005; Holder 1998; McCollister and French 2003; Murphy and Polsky 2016). Moreover, receiving SUD treatment is not uncommon. For instance, in 2016, 3.8M Americans 12 years and older received SUD treatment (Center for Behavioral Health Statistics and Quality 2017).

SUD treatment is generally regarded as valuable to society. However, situating an SUDTC, a setting in which many patients receive care for their SUDs, is often an unpopular and contentious decision. In particular, there is a ‘not in my back yard’ (NIMBY) sentiment, where local residents boycott SUDTC openings as they are concerned that the introduction of an SUDTC may increase noise, traffic, crime, nuisance behavior, and generally unpleasant activities in the neighborhood (Keiger 2016).⁴ These perceived negative attributes of SUDTCs could plausibly translate into reductions in residential property values. As residential properties reflect the most substantial investment that most Americans undertake in their lives (Kraft and Munk 2011), this potential external cost of SUDTCs may result in a considerable reduction in wealth for many individuals and families. In 2016, there were 18,087 licensed SUDTCs in the U.S. (Substance Abuse and Mental Health Services Administration 2017). Thus, if NIMBY concerns are valid, then many individuals and families are exposed to centers that may substantially reduce the worth of their most valuable investment.

While there is a large literature evaluating the extent to which a wide range of both amenities and dis-amenities affect residential property values (Chay and Greenstone 2005; Gawande and Jenkins-Smith 2001; Gibbons 2004; Muehlenbachs, Spiller, and Timmins 2015;

⁴ For instance, recent articles by media outlets in both Massachusetts and New York document the negative sentiment towards SUDTC openings by local residents. We refer an interested reader to the following websites: <https://www.urbancny.com/urban-colonialism-and-how-a-neighborhood-fought-a-development-and-won/>, <https://theswellesleyreport.com/2018/10/wellesley-residents-urge-opioid-treatment-center-reps-to-reconsider-location/> (accessed December 20, 2018).

Pope and Pope 2012; Thaler 1978; Li et al. 2015; Davidoff and Leigh 2008), there is surprisingly little empirical work investigating the effect of SUDTCs. To the best of our knowledge, only one study explores this question. In a real estate study, La Roche, Waller, and Wentland (2014) apply three-stage-least squares to property sales data from Central Virginia over the period 2001 to 2011 to test for SUDTC effects. The authors document that SUDTCs are associated with an 8% reduction in residential property values. The results of La Roche, Waller, and Wentland (2014) suggest a substantial negative effect of SUDTCs on property values and provide *prime facie* support for NIMBY concerns. However, given the identification strategy employed by La Roche, Waller, and Wentland (2014), how best to interpret these findings is unclear. In particular, the three stage least squares approach used by LaRoche and colleagues is identified off non-linearities in the model. Such identification departs from approaches based on quasi-experimental variation that are used in many recent empirical economic studies studying factors that influence property values (outlined in Section 2.1).

Moreover, the net effect of SUDTCs on property value is *ex ante* ambiguous. In addition to the potentially negative aspects of SUDTCs articulated in NIMBY concerns, there are factors associated with SUDTCs that may in fact increase property values. First, if SUDTCs offer effective treatment to neighborhood residents, these facilities can reduce SUD prevalence and associated harms. Swensen (2015) shows that SUDTC entry reduces the level of SUDs, proxied by overdose deaths, within the local area. In terms of reducing costs associated with SUDs, recent economic work by Bondurant, Lindo, and Swensen (2018), and Wen, Hockenberry, and Cummings (2017) shows that SUDTCs reduce crime within the local area. Clinical evidence provides further support for the inverse treatment-crime relationship (Doran 2008; Ettner et al. 2006; McCollister et al. 2003; Rajkumar and French 1997; Westerberg et al. 2016).

Furthermore, Freeborn Fand McManus (2010) document that additional SUDTCs in a county decrease alcohol-related fatal traffic fatalities in that locality. A second pathway through which SUDTCs could raise property values is increased employment opportunities (e.g., hiring SUDTC employees) and economic activity (e.g., demand for SUDTC-related goods and services) within a local area. For instance, in 2016, the average SUDTC employed 22 workers and the economic opportunities for local residents are often touted when a center opens.⁵

Finally, an empirical reason for an observed association between SUDTC entry and property values is the potential endogeneity of SUDTC location choices. If SUDTCs strategically locate in areas with lower (or higher) property values, such sorting could lead to biased estimates of property value effects. This final pathway suggests that any observed correlation between SUDTC entry and property values could be spurious and not causal.

To empirically address endogenous location choices in estimation of amenities and disamenities, several recent studies apply a spatial differences-in-differences (SDD) estimator (Congdon-Hohman 2013; Dealy, Horn, and Berrens 2017; Linden and Rockoff 2008). The SDD model is comparable in many ways to canonical differences-in-differences (DD) methods, which estimate average changes in outcomes in treatment and comparison groups, pre- and post-treatment (Angrist and Pischke 2008). In the SDD model, spatial location information (as opposed to legislatively defined geographic areas or groups defined by their demographics, e.g., age and/or gender) is used to construct the treatment and comparison groups in close proximity to the (dis)amenity. No study has applied an SDD to estimate the effects of SUDTCs.

⁵ Authors' calculation of the 2016 U.S. Census Bureau Community Business Patterns data base for the following industry codes: 621420 (outpatient treatment facilities) and 623220 (residential inpatient treatment facilities) (Swensen 2015; Bondurant, Lindo, and Swensen 2018). More details available on request. Please see the following news article: <https://www.bizjournals.com/dayton/news/2018/12/14/addiction-treatment-center-invests-1m-in-dayton.html> (accessed December 20, 2018).

In this paper, we follow the recent hedonic pricing model literature and estimate the effect of SUDTCs on residential property values using an SDD model. We use granular residential property value and administrative SUDTC data from Seattle, Washington. Specifically, we link property values data over the period 2003 to 2016 with geocoded government administrative data on the exact locations of all licensed SUDTCs in Seattle.

Several findings emerge from our analysis. First, we document that SUDTCs endogenously locate in lower property values areas, which implies that estimates generated in models which do not address such sorting are vulnerable to bias. Second, naïve (non-SDD) models that do not account for endogenous location choices produce estimates that imply a modest, but statistically significant, negative effect of SUDTC entry on property values of 3.4% to 4.6%. Third, when an SDD estimator is used, we find no statistically significant evidence that SUDTC entrance into a local area leads to changes property values. Indeed, in our preferred specifications we can rule out all but modest decreases in property values. Our findings are stable across numerous robustness checks, including alternative distance band specifications and time dynamics. Our findings suggest that anecdotal NIMBY concerns regarding the stigma associated with being located in close proximity to an SUDTC, and related reductions in residential property values, may not be fully warranted.

The paper proceeds as follows. Section 2 provides background on the related residential property value literature, SUDs, and SUDTCs. Our conceptual framework and empirical model are presented in Section 3. Data are reported in Section 4. Section 5 presents our main results and robustness checking. Section 6 concludes.

2. Background

2.1 Background on amenities and dis-amenities, stigma, and residential property values

There is a large and historic hedonic pricing model literature evaluating the effect of various amenities and dis-amenities on residential property values. Comprehensively reviewing this vast literature is beyond the scope of this study. Instead, we attempt to briefly summarize studies most relevant for our research question.

In terms of amenities, access to high quality schools (Davidoff and Leigh 2008), ‘walkability’ (Rauterkus and Miller 2011), diversity (Koster and Rouwendal 2012), and proximity to parks and green spaces (Anderson and West 2006; Voicu and Been 2008) increase residential property values. On the other hand, dis-amenities such as airport noise (Espey and Lopez 2000; Pope 2008), forest infestations (Price, McCollum, and Berrens 2010), nuclear waste sites (Gawande and Jenkins-Smith 2001; McCluskey and Rausser 2003a), rail stations (Bowes and Ihlanfeldt 2001), and wildfires (Kalhor et al. 2018) reduce residential property values.

Similarly, undesirable and socially repugnant behaviors by neighborhood residents, which can be viewed as dis-amenities, within the local area have been linked with lower residential property values. In particular, several studies show that increased crime reduces property values (Gibbons 2004; Thaler 1978; Pope and Pope 2012). For instance, Pope and Pope (2012) find a substantial increase in residential property values following the large decline in U.S. crime rates that occurred in the 1990s. Studies also evaluate the effect of convicted sex offenders migrating into a neighborhood on local residential property values. Federal legislation passed in 1996, known as ‘Megan’s Law’, requires that all states create a sex offender registry and make information regarding sex offender residential addresses publicly available. Evaluating this law, Larsen, Lowrey, and Coleman (2003) find a reduction in value of 17% for residential properties in close proximity to sex offenders in Montgomery County, Ohio.

In sum, the hedonic pricing literature documents that many forms of dis-amenities reduce residential property values. In addition to an initial decline in residential property values, several studies provide convincing evidence that this reduction in value persists over time. For instance, several environmental risks leave a permanent, or highly persistent, 'scar' on property values (McCluskey and Rausser 2003b). Put differently, even after the dis-amenity is removed from the local area, residential property values persistently remain at a lower level. The particular mechanisms behind a scaring effect are not entirely clear and are likely heterogeneous across dis-amenities, but this phenomena suggests that affected property owners may persistently own a less valuable asset. Given the importance of residential properties for overall wealth and financial well-being, permanent reductions in property values are concerning.

A key empirical challenge in estimating the effect of any local (dis)amenity on property values is the potential endogeneity of (dis)amenity location. Put differently, amenities and dis-amenities, including SUDTCs, are not likely to be randomly assigned across neighborhoods and instead are plausibly located based on the (presumably) rational decisions of economic agents; in our context SUDTC owners and operators. Taking such systematic location selection into account, Linden and Rockoff (2008) reevaluate the effect of sex offenders on property values using an SDD estimator, which creates treatment and comparison groups based on geographic distance to the sex offender location. Applying this model to data from Mecklenburg County, North Carolina, the authors document that, on average sex, offenders locate in lower property value areas, and failure to account for these endogenous location choices can lead to a substantial overestimate of the effect of a sex offender on property values. After accounting for the endogenous location of offenders, Linden and Rockoff find that the arrival of sex offender within

a neighborhood reduces the average residential property values by 4%. This estimate is less than one quarter of the Larsen et al (2003) non-SDD estimate of a 17% reduction in property values.

The SDD approach has also recently been used to study the effect of several other dis-amenities on residential property values. Congdon-Hohman (2013) and Dealy, Horn, and Berrens (2017) use this technique to study the effect of clandestine methamphetamine laboratories ('meth labs') on property values. The production of meth involves the combination of explosive and deadly chemicals; this process is harmful to health. Both studies show that meth labs endogenously locate in lower value areas and a significant decrease in property values associated with lab discovery. Dealy, Horn, and Berrens (2017) also identify a stigma effect: property values of residences surrounding the meth lab remain persistently lower even after the lab is fully decontaminated following a state-mandated environmental clean-up process. Stigma effects suggest that the dis-amenity permanently, or at least persistently, alters neighborhood characteristics (real or perceived) in a way that reduces the value of nearby properties. For instance, clandestine meth labs may result in lingering environmental toxins in the neighborhood that persistently harm (or are perceived to harm) residents' health.

Brooks, Humphreys, and Nowak (2016) study the effect of strip clubs on residential property values in Seattle, Washington – the same location that we examine – using an SDD model. The authors find that club openings and closing have no statistically significant effect on the value of nearby residences. This study is important for our work as it focuses a dis-amenity that may plausibly impose similar costs and benefits on the neighborhood as an SUDTC.

Our contribution to this literature is twofold. First, we examine the effects of SUDTCs on property values using an SDD estimator which will allow us to account for endogenous

location choices and hence recover causal estimates of SUDTC effects on residential property values. Second, we test for potential stigma effects associated with SUDTCs.

2.2 Background on SUDs and SUDTCs

In 2016, 20 million U.S. residents 12 years and older, or 7.5% of the population, met diagnostic criteria for an SUD (Center for Behavioral Health Statistics and Quality 2017). According to the American Psychiatric Association (2013) SUDs ‘occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.’ Afflicted individuals may act out in violent and reckless ways, and turn to illegal activities to procure funds to purchase substances. Many individuals with an SUD have co-occurring mental illness (Grant, Stinson, Dawson, Chou, Dufour, et al. 2004; Grant, Stinson, Dawson, Chou, Ruan, et al. 2004), which plausibly exacerbates substance-related problems.

In addition to individuals meeting the clinical definition of an SUD, millions of Americans engage in risky substance misuse such as binge drinking, heavy drinking, and nonmedical use of prescription drugs, and are thus at risk of developing an SUD.⁶ For instance, in 2016, 24.5% and 6.0% of U.S. residents 12 year and older were classified as binge and heavy drinkers respectively, while 10.6% of adults used illicit drugs in the past 30 days (Center for Behavioral Health Statistics and Quality 2017).

Given the high levels of substance misuse, unintentional fatal alcohol poisonings and (overall) psychoactive drug overdoses are the leading causes of injury death in the U.S. with over

⁶ According to the Centers for Disease Control and Prevention (CDC), binge drinking is defined as consuming five (four) or more drinks in one drinking session for men (women) while heaving drinking is defined as drinking two (one) or more drinks per day for men (women). Non-medical use of prescription medications is defined as the use of medications without a prescription from a healthcare provider, use of the medication in a manner other than as directed (e.g., taking a higher dosage than prescribed), and/or use only for the medication’s psychotropic experience.

58,000 deaths in 2016, which exceeds the deaths attributable to suicides, traffic accidents, and firearm-related accidents (Centers for Disease Control and Prevention 2018a). Further, the U.S. is currently experiencing an unprecedented rise in SUD-related mortality, largely due to OUD overdoses (Rudd et al. 2016). For instance, each day there are 115 OUD-related overdose deaths and this rate has more than quadrupled since 1999 (Centers for Disease Control and Prevention 2018b). The rise in OUD and associated harms has prompted the federal government to declare that the country is experiencing an ‘opioid epidemic’ (Centers for Disease Control and Prevention 2018b) and allocate billions of dollars in financing to support OUD prevention, treatment, and harm reduction (114th U.S. Congress 2015).

Although SUDs are incredibly harmful, numerous treatment modalities have been shown to be effective in treating these conditions (Collins et al. 2010; Doran 2008; French and Drummond 2005; Holder 1998; McCollister and French 2003; Murphy and Polsky 2016; Schori 2011). In 2016, 3.8M Americans ages 12 years and older received some form of SUD treatment (Center for Behavioral Health Statistics and Quality 2017). However, addiction specialists contend that treatment is substantially underused: only 10% of individuals who meet diagnostic criteria for an SUD receive treatment in any given year (Center for Behavioral Health Statistics and Quality 2017). While there are myriad reasons for not seeking treatment, including not wanting to stop using substances, inability to locate a provider is a commonly stated barrier. Taking this reason for not receiving treatment at face value, expanding the number of providers (including the specialized SUDTCs that we examine in our study) could increase treatment uptake and, in turn, reduce SUD prevalence and associated harms. Further, allowing providers to locate in areas that are convenient to patients may enhance treatment uptake and outcomes.

SUD treatment often begins with detoxification, a process that many times involves the use of medications to ease withdrawal symptoms (e.g., tremors, pain, and nausea) and allows the body to rid itself of substances. After detoxification is complete, there are a wide range of effective treatment options available to patients. For example, counselling services, outpatient care, residential treatment, and inpatient hospital care are all widely used, and in many cases, highly effective treatment modalities. In our analysis we focus on care that is offered in specialized outpatient and inpatient treatment centers (residential facilities and psychiatric hospitals). This modality of care represents the majority of care received within the U.S. Further, specialty care involves patients residing in the center and/or regularly visiting the center for an extended period of time (e.g., a common treatment duration is 30 days), and SUDTCs are large in size with approximately 88 patients on any given day receiving treatment.⁷ Thus, if NIMBY concerns exist, we contend that they are most likely to be observed in this the type of care we consider in this study. We do not consider office-based care or treatment received in non-psychiatric hospitals. We refer interested readers to an excellent review of treatment modalities available to patients provided by the National Institute on Drug Abuse (2018).

3. Conceptual framework and empirical approach

3.1 Hedonic pricing model

Our empirical analysis, outlined below, is grounded in hedonic pricing theory. Within this framework residential properties are viewed as assets that provide owners with a bundle of characteristics that, in turn, affects utility. The characteristics that define the residential property as an asset include structural attributes (e.g., property size and quality; S_i) and neighborhood

⁷ Authors' calculation based on the National Survey of Substance Abuse Treatment Services (N-SSATS).

attributes (e.g., schools and parks; N_i). We augment the standard hedonic pricing framework to incorporate proximity to an SUDTC (Q_i) as a residential property attribute that affects utility.

Rational consumers are assumed to choose the residential property that maximizes their utility function subject to a standard budget constraint. At market equilibrium, residential property i will sell at price P_i according to the following pricing equation:

$$P_i = f(S_i, N_i, Q_i) \tag{1}$$

The effect of each attribute on price is simply the partial derivative of that attribute with respect to price in Equation (1): $\partial P_i / \partial X_i$ where $X_i \in \{S_i, N_i, Q_i\}$. All else equal, we expect amenities (e.g., larger properties and good schools) to increase values and dis-amenities (e.g., poor quality properties and limited access to parks) to reduce values.

As noted in Section 1, the relationship between proximity of a residential property i to an SUDTC (Q_i) has an ambiguous effect on the price (P_i). SUDTCs are associated with numerous factors in the local area that could have both positive (e.g., reduced SUD prevalence, and increased employment opportunities and demand for local goods and services) and negative (e.g., crime, violence, traffic, noise pollution, and nuisance behaviors) effects on property values, leaving the net effect unclear. While we are not able to separately estimate each of the possible pathways through which SUDTCs could influence residential property values, our objective is to provide an estimate of the overall average SUDTC effect, which is a first order question.

3.2 SDD model

We apply an SDD model to test for the causal effect of SUDTCs on proximal property values. The treatment and comparison groups are constructed using geographic distance bands, or ‘rings’, surrounding each SUDTC. Residential properties located within a ring with radius r around the SUDTC form the treatment group. Residential properties located in a second

concentric ring, with radius $k = r + \varepsilon$ with $\varepsilon > 0$, form the comparison group. This identification strategy compares properties adjacent to an SUDTC with a comparison group of properties in very close proximity to, but just far enough away, so as to be unaffected by the SUDTC.

Figure 1 displays an example of a location-defined treatment group and comparison group. In our main specifications, we define the treatment group as those properties within 0.2 miles of a SUDTC as the treatment group and define those properties 0.2 to 0.4 miles from an SUDTC as the comparison group. Clearly the true geographic definitions of the treatment and comparison group are *a priori* unknown, and any selected definition is to some extent arbitrary. Moreover, it is plausible that the true definition varies across (dis)amenities (e.g., clandestine methamphetamine labs, parks, schools, and sex offenders) and, indeed, different studies use different distances (see studies applying an SDD cited in Section 2.1). Thus, in robustness checks, and following Dealy, Horn, and Berrens (2017), we re-estimate our SDD regressions using alternate distance-ring specifications. Results (reported later in the manuscript) are highly robust across these alternative specifications, which supports the hypothesis that our findings are not driven by selection of a specific treatment and comparison group combination.

Specifically, we apply the following SDD model:

$$\ln(P_{i,j,t}) = X_{i,j,t}\beta + (\theta_1 D_{i,j,t}^{0.2} + \theta_2 D_{i,j,t}^{0.4}) + (\theta_3 D_{i,j,t}^{0.2} + \theta_4 D_{i,j,t}^{0.4})\tau_{i,t}^{entry} + \alpha_{j,t} + \varepsilon_{i,j,t} \quad (2)$$

In this equation, $P_{i,j,t}$ is the inflation adjusted sales price, where i indicates an individual property, j indicates the location of the property (i.e., zip code) and t indicates the time period (i.e., year) in which the property is sold. We take the logarithm to account for skewness in sales prices. In terms of explanatory variables, $X_{i,j,t}$ is vector of property characteristics, $\alpha_{j,t}$ is a vector of year-by-area fixed effects, and $\varepsilon_{i,j,t}$ is the error term.

We cluster standard errors at the zip code level. We have 34 zip codes in our sample, which implies that we may have too few clusters in our data to generate consistent estimates of our standard errors. However, in robustness checking reported later in the manuscript, we show that our results are not appreciably different if we instead apply a wild-cluster bootstrap approach to inference that has been shown to produce consistent standard error estimates when the number of clusters is small (Cameron and Miller 2015).

We also estimate a variant of Equation (2) in a ‘limited sales sample’ which includes only property sales that occur within 0.4 miles of an SUDTC. Thus, sales that occur outside the treatment and comparison groups are excluded from this analysis sample. In this specification we include year-by-SUDTC fixed effects, and cluster standard errors at the SUDTC level. We have 114 clusters in this specification. While the full sample is more common in the extant hedonic pricing model literature, the limited sales sample is more analogous to the canonical DD model in which all localities are either in the treatment or comparison group. For these reasons, we present results based on both samples and specifications. Our results are not appreciably different across these two specifications, however.

The treatment group is indicated by $D_{i,j,t}^{0.2}$, which represents properties within 0.2 miles of where an SUDTC is located and the comparison group is indicated by $D_{i,j,t}^{0.4}$, which represents properties within 0.4 miles of where an SUDTC is located. Due to the overlapping structure of the distance variables, θ_2 captures preexisting level differences in properties within 0.4 of an SUDTC compared with properties more than 0.4 miles away from an SUDTC. Analogously, θ_1 will capture preexisting level differences in property values for residences located within 0.2 miles of an SUDTC and properties located within 0.2 to 0.4 miles of an SUDTC. These variables are akin to the ‘treatment’ indicator in a canonical DD model. The timing of SUDTC

opening is captured by $\tau_{i,t}^{entry}$, which indicates the time period after the SUDTC enters a local area and parallels the ‘treatment*post’ interaction in the canonical DD model. The parameter of interest (θ_3) estimates the change in property values for properties within 0.2 miles of an SUDTC relative to properties 0.2 to 0.4 miles and θ_4 will capture any time trends associated with properties in the general vicinity of where an SUDTC locates.

As noted in Section 2.1, another important consideration when estimating the effect of SUDTCs on property values is stigma, or a potential lasting effect of an SUDTC on proximal residential property values after the SUDTC has exited the local area. To test for stigma effects, we estimate an augmented version of Equation (2) that incorporates SUDTC exits:

$$\ln(P_{i,j,t}) = X_{i,j,t}\beta + (\theta_1 D_{i,j,t}^{0.2} + \theta_2 D_{i,j,t}^{0.4}) + (\theta_3 D_{i,j,t}^{0.2} + \theta_4 D_{i,j,t}^{0.4})\tau_{i,t}^{entry} + (\theta_5 D_{i,j,t}^{0.2} + \theta_6 D_{i,j,t}^{0.4})\tau_{i,t}^{exit} + \alpha_{j,t} + \varepsilon_{i,j,t} \quad (3)$$

In this specification $\tau_{i,t}^{exit}$ is an indicator variable for the time period after an SUDTC exits, and θ_5 will capture any rebound effect on property values of the SUDTC exiting. Thus, $\theta_3 + \theta_5$ will represent any lasting stigma effect of an SUDTC on property values. Stigma effects may occur if, for instance, SUDTCs permanently reduce SUD prevalence within the neighborhood, then this change could reduce SUD-related behaviors (crime, violence, etc.). On the other hand, if an SUDTC permanently draws individuals with SUDs and who engage in crime, violence, nuisance behaviors, and so forth into the neighborhood, then we may observe persistently lower residential property values. We test for such effects through Equation (3). We investigate joint significance of these terms with an F -test.

4. Data

4.1 Residential property sales data

We use all residential property transactions in Seattle, Washington between January 1st, 2003 and December 31st, 2016 in our analysis. In 2016 Seattle was the 18th largest city in the U.S., with 704,352 residents, and was the largest city in Washington State. Thus, our effects are representative of a large, Pacific coast U.S. city. We obtained residential property sales data from the King County Department of Assessments (Seattle is located in King County). This agency provides detailed property sales through its online platform.⁸ These data include all legal sales that occurred in the county, and contain the exact location and sales price. In particular, in Seattle all residential property sales are required to be registered with the Department of Assessments. We convert all sales prices to 2016 dollars using the Consumer Price Index.

The King County Department of Assessments data also contain a wide range of property characteristics including: the number of living units, number of stories, number of bedrooms, number of bathrooms, total living space, percentage of the property constructed with brick stone, whether the property had been renovated prior to its sale, and the age of the property. Also, the data contain square footage information for the basement, garage, porch, and deck. For all properties, the King County Department of Assessment provides a variable that captures building quality. This variable ranges from 1 to 20, where higher values indicate greater property quality.

We exclude some observations from the analysis sample to minimize outliers and remove other observations unlikely to be actual residential properties. Observations with sale price less than \$50,000 ($n=1,157$) and above \$2 million ($n=926$) are excluded. Likewise, observations with no bathrooms ($n=1,043$), no bedrooms ($n=80$), and living space less than 100 square feet ($n=7$), and observations sold pre-construction ($n=4,248$) are excluded. After exclusions, the final analysis dataset contains 131,862 residential property sale transactions.

⁸ These data are publicly available: <http://info.kingcounty.gov/assessor/DataDownload/default.aspx> (last accessed, December 20, 2018).

4.2 SUD treatment centers (SUDTCs)

We obtain SUDTC information from the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Directory of Drug and Alcohol Abuse Treatment Programs (NDDAATP).⁹ This directory includes all licensed specialty SUDTCs that are known to SAMHSA and complete the National Substance Abuse Treatment Services Survey (N-SSATS). The N-SSATS is used by SAMHSA to monitor SUD treatment service provision within the U.S.; we do not use the N-SSATS information directly in our study.

The NDDAATP is the premier resource available to prospective patients and providers seeking a center that can provide specialized SUD treatment for themselves, their family members, or their patients. Given the importance of being listed on this directory for SUDTCs, response rates for N-SSATS (which forms the survey frame for the NDDAATP) are very high: 91% to 96% over our study period. The NDDAATP directories include the name, exact street address (which we leverage in our study), offered services, and accepted forms of payments for all SUDTCs licensed to provide SUD treatment that are known to SAMHSA. In 2016, there were 18,087 known and licensed specialty SUDTCs in the U.S. (Substance Abuse and Mental Health Services Administration 2017). Thus, we are able to capture the vast majority of licensed specialty SUDTCs using these data. Moreover, the NDDAATP is the only dataset that includes exact location of specialty SUDTCs and is therefore the best available data for our study.

Specialty SUD treatment is defined by SAMHSA as a hospital, a residential facility, an outpatient treatment facility, or other facility with a SUD treatment program. For background,

⁹ Data were accessed from the following website: <https://www.dasis.samhsa.gov/dasis2/nssats.htm> (last accessed December 20, 2018).

this modality represents 75% of non-self-help SUD treatment and reflects the majority of SUD treatment expenditures in the U.S. (Center for Behavioral Health Statistics and Quality 2017).¹⁰

SUDTC opening and closings offer the variation that we use to identify SUDTC effects in our SDD model. Openings reflect the ‘entrance’ of an SUDTC into the neighborhood while closings capture SUDTC ‘exit.’ We use the NDDAATP information to construct a year-by-year panel of all licensed SUDTCs in Seattle. In particular, we link SUDTC entrance and exit information to residential property sales data using geographic information system (GIS) coordinates. Because of the annual structure of the NDDAATP directory (i.e., the N-SSATS, which forms the survey frame, is completed once per year and the NDDAATP is thus updated annually), SUDTC entry (exits) are coded in the year the SUDTC appeared (no longer appeared) in the NDDAATP directories.¹¹ This linking process likely introduces some measurement error into our analysis dataset. We explore the potential implications of such measurement error in robustness checking later in the manuscript.

Residential property sale transactions are matched to SUDTCs both in terms of geodetic distances and timing of the proximate SUDTCs. Over the study period there are 120 SUDTC openings and 69 SUDTC closings in Seattle. On average there are 54 operating SUDTCs in Seattle in a given year.¹² Figure 2 graphically displays all SUDTCs that operated in Seattle over

¹⁰ Authors’ calculations based on Table 5.18B. Self-help involves informal care such as religious counselling and Alcoholics Anonymous. Details on this calculation available on request. Details on specialty SUD treatment can be found at <https://www.dasis.samhsa.gov/dasis2/nssats.htm> (last accessed December 20, 2018).

¹¹ In particular, as noted above, SUDTCs listed on NDDAATP must complete the above-noted N-SSATS survey. The N-SSATS is administered in the last week of March in each year of our study period and captures information on services offered by each SUDTC, including whether or not the facility is in operation. We use March 31st as the date on which SUDTCs opened and April 1st as the date on which they closed. Details available on request.

¹² During our study period, there are three non-psychiatric hospitals that provide SUD treatment listed on the NDDAATP: Swedish Medical Center- Ballard, VA Puget Sound Health Care System, and Seattle Children’s Hospital. Although these hospitals provide SUD treatment, the primary focus of non-psychiatric hospitals is to provide general inpatient healthcare services to patients. We expect that non-psychiatric hospitals may affect residential property values through different mechanisms than outlined in our conceptual framework. We exclude non-psychiatric hospitals providing SUD treatment services from our analysis. Details available on request.

our study period. While there is some evidence of clustering of SUDTCs in the central portion of Seattle, SUDTCs appear to operate in a range of different neighborhoods in the city.

A concern with our analysis is that zoning regulations may limit the locations in which an SUDTC may operate. As is the case with businesses in general, SUDTCs must locate in commercial zones. However, as discussed by La Roche, Waller, and Wentland (2014), there are numerous Federal regulations that prohibit many forms of discrimination in center location (e.g., the Fair Housing Act, Rehabilitation Act, Americans with Disabilities Act). In addition, we have communicated with administrators at the Washington State Substance Abuse Agency regarding zoning regulations related to SUDTC location. Our conversations with administrators at this agency suggest that there are no such regulations that will limit SUDTC location choices. Overall, our review of the available evidences suggests that SUDTCs face no additional (legal) restrictions on location than other businesses.

5. Results

5.1 Summary statistics

Table 1 presents the summary statistics of characteristics for all properties within 0.2 miles of where an SUDTC has located, and properties within 0.2 and 0.4 miles of where an SUDTC locates. Between 2003 and 2016, there was a total of 131,862 residential property sales, 8,982 of which were within 0.2 miles of an SUDTC and 22,671 that were within 0.2 and 0.4 miles. Median sale prices in Seattle are relatively high (\$554K in January of 2016) in comparison to the U.S. median cities (\$182k in January of 2016).¹³ However, Seattle residential property values are comparable to other large U.S. cities such as New York City (\$567K), Los Angeles (\$559K), and San Diego (\$529K); values reflect median prices in January 2016.

¹³ Median home prices are obtained from <https://www.zillow.com/research/data/> (accessed December 20, 2018).

In our sample, the average sale prices for the treatment group (\$471k in 2016 dollars) is approximately 3.4% lower than the full sample. Properties within 0.2 miles of an SUDTC and properties within 0.2 and 0.4 miles of an SUDTC are not identical, in terms of sales price or housing characteristics, but are more similar compared to the full sample. Importantly, we control for all characteristics listed in table 1 in our regressions.

5.2 Graphical evidence

Figure 3 presents a graph of the logarithm of daily sales prices using optimal Epanechnikov kernel smoothing for two-year periods before and after SUDTC entry,¹⁴ for both properties within 0.2 miles of an SUDTC, and between 0.2 and 0.4 miles of an SUDTC. A necessary assumption for the SDD model to recover causal estimates is that the treatment and the comparison groups would have trended similarly in terms of outcomes (residential property sales prices in our context) had the treatment group not been treated (the entrance of an SUDTC in our study); i.e., ‘parallel trends.’ In figure 3, prior to SUDTC entry, we observe that the treatment and comparison groups exhibit generally similar trends, this pattern provides suggestive evidence that the data can satisfy the parallel trends assumption. We return to parallel trends more formally through estimation of an event-study model later in the manuscript. Examination of the trends post-SUDTC entry reveals no evidence of substantial differences between the two groups, which foreshadows our null findings for SUDTC effects on residential property values.

5.3 Non-SDD regression results

Table 2 presents the results for a naïve empirical model that does not account for endogenous SUDTC location choices. Column 1 presents selected parameter estimates from a model estimated with housing characteristics and year fixed effects, column 2 presents selected

¹⁴ In particular, we use local polynomial smoothing with a bandwidth of 35 days. Details available on request.

parameter estimates for a model estimated with housing characteristics and year-zip code fixed effects, and column 3 additionally clusters standard errors at the zip code level. In all models coefficient estimates are negative and significant, suggesting that SUDTCs are associated lower residential property values. Coefficient estimates from table 2 imply that the entrance of an SUDTC in a neighborhood is associated with a 3.4% to 4.6% reduction in property values.¹⁵

5.4 SDD regression results

Table 3 presents testing for endogenous location choices by SUDTCs and the main regression results from our preferred SDD model. First, column 1 presents results from a test for endogenous location choice by SUDTC. In this test observations are dropped if the sale occurred within 0.4 miles of an SUDTC after the SUDTC becomes active (i.e., the only remaining SUDTC observations are before the SUDTC enters). This model allows us to test whether SUDTCs endogenously locate in areas with lower residential property values. Columns 2 and 3 present SDD models estimated using the full sample. Columns 4 and 5 present SDD estimates generated in the limited sales sample, where all observations are dropped that are outside of a 0.4 miles radius of an SUDTC. Columns 2 and 4 present results without the exit parameters, corresponding to Equation (2), and columns 3 and 5 present the results with the exit parameters included, corresponding to Equation (3). A full set of control variable coefficient estimates for the full sample model, including exit parameters, is reported in appendix table 1.

There are two main findings in table 3. First, in column 1 the $D^{0.4}$ parameter estimate is negative and statistically significant, documenting that on average SUDTCs endogenously locate in areas with lower residential property values. In particular, SUDTCs locate in areas with 2.2% lower property values. Second, once this endogeneity in location choice is accounted for through

¹⁵ Semi-log point estimates are converted to percent changes using the following formula: $(exp^{\hat{\beta}} - 1) \times 100\%$.

the use of the SDD model, we find no statistically significant evidence that SUDTC entries and exits affect residential property values. In both the full and limited sales sample models the parameter estimates are statistically indistinguishable from zero and very small in magnitude. Similarly, exit parameter estimates are statistically indistinguishable from zero and small. Finally, joint F -tests for the joint significance of the entry and exit parameter estimates (which capture stigma effects) are not statistically different from zero.

Our standard errors are sufficiently small that we can rule out all but relatively modest decreases in residential property values following SUDTC entry. For instance, in the basic SDD model in the full sample model reported in column 2, we can rule out decreases in residential property values greater than 3.2% with 95% confidence. Similarly, in the basic SDD model in the limited sales sample, reported in column 4, we can rule out decreases in residential property values greater than 2.2% at this level of confidence. Results based on Equation (3), which incorporates SUDTC entrances and exits, provide similar results: 3.8% and 2.7% respectively.¹⁶ Using these estimates, we can generate 95% confidence intervals for the maximum dollar value reduction in residential property values. Over our study period, the average property value in our treatment group is \$471K (see table 1). Thus, using a 3.8% decline, we can rule out any more than a \$18K in lost residential property values associated with SUDTC entry. Finally, we are able to rule out all but modest increases in values following SUDTC exit as well.

5.5 Robustness checks

We conducted a number of robustness checks to assess the stability of our findings. Overall, our results are highly stable across these additional analyses. First, as noted above, to mitigate bias from endogenous location choices of SUDTCs, we construct treatment and

¹⁶ This specification is more data hungry than Equation (2) and thus our standard errors necessarily increase in size, which implies that larger values are included in our 95% confidence intervals.

comparison groups using geographic proximity to SUDTCs. To this end, in our main analysis, SUDTC distance bands for the treatment and comparison groups are defined as within 0.2 miles and within 0.2 to 0.4 miles of an SUDTC. We re-estimate Equation (2) in which we both expand and contract the distance based used to form the treatment and comparison groups. Results are presented for regressions using 0.1/0.3 miles, 0.1/0.4 miles, 0.1/0.5 miles, 0.2/0.4 miles (our baseline specification), 0.2/0.5 miles, 0.2/0.6 miles, 0.3/0.5 miles, and 0.3/0.6 miles distance band specifications. Table 4a presents results for the full sample and table 4b presents results for the limited sales sample. Treatment-entry and treatment-exit parameter estimates are statistically indistinguishable from zero in all specifications. Joint *F*-tests assessing stigma effects are also statistically indistinguishable from zero in every specification.

Second, we investigate time dynamics in the effects of SUDTC entry/exit on residential property values. As outlined by Wolfers (2006), in a study testing the effects of state unilateral divorce laws, it is plausible that the effect of an SUDTC entry/exit may change over time. Put differently, our primary specification, Equation (3), forces an abrupt change in property values at SUDTC entrance/exit than remains constant thereafter. This pattern may depart from real world SUDTC effects if the social disruption (e.g., crime, noise, traffic) or benefits (e.g., reduced SUD prevalence, increased economic activity) vary over time. To evaluate potential dynamics in the effect of SUDTCs on residential property values, we estimate an event-study model in the spirit of Autor (2003). In particular, we decompose the SUDTC entrance variable into one-year windows both before and after SUDTC entry. The omitted category is one year prior to SUDTC entrance. We impose endpoint restrictions: we assume that effects are not observable more than four years before or after SUDTC entrance (Kline 2012; McCrary 2007). We code all areas in which an SUDTC does not enter as zero for all lead and lag indicators (Lovenheim 2009). In

addition to allowing for dynamic effects in the post-period, the event-study allows us to test a conditional version of the parallel trends tests by examining coefficient estimates on the lead variables. If lead variable coefficient estimates are small in magnitude and imprecise, that pattern of results supports the hypothesis that our data satisfies a conditional version of the parallel trends assumption.

We report event-study results for the full sample and the limited sales sample. As can be observed in figure 4, all event-study point estimates are small and statistically indistinguishable from zero, and no pre- or post-trends are evident. Overall, the event-study analysis suggests: (i) our data satisfy the parallel trends assumption and (ii) there are no dynamic SUDTC effects.

Third, recall that a limitation of the SUDTC data provided by the NDDAATP directory is that the data are only updated yearly (see Section 4.2). Thus, SUDTC entry and exits are only observed on an annual basis, and we will miss some entries/exits in the one-year period between surveys. This data feature may lead to some measurement error in our data; the bias from such error is difficult to sign (Bound, Brown, and Mathiowetz 2001).¹⁷ To explore the empirical importance of this data limitation, we estimate ancillary models in which we exclude observations in the between-directory period where entry and exits could be mis-classified. Results generated in this ancillary analysis are presented in in appendix table 2. The results are not appreciably different from our core specification (table 3).

Fourth, we implement several robustness checks regarding SUDTC heterogeneity, and both fixed-effect and clustering specifications. Specifically, we (i) estimate the effect of multiple SUDTCs within a locality to assess whether there is a dose-response effect of SUDTC entrance;

¹⁷ We attempted to locate exact opening and closing dates through SAMHSA (the agency that manages the NDDAATP) and the Washington State Substance Abuse Agency (the agency tasked with overseeing licensed SUDTCs in Seattle and that provides data to SAMHSA for management of NDDAATP). Collecting exact SUDTC opening and closing dates is not feasible based on our investigations into this issue. Details available on request.

(ii) estimate the effect of SUDTCs that provide methadone treatment;¹⁸ (iii) estimate models using quarter-by-year fixed effects to better capture seasonality in housing sales prices (U.S. Census Bureau 2018); (iv) estimate limited sales sample models with standard errors clustered at the zip code level; and (v) estimate full-sample models using a wild cluster bootstrap approach to estimate standard errors (Cameron & Miller, 2015).¹⁹ Results generated in these alternate specifications are presented in appendix tables 3 to 6. Findings are comparable to our main results (table 3). Finally, we exclude all residential property value variables and re-estimate Equations (2) and (3). We exclude the property-level controls as some of these could plausibly be influenced by SUDTC entrances/exits if – for instance – these entrances/exits alter the composition of residential properties listed for sale, thus leading to over-controlling bias in our estimates (Angrist and Pischke 2008). Results, reported in appendix table 7, are not appreciably different from our adjusted models (table 3).

6. Discussion

SUDs are prevalent and harmful health conditions within the U.S. and other developed countries. Treatment can effectively allow afflicted individuals to obtain abstinence, which additionally can reduce the associated negative societal costs of SUDs. However, SUDTCs require a physical space to occupy. There are anecdotal NIMBY concerns that these centers increase crime, littering, noise, and nuisance behaviors, which stigmatizes these centers and potentially reduces property values for residences in close proximity to the SUDTCs. On the

¹⁸ We study centers that offer OUD treatment – specifically centers offering methadone – as the U.S. is in the midst of an opioid epidemic and how best to address this epidemic is a pressing question facing local, state, and federal governments. We note that buprenorphine is also indicated to treat OUD. However, this medication is generally prescribed in general physicians' outpatient offices and not specialty treatment facilities such as we study here.

¹⁹ In our main specifications we cluster at the SUDTC area and zip code level respectively.

other hand, SUDTCs may increase property values by reducing SUD prevalence and associated behaviors and increasing employment opportunities within the neighborhood.

Given the scope of the SUD epidemic currently facing the U.S., the number of treatment facilities is expanding. For instance in 2003 (the first year of our study) there were 15,124 licensed specialty SUDTC facilities in the U.S. and by 2016 (the last year of our study) this number had risen to 18,087 (Substance Abuse and Mental Health Services Administration 2017, 2004), representing a 20% increase.²⁰ Thus, understanding the implications of SUDTC locations on the values of residential properties, which reflect major financial investments for many Americans, is of growing importance. Further, accurately understanding the effects of SUDTCs on property values is necessary to assess the overall costs of SUDs to society. While much of the literature that explores the costs of SUDs has focused on negative externalities such as crime and/or direct treatment costs, we explore a potential indirect treatment cost: financial spillovers to individuals who reside near an SUDTC.

In this study we provide new evidence on the effect of SUDTCs on residential property values using data from Seattle, Washington from 2003 to 2016, and an SDD estimator that mitigates bias from endogenous SUDTC location choices. We find that SUDTCs endogenously locate in areas with somewhat lower property values (2.2%). When we do not account for endogenous location choice, we find that SUDTCs reduce residential property values by 3.4% to 4.6%. However, after accounting for such location choices through the use of an SDD model, we find no statistically significant evidence that SUDTC entrance or exit influences residential property values. Moreover, our point estimates for both entrances and exits are very small in magnitude. Indeed, in our preferred SDD models we can rule out declines in property values

²⁰ Authors' calculations based on the 2003 and 2016 N-SSATS, details available on request.

following SUDTC entrance larger than 2.2% to 3.8% with 95% confidence. Our SDD estimates are robust to a wide range of specifications and sensitivity checks.

We note that our findings change when we apply the SDD model to account for endogenous location selection on the part of SUDTC owners and operators. In particular, we find no statistically significant evidence that SUDTCs affect property values when we apply the SDD estimator; coefficient estimates decline in magnitude and become statistically indistinguishable from zero. This pattern of results suggests that perhaps the perceived negative effects of SUDTCs on residential property values may be overstated. Previous economic research estimating dis-amenity effects also documents that failure to account for endogenous location choices can lead to estimates biased away from zero (Linden and Rockoff 2008). Our results thus link to a growing literature suggesting that empirical studies account for endogenous location choices when evaluating the effect of both amenities and dis-amenities on property values (Congdon-Hohman 2013; Dealy, Horn, and Berrens 2017; Linden and Rockoff 2008).

Local residents are often concerned that entrance of an SUDTC will impose costs on the neighborhood and, in turn, reduce residential property values. However, our findings suggest that the potential benefits of SUDTCs to the community may offset potential costs, leaving property values unchanged. Notably, SUDTCs reduce the prevalence of SUDs within the local area (Swensen 2015). Additionally, many studies document reductions in crime associated with SUDs treatment, and these effects have a considerable economic impact (Cohen and Piquero 2009; Doran 2008; McCollister et al. 2017; McCollister, French, and Fang 2010). In terms of SUDTCs, Bondurant et al., (2018) and Wen, Hockenberry, and Cummings (2017) show that that SUDTCs reduce both violent and financially motivated crimes in local areas. The social costs (e.g., legal system and healthcare costs) of one murder are very high: \$11M (McCollister et al.

2017).²¹ Finally, our study suggests that cost-benefit analyses of social goods (such as SUDTCs that reduce SUDs for individuals and associated harms to society) should incorporate the potential financial costs to individuals who reside near the location of the social good.

Our study has several limitations. First, we consider only SUDTCs licensed to deliver SUD treatment that are known to SAMHSA and complete the N-SSATS. We suspect that the number of SUDTCs that we miss is small given the importance of being listed on the NDDAATP for attracting patients and that SUDTCs are legally required to be licensed prior to delivering treatment to patients. Second, a critical step in application of the SDD model is selection of a suitable treatment and comparison group combination. In particular, the econometrician must locate a comparison group that can be used to estimate counterfactual trends in residential property values for the treatment group but is untreated by the event. While our results are robust to several alternative distance band specifications, we acknowledge that the most appropriate treatment-comparison group combination is unknown. Third, due to data limitations we are not able to determine the exact date at which SUDTCs enter and exit the market. However, our findings appear to be robust to several sensitivity analyses related to these limitations. Finally, we rely on a single city (Seattle). Moreover, Seattle experienced a large housing boom over our study period, which may alter the effects of dis-amenities. We note that our results are robust to numerous time and location fixed-effect specifications, which should account for non-linear changes in residential property values over time. Future studies are needed in more areas to fully understand the effect of SUDTCs on residential property values.

In summary, our findings shed new light on an important and relatively unstudied potential cost associated with SUDs, potential reductions in the value of housing values in close

²¹ Inflated by the authors from the estimate reported in the original manuscript (\$10,086,337 in 2016) to 2018 dollars using the CPI.

proximity to SUDTCs. We show that previous empirical evidence and anecdotes likely overstated the negative effects of SUDTCs on residential property values. While we did not study this question in our paper, it is possible that stigma against SUDTCs and NIMBY local efforts may have prevented these centers from optimally locating, which may impede treatment effectiveness and, in turn, patient outcomes and exacerbate social costs associated with SUDs.

Table 1: Residential Property Characteristics

Variable	Sample		
	Full sample	Treatment (0.2 miles)	Comparison (0.2 to 0.4 miles)
Sale Price (\$1,000 in 2016 dollars)	487.56 (283.80)	471.02 (259.49)	479.14 (270.10)
More than 1 No. of living unit (1= yes, 0 = no)	0.03 (0.17)	0.07 (0.25)	0.04 (0.20)
No. of Stories	1.37 (0.49)	1.54 (0.60)	1.43 (0.52)
No. of Bedrooms	3.23 (1.00)	3.13 (1.05)	3.20 (1.00)
No. of Bathrooms	1.45 (0.65)	1.48 (0.66)	1.46 (0.66)
Age	58.10 (29.58)	57.69 (36.93)	61.02 (32.26)
Renovated (1= yes, 0 = no)	4.25 (3.22)	4.69 (3.93)	4.76 (3.59)
Total Living (1,000 Square Feet)	1.83 (0.77)	1.71 (0.74)	1.77 (0.73)
Total Basement (1,000 Square Feet)	0.67 (0.53)	0.61 (0.48)	0.63 (0.49)
Total Garage (1,000 Square Feet)	0.17 (0.22)	0.14 (0.20)	0.15 (0.20)
Total Porch (1,000 Square Feet)	0.05 (0.09)	0.05 (0.08)	0.05 (0.09)
Total Deck (1,000 Square Feet)	0.11 (0.17)	0.08 (0.14)	0.10 (0.16)
Percent Brick Stone	7.71 (24.65)	3.89 (17.88)	5.27 (20.64)
Building Grade (quality)	7.25 (0.94)	7.23 (0.93)	7.20 (0.91)
N	131,862	8,982	22,671

Notes: Residential properties can have more than one living unit.

Table 2: Effect of SUDTC Entrance and Exit on Residential Property values: Naïve OLS Model

Model:	(1)	(2)	(3)
Mean value of outcome variable (\$1,000 in 2016 dollars):	487.56	487.56	487.56
$D^{0.2}$	-0.0467*** (0.0054)	-0.0344*** (0.0048)	-0.0344* (0.0181)
Constant	11.7253*** (0.0566)	12.2773*** (0.0568)	12.2773*** (0.0740)
N	131,862	131,862	131,862
adj. R^2	0.533	0.646	0.646
Housing Characteristics	✓	✓	✓
Year FE	✓		
Year × Zip code Fixed Effects		✓	✓
Zip Code SE Cluster			✓

Notes: Standard errors in parentheses

* $p < .1$, ** $p < .05$, *** $p < .01$.

Table 3: Effect of SUDTC Entrance and Exit on Residential Property values: SDD Results

Model:	(1) Test for Endogenous locations	(2) Full Sample	(3) Full Sample	(4) Limited Sales Sample	(5) Limited Sales Sample
Mean value of outcome variable (\$1,000 in 2016 dollars):	486.65	487.56	487.56	476.84	476.84
D ^{0.2}	-0.0101 (0.0138)	-0.0079 (0.0136)	-0.0080 (0.0137)	-0.0302** (0.0138)	-0.0304** (0.0137)
D ^{0.4}	-0.0223* (0.0117)	-0.0225* (0.0126)	-0.0228* (0.0125)		
D ^{0.2} * _{entry}		-0.0055 (0.0135)	-0.0111 (0.0143)	0.0098 (0.0161)	0.0064 (0.0172)
D ^{0.4} * _{entry}		0.0032 (0.0149)	0.0008 (0.0177)	-0.0094 (0.0188)	-0.0086 (0.0184)
D ^{0.2} * _{exit}			0.0198 (0.0164)		0.0134 (0.0142)
D ^{0.4} * _{exit}			0.0096 (0.0161)		0.0291 (0.0177)
Constant	12.3972*** (0.0703)	12.2954*** (0.0762)	12.2923*** (0.0761)	12.1320*** (0.1039)	12.1371*** (0.1074)
N	108,128	131,862	131,862	31,653	31,653
adj. R ²	0.651	0.646	0.646	0.630	0.630
Housing Characteristics	✓	✓	✓	✓	✓
Year × Zip code Fixed Effects	✓	✓	✓		
Year Fixed Effects				✓	✓
SUDTC Fixed Effect				✓	✓
Zip Code SE Cluster		✓	✓		
SUDTC area SE Cluster				✓	✓
Restricted to 0.4 miles				✓	✓
Observation within 0.4 miles after SUDTC entry dropped	✓				

Notes: Standard errors in parentheses

* $p < .1$, ** $p < .05$, *** $p < .01$.

Table 4A: Effect of SUDTC Entrance and Exit on Residential Property values: SDD Results with Alternative Distance Band Specifications – Full

	Sample							
Model:	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Treatment group	0.1	0.1	0.1	0.2	0.2	0.2	0.3	0.3
Comparison group	0.3	0.4	0.5	0.4	0.5	0.6	0.5	0.6
Mean value of outcome variable (\$1,000 in 2016 dollars):	487.56	487.56	487.56	487.56	487.56	487.56	487.56	487.56
D ^{Treatment}	-0.0168 (0.0177)	-0.0169 (0.0199)	-0.0174 (0.0204)	-0.0080 (0.0137)	-0.0081 (0.0153)	-0.0078 (0.0169)	0.0019 (0.0155)	0.0021 (0.0161)
D ^{Comparison}	-0.0199 (0.0142)	-0.0242* (0.0130)	-0.0297* (0.0162)	-0.0228* (0.0125)	-0.0288* (0.0165)	-0.0365* (0.0182)	-0.0295 (0.0182)	-0.0370* (0.0195)
D ^{Treatment*_tentry}	0.0117 (0.0172)	0.0092 (0.0188)	0.0105 (0.0205)	-0.0111 (0.0143)	-0.0085 (0.0164)	-0.0107 (0.0165)	-0.0081 (0.0178)	-0.0110 (0.0174)
D ^{Comparison*_tentry}	-0.0044 (0.0209)	-0.0017 (0.0182)	-0.0025 (0.0192)	0.0008 (0.0177)	-0.0014 (0.0192)	0.0013 (0.0192)	-0.0022 (0.0194)	0.0011 (0.0193)
D ^{Treatment*_texit}	-0.0035 (0.0251)	0.0029 (0.0280)	-0.0030 (0.0287)	0.0198 (0.0164)	0.0117 (0.0158)	0.0123 (0.0157)	0.0123 (0.0158)	0.0132 (0.0157)
D ^{Comparison*_texit}	0.0181 (0.0183)	0.0115 (0.0151)	0.0195 (0.0155)	0.0096 (0.0161)	0.0196 (0.0160)	0.0202 (0.0144)	0.0202 (0.0154)	0.0206 (0.0139)
Constant	12.2830*** (0.0750)	12.2918*** (0.0758)	12.2979*** (0.0754)	12.2923*** (0.0761)	12.2992*** (0.0758)	12.3107*** (0.0745)	12.2960*** (0.0760)	12.3074*** (0.0748)
N	131,862	131,862	131,862	131,862	131,862	131,862	131,862	131,862
adj. R ²	0.646	0.646	0.646	0.646	0.646	0.646	0.646	0.646
Housing Characteristics	✓	✓	✓	✓	✓	✓	✓	✓
Year × Zip code Fixed Effects	✓	✓	✓	✓	✓	✓	✓	✓
Zip Code SE Cluster	✓	✓	✓	✓	✓	✓	✓	✓

Notes: Standard errors in parentheses

* $p < .1$, ** $p < .05$, *** $p < .01$.

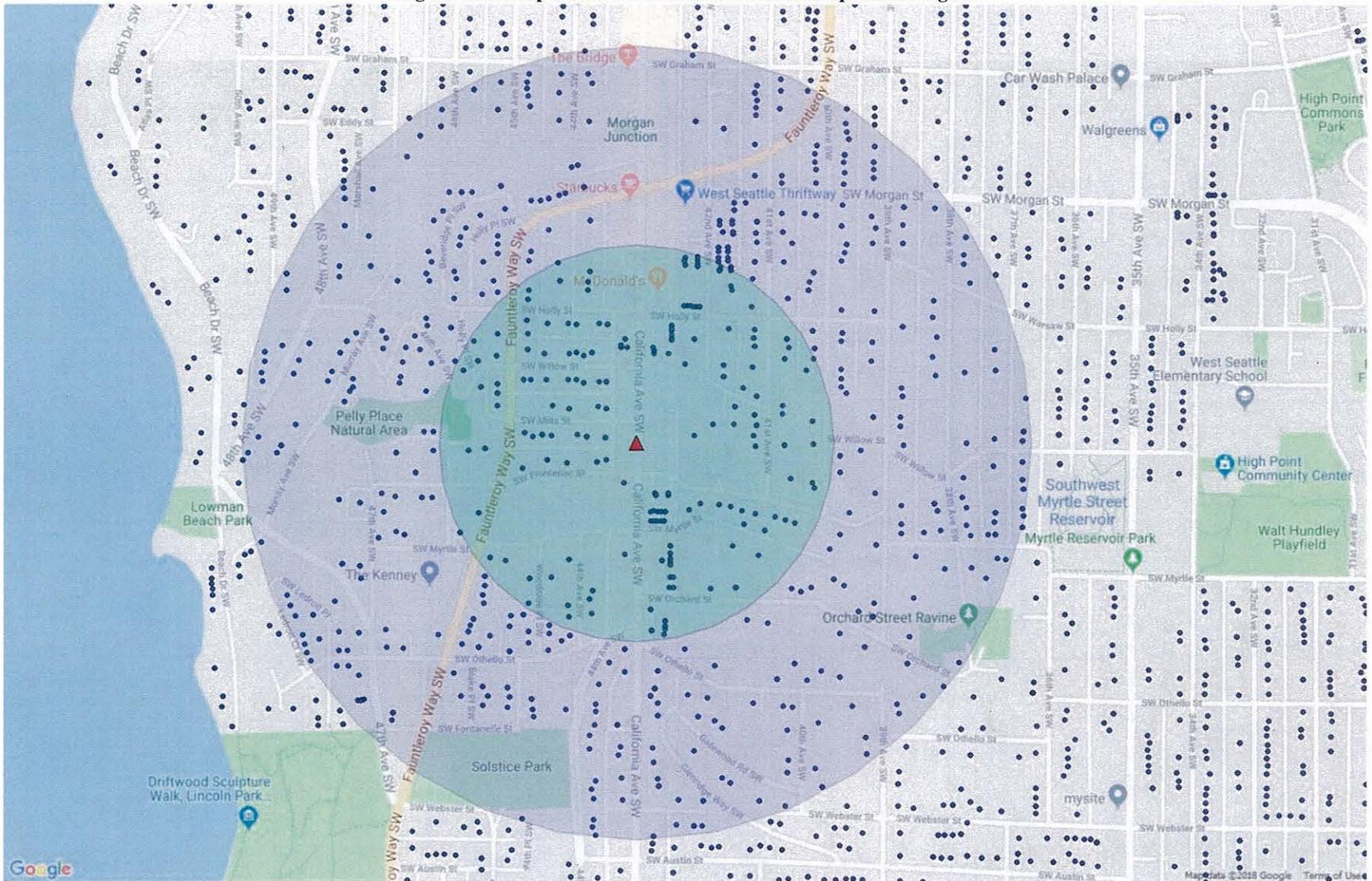
Table 4B: Effect of SUDTC Entrance and Exit on Residential Property values: SDD Results with Alternative Distance Band Specifications – Limited Sales Sample

Model:	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Treatment group	0.1	0.1	0.1	0.2	0.2	0.2	0.3	0.3
Comparison group	0.3	0.4	0.5	0.4	0.5	0.6	0.5	0.6
Mean value of outcome variable (\$1,000 in 2016 dollars):	473.77	476.84	474.33	476.84	474.33	474.50	474.33	474.50
D ^{Treatment}	-0.0406** (0.0161)	-0.0411** (0.0173)	-0.0436** (0.0186)	-0.0304** (0.0137)	-0.0323** (0.0154)	-0.0320* (0.0163)	-0.0097 (0.0105)	-0.0096 (0.0114)
D ^{Treatment} * τ_{entry}	0.0214 (0.0232)	0.0161 (0.0246)	0.0184 (0.0265)	0.0064 (0.0172)	0.0093 (0.0190)	0.0075 (0.0190)	0.00001 (0.0134)	-0.0025 (0.0131)
D ^{Comparison} * τ_{entry}	-0.0120 (0.0200)	-0.0067 (0.0184)	0.0003 (0.0176)	-0.0086 (0.0184)	-0.0014 (0.0179)	-0.0009 (0.0174)	-0.0017 (0.0181)	-0.0005 (0.0175)
D ^{Treatment} * τ_{exit}	-0.0005 (0.0285)	0.0073 (0.0297)	0.0033 (0.0304)	0.0134 (0.0142)	0.0097 (0.0142)	0.0133 (0.0135)	0.0136 (0.0132)	0.0171 (0.0127)
D ^{Comparison} * τ_{exit}	0.0331* (0.0192)	0.0288 (0.0180)	0.0344** (0.0168)	0.0291 (0.0177)	0.0353** (0.0164)	0.0382** (0.0161)	0.0321** (0.0157)	0.0346** (0.0155)
Constant	11.8386*** (0.3415)	12.1270*** (0.1083)	12.1568*** (0.1149)	12.1371*** (0.1074)	12.1642*** (0.1141)	12.1473*** (0.1010)	12.1461*** (0.1141)	12.1344*** (0.1014)
N	19,390	31,653	43,847	31,653	43,847	56,799	43,847	56,799
adj. R ²	0.636	0.630	0.622	0.630	0.622	0.622	0.622	0.622
Housing Characteristics	✓	✓	✓	✓	✓	✓	✓	✓
Year Fixed Effects	✓	✓	✓	✓	✓	✓	✓	✓
SUDTC Fixed Effects	✓	✓	✓	✓	✓	✓	✓	✓
SUDTC SE Cluster	✓	✓	✓	✓	✓	✓	✓	✓
Restricted to Comparison Region	✓	✓	✓	✓	✓	✓	✓	✓

Notes: Standard errors in parentheses

* $p < .1$, ** $p < .05$, *** $p < .01$.

Figure 1: Example SUDTC Treatment and Comaparision Region



Notes: ▲ is the SUDTC Center, ● are the residential properties sales.
 First circle: within 0.2 miles of SUDTC, Second Circle: within 0.2-0.4 miles of SUDTC

Figure 2: SUDTC Locations in Seattle from 2003 to 2016

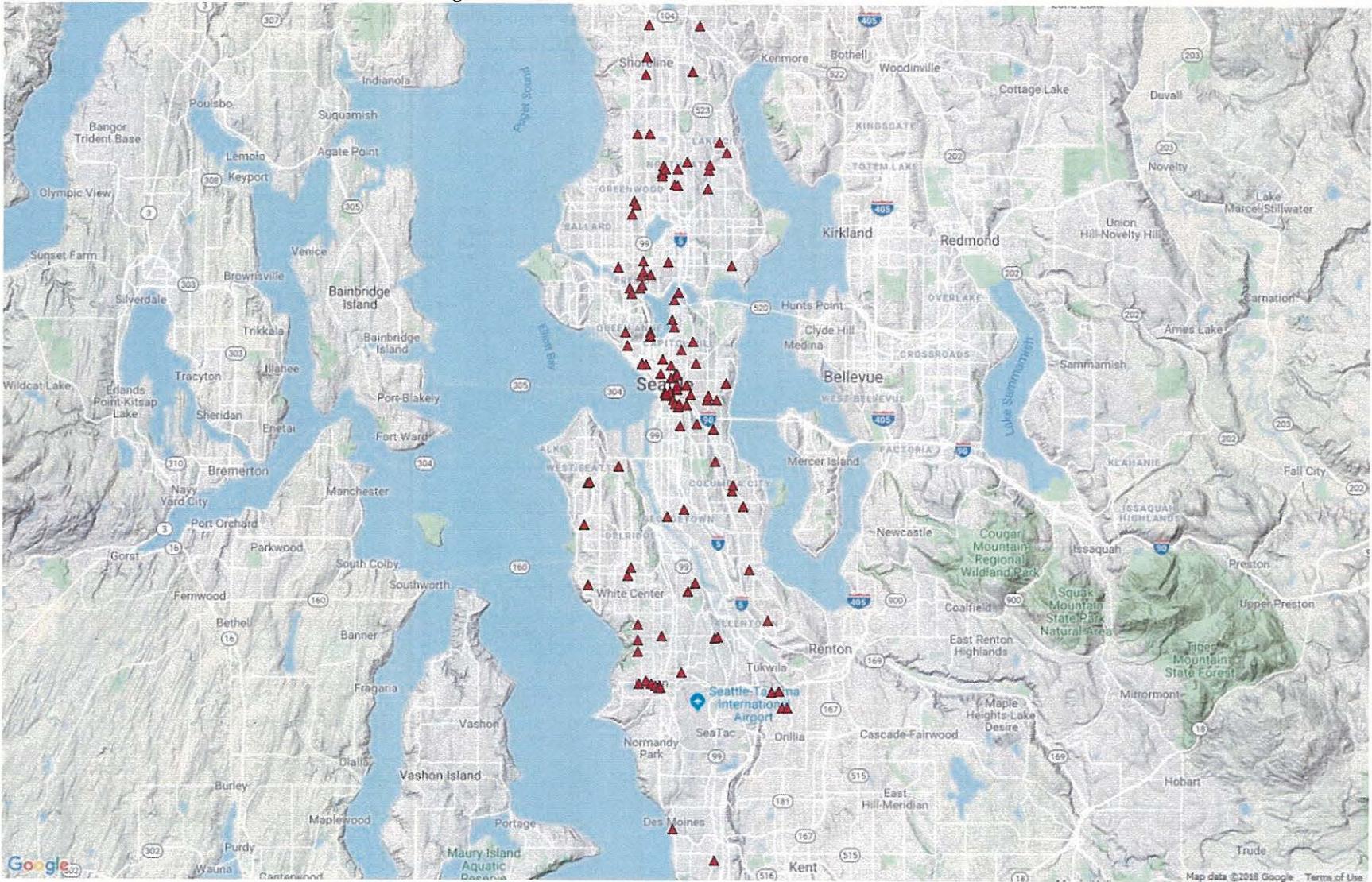
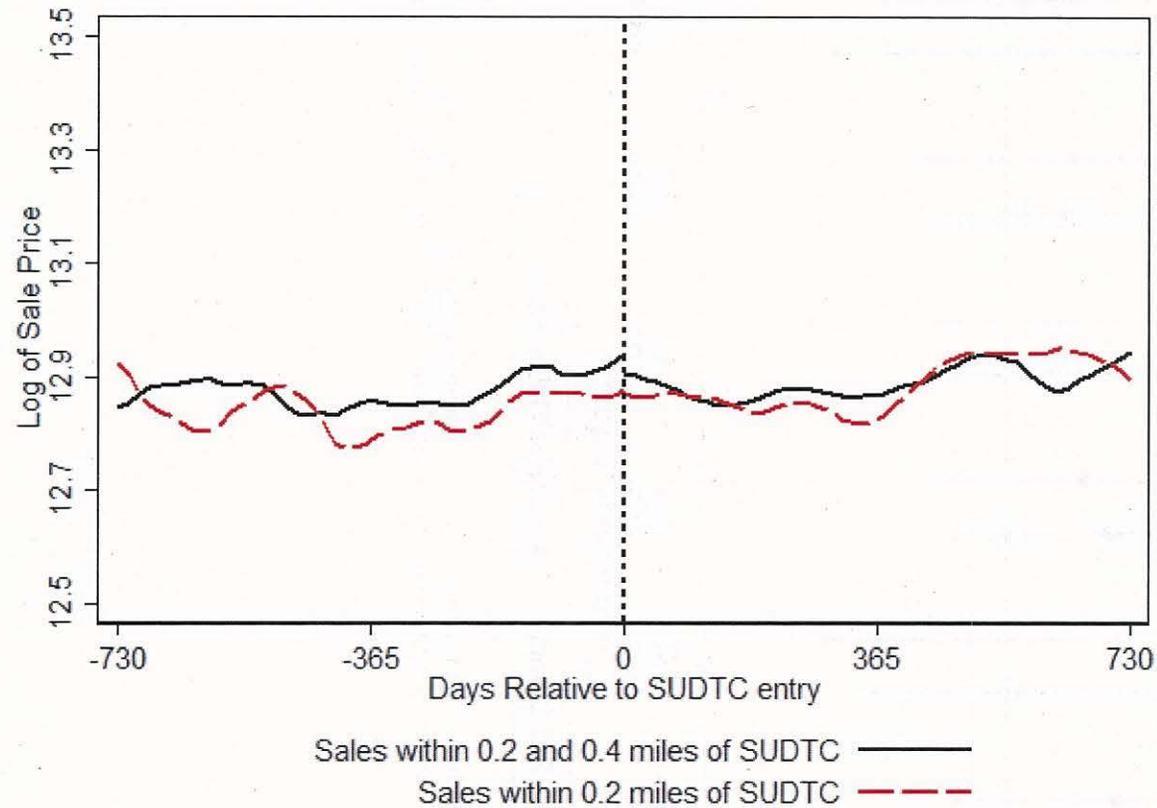
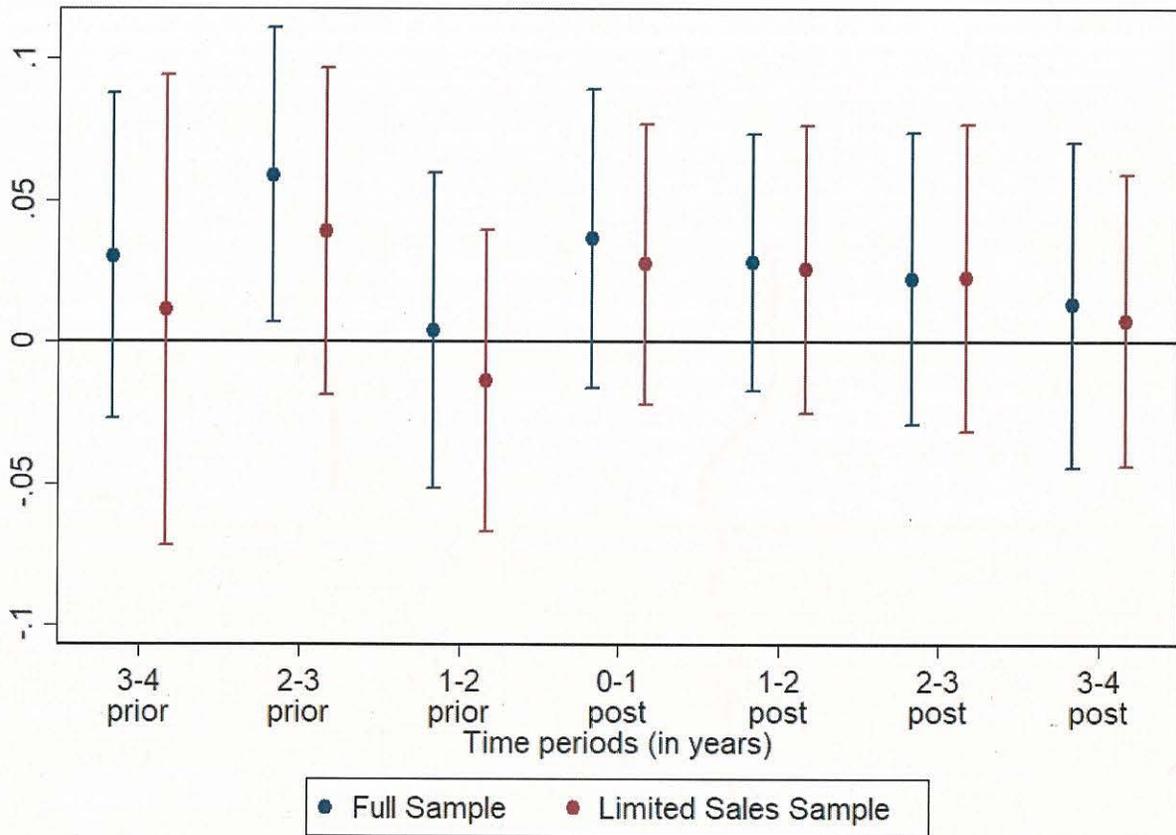


Figure 3: Trends in Residential Housing Prices in Seattle: Pre-and Post- SUDTC Entry



Notes: Data are centered around the SUDTC entry. The treatment group includes residential property sales that occur 0 to < 0.20 miles from an SUDTC. The comparison group includes residential property sales that occur 0.2 to 0.4 miles from an SUDTC. Epanechnikov local polynomial smoothing with bandwidth of 35 days.

Figure 4: Effect of SUDTC Entrance and Exit on Residential Property values: Event-study Coefficients Plotted for Treatment Region (0.2 miles from SUDTC)



Notes: Entry period defined as 0-1 years prior to survey date. Observations restricted to 4-years prior and 4-years post SUDTC entry. The omitted category is 0-1 years prior to SUDTC entry. Mean value of the outcome variable (\$1,000 in 2016 dollars): 487.

Appendix Table 1: Effect of SUDTC Entrance and Exit on Residential Property values: SDD Model Full Set of Control Variable Coefficient Estimate

Control Variable Coefficient Estimates for Column (3) in Table 3	Beta (Standard error)
Mean value of outcome variable (\$1,000 in 2016 dollars):	487.56
More than 1 No. of living unit (1= yes, 0 = no)	-0.0266** (0.0116)
No. of Stories	0.0257*** (0.0079)
No. of Bedrooms	-0.0115*** (0.0033)
No. of Bathrooms	-0.0024 (0.0033)
Age	0.0018*** (0.0005)
Age-squared	-0.0035 (0.0045)
Renovated (1= yes, 0 = no)	0.0578*** (0.0079)
Total Living (1,000 Square Feet)	0.1726*** (0.0060)
Total Basement (1,000 Square Feet)	0.0345*** (0.0063)
Total Garage (1,000 Square Feet)	0.0904*** (0.0104)
Total Porch (1,000 Square Feet)	0.1252*** (0.0199)
Total Deck (1,000 Square Feet)	0.1611*** (0.0146)
Percent Brick Stone	0.0004*** (0.0001)
Constant	12.2923*** (0.0761)
<i>N</i>	131,862
adj. <i>R</i> ²	0.646
Building Grade Variables	✓

Notes: All models estimated with OLS. Standard errors clustered at Zip Code level reported in parentheses.

* $p < .1$, ** $p < .05$, *** $p < .01$.

**Appendix Table 2: Effect of SUDTC Entrance and Exit on Residential Property values: SDD Results
Dropping Observations in the Between-N-SSATS Survey Period**

Model:	(1) Full Sample	(2) Full Sample	(3) Limited Sales Sample	(4) Limited Sales Sample
Mean value of outcome variable (\$1,000 in 2016 dollars):	487.56	487.56	476.84	476.84
D ^{0.2}	-0.0008 (0.0147)	-0.0008 (0.0147)	-0.0267 (0.0167)	-0.0269 (0.0166)
D ^{0.4}	-0.0236* (0.0123)	-0.0241* (0.0121)		
D ^{0.2} * _t entry	-0.0135 (0.0136)	-0.0184 (0.0142)	0.0056 (0.0186)	0.0028 (0.0195)
D ^{0.4} * _t entry	0.0047 (0.0145)	0.0016 (0.0172)	-0.0074 (0.0209)	-0.0050 (0.0206)
D ^{0.2} * _t exit		0.0178 (0.0151)		0.0122 (0.0143)
D ^{0.4} * _t exit		0.0125 (0.0153)		0.0332* (0.0175)
Constant	12.2952*** (0.0765)	12.2918*** (0.0764)	12.1243*** (0.1052)	12.1299*** (0.1087)
N	130,380	130,380	30,171	30,171
adj. R ²	0.647	0.647	0.632	0.632
Housing Characteristics	✓	✓	✓	✓
Year × Zip code Fixed Effects	✓	✓		
Year Fixed Effects			✓	✓
SUDTC Fixed Effect			✓	✓
Zip Code SE Cluster	✓	✓		
SUDTC area SE Cluster			✓	✓
Restricted to 0.4 miles			✓	✓
Observation dropped within 0.4 miles for 365 days before entry	✓	✓	✓	✓

Notes: Standard errors in parentheses. Sale observations 365 days before the survey date dropped at control level (0.4 miles). * $p < .1$, ** $p < .05$, *** $p < .01$.

Appendix Table 3: Effect of SUDTC Entrance and Exit on Residential Property values: SDD Results with Alternate Fixed Effect and Clustering Specifications

Model:	(1) Full Sample	(2) Full Sample	(3) Full Sample	(4) Limited Sales Sample	(5) Limited Sales Sample	(6) Limited Sales Sample
Mean value of outcome variable (\$1,000 in 2016 dollars):	487.56	487.56	487.56	476.84	476.84	476.84
D ^{0.2}	-0.0080 (0.0137)	-0.0043 (0.0157)	-0.0080 (0.0120)	-0.0036 (0.0141)	-0.0295** (0.0135)	-0.0295** (0.0135)
D ^{0.4}	-0.0228* (0.0125)	-0.0246 (0.0149)	-0.0228* (0.0124)			
D ^{0.2} * _t entry	-0.0111 (0.0143)	-0.0158 (0.0158)	-0.0111 (0.0173)	-0.0156 (0.0138)	0.0073 (0.0142)	0.0073 (0.0169)
D ^{0.4} * _t entry	0.0008 (0.0177)	-0.0034 (0.0192)	0.0008 (0.0046)	-0.0184 (0.0204)	-0.0148 (0.0214)	-0.0148 (0.0181)
D ^{0.2} * _t exit	0.0198 (0.0164)	0.0193 (0.0173)	0.0198 (0.0176)	0.0194 (0.0168)	0.0119 (0.0170)	0.0119 (0.0139)
D ^{0.4} * _t exit	0.0096 (0.0161)	0.0275 (0.0171)	0.0096 (0.0194)	0.0113 (0.0222)	0.0216 (0.0167)	0.0216 (0.0175)
Constant	12.2923*** (0.0761)	12.2558*** (0.0736)	12.4368*** (0.0000)	12.1275*** (0.1785)	12.0576*** (0.1685)	12.0576*** (0.1091)
N	131,862	131,862	131,862	31,653	31,653	31,653
adj. R ²	0.646	0.639	0.646	0.616	0.636	0.636
Housing Characteristics	✓	✓	✓	✓	✓	✓
Year × Zip code Fixed Effects	✓		✓			
Quarter Year Fixed Effects		✓		✓	✓	✓
Zip Code Fixed Effects		✓	✓	✓		
SUDTC fixed effects					✓	✓
Zip Code SE Cluster	✓	✓	✓	✓	✓	
SUDTC SE Cluster						✓
Wild Cluster Boot Strap at Zip Code level			✓			
Restricted to 0.4 miles				✓	✓	✓

Notes: All models estimated with OLS. Standard errors reported in parentheses. Treatment group is defined as all properties sold 0 to <0.2 miles from an SUDTC. Comparison group is defined as all properties sold 0.2 to 0.4 miles from an SUDTC. * $p < .1$, ** $p < .05$, *** $p < .01$.

Appendix Table 4: Effect of SUDTC Entrance and Exit on Residential Property values: SDD Result using Methadone Maintenance and Methadone Detoxification SUDTCs Only

Model:	(1) Full Sample	(2) Full Sample	(3) Limited Sales Sample	(4) Limited Sales Sample
Mean value of outcome variable (\$1,000 in 2016 dollars):	487.56	487.56	476.84	476.84
$D^{0.2}$	-0.0080 (0.0137)	-0.0080 (0.0137)	-0.0303** (0.0137)	-0.0306** (0.0135)
$D^{0.4}$	-0.0225* (0.0126)	-0.0229* (0.0126)		
$D^{0.2} * \tau_{\text{entry}}$	-0.0084 (0.0139)	-0.0160 (0.0145)	0.0075 (0.0166)	0.0027 (0.0178)
$D^{0.2} * \tau_{\text{entry}} * \theta^{\text{Methadone}}$	0.0359 (0.0397)	0.0437 (0.0383)	0.0256 (0.0410)	0.0305 (0.0414)
$D^{0.4} * \tau_{\text{entry}}$	0.0027 (0.0135)	-0.0004 (0.0163)	-0.0122 (0.0199)	-0.0129 (0.0191)
$D^{0.4} * \tau_{\text{entry}} * \theta^{\text{Methadone}}$	0.0049 (0.0353)	0.0084 (0.0354)	0.0214 (0.0217)	0.0358 (0.0241)
$D^{0.2} * \tau_{\text{exit}}$		0.0246 (0.0157)		0.0169 (0.0138)
$D^{0.4} * \tau_{\text{exit}}$		0.0108 (0.0158)		0.0316* (0.0184)
Constant	12.2955*** (0.0765)	12.2918*** (0.0763)	12.1325*** (0.1026)	12.1389*** (0.1062)
<i>N</i>	131,862	131,862	31,653	31,653
adj. <i>R</i> ²	0.646	0.646	0.630	0.630
Housing Characteristics	✓	✓	✓	✓
Year × Zip code Fixed Effects	✓	✓		
Year Fixed Effects			✓	✓
SUDTC Fixed Effect			✓	✓
Zip Code SE Cluster	✓	✓		
SUDTC area SE Cluster			✓	✓
Restricted to 0.4 miles			✓	✓

Notes: Standard errors in parentheses. $\theta^{\text{Methadone}}$ represents SUDTC providing Methadone maintenance and Methadone detoxification service in operation. * $p < .1$, ** $p < .05$, *** $p < .01$.

**Appendix Table 5: Effect of SUDTC Entrance and Exit on Residential Property values: SDD Results
Accounting for Multiple SUDTCs in Proximity to Property**

Model:	(1)	(2)	(3)	(4)
	Full Sample	Full Sample	Limited Sales	Limited Sales
Mean value of outcome variable:	487.56	487.56	476.84	476.84
D ^{0.2}	-0.0079 (0.0136)	-0.0080 (0.0137)	-0.0302** (0.0138)	-0.0303** (0.0137)
D ^{0.4}	-0.0224* (0.0126)	-0.0228* (0.0125)		
D ^{0.2} * τ_{entry}	-0.0050 (0.0131)	-0.0110 (0.0134)	0.0105 (0.0161)	0.0066 (0.0173)
D ^{0.2} * τ_{entry} * $\theta^{\text{Secondary SUDTC}}$	-0.0099 (0.0347)	-0.0009 (0.0334)	-0.0167 (0.0238)	-0.0057 (0.0237)
D ^{0.4} * τ_{entry}	0.0031 (0.0149)	0.0007 (0.0177)	-0.0097 (0.0189)	-0.0087 (0.0185)
D ^{0.2} * τ_{exit}		0.0197 (0.0155)		0.0131 (0.0139)
D ^{0.4} * τ_{exit}		0.0096 (0.0161)		0.0290 (0.0178)
Constant	12.2952*** (0.0762)	12.2923*** (0.0761)	12.1314*** (0.1041)	12.1369*** (0.1076)
N	131,862	131,862	31,653	31,653
adj. R ²	0.646	0.646	0.630	0.630
Housing Characteristics	✓	✓	✓	✓
Year × Zip code Fixed Effects	✓	✓		
Year Fixed Effects			✓	✓
SUDTC Fixed Effect			✓	✓
Zip Code SE Cluster	✓	✓		
SUDTC area SE Cluster			✓	✓
Restricted to 0.4 miles			✓	✓

Notes: Standard errors in parentheses. $\theta^{\text{Secondary SUDTC}}$ represents other SUDTCs in operation within 0.2 miles.
* $p < .1$, ** $p < .05$, *** $p < .01$.

Appendix Table 6: Effect of SUDTC Entrance and Exit on Residential Property values: SDD Results for Sample with Exit Parameter Suppressed for SUDTC that Entered Multiple Times

Model:	(1) Full Sample	(2) Full Sample	(3) Limited Sales Sample	(4) Limited Sales Sample
Mean value of outcome variable:	487.56	487.56	476.84	476.84
D ^{0.2}	-0.0079 (0.0136)	-0.0080 (0.0137)	-0.0302** (0.0138)	-0.0300** (0.0139)
D ^{0.4}	-0.0225* (0.0126)	-0.0230* (0.0125)		
D ^{0.2} *t _{entry}	-0.0055 (0.0135)	-0.0070 (0.0147)	0.0096 (0.0161)	0.0091 (0.0169)
D ^{0.4} *t _{entry}	0.0032 (0.0149)	-0.0020 (0.0173)	-0.0094 (0.0189)	-0.0073 (0.0188)
D ^{0.2} *t _{exit}		0.0069 (0.0142)		0.0038 (0.0143)
D ^{0.4} *t _{exit}		0.0205 (0.0153)		0.0424** (0.0193)
Constant	12.2954*** (0.0762)	12.2916*** (0.0761)	12.1321*** (0.1041)	12.1368*** (0.1085)
N	131,862	131,862	31,653	31,653
adj. R ²	0.646	0.646	0.630	0.630
Housing Characteristics	✓	✓	✓	✓
Year × Zip code Fixed Effects	✓	✓		
Year Fixed Effects			✓	✓
SUDTC Fixed Effect			✓	✓
Zip Code SE Cluster	✓	✓		
SUDTC area SE Cluster			✓	✓
Restricted to 0.4 miles			✓	✓
Exit parameter suppressed for SUDTC with multiple entry	✓	✓	✓	✓

Notes: Standard errors in parentheses. SUDTC with multiple entry at the same locations are considered to have never left the location. * $p < .1$, ** $p < .05$, *** $p < .01$.

**Appendix Table 7: Effect of SUDTC Entrance and Exit on Residential Property values: SDD Results
Excluding Residential Property Controls**

Model:	(1) Full Sample	(2) Full Sample	(3) Limited Sales Sample	(4) Limited Sales Sample
Mean value of outcome variable (\$1,000 in 2016 dollars):	487.56	487.56	476.84	476.84
$D^{0.2}$	-0.0343 (0.0235)	-0.0344 (0.0235)	-0.0639*** (0.0222)	-0.0641*** (0.0220)
$D^{0.4}$	-0.0728*** (0.0257)	-0.0734*** (0.0257)		
$D^{0.2} * \tau_{\text{entry}}$	-0.0003 (0.0203)	-0.0095 (0.0237)	0.0291 (0.0259)	0.0226 (0.0277)
$D^{0.4} * \tau_{\text{entry}}$	0.0199 (0.0302)	0.0158 (0.0329)	-0.0028 (0.0206)	-0.0011 (0.0203)
$D^{0.2} * \tau_{\text{exit}}$		0.0324 (0.0419)		0.0235 (0.0336)
$D^{0.4} * \tau_{\text{exit}}$		0.0162 (0.0285)		0.0258 (0.0211)
Constant	13.4539*** (0.0145)	13.4490*** (0.0154)	12.8962*** (0.0101)	12.9038*** (0.0106)
N	131,862	131,862	31,653	31,653
adj. R^2	0.403	0.403	0.466	0.467
Year \times Zip code Fixed Effects	✓	✓		
Year Fixed Effects			✓	✓
SUDTC Fixed Effect			✓	✓
Zip Code SE Cluster	✓	✓		
SUDTC area SE Cluster			✓	✓
Restricted to 0.4 miles			✓	✓

Notes: Standard errors in parentheses. * $p < .1$, ** $p < .05$, *** $p < .01$.

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IDEA

DO DRUG TREATMENT CENTERS BRING MORE CRIME TO A NEIGHBORHOOD?



LINUS CURCI

Dale Keiger / Spring 2016

Denizens of urban neighborhoods often resist certain additions to the community: commercial enterprises like bars or dance clubs, group homes, subsidized housing developments, halfway

houses. The phenomenon is common enough to merit an acronym—NIMBY, for "not in my backyard."

Situating a drug treatment center—a DTC, in public health parlance—in a neighborhood is a particularly unpopular move, even in communities where the need is most acute. People with drug problems need a place to obtain methadone and other treatment services. But neighborhoods fear that any facility that attracts addicts will also attract crime to places already dealing with too much urban violence. Debra Furr-Holden, A&S '96, SPH '99 (PhD), an associate professor in the Bloomberg School of Public Health's Department of Mental Health, led a recent study, published in the *Journal of Studies on Alcohol and Drugs*, that analyzed Baltimore crime statistics in the vicinities of various establishments, including DTCs. The data reveal that community members should be more worried about liquor stores than drug treatment centers.

Context

Urban residents are right to be concerned about safety, property values, noise and traffic, and unpleasant behavior on the street, all of which reduce the quality of their lives. Everyone worries about those things, wherever they live. Research has shown that facilities designed to serve special populations such as people with mental health issues, insecure housing, or drug abuse problems often are stigmatized and disdained. Frequently the main concern is crime—for example, that a DTC will bring with it an increase in violent crimes such as homicides and violent assaults.

Data

Furr-Holden and her co-authors obtained data on violent crimes—defined as homicide, manslaughter, rape, aggravated assault, and robbery—from the Baltimore City Police Department's Uniform Crime Report and plotted more than 9,000 of those crimes on a map. Then, for each of 53 public DTCs located in the city, they tabulated violent crimes committed within 1,400 feet of each center. They did the same for liquor stores, convenience stores, and corner stores. (The key distinction between the last two was ownership: convenience stores are chain operations, while corner stores are independent mom-and-pop shops.) When they calculated the mean number of violent crimes for each type of establishment, they found that roughly the same number of crimes were committed near convenience stores as near DTCs. But the data reveal that 38 percent more violent crimes were committed near liquor stores, and 31 percent more near corner stores.

Upshot

The standard public anxiety about a DTC attracting crime to the neighborhood is not borne out by the data. Crimes tend to cluster around any sort of public establishment because stores, clinics, etc., draw people to the streets and crime happens where there are concentrations of people. But according to these research results, you are significantly more likely to encounter

violent crime near a liquor or corner store than a DTC, and neighborhoods often recruit the former (especially corner food stores) while trying to discourage the latter.

Conclusion

"Drug treatment centers are a public health need; they are as necessary as urgent care centers and emergency departments," says Furr-Holden. "Our research shows that DTCs do not impact communities any more than other commercial businesses. Moving forward, communities should work with researchers, policymakers, and DTCs to have an honest dialogue regarding placement of this needed resource."

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So if we put a methadone clinic in the safest upper income suburb of Baltimore, the crime will not increase?

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Not in My Back Yard: A Comparative Analysis of Crime Around Publicly Funded Drug Treatment Centers, Liquor Stores, Convenience Stores, and Corner Stores in One Mid-Atlantic City

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ABSTRACT. Objective: This research examined whether publicly funded drug treatment centers (DTCs) were associated with violent crime in excess of the violence happening around other commercial businesses. **Method:** Violent crime data and locations of community entities were geocoded and mapped. DTCs and other retail outlets were matched based on a Neighborhood Disadvantage score at the census tract level. Street network buffers ranging from 100 to 1,400 feet were placed around each location. Negative binomial regression models were used to estimate the relationship between the count of violent crimes and the distance from each business type. **Results:** Compared with the mean count of violent crime around drug treatment centers, the mean count of violent crime ($M = 2.87$) was significantly higher around liquor stores

($M = 3.98$; t test; $p < .01$) and corner stores ($M = 3.78$; t test; $p < .01$), and there was no statistically significant difference between the count around convenience stores ($M = 2.65$; t test; $p = .32$). In the adjusted negative binomial regression models, there was a negative and significant relationship between the count of violent crime and the distance from drug treatment centers ($\beta = -.069$, $p < .01$), liquor stores ($\beta = -.081$, $p < .01$), corner stores ($\beta = -.116$, $p < .01$), and convenience stores ($\beta = -.154$, $p < .01$). **Conclusions:** Violent crime associated with drug treatment centers is similar to that associated with liquor stores and is less frequent than that associated with convenience stores and corner stores. (*J. Stud. Alcohol Drugs*, 77, 17–24, 2016)

THE PHENOMENON KNOWN AS the “Not in My Back Yard,” or NIMBY, syndrome is characterized by neighborhoods’ resistance to having technologies, services, commercial outlets, housing developments, group housing programs, or other initiatives in their neighborhood. Although many residents may support these initiatives in theory, they are against having them located in their neighborhood (Davidson & Howe, 2014; Krause et al., 2014; Piat, 2000; Polcin et al., 2012; Takahashi, 1997). Polcin and colleagues (2012) examined community concerns about “sober living houses” (i.e., alcohol- and other drug-free living environments aimed to help residents maintain sobriety) and found that concerns centered on issues such as noise, traffic, violent crime, and unpleasant resident behavior. Other research highlights residents’ concerns about property values and quality of life (Piat, 2000).

Takahashi (1997) argues that NIMBY syndrome stems from stigmatization and disdain, particularly for services designed for special populations, such as people with substance use disorders and other mental health problems, people who have been involved in the criminal justice system, and people with insecure housing. NIMBY syndrome has been repeatedly observed in the placement of drug treatment centers (DTCs)—such as methadone clinics—as many believe that people in recovery are objectionable (Boyd et al., 2012; Polcin et al., 2012). Residents are particularly concerned about violence increasing in their neighborhoods subsequent to the establishment of behavioral health or housing initiatives for people with substance use disorders in their neighborhoods (Boyd et al., 2012; Davidson & Howe, 2014; Polcin et al., 2012; Takahashi, 1997).

Empirical data on whether DTCs are associated with increased levels of violence may provide information to (a) help communities make informed, data-driven decisions

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about whether to support such centers and (b) help advocates mitigate strong opposition with evidence as opposed to moral or rhetorical arguments. We, therefore, sought to empirically test whether publicly funded DTCs are associated with violence in excess of the violence happening around other commercial businesses by matching DTCs with other retail entities by neighborhood disadvantage and comparing the relative rate of crime around DTCs with crime around other business types. Other commercial businesses attract foot and vehicular traffic and have hours of operation inclusive of the standard hours of a DTC.

Method

This was a cross-sectional analysis comparing violent crime around DTCs to violent crime around similar community entities matched by neighborhood disadvantage in Baltimore, MD, in 2011. Similar community entities were selected if they operated in a residential or mixed residential/commercial zone, were open at least 8 hours per day 6 days per week, and were classified as commercial entities. Such locations included liquor stores, major chain convenience stores (e.g., 7-Eleven and Royal Farms), and “mom-and-pop” corner stores.

Violent crimes

Data on violent crimes in 2011 were obtained from the Baltimore City Police Department. These data included the address where the violent crime occurred and a description of the crime. Violent crimes include robbery, aggravated assault, rape, manslaughter, and homicide (Franklin et al., 2010). These are the Uniform Crime Report violent crime offenses reported to the Baltimore police and do not include arrests or calls for service. There were 9,378 violent crimes in 2011; most were aggravated assaults (53.9%) and robberies (40.9%). Respectively, 2.1% and 3.1% were homicides and sexual assaults. Ninety-nine percent of the violent crimes were geocoded in ArcMap Version 10 (ArcGIS, 2011). The remaining 1% of addresses were not geocoded because of missing addresses or because the addresses were illogical or invalid.

Counts of the number of violent crimes were calculated for each of the community entities in 100-foot buffer increments, from 0 feet to 1,400 feet (i.e., 0–100 feet, 101–200 feet, etc.). Boyd and colleagues (2012) used a similar distance (25 m or 82 feet) but went only as far as 300 m (equivalent to 984 feet or 0.19 miles). The current investigation extended that distance to a full quarter mile, a standard for walking distance in urban centers (Milam et al., 2013; Salbach et al., 2015). In addition, we summed the number of violent crimes for all sites within each category and divided by the number of sites to generate a mean number of violent crimes for DTCs, liquor stores, convenience stores, and cor-

ner stores. This allows for comparison of the mean level of violent crime across each of the different sites.

Drug treatment centers (n = 53)

Information on the presence of publicly funded outpatient DTCs was obtained from Baltimore Substance Abuse Systems, Inc. (BSAS), the City of Baltimore’s substance use disorder authority (the name has since been changed to “Behavioral Health Systems Baltimore”). Publicly funded DTCs in Baltimore receive funding for uninsured and underinsured clients through federal block grant dollars administered by BSAS. Data included the addresses of all licensed and operating drug treatment facilities in the city of Baltimore in 2011. To be counted as publicly funded DTCs, centers had to be licensed through the Maryland Alcohol and Drug Abuse Administration, receive federal block grant dollars through BSAS, and meet all federal and state regulations for such a facility.

Private DTCs were excluded from these analyses for two reasons. First, most do not receive any treatment block grant dollars (primarily because they take only patients who pay with cash or with private insurance), and they have different reporting requirements, making it more difficult to ascertain data on their locations. Second, they tend to be located in areas outside of Baltimore City and/or in locales that are not comparable to the neighborhoods that are of interest to this investigation. We found only three DTCs in Baltimore City that were excluded from this investigation because they were private.

There were 83 publicly funded DTCs in Baltimore. Five of those were located outside of Baltimore City boundaries and were excluded from these analyses. The remaining 78 DTCs were housed in 53 different locations. Twenty-two centers were co-located in the same building as one or two other DTCs (e.g., a separately run inpatient and outpatient program located in the same building). The unit of analysis for this work is the location of a DTC; therefore, when multiple DTCs were in a single location, we counted that as a single DTC site. Treatment programs included 37% outpatient and intensive outpatient treatment programs (including medication-assisted programs with buprenorphine and methadone); 29% halfway houses; 19% primarily opioid maintenance therapy programs; 9% medium-intensity residential programs; and 6% therapeutic communities, intermediate care facilities, or inpatient detox facilities.

Liquor stores (n = 476)

Data on all alcohol outlets were obtained from the Board of Liquor License Commissioners for Baltimore City. These data included the address and license type for all establishments licensed to sell alcohol in Baltimore City in 2011. There were 1,285 alcohol outlets, and 99% (1,277) of those

were geocoded in ArcMap Version 10. Locations without a valid address were not geocoded. We restricted this investigation to the 476 liquor stores that allow sales for both on- and off-premise alcohol consumption 7 days a week from 6 A.M. to 2 A.M.; these are classified by the Liquor Board as “BD-7” outlets, and we refer to them as *liquor stores* in this article. The following types of alcohol outlets were excluded: restaurants, nonprofit private clubs, arenas, hotels, and package goods stores that sell alcohol exclusively for off-premise consumption. BD-7 outlets are comparable to those with bar/tavern licenses in other states that have the capacity to also sell off-premise consumption package goods (e.g., Pennsylvania or Virginia).

Food stores

The addresses and facility names of all 803 package goods food stores from 2011 were obtained from the Baltimore City Health Department; all sell food intended for off-premise consumption. The food stores were classified into seven categories using the schema developed by The Johns Hopkins Center for a Livable Future (Haering & Franco, 2010). These include supermarkets ($n = 47$), small grocery stores ($n = 19$), corner stores ($n = 308$), convenience stores ($n = 195$), behind-the-glass corner stores ($n = 128$), pharmacy stores ($n = 51$), and discount stores ($n = 55$).

The investigation is restricted to corner stores, behind-the-glass stores, and convenience stores. The former two were combined into a single category because of the considerable overlap in their composition, offerings, and locations. Notably, some liquor stores are also food stores. For these analyses, any stores that sold alcohol and food for off-site consumption were classified as liquor stores to ensure mutual exclusivity across sites.

Corner stores and behind-the-glass stores ($n = 436$). Corner stores are generally independently owned and managed (i.e., they lack national franchise affiliation), have a limited supply network, do not have name recognition outside their neighborhood, and have fewer than five cashiers. Behind-the-glass stores are a subtype of corner stores that are found almost exclusively in Baltimore’s low-income African American neighborhoods. Access to goods is limited by Plexiglas serving as a barrier between the customers on one side and the cashiers and merchandise on the other. The barrier is considered a necessary safety measure by many store owners. Many corner stores have been converted to behind-the-glass stores in recent decades. Although some corner stores stock healthy food options, most do not. Typical items include ramen noodles, high-sodium canned goods, snack foods, sodas, and candy. Behind-the-glass stores have the lowest availability of healthy foods in Baltimore, as measured by the Healthy Food Availability Index ratings (Casagrande et al., 2011). After excluding food stores that were also liquor stores, there were 396 corner ($n = 281$) and

behind-the-glass stores ($n = 115$). For simplicity, we will refer to these types of food stores as *corner stores* throughout the rest of this article.

Convenience stores ($n = 195$). Convenience stores are franchises of nationally or regionally recognized stores but are much smaller than supermarkets and by definition have fewer than five cash registers. They generally have long hours of operation, well-established distribution systems, and name recognition beyond their immediate area (e.g., 7-Eleven and Royal Farms). Although the stores’ different locations are homogeneous in appearance, their offerings may vary greatly based on the socioeconomic and racial composition of the neighborhoods where they are located. Nine convenience stores were excluded because they were also liquor stores.

Matching sites by neighborhood disadvantage

Studies have consistently found an association between neighborhood-level disadvantage and violent crime (Franklin et al., 2010; Ross & Mirowsky, 2001). The presence of corner stores, liquor stores, and convenience stores is also associated with neighborhood-level disadvantage, (e.g., LaVeist & Wallace, 2000; Matheson et al., 2014), making it a potentially important confounding variable. To control for neighborhood disadvantage, we matched DTCs to convenience stores, corner stores, and liquor stores based on the “Neighborhood Disadvantage” score of the census tract in which they were located. This metric has been used in similar investigations examining relationships between alcohol outlets and violent crime in an urban center (Franklin et al., 2010; Ross & Mirowsky, 2001).

The Neighborhood Disadvantage score is calculated using census-tract level items. We used census data from the 2005–2009 American Community Survey (U.S. Census, 2009). The items used to create the index include the percentages of (a) adults 25 years or older with a college degree, (b) owner-occupied housing, (c) households with incomes below the federal poverty threshold, and (d) female-headed households with children. We used Ross & Mirowsky’s (2001) formula to generate the index: $\{[(c / 10 + d / 10) - (a / 10 + b / 10)] / 4\}$ (percentages are entered as whole numbers, not decimals).

Each one-unit increase in the Neighborhood Disadvantage score is equivalent to an increase of 10 percentage points for each component item of the index (Franklin et al., 2010; Jennings et al., 2014; Ross & Mirowsky, 2001). The total score has a possible range from -5 to +5, where -5 is very low/little disadvantage and +5 is very severe disadvantage. We trichotomized the Neighborhood Disadvantage score into low (<0.00), moderate (0.00–1.00), and high (>1.00). The cut points were based on the distribution of the study data across all venues. This trichotomy produced nearly equal tertiles.

A random number generator was used to match each of

the DTCs with comparison sites. Matching was conducted within each tier of neighborhood disadvantage (i.e., low, moderate, and high). There were fewer DTCs than liquor stores, corner stores, and convenience stores. We matched just one of each facility with each of the 53 DTCs based on the Neighborhood Disadvantage score.

Spatial analysis

The Network Analyst “create new service area” tool in ArcGIS was used to create network buffers around each site. Network buffers are based on the distance, accounting for navigating street networks. By contrast, a “straight-line” buffer would not account for street networks, highways, or buildings in calculating distance. Straight-line buffers will more often produce overestimates of events within a buffer, as the distance to navigate a street network, to go around a body of water (for example), is greater than an imaginary line that cuts across that body of water with a straight line. The service area tool allows creation of buffers that take these complexities into account. The buffers ranged from 101 to 200 feet around the outlet to 1,301 to 1,400 feet around the outlet, in 100-foot intervals. We did not include the 1- to 100-foot buffers in the regression models (described below) to remove crime occurring at the facility, because in these data, convenience stores, corner stores, and liquor stores had substantially more violent crime (e.g., robberies) occurring onsite compared with DTCs. The *t* test result for each venue compared with DTCs at the 0- to 100-foot buffer revealed a significant difference between the results for DTCs and convenience stores ($p = .013$) but not for corner stores and liquor stores. This most likely reflects the higher likelihood of convenience stores being robbed compared with the other venues.

We extended the buffers to 1,400 feet because a quarter mile (1,320 feet) is generally considered walking distance in urban centers (Milam et al., 2013; Salbach et al., 2015). The buffers were “non-overlapping,” meaning that each subsequent buffer excluded the area of the smaller buffer(s) nested inside of it. This also means that the amount of area within each buffer is not equal, because placing a buffer around a buffer creates a larger surface area for the subsequent buffer.

We used a methodology developed by Boyd and colleagues (2012) to determine the levels of violent crime around each site. The count of violent crimes for each buffer was determined using the “Spatial Join” tool, which appends data from two map layers using geographic location. We appended the layer with the location of DTCs, food stores, and liquor stores to the layer with counts of violent crime.

Statistical analysis

The purpose of this investigation was to assess the level of violent crime near DTCs and to compare it with the level

of violent crime near liquor stores, corner stores, and convenience stores. As a first step, we calculated the scores on the scale of neighborhood disadvantage and summarized them for each type of facility. Second, we matched DTCs to liquor stores, corner stores, and convenience stores by level of neighborhood disadvantage. The remaining analyses are restricted to the 53 DTCs and the 53 liquor stores, 53 corner stores, and 53 convenience stores that were randomly selected in the matching process.

We calculated the mean level of violent crime overall for each of the four types of facilities at each buffer level. We calculated the mean by summing the counts of violent events and dividing by the number of facilities ($n = 53$ for all four types of facilities). *T* tests were used to compare the mean count of violent crimes for all buffers around treatment centers to other facilities.

Because the outcome of interest, count of violent crimes, was consistent with a negative binomial distribution, we used negative binomial regression models to estimate the relationship between the count of violent crimes and the distance from each facility. The negative binomial regression model, rather than the Poisson regression model, also accounted for the overdispersion of violent crime (Byers et al., 2003; Long, 1997). The log area of each buffer was used as an offset to adjust for differences in buffer sizes, transforming the count of violent crimes to the density of violent crimes. A statistically significant positive slope (β) would indicate that crime increases as the distance from the facility increases. A variant of the Huber–White sandwich estimator of variance was used to obtain robust standard errors to account for clustering within facility (each facility included 14 buffers in the regression model). A statistically significant negative slope (β) would indicate that crime decreases as the distance from the facility increases (i.e., crime is highest closest to the facility, consistent with the facility being a “magnet for crime”). A slope of zero would indicate that violent crime does not significantly change as the distance from the facility increases, indicating that the facility is independent of the occurrence of crime. Incident rate ratios (IRRs) were used to convey the strength of association, allowing the rate of crime change for each buffer to be expressed as a percentage. Significant findings were reported for α levels below .05, and analyses were stratified by facility. An interaction term between facility and distance was used to determine whether there were statistically significant differences in the slope between facilities. Stata 11.0 (StataCorp LP, College Station, TX) was used for statistical analyses, including negative binomial regression modeling. All geocoding and spatial analyses were conducted using ArcGIS.

Sensitivity analysis

We performed sensitivity analysis to assess the potential impact of biases associated with the joint concerns of spatial

TABLE 1. Objective Neighborhood Disadvantage score and total number of retail entities

Variable	Drug treatment centers (n = 53)	Liquor stores (n = 476)	Corner stores (n = 396)	Convenience stores (n = 186)
Scale score, <i>M</i> (<i>SD</i>)	0.90, (1.41)	-0.23, (1.32)	0.62, (1.09)	0.00, (1.10)
Range	-2.78, 3.58	-2.85, 2.93	-2.78, 3.60	-2.41, 4.09
Category, ^a % (n)				
Low (<0.00)	26.4% (14)	51.1% (243)	25.0% (099)	47.3% (88)
Moderate (0.00–1.00)	20.8% (11)	30.0% (143)	36.1% (143)	37.1% (69)
High (>1.00)	52.8% (28)	18.9% (090)	38.9% (154)	15.6% (29)

^aThe total Neighborhood Disadvantage score has a possible range from -5 to +5, where -5 is very low/little disadvantage and +5 is very severe disadvantage.

autocorrelation and clustering. We checked for and detected spatial autocorrelation among DTCs using one large 1,400-foot buffer around each center (Moran's $I = 0.393, p < .001$). Two approaches were tested to address this issue. First, we excluded all venues that had a similar venue in any of the 14 100-foot buffers and reran the regression models. We reran the regression models using only these venues. A second approach that we tested was to include a covariate in the adjusted regression model for the number of similar venues in each of the 14 buffers for each venue type.

Results

Neighborhood disadvantage and matching

Table 1 shows the number of DTCs, liquor stores, corner stores, and convenience stores by level of neighborhood disadvantage for the total sample of facilities. The Neighborhood Disadvantage score for all the facilities ranged from -2.41 to 4.09. DTCs and corner stores had the highest mean disadvantage score; 52.8% of DTCs were in high-disadvantage census tracts. After we matched facilities on Neighborhood Disadvantage score, the resultant analytic sample had similar mean Neighborhood Disadvantage scores

across facilities, minimizing the likelihood of confounding by neighborhood characteristics.

Mean level of violent crime

The mean count of violent crimes was calculated for each buffer and facility type (Table 2). Mean counts of violent crime, averaged across all buffers in rank order, were liquor stores (3.98), corner stores (3.78), treatment centers (2.87), and convenience stores, (2.65). The mean count of violent crime was significantly higher around liquor stores (t test; $p < .01$) and corner stores (t test; $p < .01$) compared with DTCs, and there was no statistically significant difference between convenience stores and DTCs ($p = .32$).

Negative binomial regression results

Negative binomial regression models were used to estimate the association between the violent crime count and the distance from each facility (Table 3). There was a negative association with violent crime for each facility: Namely, there was a high likelihood of violence occurring closer to each venue, and violence decreased as you moved away

TABLE 2. Mean number of violent crimes by distance from facility (independent of surface area)

Distance, feet	Drug treatment centers <i>M</i> (<i>SD</i>)	Liquor stores <i>M</i> (<i>SD</i>)	Corner stores <i>M</i> (<i>SD</i>)	Convenience stores <i>M</i> (<i>SD</i>)
1–100	0.92 (1.72)	1.68 (2.64)	1.57 (1.86)	2.06 (3.09)
101–200	0.87 (1.99)	2.17 (4.36)	0.74 (1.27)	0.66 (1.95)
201–300	1.25 (2.11)	1.79 (3.65)	1.96 (3.25)	1.36 (2.87)
301–400	1.26 (2.41)	1.75 (3.06)	2.53 (3.90)	1.15 (2.72)
401–500	2.28 (3.53)	2.70 (4.32)	2.89 (3.52)	3.08 (5.47)
501–600	1.53 (2.32)	3.55 (3.59)	3.17 (3.73)	2.64 (4.91)
601–700	2.83 (4.27)	3.13 (3.63)	3.09 (3.73)	2.34 (3.33)
701–800	2.94 (4.56)	3.55 (4.10)	3.83 (4.37)	2.30 (3.61)
801–900	4.00 (4.78)	4.70 (5.54)	3.92 (4.21)	3.94 (4.26)
901–1,000	3.66 (5.39)	4.72 (4.71)	4.75 (4.25)	2.94 (5.10)
1,001–1,100	4.06 (4.84)	4.75 (4.76)	4.57 (5.60)	4.13 (4.14)
1,101–1,200	4.79 (5.90)	5.94 (7.19)	6.08 (7.21)	2.98 (4.91)
1,201–1,300	5.25 (5.13)	7.57 (8.94)	5.85 (5.57)	3.94 (4.59)
1,301–1,400	4.51 (5.68)	7.75 (8.89)	7.98 (11.67)	3.53 (4.29)
Grand mean (<i>SD</i>)	2.87 (4.38)	3.98 (5.62)	3.78 (5.46)	2.65 (4.17)
<i>t</i> test		-4.26 ($p < .01$) ^a	-3.54 ($p < .01$) ^a	1.00 ($p = .32$) ^a

Notes: $n = 53$ for all types of facilities. ^a p value for two-sided t test comparing violent crime around facility to treatment centers.

TABLE 3. Incident rate ratios (IRRs) from negative binomial regression (per 100 feet) for the association between violent crime count and distance from each retail entity

Variables	IRR	[95% CI]	<i>p</i>
Treatment centers	0.968	[0.938, 0.998]	.037
Liquor stores	0.944	[0.917, 0.972]	<.001
Corner stores	0.963	[0.941, 0.985]	.001
Convenience stores	0.934	[0.898, 0.972]	.001

Notes: From negative binomial regression, in 100 feet increments, minus first buffer controlling for surface area. CI = confidence interval.

from the venue. This indicates that, in general, crime was happening at a greater rate proximal to each of the venues. This relationship was the strongest for liquor stores and convenience stores. For each 100-foot increase in buffer distance away from liquor stores and convenience stores, there was a 5.6% and 6.6% decrease in crime, respectively (IRR = 0.944, $p < .001$; IRR = 0.934, $p < .001$). The relationship was similar, but smaller, for corner stores. For each 100-foot increase in buffer distance away from corner stores, there was a 3.7% decrease in violent crime (IRR = 0.963, $p = .001$). DTCs had the largest IRR, indicating the slowest drop-off in violent crime as you move away from the venue. There was a 3.2% decrease in the average predicted count of violent crimes for each 100-foot increase in buffer distance away from DTCs (IRR = 0.968, $p = .037$).

All of the facility types were included in the same model to test for interactions between facility type and buffer distance. There were no significant differences in IRR between treatment centers and any venues, indicating that the rate of change in crime as you move away from these venues was not statistically different.

Sensitivity analysis

The resultant sample from our first sensitivity analysis of excluding overlapping outlets included 24 DTCs that had no other DTCs in any of the buffers, 19 convenience stores that had no other convenience stores in any of the buffers, and 16 liquor stores and 17 corner stores that fit similar criteria. We reran the regression models using only these venues. The results were similar in magnitude and direction. For example, the IRR for DTCs in the model with the full sample ($n = 53$) was 0.933 ($p < .01$). In the reduced sample with only DTCs without overlap ($n = 24$), the IRR was 0.924 ($p = .03$). These findings were consistent across all venue types. The second approach, which included a covariate in the adjusted regression model for the number of similar venues in each of the 14 buffers for each venue type, showed that the range of DTCs within each buffer was between 0 and 2, with a mean of 0.136. We reran the regression models adjusting for the count within each buffer. The resulting IRR for DTCs was 0.968 ($p = .036$)—nearly identical to the models without adjustment.

These results were mirrored in the analysis of the other venue types (e.g., adjusted IRR = 0.953, $p < .001$, for corner stores vs. 0.963, $p < .001$, unadjusted). We opted not to use these estimates as the final reported results even though they were statistically adjusted for the clustering of the same venues. We made this decision for several reasons. First, there are substantially more of the other types of venues than DTCs (Table 1). Second, these adjustments do not take into account the other types of venues that may also be within the buffers that may affect violent crime rates. Most importantly, the goal of the sensitivity analyses was to assess the validity of our results; as the results were very similar, it suggests that our initial approach was valid.

Discussion

NIMBYism poses a significant threat to vital behavioral health services being located in communities. The current investigation sought empirical evidence for whether DTCs were associated with violent crime in excess of the violence occurring around other retail entities located within communities—namely, liquor stores, corner stores, and convenience stores. If DTCs, in fact, do pose a unique threat to communities as magnets for crime, we would have found higher rates of crime closer to the DTCs compared with the other entities. We would also have found statistically significant differences in the rate of change in crime farther from (or closer to) the venue. We empirically tested these relationships and found no statistical evidence that DTCs specifically attract violent crime. The estimated means of violent crime showed a decrease in crime as you move away from each of the venue types, even after the increasing size of the buffer was controlled for.

This implies that all of the venues to some degree are located in sites where violent crime occurs. However, there was significant variation in the magnitude of this effect, with DTCs having the smallest rate of crime proximal to the venue, and corner stores, liquor stores, and convenience stores having an increasingly larger magnetic effect on violent crime. These data suggest that businesses in general tend to attract crime, but this effect is less pronounced for DTCs than for the other locales we studied. Commercial businesses tend to be in areas with greater foot traffic, vehicle traffic, and routine activity, creating both cover for and opportunity for crime.

As an alternative explanation, it is possible that each of these venues has a different spatial function to crime. The area of impact could be greater or smaller, depending on the venue and whether its patrons are mostly residents of the community or come from outside the community. In addition, we found a larger magnetic effect for non-DTC venues, specifically convenience stores at the 0- to 100-foot buffer range (equivalent to events inside the venue or immediately outside the venue). These findings most likely reflect

the higher likelihood of convenience stores being robbed compared with the other venues. Understanding and better clarifying the mechanisms underlying this association is an area for inquiry in future research.

The estimated mean of violent crime was significantly higher for liquor stores and corner stores compared with that for DTCs, but there was no mean difference in the rate of crime change as you moved away from corner stores. Behind-the-glass and corner stores are concentrated in higher disadvantage neighborhoods, and it is possible that they are simply located in communities where crime is endemic and independent of their presence. We matched venues on neighborhood disadvantage to constrain this potential bias, but it is possible that some within-neighborhood variation still remained. In contrast, liquor stores had elevated mean rates of crime compared with all the other venue types, and the rate of decrease in crime as you moved away from liquor stores was significantly faster than it was for corner stores and treatment centers. This supports the notion that liquor stores are magnets for crime and is consistent with the results of other published studies that have found associations between the presence of liquor stores and elevated rates of violent crime proximal to the store (Gruenewald & Remer, 2006; Jennings et al., 2014; LaVeist & Wallace, 2000; Lipton et al., 2013; Scribner et al., 1995).

Before further discussion of these results, a few limitations merit mention. First, there was some evidence of confounding with convenience stores by neighborhood advantage, but we addressed that as best we could with matching. Second, we did not control for other venue types within each of the buffers, such that it was possible, for example, that a DTC had a liquor store in one of its buffers. There was such a large number of venues, however, that we opted to randomly select venues and match them to DTCs based on Neighborhood Disadvantage scores to minimize potential confounding. Random selection was the best approach here to ensure that, if there was some spatial overlap, it would be evenly distributed. To test this hypothesis, we conducted sensitivity analyses—namely, we excluded venues with overlap within any of the buffers and in a separate model adjusted for similar venues within the buffer; the results remained consistent. Last, our study design was focused on contrasting DTCs with other community businesses, but we found interesting results pointing to liquor stores as potential crime attractors. Future investigations will further explore this relationship using the full range of alcohol outlet data, and further research is needed to establish the causal link between liquor stores and crime.

In conclusion, DTCs have an unfairly poor reputation as being magnets for crime and a threat to community safety that is not backed up by empirical evidence. By contrast, other community businesses that have a more pronounced magnetic effect on crime are often solicited by communities to locate within their neighborhoods. Future investigations

should include a more comprehensive examination of the synergistic effect of having multiple venue types within a defined geographic area, as well as incorporate a broad range of community perspectives to balance the empirical data with residential experiences.

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Citizens' concerns that methadone treatment centers (MTCs) might be focal points for serious crime are unwarranted, a recent NIDA-supported study suggests. Dr. Susan Boyd and colleagues at the University of Maryland School of Medicine in Baltimore found that crime rates in the immediate vicinities of that city's MTCs were level with the rates in the surrounding neighborhoods.

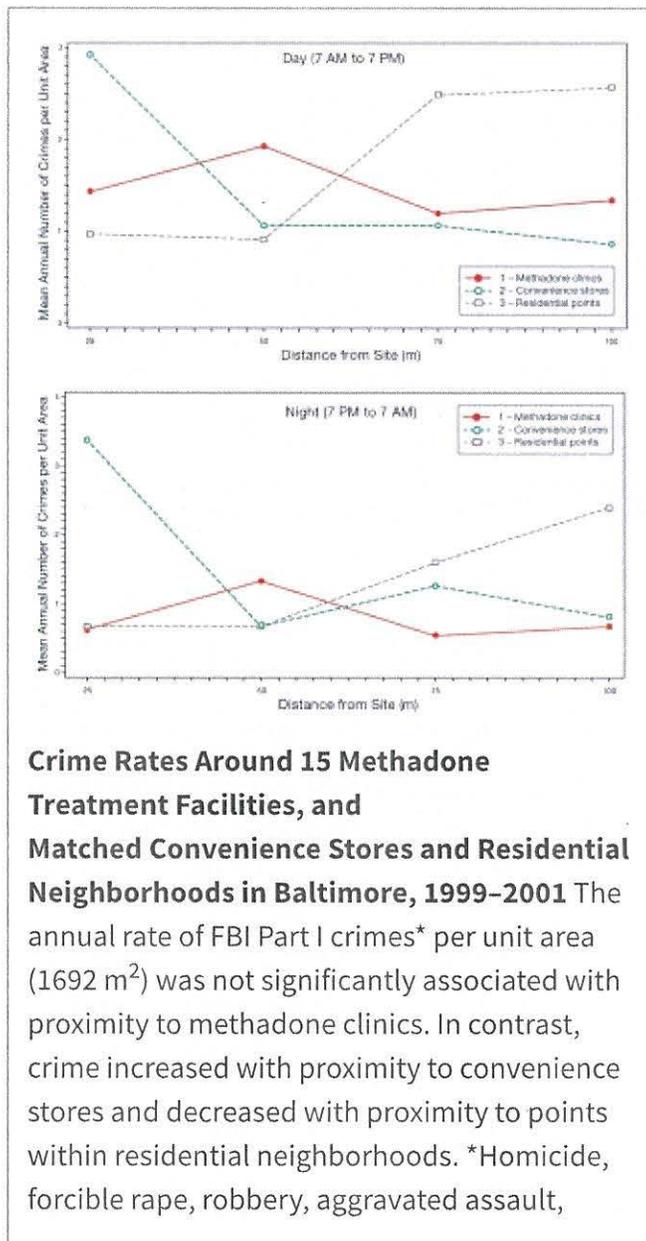
The researchers used Baltimore City Police Department records from 1999–2001 and global positioning data to plot the distribution of FBI Part I crimes (homicide, forcible rape, robbery, aggravated assault, burglary, larceny theft, motor vehicle theft, and arson) within a 100-meter (328-foot) radius of 15 MTCs. A statistical analysis of the plots showed that the crimes were no more frequent within 25 meters of the MTCs than they were 75 to 100 meters away.



In contrast to the case with MTCs, the likelihood of Part I crimes rose with closer proximity to convenience stores. The researchers suggest that the high volume of foot traffic around these stores provides opportunities for criminals to find victims. Consistent with this surmise, the frequency of crime declined near mid-block residences, where foot traffic is relatively sparse.

The study MTCs included all but one of the 16 centers located in Baltimore. They were situated in diverse communities, including inner-city, working-class, and middle-class neighborhoods, according to Dr. Boyd. The convenience stores and residences were located in neighborhoods that closely resembled those of the MTCs in demographic and social features that influence crime rates.

“There’s no evidence from our study of increased reports of crime around the methadone clinics,” says Dr. Boyd. She and colleagues are now analyzing data on actual arrests around the study sites to see whether drug sales and possession increase with proximity to methadone treatment centers. The researchers hope that demonstrating that MTCs are not hot spots for crime will reduce public resistance to the building of new centers, and thus remove an impediment to making methadone treatment more widely available.



burglary, larceny theft, motor vehicle theft, and arson.

Text description



Source: Boyd, S.J., et al. Use of a “microecological technique” to study crime incidents around methadone maintenance treatment centers. *Addiction* 107(9):1632–1638, 2012. [Abstract Available](#)

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Resources

Study finds methadone clinics don't increase crime in Baltimore neighborhoods

Posted on February 13, 2014 (<https://ireta.org/resources/study-finds-methadone-clinics-dont-increase-crime-in-baltimore-neighborhoods/>) by IRETA (<https://ireta.org/author/imagebox/>)



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in front of the methadone clinic 1. Photo: [D.C. Atty.](#)

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Methadone is a federally-regulated medication that, by law, is dispensed only by licensed treatment settings when used to treat opioid addiction. It has been studied exhaustively and many of its benefits are undisputed in the research literature. The [Centers for Disease Prevention and Control reports that the benefits of methadone maintenance therapy include](#) (<http://www.cdc.gov/odu/facts/methadonefin.pdf>):

- reduced or stopped use of injection drugs;
- reduced risk of overdose and of acquiring or transmitting diseases such as HIV, hepatitis B or C, bacterial infections, endocarditis, soft tissue infections, thrombophlebitis, tuberculosis, and STDs;
- reduced mortality – the median death rate of opiate-dependent individuals in MMT is 30 percent of the rate of those not in MMT;
- possible reduction in sexual risk behaviors, although evidence on this point is conflicting;
- reduced criminal activity;
- improved family stability and employment potential; and
- improved pregnancy outcomes.

(<http://www.cdc.gov/odu/facts/methadonefin.pdf>)

Many studies (<http://archive.is/d5tg>) also show that methadone maintenance is a cost effective treatment.

So the benefits to society at large seem pretty significant. But ask most of the public where they'd like to house a methadone clinic, and you'll hear "Not in my backyard."

That's because methadone clinics (known in the field as Opioid Treatment Programs or OTPs) are widely-regarded as crime magnets.

The logic goes like this: if you build a methadone clinic in an area, it will attract "the addicts" and "junkies"; "the addicts" and "junkies" are the ones who commit crimes; murder, rape, and theft will increase, and the neighborhood will then go to pot.

News articles feed this narrative (<http://www.rcnky.com/articles/2012/10/22/prosecutor-addicts-will-flock-here-methadone-clinic>), from [reporting on neighborhoods protesting methadone clinics](#) (<http://www.wftv.com/news/news/neighbors-say-methadone-clinic-bringing-crime/nLPyN/>) to

[sensationalizing crime \(http://www.pressofatlanticcity.com/news/top_three/article_68980e70-bee0-11df-be4a-001cc4c03286.html\)](http://www.pressofatlanticcity.com/news/top_three/article_68980e70-bee0-11df-be4a-001cc4c03286.html) in areas where OTPs are located.



(<http://www.flickr.com/photos/vandalog/6383405019/in/photolist-aJ5BVe-7yht3N-f3SQQ7-9xoz4V-bSpzSK-9AFmvC-aMcvAZ-aMcz9g-awsYaY-dxBL3g-7QkRNA-dZCsNY-fFxnVP-ahDZPj-8fbEmc-b4R7Pa-bzKgvf-c5ayD1-dKPDZK-969VHV-bnTTnT-eHgxt-8oEuNj-asRbkA-abnMpb-dsDzUz-gjsKnz-j7ZF2N-apxyNs-apuSck-apuRQP-apuSqn-apxz3y-apuRJD-apxyaS-apxyg7-apuRWn-85zuxJ-9sXcaQ-86gRRH-agPWWf-j5gKXp-j5hwmL-j5juKN-hdKkM-7NvXp7-dJqsCF-aDQV3e-ajUtTs-8RY2Tf-7WhQqK/lightbox/>)

Methadone clinic protest sign. Photo: [RJ vandalog](#)

(<http://www.flickr.com/photos/25814320@N02/6383405019/in/photolist-aJ5BVe-aDuGM7>)

Negative attitudes about heroin, in particular, have a long history in our country. Captions like [this](http://nymag.com/daily/intelligencer/2011/05/union_square_is_a_lawless_city.html) (http://nymag.com/daily/intelligencer/2011/05/union_square_is_a_lawless_city.html), that announce to readers “See if you can pick out the stabby drug addicts!” continue to dehumanize people who use heroin, including—unfortunately—those who seek treatment for it.

Perhaps the last decade’s massive growth of recreational prescription opioid use—people who are essentially abusing the same drug as heroin users and, as such, may benefit equally from methadone treatment—will help ease our vague, but powerful fear of OTPs. Or maybe the recent death of Phillip Seymour Hoffman, which has provoked a string of online articles by people openly discussing [family](#).

(<http://www.usatoday.com/story/news/nation-now/2014/02/04/heroin-addiction-overdose-relapse-family-kills/5200503>) and friends (http://www.huffingtonpost.com/isaac-saul/philip-seymour-hoffman-t_1_b_4724084.html) who have used heroin, will dampen long-held prejudices against clinics designed to treat heroin addiction.

In many cases, methadone treatment becomes connected with the conditions surrounding the drug addiction it actually treats. Methadone is equated with heroin—and drugs in general. This spirited online debate over the placement of an OTP in Portsmouth, Virginia, shows how “methadone clinic” and “meth lab” are often conflated—and in this case, the local ABC affiliate contributed to the confusion.)

Emmett Velten, a longtime methadone advocate, [points to the catch-22 that has contributed to the persistent attitudes of prejudice around methadone treatment](http://becauseilive.hubpages.com/hub/The_Truth_About_Methadone_Myths_Dispelled) (http://becauseilive.hubpages.com/hub/The_Truth_About_Methadone_Myths_Dispelled):

“The emotionality surrounding methadone largely causes the lack of information about it. What causes the emotionality? Prejudice!”

And of course, if you build it, they *will* come. As you might expect, it is primarily people with opioid addictions who are interested in the services that an OTP offers. But will the clients commit crimes in its vicinity? Or somehow attract criminal behavior?

Here's where science can address ideas based in emotionality and prejudice

The January issue of [NIDA Notes](http://www.drugabuse.gov/news-events/nida-notes/2012/12/crime-does-not-increase-around-methadone-clinics-in-baltimore) (<http://www.drugabuse.gov/news-events/nida-notes/2012/12/crime-does-not-increase-around-methadone-clinics-in-baltimore>), an e-publication of National Institute on Drug Abuse, reports on a well-designed study that suggests OTPs do not bring crime.

The study, led by Dr. Susan Boyd and researchers from the University of Maryland School of Medicine in Baltimore found that “crime rates in the immediate vicinities of that city’s [methadone treatment centers] were level with the rates in the surrounding neighborhoods.”

Not only that, but they found that *crime rates in the vicinities of OTPs were lower than that of convenience stores with the same demographic characteristics*. Researchers attributed the “high volume of foot traffic around these stores” as a contributing factor in crime opportunity.

To obtain and analyze information, the researchers used global positioning data and Baltimore City Police Department records from 1999?2001 to track the distribution of homicides, rapes, robberies, aggravated assaults, burglaries, larceny thefts, motor vehicle thefts, and arson within a 100-meter radius of 15 out of the 16 Baltimore OTPs.

Analyses of the plots showed that crime frequency did not increase with proximity to OTPs; crimes were “no more frequent within 25 meters” of the OTPs “than they were 75 to 100 meters away.”

"There's no evidence from our study of increased reports of crime around the methadone clinics," Boyd concludes.

Boyd and her colleagues are now working to analyze data on actual arrests around the 15 OTP sites to determine whether drug sales and possession increase in the vicinity of OTPs.

Resources

Methadone Research Guide

(<http://www.drugabuse.gov/sites/default/files/pdf/methadoneresearchwebguide.pdf>) (NIDA)

MAT with Methadone or Buprenorphine: Assessing the Evidence for Effectiveness

(<http://atforum.com/news/2014/02/mat-with-methadone-or-buprenorphine-assessing-the-evidence-for-effectiveness/>) (AT Forum)

Commentary: Countering the Myths about Methadone

(<https://www.drugfree.org/join-together/addiction/commentary-countering-the-myths-about-methadone>) (Join Together)

Is Maintenance the Best Therapy for Opiate Addiction? (<http://mattsub.blogspot.com/2013/07/is-maintenance-best-therapy-for-opioid.html>) (Substance Matters)

Recovery-Oriented Methadone Maintenance (<http://www.atforum.com/addiction-resources/documents/Recovery.pdf>) (William White)

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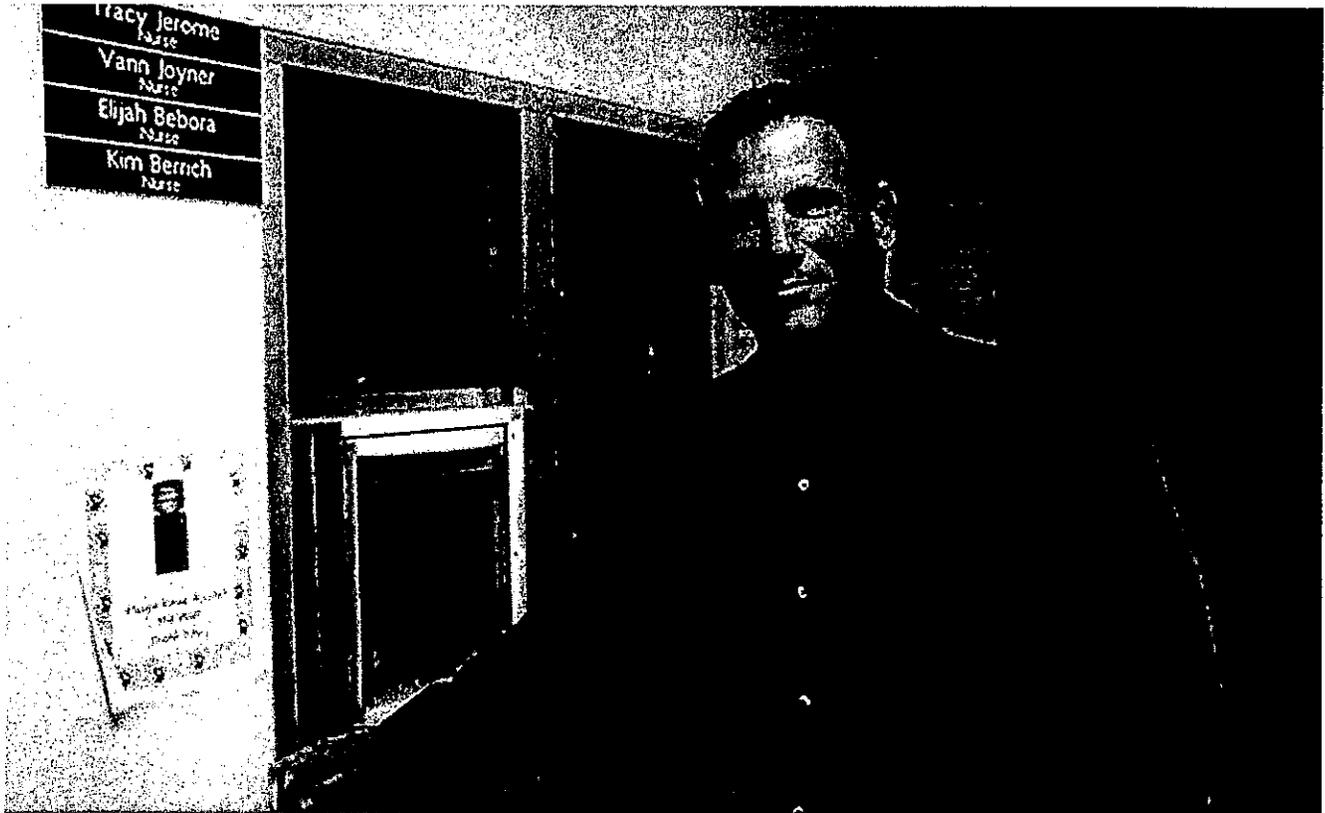
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HEALTH

Methadone clinics don't attract crime, study finds

By BY ANDREA K. WALKER and THE BALTIMORE SUN
APR 30, 2012 AT 7:36 PM



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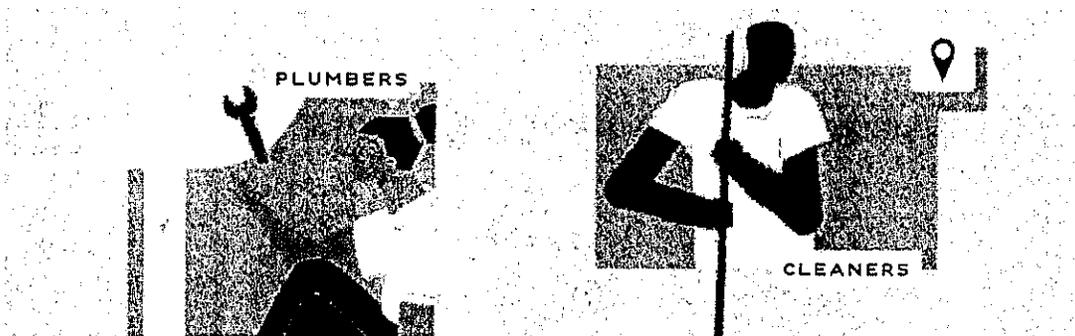
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Methadone clinics are often seen as the bad neighbor nobody wants.

Residents concerned about crime and other quality-of-life issues often protest if they even hear word of a methadone clinic, which treats those addicted to heroin and other opiates, is considering moving into the area.

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The study is the first of its kind that takes a geographic look at crime around clinics, according to the National Institute on Drug Abuse. Previous research only has examined the link between crime and methadone users.

"The concern is that methadone treatment facilities are related to a higher crime rate in the area, but there is no evidence that this is what happens," said Antonello Bonci, scientific director of the institute. "We hope this study will alleviate this concern. I hope people will look at this data and realize it is not a problem."

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The research, led by UM's Dr. Susan Boyd and others, found that crime doesn't increase because a methadone clinic opens.

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Researchers compared these reports to crime reports from areas where there were no methadone clinics.

They also compared crime around methadone clinics to crime near hospitals and convenience stores in the city. Crime was more likely to occur around convenience stores, the researchers found.

"I think there is still a very bad perception of methadone clinics," Boyd said. "There are many more people out there who need treatment, but there are not enough slots and clinics available, and part of it is because of the community stereotypes they have about methadone clinics."

Methadone clinics in the state are tightly regulated by the Department of Health and Mental Hygiene.

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Still, the clinics' locations have caused bitter, and sometimes politically charged battles, some of which have ended up in court. Zoning restrictions keep the clinics out of certain communities. Owners of the clinics said it is sometimes tough to get landlords to lease to them.

In many of these incidents, residents said that they believe crime increases and that methadone users, many of whom must come to the clinic daily, loiter after getting their dose of methadone to control their drug urges.

There also is debate about whether methadone users just trade one addiction for another and that the clinics continue to feed a drug culture. And even though

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Most recently, residents in Southwest Baltimore have protested a methadone clinic opened by the University of Maryland Medical Center, which runs that and other treatment services for the Baltimore City Office of Addiction Services. It was among several treatment programs that were relocated.

University officials said there was no connection between the study and its decision to move the Southwest Baltimore clinic.

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The clinic, which serves more than 500 addicts, relocated in January to West Pratt Street after its former building on nearby West Fayette Street was torn down due to its poor condition, said a medical system spokeswoman, Mary Lynn Carver. The new location is accessible to public transportation and close to the university and medical center, she said.

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Residents said they were caught by surprise when the clinic opened and said they believe there are too many substance-abuse treatment programs concentrated in their neighborhood. They say they are not against drug treatment.

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street in front of a bus stop. The caption 1 poster image for why more rehab services are not needed in the neighborhood."

Also on the page are charts with neighborhood crime data and promises to monitor crime levels because of the clinic.

"It's very frustrating that our community is the headquarters for drug addicts and mental health patients from all over," wrote one resident, Jane Buccheri, in an essay posted on the Facebook page.

[\[Most read\] Baltimore's Union Craft Brewing removes employee accused of sexual harassment »](#)

In a phone interview, Buccheri, also a leader of the Southwest Partnership, said residents have no statistics to back up claims the clinic is causing increases crime. But residents know what they see, she said.

"After they have treatment they don't necessarily leave the neighborhood," she said. "It's hard to attract homeowners and quality businesses if there is a lot of loitering.

She added: "It has the potential to attract drug dealers. If you have this many potential clients why would you drive around?"

University of Maryland officials have met with residents to address their concerns, Carver said. She said that there were problems with loitering and security in the area before the clinic opened in January, but that she was not aware of issues because of any of the university's services.

A 73-year-old Baltimore man who uses the UM methadone clinic said that when he started using methadone to beat his heroin addiction he stopped committing crimes. The man, who didn't want to use his name because of the stigma attached to methadone users, said he used to pick pockets and rob people to support his habit.

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Most methadone users are living good lives, he said. People oppose methadone clinics, he said, because of misperceptions.

"People don't know about methadone," he said. "A lot of people aren't aware of the good things that methadone does for patients."

A Pikesville methadone clinic operated by Joel Prell got caught up in a legal battle after Baltimore County Executive Kevin Kamenetz, then a county councilman, passed buffer legislation restricting the location of such clinics.

At the time, Kamenetz said he wasn't opposed to drug treatment programs but thought they should be located "in areas where they don't impact the surrounding areas." Prell's A Helping Hand clinic was located near a residential neighborhood.

The 2002 legislation required that methadone clinics and other state-licensed medical facilities that want to open less than 750 feet from homes in areas zoned for business and office use seek additional approval from the county.

Prell sued to challenge the law and to determine whether he should be forced to move. Residents picketed his house.

Prell eventually closed the facility and relocated to Woodlawn, where he hasn't had any opposition. For another center he runs in Westminster, he got council support before opening. That center is in a business park near an airport, not a residential neighborhood.

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"It's fear of the unknown and stereotypes," he said. "What most people don't understand about drug treatment programs is that it works."

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Prell said he works to keep order at his clinics, urging people to leave soon after taking the medication. He also said some may perceive patients as loitering when they just stop for a conversation on the way to their cars. But, he noted, not every clinic operates to the same standards as his.

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Prell and others said methadone users come from all walks of life, especially as more people are becoming addicted to prescription pain killers after routine surgeries.

Royd said she hopes her study opens the doors for more clinics to open and addicts

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"When they choose to go to treatment it shows they are willing to work to change," Bonci said. "We want to make sure people are not stigmatized because they seek treatment."

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Confronting the opioid epidemic: public opinion toward the expansion of treatment services in Virginia

Amy Kyle Cook^{1*}  and Nicola Worcman²

Abstract

Background: Public opinion polls have consistently shown Americans prefer treatment over arrest policies for opioid users. As the opioid epidemic remains a major health problem in the United States, it is important to determine the type of treatment policies the public would support. Theoretically, government should take into consideration the opinion of its constituents when deciding how to act. As such, the 2018 Virginia Commonwealth Public Policy Poll determined levels of support for the expansion of community-based treatment in one's community.

Results: Overall, the results showed 80% of Virginians ($n = 788$) supported the expansion of community-based treatment centers in their neighborhood, 69% supported the use of housing in their community, while less than half supported the provision of clean needles to IV drug users so they do not use dirty needles that could spread infection. Multivariate analyses revealed education, sex, and political party affiliation are significant factors in predicting support for the expansion of services.

Conclusions: Given the lack of progress made by the government in reducing the supply and demand of drugs over the course of the war on drugs, it is time to move away from punitive policies to responsible and pragmatic approaches that include the expansion of community-based treatment.

Keywords: Opioids, Public opinion, Community-based treatment, Recovery housing, Needle exchange

Background

Opioid use disorder remains a major health problem worldwide with 70% of the burden of disease attributable to the use of opioids (United Nations Office on Drugs and Crime [UNODC], 2017). The United States is responsible for 25% of drug related deaths worldwide, mostly from the use of opioids (UNODC, 2017). In the United States in 2017, there were over 72,000 fatal drug overdoses with over 47,000 the result of opioids (National Institute of Drug Abuse [NIDA], 2019). The effects of those numbers are profound considering more people die from the misuse of opioids than do from car accidents or violence (UNODC, 2017). Economists have estimated the United States' economic burden of both the dependence of and fatal overdoses from heroin, prescription opioids, and synthetic

opioids at \$78.5 billion annually, including increased costs for health care, treatment, lost productivity, and criminal justice system involvement (Florence, Luo, Xu, & Zhou, 2016). Moreover, drug related deaths were attributed to a loss of .28 years in life expectancy (Dowell et al., 2017). Globally it was estimated that 17 million years of life lost were attributable to drug use in 2015 alone (UNODC, 2017).

The impact of drug abuse has far-reaching consequences in the lives of Americans. A recent public opinion poll showed that 30% of respondents felt drug abuse was a cause of trouble for their family (Gallup, 2018). When asked about the extent of the heroin problem in their area, 47% of respondents reported heroin was a very serious or somewhat serious problem with an additional 17% reporting it to be at crisis levels. Similar trends emerge with respect to prescription opioids. A number of public opinion polls show that addiction to prescription pain medication is a serious or major problem nationally (CBS News Poll, 2018; Gallup, 2018;

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Kaiser Family Foundation, 2016; Marist Poll, 2017; AP-NORC Poll, 2018; Pew Research Center, 2017) with 20 to 54% of Americans knowing someone who has suffered from opioid addiction (American Psychiatric Association, 2017; CBS News Poll, 2018; Marist Poll, 2017; Stat and Harvard T.H. Chan, School of Public Health, 2016). Moreover, roughly 20 to 25% of Americans reported knowing someone who died from prescription opioid use (Kaiser Family Foundation, 2017; Marist Poll, 2017; Stat and Harvard T.H. Chan, School of Public Health, 2016).

Public opinion polls have also compared preferences for treatment to criminal justice system responses. When faced with the choice to either increase access to treatment or impose stricter punishments and enforcement, Americans prefer policymakers increase access to treatment by 58% and 26%, respectively (APA, 2017). Similarly, the preference of treatment over arrest for prescription opioids and heroin use was found in other polls (Cook & Brownstein, 2017; Pew Research Center, 2014). Despite the vast attention dedicated to the current opioid crisis, 43% of Americans believe the country is headed in the wrong direction as opposed to only 20% who feel the country is headed in the right direction in addressing the opioid crisis; 37% were not sure (APA, 2017). Furthermore, 37% of Americans feel the nation has lost ground in making progress with the drug problem (Gallup, 2017).

While the reasons are unknown as to why Americans reported feeling the country is headed in the wrong direction or that insufficient progress has been made in coping with the drug problem, it is important to consider the observed public support for the expansion of community-based treatment options. The following sections discuss various programs through which communities can utilize best practices to address the ever-growing substance abuse crisis as a public health problem. These include community-based treatment, recovery housing, and needle-exchange programs.

Community-based treatment

Community-based treatment refers to comprehensive outpatient health care and psychiatric services offered in the community (United Nations Office on Drugs and Crime [UNODC], 2014). Based on a bio-psycho-social approach, community-based treatments are designed to help people with substance use problems develop the skills to manage their addiction in the community using a continuum of care model that reduces the need for residential and custodial services where possible (UNODC, 2014). According to UNODC (2014), community-based treatments are the most cost-effective method addressing drug use and dependence and have been associated with a reduction in hospital stays, emergency department visits, and criminal behavior.

Community-based treatments address a wide range of needs from detoxification through aftercare and involves

the coordination of any number of health and social services needed to meet client's needs to encourage change of behavior in the community (UNODC, 2014). Importantly, treatment services need to be available, accessible, affordable and evidence-based to deliver quality care for all people in need of support to help them reduce or stop the use of alcohol and other drugs (UNODC, 2014). Given that drug use is also associated with increased healthcare problems, particularly for people who inject drugs (PWID), expanding prevention and treatment opportunities and access is critical.

Currently, the United States offers a broad range of services based on evidence-based programs designated for people who use drugs; however, availability and access to treatment for drug use remains a challenge. According to Substance Abuse and Mental Health Services Administration (2018), 20.7 million people in the United States were estimated to need substance use treatment, yet only 2.5 million received treatment. Some of the reasons for not receiving treatment include not being ready to stop using, a lack of healthcare coverage, not being able to afford the cost of treatment, believing seeking treatment would have a negative impact on employment, stigma from others, not knowing where to go for treatment, and not finding the type of treatment wanted (SAMSHA, 2018). Globally, only one out of six people with drug use disorders has access to treatment (UNODC, 2014, 2017).

Recovery housing

Recovery housing or recovery residences are peer-run sober living environments that support individuals in their recovery from addiction or co-occurring mental health and substance use disorders (National Association Recovery Residences, 2012; Reif et al., 2014). Residents living in recovery homes receive a variety of services such as case management, therapeutic recreational activities, and peer support in order to improve functioning with the ultimate goal of integration back into the community (Reif et al., 2014). Safe and stable living environments are important to the recovery process especially for individuals with substance use disorders who need more structured care, typically after release from an inpatient facility (Reif et al., 2014). Often times those released from jail or prison are also in need of safe and stable living environments to continue recovery efforts. Blue and Rosenberg (2017) describe recovery housing as an essential component to the recovery process and without it, they contend recovery from addiction is unlikely, particularly given the challenges associated with low recovery capital. Low recovery capital refers to the challenges faced by those with substance abuse histories such as criminal history, low or no income, minimal work history, and poor credit resulting in difficulty in obtaining housing (Blue & Rosenberg, 2017).

Studies of recovery homes have shown a variety of improvements in residents functioning, employment, a reduction in substance use, lower rates of incarceration, improved family relationships, and a reduction in criminal activity (Jason, Aase, Mueller, & Ferrari, 2009; Jason, Davis, & Ferrari, 2007; Jason, Olson, Ferrari, & Lo Sasso, 2006; Mericle, Miles, & Way, 2015; Polcin, Korcha, Bond, & Galloway, 2010; Reif et al., 2014; Tuten, DeFulio, Jones, & Stitzer, 2012). Moreover, cost benefit analyses have shown that recovery housing saves nearly \$29,000 per person considering the reduction in substance abuse, criminal activity, and incarceration (Lo Sasso, Byro, Jason, Ferrari, & Olson, 2012). Community-wide benefits such as reductions in homeless populations, a strengthened sense of community, and increased recovery capital in the community have also been noted in neighborhoods with recovery homes (Mericle & Miles, 2017; Polcin, Henderson, Trocki, Evans, & Wittman, 2012). Although studies of recovery houses are limited and not without criticism, research has shown that they are an important and preferred alternative to criminal justice involvement (Polcin et al., 2012).

Harm reduction, including needle exchange programs

Harm Reduction is an umbrella term used to describe interventions and policies aimed to reduce the negative health consequences from substance abuse, particularly for those who inject drugs (Hawk et al., 2017; Logan & Marlatt, 2010) with the two primary goals of keeping people alive and protecting their health (Harm Reduction International, 2019). Harm reduction seeks to facilitate positive change regardless of how small or incremental and empower users to be primary agents of reducing the harms associated with their drug use (Harm Reduction Coalition, n.d). PWID are at greater risk for contracting HIV and Hepatitis C (Centers for Disease Control and Prevention, 2016). Considering that between 2000 and 2014 the number of acute infections of Hepatitis C among PWID doubled (Zibbell et al., 2018), needle exchange programs are an important component of harm reduction approaches as the sharing of needles increases the risk of transmission of blood-borne infections. The CDC (2016) estimates about one-third of PWID between the ages of 18–30 have Hepatitis C. Among older users, the rates are more concerning as 70–90% of older intravenous users have been diagnosed with Hepatitis C.

The use of needle exchange programs has demonstrated a reduction in both HIV and Hepatitis C infections (Abdul-Quader et al., 2013; Fernandes et al., 2017; Saab, Le, Saggi, Sundaram, & Tong, 2018). In addition to a reduction in the transmission of HIV and Hepatitis C, needle exchange programs are crucial to increasing access to other medical and social support services for PWID (European Monitoring

Centre for Drugs and Drug Addiction, 2010; Hawk et al., 2017; Heimer, 1998; Wilson, Donald, Shattock, Wilson, & Fraser-Hurt, 2015; Wodak & Cooney, 2006). Although studies of needle exchange programs have shown promising outcomes for PWID, it is important to acknowledge that the widespread use of needle exchange programs is still limited (Abdul-Quader et al., 2013; Wilson et al., 2015). The limited use associated with needle exchange, despite their feasibility and cost-effectiveness, is likely a result of community resistance in which critics argue that harm reduction interventions may enable and encourage drug use and produce more risks and harm to the community (see Wodak & Cooney, 2006).

Not in My Back Yard

The Not in My Back Yard (NIMBY) phenomenon is characterized by community resistance to having particular services such as housing developments, commercial establishments, health centers and other initiatives in one's neighborhood (Furr-Holden et al., 2016; Kolla et al., 2017; Takahashi, 1997). Rather than being understood as a public good, community members oppose these facilities based on the assumption that characteristics of the clients that benefit from these services are objectionable (Davidson & Howe, 2014; Takahashi, 1997). According to Takahashi (1997), NIMBY is also related to the stigma associated with drug users, those with mental health problems, and the homeless. Lake (1993) described NIMBYism as an expression of needs and fears of community members.

Communities affected by NIMBYism may constitute an important barrier to not only the implementation but the continuing existence of health services such as drug treatment centers, housing, and needle exchange programs targeting PWUD (see Furr-Holden et al., 2016). Concerns related to property values, community safety, neighborhood identity, condoning and increasing drug use, and an increase in crime and violence have been cited as reasons residents have opposed services in their neighborhood (Davidson & Howe, 2014; Furr-Holden et al., 2016; Knopf, 2016; Kolla et al., 2017; Marx et al., 2000; Polcin et al., 2012). Marx et al. (2000) did not find a statistically significant difference in drug related offenses after the implementation of a needle exchange program. In a study examining whether there was an increase of violence near drug treatment centers as compared to the violence around convenience stores, corner stores, and liquor stores, Furr-Holden et al. (2016) found no statistical evidence that the presence of a drug treatment center attracted violent crime.

Similarly, in Sydney, Australia, researchers did not find that theft and robbery incidents increased around a medically supervised injection site (MSIC Evaluation Committee, 2003). Though the literature has not empirically shown a

significant increase in crime, nonetheless, community members concerns related to NIMBYism are important considerations for planners (see Takahashi, 1997). As stated by Furr-Holden et al. (2016), “NIMBYism poses a significant threat to vital behavioral health services being located in communities” (p. 22).

Given the role NIMBYism plays regarding the inclusion of health services for people who use drugs (PWUD) coupled with previous public opinion polls that show Americans overwhelmingly support treatment over arrest policies, this study was designed to examine specific levels of public support for the expansion of community-based treatment services, recovery housing, and needle exchange programs in the respondent’s community.

Methodology: a statewide public opinion poll

Given the importance of public opinion on the policy making process, the 2018 Commonwealth Public Policy Poll¹ measured levels of support for the expansion of treatment services given the surge in opioid-related deaths in Virginia. In 2017, 1227 Virginians died of opioid overdoses that involved prescription pills, heroin, and fentanyl; more than half of those deaths were caused by fentanyl (Cammarata, 2018). Fentanyl is a synthetic opioid that is 100 times more potent than morphine and 50 times more potent than heroin (Drug Enforcement Administration (DEA), 2017). Between 2015 and 16, Virginia experienced a statistically significant increase in fentanyl related deaths (CDC, 2018). More specifically, the CDC (2018) reports that in 2015 there were 270 fentanyl related deaths in Virginia whereas in 2016, 648 deaths were attributed to illicitly manufactured fentanyl. Nationally, there was a 100% increase in fentanyl deaths from 2015 to 2016 (CDC, 2018). Given the significant increases in fentanyl related deaths, evidence suggests that the nature of the opioid crisis has evolved from prescription pills and heroin to illicitly manufactured fentanyl, causing the death toll to drastically increase.

For the Commonwealth Poll, between December 8–26, 2017, Issues and Answers Network conducted 788 telephone interviews with adult residents in the 5 regions in Virginia using random digit dialing. Soft quotas were implemented for gender and region. Two distinct sampling frames were used for wireless ($n = 396$; 50.3%) and landline phones ($n = 392$; 49.7%). Interviews were administered in English. The sampling margin of error is ± 3.49 percentage points (95% confidence interval). Table 1 shows the demographic characteristics of the sample that comprises 52.3% females, 73% White, 2.8%

Table 1 Demographic characteristics of respondents ($N = 788$)

Characteristic	Sample Percentage
Sex	
Male	47.7
Female	52.3
Race	
White	73.4
Minority	21.1
Ethnicity	
Hispanic	2.8
Non-Hispanic	94.8
Education	
High school graduate or less	19.8
Post secondary education	77.8
Political Party Affiliation	
Democrat	33.0
Republican	24.5
Independent	33.1

Note. 5.6%, 2.4%, and 2.4% of the sample did not know or refused to identify race, ethnicity, and educational attainment, respectively. As for political party affiliation, 9.4% of the sample identified as something else, did not know, or refused to identify their party affiliation

Hispanic, with most respondents having post-secondary education (78%), and politically identifying as Democrat (33%), Republican (25%), and Independent (33%).

Measures

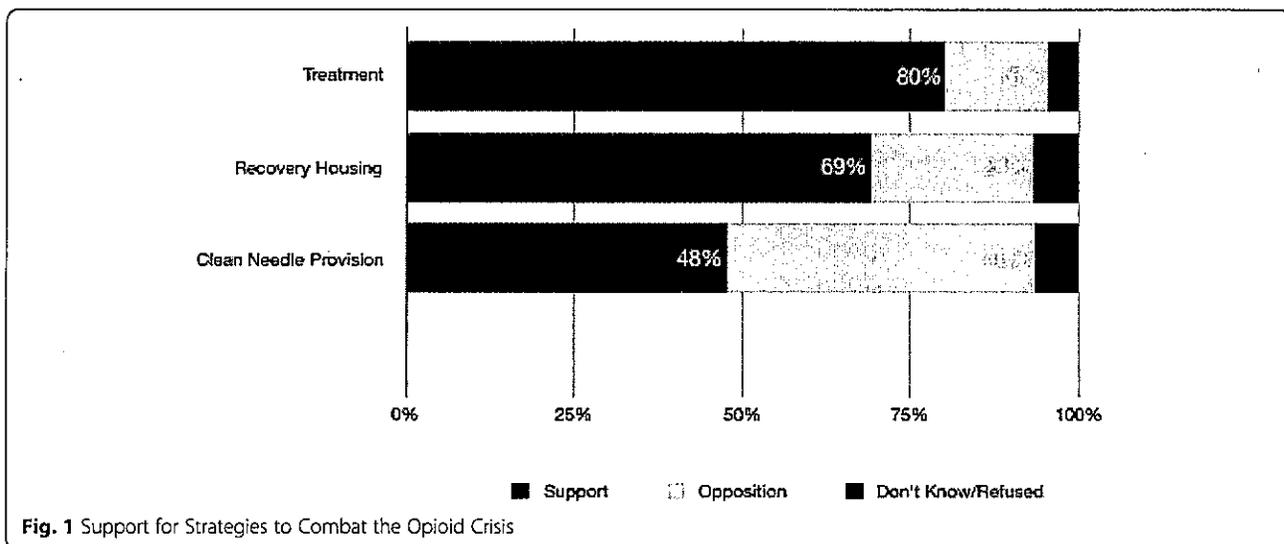
To determine whether or not Virginians support the expansion of treatment services, the following vignette was read to respondents: “In November 2016, the State Health Commissioner declared a public health emergency because of the opioid crisis. A public health approach recognizes the need to reduce the harms associated with drug use to both the individual user and the public through the expansion of treatment services.” Would you support or oppose

- The expansion of community-based treatment centers in your community?
- The use of housing in your community for those in recovery?
- Providing clean needles to IV drug users in your community so they don’t use dirty needles that could spread infection?

Results

Overall, as shown in Fig. 1, 80% of Virginians supported the expansion of community-based treatment centers in their neighborhood, 69% supported the use of housing in their community, with less than half (48%) supporting the provision of clean needles to IV drug users so they

¹The 2018 Commonwealth Public Policy Poll was conducted by the L. Douglas Wilder School of Government and Public Affairs’ Office of Public Policy Outreach (OPPO) at Virginia Commonwealth University in partnership with the Virginia Secretaries of Public Safety and Homeland Security and Health and Human Resources.



do not use dirty needles that could spread infection. While the expansion of treatment centers and recovery housing is high, support for providing clean needles to users is much lower. Further means testing shows significant differences between race and ethnicity for the expansion of community-based treatment centers as well as race for the support for recovery housing. Specifically, significant differences were found between Whites ($M = 1.54$, $SD = 1.62$) and minorities ($M = 1.23$, $SD = .83$) in support for the expansion of community-based treatment centers [$t(742) = 3.305$, $p = .000$] and between Hispanics ($M = 1.05$, $SD = .213$) and non-Hispanics ($M = 1.49$, $SD = 1.503$) for the expansion of community-based treatment centers [$t(767) = -6.212$, $p = .012$]. With respect to support for recovery housing, there are significant differences between Whites ($M = 1.75$, $SD = 1.81$) and minorities ($M = 1.55$, $SD = 1.42$) [$t(742) = 1.469$, $p = .04$]. There were no significant differences found between sex, education level, or political party affiliation.

Three logistic regression models were estimated using those questions as dependent variables (dummy coded as 0 = opposition and 1 = support). Demographic variables were coded in such a way as to reflect differences in policy perspectives: sex (0 = male, 1 = female), race (0 = White, 1 = minority), ethnicity (0 = non-Hispanic, 1 = Hispanic), education level (0 = high school graduate or less, 1 = post secondary education), and political party affiliation (1 = Democrat, 2 = Republican, 3 = Independent). Table 2 presents the results of the logistic regression models that examine factors associated with support or opposition for the expansion of community-based treatment services (a), recovery housing (b), and needle-exchange programs (c).

Model 1 was statistically significant (chi square = 31.035, $p = .000$) and explained 9% of the variation in supporting the expansion of community-based treatment centers in

one's community. Three significant relationships emerged: education ($p = .006$), sex ($p = .01$), and identifying as a Republican ($p = .01$). Post secondary education and sex were positively associated with supporting the expansion of community-based treatment in one's community while identifying as a Republican was negatively associated with expanding services. More specifically, having post-secondary education and being female increased the odds of supporting the expansion of community-based treatment services by 93 and 85%, respectively. Identifying as a Republican decreased the odds of supporting the expansion of community-based treatment services by 50%. Conversely, Republicans were more likely to oppose rather than support the expansion of community-based treatment services.

Model 2 explained 7% of the variation in support for the use of housing in their own community; the model was statistically significant (chi square = 33.157, $p = .000$). Identifying as a Democrat ($p = .02$) and female ($p = .001$) were revealed as statistically significant factors supporting the use of housing in their community. Being female increased the odds of supporting housing by 97% while identifying as a Democrat increased the odds by 76%. It is worth noting that the education variable approached significance ($p = .07$).

Model 3 examined support for providing clean needles to IV drug users to reduce the spread of infection. The model was statistically significant (chi square = 58.766, $p = .000$) and explained 12% of the variation in supporting the provision of clean needles to users. Three significant relationships developed: being Hispanic ($p = .001$), and identifying as both a Democrat ($p = .006$) and Republican ($p = .001$). Being Hispanic increased the odds of supporting the provision of clean needles to IV drug users by 638% and identifying as a Democrat increased the odds of support by 80%; however, identifying as a Republican reduced the odds of support for the provision of clean needles to IV

Table 2 An examination of the factors regarding Virginians support for the expansion of community based treatment services, recovery housing, and needle exchange programs

Variables grams	Model 1 Community based treatment		Model 2 Recovery housing		Model 3 Needle exchange programs	
	b(SE)	OR	b(SE)	OR	b(SE)	OR
Education	.656(.240)	1.927**	.357(.201)	1.430	.112(.182)	1.119
Sex	.614(.240)	1.848*	.678(.196)	1.969**	.178(.172)	1.194
Democrat	.383(.334)	1.466	.568(.258)	1.765*	.586(.215)	1.798**
Republican	-.700(.278)	.496*	-.272(.234)	.762	-.761(.220)	.467**
Race	-.284(.323)	.752	-.319(.257)	.727	-.309(.218)	.734
Hispanic	.577(.772)	1.780	1.104(.670)	3.015	1.999(.582)	7.383**
Cox & Snell R ²	.047		.051		.092	
Nagelkerke R ²	.086		.077		.123	
Chi-square	31.035***		33.157***		58.766***	

$p < .000$ ***, $p < .01$ ** , $p < .05$ *

drug users by 53%. The following section will provide a discussion of these results as well as policy implications.

Discussion

Previous work has shown the importance of public opinion polls on policy making (Cook & Brownstein, 2017). As the opioid problem evolves and even worsens, determining public support (or opposition) for the expansion of treatment services in one's own community is a critical component for policy makers given the devastating impact of the opioid epidemic. Not only did these measures examine support for the expansion of treatment services, it did so in the context of asking about specific support "in your community", an important inclusion considering the NIMBY phenomenon. The current study found that Virginians overwhelmingly supported the expansion of treatment centers and recovery housing in their own community although much lower levels of support were found for the provision of needle exchanges to IV drug users (further discussion provided later).

When examining the factors that indicated support for the expansion of treatment in one's own community, higher levels of education, that is being educated beyond high school and being female were statistically significant factors whereas identifying as a Republican showed opposition to the expansion of treatment services. As for the expansion of recovery housing "in your community", significant determinants were being female and identifying as a Democrat. The significance of being female likely reflects the 260% increase in drug overdose deaths among women aged 30–64 between 1999 and 2017 (VanHouten, Rudd, Ballesteros, & Mack, 2019). There are a variety of factors that explain the increase in overdose deaths illustrating the unique experiences faced by women who use drugs. As compared to men, women who use drugs become addicted sooner, show different impacts on the brain, and are more likely to relapse, overdose, attempt

suicide, report adverse childhood experiences, and have mental and physical health problems (Bloom, Owen, & Covington, 2003; Darke, Campbell, & Popple, 2012; Felitti et al., 1998; NIDA, 2018a).

At the turn of the twentieth century, the first wave of the opioid epidemic, women were front and center to the marketing of and prescribing of opioids - they were prescribed opioids for menstrual cramps and hysteria (Terplan, 2017). While the reasons for prescribing opioids may have changed, the iatrogenic nature of the current opioid crisis parallels that of the first (Kolodny et al., 2015; Terplan, 2017). Understanding the experiences and challenges faced by women are paramount to adequately addressing and treating their substance abuse needs; substance abuse programming and treatment should reflect those differences. The results also reveal the importance of education among its citizenry. Higher levels of education may be the foundation for a more informed understanding of addiction and treatment needs.

Expanding community-based treatment services and recovery housing are essential components in the recovery process and fills a service gap (Blue & Rosenberg, 2017; Substance Abuse and Mental Health Services Administration, 2013). The current study underscores the importance of expanding the accessibility of both community-based treatment and recovery housing for those with substance abuse histories because without both, users will likely find recovery unattainable given the challenges with respect to low recovery capital (Blue & Rosenberg, 2017). As previously noted, community-based treatment programs are cost-effective as compared to hospital emergency room usage and incarceration (UNODC, 2014). Moreover, participants in recovery homes have shown improvements in social and family functioning, employment, and reductions in criminal behavior, substance abuse, and incarceration (Jason et al., 2006, 2007, 2009; Mericle et al., 2015; Polcin et al., 2010; Reif et al., 2014; Tuten et al., 2012).

With respect to providing clean needles to IV drug users, being Hispanic and identifying as a Democrat significantly predicted support; conversely, identifying as a Republican significantly indicated opposition. The robustness of political affiliation across models is interesting given recent bipartisan political support for dealing with the current crisis. Despite the current study's findings among the general population, support by Republican politicians for sensible and pragmatic policies such as harm reduction approaches, including needle exchange programs is growing in response to the current crisis (Nadelmann & LaSalle, 2017).

Virginians' opinions: harm reduction and needle exchange programs

Given the public's high levels of support for the expansion of community-based treatment and recovery housing, lower levels of support for the provision of needle exchanges may be explained by a number of factors such as lack of education about the scope of such programs considering their benefits to users, stigma associated with people who use and inject drugs, the NIMBY phenomenon. It may also be that citizens distinguish community-based treatment and recovery housing from needle exchange programs because the former helps users stop using drugs whereas needle exchange programs allow drug use to continue, although more safely. Regardless, the benefits of needle exchange programs cannot be overstated - they reduce the harms associated with opioid use by offering clean syringes and needles as well as other injection equipment and safe disposal containers, offer HIV and hepatitis testing, provide overdose prevention, educate users about safe injecting practices, and offer tools to prevent HIV and other sexually transmitted diseases that includes condoms and counseling. Most notably, exchange programming includes referrals to substance abuse treatment, medical and mental health care, and other social services (CDC, 2017). Research has shown that exchange programs are compatible with the goals of treatment and do not increase drug use or crime (CDC, 2017; Furr-Holden et al., 2016; Hagan et al., 2000; Heimer, 1998; Marx et al., 2000). Furthermore, needle exchange programs save on costs associated with healthcare while participants of needle exchange programs are five times more likely to enter into treatment than those that are not participants of exchange programs (CDC, 2017; Hagan et al., 2000).

With respect to model 3 and examining support for needle exchange programs, it is important to note the small percentage of Hispanics included in the study (less than 3%). However, the significance of identifying as Hispanic was initially an unexpected finding as research has shown Hispanics are less likely to have a SUD compared to individuals born in the United States (Salas-Wright,

Vaughn, Clark Goings, Córdova, & Schwartz, 2018). It should be noted however, that Salas-Wright et al. (2018) suggest that the lower rates of Hispanics self-reports of substance use may be related to immigration status and fear of deportation. Nevertheless, the significance of identity as Hispanic could be related to two hypothesis.

First, health outcomes associated with substance use among Hispanics may explain the significant support for needle exchange programs. For example, intravenous drug use among Hispanics accounted for 19% of the cases diagnosed with HIV in 2015 (CDC, 2016). Moreover, recent changes in opioid related deaths among Latinos may explain support. Between 2013 and 2015 Hispanics made up 2 % of opioid related deaths in Virginia; that number rose to 3 % in 2016 (Kaiser Family Foundation, 2018). Other states such as New York and Massachusetts have also experienced increases in deaths among Hispanics. In Massachusetts the death rate among Hispanics doubled between 2014 and 16 (twice the rate of other groups) while in New York, over half of the deaths were attributed to fentanyl (Bebinger, 2018; Frisneda, 2017). Nationally, opioid related deaths among Latinos rose 35% while synthetic deaths increased by 183%, between 2015 and 2016 (as cited in Rosello, 2018). Support among Latinos for needle exchange programs may also reflect broader changes in attitudes or moral values which occurs as part of the acculturation process to the American culture especially for Latinos in the United States (Flórez et al., 2015). Florez et al. also explain that the escalating violence in Latin American countries may shape attitudes toward drug use. Second, the growing levels of substance use among Hispanics might be seen as a maladaptive coping strategy among emerging adults (Allem, Soto, Baezconde-Garbanati, & Unger, 2015).

The considerable focus on harm reduction, including needle exchange programs are important considerations because Virginia has been identified as a jurisdiction that is experiencing or is at-risk of experiencing significant increases in HIV or Hep C as a result of intravenous drug use with 8 localities in particular considered vulnerable (Van Handel et al., 2016). In response to these high rates of HIV and Hepatitis C in Virginia, in July 2017, House Bill 2317 authorized needle exchange programs to operate in 55 pre-identified localities; however, to date there are only two programs operating in the state. One in Wise County, where the rate of Hepatitis C is double that of the state rate (Friedenberger, 2018) and the other that opened in Richmond in November, 2018 (Balch, 2018). The law requires that entities applying to operate needle exchange programs in those pre-approved localities must have the support of both local law enforcement and the health department (Virginia House Bill 2317, 2017).

Garnering support from local law enforcement agencies may be more problematic than originally thought given that only two applications have been approved to

operate such a program (Friedenberger, 2018). It is not difficult to understand the reticence of police to support needle exchange programs given the enforcement aspect of their job. After all, police serve to enforce laws, which means possession of paraphernalia laws are likely enforced when police come across a user with drug laced needles or other injection equipment. Although police and other abstinence groups may oppose such programs, they are an important partner to have in developing programs to avoid interference and client harassment with exchange programs (see Beletsky, Grau, White, Bowman, & Heimer, 2011; Strike, Myers, & Millson, 2004).

Though it has been noted that police and other groups have complicated the establishment of needle exchange programs, over time they have been swayed to support such programs based on the scientific evidence of their effectiveness (Strike et al., 2004). As Strike et al. (2004) noted, a police officer on the committee initially was not supportive of the program and wanted to make sure it never happened but after learning about the benefits to the users of the program, he eventually became an advocate of the program. More recently, in North Carolina, a border state just south of Virginia, a study of police officers indicated that officers were supportive of decriminalization of syringes to reduce Hepatitis C and HIV and believed that decriminalization would be good for the community as well as law enforcement (Davis et al., 2014). Given these concerns, collaborative efforts that include voices of opposition coupled with evidence from the scientific community highlighting the effectiveness of needle exchange programs while debunking concerns such as condoning drug use and increasing crime rates are critical to their success. The CDC (2016) recommends health departments should work with police and local leaders to expand needle exchange programs.

Despite the fact that addiction is defined as a chronic disease of the brain (NIDA, 2018b), many Americans believe addiction is the result of choice, a lack of willpower or discipline, character defect, bad parenting, or they outright blame users (AP-NORC Poll, 2018; Kaiser Family Foundation, 2016; Palamar, 2013). This lack of understanding of addiction clouds perceptions and contributes further to addiction related stigma. By simplifying addiction to a mere choice, we ignore both the medical and environmental factors associated with addiction via the disease model (see McLellan, Lewis, O'Brien, & Kleber, 2000). Interviews with participants in treatment have provided evidence that understanding addiction from a genetic framework would decrease stigma (Dingel, Ostergren, Heaney, Koenig, & McCormick, 2017).

In a study that examined vignettes regarding individuals with untreated versus treated mental health and opioid addiction, differences were noted (McGinty, Goldman, Pescosolido, & Barry, 2015). Respondents who received

more information regarding successful treatment showed improved attitudes towards mental illness and addiction, suggesting that portrayals of successful treatment may mitigate negative attitudes held by society (McGinty et al., 2015). Moreover, personalizing accounts of those directly impacted by opioids may be one of the best ways to overcome addiction related stigma. In fact, the CDC (2019) explains that the use of evidence-based campaigns work to increase awareness by humanizing those that suffer from addiction and by extension, address and reduce stigma and increase access to services including harm reduction strategies. The implications of stigma can be far reaching and as Olsen and Sharfstein (2014) so poignantly stated, "this stigma is impeding progress in reducing the toll of overdose" (1393).

Policy implications

The importance of political influence and persuasion cannot be overstated. Just as politicians had an influence on public opinion during the get tough on crime movement in the 1980s and 1990s, Wozniak (2016) asserts that the public can be reassured by politicians that the programs they endorse are effective. Considering their powers of persuasion it is likely that politicians have the clout to influence the general public and the law enforcement community on the benefits of community-based resources and harm reduction approaches. As research shows, community-based treatments and harm reduction strategies such as needle exchange programs are cost-effective and improve the lives of PWUD (Wilson et al., 2015).

Given the sentiment of law enforcement that "We can't arrest our way out of this problem" (see Truong, 2017), law enforcement would benefit from accurate education from the public health and scientific communities about the advantages of and opportunities for non-arrest pathways to treatment (see the Police Assisted Addiction and Recovery Initiative [PAARI], n.d; Police, Treatment, And Community Collaborative, n.d; Seattle's LEAD Program, 2018; Cloud & Davis, 2015). Non-arrest pathways are important tools for police in that they create opportunities to respond to the demand side of the supply and demand drug markets (see PAARI).

Since the latter part of the twentieth century, the war on drugs has primarily been the paradigm in which our government has responded to eradicating drugs and punishing offenders (Neil, 2014). The punitive focus on zero-tolerance policies, increased penalties, and incarceration became a substitute for treatment, leaving the needs of drug users unmet (Neil, 2014). Even in the realm of corrections, mainly prisons, the focus on offenders was more about punishment rather than rehabilitation (Balboni, 2013). Interestingly enough, a National Association of Chiefs of Police (2005) survey found that 82% of chiefs and sheriffs did not believe the

war on drugs has been successful in reducing the use of illegal drugs. This suggests that police - those at the forefront of the drug crisis - have great insight to the limited nature and failures of the war on drugs. Perhaps it is the cost of the war on drugs, estimated at 1 trillion dollars since the early 1970s (Pearl, 2018), coupled with the current opioid crisis that has resulted in a shift away from the war on drugs to a public health approach with increasing momentum (Pope, Davis, Cloud, & Delaney-Brumsey, 2017).

This is not suggested that arrest policies may not be necessary at times but rather thinking about how public health initiatives over time improve lives of some of our most vulnerable citizens and how the criminal justice system can serve as a pathway to treatment (see Pope et al., 2017). As police and other criminal justice officials are increasingly having to deal with issues of behavioral health such as drug use, mental illness, and other social ills, creating opportunities that advance health and justice are necessary (Cloud & Davis, 2015). As Cloud and Davis (2015) assert, "The lack of adequate community-based mental health treatment, housing options, and harm reduction services across the United States underlies many of the challenges that police, courts, and jails encounter when interacting with people with complex health needs" (p.20).

To advance public safety, criminal justice, and public health, those working to ameliorate the effects of addiction must continue to educate the public and partner with public safety agencies. By reshaping our understanding of addiction and treatment, it not only benefits PWUD but it also serves to enhance public safety. Future studies regarding the perceptions of law enforcement's support for needle exchange programs and those deserving of diversion efforts are needed.

Limitations

Several limitations are noted. First, in terms of generalizability, the results from the current study may be generalizable to other states with similar levels of opioid problems and demographics as that of Virginia. Though this study showed that Democrats were more supportive of needle-exchange programs, it is important to note that Republican leaning states have passed legislation authorizing needle exchange programs to combat the transmission of Hepatitis and HIV (Kaiser Family Foundation, 2019). At the top levels of the federal government, the Secretary of Health and Human Services Alex Azar, a Republican, also supports the use of needle exchange programs (Azar, 2019).

Although the Commonwealth of Virginia is a "blue state" with Democratic leadership in the executive branch of government, political orientation is complicated as it relates to the expansion of services, particularly in Virginia where the support of law enforcement is necessary by law to establish needle exchange programs.

In bordering North Carolina, a number of police chiefs and sheriffs support syringe programs because of the positive impacts on communities and intravenous drug users (North Carolina Harm Reduction Coalition). Regardless of political orientation, the findings underscore the need for government, health departments, local service providers, including law enforcement, to work together to implement evidence-based strategies that expand services.

Second, the time-dimension is cross-sectional in nature. Third, the study is limited in terms of explanatory factors and does not consider factors beyond demographics that may explain levels of support (or lack thereof) for treatment strategies. The inclusion of additional survey items such as knowing someone with a substance abuse problem or personal experience with substance abuse may help explain levels of support. Fourth, it should be noted that the questions were broadly worded to account for a lack of prior knowledge of such approaches. For example, the question pertaining to the provision of clean needles to PWID was initially worded as support or opposition for NEP; however, pilot testing revealed some confusion on that question as respondents were not familiar enough with the term "needle exchange" and therefore unable to answer the question. As such, the question was reworded to include an explanation of the concept of needle exchange programs: Would you support or oppose "Providing clean needles to IV drug users so they don't use dirty needles that could spread infection?" Nevertheless, the data provides valuable insight for communities, health departments, law enforcement agencies, and politicians as it relates to the expansion of community based treatment.

Conclusion

Given the iatrogenic nature of the opioid crisis, comprehensive education that includes scientific information is needed so that the public can understand the nature of addiction. The failure to understand addiction means we also fail to respond appropriately to the needs of users which in turn compromises public safety. As the number of drug related harms and number of deaths continue to rise, so does the need to respond in a way consistent with harm reduction approaches that seek to ameliorate the harmful effects of drug use and stigma. Objective education about addiction and treatment through a public health paradigm could go a long way in reducing stigma and expanding treatment services (Palamar, 2013).

Given the lack of progress in reducing both the supply and demand of drugs over the course of the war on drugs, the time has come for a shift away from punitive policies to a more responsible and pragmatic approach where community-based treatment becomes standard practice whereby it is accessible to those in need. In

closing, public opinion polls have consistently shown that the public supports treatment over arrest policies for drug related crimes. The current study adds to that body of literature by examining specific support for community-based treatment options. The results underscore the growing need for the expansion of community-based treatment, recovery housing, and harm reduction approaches to combat the crisis of addiction. Besides lives, what do we have to lose?

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AKC conceptualized the project, developed the measures, analyzed and interpreted the data, and wrote the bulk of the manuscript. NW helped with the literature review search, particularly global perspectives on public health initiatives. Both authors read and approved the final manuscript.

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Use of a 'microecological technique' to study crime incidents around methadone maintenance treatment centers

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ABSTRACT

Aims Concern about crime is a significant barrier to the establishment of methadone treatment centers (MTCs). Methadone maintenance reduces crime among those treated, but the relationship between MTCs and neighborhood crime is unknown. We evaluated crime around MTCs. **Setting** Baltimore City, MD, USA. **Participants** We evaluated crime around 13 MTCs and three types of control locations: 13 convenience stores (stores), 13 residential points and 10 general medical hospitals. **Measures** We collected reports of Part 1 crimes from 1 January 1999 to 31 December 2001 from the Baltimore City Police Department. **Design** Crimes and residential point locations were mapped electronically by street address (geocoded), and MTCs, hospitals and stores were mapped by visiting the sites with a global positioning satellite (GPS) locator. Concentric circular 'buffers' were drawn at 25-m intervals up to 300 m around each site. We used Poisson regression to assess the relationship between crime counts (incidents per unit area) and distance from the site. **Findings** There was no significant geographic relationship between crime counts and MTCs or hospitals. A significant negative relationship (parameter estimate -0.3127 , $P < 0.04$) existed around stores in the daytime (7 am–7 pm), indicating higher crime counts closer to the stores. We found a significant positive relationship around residential points during daytime (0.5180, $P < 0.0001$) and at night (0.3303, $P < 0.0001$), indicating higher crime counts further away. **Conclusions** Methadone treatment centers, in contrast to convenience stores, are not associated geographically with crime.

Keywords Crime, geocoding, methadone maintenance, neighborhood, spatial analysis.

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INTRODUCTION

The aim of this study is to determine whether there is a geographic relationship between methadone treatment centers (MTCs) and neighborhood crime. Methadone maintenance is well established as an effective treatment for opiate dependence [1–3]. Opioid dependence is a global public health problem, with an estimated 24–32 million opioid users (12–14 million heroin users) worldwide in 2009, including 3.1–3.5 million users in Europe [4]. Nevertheless, access to treatment is limited in many communities that oppose the establishment of new methadone maintenance treatment centers (MTCs), due

largely to concerns about crime [5,6]. This resistance exists despite extensive research over several decades, showing that methadone maintenance treatment decreases crime among treated patients. For example, a study of 1075 heroin users found that methadone maintenance plus psychosocial treatment decreased crime, resulting in decreased societal costs [7].

Community concerns about MTCs causing crime reflect a difference between 'clinical' and 'ecological' perspectives. While the clinical perspective has established that successfully treated patients commit fewer crimes [8], there is no empirical evidence on the ecological relationship between MTCs and neighborhood crime. Three

possible relationships could exist, and plausible theories support each relationship. MTCs could decrease neighborhood crime by treating opiate users who live nearby, thereby decreasing their risk of criminal behavior. MTCs could increase crime if they attract untreated or partially treated users into the neighborhood, thereby increasing the local density of people likely to commit crimes [9]. Finally, MTCs could have no crime impact if neighborhood crime relates largely to other factors.

This study addresses the debate by evaluating relevant empirical data with a technique that has not been applied previously to this issue. Previous studies of the geographic (spatial) relationship between locations of substance availability (e.g. alcohol outlets, location of illegal drug possession and sales) and crime have used relationships between locations and crime rates averaged over large areas, typically postal codes or census tracts [9–11]. This study is the first of which we are aware to use a more fine-grained 'microecological' approach. Instead of studying a population of patients or a large geographic area where the MTCs are located, we evaluated crime rates in terms of increasing spatial distance *within* individual MTC neighborhoods.

The study was conducted in Baltimore, MD, USA, an urban environment with a high rate of heroin use [12,13] and high crime rate [14]. The city had 16 methadone treatment centers (MTCs) in operation during the study period. A comparison of crime before and after the establishment of MTCs was not possible, because most of the MTCs in Baltimore had been in operation before the advent of geocodable electronic crime data.

METHODS

Details of the 'microecologic technique' have been published previously [15]. In brief, we obtained a database listing all Federal Bureau of Investigation (FBI) Uniform Crime Report 'Part 1' crimes [homicide, sexual assault, robbery, aggravated assault, burglary, larceny (including theft from a motor vehicle), auto theft and arson] [16] in Baltimore City, MD, from 1 January 1999 to 31 December 2001 from the Baltimore City Police Department. We identified 16 MTCs operating in Baltimore during this study period. One was excluded because it was located on the sixth floor of a general medical hospital, making it impossible to differentiate its crimes from those associated with the hospital. Three of the remaining MTCs were analyzed as one clinic, because their front entrances were within 25 m of each other, making it impossible to analyze their crime data separately. Thus, we included data from 13 MTC's whose characteristics we obtained by telephone survey (Table 1). Of these, eight were on the campus of or near a hospital, but not in the same building as the hospital. Four MTCs offered buprenorphine for

Table 1 Characteristics of 13^a Baltimore City, Maryland methadone maintenance treatment centers (MTCs) operating 1 January 1999 to 31 December 2001.

	<i>Min</i>	<i>Max</i>	<i>Mode</i>	
Opening time	5:30 am	11 am	7 am	
Closing time	4 pm	7:30 pm	6 pm	
	<i>Min</i>	<i>Max</i>	<i>Mean</i>	<i>Median</i>
Daily patient census	55	600	298	300

^aIncludes combined data from three MTCs whose entrances were within 25 m of another MTC (see text).

opioid detoxification or maintenance therapy, in addition to methadone.

To help assess the significance of any relationship between MTCs and crime, we evaluated crime around three types of control sites in Baltimore City, MD. MTCs might have more crime than adjacent locations because of having higher foot traffic. High foot-traffic areas (areas with higher density of people) may have more crime than low foot-traffic areas because offenders are more likely to meet victims/targets in such areas [17]. Therefore, we selected two 'high foot-traffic' sites (general hospitals and convenience stores) and one 'low foot-traffic' site (residential points) as controls. General medical hospitals (10 in operation in Baltimore during the study period) were chosen because they, like MTCs, provide medical care. 'Convenience stores' were those defined as such on the Switchboard.com [18] website. Residential points were defined as addresses in the middle of a block on a small secondary street within a geographic area identified as 'residential' by local zoning maps.

Thirteen convenience stores and 13 residential sites were matched to the 13 MTCs based on 20 relevant census and crime variables (Table 2), which previous factor analytical research has shown can identify neighborhoods with high rates of violent crime [19]. These variables were entered into a factor analysis by Baltimore City Census Block Group (CBG); the analysis was pre-defined to generate a single factor score. Control sites were chosen for each clinic so that the factor scores of their CBGs were closest to the factor score of their matched clinic. Hospitals could not be matched to the MTCs due to the limited number of hospitals (10) available for matching.

Data and geocoding

Crime locations and residential control sites were mapped electronically by 'geocoding' their street addresses using the ArcGIS 9 computer program [20]. Geocoding is a computerized process in which a street address is con-

Table 2 Variables used in the factor analysis for matching census block groups of methadone maintenance treatment centers (MTCs) and control study sites.

Census variables	
% Staying at the same house for more than 5 years	
Population per square mile	
Household size	
% Female-headed households	
% People with no high school diploma	
Per capita income	
Median household income	
Percent with income below poverty level	
% Service workers	
% People unemployed	
% Households with public assistance income	
% Households with no worker	
% Non-white	
'Racial heterogeneity' (count of different races reported)	
% Vacant houses	
% Households renting home	
Median gross rent	
Median value of owner-occupied home	
Crime variables	
Total crimes in 2000	
Total drug-related crimes	

verted into a map location (latitude and longitude) [21]. The locations of MTCs, convenience stores and hospitals were determined by visiting the sites and reading the latitude and longitude on a global positioning satellite (GPS) locator. Site visits were necessary in these cases, because street addresses of non-residential sites are sometimes not precise enough to generate an accurate latitude and longitude. For example, convenience stores are sometimes located in large parking lots or malls, along with other stores. In order to maintain the privacy of people living at the residential sites, the locations of the residential sites were found by geocoding, rather than by visiting the site.

'Buffering' sites and counting crimes

We used a 'buffer' methodology to determine the geographic relationship between study sites and neighborhood crime. Concentric circular, non-overlapping, doughnut-shaped buffers were defined at 25-m intervals for up to 300-m radius around each study site. Crimes were counted within each buffer. In order to compare crime quantitatively across buffers of increasing size, the number of crimes was corrected for the area of each buffer to generate crime counts per unit area ('crime counts'). To avoid crime counts <1, the 'unit area' was defined as 1962.5 m² [the size of the smallest (25-m) buffer]. Similar buffer methodologies have been used to study crime around housing projects [22] and supportive housing [23].

Statistical analysis

Poisson regression analyses were used to evaluate the relationship between crime counts and distance from a site. First, a generalized additive model (GAM) with a spline term was used to fit a line to scatter-plots to visualize the data. The GAM graphs indicated that most of the variation in crime incidents was within the first 100 m (first four buffers) of the sites (data not shown). Thus, further data analysis included only crime incidents within 100 m of the study sites. Further analyses used a Poisson distribution and generalized linear model to analyze crime counts around the study sites, generating a parameter estimate (β) through a least-squares analysis. A significant positive β ('positive crime slope') indicates a higher crime rate with increasing distance from the study site, while a significant negative β ('negative crime slope') indicates a higher crime rate closer to the study site. All analyses were performed with SAS version 9.1 [24].

'Within-group' comparisons to evaluate the relationship between crime counts and distance from the site (crime slopes) were performed separately for MTCs, convenience stores, hospitals and residential points. Because crimes can occur at night, when MTCs are closed, we controlled for time of day by analyzing separately crimes occurring during the day (7 a.m.–7 p.m.), the hours when most MTCs are open (Table 1), and at night (7 p.m.–7 a.m.).

RESULTS

There was no significant change in crime counts with increasing distance from MTCs or hospitals (Fig. 1), as indicated by non-significant values for parameter estimates of crime slopes (Table 3). In contrast, there was a significant decrease in crime counts with increasing distance from convenience stores during both daytime and night-time (Fig. 1, Table 3, daytime parameter estimate -0.3127 , $P < 0.04$, night time parameter estimate -0.3235 , $P < 0.0623$). Around residential sites, there was a significant increase in crime counts, with increasing distance from the site during both daytime (0.5180, $P < 0.0001$) and night-time (0.3303, $P < 0.0001$).

DISCUSSION

This study found no significant change in crime counts with increasing distance (up to 100 m) from MTCs, suggesting that MTCs are not a geographic focus for crime. In contrast, there was a significant decline in crime counts with increasing distance from convenience stores and a significant increase in crime counts with increasing

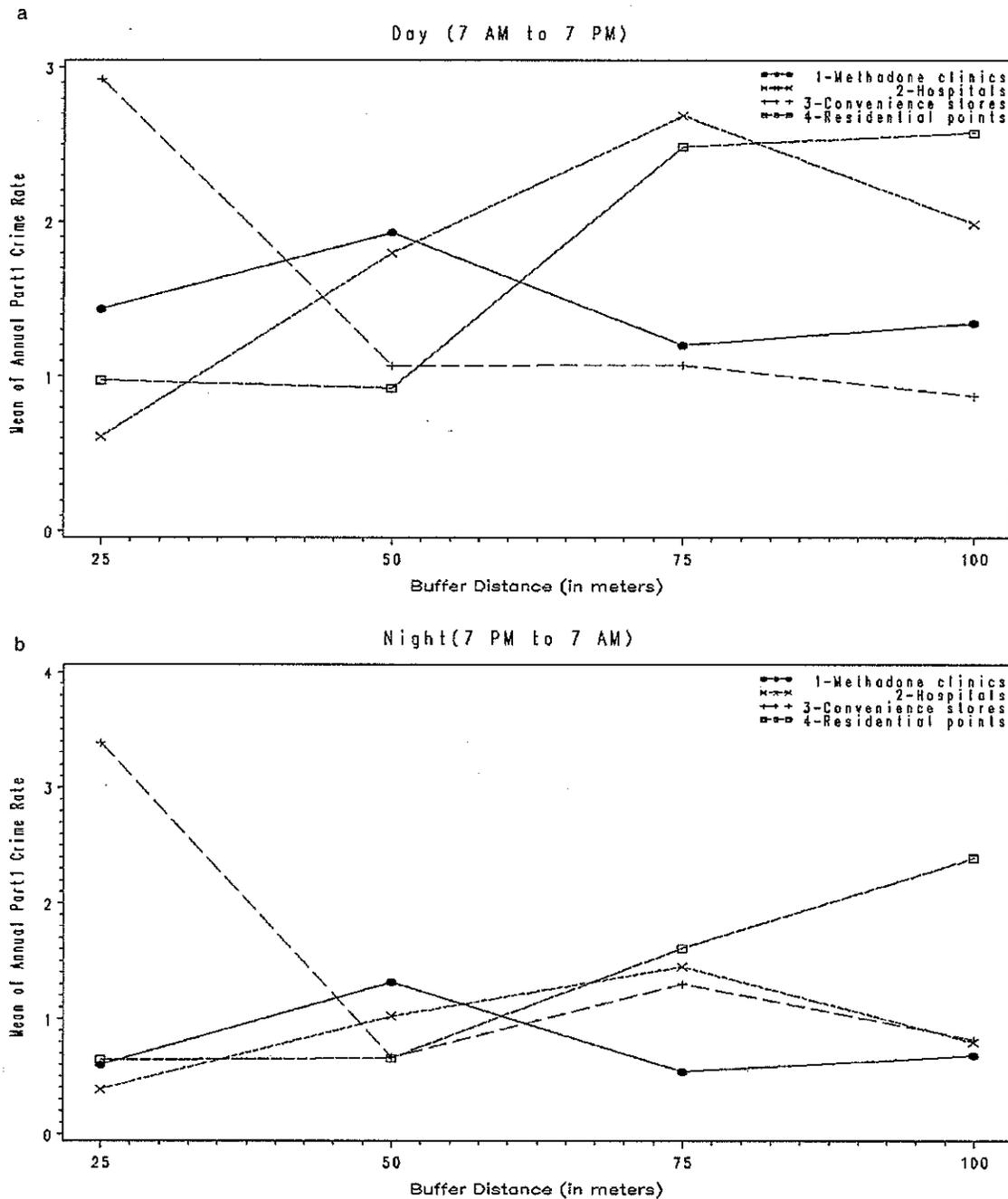


Figure 1 Crime rates around methadone maintenance treatment clinics, general medical hospitals, convenience stores and residential points in Baltimore City, MD (1999–2001). Crimes were all Federal Bureau of Investigation (FBI) Part I crimes [homicide, sexual assault, robbery, aggravated assault, burglary, larceny (including theft from a motor vehicle), auto theft, and arson] reported in Baltimore City, MD between 1 January 1999 and 31 December 2001. Crime rate—crimes per 'unit area' (1962 m², the area of a 25-m circle/buffer). Buffer distance—radius of circular/doughnut-shaped areas defined around study sites. Study sites were 13 methadone maintenance treatment centers (MTCs), 10 general medical hospitals, 13 convenience stores and 13 residential points (residential addresses in the middle of the block on secondary streets). Convenience stores were matched to the MTCs by neighborhood characteristics (see text for details). Mapping of locations was based on street address for crime locations and residential sites and global positioning satellite (GPS) for other sites. (a) Crimes between 7 a.m. and 7 p.m., when MTCs are open. (b) Crimes between 7 p.m. and 7 a.m., when MTCs are closed

Table 3 Poisson regression analysis of the relationship between crime counts^a and distance (≤ 100 m) from study site.

Type of site	Time of day	Parameter estimate ^b	Standard error	Lower confidence limit	Upper confidence limit	Z	P value
MTC ^c [13]	Day ^d	-0.0938	0.2243	-0.5334	0.3457	-0.42	0.6757
	Night ^e	-0.1614	0.2167	-0.5862	0.2634	-0.74	0.4564
Convenience Store [13]	Day	-0.3127	0.1553	-0.6171	-0.0083	-2.01	0.0441
Residential Site [13]	Night	-0.3235	0.1735	-0.6635	0.0166	-1.86	0.0623
General medical hospital [10]	Day	0.3303	0.0511	0.2302	0.4304	6.47	<.0001
	Night	0.518	0.0947	0.3325	0.7035	5.47	<.0001
General medical hospital [10]	Day	0.086	0.1353	-0.1792	0.3511	0.64	0.5251
	Night	-0.056	0.1533	-0.3564	0.2443	-0.37	0.7146

^aCrime count: number of crime incidents per area in each concentric ring at 25-m intervals around the site. ^bParameter estimate: estimated 'crime slope' relating crime counts with distance from study site. Positive parameter estimate indicates increasing crime counts with increasing distance from the site. Negative parameter estimate indicates decreasing crime counts with increasing distance from the site. ^cMTC: methadone maintenance treatment center.

^dDay: 7 a.m.–7 p.m. ^eNight: 7 p.m.–7 a.m. Italics indicate significant results.

distance from the residential sites, indicating that the microecological technique is capable of detecting places that are or are not geographic foci of crime. The observed crime pattern around convenience stores (high foot-traffic areas) and around residential sites (low foot-traffic areas in the middle of small residential blocks) is consistent with the previously shown positive correlation between crime and increased density of people at a site [17]. Overall, the pattern of findings supports the validity and sensitivity of our microecological technique, and strengthens confidence in our primary finding of no significant increase in crime counts closer to MTCs.

An estimated 282 000 Americans were dependent on or abusing heroin and another 1.72 million were dependent on or abusing prescription pain relievers in 2008 [25]. In contrast, only about 265 000 patients were receiving opiate agonist treatment in 1108 US treatment facilities [26]. The European Union had more than 1 million regular opioid users in 2006, but only 25 000 patients receiving methadone maintenance treatment [27]. Thus, there is a public health need for more MTCs to treat the large numbers of people addicted to opiates. Our finding that MTCs are not associated with increases in neighborhood crime addresses a major impediment to the establishment of new clinics, and should lead to greater availability of methadone maintenance treatment for the many people who need it.

This study has several strengths, including the use of a microecological technique that evaluates geographic neighborhoods rather than patient populations, use of control sites matched to the MTCs to minimize confounding by degree of foot traffic and other neighborhood characteristics known to influence crime rates, and the inclusion of data from all but one of the MTCs operating in Baltimore City during the study period.

This study has several limitations. First, the data show substantial variability, as reflected in large confidence

intervals. For example, although methadone clinics and residential points have different crime slopes (different sign for the parameter estimate), there is no significant interaction term between the two groups when they are compared in a between-groups comparison. Secondly, this study has uncertain external validity because it involved a relatively small number [15] of MTCs in a single city. However, there is no obvious manner in which Baltimore City MTCs differ from those in other areas of the United States or abroad, nor is there any reason that the neighborhood factors influencing crime in Baltimore should differ from those elsewhere. Indeed, Baltimore may be an 'ideal' setting for this type of study, given its high rate of heroin use (Baltimore has been called the 'heroin capital' of the United States [12,13]), urban environment and high crime rate [14].

The stigma against methadone maintenance treatment, including concerns about crime, exists throughout the world [28–31], regardless of whether methadone is dispensed in centralized methadone treatment centers or by prescription through community pharmacies. For example, a survey of pharmacists in England found that many expressed concern about shoplifting and aggression if they were to begin to dispense methadone [32]. Residents both in the United Kingdom and Canada voice fears that methadone treatment centers may increase crime, resulting in difficulty opening or keeping open methadone clinics [33–35]. This study provides strong evidence against a major reason for the social stigma concerning methadone maintenance, i.e. concerns about crime. A major issue in the NIMBY ('not in my back yard') phenomenon for MTCs is the need for patients to come in daily for dosing. Buprenorphine, an opioid partial agonist now used in many countries for opioid substitution, can be prescribed by physicians and dispensed for home administration. Because there is no need for patients to come to a specialized clinic for regular dosing, the hope is

that buprenorphine treatment will be less stigmatized and better accepted than methadone treatment.

Finally, a key conceptual issue for any study involving crime is how to quantify crime. Three major parameters have been used to measure crime in social science studies, each with its own advantages and disadvantages: crime incidents (used in this study), arrests and 911 calls. Crime incidents, being generated from complaints of crime, are not subject to policy changes in police enforcement, unlike arrest data. However, incident data have the disadvantage of not recording 'victimless' crimes, such as many drug crimes. Databases of 911 calls have the disadvantage of containing a large number of 'unfounded' events; that is, when the police arrive at the scene of the call, there is no evidence of the reported crime. However, 911 databases may be a more sensitive measure of community concerns about crime.

Overall, our data show that MTCs are not a geographic focus of crime, thus providing both strong evidence to alleviate neighborhood concerns about the establishment and operation of MTCs and quantitative information to combat the stigma of methadone substitution treatment. As more MTCs open and more geocodable crime data become available, future research can attempt to confirm and expand our findings using before-and-after designs and different types of crime data.

CONCLUSION

This study found no significant increase in crime around MTCs, while finding the expected significant increase around convenience stores, which also have high foot traffic. These results do not support the common neighborhood concern of MTCs as geographic foci of crime, and may ease the establishment of new MTCs. Studies using the microecological technique may inform more clearly the social and political debate around the siting of MTCs.

Declarations of interest

SB is Medical Director of the Baltimore Veterans Affairs Medical Center Opiate Agonist Treatment Program. Otherwise, the authors have no conflicts of interest in relation to this study or connection with the tobacco, alcohol, pharmaceutical or gaming industries. There are no contractual constraints on publishing this study.

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Planning and Zoning Code- Section 23A

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Official copies can be viewed or purchased at the
Department of Planning, Conservation, and Development.*

[Return to Zoning Code- Table of Contents](#)

Section 23A- MX ZONE

23.00A- Mixed Use Zone- Multi-Family and Miscellaneous Uses as shown in the Use Schedule, Section 60. The geographic locations of the zones are shown on the official zoning map.

23.01A- Lot Sizes- Multi-Family Uses proposals shall comply with the requirements of the M zones.

Other uses, authorized in the Use Schedule, shall comply with the requirements in the Special Exception Provisions or as below, whichever is most restrictive.

LOT FRONTAGE: 75 feet (minimum)

LOT AREA: 10,000 sq. ft. (minimum)

23.02A- Yards- Front yard setback 25 feet; Other yards one foot for each foot of wall height except that no yard shall be less than 10 feet.

23.03A- Height- Maximum height of a structure in this zone, unless specifically permitted elsewhere herein, shall be three stories or thirty-six feet.

23.04A- Lot Coverage- The ground covered by the principal structure and its accessory building shall not be greater than 30 percent of the lot area.

23.05A- Off-Street Parking- Off-street parking spaces and related provisions shall be in accordance with Section 40.
(Addition effective 9/1/87.)

Planning and Zoning Code- Section 60

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[Return to Zoning Code- Table of Contents](#)

SECTION 60- RESIDENTIAL ZONES AND SOME T.D. ZONE USE SCHEDULES-

60.00- No land shall be used or occupied and no structure shall be erected, constructed, reconstructed, altered or used, except for any use of the following permitted uses, special exception uses, accessory use, permitted Residential Unit Business Pursuit uses, or uses by temporary uses.

In any case where a use is alleged to be similar to a specified use referred to in the following schedule its status shall be determined by the Commission by reference to the most clearly similar use or uses that are specifically referred to in the use schedule or declared that the use is not similar. When the status of a use has been so determined, such determination shall thereafter have general applicability to all uses of the same type.

60.01- PERMITTED USES- The following uses may be operated as Permitted Uses:

- 60.01.01- Single-Family Dwelling, detached
ZONES: RPZ, R-30, R-45, R-60, TD*, M, MX, R-1, R-15
- 60.01.02- Two-Family Dwelling
ZONES: RPZ, TD*, M, MX
- 60.01.03- Farming or other agriculture uses--any green house that brings the total of such ground area to 5,000 sq. ft. or more shall be a Special Exception. Seasonal farm stands shall be allowed provided they receive site plan approval and are a part of a farming operation in excess of twenty (20) acres and selling only products grown on-site. Appropriate parking as determined during the site plan process shall be required.
ZONES: R-15, R-30, R-45, R-60, RPZ
(Amended effective 10/31/92)
- 60.01.04- Residential Unit Business Pursuit
ZONES: RPZ, R-30, R-45, R-60, TD*, M, MX, R-1, R-15
- 60.01.05- Park Land ZONES: PL
- 60.01.06- Business and Professional Offices
ZONES: IM
(Added effective 3/28/90)
- 60.01.07- Assisted Elderly Housing on city property and within 500 feet of an existing city operated elderly housing facility. Density 11 units per acre, parking in accordance with Section 40.04.18, all other requirements in accordance with the R-15 zone.

ZONES: R-15
(Amended effective 6/1/91)
(Revised effective 7/22/92)

60.02- SPECIAL EXCEPTION USES- the following uses by Special Exception may be permitted in accordance with the provision of SECTION 44:

- 60.02.01- Ambulance Service (44.08.01)
ZONES: TD (Amended Effective 5/15/14)
- 60.02.02- Child Care Facilities (44.08.02)
ZONES: RPZ, R-15, R-30, R-45, R-60, TD, M, MX, R-1
- 60.02.03- Conversion of existing residential buildings to a different number of dwelling units. (44.08.22)
ZONES: MX, TD, RPZ (Amended effective January 30, 1998)
- 60.02.04- Fraternity and Sorority Houses (44.08.04)
ZONES: TD, MX
- 60.02.05- Private clubs, service organizations, including community buildings and similar recreational uses privately owned and/or operated (44.08.05)
ZONES: TD, MX
- 60.02.06- DELETED (Amended effective 5/1/97)
- 60.02.07- Housing for elderly or physically handicapped persons (44.08.07)
ZONES: TD, MX
- 60.02.08- Professional and business offices not including medical or dental clinics or mental health/substance abuse treatment facilities, offices or clinics (44.08.08)
ZONES: TD, MX
(Amended effective 5/1/97)
- 60.02.09- Neighborhood stores (44.08.09)
ZONES: TD, MX
- 60.02.10- Two (2) family dwellings and single family dwellings with less than fifty (50) feet of frontage on lots of record (44.08.28)
ZONES: RPZ
(amended effective 6/30/92)
- 60.02.11- Public Utility buildings and structures (44.08.11) ZONES: All zones
(effective 1/25/89)
- 60.02.12- DELETED (Amended effective 5/1/97)
- 60.02.13- Multi-family Dwelling (44.08.21) ZONES: M, MX, TD, MR (Added effective 2/20/89) IM (Added effective 3/28/90)
- 60.02.14- Natural Resource Extraction (44.08.10)(Effective 5/1/86) ZONES: R-45, R-60, R-1, R-15, R-30
- 60.02.15- Adaptive residential use for structures currently or recently occupied by non-conforming use.
(effective 5/1/89)
ZONES: RPZ, R-15, R-30, R-45, R-60, TD, M, MX

- 60.02.16- Adaptive historic preservation use harmonious with the physical characteristics and originally designed use of the structure (44.08.26)
ZONES: ALL ZONES
- 60.02.17- Banking facilities with the drive-up windows (44.08.12) ZONES: TD
(Amended Effective 5/15/14)
- 60.02.18- Restaurants, providing services for customers either at counters or at tables including sale of alcoholic beverages
ZONES: RF
- 60.02.19- Marinas and boatyards for the building, storage, repair, sale, or rental of boats; docks, wharfs, piers for the storage and transport of goods, merchandise, and/or people. If such a facility is located adjacent to an industrial zone, it shall be treated as a permitted use subject to site plan approval. (44.04)
ZONE: RF
(Amended effective 6/30/92)
- 60.02.20- Cemeteries and other places of burial of the dead (44.04) ZONES: R-45, R-60, R-1, R-15, R-30, M (Amended effective (10/15/13)
- 60.02.21- Churches and other places of worship, including parish houses. Parish house shall include a one or two family house used by a Church as personal residence by members of its clergy and/or its fulltime employees.
ZONES: RPZ, R-15, R-30, R-45, R-60, R-1, MX
(Added effective 3/1/91)
- 60.02.22- Convents, monasteries and similar uses
ZONES: RPZ, R-15, R-30, R-45, R-60, R-1
- 60.02.23- Educational Institutions
ZONES: RPZ, R-15, R-30, R-45, R-60, R-1
- 60.02.24- Group Homes pursuant to Section 16.07.05 of the Zoning Code provided said Use shall not be within twenty-five hundred (2,500) feet of another group home as defined by 16.07.05. Parking shall be provided at a rate of one (1) space for each adult resident. As a reasonable accommodation the Commission may waive any requirement, including the public hearing process, during the special exception process.
ZONES: RPZ, R-15, R-30, R-45, R-60 (Modified effective 3/31/04)
- 60.02.25- Libraries, museums and similar institutions of non-commercial nature
ZONES: MX, TD, M (Modified effective 12/29/11)
- 60.02.26- NONE
- 60.02.27- Outdoor Recreational uses such as: Parks, Playgrounds, Playfields, Golf courses, Boating areas, Community buildings, Developed open space, such as Arboreta, Botanical and Zoological gardens and similar recreational uses.
ZONES: R-15, R-30, R-45, R-60, RF, R-1 (Revised 2/15/88)
- 60.02.28- Existing Neighborhood Restaurants not to exceed 1800 square feet. Drive-thru permitted by Special Exception. (Amended effective 7/30/04)
ZONES: MX (Added effective 2/28/94)
- 60.02.29- Care/Nursing Homes (44.08.29)
ZONES: TD, MX, M (Amended effective 7/1/95)
- 60.02.30- Bed and Breakfast in the RPZ (44.08.30)
ZONES: TD, MX, RPZ, R-15 (Amended effective 6/5/09)

- 60.02.31- NONE
- 60.02.32- Bus stop Passenger Shelter (44.08.25)
ZONES: ALL ZONES
- 60.02.33- Deleted (Amended Effective 5/15/14)
- 60.02.34- Veterinary Hospitals/Practice (44.08.34)
ZONES: RPZ (Added effective 7/11/90)
- 60.02.35- Leaf Composting Area (44.08.37)
ZONES: ID, R-45, R-60 (Added effective 6/30/92)
- 60.02.36- Adaptive Reuse as a professional office of a structure formerly used a place of congregation for members of a religious faith (44.08.38)
ZONE: RPZ (Added effective 5/30/94)
- 60.02.37- Modification of Frontage and Area Requirements on Lots Established Subsequent to 1982
ZONE: R-1 (Added effective 4/30/95)
- 60.02.38- Permanent Year Round Farm Markets
ZONES: R-30, R-45, R-60 (Added effective 6/1/01) RPZ (Added effective 3/30/07)
- 60.02.39- Active Adult Housing
ZONES: RPZ, R-15, R-30 (Added effective 9/1/03)
- 60.02.40- Elderly Housing within 500 feet of an existing housing facility. Density 11 units per acre, parking in accordance with the R-15 zone. ZONE:R-15 (Added effective 5/31/05)
- 60.02.41- Mixed Use Development (44.08.45)
ZONES MX (Added effective 3/30/13)
- 60.02.42- "On properties that contain" Existing Age Restricted (55 & Older Multi-Family Housing density not to exceed 24 units per acre on property having at least 2 ½ acres or more. ZONE M (Added effective 10/25/13)

60.03- ACCESSORY USES- The following accessory uses shall be permitted in accordance with the provisions of subsection 10.07 of this code.

- 60.03.01- Uses customarily incidental to the main or principal building or land use.
ZONES: ALL ZONES
- 60.03.02- Required off-street parking and loading space
ZONES: ALL ZONES
- 60.03.03- Business offices, provided that there is conducted in said office only business incidental to the rental, operation, service and maintenance of the dwelling.
ZONES: TD, M, MX
- 60.03.04- Incidental services for the convenience of occupants, such as news stands, snack bars, personal service shops, provided that not more than five (5) percent of the total floor area of the building is used.
ZONES: TD, M, MX
- 60.03.05- In addition to the permitted uses set forth in Section 39.02.01- .02, uses customarily incidental to the main or principal building or land use and as

set forth elsewhere in this code shall be permitted, including employees within such buildings, such as garages, but not limited to cafeterias and like facilities designed to serve only the occupants of the buildings in the zone. Conference and meeting facilities, data processing and storage shall be included within the definition of accessory uses.

ZONES: IM (Added effective 3/28/90)

60.04- NONE

60.05- USES BY TEMPORARY PERMIT- The following are permitted as temporary uses:

- 60.05.01- Temporary buildings or yards for construction material or equipment both incidental and necessary to construction within the immediate area, provided, however, that each permit shall be valid six (6) months and shall not be renewed for more than four (4) successive periods at the same location.

ALL ZONES

- 60.05.02- Temporary office or model house, both incidental and necessary for sale or rental of real property within the immediate area provided, however, that each permit shall be valid for a period of not more than four (4) successive periods at the same location.

ALL ZONES

60.06- PROHIBITED USES- Any use not specified as a permitted use, special exception, accessory use, permitted home occupation use or use by temporary permit are prohibited uses.

- 60.06.01- JUNK YARDS-
ZONES ALL (Added eff. 1/22/03)

* TD- Transitional Development Zone- All proposals treated as Special Exception Uses.

* Eliminated Meeting 1/6/88 effective 1/18/88

TECHNICAL MEMORANDUM

TO: Attorney Tim Hollister
Shipman and Goodwin

FROM: Mark Vertucci, PE, PTOE
Fuss & O'Neill, Inc.

DATE: September 16, 2020

RE: Response to Town Planner, PZC, and Public Traffic Comments
Proposed Root Center Substance Abuse Treatment Facility
Route 66 (Washington Street), Middletown, CT

This memorandum will summarize our response to a variety of traffic related comments that were raised last week in the memo provided by the City Planner Marek Kozikowski, AICP, dated September 8, 2020 as well as in the PZC meeting on September 9, 2020.

City Planner Comments:

1. Trip Generation – Rates for the ITE land use code “clinic” were chosen as they most closely resemble the anticipated operations at the treatment facility. By ITE definition, a “clinic” is any facility that provides limited diagnostic and/or outpatient care but is unable to provide prolonged in-house medical and surgical care. A review of trip generation rates for a clinic were similar to operational data provided by the Root Center in the morning peak hour and higher than what is typically experienced by Root Center’s other facilities in the afternoon peak hour. The trip generation rates utilized in this study should be considered conservative in the afternoon peak hour.
2. Driveway Level of Service – The LOS for vehicles exiting the site driveway is projected to be F during both peak hours, the same as what currently exists on the auto repair driveway and at the majority of the commercial access driveways along the corridor. This LOS F operation is unavoidable given the significant background traffic volumes that currently exist along Washington Street and the driveway does not warrant a traffic signal based on CTDOT and MUTCD criteria. It should be noted that LOS is a measure of vehicle delay, not intersection safety, and a LOS F operation is not correlated to crash rates and how “dangerous” the intersection is.

While vehicles exiting the site are delayed, the site has been designed with parking in the rear and can accommodate several queued vehicles along the driveway approach to Washington Street. Queue analysis revealed that these queues will rarely exceed two vehicles. It is important to note that these delayed vehicles experiencing LOS F conditions are stored and confined along the site driveway approach and do not impact traffic operations on Washington Street.

The presence of the traffic signal at the nearby intersection with Route 3 (Newfield Street) was observed to provide gaps in traffic enabling vehicles to exit the site.

3. **Crash Analysis** – the crash analysis was conducted by reviewing all crashes that occurred in the last three years along the site frontage and within 200 feet of the site driveway in each direction. The analysis revealed that there were no crashes reported involving a vehicle turning into or out of the existing site driveway and no identifiable crash patterns that would be exacerbated by the proposed development traffic. With the exception of one injury crash, all of the crashes reported were property damage only. There were no fatalities.

As noted in Steven Zuckerman's presentation, the treatments patients receive do not impact the patient's ability to drive a vehicle. The majority of the patients receiving treatment in the morning peak hour leave the site and drive into work. Additionally, there have not been higher than normal crash rates reported at the site driveways of other Root Center facilities.

PZC/Public Comments:

1. **Existing Trip Generation from auto repair shop is overestimated** – The owner of the existing auto shop indicated that the estimated ITE trip generation rates for the existing shop seemed high. The main point of providing a trip generation comparison is to illustrate the site is generating traffic today and therefore the proposed development will not be generating all "new" traffic to the road network. At least a portion of this site generated traffic exists today. Regardless of the trip generation of the existing site (even if it was zero), there would be no change to the findings of the traffic study that the proposed development will not significantly impact traffic operations on Washington Street.
2. **Transit and Pedestrian Traffic** – It is anticipated that a significant number of patients will arrive to the site by foot or via transit which will serve to reduce the overall traffic generation from the site. Good transit and pedestrian accommodations are provided nearby. Middletown Transit Route 583 runs past the site with stops permitted close by near the intersection with Newfield and Vine Street. A sidewalk also exists along the north side of Washington Street along the site frontage and continues east to the Newfield/Vine Street signalized intersection where crosswalks and exclusive pedestrian signal phasing are provided.
3. **Left Turns into the Site** – left turns into the site are projected to operate at the most efficient traffic operation (LOS A) with average queues less than one vehicle length. A vehicle waiting to turn left into the site in the left travel lane will not be there long as the traffic signal at Newfield Street provides frequent gaps in traffic. In addition, it is noted that any vehicle waiting in the left travel lane can be bypassed in the right travel lane.

Tim Hollister
September 16, 2020
Page 3 of 3

4. Butternut Street – This approach to Washington Street experiences peak hour delays similar to many of the commercial driveways that exist along Washington Street. This is an existing condition. The proposed development will add a projected 10 peak hour trips to Washington Street at this intersection. This equates to a negligible 0.04% increase in traffic on Washington Street, which in comparison currently handles 2,500+ vehicles in the peak hours. This increase in traffic is well below the daily fluctuations in traffic that already occur at this intersection and will not be noticeable to the driver.

5. Background traffic volumes – it was noted that the base 2016 CTDOT traffic volumes utilized in this study were taken before several new developments came on line on Washington Street in the past 5 years. These developments were factored in the study by growing the 2016 counts to the 2021 design year using an 0.75% per year growth factor to account for normal growth of traffic. These grown 2021 background traffic volumes were used as a basis for the study. These volumes, while grown, should be considered highly conservative as current traffic volumes in the State of CT are running 20% below normal on average.

Root Center – Proposed Middletown Clinic
September 16, 2020

**Re: Middletown PCD Staff Comments dated September 8, 2020
"Issues Remaining to be Addressed"**

The following are Tecton's responses to two specific architectural comments for the team's consideration and addition to the consolidated response. Only one requires a revision to the architectural drawings.

• **Item #5, #6 & #7 ...Rear Facing Building:**

Tecton believes the most appropriate building entrance and operational plan orientation is as submitted, and the design complies with current regulations, for the following reasons:

1. Per page 5 of 7, 1st paragraph, Compliance with City Plan (2nd sentence) "The planning and Zoning Commission has not yet adopted form-based design standard for this section of Washington Street". While we believe our façade design, proportions, and materiality appeal to the guidelines of a form-based code and an enhanced streetscape fabric, we do not feel this comment compels us to comply with a street-front entrance.
2. Federal regulations regarding privacy rights of patients specifically recognize those receiving substance abuse treatment as entitled to have the fact and records of their treatment be private. Providing a rear entrance and a side exit at a treatment facility ideally provides for such privacy and confidentiality. Further, this facility is not a walk-in retail medical destination. Visits are scheduled, and the current design intentionally separates the primary patient pedestrian flow from the vehicular movement and streetscape activity. The daily entrance from the parking lot within the site is most appropriate.
3. The front of the building is designed to have an architectural aesthetic befitting a main façade and active business brand. The high-end materials are the same as the west and north facades, the windows are large with clear glass (contrary to commentary), and the landscaping is enhanced. The DRPB found the design to be attractive and appropriate, with unanimous approval.

• **Item #7...More than one Building Sign**

In the attached revised building views, we have eliminated the Root building mounted signage on the entrance elevation to the north. We have also eliminated the monument signage, as the building mounted signage that faces Washington Avenue offers good brand visibility and is well integrated into the façade design.

I trust the above appropriately responds to the PCD comments.
Best Regards,



Ted Cutler, AIA, LEED AP
Principal & CEO

Code of Federal Regulations
Title 42. Public Health
Chapter I. Public Health Service, Department of Health and Human Services
Subchapter A. General Provisions
Part 2. Confidentiality of Substance Use Disorder Patient Records

C.F.R. T. 42, Ch. I, Subch. A, Pt. 2, Refs & Annos
Currentness

Authority: 42 U.S.C. 290dd-2.

Credits

Source: 82 FR 6115, Jan. 18, 2017; 82 FR 10863, Feb. 16, 2017, unless otherwise noted.

Current through September 10, 2020; 85 FR 56106.

End of Document

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Code of Federal Regulations
Title 42. Public Health
Chapter I. Public Health Service, Department of Health and Human Services (Refs & Annos)
Subchapter A. General Provisions
Part 2. Confidentiality of Substance Use Disorder Patient Records (Refs & Annos)
Subpart A. Introduction

42 C.F.R. § 2.1

§ 2.1 Statutory authority for confidentiality of substance use disorder patient records.

Effective: March 21, 2017
Currentness

Title 42, United States Code, Section 290dd-2(g) authorizes the Secretary to prescribe regulations. Such regulations may contain such definitions, and may provide for such safeguards and procedures, including procedures and criteria for the issuance and scope of orders, as in the judgment of the Secretary are necessary or proper to effectuate the purposes of this statute, to prevent circumvention or evasion thereof, or to facilitate compliance therewith.

SOURCE: 82 FR 6115, Jan. 18, 2017; 82 FR 10863, Feb. 16, 2017, unless otherwise noted.

AUTHORITY: 42 U.S.C. 290dd-2.

Notes of Decisions (6)

Current through September 10, 2020; 85 FR 56106.

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Code of Federal Regulations
Title 42. Public Health
Chapter I. Public Health Service, Department of Health and Human Services (Refs & Annos)
Subchapter A. General Provisions
Part 2. Confidentiality of Substance Use Disorder Patient Records (Refs & Annos)
Subpart A. Introduction

42 C.F.R. § 2.2

§ 2.2 Purpose and effect.

Effective: March 21, 2017
Currentness

(a) Purpose. Pursuant to 42 U.S.C. 290dd-2(g), the regulations in this part impose restrictions upon the disclosure and use of substance use disorder patient records which are maintained in connection with the performance of any part 2 program. The regulations in this part include the following subparts:

- (1) Subpart B of this part: General Provisions, including definitions, applicability, and general restrictions;
- (2) Subpart C of this part: Disclosures with Patient Consent, including disclosures which require patient consent and the consent form requirements;
- (3) Subpart D of this part: Disclosures without Patient Consent, including disclosures which do not require patient consent or an authorizing court order; and
- (4) Subpart E of this part: Court Orders Authorizing Disclosure and Use, including disclosures and uses of patient records which may be made with an authorizing court order and the procedures and criteria for the entry and scope of those orders.

(b) Effect.

- (1) The regulations in this part prohibit the disclosure and use of patient records unless certain circumstances exist. If any circumstance exists under which disclosure is permitted, that circumstance acts to remove the prohibition on disclosure but it does not compel disclosure. Thus, the regulations do not require disclosure under any circumstances.
- (2) The regulations in this part are not intended to direct the manner in which substantive functions such as research, treatment, and evaluation are carried out. They are intended to ensure that a patient receiving treatment for a substance use disorder in a part 2 program is not made more vulnerable by reason of the availability of their patient record than an individual with a substance use disorder who does not seek treatment.

(3) Because there is a criminal penalty for violating the regulations, they are to be construed strictly in favor of the potential violator in the same manner as a criminal statute (see *M. Kraus & Brothers v. United States*, 327 U.S. 614, 621–22, 66 S. Ct. 705, 707–08 (1946)).

SOURCE: 82 FR 6115, Jan. 18, 2017; 82 FR 10863, Feb. 16, 2017, unless otherwise noted.

AUTHORITY: 42 U.S.C. 290dd–2.

Notes of Decisions (8)

Current through September 10, 2020; 85 FR 56106.

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Code of Federal Regulations
Title 42. Public Health
Chapter I. Public Health Service, Department of Health and Human Services (Refs & Annos)
Subchapter A. General Provisions
Part 2. Confidentiality of Substance Use Disorder Patient Records (Refs & Annos)
Subpart A. Introduction

42 C.F.R. § 2.3

§ 2.3 Criminal penalty for violation.

Effective: March 21, 2017
Currentness

Under 42 U.S.C. 290dd-2(f), any person who violates any provision of this section or any regulation issued pursuant to this section shall be fined in accordance with Title 18 of the U.S. Code.

SOURCE: 82 FR 6115, Jan. 18, 2017; 82 FR 10863, Feb. 16, 2017, unless otherwise noted.

AUTHORITY: 42 U.S.C. 290dd-2.

Notes of Decisions (2)

Current through September 10, 2020; 85 FR 56106.

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Code of Federal Regulations
Title 42. Public Health
Chapter I. Public Health Service, Department of Health and Human Services (Refs & Annos)
Subchapter A. General Provisions
Part 2. Confidentiality of Substance Use Disorder Patient Records (Refs & Annos)
Subpart A. Introduction

42 C.F.R. § 2.4

§ 2.4 Reports of violations.

Effective: March 21, 2017
Currentness

(a) The report of any violation of the regulations in this part may be directed to the United States Attorney for the judicial district in which the violation occurs.

(b) The report of any violation of the regulations in this part by an opioid treatment program may be directed to the United States Attorney for the judicial district in which the violation occurs as well as to the Substance Abuse and Mental Health Services Administration (SAMHSA) office responsible for opioid treatment program oversight.

SOURCE: 82 FR 6115, Jan. 18, 2017; 82 FR 10863, Feb. 16, 2017, unless otherwise noted.

AUTHORITY: 42 U.S.C. 290dd-2.

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Part 2. Confidentiality of Substance Use Disorder Patient Records (Refs & Annos)
Subpart B. General Provisions

42 C.F.R. § 2.11

§ 2.11 Definitions.

Effective: August 14, 2020
Currentness

For purposes of the regulations in this part:

Central registry means an organization which obtains from two or more member programs patient identifying information about individuals applying for withdrawal management or maintenance treatment for the purpose of avoiding an individual's concurrent enrollment in more than one treatment program.

Diagnosis means any reference to an individual's substance use disorder or to a condition which is identified as having been caused by that substance use disorder which is made for the purpose of treatment or referral for treatment.

Disclose means to communicate any information identifying a patient as being or having been diagnosed with a substance use disorder, having or having had a substance use disorder, or being or having been referred for treatment of a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person.

Federally assisted—see § 2.12(b).

Informant means an individual:

- (1) Who is a patient or employee of a part 2 program or who becomes a patient or employee of a part 2 program at the request of a law enforcement agency or official; and
- (2) Who at the request of a law enforcement agency or official observes one or more patients or employees of the part 2 program for the purpose of reporting the information obtained to the law enforcement agency or official.

Maintenance treatment means long-term pharmacotherapy for individuals with substance use disorders that reduces the pathological pursuit of reward and/or relief and supports remission of substance use disorder-related symptoms.

Member program means a withdrawal management or maintenance treatment program which reports patient identifying information to a central registry and which is in the same state as that central registry or is in a state that participates in data sharing with the central registry of the program in question.

Minor, as used in the regulations in this part, means an individual who has not attained the age of majority specified in the applicable state law, or if no age of majority is specified in the applicable state law, the age of 18 years.

Part 2 program means a federally assisted program (federally assisted as defined in § 2.12(b) and program as defined in this section). See § 2.12(e)(1) for examples.

Part 2 program director means:

- (1) In the case of a part 2 program that is an individual, that individual.
- (2) In the case of a part 2 program that is an entity, the individual designated as director or managing director, or individual otherwise vested with authority to act as chief executive officer of the part 2 program.

Patient means any individual who has applied for or been given diagnosis, treatment, or referral for treatment for a substance use disorder at a part 2 program. Patient includes any individual who, after arrest on a criminal charge, is identified as an individual with a substance use disorder in order to determine that individual's eligibility to participate in a part 2 program. This definition includes both current and former patients.

Patient identifying information means the name, address, social security number, fingerprints, photograph, or similar information by which the identity of a patient, as defined in this section, can be determined with reasonable accuracy either directly or by reference to other information. The term does not include a number assigned to a patient by a part 2 program, for internal use only by the part 2 program, if that number does not consist of or contain numbers (such as a social security, or driver's license number) that could be used to identify a patient with reasonable accuracy from sources external to the part 2 program.

Person means an individual, partnership, corporation, federal, state or local government agency, or any other legal entity, (also referred to as "individual or entity").

Program means:

- (1) An individual or entity (other than a general medical facility) who holds itself out as providing, and provides, substance use disorder diagnosis, treatment, or referral for treatment; or
- (2) An identified unit within a general medical facility that holds itself out as providing, and provides, substance use disorder diagnosis, treatment, or referral for treatment; or
- (3) Medical personnel or other staff in a general medical facility whose primary function is the provision of substance use disorder diagnosis, treatment, or referral for treatment and who are identified as such providers.

Qualified service organization means an individual or entity who:

- (1) Provides services to a part 2 program, such as data processing, bill collecting, dosage preparation, laboratory analyses, or legal, accounting, population health management, medical staffing, or other professional services, or services to prevent or treat child abuse or neglect, including training on nutrition and child care and individual and group therapy, and
- (2) Has entered into a written agreement with a part 2 program under which that individual or entity:
 - (i) Acknowledges that in receiving, storing, processing, or otherwise dealing with any patient records from the part 2 program, it is fully bound by the regulations in this part; and
 - (ii) If necessary, will resist in judicial proceedings any efforts to obtain access to patient identifying information related to substance use disorder diagnosis, treatment, or referral for treatment except as permitted by the regulations in this part.

Records means any information, whether recorded or not, created by, received, or acquired by a part 2 program relating to a patient (e.g., diagnosis, treatment and referral for treatment information, billing information, emails, voice mails, and texts), provided, however, that information conveyed orally by a part 2 program to a non-part 2 provider for treatment purposes with the consent of the patient does not become a record subject to this Part in the possession of the non-part 2 provider merely because that information is reduced to writing by that non-part 2 provider. Records otherwise transmitted by a part 2 program to a non-part 2 provider retain their characteristic as records in the hands of the non-part 2 provider, but may be segregated by that provider. For the purpose of the regulations in this part, records include both paper and electronic records.

Substance use disorder means a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems such as impaired control, social impairment, risky use, and pharmacological tolerance and withdrawal. For the purposes of the regulations in this part, this definition does not include tobacco or caffeine use.

Third-party payer means an individual or entity who pays and/or agrees to pay for diagnosis or treatment furnished to a patient on the basis of a contractual relationship with the patient or a member of the patient's family or on the basis of the patient's eligibility for federal, state, or local governmental benefits.

Treating provider relationship means that, regardless of whether there has been an actual in-person encounter:

- (1) A patient is, agrees to, or is legally required to be diagnosed, evaluated, and/or treated, or agrees to accept consultation, for any condition by an individual or entity, and;
- (2) The individual or entity undertakes or agrees to undertake diagnosis, evaluation, and/or treatment of the patient, or consultation with the patient, for any condition.

Treatment means the care of a patient suffering from a substance use disorder, a condition which is identified as having been caused by the substance use disorder, or both, in order to reduce or eliminate the adverse effects upon the patient.

Undercover agent means any federal, state, or local law enforcement agency or official who enrolls in or becomes an employee of a part 2 program for the purpose of investigating a suspected violation of law or who pursues that purpose after enrolling or becoming employed for other purposes.

Withdrawal management means the use of pharmacotherapies to treat or attenuate the problematic signs and symptoms arising when heavy and/or prolonged substance use is reduced or discontinued.

Credits

[85 FR 43036, July 15, 2020]

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42 C.F.R. § 2.12

§ 2.12 Applicability.

Effective: August 14, 2020
Currentness

(a) General—

(1) Restrictions on disclosure. The restrictions on disclosure in the regulations in this part apply to any records which:

(i) Would identify a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person; and

(ii) Contain drug abuse information obtained by a federally assisted drug abuse program after March 20, 1972 (part 2 program), or contain alcohol abuse information obtained by a federally assisted alcohol abuse program after May 13, 1974 (part 2 program); or if obtained before the pertinent date, is maintained by a part 2 program after that date as part of an ongoing treatment episode which extends past that date; for the purpose of treating a substance use disorder, making a diagnosis for that treatment, or making a referral for that treatment.

(2) Restriction on use. The restriction on use of information to initiate or substantiate any criminal charges against a patient or to conduct any criminal investigation of a patient (42 U.S.C. 290dd-2(c)) applies to any information, whether or not recorded, which is drug abuse information obtained by a federally assisted drug abuse program after March 20, 1972 (part 2 program), or is alcohol abuse information obtained by a federally assisted alcohol abuse program after May 13, 1974 (part 2 program); or if obtained before the pertinent date, is maintained by a part 2 program after that date as part of an ongoing treatment episode which extends past that date; for the purpose of treating a substance use disorder, making a diagnosis for the treatment, or making a referral for the treatment.

(b) Federal assistance. A program is considered to be federally assisted if:

(1) It is conducted in whole or in part, whether directly or by contract or otherwise by any department or agency of the United States (but see paragraphs (c)(1) and (2) of this section relating to the Department of Veterans Affairs and the Armed Forces);

(2) It is being carried out under a license, certification, registration, or other authorization granted by any department or agency of the United States including but not limited to:

(i) Participating provider in the Medicare program;

(ii) Authorization to conduct maintenance treatment or withdrawal management; or

(iii) Registration to dispense a substance under the Controlled Substances Act to the extent the controlled substance is used in the treatment of substance use disorders;

(3) It is supported by funds provided by any department or agency of the United States by being:

(i) A recipient of federal financial assistance in any form, including financial assistance which does not directly pay for the substance use disorder diagnosis, treatment, or referral for treatment; or

(ii) Conducted by a state or local government unit which, through general or special revenue sharing or other forms of assistance, receives federal funds which could be (but are not necessarily) spent for the substance use disorder program; or

(4) It is assisted by the Internal Revenue Service of the Department of the Treasury through the allowance of income tax deductions for contributions to the program or through the granting of tax exempt status to the program.

(c) Exceptions—

(1) Department of Veterans Affairs. These regulations do not apply to information on substance use disorder patients maintained in connection with the Department of Veterans Affairs' provision of hospital care, nursing home care, domiciliary care, and medical services under Title 38, U.S.C. Those records are governed by 38 U.S.C. 7332 and regulations issued under that authority by the Secretary of Veterans Affairs.

(2) Armed Forces. The regulations in this part apply to any information described in paragraph (a) of this section which was obtained by any component of the Armed Forces during a period when the patient was subject to the Uniform Code of Military Justice except:

(i) Any interchange of that information within the Armed Forces; and

(ii) Any interchange of that information between the Armed Forces and those components of the Department of Veterans Affairs furnishing health care to veterans.

(3) Communication within a part 2 program or between a part 2 program and an entity having direct administrative control over that part 2 program. The restrictions on disclosure in the regulations in this part do not apply to communications

of information between or among personnel having a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment, or referral for treatment of patients with substance use disorders if the communications are:

(i) Within a part 2 program; or

(ii) Between a part 2 program and an entity that has direct administrative control over the program.

(4) Qualified service organizations. The restrictions on disclosure in the regulations in this part do not apply to communications between a part 2 program and a qualified service organization of information needed by the qualified service organization to provide services to the program.

(5) Crimes on part 2 program premises or against part 2 program personnel. The restrictions on disclosure and use in the regulations in this part do not apply to communications from part 2 program personnel to law enforcement agencies or officials which:

(i) Are directly related to a patient's commission of a crime on the premises of the part 2 program or against part 2 program personnel or to a threat to commit such a crime; and

(ii) Are limited to the circumstances of the incident, including the patient status of the individual committing or threatening to commit the crime, that individual's name and address, and that individual's last known whereabouts.

(6) Reports of suspected child abuse and neglect. The restrictions on disclosure and use in the regulations in this part do not apply to the reporting under state law of incidents of suspected child abuse and neglect to the appropriate state or local authorities. However, the restrictions continue to apply to the original substance use disorder patient records maintained by the part 2 program including their disclosure and use for civil or criminal proceedings which may arise out of the report of suspected child abuse and neglect.

(d) Applicability to recipients of information—

(1) Restriction on use of information. The restriction on the use of any information subject to the regulations in this part to initiate or substantiate any criminal charges against a patient or to conduct any criminal investigation of a patient applies to any person who obtains that information from a part 2 program, regardless of the status of the person obtaining the information or whether the information was obtained in accordance with the regulations in this part. This restriction on use bars, among other things, the introduction of that information as evidence in a criminal proceeding and any other use of the information to investigate or prosecute a patient with respect to a suspected crime. Information obtained by undercover agents or informants (see § 2.17) or through patient access (see § 2.23) is subject to the restriction on use.

(2) Restrictions on disclosures—

(i) Third-party payers, administrative entities, and others. The restrictions on disclosure in the regulations in this part apply to:

(A) Third-party payers with regard to records disclosed to them by part 2 programs or under § 2.31(a)(4)(I);

(B) Entities having direct administrative control over part 2 programs with regard to information that is subject to the regulations in this part communicated to them by the part 2 program under paragraph (c)(3) of this section; and

(C) Individuals or entities who receive patient records directly from a part 2 program or other lawful holder of patient identifying information and who are notified of the prohibition on re-disclosure in accordance with § 2.32.

(ii) Notwithstanding paragraph (d)(2)(i)(C) of this section, a non-part 2 treating provider may record information about a substance use disorder (SUD) and its treatment that identifies a patient. This is permitted and does not constitute a record that has been re-disclosed under part 2, provided that any SUD records received from a part 2 program or other lawful holder are segregated or segmented. The act of recording information about a SUD and its treatment does not by itself render a medical record which is created by a non-part 2 treating provider subject to the restrictions of this part 2.

(e) Explanation of applicability—

(1) Coverage. These regulations cover any information (including information on referral and intake) about patients receiving diagnosis, treatment, or referral for treatment for a substance use disorder created by a part 2 program. Coverage includes, but is not limited to, those treatment or rehabilitation programs, employee assistance programs, programs within general hospitals, school-based programs, and private practitioners who hold themselves out as providing, and provide substance use disorder diagnosis, treatment, or referral for treatment. However, the regulations in this part would not apply, for example, to emergency room personnel who refer a patient to the intensive care unit for an apparent overdose, unless the primary function of such personnel is the provision of substance use disorder diagnosis, treatment, or referral for treatment and they are identified as providing such services or the emergency room has promoted itself to the community as a provider of such services.

(2) Federal assistance to program required. If a patient's substance use disorder diagnosis, treatment, or referral for treatment is not provided by a part 2 program, that patient's record is not covered by the regulations in this part. Thus, it is possible for an individual patient to benefit from federal support and not be covered by the confidentiality regulations because the program in which the patient is enrolled is not federally assisted as defined in paragraph (b) of this section. For example, if a federal court placed an individual in a private for-profit program and made a payment to the program on behalf of that individual, that patient's record would not be covered by the regulations in this part unless the program itself received federal assistance as defined by paragraph (b) of this section.

(3) Information to which restrictions are applicable. Whether a restriction applies to the use or disclosure of a record affects the type of records which may be disclosed. The restrictions on disclosure apply to any part 2-covered records which would identify a specified patient as having or having had a substance use disorder. The restriction on use of part 2 records to bring criminal charges against a patient for a crime applies to any records obtained by the part 2 program for the purpose of diagnosis, treatment, or referral for treatment of patients with substance use disorders. (Restrictions on use and disclosure apply to recipients of part 2 records under paragraph (d) of this section.)

(4) How type of diagnosis affects coverage. These regulations cover any record reflecting a diagnosis identifying a patient as having or having had a substance use disorder which is initially prepared by a part 2 provider in connection with the treatment or referral for treatment of a patient with a substance use disorder. A diagnosis prepared by a part 2 provider for the purpose of treatment or referral for treatment, but which is not so used, is covered by the regulations in this part. The following are not covered by the regulations in this part:

(i) Diagnosis which is made solely for the purpose of providing evidence for use by law enforcement agencies or officials; or

(ii) A diagnosis of drug overdose or alcohol intoxication which clearly shows that the individual involved does not have a substance use disorder (e.g., involuntary ingestion of alcohol or drugs or reaction to a prescribed dosage of one or more drugs).

Credits

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42 C.F.R. § 2.13

§ 2.13 Confidentiality restrictions and safeguards.

Effective: August 14, 2020
Currentness

(a) General. The patient records subject to the regulations in this part may be disclosed or used only as permitted by the regulations in this part and may not otherwise be disclosed or used in any civil, criminal, administrative, or legislative proceedings conducted by any federal, state, or local authority. Any disclosure made under the regulations in this part must be limited to that information which is necessary to carry out the purpose of the disclosure.

(b) Unconditional compliance required. The restrictions on disclosure and use in the regulations in this part apply whether or not the part 2 program or other lawful holder of the patient identifying information believes that the person seeking the information already has it, has other means of obtaining it, is a law enforcement agency or official or other government official, has obtained a subpoena, or asserts any other justification for a disclosure or use which is not permitted by the regulations in this part.

(c) Acknowledging the presence of patients: Responding to requests.

(1) The presence of an identified patient in a health care facility or component of a health care facility which is publicly identified as a place where only substance use disorder diagnosis, treatment, or referral for treatment is provided may be acknowledged only if the patient's written consent is obtained in accordance with subpart C of this part or if an authorizing court order is entered in accordance with subpart E of this part. The regulations permit acknowledgement of the presence of an identified patient in a health care facility or part of a health care facility if the health care facility is not publicly identified as only a substance use disorder diagnosis, treatment, or referral for treatment facility, and if the acknowledgement does not reveal that the patient has a substance use disorder.

(2) Any answer to a request for a disclosure of patient records which is not permissible under the regulations in this part must be made in a way that will not affirmatively reveal that an identified individual has been, or is being, diagnosed or treated for a substance use disorder. An inquiring party may be provided a copy of the regulations in this part and advised that they restrict the disclosure of substance use disorder patient records, but may not be told affirmatively that the regulations restrict the disclosure of the records of an identified patient.

(d) List of disclosures. Upon request, patients who have consented to disclose their patient identifying information using a general designation pursuant to § 2.31(a)(4)(ii)(B) must be provided a list of entities to which their information has been disclosed pursuant to the general designation.

(1) Under this paragraph (d), patient requests:

(i) Must be made in writing; and

(ii) Are limited to disclosures made within the past two years;

(2) Under this paragraph (d), the entity named on the consent form that discloses information pursuant to a patient's general designation (the entity that serves as an intermediary, as described in § 2.31(a)(4)(ii)(B)) must:

(i) Respond in 30 or fewer days of receipt of the written request; and

(ii) Provide, for each disclosure, the name(s) of the entity(-ies) to which the disclosure was made, the date of the disclosure, and a brief description of the patient identifying information disclosed.

(3) The part 2 program is not responsible for compliance with this paragraph (d); the entity that serves as an intermediary, as described in § 2.31(a)(4)(ii)(B), is responsible for compliance with the requirement.

Credits

[85 FR 43037, July 15, 2020]

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42 C.F.R. § 2.14

§ 2.14 Minor patients.

Effective: March 21, 2017
Currentness

(a) State law not requiring parental consent to treatment. If a minor patient acting alone has the legal capacity under the applicable state law to apply for and obtain substance use disorder treatment, any written consent for disclosure authorized under subpart C of this part may be given only by the minor patient. This restriction includes, but is not limited to, any disclosure of patient identifying information to the parent or guardian of a minor patient for the purpose of obtaining financial reimbursement. These regulations do not prohibit a part 2 program from refusing to provide treatment until the minor patient consents to the disclosure necessary to obtain reimbursement, but refusal to provide treatment may be prohibited under a state or local law requiring the program to furnish the service irrespective of ability to pay.

(b) State law requiring parental consent to treatment.

(1) Where state law requires consent of a parent, guardian, or other individual for a minor to obtain treatment for a substance use disorder, any written consent for disclosure authorized under subpart C of this part must be given by both the minor and their parent, guardian, or other individual authorized under state law to act in the minor's behalf.

(2) Where state law requires parental consent to treatment, the fact of a minor's application for treatment may be communicated to the minor's parent, guardian, or other individual authorized under state law to act in the minor's behalf only if:

(i) The minor has given written consent to the disclosure in accordance with subpart C of this part; or

(ii) The minor lacks the capacity to make a rational choice regarding such consent as judged by the part 2 program director under paragraph (c) of this section.

(c) Minor applicant for services lacks capacity for rational choice. Facts relevant to reducing a substantial threat to the life or physical well-being of the minor applicant or any other individual may be disclosed to the parent, guardian, or other individual authorized under state law to act in the minor's behalf if the part 2 program director judges that:

(1) A minor applicant for services lacks capacity because of extreme youth or mental or physical condition to make a rational decision on whether to consent to a disclosure under subpart C of this part to their parent, guardian, or other individual authorized under state law to act in the minor's behalf; and

(2) The minor applicant's situation poses a substantial threat to the life or physical well-being of the minor applicant or any other individual which may be reduced by communicating relevant facts to the minor's parent, guardian, or other individual authorized under state law to act in the minor's behalf.

SOURCE: 82 FR 6115, Jan. 18, 2017; 82 FR 10863, Feb. 16, 2017, unless otherwise noted.

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42 C.F.R. § 2.15

§ 2.15 Incompetent and deceased patients.

Effective: February 2, 2018
Currentness

(a) Incompetent patients other than minors—

(1) Adjudication of incompetence. In the case of a patient who has been adjudicated as lacking the capacity, for any reason other than insufficient age, to manage their own affairs, any consent which is required under the regulations in this part may be given by the guardian or other individual authorized under state law to act in the patient's behalf.

(2) No adjudication of incompetency. In the case of a patient, other than a minor or one who has been adjudicated incompetent, that for any period suffers from a medical condition that prevents knowing or effective action on their own behalf, the part 2 program director may exercise the right of the patient to consent to a disclosure under subpart C of this part for the sole purpose of obtaining payment for services from a third-party payer.

(b) Deceased patients—

(1) Vital statistics. These regulations do not restrict the disclosure of patient identifying information relating to the cause of death of a patient under laws requiring the collection of death or other vital statistics or permitting inquiry into the cause of death.

(2) Consent by personal representative. Any other disclosure of information identifying a deceased patient as having a substance use disorder is subject to the regulations in this part. If a written consent to the disclosure is required, that consent may be given by an executor, administrator, or other personal representative appointed under applicable state law. If there is no such applicable state law appointment, the consent may be given by the patient's spouse or, if none, by any responsible member of the patient's family.

Credits

[83 FR 251, Jan. 3, 2018]

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42 C.F.R. § 2.16

§ 2.16 Security for records.

Effective: March 21, 2017
Currentness

(a) The part 2 program or other lawful holder of patient identifying information must have in place formal policies and procedures to reasonably protect against unauthorized uses and disclosures of patient identifying information and to protect against reasonably anticipated threats or hazards to the security of patient identifying information. These formal policies and procedures must address:

(1) Paper records, including:

(i) Transferring and removing such records;

(ii) Destroying such records, including sanitizing the hard copy media associated with the paper printouts, to render the patient identifying information non-retrievable;

(iii) Maintaining such records in a secure room, locked file cabinet, safe, or other similar container, or storage facility when not in use;

(iv) Using and accessing workstations, secure rooms, locked file cabinets, safes, or other similar containers, and storage facilities that use or store such information; and

(v) Rendering patient identifying information non-identifiable in a manner that creates a very low risk of re-identification (e.g., removing direct identifiers).

(2) Electronic records, including:

(i) Creating, receiving, maintaining, and transmitting such records;

(ii) Destroying such records, including sanitizing the electronic media on which such records are stored, to render the patient identifying information non-retrievable;

(iii) Using and accessing electronic records or other electronic media containing patient identifying information; and

(iv) Rendering the patient identifying information non-identifiable in a manner that creates a very low risk of re-identification (e.g., removing direct identifiers).

(b) [Reserved]

SOURCE: 82 FR 6115, Jan. 18, 2017; 82 FR 10863, Feb. 16, 2017, unless otherwise noted.

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42 C.F.R. § 2.17

§ 2.17 Undercover agents and informants.

Effective: March 21, 2017
Currentness

(a) Restrictions on placement. Except as specifically authorized by a court order granted under § 2.67, no part 2 program may knowingly employ, or enroll as a patient, any undercover agent or informant.

(b) Restriction on use of information. No information obtained by an undercover agent or informant, whether or not that undercover agent or informant is placed in a part 2 program pursuant to an authorizing court order, may be used to criminally investigate or prosecute any patient.

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42 C.F.R. § 2.18

§ 2.18 Restrictions on the use of identification cards.

Effective: March 21, 2017
Currentness

No person may require any patient to carry in their immediate possession while away from the part 2 program premises any card or other object which would identify the patient as having a substance use disorder. This section does not prohibit a person from requiring patients to use or carry cards or other identification objects on the premises of a part 2 program.

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42 C.F.R. § 2.19

§ 2.19 Disposition of records by discontinued programs.

Effective: March 21, 2017
Currentness

(a) General. If a part 2 program discontinues operations or is taken over or acquired by another program, it must remove patient identifying information from its records or destroy its records, including sanitizing any associated hard copy or electronic media, to render the patient identifying information non-retrievable in a manner consistent with the policies and procedures established under § 2.16, unless:

- (1) The patient who is the subject of the records gives written consent (meeting the requirements of § 2.31) to a transfer of the records to the acquiring program or to any other program designated in the consent (the manner of obtaining this consent must minimize the likelihood of a disclosure of patient identifying information to a third party); or
- (2) There is a legal requirement that the records be kept for a period specified by law which does not expire until after the discontinuation or acquisition of the part 2 program.

(b) Special procedure where retention period required by law. If paragraph (a)(2) of this section applies:

(1) Records, which are paper, must be:

(i) Scaled in envelopes or other containers labeled as follows: "Records of [insert name of program] required to be maintained under [insert citation to statute, regulation, court order or other legal authority requiring that records be kept] until a date not later than [insert appropriate date]";

(A) All hard copy media from which the paper records were produced, such as printer and facsimile ribbons, drums, etc., must be sanitized to render the data non-retrievable; and

(B) [Reserved]

(ii) Held under the restrictions of the regulations in this part by a responsible person who must, as soon as practicable after the end of the required retention period specified on the label, destroy the records and sanitize any associated hard copy

media to render the patient identifying information non-retrievable in a manner consistent with the discontinued program's or acquiring program's policies and procedures established under § 2.16.

(2) Records, which are electronic, must be:

(i) Transferred to a portable electronic device with implemented encryption to encrypt the data at rest so that there is a low probability of assigning meaning without the use of a confidential process or key and implemented access controls for the confidential process or key; or

(ii) Transferred, along with a backup copy, to separate electronic media, so that both the records and the backup copy have implemented encryption to encrypt the data at rest so that there is a low probability of assigning meaning without the use of a confidential process or key and implemented access controls for the confidential process or key; and

(iii) Within one year of the discontinuation or acquisition of the program, all electronic media on which the patient records or patient identifying information resided prior to being transferred to the device specified in (i) above or the original and backup electronic media specified in (ii) above, including email and other electronic communications, must be sanitized to render the patient identifying information non-retrievable in a manner consistent with the discontinued program's or acquiring program's policies and procedures established under § 2.16; and

(iv) The portable electronic device or the original and backup electronic media must be:

(A) Sealed in a container along with any equipment needed to read or access the information, and labeled as follows: "Records of [insert name of program] required to be maintained under [insert citation to statute, regulation, court order or other legal authority requiring that records be kept] until a date not later than [insert appropriate date];" and

(B) Held under the restrictions of the regulations in this part by a responsible person who must store the container in a manner that will protect the information (e.g., climate controlled environment); and

(v) The responsible person must be included on the access control list and be provided a means for decrypting the data. The responsible person must store the decryption tools on a device or at a location separate from the data they are used to encrypt or decrypt; and

(vi) As soon as practicable after the end of the required retention period specified on the label, the portable electronic device or the original and backup electronic media must be sanitized to render the patient identifying information non-retrievable consistent with the policies established under § 2.16.

SOURCE: 82 FR 6115, Jan. 18, 2017; 82 FR 10863, Feb. 16, 2017, unless otherwise noted.

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42 C.F.R. § 2.20

§ 2.20 Relationship to state laws.

Effective: March 21, 2017
Currentness

The statute authorizing the regulations in this part (42 U.S.C. 290dd-2) does not preempt the field of law which they cover to the exclusion of all state laws in that field. If a disclosure permitted under the regulations in this part is prohibited under state law, neither the regulations in this part nor the authorizing statute may be construed to authorize any violation of that state law. However, no state law may either authorize or compel any disclosure prohibited by the regulations in this part.

SOURCE: 82 FR 6115, Jan. 18, 2017; 82 FR 10863, Feb. 16, 2017, unless otherwise noted.

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42 C.F.R. § 2.21

§ 2.21 Relationship to federal statutes protecting research
subjects against compulsory disclosure of their identity.

Effective: March 21, 2017
Currentness

(a) Research privilege description. There may be concurrent coverage of patient identifying information by the regulations in this part and by administrative action taken under section 502(c) of the Controlled Substances Act (21 U.S.C. 872(c) and the implementing regulations at 21 CFR part 1316); or section 301(d) of the Public Health Service Act (42 U.S.C. 241(d) and the implementing regulations at 42 CFR part 2a). These research privilege statutes confer on the Secretary of Health and Human Services and on the Attorney General, respectively, the power to authorize researchers conducting certain types of research to withhold from all persons not connected with the research the names and other identifying information concerning individuals who are the subjects of the research.

(b) Effect of concurrent coverage. These regulations restrict the disclosure and use of information about patients, while administrative action taken under the research privilege statutes and implementing regulations protects a person engaged in applicable research from being compelled to disclose any identifying characteristics of the individuals who are the subjects of that research. The issuance under subpart E of this part of a court order authorizing a disclosure of information about a patient does not affect an exercise of authority under these research privilege statutes.

SOURCE: 82 FR 6115, Jan. 18, 2017; 82 FR 10863, Feb. 16, 2017, unless otherwise noted.

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42 C.F.R. § 2.22

§ 2.22 Notice to patients of federal confidentiality requirements.

Effective: March 21, 2017
Currentness

(a) Notice required. At the time of admission to a part 2 program or, in the case that a patient does not have capacity upon admission to understand his or her medical status, as soon thereafter as the patient attains such capacity, each part 2 program shall:

(1) Communicate to the patient that federal law and regulations protect the confidentiality of substance use disorder patient records; and

(2) Give to the patient a summary in writing of the federal law and regulations.

(b) Required elements of written summary. The written summary of the federal law and regulations must include:

(1) A general description of the limited circumstances under which a part 2 program may acknowledge that an individual is present or disclose outside the part 2 program information identifying a patient as having or having had a substance use disorder;

(2) A statement that violation of the federal law and regulations by a part 2 program is a crime and that suspected violations may be reported to appropriate authorities consistent with § 2.4, along with contact information;

(3) A statement that information related to a patient's commission of a crime on the premises of the part 2 program or against personnel of the part 2 program is not protected;

(4) A statement that reports of suspected child abuse and neglect made under state law to appropriate state or local authorities are not protected; and

(5) A citation to the federal law and regulations.

(c) Program options. The part 2 program must devise a notice to comply with the requirement to provide the patient with a summary in writing of the federal law and regulations. In this written summary, the part 2 program also may include information concerning state law and any of the part 2 program's policies that are not inconsistent with state and federal law on the subject of confidentiality of substance use disorder patient records.

SOURCE: 82 FR 6115, Jan. 18, 2017; 82 FR 10863, Feb. 16, 2017, unless otherwise noted.

AUTHORITY: 42 U.S.C. 290dd-2.

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42 C.F.R. § 2.23

§ 2.23 Patient access and restrictions on use.

Effective: March 21, 2017
Currentness

(a) Patient access not prohibited. These regulations do not prohibit a part 2 program from giving a patient access to their own records, including the opportunity to inspect and copy any records that the part 2 program maintains about the patient. The part 2 program is not required to obtain a patient's written consent or other authorization under the regulations in this part in order to provide such access to the patient.

(b) Restriction on use of information. Information obtained by patient access to his or her patient record is subject to the restriction on use of this information to initiate or substantiate any criminal charges against the patient or to conduct any criminal investigation of the patient as provided for under § 2.12(d)(1).

SOURCE: 82 FR 6115, Jan. 18, 2017; 82 FR 10863, Feb. 16, 2017, unless otherwise noted.

AUTHORITY: 42 U.S.C. 290dd-2.

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42 C.F.R. § 2.31

§ 2.31 Consent requirements.

Effective: August 14, 2020
Currentness

(a) Required elements for written consent. A written consent to a disclosure under the regulations in this part may be paper or electronic and must include:

(1) The name of the patient.

(2) The specific name(s) or general designation(s) of the part 2 program(s), entity(ies), or individual(s) permitted to make the disclosure.

(3) How much and what kind of information is to be disclosed, including an explicit description of the substance use disorder information that may be disclosed.

(4)(i) General requirement for designating recipients. The name(s) of the individual(s) or the name(s) of the entity(-ies) to which a disclosure is to be made.

(ii) Special instructions for entities that facilitate the exchange of health information and research institutions. Notwithstanding paragraph (a)(4)(i) of this section, if the recipient entity facilitates the exchange of health information or is a research institution, a written consent must include the name(s) of the entity(-ies) and

(A) The name(s) of individual or entity participant(s); or

(B) A general designation of an individual or entity participant(s) or class of participants that must be limited to a participant(s) who has a treating provider relationship with the patient whose information is being disclosed. When using a general designation, a statement must be included on the consent form that the patient (or other individual authorized to sign in lieu of the patient), confirms their understanding that, upon their request and consistent with this part, they must be provided a list of entities to which their information has been disclosed pursuant to the general designation (see § 2.13(d)).

(5) The purpose of the disclosure. In accordance with § 2.13(a), the disclosure must be limited to that information which is necessary to carry out the stated purpose.

(6) A statement that the consent is subject to revocation at any time except to the extent that the part 2 program or other lawful holder of patient identifying information that is permitted to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third-party payer

(7) The date, event, or condition upon which the consent will expire if not revoked before. This date, event, or condition must ensure that the consent will last no longer than reasonably necessary to serve the purpose for which it is provided.

(8) The signature of the patient and, when required for a patient who is a minor, the signature of an individual authorized to give consent under § 2.14; or, when required for a patient who is incompetent or deceased, the signature of an individual authorized to sign under § 2.15. Electronic signatures are permitted to the extent that they are not prohibited by any applicable law.

(9) The date on which the consent is signed.

(b) Expired, deficient, or false consent. A disclosure may not be made on the basis of a consent which:

(1) Has expired;

(2) On its face substantially fails to conform to any of the requirements set forth in paragraph (a) of this section;

(3) Is known to have been revoked; or

(4) Is known, or through reasonable diligence could be known, by the individual or entity holding the records to be materially false.

Credits

[85 FR 43037, July 15, 2020]

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42 C.F.R. § 2.32

§ 2.32 Prohibition on re-disclosure.

Effective: August 14, 2020
Currentness

(a) Notice to accompany disclosure. Each disclosure made with the patient's written consent must be accompanied by one of the following written statements:

(1) This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65; or

(2) 42 CFR part 2 prohibits unauthorized disclosure of these records.

(b) [Reserved]

Credits

[83 FR 251, Jan. 3, 2018; 85 FR 43037, July 15, 2020]

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AUTHORITY: 42 U.S.C. 290dd-2.

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42 C.F.R. § 2.33

§ 2.33 Disclosures permitted with written consent.

Effective: August 14, 2020
Currentness

(a) If a patient consents to a disclosure of their records under § 2.31, a part 2 program may disclose those records in accordance with that consent to any person or category of persons identified or generally designated in the consent, except that disclosures to central registries and in connection with criminal justice referrals must meet the requirements of §§ 2.34 and 2.35, respectively.

(b) If a patient consents to a disclosure of their records under § 2.31 for payment or health care operations activities, a lawful holder who receives such records under the terms of the written consent may further disclose those records as may be necessary for its contractors, subcontractors, or legal representatives to carry out payment and/or health care operations on behalf of such lawful holder. In accordance with § 2.13(a), disclosures under this section must be limited to that information which is necessary to carry out the stated purpose of the disclosure. Examples of permissible payment or health care operations activities under this section include:

- (1) Billing, claims management, collections activities, obtaining payment under a contract for reinsurance, claims filing, and/or related health care data processing;
- (2) Clinical professional support services (e.g., quality assessment and improvement initiatives; utilization review and management services);
- (3) Patient safety activities;
- (4) Activities pertaining to:
 - (i) The training of student trainees and health care professionals;
 - (ii) The assessment of practitioner competencies;
 - (iii) The assessment of provider or health plan performance; and/or

- (iv) Training of non-health care professionals;
- (5) Accreditation, certification, licensing, or credentialing activities;
- (6) Underwriting, enrollment, premium rating, and other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits, and/or ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care;
- (7) Third-party liability coverage;
- (8) Activities related to addressing fraud, waste and/or abuse;
- (9) Conducting or arranging for medical review, legal services, and/or auditing functions;
- (10) Business planning and development, such as conducting cost management and planning-related analyses related to managing and operating, including formulary development and administration, development or improvement of methods of payment or coverage policies;
- (11) Business management and general administrative activities, including management activities relating to implementation of and compliance with the requirements of this or other statutes or regulations;
- (12) Customer services, including the provision of data analyses for policy holders, plan sponsors, or other customers;
- (13) Resolution of internal grievances;
- (14) The sale, transfer, merger, consolidation, or dissolution of an organization;
- (15) Determinations of eligibility or coverage (e.g., coordination of benefit services or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;
- (16) Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- (17) Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
- (18) Care coordination and/or case management services in support of payment or health care operations; and/or
- (19) Other payment/health care operations activities not expressly prohibited in this provision.

(c) Lawful holders who wish to disclose patient identifying information pursuant to paragraph (b) of this section must have in place a written contract or comparable legal instrument with the contractor or voluntary legal representative, which provides that the contractor, subcontractor, or voluntary legal representative is fully bound by the provisions of part 2 upon receipt of the patient identifying information. In making any such disclosures, the lawful holder must furnish such recipients with the notice required under § 2.32; require such recipients to implement appropriate safeguards to prevent unauthorized uses and disclosures; and require such recipients to report any unauthorized uses, disclosures, or breaches of patient identifying information to the lawful holder. The lawful holder may only disclose information to the contractor or subcontractor or voluntary legal representative that is necessary for the contractor or subcontractor or voluntary legal representative to perform its duties under the contract or comparable legal instrument. Contracts may not permit a contractor or subcontractor or voluntary legal representative to re-disclose information to a third party unless that third party is a contract agent of the contractor or subcontractor, helping them provide services described in the contract, and only as long as the agent only further discloses the information back to the contractor or lawful holder from which the information originated.

Credits

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42 C.F.R. § 2.34

§ 2.34 Disclosures to prevent multiple enrollments.

Effective: August 14, 2020
Currentness

(a) Restrictions on disclosure. A part 2 program, as defined in § 2.11, may disclose patient records to a central registry or to any withdrawal management or maintenance treatment program not more than 200 miles away for the purpose of preventing the multiple enrollment of a patient only if:

(1) The disclosure is made when:

(i) The patient is accepted for treatment;

(ii) The type or dosage of the drug is changed; or

(iii) The treatment is interrupted, resumed or terminated.

(2) The disclosure is limited to:

(i) Patient identifying information;

(ii) Type and dosage of the drug; and

(iii) Relevant dates.

(3) The disclosure is made with the patient's written consent meeting the requirements of § 2.31, except that:

(i) The consent must list the name and address of each central registry and each known withdrawal management or maintenance treatment program to which a disclosure will be made; and

(ii) The consent may authorize a disclosure to any withdrawal management or maintenance treatment program established within 200 miles of the program, but does not need to individually name all programs.

(b) Use of information limited to prevention of multiple enrollments. A central registry and any withdrawal management or maintenance treatment program to which information is disclosed to prevent multiple enrollments may not re-disclose or use patient identifying information for any purpose other than the prevention of multiple enrollments or to ensure appropriate coordinated care with a treating provider that is not a part 2 program unless authorized by a court order under subpart E of this part.

(c) Permitted disclosure by a central registry to prevent a multiple enrollment. When a member program asks a central registry if an identified patient is enrolled in another member program and the registry determines that the patient is so enrolled, the registry may disclose:

(1) The name, address, and telephone number of the member program(s) in which the patient is already enrolled to the inquiring member program; and

(2) The name, address, and telephone number of the inquiring member program to the member program(s) in which the patient is already enrolled. The member programs may communicate as necessary to verify that no error has been made and to prevent or eliminate any multiple enrollments.

(d) Permitted disclosure by a central registry to a non-member treating provider, to prevent a multiple enrollment. When, for the purpose of preventing multiple program enrollments or duplicative prescriptions, or to inform prescriber decision making regarding prescribing of opioid medication(s) or other prescribed substances, a provider with a treating provider relationship that is not a member program asks a central registry if an identified patient is enrolled in a member program, the registry may disclose:

(1) The name, address, and telephone number of the member program(s) in which the patient is enrolled;

(2) Type and dosage of any medication for substance use disorder being administered or prescribed to the patient by the member program(s); and

(3) Relevant dates of any such administration or prescription. The central registry and non-member program treating prescriber may communicate as necessary to verify that no error has been made and to prevent or eliminate any multiple enrollments or improper prescribing.

(e) Permitted disclosure by a withdrawal management or maintenance treatment program to prevent a multiple enrollment. A withdrawal management or maintenance treatment program which has received a disclosure under this section and has determined that the patient is already enrolled may communicate as necessary with the program making the disclosure to verify that no error has been made and to prevent or eliminate any multiple enrollments.

Credits

[85 FR 43038, July 15, 2020]

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42 C.F.R. § 2.35

§ 2.35 Disclosures to elements of the criminal justice system which have referred patients.

Effective: February 2, 2018
Currentness

(a) A part 2 program may disclose information about a patient to those individuals within the criminal justice system who have made participation in the part 2 program a condition of the disposition of any criminal proceedings against the patient or of the patient's parole or other release from custody if:

- (1) The disclosure is made only to those individuals within the criminal justice system who have a need for the information in connection with their duty to monitor the patient's progress (e.g., a prosecuting attorney who is withholding charges against the patient, a court granting pretrial or post-trial release, probation or parole officers responsible for supervision of the patient); and
- (2) The patient has signed a written consent meeting the requirements of § 2.31 (except paragraph (a)(6) of this section which is inconsistent with the revocation provisions of paragraph (c) of this section) and the requirements of paragraphs (b) and (c) of this section.

(b) Duration of consent. The written consent must state the period during which it remains in effect. This period must be reasonable, taking into account:

- (1) The anticipated length of the treatment;
- (2) The type of criminal proceeding involved, the need for the information in connection with the final disposition of that proceeding, and when the final disposition will occur; and
- (3) Such other factors as the part 2 program, the patient, and the individual(s) within the criminal justice system who will receive the disclosure consider pertinent.

(c) Revocation of consent. The written consent must state that it is revocable upon the passage of a specified amount of time or the occurrence of a specified, ascertainable event. The time or occurrence upon which consent becomes revocable may be no later than the final disposition of the conditional release or other action in connection with which consent was given.

(d) Restrictions on re-disclosure and use. An individual within the criminal justice system who receives patient information under this section may re-disclose and use it only to carry out that individual's official duties with regard to the patient's conditional release or other action in connection with which the consent was given.

Credits

[83 FR 251, Jan. 3, 2018]

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42 C.F.R. § 2.36

§ 2.36 Disclosures to prescription drug monitoring programs.

Effective: August 14, 2020
Currentness

A part 2 program or other lawful holder is permitted to report any SUD medication prescribed or dispensed by the part 2 program to the applicable state prescription drug monitoring program if required by applicable state law. A part 2 program or other lawful holder must obtain patient consent to a disclosure of records to a prescription drug monitoring program under § 2.31 prior to reporting of such information.

Credits

[85 FR 43038, July 15, 2020]

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42 C.F.R. § 2.51

§ 2.51 Medical emergencies.

Effective: August 14, 2020

Currentness

(a) General rule. Under the procedures required by paragraph (c) of this section, patient identifying information may be disclosed to medical personnel to the extent necessary to:

(1) Meet a bona fide medical emergency in which the patient's prior written consent cannot be obtained; or

(2) Meet a bona fide medical emergency in which a part 2 program is closed and unable to provide services or obtain the prior written consent of the patient, during a temporary state of emergency declared by a state or federal authority as the result of a natural or major disaster, until such time that the part 2 program resumes operations.

(b) Special rule. Patient identifying information may be disclosed to medical personnel of the Food and Drug Administration (FDA) who assert a reason to believe that the health of any individual may be threatened by an error in the manufacture, labeling, or sale of a product under FDA jurisdiction, and that the information will be used for the exclusive purpose of notifying patients or their physicians of potential dangers.

(c) Procedures. Immediately following disclosure, the part 2 program shall document, in writing, the disclosure in the patient's records, including:

(1) The name of the medical personnel to whom disclosure was made and their affiliation with any health care facility;

(2) The name of the individual making the disclosure;

(3) The date and time of the disclosure; and

(4) The nature of the emergency (or error, if the report was to FDA).

Credits

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42 C.F.R. § 2.52

§ 2.52 Research.

Effective: August 14, 2020
Currentness

(a) Notwithstanding other provisions of this part, including paragraph (b)(2) of this section, patient identifying information may be disclosed for the purposes of the recipient conducting scientific research if:

(1) The individual designated as director or managing director, or individual otherwise vested with authority to act as chief executive officer or their designee, of a part 2 program or other lawful holder of part 2 data, makes a determination that the recipient of the patient identifying information is:

(i) A HIPAA-covered entity or business associate that has obtained and documented authorization from the patient, or a waiver or alteration of authorization, consistent with the HIPAA Privacy Rule at 45 CFR 164.508 or 164.512(i), as applicable;

(ii) Subject to the HHS regulations regarding the protection of human subjects (45 CFR part 46), and provides documentation either that the researcher is in compliance with the requirements of 45 CFR part 46, including the requirements related to informed consent or a waiver of consent (45 CFR 46.111 and 46.116) or that the research qualifies for exemption under the HHS regulations (45 CFR 46.104) or any successor regulations;

(iii) Subject to the FDA regulations regarding the protection of human subjects (21 CFR parts 50 and 56) and provides documentation that the research is in compliance with the requirements of the FDA regulations, including the requirements related to informed consent or an exception to, or waiver of, consent (21 CFR part 50) and any successor regulations; or

(iv) Any combination of a HIPAA covered entity or business associate, and/or subject to the HHS regulations regarding the protection of human subjects, and/or subject to the FDA regulations regarding the protection of human subjects; and has met the requirements of paragraph (a)(1)(i), (ii) (iii), and/or (iv) of this section, as applicable.

(2) The part 2 program or other lawful holder of part 2 data is a HIPAA covered entity or business associate, and the disclosure is made in accordance with the HIPAA Privacy Rule requirements at 45 CFR 164.512(i).

(3) If neither paragraph (a)(1) or (2) of this section apply to the receiving or disclosing party, this section does not apply.

(b) Any individual or entity conducting scientific research using patient identifying information obtained under paragraph (a) of this section:

(1) Is fully bound by the regulations in this part and, if necessary, will resist in judicial proceedings any efforts to obtain access to patient records except as permitted by the regulations in this part.

(2) Must not re-disclose patient identifying information except back to the individual or entity from whom that patient identifying information was obtained or as permitted under paragraph (c) of this section.

(3) May include part 2 data in research reports only in aggregate form in which patient identifying information has been rendered non-identifiable such that the information cannot be re-identified and serve as an unauthorized means to identify a patient, directly or indirectly, as having or having had a substance use disorder.

(4) Must maintain and destroy patient identifying information in accordance with the security policies and procedures established under § 2.16.

(5) Must retain records in compliance with applicable federal, state, and local record retention laws.

(c) Data linkages—

(1) Researchers. Any individual or entity conducting scientific research using patient identifying information obtained under paragraph (a) of this section that requests linkages to data sets from a data repository(-ies) holding patient identifying information must:

(i) Have the request reviewed and approved by an Institutional Review Board (IRB) registered with the Department of Health and Human Services, Office for Human Research Protections in accordance with 45 CFR part 46 to ensure that patient privacy is considered and the need for identifiable data is justified. Upon request, the researcher may be required to provide evidence of the IRB approval of the research project that contains the data linkage component.

(ii) Ensure that patient identifying information obtained under paragraph (a) of this section is not provided to law enforcement agencies or officials.

(2)¹ Data repositories. For purposes of this section, a data repository is fully bound by the provisions of part 2 upon receipt of the patient identifying data and must:

(i) After providing the researcher with the linked data, destroy or delete the linked data from its records, including sanitizing any associated hard copy or electronic media, to render the patient identifying information non-retrievable in a manner consistent with the policies and procedures established under § 2.16 Security for records.

(ii) Ensure that patient identifying information obtained under paragraph (a) of this section is not provided to law enforcement agencies or officials.

(2)¹ Except as provided in paragraph (c) of this section, a researcher may not redisclose patient identifying information for data linkages purposes.

Credits

[85 FR 43038, July 15, 2020]

SOURCE: 82 FR 6115, Jan. 18, 2017; 82 FR 10863, Feb. 16, 2017, unless otherwise noted.

AUTHORITY: 42 U.S.C. 290dd-2.

Notes of Decisions (2)

Current through September 10, 2020; 85 FR 56106.

Footnotes

1 So in original; there are two subsections (c)(2). See 82 FR 6123.

1 So in original; there are two subsections (c)(2). See 82 FR 6123.

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Subpart D. Disclosures Without Patient Consent

42 C.F.R. § 2.53

§ 2.53 Audit and evaluation.

Effective: August 14, 2020
Currentness

(a) Records not copied or removed. If patient records are not downloaded, copied or removed from the premises of a part 2 program or other lawful holder, or forwarded electronically to another electronic system or device, patient identifying information, as defined in § 2.11, may be disclosed in the course of a review of records on the premises of a part 2 program or other lawful holder to any individual or entity who agrees in writing to comply with the limitations on re-disclosure and use in paragraph (f) of this section and who:

(1) Performs the audit or evaluation on behalf of:

(i) Any federal, state, or local governmental agency that provides financial assistance to a part 2 program or other lawful holder, or is authorized by law to regulate the activities of the part 2 program or other lawful holder;

(ii) Any individual or entity which provides financial assistance to the part 2 program or other lawful holder, which is a third-party payer covering patients in the part 2 program, or which is a quality improvement organization performing a QIO review, or the contractors, subcontractors, or legal representatives of such individual, entity, or quality improvement organization.

(iii) An entity with direct administrative control over the part 2 program or lawful holder.

(2) Is determined by the part 2 program or other lawful holder to be qualified to conduct an audit or evaluation of the part 2 program or other lawful holder.

(b) Copying, removing, downloading, or forwarding patient records. Records containing patient identifying information, as defined in § 2.11, may be copied or removed from the premises of a part 2 program or other lawful holder or downloaded or forwarded to another electronic system or device from the part 2 program's or other lawful holder's electronic records by any individual or entity who:

(1) Agrees in writing to:

(i) Maintain and destroy the patient identifying information in a manner consistent with the policies and procedures established under § 2.16;

(ii) Retain records in compliance with applicable federal, state, and local record retention laws; and

(iii) Comply with the limitations on disclosure and use in paragraph (f) of this section; and

(2) Performs the audit or evaluation on behalf of:

(i) Any federal, state, or local governmental agency that provides financial assistance to the part 2 program or other lawful holder, or is authorized by law to regulate the activities of the part 2 program or other lawful holder; or

(ii) Any individual or entity which provides financial assistance to the part 2 program or other lawful holder, which is a third-party payer covering patients in the part 2 program, or which is a quality improvement organization performing a QIO review, or the contractors, subcontractors, or legal representatives of such individual, entity, or quality improvement organization.

(iii) An entity with direct administrative control over the part 2 program or lawful holder.

(c) Activities included. Audits and evaluations under this section may include, but are not limited to:

(1) Activities undertaken by a federal, state, or local governmental agency, or a third-party payer entity, in order to:

(i) Identify actions the agency or third-party payer entity can make, such as changes to its policies or procedures, to improve care and outcomes for patients with SUDs who are treated by part 2 programs;

(ii) Ensure that resources are managed effectively to care for patients; or

(iii) Determine the need for adjustments to payment policies to enhance care or coverage for patients with SUD.

(2) Reviews of appropriateness of medical care, medical necessity, and utilization of services.

(d) Quality assurance entities included. Entities conducting audits or evaluations in accordance with paragraphs (a) and (b) of this section may include accreditation or similar types of organizations focused on quality assurance.

(e) Medicare, Medicaid, Children's Health Insurance Program (CHIP), or related audit or evaluation.

(1) Patient identifying information, as defined in § 2.11, may be disclosed under paragraph (e) of this section to any individual or entity for the purpose of conducting a Medicare, Medicaid, or CHIP audit or evaluation, including an audit or evaluation necessary to meet the requirements for a Centers for Medicare & Medicaid Services (CMS)-regulated accountable care organization (CMS-regulated ACO) or similar CMS-regulated organization (including a CMS-regulated Qualified Entity (QE)), if the individual or entity agrees in writing to comply with the following:

(i) Maintain and destroy the patient identifying information in a manner consistent with the policies and procedures established under § 2.16;

(ii) Retain records in compliance with applicable federal, state, and local record retention laws; and

(iii) Comply with the limitations on disclosure and use in paragraph (f) of this section.

(2) A Medicare, Medicaid, or CHIP audit or evaluation under this section includes a civil or administrative investigation of a part 2 program by any federal, state, or local government agency with oversight responsibilities for Medicare, Medicaid, or CHIP and includes administrative enforcement, against the part 2 program by the government agency, of any remedy authorized by law to be imposed as a result of the findings of the investigation.

(3) An audit or evaluation necessary to meet the requirements for a CMS-regulated ACO or similar CMS-regulated organization (including a CMS-regulated QE) must be conducted in accordance with the following:

(i) A CMS-regulated ACO or similar CMS-regulated organization (including a CMS-regulated QE) must:

(A) Have in place administrative and/or clinical systems; and

(B) Have in place a leadership and management structure, including a governing body and chief executive officer with responsibility for oversight of the organization's management and for ensuring compliance with and adherence to the terms and conditions of the Participation Agreement or similar documentation with CMS; and

(ii) A CMS-regulated ACO or similar CMS-regulated organization (including a CMS-regulated QE) must have a signed Participation Agreement or similar documentation with CMS, which provides that the CMS-regulated ACO or similar CMS-regulated organization (including a CMS-regulated QE):

(A) Is subject to periodic evaluations by CMS or its agents, or is required by CMS to evaluate participants in the CMS-regulated ACO or similar CMS-regulated organization (including a CMS-regulated QE) relative to CMS-defined or approved quality and/or cost measures;

(B) Must designate an executive who has the authority to legally bind the organization to ensure compliance with 42 U.S.C. 290dd-2 and this part and the terms and conditions of the Participation Agreement in order to receive patient identifying information from CMS or its agents;

(C) Agrees to comply with all applicable provisions of 42 U.S.C. 290dd-2 and this part;

(D) Must ensure that any audit or evaluation involving patient identifying information occurs in a confidential and controlled setting approved by the designated executive;

(E) Must ensure that any communications or reports or other documents resulting from an audit or evaluation under this section do not allow for the direct or indirect identification (e.g., through the use of codes) of a patient as having or having had a substance use disorder; and

(F) Must establish policies and procedures to protect the confidentiality of the patient identifying information consistent with this part, the terms and conditions of the Participation Agreement, and the requirements set forth in paragraph (e)(1) of this section.

(4) Program, as defined in § 2.11, includes an employee of, or provider of medical services under the program when the employee or provider is the subject of a civil investigation or administrative remedy, as those terms are used in paragraph (e)(2) of this section.

(5) If a disclosure to an individual or entity is authorized under this section for a Medicare, Medicaid, or CHIP audit or evaluation, including a civil investigation or administrative remedy, as those terms are used in paragraph (e)(2) of this section, the individual or entity may further disclose the patient identifying information that is received for such purposes to its contractor(s), subcontractor(s), or legal representative(s), to carry out the audit or evaluation, and a quality improvement organization which obtains such information under paragraph (a) or (b) of this section may disclose the information to that individual or entity (or, to such individual's or entity's contractors, subcontractors, or legal representatives, but only for the purposes of this section).

(6) The provisions of this paragraph do not authorize the part 2 program, the federal, state, or local government agency, or any other individual or entity to disclose or use patient identifying information obtained during the audit or evaluation for any purposes other than those necessary to complete the audit or evaluation as specified in paragraph (e) of this section.

(f) Limitations on disclosure and use. Except as provided in paragraph (e) of this section, patient identifying information disclosed under this section may be disclosed only back to the part 2 program or other lawful holder from which it was obtained and may be used only to carry out an audit or evaluation purpose or to investigate or prosecute criminal or other activities, as authorized by a court order entered under § 2.66.

(g) Audits and evaluations mandated by statute or regulation. Patient identifying information may be disclosed to federal, state, or local government agencies, and the contractors, subcontractors, and legal representatives of such agencies, in the course of conducting audits or evaluations mandated by statute or regulation, if those audits or evaluations cannot be carried out using deidentified information.

Credits

[83 FR 252, Jan. 3, 2018; 85 FR 43039, July 15, 2020]

SOURCE: 82 FR 6115, Jan. 18, 2017; 82 FR 10863, Feb. 16, 2017, unless otherwise noted.

AUTHORITY: 42 U.S.C. 290dd-2.

Notes of Decisions (11)

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42 C.F.R. § 2.61

§ 2.61 Legal effect of order.

Effective: March 21, 2017
Currentness

(a) Effect. An order of a court of competent jurisdiction entered under this subpart is a unique kind of court order. Its only purpose is to authorize a disclosure or use of patient information which would otherwise be prohibited by 42 U.S.C. 290dd-2 and the regulations in this part. Such an order does not compel disclosure. A subpoena or a similar legal mandate must be issued in order to compel disclosure. This mandate may be entered at the same time as and accompany an authorizing court order entered under the regulations in this part.

(b) Examples.

(1) A person holding records subject to the regulations in this part receives a subpoena for those records. The person may not disclose the records in response to the subpoena unless a court of competent jurisdiction enters an authorizing order under the regulations in this part.

(2) An authorizing court order is entered under the regulations in this part, but the person holding the records does not want to make the disclosure. If there is no subpoena or other compulsory process or a subpoena for the records has expired or been quashed, that person may refuse to make the disclosure. Upon the entry of a valid subpoena or other compulsory process the person holding the records must disclose, unless there is a valid legal defense to the process other than the confidentiality restrictions of the regulations in this part.

SOURCE: 82 FR 6115, Jan. 18, 2017; 82 FR 10863, Feb. 16, 2017, unless otherwise noted.

AUTHORITY: 42 U.S.C. 290dd-2.

Notes of Decisions (22)

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42 C.F.R. § 2.62

§ 2.62 Order not applicable to records disclosed without
consent to researchers, auditors and evaluators.

Effective: March 21, 2017
Currentness

A court order under the regulations in this part may not authorize qualified personnel, who have received patient identifying information without consent for the purpose of conducting research, audit or evaluation, to disclose that information or use it to conduct any criminal investigation or prosecution of a patient. However, a court order under § 2.66 may authorize disclosure and use of records to investigate or prosecute qualified personnel holding the records.

SOURCE: 82 FR 6115, Jan. 18, 2017; 82 FR 10863, Feb. 16, 2017, unless otherwise noted.

AUTHORITY: 42 U.S.C. 290dd-2.

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42 C.F.R. § 2.63

§ 2.63 Confidential communications.

Effective: March 21, 2017
Currentness

(a) A court order under the regulations in this part may authorize disclosure of confidential communications made by a patient to a part 2 program in the course of diagnosis, treatment, or referral for treatment only if:

(1) The disclosure is necessary to protect against an existing threat to life or of serious bodily injury, including circumstances which constitute suspected child abuse and neglect and verbal threats against third parties;

(2) The disclosure is necessary in connection with investigation or prosecution of an extremely serious crime allegedly committed by the patient, such as one which directly threatens loss of life or serious bodily injury, including homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, or child abuse and neglect; or

(3) The disclosure is in connection with litigation or an administrative proceeding in which the patient offers testimony or other evidence pertaining to the content of the confidential communications.

(b) [Reserved]

SOURCE: 82 FR 6115, Jan. 18, 2017; 82 FR 10863, Feb. 16, 2017, unless otherwise noted.

AUTHORITY: 42 U.S.C. 290dd-2.

Notes of Decisions (33)

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42 C.F.R. § 2.64.

§ 2.64 Procedures and criteria for orders authorizing disclosures for noncriminal purposes.

Effective: March 21, 2017

Currentness

(a) Application. An order authorizing the disclosure of patient records for purposes other than criminal investigation or prosecution may be applied for by any person having a legally recognized interest in the disclosure which is sought. The application may be filed separately or as part of a pending civil action in which the applicant asserts that the patient records are needed to provide evidence. An application must use a fictitious name, such as John Doe, to refer to any patient and may not contain or otherwise disclose any patient identifying information unless the patient is the applicant or has given written consent (meeting the requirements of the regulations in this part) to disclosure or the court has ordered the record of the proceeding sealed from public scrutiny.

(b) Notice. The patient and the person holding the records from whom disclosure is sought must be provided:

(1) Adequate notice in a manner which does not disclose patient identifying information to other persons; and

(2) An opportunity to file a written response to the application, or to appear in person, for the limited purpose of providing evidence on the statutory and regulatory criteria for the issuance of the court order as described in § 2.64(d).

(c) Review of evidence: Conduct of hearing. Any oral argument, review of evidence, or hearing on the application must be held in the judge's chambers or in some manner which ensures that patient identifying information is not disclosed to anyone other than a party to the proceeding, the patient, or the person holding the record, unless the patient requests an open hearing in a manner which meets the written consent requirements of the regulations in this part. The proceeding may include an examination by the judge of the patient records referred to in the application.

(d) Criteria for entry of order. An order under this section may be entered only if the court determines that good cause exists. To make this determination the court must find that:

(1) Other ways of obtaining the information are not available or would not be effective; and

(2) The public interest and need for the disclosure outweigh the potential injury to the patient, the physician-patient relationship and the treatment services.

(e) Content of order. An order authorizing a disclosure must:

- (1) Limit disclosure to those parts of the patient's record which are essential to fulfill the objective of the order;
- (2) Limit disclosure to those persons whose need for information is the basis for the order; and
- (3) Include such other measures as are necessary to limit disclosure for the protection of the patient, the physician-patient relationship and the treatment services; for example, sealing from public scrutiny the record of any proceeding for which disclosure of a patient's record has been ordered.

SOURCE: 82 FR 6115, Jan. 18, 2017; 82 FR 10863, Feb. 16, 2017, unless otherwise noted.

AUTHORITY: 42 U.S.C. 290dd-2.

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42 C.F.R. § 2.65

§ 2.65 Procedures and criteria for orders authorizing disclosure
and use of records to criminally investigate or prosecute patients.

Effective: March 21, 2017
Currentness

(a) Application. An order authorizing the disclosure or use of patient records to investigate or prosecute a patient in connection with a criminal proceeding may be applied for by the person holding the records or by any law enforcement or prosecutorial officials who are responsible for conducting investigative or prosecutorial activities with respect to the enforcement of criminal laws. The application may be filed separately, as part of an application for a subpoena or other compulsory process, or in a pending criminal action. An application must use a fictitious name such as John Doe, to refer to any patient and may not contain or otherwise disclose patient identifying information unless the court has ordered the record of the proceeding sealed from public scrutiny.

(b) Notice and hearing. Unless an order under § 2.66 is sought in addition to an order under this section, the person holding the records must be provided:

- (1) Adequate notice (in a manner which will not disclose patient identifying information to other persons) of an application by a law enforcement agency or official;
- (2) An opportunity to appear and be heard for the limited purpose of providing evidence on the statutory and regulatory criteria for the issuance of the court order as described in § 2.65(d); and
- (3) An opportunity to be represented by counsel independent of counsel for an applicant who is a law enforcement agency or official.

(c) Review of evidence: Conduct of hearings. Any oral argument, review of evidence, or hearing on the application shall be held in the judge's chambers or in some other manner which ensures that patient identifying information is not disclosed to anyone other than a party to the proceedings, the patient, or the person holding the records. The proceeding may include an examination by the judge of the patient records referred to in the application.

(d) Criteria. A court may authorize the disclosure and use of patient records for the purpose of conducting a criminal investigation or prosecution of a patient only if the court finds that all of the following criteria are met:

(1) The crime involved is extremely serious, such as one which causes or directly threatens loss of life or serious bodily injury including homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, and child abuse and neglect.

(2) There is a reasonable likelihood that the records will disclose information of substantial value in the investigation or prosecution.

(3) Other ways of obtaining the information are not available or would not be effective.

(4) The potential injury to the patient, to the physician-patient relationship and to the ability of the part 2 program to provide services to other patients is outweighed by the public interest and the need for the disclosure.

(5) If the applicant is a law enforcement agency or official, that:

(i) The person holding the records has been afforded the opportunity to be represented by independent counsel; and

(ii) Any person holding the records which is an entity within federal, state, or local government has in fact been represented by counsel independent of the applicant.

(e) Content of order. Any order authorizing a disclosure or use of patient records under this section must:

(1) Limit disclosure and use to those parts of the patient's record which are essential to fulfill the objective of the order;

(2) Limit disclosure to those law enforcement and prosecutorial officials who are responsible for, or are conducting, the investigation or prosecution, and limit their use of the records to investigation and prosecution of the extremely serious crime or suspected crime specified in the application; and

(3) Include such other measures as are necessary to limit disclosure and use to the fulfillment of only that public interest and need found by the court.

SOURCE: 82 FR 6115, Jan. 18, 2017; 82 FR 10863, Feb. 16, 2017, unless otherwise noted.

AUTHORITY: 42 U.S.C. 290dd-2.

Notes of Decisions (33)

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Subchapter A. General Provisions

Part 2. Confidentiality of Substance Use Disorder Patient Records (Refs & Annos)

Subpart E. Court Orders Authorizing Disclosure and Use

42 C.F.R. § 2.66

§ 2.66 Procedures and criteria for orders authorizing disclosure and use of records to investigate or prosecute a part 2 program or the person holding the records.

Effective: March 21, 2017

Currentness

(a) Application.

(1) An order authorizing the disclosure or use of patient records to investigate or prosecute a part 2 program or the person holding the records (or employees or agents of that part 2 program or person holding the records) in connection with a criminal or administrative matter may be applied for by any administrative, regulatory, supervisory, investigative, law enforcement, or prosecutorial agency having jurisdiction over the program's or person's activities.

(2) The application may be filed separately or as part of a pending civil or criminal action against a part 2 program or the person holding the records (or agents or employees of the part 2 program or person holding the records) in which the applicant asserts that the patient records are needed to provide material evidence. The application must use a fictitious name, such as John Doe, to refer to any patient and may not contain or otherwise disclose any patient identifying information unless the court has ordered the record of the proceeding sealed from public scrutiny or the patient has provided written consent (meeting the requirements of § 2.31) to that disclosure.

(b) Notice not required. An application under this section may, in the discretion of the court, be granted without notice. Although no express notice is required to the part 2 program, to the person holding the records, or to any patient whose records are to be disclosed, upon implementation of an order so granted any of the above persons must be afforded an opportunity to seek revocation or amendment of that order, limited to the presentation of evidence on the statutory and regulatory criteria for the issuance of the court order in accordance with § 2.66(c).

(c) Requirements for order. An order under this section must be entered in accordance with, and comply with the requirements of, paragraphs (d) and (e) of § 2.64.

(d) Limitations on disclosure and use of patient identifying information.

(1) An order entered under this section must require the deletion of patient identifying information from any documents made available to the public.

(2) No information obtained under this section may be used to conduct any investigation or prosecution of a patient in connection with a criminal matter, or be used as the basis for an application for an order under § 2.65.

SOURCE: 82 FR 6115, Jan. 18, 2017; 82 FR 10863, Feb. 16, 2017, unless otherwise noted.

AUTHORITY: 42 U.S.C. 290dd-2.

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42 C.F.R. § 2.67

§ 2.67 Orders authorizing the use of undercover agents and informants to investigate employees or agents of a part 2 program in connection with a criminal matter.

Effective: August 14, 2020
Currentness

(a) Application. A court order authorizing the placement of an undercover agent or informant in a part 2 program as an employee or patient may be applied for by any law enforcement or prosecutorial agency which has reason to believe that employees or agents of the part 2 program are engaged in criminal misconduct.

(b) Notice. The part 2 program director must be given adequate notice of the application and an opportunity to appear and be heard (for the limited purpose of providing evidence on the statutory and regulatory criteria for the issuance of the court order in accordance with § 2.67(c)), unless the application asserts that:

(1) The part 2 program director is involved in the suspected criminal activities to be investigated by the undercover agent or informant; or

(2) The part 2 program director will intentionally or unintentionally disclose the proposed placement of an undercover agent or informant to the employees or agents of the program who are suspected of criminal activities.

(c) Criteria. An order under this section may be entered only if the court determines that good cause exists. To make this determination the court must find all of the following:

(1) There is reason to believe that an employee or agent of the part 2 program is engaged in criminal activity;

(2) Other ways of obtaining evidence of the suspected criminal activity are not available or would not be effective; and

(3) The public interest and need for the placement of an undercover agent or informant in the part 2 program outweigh the potential injury to patients of the part 2 program, physician-patient relationships and the treatment services.

(d) Content of order. An order authorizing the placement of an undercover agent or informant in a part 2 program must:

- (1) Specifically authorize the placement of an undercover agent or an informant;
 - (2) Limit the total period of the placement to twelve months, starting on the date that the undercover agent or informant is placed on site within the program. The placement of an undercover agent or informant must end after 12 months, unless a new court order is issued to extend the period of placement;
 - (3) Prohibit the undercover agent or informant from disclosing any patient identifying information obtained from the placement except as necessary to investigate or prosecute employees or agents of the part 2 program in connection with the suspected criminal activity; and
 - (4) Include any other measures which are appropriate to limit any potential disruption of the part 2 program by the placement and any potential for a real or apparent breach of patient confidentiality; for example, sealing from public scrutiny the record of any proceeding for which disclosure of a patient's record has been ordered.
- (e) Limitation on use of information. No information obtained by an undercover agent or informant placed in a part 2 program under this section may be used to investigate or prosecute any patient in connection with a criminal matter or as the basis for an application for an order under § 2.65.

Credits

[85 FR 43039, July 15, 2020]

SOURCE: 82 FR 6115, Jan. 18, 2017; 82 FR 10863, Feb. 16, 2017, unless otherwise noted.

AUTHORITY: 42 U.S.C. 290dd-2.

Notes of Decisions (5)

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Ben Florsheim
September 9 at 5:55 PM ·

Below is the statement I gave to the Planning and Zoning Commission at tonight's meeting regarding the Root Center for Advanced Recovery's application to open a new facility in Middletown.

Good evening, and thank you for the opportunity to speak tonight. Because of my occupation as mayor of Middletown, I want to note that the Planning and Zoning Commission is, of course, an independent elected body, and it is not my intention to use my own elected position to dictate policy to this board-- nor do I have such an ability under the city charter, even if I wanted to. I don't want to leave anyone with any impression other than that I am here to share my own views.

A few days after I took office last year, I got an email from someone I know from outside Middletown who works in behavioral health. This was someone I met when our career paths overlapped in the policy world surrounding mental health and addiction. He'd been visiting a medically-assisted treatment (MAT) clinic run by the Root Center in Hartford where, he was told, clients from Middletown traveled every day to receive treatment. He asked, understandably, why people from Middletown would travel all the way to Hartford to receive daily treatment. He was told that it's because Middletown had a zoning regulation prohibiting MAT clinics from being opened.

Hence, his email to me. As a person active in government and as a behavioral health professional, he was astonished that a city of Middletown's size, demographics, and progressive reputation (especially around community public health) would not only not have a clinic of its own, but in fact actually BANNED such clinics from opening up in town. I knew we didn't have a clinic-- but even I was taken aback by the existence of that ordinance.

This commission, wisely, repealed the regulation earlier this year. Now you have before you a proposal that would allow the same provider, the Root Center, to open a new MAT clinic on Washington Street in Middletown.

There are a lot of misconceptions and stereotypes about MAT clinics. Most of these have been fairly thoroughly debunked in recent years thanks to readily available evidence, but I have heard some of them bubbling up in recent days. One is that clinics create unsafe environments in the neighborhoods or communities they serve. To the extent this was ever true, it is certainly not true today. Study after study has shown that MAT clinics do not make neighborhoods unsafe, and are associated with lower levels of crime than other types of businesses like package stores or convenience stores.

Another is that clinics are a magnet to draw in an "outside element" of dangerous people from other cities who use the services and then place a burden on the host community. To the extent that this is true at all, it's Middletown's lack of a clinic causing it-- as I mentioned earlier, our own residents are forced to go to Hartford to receive daily treatments, making them much less likely to stay in recovery. Anyone under the impression that addiction is not a problem that is Middletown's to solve as much as it is Hartford's, Meriden's, New Britain's, or Bridgeport's problem has a lot to learn about the opioid crisis, about treatment and recovery, and about Middletown.

Addiction is not an individual moral failing. It is a deadly disease. To the extent it is any kind of moral failing, it is a collective moral failing, a moral failing of a society that allows it to persist, despite having the resources to address it. Many of our neighbors, our friends, our families-- our constituents-- are struggling with addiction. Virtually all of our constituents know and love someone who has struggled with it. And too many, far too many, have lost those loved ones because of it. We've learned a lot this year about how wishing away a disease is not a public health strategy. Prevention is critical, and so is treatment.

A few days ago, August 31, was International Overdose Awareness Day. Middletown experienced 17 overdose deaths in 2019, 18 in 2018, and 18 in 2017. There has been a lot of rhetoric, locally and nationally, in those years about the ravages of the opioid crisis and the pressing need to "do something"-- but despite all that awareness-raising, the actual do-something part has not been happening, at least not enough to move the numbers.

This evening is an opportunity to do something-- the right thing. People are in need of treatment, and they deserve to be able to get it in their own community. We do not require our residents to go to Hartford to get COVID-19 treatment. We shouldn't be doing that for people with substance use disorders either.

Thank you for your time this evening and for your work on behalf of our city.

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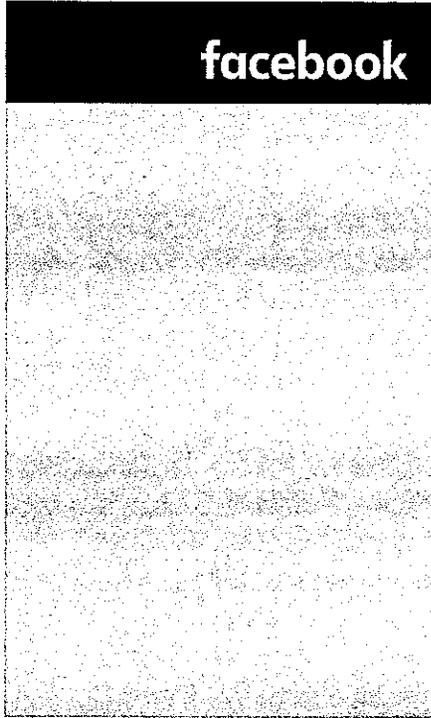
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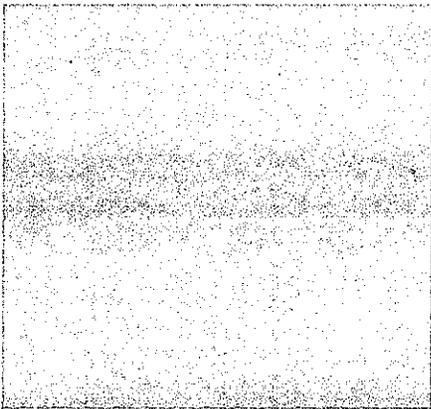
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to receive treatment. He
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Thank you for your time this evening and for your work on behalf of our city.



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Comments

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 Amy Di Mauro Thank you so much for being outspoken and advocating for your constituents in this way. Your passion was clear tonight and I respect your leadership and forward thinking around the need for an evidence based treatment that only a select few can provide. Being able to increase the ease of access to such a life saving treatment is something we can be proud of and stand behind. ❤️

6

1d · Edited

 Lori Davis Amy Di Mauro The proposed location is completely inappropriate.

1

1d

 Thea Elizabeth Thank you. A million times thank you. You are kind, open minded and exactly the kind of leader needed! As a nurse in one of the clinics I can tell you that reasonable access to a clinic makes a huge difference in the ability of an individual to reach sobriety. The misconceptions about are clients are so far off. They are so strong and amazing. They are there to get help, not cause trouble. Thank you for seeing this and advocating for them!

3

1d

 Amy Michaels-Purohit I wish I saw this post yesterday since I don't think many people will see my comment today. I worked in counseling at various MAT clinics for years. The concerns here seem to focus on medical emergencies and on traffic. MAT clinics have a nursing staff and a nursing director on site because the clinic is considered a medical facility. There is also a medical director overseeing patient care. This team can address any urgent issues immediately and make sure the patient gets to another facility like a hospital if needed (something that really doesn't happen that often). As far as traffic, there just aren't big groups of cars pouring out of a MAT clinic. Many MAT patients are in

long-term treatment and don't go in every day - for example, they may only go in once a week to pick up medication. And even at more crowded times like 5:30am when the facility opens for dosing and you might see a line of people going in, they have to wait to have medication dispensed, or take a drug test, see their counselor, get their vitals taken because they just went down on their medication dose, etc. So they're leaving at staggered times. And yes, I can confirm that the vast majority are leaving to head to jobs: as teachers, mechanics, medical professionals, white-collar executives, restaurant workers, stay-at-home moms. Addiction crosses ALL lines, and providing safe, effective treatment that is more likely to keep people in recovery is a valuable addition to our community!

7h



Kim Viel Girven Thank you Mr Mayor for your input. I agree that we need to do the right thing. The morning traffic could cause a bit of a problem. They have a small parking lot, and a narrow driveway. Even if they will only be doing most of their business between the hours of 6am-9:30(ish), Rt 66 is a state highway, and to my knowledge, when an accident occurs, or a breakdown, or 911 is called because of an accident, there will be a wait time for the state police to arrive. My point is that I would hope a better location, away from Rt 66, with a parking lot, might be a better option, still located here in town. Keep in mind, when there is an accident on 91, the traffic comes to a standstill on 66. I live right off of Rt 66 and some days, you have to right, to go left.

1d



Lori Davis Kim Viel Girven Traffic will be a big problem. As well as increased crime.

1d



Diane-Frances Champagne Kim Viel Girven So when they fix your traffic issue, will you support it?

Thursday, September 10, 2020 at 8:13 PM



Lori Davis Diane-Frances Champagne The traffic issue will never be fixed. It will only get worse. Have you noticed all the new businesses that have opened on Washington St in the last year and a half that are about a 1/2 mile down the road from this proposal? MedExpress, mozzicato's, Chipotle, car parts store, haircut place. And coming: a new smoke shop and possibly a bagel place. My house sits on a hill just above Washington St. 300 feet from the proposed location. I see the traffic ALL DAY LONG! It's constant. Seriously. I don't even understand why they're trying to put this there.

19h



Kim Viel Girven Diane-Frances Champagne I support it, wherever it goes. I merely suggested a less busy section and maybe not necessarily on Rte 66. I vote yes!

17h



Kim Viel Girven Lori Davis why do you think it will be an increase in crime? Have you ever seen the people that actually go to a clinic in the mornings? They are carpenters, store clerks, family people, bankers, lawyers, Sons, daughters. Brothers, sisters, moms and dads. They are people who are trying to get to work in the morning, or back home to get the kids on the bus. Maybe not all of them, but I'll bet the majority of them. I used to drive for a company that was paid for, by the state, to actually transport these folks, out of town, just to get their prescribed doses, and then bring them back home so they can get ready for work. Before dawn. In one of the towns mentioned below. Never once

feeling or being threatened. These are people who are fighting an addiction disease. I could go on and on. And believe me, they come and go very quickly, and do not hang around once they got their doses. I don't believe there will be any change in crime in the area. But you can perhaps get access to crime reports, in and around the area, in Hartford, New Britain, New Haven or Bridgeport, especially if you are concerned about an uptick in crime.

17h

 Lori Davis Kim Viel Girven A police officer that spoke at the public hearing corroborate d the fact that there is crime associated with these clinics. And a few other people cited studies that found an increase in crime around dispensaries.

15h

 DeLita Marie Rose-Daniels Thank you Mayor Florsheim for your statement - well stated. Access to care of any juncture should not be a barrier anywhere - including our town!   3

1d

 Ag.Fazzino Thank you, Mr. Mayor, for speaking up for people who don't always have a voice.

21h

 Ann Lindstrom Thank you. My 28 yr old daughter was one of those deaths in Middletown in 2017. She had no way to get herself to Hartford to get Methadone and that definitely played a factor in her death. I appreciate the efforts being made to open a clinic in Middletown. It is very much needed. If addiction was a choice we wouldn't see so many struggling or dying.    34

1d

 Diane-Frances Champagne Ann Lindstrom I am so sorry for your loss. No one should be put through that kind of neglect.  1

1d

 Cristie Kruvka I think it's a very bad location choice with how busy Route 66 is. Its hard to get in and out of the spot now, imagine then. Also the current business that is open there will close which gives a close friend of mine a job to provide for his family. Also don't we currently have a clinic on saybrook road somewhere  4

1d

 William Wilson <https://rootcenter.org/middletown-clinic/> at 520 Saybrook Rd.



Root Center for Advanced Recovery

ROOTCENTER.ORG
Middletown Clinic - Root Center for Advanced Recovery

1d

Michael Sutherland Isn't expansion of their existing clinic on Saybrook Road a better option? It's part of a medical facility to address a medical issue and wouldn't impact adjacent businesses or residences in that location.

Two MATs in one relatively small city on opposite sides doesn't serve the constituents well.

Expansion of the existing location (vs zoning for a new one) seems like a viable alternative.

6

1d

Caite Berg Michael Sutherland the current clinic is not large enough and already open for business I doubt that they will expand that one although I don't disagree. I myself as an MAT client at the new Britain clinic (even though I live in Middletown) was saddened to find out they are only offering one of many treatments there which again leads to less access of other routes of medication assisted treatment. Usually these clinics are put in a single building as to not disturb other businesses and to keep anonymity of patients. I'm quite surprised that clinic was even located there however I think it's more of an appointment based approach vs a clinic where there could be lines of people waiting. Anyhow, my point is I do agree maybe it could be moved to a better area. However I am all for the clinic being added in by any means necessary!

1

1d

Caite Berg Thank you, thank you, thank you! I have been in recovery for over 7 years myself and MAT had been a HUGE part of finally staying the course! All of these stereotypes need to end, we NEED to break the stigma and help these people not shame them! All of the shame and lack of access to treatments in certain areas is what leads to even more deaths! More children without their parents; more parents without their children! I understand traffic can be an issue but for the people who are more worried about that; imagine it's your child who needs that very MAT clinic to save their life! Thank you for all you're doing Mr Mayor, I am proud to be a Middletown Resident!

3

1d

Thea Elizabeth I understand everyone's concerns about traffic and location. I can promise you that with the strong and experienced leaders planning this project, they will work out those issues.

3

1d

Vanessa Mae Cardella Proud to live in the town you're leading. Thank you.

3

1d

Dave Durbin Jr Just from a privacy standpoint point it should be moved to the facility on Saybrook rd .as they are better prepared for any medical emergency should one arise.as well as anonymity with as many people that use that facility people would just blend in

2

1d

William Wilson We have a Medical zone on Saybrook Rd in Middletown and that is where the facility should go, not on Washington St near two small businesses and small row houses.

7

1d

Jeff Myjak That is a terrible location for the clinic. And as I understand it,

it will force the other business in that building to close as they will no longer be zoned to operate there.

5

1d

James Demetriades Jeff Myjak no businesses would be forced to close because of a zoning change. What's your source for that?

1

1d

Wendy Jessen Sheil James Demetriades the business currently at 392 wuld be forced out of that location in order for the clinic to move in. They will be taking the entire building for their use.

1d

Verna Ouellette Ellam I lost someone very dear to me who might have been helped with what MAT is offering. I agree that Middletown people need this treatment. If voted down couldn't it be available at Rushford or at the new building on the corner of Main and Grand Streets? (Sorry I forgot the name of the building).

4

1d

Diane-Frances Champagne Ben Florsheim, has anyone done a traffic feasibility study for this site? It has been consistently reported that the majority of patrons take public transportation, but there are many people on here insisting the traffic will be a problem. I'm just wondering if we can address this topic to quell all the worried minds.

2

1d

Patricia Mangini We already have the Community Health Center Add it to that The have bus route and parking

1d

Liz Lake Well said, Ben. I couldn't agree more, and I welcome this MAT clinic in Middletown.

2

1d

Lisa Lombardo Dipiro I agree woth you and welcome one to Middletown BUT that stretch of road is just BAD idea. There appear To be empty buildings flots down near and across from victor auto body and Mobil one— can't it be moved down that way ?

3

1d

Joe LaBella We currently have a Root Center located in Middletown on 520 Saybrook Rd. Why couldn't the existing location be used? It's already up and running, so the methadone and other treatments could start almost immediately.

8h

Julie Hurlburt I'm sorry to say I was not aware that our town did not have this center already..... I hope changes come soon

1

1d

Chris Petersen Well said! Thanks Mayor Florsheim!

1d

Mike Fallon Thank you mayor for this reasoned message.

-  1d   2
-  Jeanette Duckson Pure Excellence Mayor Ben...!!!
2h
-  Geoff Luxenberg Thank you for your leadership Ben! Root Center for Advanced Recovery has done outstanding work in Manchester and you are demonstrating great leadership here.
1d  1
-  Jennifer Frazier Chadukiewicz Thank you mayor.
1d  1
-  Gabrielle Paige Thank you, mayor.
1d  1
-  Matthew Scarozzo Well said Ben.
1d  1
-  Connie McDonald Shakin Well said Mayor!!
1d  1
-  Jay Mortensen Why cant middlesex hospital do it. Doesnt that just make sense
1d  1
-  M.J Hewitt-Burr Very well stated !! I appreciate all you do for this community
1d  2
-  Robert Anthony Noonan Great news but location is terrible idea
1d  2
-  Amy Zipf Well said.
1d  2
-  Alicia Moody-Brown Well Said
1d  1
-  Lori Davis No one that spoke at the public hearing tonight disputed the necessity of a methadone clinic. Myself included. BUT it is a completely unfeasible, inappropriate location. It is a medical-related function and should be located on a medical-related campus. Why aren't they looking to expand their clinic at 520 Saybrook Rd. and dispense methadone there? Plenty of parking, accessible via public transportation. Or how about the empty buildings at CVH? A methadone dispensary doesn't belong on an already over-burdened roadway, in proximity of a university/residential/ business area , and just 7 blocks up from Main St.
1d  3
-  Judy Hoffman Lori Davis I totally agree.
1d  2
-  Cindy Resster well said.
1d  1
-  Karla Woods Yes, yes, yes please!! 

 1d  2

 Katie Chesnek  1d  1

 Karen Springman Crain Why do we need another clinic of this nature?

1d

 Wendy Jessen Shell I agree with all you said, Mayor. Just not at this location. Not anywhere on Washington Street. I feel for everyone involved. People trying to access the clinic should not have to deal with the traffic and challenges of a major throughway in our town. I'm concerned for the residents that spoke up - they matter too. There is much that is misunderstood about the clinic and what it offers and it's impact on an area but I truly think the biggest issue is that there is a better location for this in Middletown. I didn't hear anyone speak tonight at the meeting about not wanting it in Middletown - I did hear many a request for a better location, for all involved. Full disclosure - my husbands business is Fine Tunes Car Audio and Auto Repair (30+ years in business) that will be ousted from 392 if this is approved. However, he is already in the process of trying to find another location. The owner and developer has made it abundantly clear for a long time that this would be necessary. Our biggest concern is not for our business but for the surrounding businesses and residents. We are hearing their concerns and trying to support them best we can. Ultimately, in order to support Middletown residents (and not outside entities) I think we would be wise to at least help these folks consider and seek out an alternate location that would be better for the clients it will ultimately serve. I have someone near and dear to me that dealt with heroine addiction and they shared with me that they too thought there would be a better option than this. Again, I see Middletown as a caring and supportive place for all its people and we need to ensure that the decision works for as many folks as it possibly can. I think this is possible somewhere other than 392 Washington Street.

 2

1d · Edited

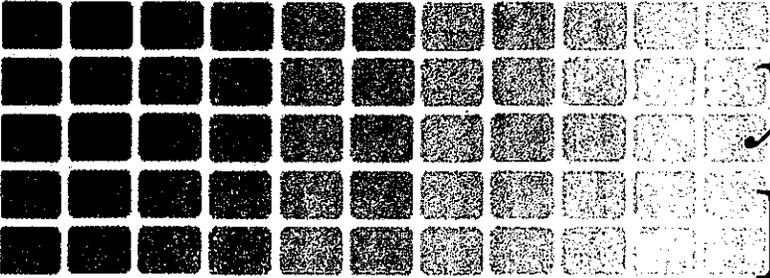
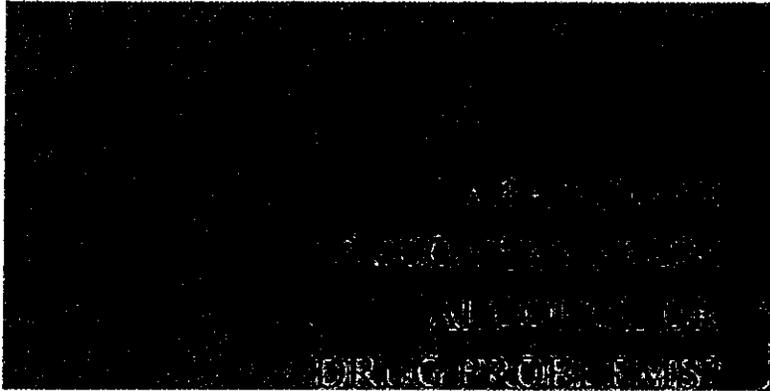
 Judy Scovill Sienna Thank you  1d  1

 Susan Glass Jeff Drewniary If I had a business, I would welcome this enterprise into my neighborhood, and as a homeowner, I have NO PROBLEM with it being within mile of my house.  1

1d

 Sarah Eve Thank you for being a voice for group that society at large ignores, stigmatizes and villainize.  2

1d



Know *your* Rights

Rights for Individuals on Medication-Assisted Treatment



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

Know Your Rights: Rights for Individuals
on Medication-Assisted Treatment

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

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Disclaimer

The views, opinions, and content of this publication are those of the author and do not necessarily reflect the views, opinions, or policies of SAMHSA or HHS.

This publication provides general guidance on the legal rights of individuals with alcohol and drug problems. It is not intended to serve as legal advice for any particular case involving or potentially involving discrimination. If you believe that you have been or are being subjected to illegal discrimination, you should immediately consult an attorney or seek assistance from the Federal agency responsible for addressing discrimination complaints or administering the program or benefits at issue.

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ARE YOU IN
RECOVERY FROM
ALCOHOL OR
DRUG PROBLEMS?

Know *your* Rights

INTRODUCTION

This brochure explains the Federal laws that prohibit discrimination against individuals with disabilities and how they protect people receiving Medication-Assisted Treatment for opioid addiction (also known as “MAT”). MAT includes a medication (e.g., methadone, buprenorphine, oral naltrexone) approved by the U.S. Food and Drug Administration (FDA) for opioid addiction detoxification or maintenance treatment.

Individuals in MAT often face discrimination despite laws that plainly prohibit it. This discrimination is largely due to lack of knowledge about MAT’s value, effectiveness and safety, and a lack of knowledge about the anti-discrimination laws that protect people in MAT. Discrimination is also common because people in MAT frequently do not have the tools necessary to educate employers, landlords, courts, and others about MAT and relevant legal protections.

What is the purpose of this brochure? This brochure aims to reduce discrimination by giving people in MAT (and their advocates) basic information necessary to exercise their rights or, at a minimum, know where to turn for help. It also seeks to reduce discrimination by educating those who might discriminate (e.g., employers, housing providers, and government agencies) about such laws, as well as about MAT itself.

Who should read this brochure? People who are in MAT and their families, friends, and advocates who want to know their rights under Federal anti-discrimination laws. It is also for employers, landlords, health care providers, government agencies, and others who are required to comply with anti-discrimination laws that protect people with disabilities.

What topics does this brochure cover?

- GENERAL INFORMATION ABOUT MAT
 - WHAT IS MAT?
 - HOW DO METHADONE AND BUPRENORPHINE WORK?
 - DO METHADONE AND BUPRENORPHINE IMPAIR PHYSICAL OR MENTAL FUNCTIONING?

- FEDERAL NON-DISCRIMINATION LAWS THAT PROTECT PEOPLE IN MAT
 - WHO IS AND IS NOT PROTECTED BY THESE LAWS
 - HOW THESE PROTECTIONS WORK IN –
 - EMPLOYMENT
 - HOUSING – INCLUDING RESIDENCES FOR PEOPLE IN RECOVERY
 - GOVERNMENT ACTIVITIES, BENEFITS AND SERVICES – INCLUDING THE CHILD WELFARE SYSTEM, PROBATION AND PAROLE, ZONING, AND THE ISSUANCE OF DRIVERS LICENSES
 - PRIVATE EDUCATIONAL, HEALTH CARE AND OTHER FACILITIES (ALSO CALLED “PUBLIC ACCOMMODATIONS”)

- HOW PEOPLE IN MAT CAN PROTECT THEIR RIGHTS UNDER THESE FEDERAL LAWS.

This brochure complements the publication, *Are You in Recovery from Alcohol or Drug Problems? Know Your Rights* available on the Partners for Recovery Web site, <http://www.pfr.samhsa.gov>. The *Know Your Rights* brochure focuses broadly on laws that protect people in recovery from alcohol or drug addiction. This publication discusses how these laws specifically protect people in MAT.

GENERAL INFORMATION ABOUT MEDICATION-ASSISTED TREATMENT (MAT)

What is Medication-Assisted Treatment?

Medication-Assisted Treatment (MAT) is treatment for opioid addiction that uses medications such as methadone or buprenorphine to treat addiction to short-acting opioids, such as heroin, morphine and codeine, as well as synthetic opioids, including oxycodone, OxyContin®, and hydrocodone.¹ MAT operates to normalize brain chemistry, block the euphoric effects of opioids, relieve physiological cravings, and normalize body functions without the negative effects of the short-acting drugs of abuse. Patients who receive treatment in an Opioid Treatment Program (OTP) are required by Federal regulations to receive medical, counseling, vocational, educational, and other assessment and treatment services, in addition to the medication for the opioid addiction.²

Methadone, when used in MAT, can only be dispensed (not prescribed) in an OTP. Buprenorphine can also be dispensed in an OTP. OTPs are any treatment program certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) in conformance with Title 42 of the Code of Federal Regulations (C.F.R.), Part 8, to provide supervised assessment and medication-assisted treatment for patients who are opioid addicted. An OTP can exist in a number of levels of care and settings, including, but not limited to, intensive outpatient, residential, and hospital settings.

The Drug Addiction Treatment Act of 2000 permits physicians who meet certain qualifications to provide office-based treatment for opioid addiction using buprenorphine. Buprenorphine, like methadone, when taken in stable doses as part of a medically supervised treatment plan, permits the patient to

¹ Though the term “MAT” can also encompass treatment for drug and alcohol addiction with other medications, this brochure focuses only on the use of methadone and buprenorphine to treat opioid addiction. This is because individuals receiving treatment with methadone – and more recently buprenorphine – face significant stigma due to the stigmatizing nature of the underlying opioid addiction. This brochure’s discussion of methadone refers exclusively to methadone used to treat opioid addiction and not to methadone used to treat pain.

² The Federal regulation requiring these services can be found at Title 42 of the Code of Federal Regulations (C.F.R) § 8.12(f).

lead a normal and productive life without any of the narcotic effects of heroin or other opioids of abuse. Buprenorphine is generally administered daily, but sometimes can be administered on alternate days.

How Do Methadone and Buprenorphine Work?

Methadone and buprenorphine, when administered at the appropriate dose, “occupy” the brain receptor sites affected by heroin and other opioids. As a result, they suppress withdrawal symptoms, block the euphoric and sedating effects of opioids, and relieve the craving for opioids that is a major factor in relapse.³ Methadone and buprenorphine are long-acting opioids and pharmacologically dissimilar from short-acting opioid such as heroin and oxycodone or hydrocodone. With stable dosing and in the absence of other medications that may produce euphoria or sedation, these medications do not cause euphoria or intoxication, thus allowing a person to lead a normal life. The appropriate dose is determined by a certified health care professional in conjunction with the patient and is calibrated to the individual’s medical and physiological needs. Once individuals are stabilized on the appropriate dose, they may be maintained on that dose for as long as medically necessary, as is the case with other medications for chronic health conditions.

MAT does not “substitute one drug for another.” This is in contrast to the extreme highs and lows that result from the waxing and waning in blood levels of short-acting opioids. Instead, these medications relieve withdrawal symptoms and physiological cravings and bring about a biochemical balance in the body. They help people return to physical and psychological stability, and live their lives just like anyone else.

People unfamiliar with the science of MAT sometimes question why an individual is taking what is perceived as a high dose of methadone. Dosing, however, is an individualized medical decision. Most patients require a dose of 60-120 milligrams per day and patients on higher doses are shown to stay in treatment longer and use less heroin and other drugs than those on lower doses.⁴ Pre-conceived attitudes about dosing that are based on any rationale other than scientific evidence detract from the potential value of MAT.

³ Methadone is administered as a liquid that a person drinks and buprenorphine is a “sublingual” tablet that a person places under her tongue.

⁴ Centers for Disease Control and Prevention (February 2002), Methadone Maintenance Treatment, IDU/HIV Prevention, <http://www.cdc.gov/idu/facts/Methadone.htm>.

Do Methadone and Buprenorphine Impair Physical or Mental Functioning?

When provided at the appropriate dose to a person stabilized on methadone or buprenorphine, these medications have no adverse effects on intelligence, mental capability, physical functioning, or employability. Research studies demonstrate that MAT patients are comparable to non-patients in reaction time and their ability to learn, focus, and make complex judgments. MAT patients do well in a wide array of work settings, including professional positions, service occupations, and skilled, technical, and support jobs. MAT patients are lawyers, engineers, secretaries, truck and taxi drivers, teachers, computer programmers, and others.

For more information about MAT and driving, read New York State's Office of Alcoholism and Substance Abuse's 1997 publication, "Driving Performance of Methadone Maintenance Patients," and Legal Action Center's 2000 publication, "Methadone Maintenance Treatment: Memorandum on Driving & Psychomotor Studies and Background Information about Methadone Treatment."

Additional information about opioid addiction and MAT is available from a variety of resources, including:

- SAMHSA Health Information Network (SHIN) of the United States Substance Abuse and Mental Health Services Administration (SAMHSA): <http://www.samhsa.gov/SHIN>
- SAMHSA's Center for Substance Abuse Treatment (CSAT): <http://www.csat.samhsa.gov>
- CSAT's Division of Pharmacologic Therapies (DPT): <http://www.dpt.samhsa.gov>
- CSAT's Buprenorphine Information Center: <http://www.buprenorphine.samhsa.gov>
- National Alliance of Methadone Advocates (NAMA): <http://www.methadone.org>
- National Alliance of Advocates for Buprenorphine Treatment (NAABT): <http://www.naabt.org>
- American Association for the Treatment of Opioid Dependence, Inc. (AATOD): <http://www.aatod.org>

FEDERAL NON-DISCRIMINATION LAWS PROTECT PEOPLE IN MAT

It is illegal to discriminate against people because they are in MAT.

Federal civil rights laws protect qualified “individuals with disabilities” from discrimination in many areas of life. People in recovery from drug addiction – including those in MAT – generally are protected from discrimination by the following statutes:

- Americans with Disabilities Act (ADA)
- Rehabilitation Act of 1973
- Fair Housing Act (FHA)
- Workforce Investment Act (WIA)

Many States and cities also have non-discrimination laws that protect individuals with disabilities – including those in MAT. This brochure does not discuss these laws, but information regarding them is typically available from the State and city agencies enforcing them.

WHO IS PROTECTED?

The non-discrimination laws mentioned above protect individuals with a “disability.” Most often, people in MAT are considered individuals with a “disability.”

Why? Under these Federal laws, an individual with a “disability” is someone who –

- Has a *current* “physical or mental impairment” that “substantially limits” one or more of that person’s “major life activities,” such as caring for one’s self, working, etc., or
- Has a *record* of such a substantially limiting impairment, or
- Is *regarded* as having such an impairment.

Addiction to opioids is an impairment that can and does, for many people, substantially limit a major life activity. For this reason, many courts have found that people in MAT have a *record* of an impairment. The same analysis

applies to buprenorphine. Many people also *regard* people in MAT as having a substantially limiting impairment.

Example: Elias has been in MAT for two years, following a decade-long addiction to heroin. He recently worked for six months in the sales office of a newspaper, but was fired after telling his supervisor that he was in MAT. The supervisor said that the newspaper did not employ people in methadone programs because “we do not want drug addicts working here.” Elias has not used heroin – or any drugs illegally – since he began MAT two years ago.

Is Elias protected by Federal anti-discrimination laws?

Yes. Elias is an individual with a “disability” because it is clear that the employer “regards” him as having a current disability – drug addiction. He also has a “record” of a disability – addiction to heroin.

WHO IS NOT PROTECTED?

People who *currently* engage in the *illegal* use of drugs are not protected under these non-discrimination laws. For instance, if Elias – from the previous example – was using cocaine while in MAT, if his cocaine use was the basis of the employer’s decision to fire him, he would not be protected by these non-discrimination laws.

But note that even though Federal anti-discrimination laws generally do not protect individuals who are currently engaging in the illegal use of drugs, they *do* protect such individuals from discrimination by health care providers. For example, if Elias was using cocaine while in MAT, it would be *illegal* for a health care provider to deny him surgery or dental care just because he was an illegal drug user.

HOW DO THESE PROTECTIONS WORK?

Discrimination means treating someone less favorably than someone else because he or she has a disability, once had a disability, or is regarded – even erroneously – as having a disability. MAT treats a chronic disease – addiction – using legally-prescribed medications. It is discrimination for employers, landlords, government agencies, and health care and treatment providers to

treat people less favorably because they are in MAT. It is also discrimination to treat people in MAT differently than people who are prescribed medication to treat *other* disabilities, such as people prescribed insulin for diabetes or people with high cholesterol who are prescribed cholesterol-lowering medication.

Treating someone less favorably for reasons *other than* the person's disability, however, is generally not illegal discrimination. For example, it is *not* illegal discrimination to deny a person a job, services, or admission to a program because that person –

- Does not meet essential eligibility requirements.
- Creates a direct threat to health or safety by his/her behavior. Simply being in MAT does *not* pose any health or safety threat.
- Violates the rules of a workplace, housing facility, or other program or commits a crime, including a drug-related crime, when that misconduct would cause *anyone* to be disciplined, evicted, or excluded.

EMPLOYMENT

General rule. Federal law protects people in MAT against job discrimination. The ADA and the Rehabilitation Act prohibit most employers from firing, refusing to hire, or discriminating in the terms and conditions of employment against any qualified job applicant or employee on the basis of a disability. Many courts have ruled that people in MAT have a disability and are therefore protected from discrimination by these laws.

Employers are covered by Federal laws as follows:

- The ADA applies to all State and local governmental units, and to private employers with 15 or more employees.
- The Rehabilitation Act applies to Federal employers and other public and private employers who receive Federal grants, contracts, or aid.

In general, these covered employers –

- *May not* deny a job to or fire a person simply because he or she is in MAT.

- *Must* provide “reasonable accommodations” when needed to enable those with a disability to perform their job duties, unless this would cause the employer undue hardship.

A “reasonable accommodation” is any change in the work environment or in the way things are customarily done that enables an individual with a disability to enjoy equal employment opportunities. Examples include:

- Job restructuring
- Part-time or modified work schedules
- Permitting a leave of absence
- Reassignment to a vacant position

An employer is not required to grant an accommodation that causes “undue hardship” to the employer, meaning significant difficulty or expense. The employer may suggest an alternative accommodation to the one proposed by the employee or job applicant.

Example: Kira works at a hospital from 2:00 p.m. to 10:00 p.m. and has been receiving MAT for one year. The program requires Kira to pick up the dose three times a week and is open only from 7:00 a.m. to 2:00 p.m.

Unfortunately, the hospital changed Kira’s shift so that she must work from 7:00 a.m. to 3:00 p.m.

Is she entitled to a “reasonable accommodation” of changing to her former shift?

Yes, unless it would cause the hospital an “undue hardship.” Allowing a schedule change so that Kira could pick up the dose would be a reasonable accommodation, and her employer should allow it.

For more information on reasonable accommodations, read *Are You in Recovery from Alcohol or Drug Problems? Know Your Rights*.

Medical Inquiries and Examinations and Drug Tests. The ADA and Rehabilitation Act strictly limit what employers may ask about an applicant’s or employee’s medical conditions and history. These rules are described in detail in the brochure, *Are You in Recovery from Alcohol or Drug Problems? Know Your Rights*. This brochure will discuss drug tests, however, because they often are the way employers learn about a job applicant’s or employee’s participation in MAT.

Under these Federal laws, a drug test is not considered a “medical examination.” Drug tests, therefore, can be administered at any time if all applicants or employees in a job category are required to be tested. Certain drug tests will detect methadone and buprenorphine, and others will not. If these medications are detected, employers may require the individual to provide documentation that s/he is in MAT. Acceptable documentation could include a letter from the individual’s physician confirming that the applicant was prescribed the medications as a part of MAT. If an applicant or employee does not provide such documentation or falsely denies participation in MAT, however, it is legal for the employer to deny the position or fire the individual.

Medical Leave. The ADA and Rehabilitation Act, as well as the Family and Medical Leave Act (FMLA), give employees the right to take medical leave – including for alcohol or drug treatment – in certain circumstances. Please read the brochure, *Are You in Recovery from Alcohol or Drug Problems? Know Your Rights*, for a complete discussion of the provisions. However, it is worth noting that it would be illegal discrimination for an employer to deny someone such medical leave solely because the treatment sought during leave was for MAT.

HOUSING

The Fair Housing Act (FHA) makes it illegal to discriminate in housing and real estate transactions because of someone’s disability. People in MAT are protected from housing discrimination under the FHA – just as are people with other disabilities. For information on how these housing protections apply to people in recovery generally, read the brochure, *Are You in Recovery from Alcohol or Drug Problems? Know Your Rights*.

Housing discrimination related to MAT sometimes arises in the context of residences for individuals in recovery. Individuals who live or want to live in halfway houses, recovery homes, or other residences for individuals in recovery are sometimes excluded because of their participation in MAT. This is *illegal* even though this type of discrimination occurs with some frequency.

The FHA applies to residences such as recovery houses because they fall under the FHA’s definition of “dwelling.” Individuals in MAT are protected by the FHA. They also are protected by the ADA if the residence receives State or local government funding, and by the Rehabilitation Act if the residence

receives Federal financial assistance. Accordingly, these residences may neither categorically exclude people in MAT nor insist that they abstain from MAT.

Some treatment and recovery residences for individuals in recovery have policies that make it difficult for individuals in MAT to live there, for example, policies prohibiting the storage of methadone or buprenorphine at the residence. Such residences must grant a “reasonable accommodation” for individuals in MAT, provided the requested accommodation does not require major financial or administrative commitments that would be considered an “undue burden.” Examples of reasonable accommodations include:

- Arranging for the individual to take medication at the OTP, physician’s office, or another off-site location – when consistent with the individual’s treatment plan.
- Storing an individual’s MAT medication in a lock box in the house and having the individual be personally responsible for it.
- Arranging to have the housing facility keep MAT medications in a locked cabinet.

Residences, of course, do not have to accept every individual who applies. Applicants may be rejected if they refuse to follow non-discriminatory house rules such as attending mandatory NA or AA meetings or violate rules prohibiting drinking or illegal drug use.

Example: Julia is receiving MAT for an addiction to OxyContin and has applied to live in a residence for people in early recovery. She is denied admission because the residence has a policy of refusing to admit people in MAT. The residence is operated by a non-profit organization that runs many such residences.

Is that illegal discrimination?

Yes. Julia is an individual with a “disability” because she is in recovery from an addiction to OxyContin and is in MAT. Excluding her because of her participation in MAT is illegal discrimination, assuming that Julia meets the residence’s other eligibility requirements.

The anti-discrimination laws that apply to the residence include the Fair Housing Act and, if the residence receives Federal funding, the

Rehabilitation Act. If the residence were operated by a local or State government, it would be governed by the ADA as well.

GOVERNMENT ACTIVITIES, BENEFITS, AND SERVICES

The ADA and Rehabilitation Act protect a person in MAT from discrimination by the government in its –

- **Services** – such as health or social services and education and training programs
- **Benefit programs** – like welfare or child care assistance and other forms of financial assistance, such as student loans
- **Activities** – like probation and parole, zoning, occupational licensing, and driver's licensing

If an individual is “qualified” – meaning the individual meets the eligibility requirements of the program or activity involved – the individual may not be denied the opportunity to participate in or be denied benefits from these and other public services, benefit programs or governmental activities because of a disability. Additionally, individuals in MAT may not be treated less favorably than other individuals simply because they are participating in MAT.

Child Welfare System. May judges, prosecuting attorneys, and others in the child welfare system require parents to end their participation in MAT in order to get their children back or to keep their children?

No. Courts and other government agencies may not single out people in MAT and require them to stop taking legally prescribed medications. Such a requirement would be no different than telling an insulin-dependent, diabetic parent that she may not have her children back unless she stops taking insulin and addresses her diabetes through nutrition and exercise alone. Courts may, however, require people in MAT to comply with treatment requirements.

Probation and Parole. May a probation or parole officer or court require individuals to end their participation in MAT as a condition of their compliance with parole or probation?

No. As in the child welfare system, probationers and parolees in MAT may not be singled out for different treatment solely because of their participation in MAT.

Zoning May local governments pass ordinances that prohibit the siting of MAT programs?

No. Local governments may not use zoning laws to discriminate against MAT programs, even if there is strong neighborhood opposition to the siting of the facility. Zoning laws that prohibit MAT programs or restrict their location generally violate Federal law. Zoning practices that treat MAT programs differently from other entities also violate Federal law.

Example: A methadone program wants to open a new facility in a mixed use district. Methadone programs fall under the zoning code's definition of a "medical facility," and that use is permitted in that district. Community leaders are worried that the program will bring more crime into the area. They convince local legislators to enact an ordinance banning the siting of methadone programs in that district.

Is that illegal discrimination?

Yes. The ADA prohibits local governments from enacting laws that single out methadone programs and treat them differently from other medical facilities.

Driver's Licenses. May a department of motor vehicles require an individual charged with DUI to end his participation in MAT in order to get his license reinstated?

No. Requiring an individual to end his participation in MAT – and perhaps to attend a drug treatment program that does not use medication – violates Federal anti-discrimination laws. Note, however, that Federal regulations pertaining to the issuance of commercial drivers licenses *do* disqualify individuals in MAT. Though these rules might appear to conflict with Federal anti-discrimination laws, they are enforceable because of the rules concerning conflicting Federal laws.

Despite the protections outlined above, some government entities do discriminate. For information about what to do when faced with such discrimination in the child welfare and criminal justice systems, read the brochure, *Educating Courts and Other Government Agencies About Methadone*, written by the Legal Action Center and available on the Legal Action Center's Web site, <http://lac.org/index.php/lac/130>.

Commercial Drivers Licenses. Regulations implemented by the Federal Highway Administration of the United States Department of Transportation (DOT) disqualify individuals from receiving an interstate commercial driver's license if they are taking methadone. Consequently, it is *not* illegal discrimination for DOT to deny an interstate commercial driver's license to someone because of their participation in MAT. The regulations do not address buprenorphine. Commercial driver's licenses for *intrastate* (within one State) driving are determined by State laws, which may vary.

PRIVATE EDUCATIONAL, HEALTH CARE, AND OTHER FACILITIES

Many private educational institutions, service providers, and other facilities must comply with Federal laws protecting people with disabilities from discrimination – including people in MAT. The ADA's anti-discrimination requirements apply to “public accommodations,” which is defined as private facilities that provide goods or services to the public. They include:

- Schools and universities
- Hospitals, clinics, and health care providers
- Social service agencies, including homeless shelters, day care centers, and senior centers

Private service providers that receive Federal grants, contracts, or aid must comply with the same non-discrimination requirements under the Rehabilitation Act.

Public accommodations (and other private entities covered by the Rehabilitation Act) must not discriminate in offering or providing their goods or services against individuals on the basis of their past, current or perceived disability. This means they must ensure individuals enjoy equal opportunity to participate and benefit from the facility's goods and services, and receive goods or services in the most integrated setting possible.

Example. Susan went to her friend's primary care doctor because she had a terrible headache. On the medical history questionnaire, she wrote that she is in MAT using methadone. The doctor refused to examine Susan because “we do not treat people on methadone” and said that she should go to the local health department instead.

Was that illegal discrimination?

Yes. Health care providers are “public accommodations” under the ADA and may not refuse to provide health services to individuals solely because they participate in MAT.

HOW PEOPLE IN MAT CAN PROTECT THEIR RIGHTS

Can people do anything to protect their rights under these Federal non-discrimination laws?

Yes. People who face discrimination because they are in MAT can challenge the violation of their rights in one or both of the following ways:

- File a complaint with one of the Federal agencies authorized to investigate and remedy violations of the disability discrimination laws. People do *not* need a lawyer to do this, and it can be faster and easier than a lawsuit and result in the same remedies. *But note:* the filing deadline is typically 180 days after the discriminatory act. Contact information for the relevant agencies is as follows:
 - Employment cases: Equal Employment Opportunity Commission (EEOC). File a complaint with the nearest field office, which can be located at <http://www.eeoc.gov>. Or call (800) 669-4000 (voice) or (800) 669-6820 (TTY).
 - Public Accommodations: United States Department of Justice (DOJ), (800) 514-0301, <http://www.ada.gov>.
 - Housing: United States Department of Housing and Urban Development (HUD), (800) 877-0246, <http://www.hud.gov>.
- In most (but not all) cases, people may also file a lawsuit in Federal or State court, in addition to or instead of filing an administrative complaint. Deadlines vary from one to three years.
- Contact the State agency that oversees alcohol and drug treatment programs. They may know of local resources and be able to provide information to educate employers, government agencies, and others who are discriminating. The Directory of the Single State Agencies

for Substance Abuse Services is accessible through the SAMHSA Web site, <http://www.samhsa.gov/Grants/ssadirectory.pdf>.

- Contact the State and/or local agency that enforces State and/or local anti-discrimination laws. Every State has an agency charged with enforcing State anti-discrimination laws. Some cities have them as well. You might be able to locate the agency in your State or city by asking your local or regional EEOC office (see contact information above), or your State's Attorney General's office. You can also try an Internet search typing the name of your state or city and the words "human rights agency."

What benefit can someone get from filing a complaint or lawsuit? Those found liable for discrimination may be directed to stop discriminating, enact new policies, and/or pay money to the individual who suffered discrimination to compensate for out-of-pocket losses and other harm.

CONCLUSION AND ADDITIONAL RESOURCES

It is illegal to discriminate against people because they are in MAT. Federal laws prohibit such discrimination in employment, housing, public accommodations, and government services. A lack of understanding about MAT – methadone in particular – is often the root cause of such discrimination. This brochure as well as the resources it references should help address concerns by employers and others who might otherwise discriminate.

In the event that discrimination cannot be prevented through education, legal means are available through complaints with government agencies and lawsuits in court.

For a copy of the ADA, visit the Department of Justice's website at <http://www.ada.gov/pubs/ada.htm>. For other resources on the information covered in this brochure, visit SAMHSA's websites:

<http://www.dpt.samhsa.gov> and <http://buprenorphine.samhsa.gov>.

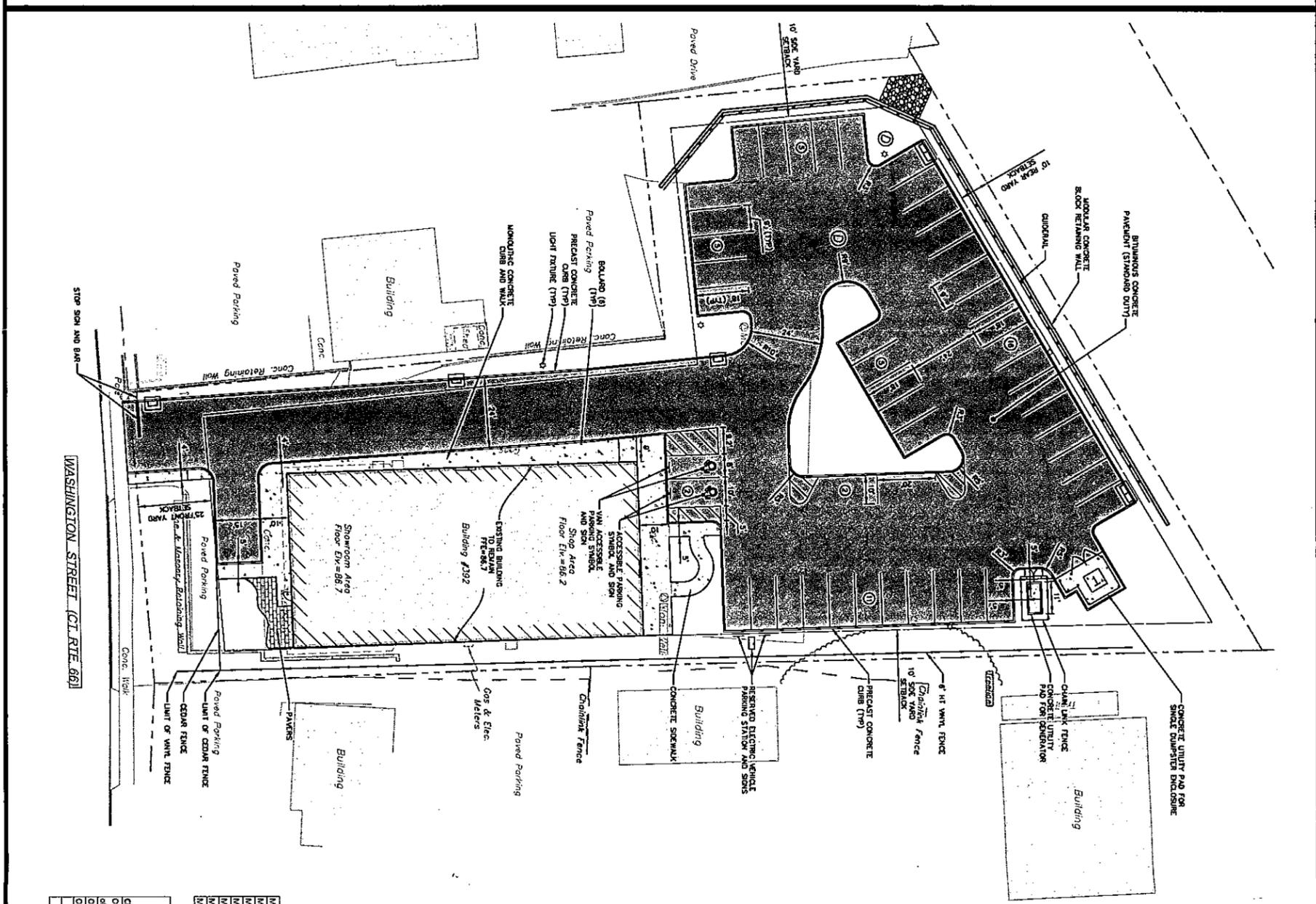
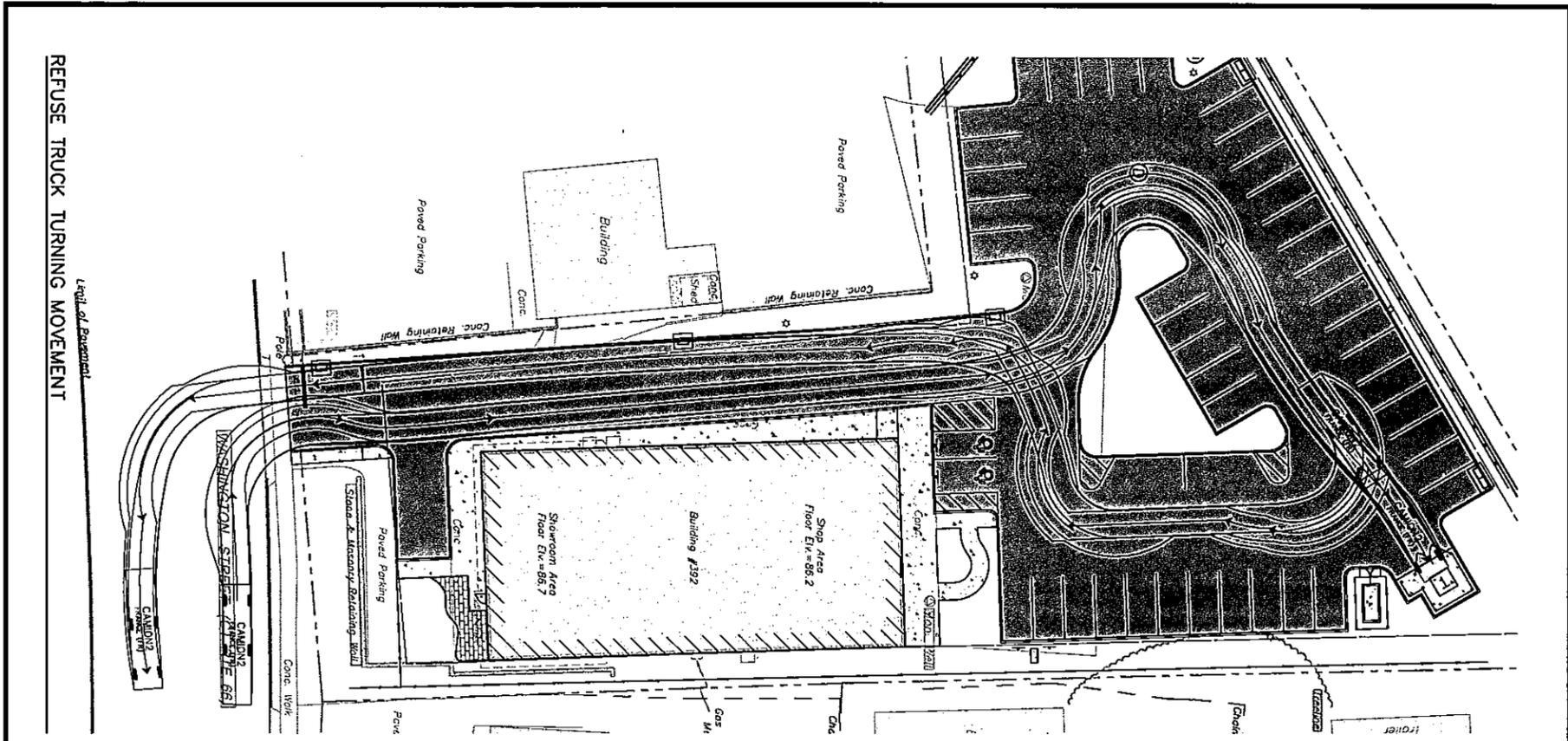
Resources also are available from private, non-profit organizations including the American Association for the Treatment of Opioid Dependence (AATOD), <http://www.aatod.org>; Legal Action Center, <http://www.lac.org>, National Alliance of Advocates for Buprenorphine Treatment (NAABT), <http://www.naabt.org>; National Alliance of Methadone Advocates (NAMA),

<http://www.methadone.org>; and Patient Support & Community Education Project (PSCEP), http://www.methadone.net/patient_support_project.htm.

Know *your* Rights

DHHS Publication No. (SMA) 09-4449
Printed 2009





Zoning Table of Standards
 392 Washington Street, Middletown, Connecticut
 Zone: Substance Abuse/Mental Health Floating Zone (SMH)
 Underlying Zone: Mixed Use Zone (MU)

Minimum Lot Frontage	Required	Proposed
Minimum Lot Area	75	107
Minimum Front	10,000 SF	48,600 SF
Minimum Front, Side	25	48
Minimum Front, Rear	10	30
Minimum Structure Height	10	15
Maximum Lot Coverage	35% (3 stories) Existing Building	30%

Parking Requirements	
Floor Area (SF) / Dweller & Employees (EN)	Parking Required (Spaces)
Office, Medical or Dental	1 SPA
One (1) for each two hundred (200) sq. ft. of floor area	36
One (1) space for each doctor	1
One (1) space for each three (3) employees	24 EN
TOTAL PARKING REQUIREMENTS	45
TOTAL PARKING PROVIDED	45

FOR LAND USE PERMITS ONLY

<p>ROOT CENTER FOR ADVANCED RECOVERY</p> <p style="text-align: center;">SITE LAYOUT PLAN</p> <p style="text-align: center;">392 WASHINGTON STREET</p> <p style="text-align: center;">MIDDLETOWN CONNECTICUT</p>	 <p>FUSS & O'NEILL</p> <p>146 HARTFORD ROAD MANCHESTER, CONNECTICUT 06040 860.646.2469 www.fussdo.com</p>	<p>SCALE: HORIZ: 1" = 20' VERT: 1" = 20'</p> <p>DATUM: HORIZ: NAD 83 VERT: NAVD 83</p> <p style="text-align: center;">20 10 0 20 GRAPHIC SCALE</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>No.</th> <th>DATE</th> <th>DESCRIPTION</th> <th>DESIGNER</th> <th>REVIEWER</th> </tr> </thead> <tbody> <tr> <td>2</td> <td>9/16/2020</td> <td>RESPONSE TO CITY STAFF COMMENTS</td> <td>JHO</td> <td>REB</td> </tr> <tr> <td>1</td> <td>9/2/2020</td> <td>RESPONSE TO DESIGN REVIEW BOARD</td> <td>JHO</td> <td>REB</td> </tr> </tbody> </table>	No.	DATE	DESCRIPTION	DESIGNER	REVIEWER	2	9/16/2020	RESPONSE TO CITY STAFF COMMENTS	JHO	REB	1	9/2/2020	RESPONSE TO DESIGN REVIEW BOARD	JHO	REB
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PLANT LIST

KEY	BOTANICAL NAME	COMMON NAME	QTY.	SIZE
TREES				
CF	CORNUS FLORIDA	FLOWERING DOGWOOD	4	2" CAL.
GT	GLEDITSIA TRICANTHOS VAR. INERMIS 'SKYCOLE'	SKYCOLE THORNLESS HONEYLOCUST	1	3" CAL.
PA	PLATANUS X ACERIFOLIA 'BLOODGOOD'	BLOODGOOD LONDON PLANETREE	1	3" CAL.
OR	QUERCUS RUBRA	RED OAK	4	3" CAL.
SHRUBS				
*AB	AZALEA BUXBY	AZALEA BUXBY	5	3 GAL.
AC	AMELANCHER CANADENSIS	SERVICEBERRY	1	5 GAL.
AM	ARONIA MELANOCARPA	BLACK CHOKEBERRY	6	3 GAL.
CA	CLETHRA ALMOFOLIA 'RUBY SPICE'	RUBY SPICE SUMMERSWEET	9	3 GAL.
CS	CORNUS SERICEA	RED TWIG DOGWOOD	6	3 GAL.
*JC	JUNIPERUS CHINENSIS 'BLUE POINT'	BLUE POINT UPRIGHT JUNIPER	3	4-5' HT.
KL	KALMIA LATIFOLIA 'SARAH'	SARAH MOUNTAIN LAUREL	2	5 GAL.
MP	MYRTICA PENNSYLVANICA	BAYBERRY	10	5 GAL.
VO	VBURNUM DENTATUM 'BLUE MUFFIN'	BLUE MUFFIN ARROWWOOD VBURNUM	3	3 GAL.
VT	VBURNUM TRILOBUM 'WENTWORTH'	AMERICAN CRANBERRY BUSH	9	5 GAL.
PERENNIALS/GRASSES/GROUNDCOVERS				
*HV	HEMEROCALLIS SP.	DAYLILY	6	1 GAL.
*JK	JUNIPERUS HORIZONTALIS 'BAR HARBOR'	BAR HARBOR JUNIPER	6	3 GAL.

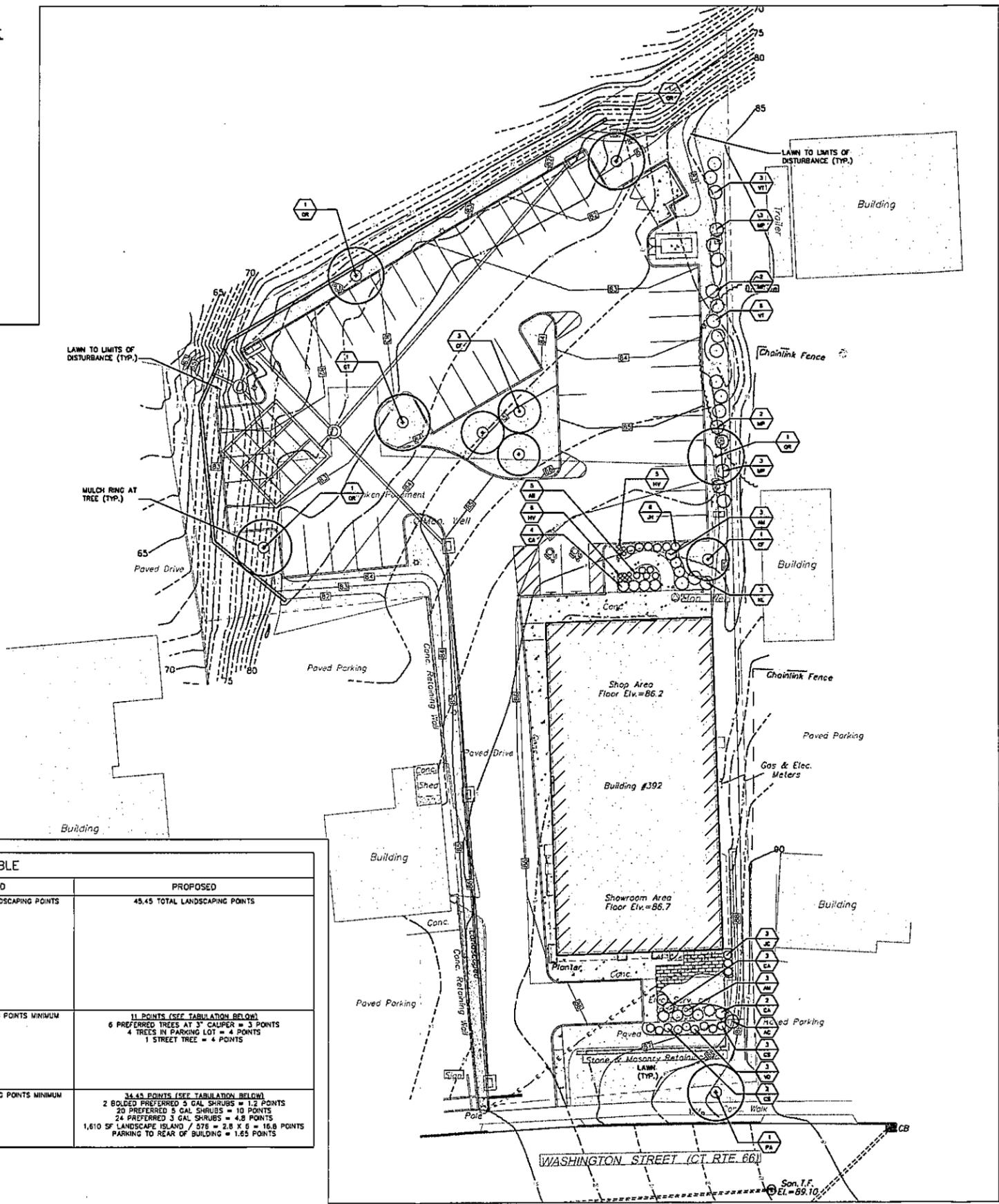
*INDICATES PLANT IS NOT ON PREFERRED SHRUB LIST AND HAS NOT BEEN INCLUDED IN CALCULATION FOR LANDSCAPING POINTS

PLANTING NOTES:

- ALL PLANTING MATERIAL TO BE NURSERY GROWN STOCK SUBJECT TO A.A.N. STANDARD.
- THE CONTRACTOR SHALL SUPPLY ALL PLANTS IN QUANTITIES SUFFICIENT TO COMPLETE THE WORK SHOWN ON THE DRAWINGS AND LISTED IN THE PLANT LIST. IN THE EVENT OF A DISCREPANCY BETWEEN QUANTITIES SHOWN IN THE PLANT LIST AND THOSE REQUIRED BY THE DRAWINGS, THE LARGER NUMBER SHALL APPLY.
- ALL PLANTS SHALL BE APPROVED PRIOR TO INSTALLATION AND SHALL BE LOCATED ON SITE BY THE CONTRACTOR FOR THE APPROVAL OF THE LANDSCAPE ARCHITECT. ANY INSTALLATIONS WHICH WERE NOT APPROVED BY THE LANDSCAPE ARCHITECT AND WHICH ARE SUBSEQUENTLY REQUESTED TO BE MOVED WILL BE DONE AT THE CONTRACTOR'S EXPENSE.
- PRECISE LOCATION OF ITEMS NOT DIMENSIONED ON THE PLAN ARE TO BE FIELD STAKED BY THE CONTRACTOR AND SHALL BE SUBJECT TO THE REQUIREMENTS SPECIFIED IN THE PREVIOUS NOTE.
- ALL SHRUB MASSINGS AND TREE PITS SHALL BE MULCHED TO A DEPTH OF 3" WITH SHREDDED PINE BARK MULCH.
- TREES SHALL NOT BE STAKED UNLESS OTHERWISE NOTED.
- THE CONTRACTOR IS RESPONSIBLE FOR ANY DAMAGED VEGETATION AND SHALL REPLACE OR REPAIR ANY DAMAGED MATERIAL, AT HIS OWN EXPENSE. THE CONTRACTOR SHALL CONTACT "CALL BEFORE YOU DIG" AT 1-800-822-4455 PRIOR TO CONSTRUCTION.
- ALL SHRUB AND GROUNDCOVER PLANTING AREAS SHALL HAVE CONTINUOUS BEDS OF TOPSOIL 12" DEEP. ALL SOO AND HYDROSEED AREAS SHALL HAVE A MINIMUM TOPSOIL BED OF 6".
- THE CONTRACTOR IS RESPONSIBLE FOR LOCATING ALL UTILITIES IN THE FIELD. WHERE PLANT MATERIAL MAY INTERFERE WITH UTILITIES, THE CONTRACTOR SHALL NOTIFY THE LANDSCAPE ARCHITECT TO COORDINATE THEIR INSTALLATION.
- FOR PLANTING SOIL MIX, SEE SPECIFICATIONS.
- ALL EXISTING RILL, GULLY OR CHANNEL EROSION SHALL BE FILLED WITH APPROPRIATE BACKFILL MATERIAL, FINE RAKED, SCARIFIED AND STABILIZED WITH APPROPRIATE VEGETATIVE MATERIAL AND / OR APPROPRIATE SEDIMENTATION AND EROSION CONTROL MEASURES.
- ADJUSTMENTS IN THE LOCATION OF THE PROPOSED PLANT MATERIAL AS A RESULT OF EXISTING VEGETATION TO REMAIN SHALL BE APPROVED BY THE LANDSCAPE ARCHITECT PRIOR TO INSTALLATION.
- THE CONTRACTOR IS RESPONSIBLE FOR ALL MAINTENANCE REPAIR AND REPLACEMENT OF PLANT MATERIAL, AS REQUIRED, FOR THE DURATION OF THE PROJECT AND SUBSEQUENT WARRANTY PERIOD.
- PLANTINGS INSTALLED IN THE DRY SUMMER MONTHS AND / OR LAWN SEEDED OUT OF SPRING OR FALL PERIODS, IF ALLOWED BY OWNER, WILL REQUIRE AGGRESSIVE IRRIGATION PROGRAMS AT THE CONTRACTOR'S EXPENSE, UNLESS OTHERWISE DIRECTED BY THE OWNER.
- UPON COMPLETION OF PLANTING, REMOVE FROM SITE ALL EXCESS SOIL, MULCH, AND MATERIALS AND DEBRIS RESULTING FROM WORK OPERATIONS. CLEAN UP SHOULD BE COMPLETED AT THE END OF EACH WORKING DAY. RESTORE TO ORIGINAL CONDITIONS ALL DAMAGED PAVEMENTS, PLANTING AREAS, STRUCTURES AND LAWN AREAS RESULTING FROM LANDSCAPE OPERATIONS.
- CONTRACTOR TO RESEED ALL DISTURBED AREAS.

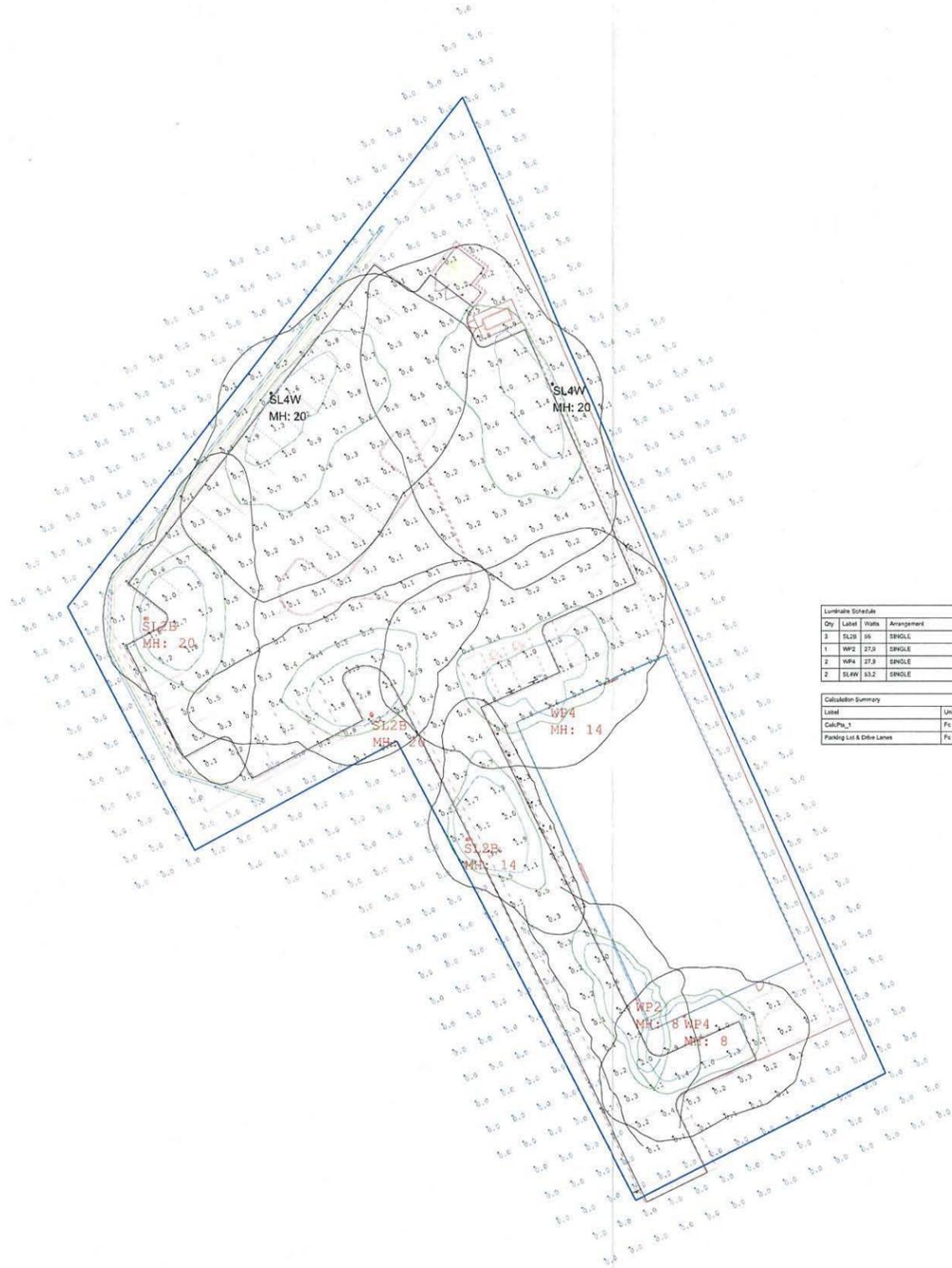
ZONING COMPLIANCE TABLE

SECTION	DESCRIPTION	REQUIRED	PROPOSED
3 - CALCULATING MINIMUM LANDSCAPING POINTS THRESHOLD	NUMBER OF PARKING SPACES 44 X 500 = 22,000 PARKING ADJUSTMENT S.F. OF DEVELOPMENT AREA 48,529 - 22,000 PARKING ADJUSTMENT = 26,529 X 0.0003 = 13.3 AREA POINTS MIN. NUMBER OF PARKING SPACES 44 X 0.075 = 3.3 PARKING MINIMUM POINTS 0 PARKING SPACES OVER MINIMUM REQUIRED 13.3 AREA POINTS + 3.3 PARKING MINIMUM POINTS + 0 EXCESS POINTS = 16.6 TOTAL MINIMUM THRESHOLD	16.6 TOTAL MINIMUM LANDSCAPING POINTS	45.45 TOTAL LANDSCAPING POINTS
3 - CALCULATING MINIMUM LANDSCAPING POINTS THRESHOLD	PERCENTAGE OF POINTS ACCUMULATED FROM TREES SHOULD BE AT LEAST 50% OF THE MINIMUM THRESHOLD TOTAL POINTS REQUIRED	TREES: 8.3 LANDSCAPING POINTS MINIMUM	11 POINTS (SEE TABULATION BELOW) 6 PREFERRED TREES AT 3" CALIPER = 3 POINTS 4 TREES IN PARKING LOT = 4 POINTS 1 STREET TREE = 4 POINTS
4 - POINTS TREES	BOLDED PREFERRED TREES AT 3" CALIPER = 0.5 POINTS EACH BONUS POINTS, TREE IN PARKING LOT: 1 POINT EACH BONUS POINTS, STREET TREE: 3 POINTS EACH		
4 - POINTS SHRUBS	BOLDED PREFERRED 5 GALLON = 0.6 POINTS EACH PREFERRED 3 GALLON = 0.3 POINTS EACH BONUS POINTS, EVERY 576 SF LANDSCAPED ISLAND = 8 POINTS BONUS POINTS, 75% OF PARKING TO REAR OF BUILDING = 3.3/2 = 1.65 POINTS	SHRUBS: 8.3 LANDSCAPING POINTS MINIMUM	34.45 POINTS (SEE TABULATION BELOW) 2 BOLDED PREFERRED 5 GAL SHRUBS = 1.2 POINTS 20 PREFERRED 3 GAL SHRUBS = 10 POINTS 24 PREFERRED 3 GAL SHRUBS = 4.8 POINTS 1,610 SF LANDSCAPE ISLAND / 576 = 2.8 X 8 = 16.8 POINTS PARKING TO REAR OF BUILDING = 1.65 POINTS



File Path: J:\DWG\20200506\10\Chw\Plan\20200506\10_LAND\10.dwg Layer: LP-101 User: jshahgier
 Plotter: AUTOCAD PDF (GENERAL DOCUMENTATION) PC3 CTB File: FOSTB
 LAYER STATE:

SCALE: HORIZ: 1" = 20'	DATE: 9/16/2020	RESPONSE TO CITY STAFF COMMENTS	DESIGNER
VERT: 1" = 20'	9/17/2020	RESPONSE TO DESIGN REVIEW BOARD	REVIEWER
		PROJECT NO: 20200506.A10 DATE: 07/24/2020	
FUSS & O'NEILL 146 HARTFORD ROAD MANCHESTER, CONNECTICUT 06040 860.646.2469 www.fussn.com		ROOT CENTER FOR ADVANCED RECOVERY LANDSCAPE PLAN 392 WASHINGTON STREET MIDDLETOWN CONNECTICUT	
LP-101		FOR LAND USE PERMITS ONLY	



Qty	Label	Watts	Arrangement	LLF	Description
3	SL2B	35	SINGLE	0.900	Beacon VPS-24L-55-3K7-410-1214-A-xx / HSS/VPS/2754 B / 14ft to 20ft Pole
1	RP2	27.5	SINGLE	0.800	Hubbell LMC3-24L-3K400-440w
2	RP4	27.5	SINGLE	0.800	Hubbell LMC3-24L-3K400-440w
2	SL4W	33.2	SINGLE	0.900	Beacon VPS-24L-55-3K7-410-BC / 14ft to 20ft Pole

Calculation Summary						
Label	Units	Avg	Max	Min	Avg/Min	Max/Min
CalcPa_1	Fc	0.26	0.1	0.0	N.A.	N.A.
Parking Lot & Drive Lanes	Fc	0.07	0.1	0.0	N.A.	N.A.

Project: RCA Middletown		Detail: Photometric Calculation	
Contact: Lisa Tuttle Specification Sales (860) 751-4388 ltuttle@illuminate.com		Date: _____ Revision: _____ Scale: N.T.S. Drawn By: LT	
 44 Sixth Road Woburn, MA 01801 (781) 935-8500		Drawing Number: <h1>L-1</h1>	
333 Pleasant Valley Road South Windsor, CT 06074 (860) 282-0537		Sheet 1 of 1	