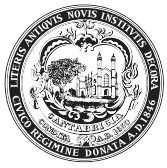
Community Experiences with Opioids and Other Substances: Insights and Recommendations Cambridge & Somerville



Cambridge
Public Health
Department

Somerville
Prevention Services

Cambridge
Public Health
Department

Community Experiences with Opioids and Other Substances: Insights and Recommendations

Cambridge & Somerville

2023-2024

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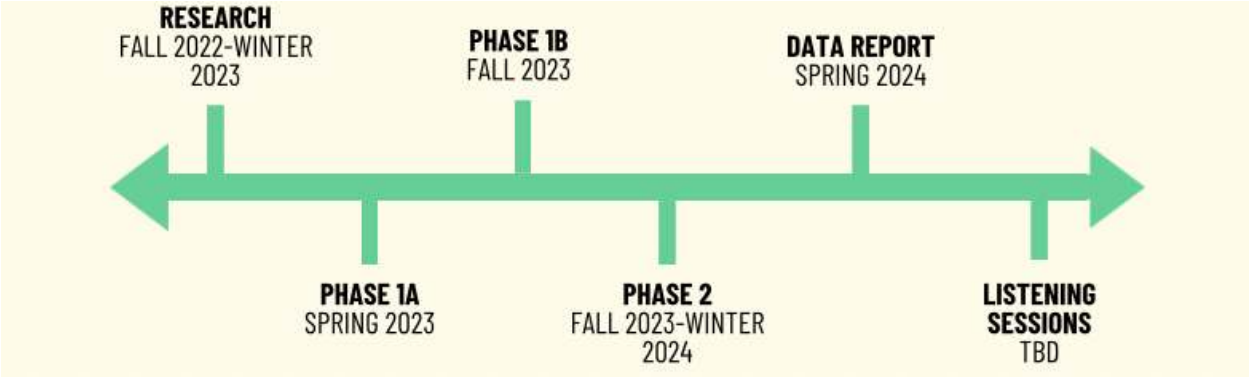
Introduction & Overview

The Commonwealth of Massachusetts participated in a nationwide financial settlement which involved several companies as a part of historic legal efforts to demand abatement of harms caused by the opioid epidemic. Opioid distributors AmerisourceBergen and Cardinal and McKesson as well as opioid manufacturer Johnson & Johnson were involved in the settlement.

Combined, these settlements will bring over $900 million to Massachusetts for substance use prevention, harm reduction, treatment, and recovery support. The funds will be distributed with intent to strengthen and supplement existing resources for communities, individuals, and families in a manner that reflects the input of these communities; of people who have personal experience with the opioid crisis; of treatment and prevention experts; and of organizations that are carrying out the abatement work. In order to distribute the funds in an inclusive manner,input from community members was essential.

The Cambridge Public Health Department (CPHD) and the City of Somerville's Health and Human Services Department (HHS) are partnering for the community engagement data collection process to gain insight into allocating the settlement funds. HHS was allotted roughly $1 million and CPHD was allotted $9 million, which will be distributed over a fifteen year period which began in July 2022 and will run through 2038**.** Both Cambridge and Somerville anticipate receiving funds from other similar settlements in the future, and findings from this report may impact spending decisions for that funding as well.

Timeline & Methods



The qualitative data collection process occurred in two primary phases. Phase One can be broken into two sub-phases, referred to as Phase One A (1A) and Phase One B (1B), which will be delineated and addressed separately in the following report sections. During each, CPHD and HHS staff conducted interviews with individuals with lived experience with opioids who receive services at community-based harm reduction agencies. The preliminary research phase was spent developing interview questions and contacting community partners to coordinate the interview

sessions. Phase 1A included conducting said interviews and reviewing the data. The data collected during Phase 1A then informed the development of separate questions for Phase 1B. Phase Two surveyed people with lived experience and individuals who professionally support people with lived experience, primarily in medical or social support settings. The survey largely replicated questions from Phase 1A, but was also supplemented with Phase 1B questions as well as questions from surveys developed by the Metropolitan Area Planning Council (MAPC) and the Boston Public Health Commission. An appendix of all interview and survey questions is available at the end of this report.

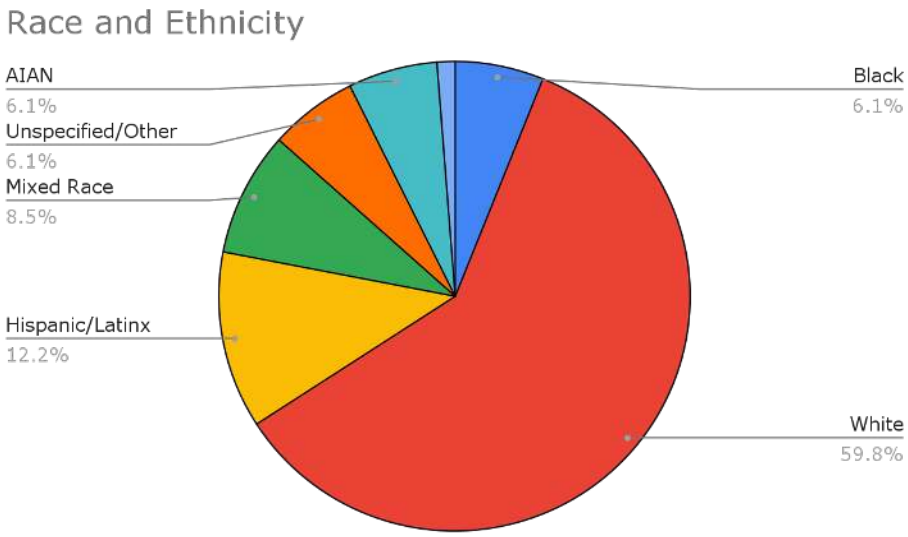
Phase One spanned mid-April 2023 to late September 2023; for the duration of this time, key informant interviews were conducted at Somerville Homeless Coalition (SHC), the Fenway Health Access Drug User Health Program (Access), and during outreach by Bay Cove/CASPAR First Step (First Step). Phase 1A included five sessions total: two each at Access and SHC and one during First Step outreach. Phase 1B included four sessions, two each at Access and SHC.

Phase Two community survey questions were developed and finalized between late September and mid-November 2023. This was then followed by survey dissemination from mid-November 2023 to mid-January 202. Finally, survey data was reviewed in March of 2024.

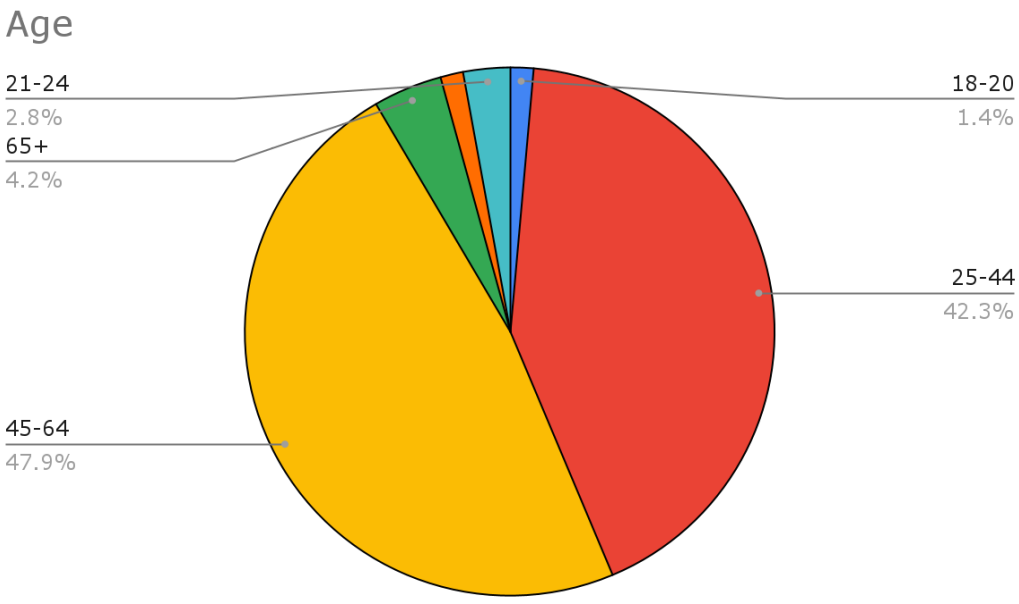
The findings from the entire data collection process are presented in this report. City officials and community partners are encouraged to use the report as they assess the needs of the community and consider which new and existing programs and resources will be supported with the amassed funds over the fifteen-year period. Feedback should be solicited regularly throughout the funding period to ensure that the perspective of those with lived experience is consistently taken into account. CPHD and Somerville HHS staff who designed this data collection process also envisioned that, as decisions are made regarding fund expenditures, city officials would engage with the larger communities of each city as part of a third phase. These listening sessions can be used to present proposed expenditures and solicit feedback on implementation and broader impacts on the general public.

Demographic Data Summary (Phase One A & B)

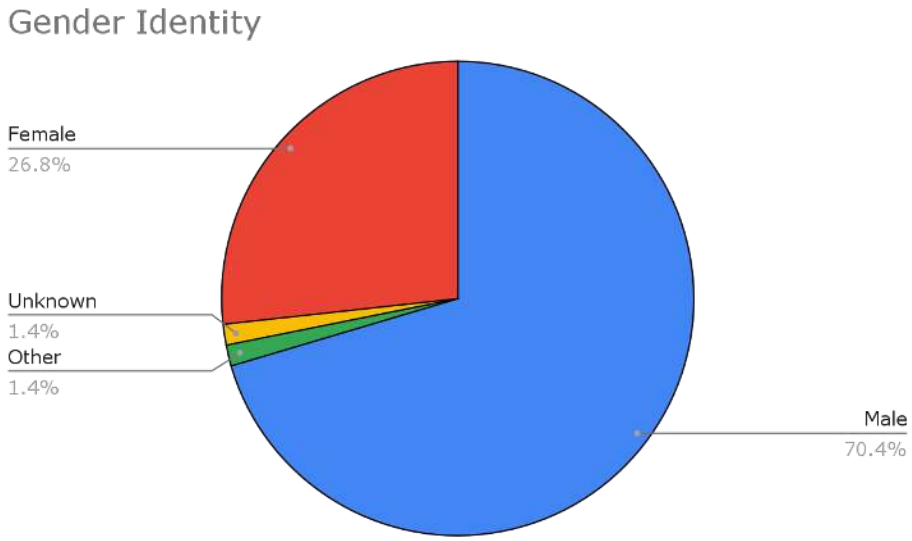
Demographic data, including race and ethnicity, gender identity, age, and lived experience was collected during Phases 1A and 1B. A written survey instrument was given to participants to complete themselves; thus, all data was self-reported. The demographic information was collected after the interview questions were completed. Responses were collected from 45 participants in phase 1A and 25 participants in phase 1B, totaling 70 participants.



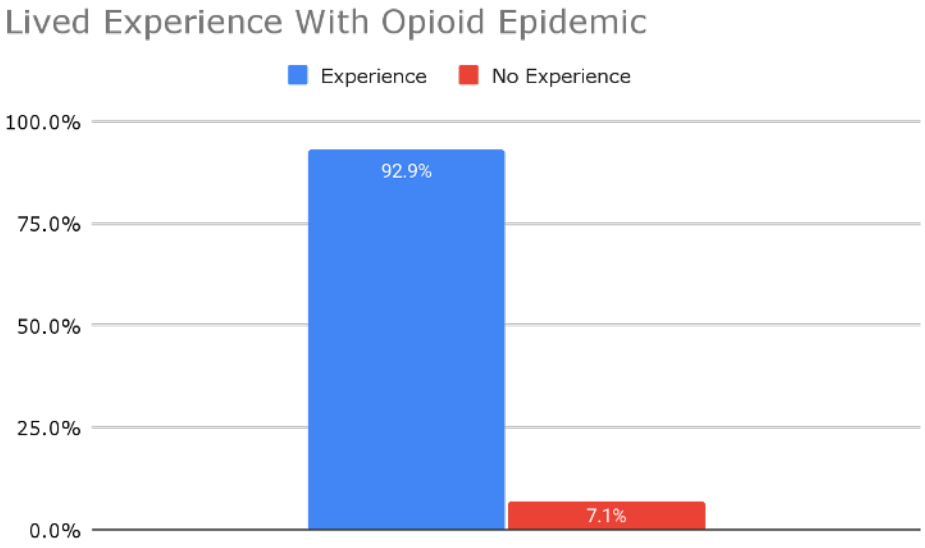
The results of the demographic data showed that 49 participants (59.8%) identified as White. 10 people (12.2%) reported that they were Hispanic/Latinx. 7 people (8.5%) reported to be mixed race. 5 individuals (6.1%) reported in each of the categories of Black, mixed race, and American Indian and Alaska Native (AIAN). 1 person (1.2%) reported that they were Asian. Participants were instructed to select all applicable options, so people may have reported multiple answers.



Of the individuals interviewed, 47.9% were between ages 45 and 64, followed by 42.3% falling between ages 25 and 44. The remaining 9.8% included all people aged below 24 and above 65 years old. This remaining 9.8% can be further broken into 4.2% of people being above the age of 65 and 4.2% of people being younger than 24 years old.



Looking at the distribution of gender identity of interviewees, Fifty (70.4%) identified as male while nineteen (26.8%) identified as female. The remaining 2.8% identified as either unknown or other.

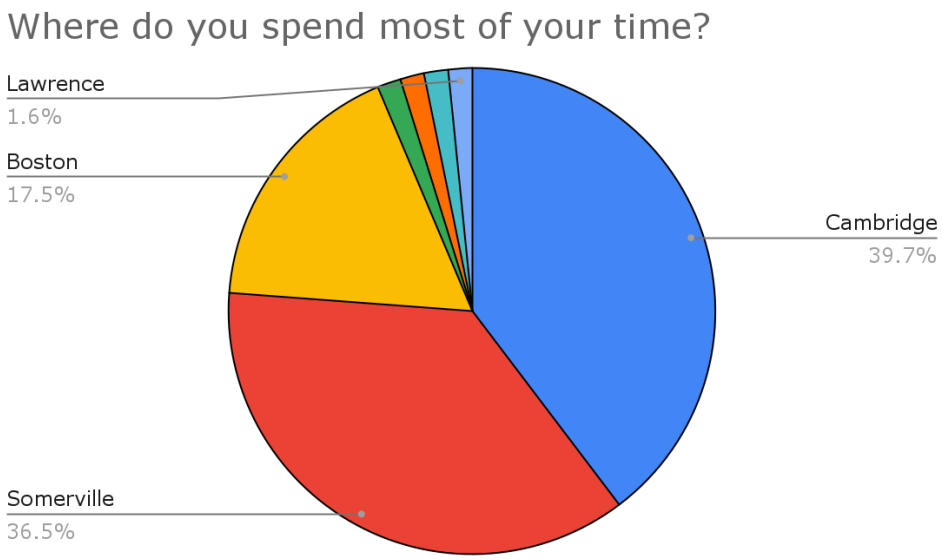


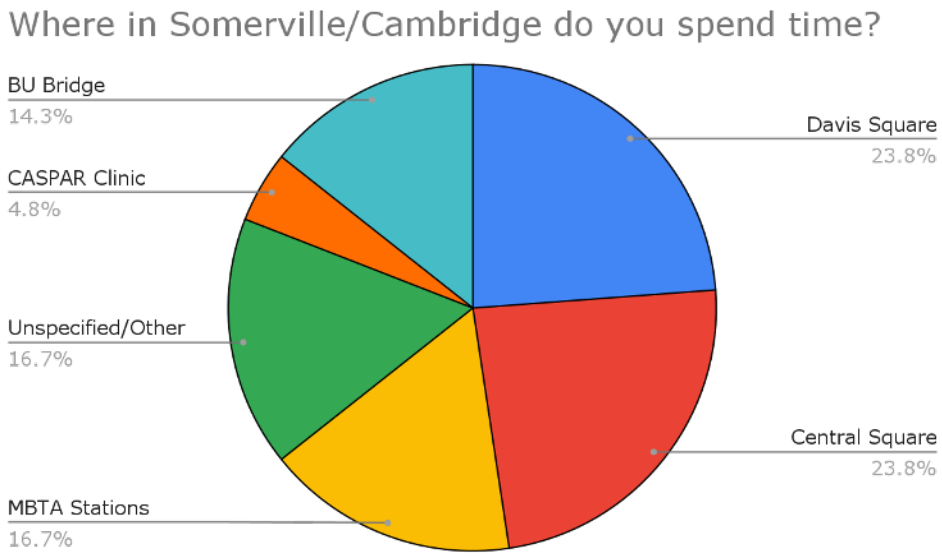
The final demographic question asked whether the participants had lived experience with the opioid epidemic. Almost everyone interviewed (92.9%) responded that they did have lived experience with the opioid epidemic, while 7.1% did not have lived experience related to opioids.

Participants were also given the opportunity to share their contact information if they would like to be informed of follow-up opportunities to provide more input. This was completely voluntary and contact information was kept entirely separate from individual responses. Follow-up contact was attempted between Phases 1A and 1B and when the Phase Two survey was released. Therefore, some participants were able to give their input across all data collection phases.

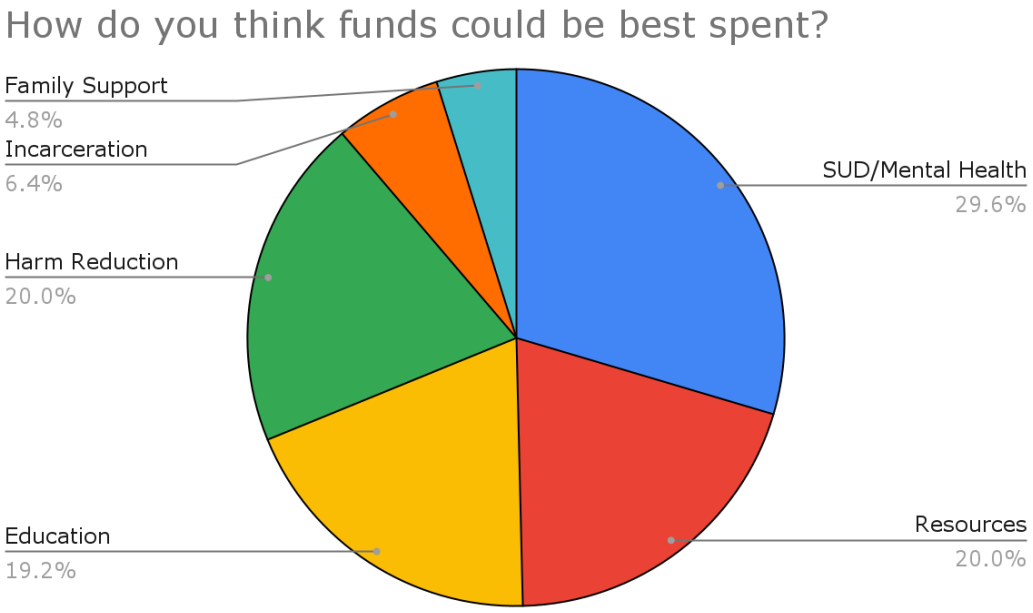
Phase 1A Summary

Phase 1A aimed to interview individuals at drop-in sessions at the SHC and Access in Cambridge as well as one on-site location, accessed by mobile van, which was in partnership with Bay Cove/CASPAR First-Step at an encampment site. These interviews were conducted to collect information from people who use drugs and have personal experience with substance use on how funds should be allocated.

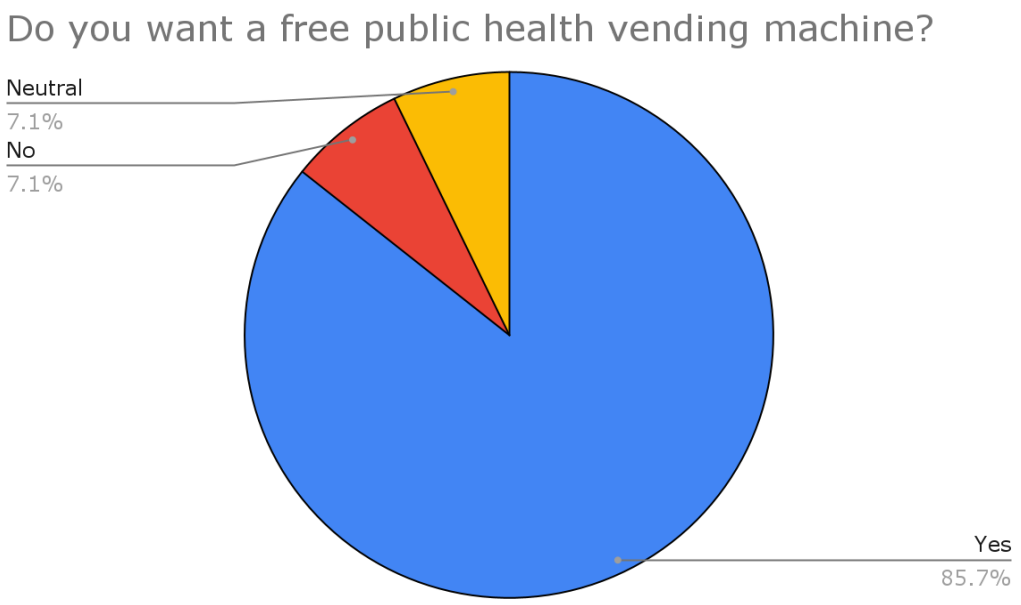




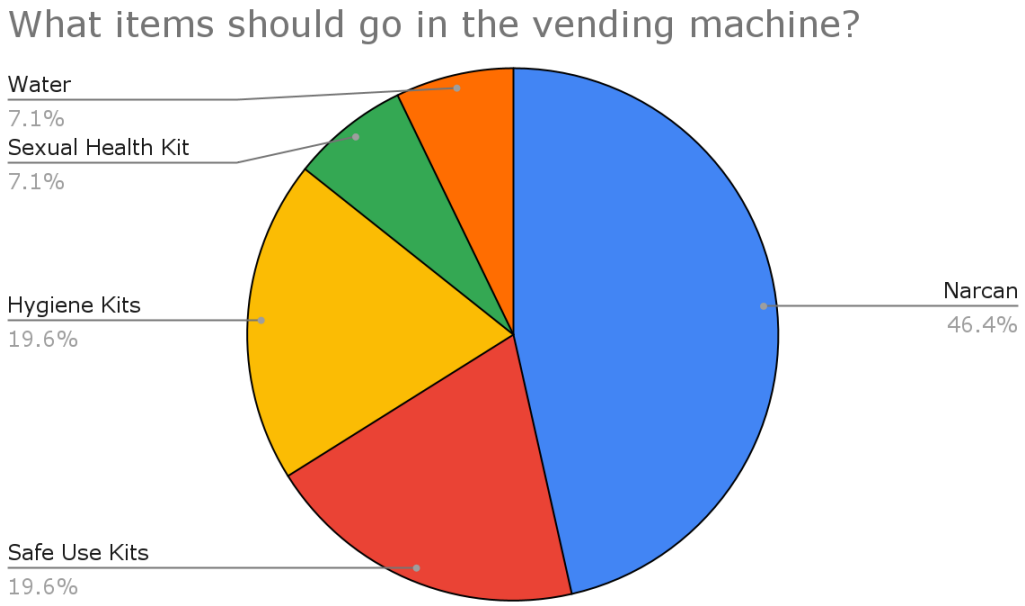
The first two questions collected data about where participants spend most of their time. Few individuals reported that they spend time in just one of the areas they listed, instead indicating that they spend time in multiple locations. The majority (39.7%) reported spending time in Cambridge, followed by 36.5% of people reporting Somerville, 17.5% reporting Boston, and the remaining (6.4%) split between Lawrence, Lynn, Peabody, and Charlestown. The specific places that individuals reported spending time included Davis Square (23.8%); Central Square (23.8%); MBTA stations (16.7%); an encampment site in Cambridge (14.3%); and the CASPAR Clinic (4.8%). The remaining 16.7% reported other answers or did not specify.



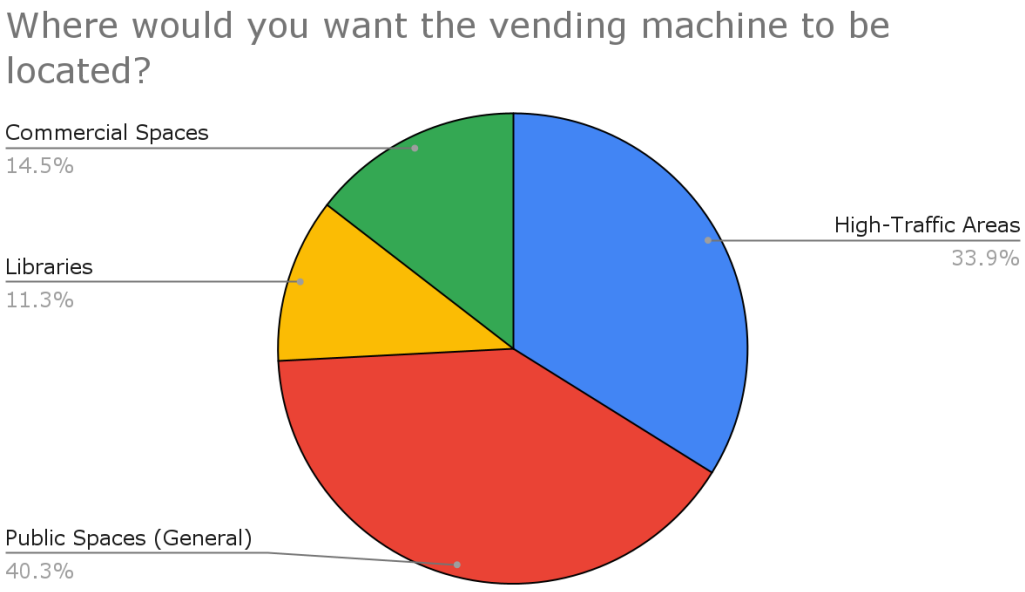
Participants were then asked about their priorities for spending the abatement funds. Educational materials explaining appropriate funding expenditures, including within the domains of prevention, harm reduction, and treatment, were distributed prior to participants answering this question to better orient their responses. The majority (29.6%) wanted substance use disorder treatment and mental health support services to be supplemented. Examples of substance use disorder treatment participants referenced included detox facilities and resources and medication-assisted treatment. Specific mental health support for people experiencing housing insecurity was also brought up by a number of participants. 20% of participants voiced support for harm reduction services to help reduce the dangers of substance use for those unable to reduce or stop their substance use. Another 20% suggested general resources including case workers, peer recovery coaches, job search assistance, and food assistance. 19.2% suggested education for shelter staff, people prescribed opioids, and the general public as the most impactful use of funds, with a focus on safe usage of opioids and harm reduction. Finally, 11.2% expressed a desire to see more support specific to people with a history of incarceration and family support.



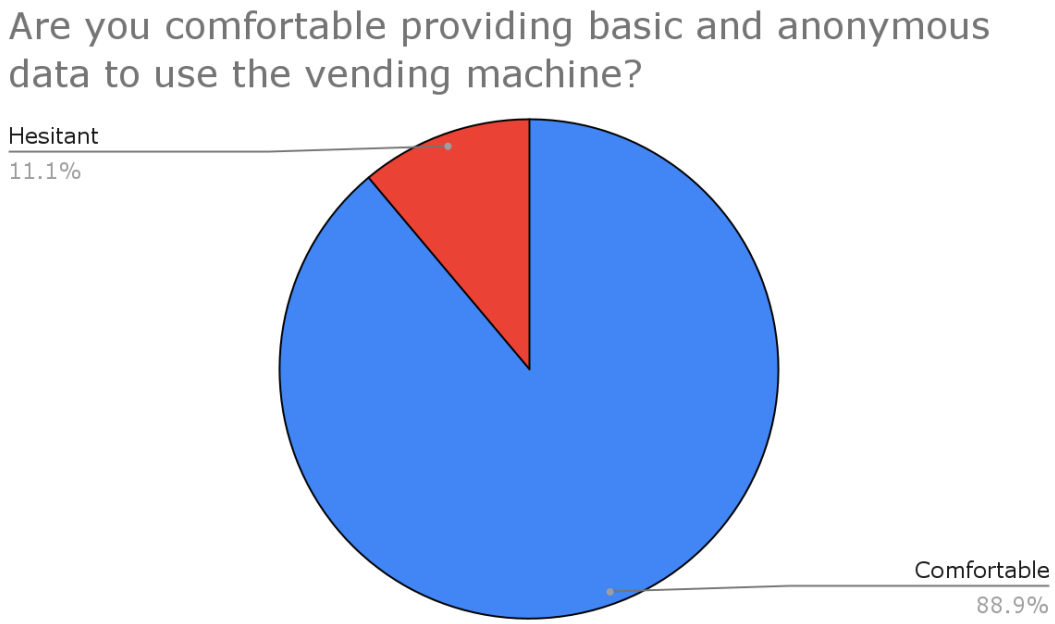
Participants were asked about their interest in a free public health vending machine. Prior to conducting the survey, CPHD and Somerville HHS staff had been exploring the possibility of vending machines that would dispense harm reduction products and other supplies. This type of vending machine has been used successfully in other cities and towns across the United States. Interview questions specific to the vending machine option were used to explicitly assess whether there would be community support for using the funds in this manner. The majority of people (85.7%) stated that yes, they would be interested in this proposal. Of the remaining total, 7.1% stated they felt neutrally about this idea and 7.1% did not want a public health vending machine.



To gain more insight on the proposed public health vending machine, respondents were asked about what kinds of products or items they would be interested in seeing in these machines. Nearly half (46.4%) stated that they would want Narcan offered. Hygiene kits and safe use kits were indicated by 19.6% of respondents, while water and sexual health kits were identified by 7.1%. Hygiene kits would include items such as soap, shampoo and conditioner, lotion, a toothbrush and toothpaste, dental floss, deodorant, pads and tampons, and hand sanitizer. Safe use kits would include items such as sterile needles, cookers and bubblers, Narcan, and Fentanyl test strips.



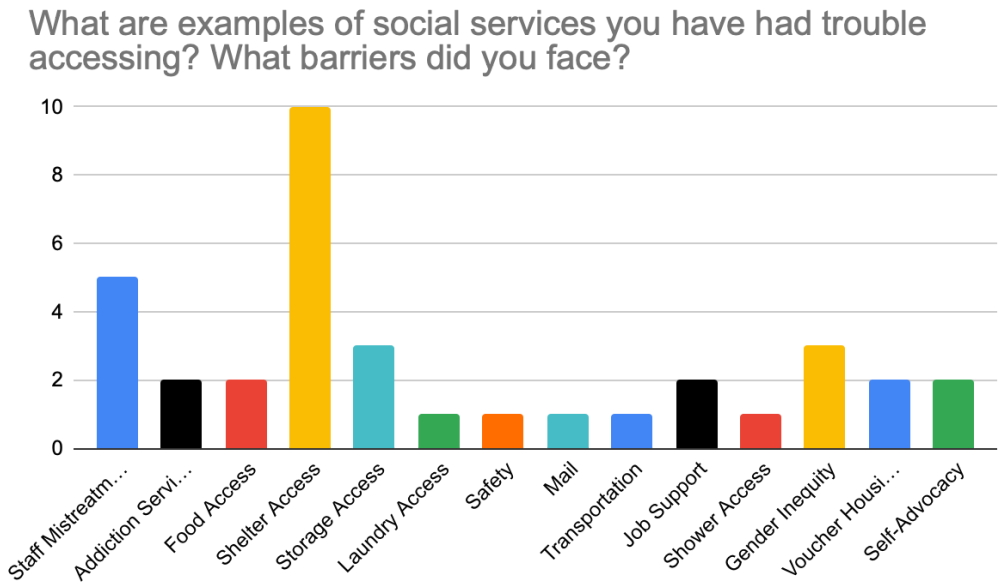
Asked where they felt these vending machines would be the most impactful and useful, the majority (40.3%) of respondents said that they should be located in general public spaces (as opposed to being co-located inside or along with a business). This includes, but is not limited to, MBTA stations (both inside and out), and Portland Loo areas, which were mentioned by multiple respondents. Additionally, 33.9% mentioned highly-trafficked areas, including Central and Davis Squares (public squares were specifically. Commercial spaces such as restaurants, pharmacies, and dispensaries and libraries made up the final 25.8%.



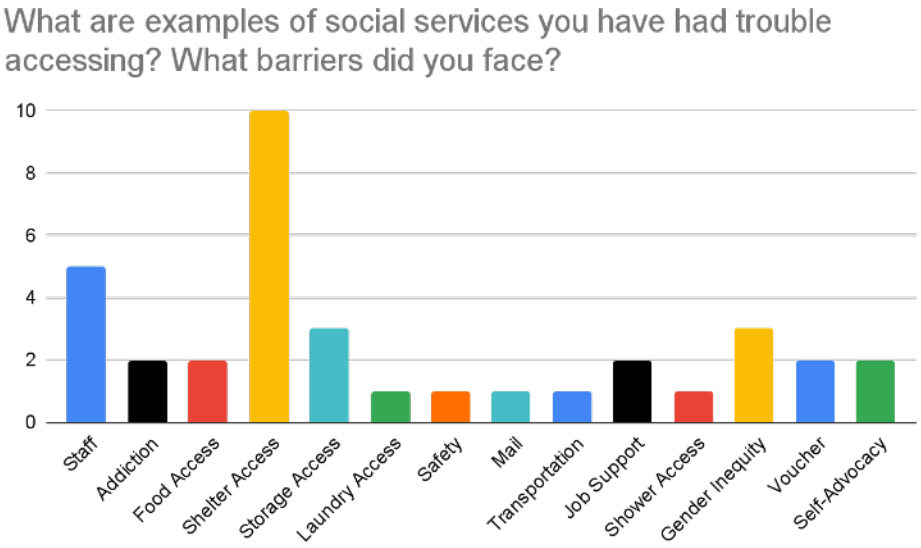
The final question regarding the vending machines asked if individuals would be comfortable providing basic and anonymous data in order to use the machine. A majority of people (89%), reported that yes, they would feel comfortable providing this data. The remaining 11.1% reported feeling either hesitant for themselves or for others, but did not state that they were completely unwilling.

Phase 1B Summary

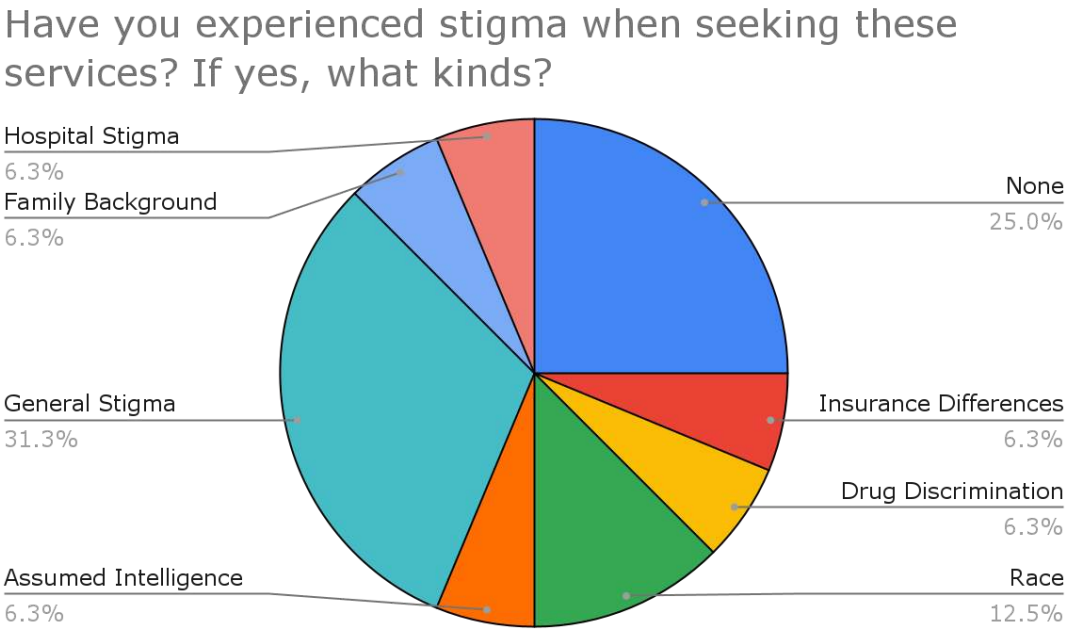
The next part of the interviews, Phase 1B, consisted of refining the questions from Phase 1A into more specific and open-ended questions to get a better understanding of the experiences of those who have personal experience with the opioid crisis in the greater Somerville and Cambridge areas. The locations that were visited for these interviews include the SHC and the Access program in Cambridge.



The first question asked about people in the participants' life who have attempted to use substance-use related services and the barriers they faced to accessing those services. The top reported answers were a lack of beds in hospitals and treatment facilities and fear of mistreatment by staff. Lack of female-specific services, the feeling that providers lacked knowledge of substance use challenges, and transportation barriers were also reported by more than one individual. The remaining answers included methadone access, increasing wait times, negative mental health impacts, fear of boredom, non-individualized care, and fear of child protective services.

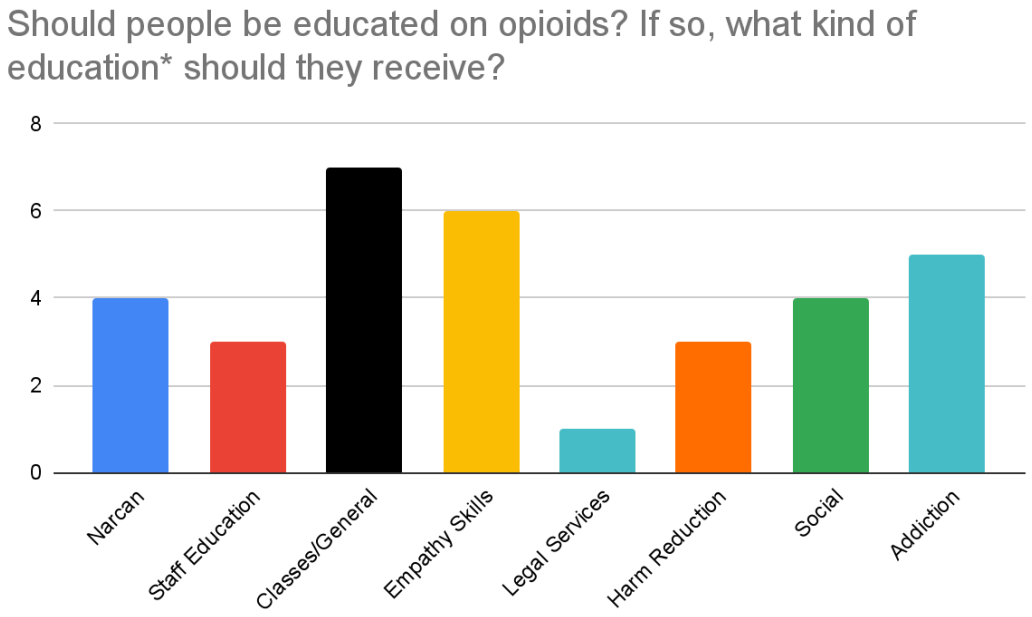


Question two asked about barriers to accessing other social services. The top reported answer, by ten respondents, was shelter accessibility. Issues of shelter accessibility included circumstances in which beds simply were not available at any shelters the participant wanted to stay at, but also included situations wherein shelters do have capacity but the shelter itself is unappealing or unwelcoming to the participant. This is especially salient for people living with substance use disorder who would rather turn down a shelter bed than stay in a "dry" shelter with policies that require people staying there to abstain from all substance use. This was followed by mistreatment by staff at these facilities and gender-specific barriers. For example, some participants who identified as women said that they felt uncomfortable staying at some shelters that are not female-specific because of concerns of harassment or assault. Other difficulties identified by two or fewer individuals included access to addiction services, food access, storage access for their belongings while they sought treatment, laundry access, general safety concerns, lack of mailing address, transportation as a barrier, a need for job support, access to clean running water, voucher housing issues, and self-advocacy.

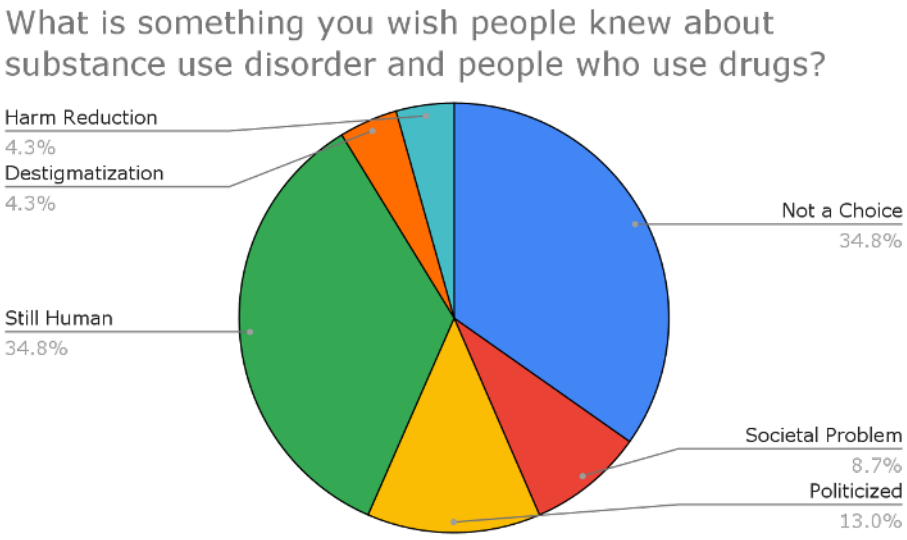


Stigma is an issue that can prevent people from seeking services and support. Respondents were asked about the kinds of stigmas individuals who use drugs have faced. 31.3% reported that there is a general negative stigma impacting these individuals. 12.5% reported that race is a factor in how they experience stigma related to their substance use disorder. Other ways that participants have experienced stigma include being treated differently than other patients in healthcare settings; assumptions that people who used drugs have a lower intelligence than people who don't use drugs; having a family who is unsupportive and from a different social

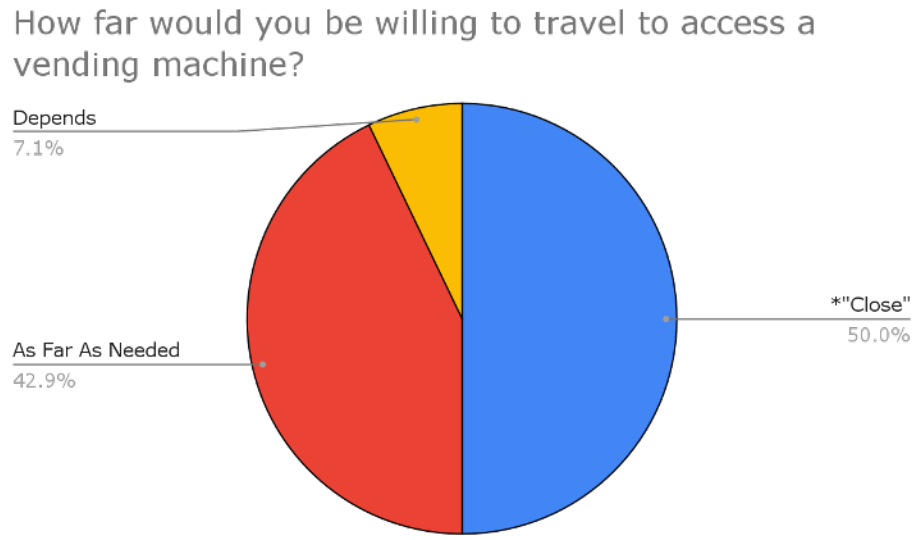
background than what the individual has experienced; insurance types determining the quality of care that is received; and discrimination specific to the type of drug used (for example, opioid users may report a different level or type of stigma compared to stimulant users). 25% of respondents reported that they feel there is no stigma when seeking social services.

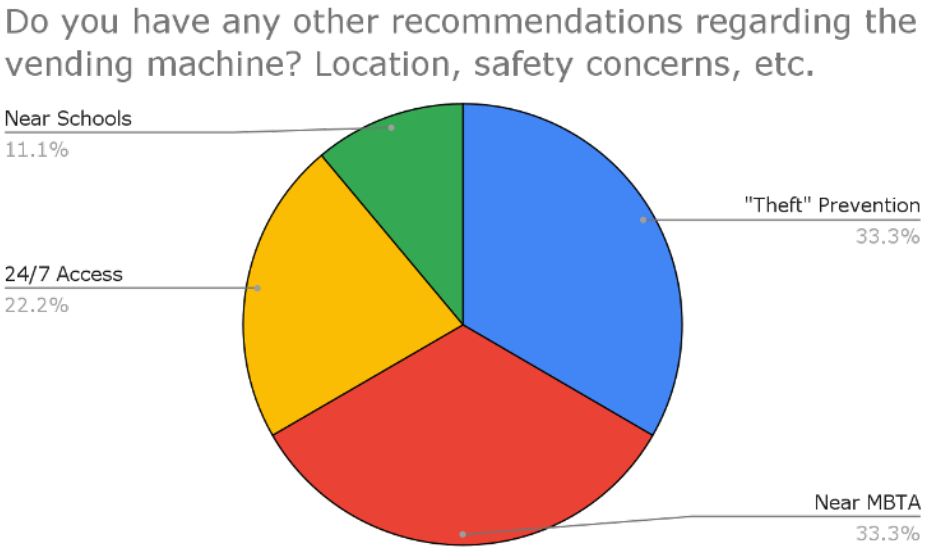


Interviewees were asked about the kinds of education that should be provided to people who work at shelters, people who are being prescribed opioids, and the general public. The most common responses were general education or classes on specific topics related to substance use; empathy skills towards those who use drugs; and addiction education. Other answers were Narcan use and access; staff education; legal services education; harm reduction topics; and education on available social services.



Question five asked interviewees about what they wish people knew about substance use disorder and people who use drugs. The most common answers, each reported by 34.8% of respondents, were that 1) people who use drugs are still human and 2) that drug misuse is a disease, not a choice. The remaining answers included a wish that drug use could be destigmatized; that people knew more about harm reduction; that drug use is a societal problem rather than an individual problem; and that substance use disorder is heavily politicized and commercialized.



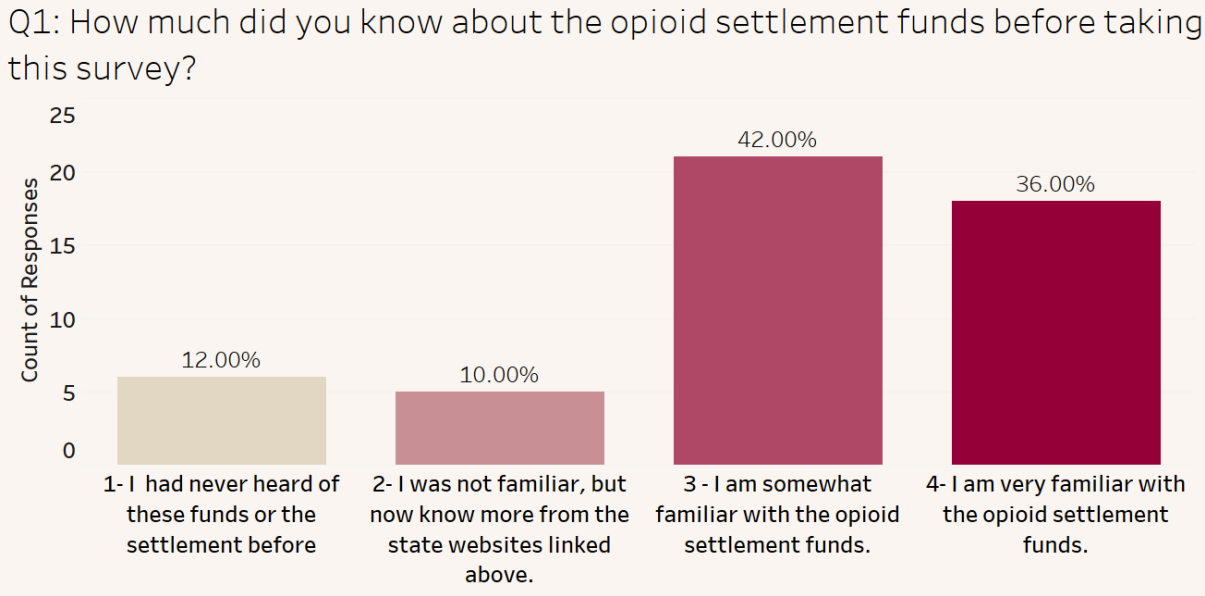


The final question related back to Phase 1A's inquiry about the free public health vending machine. The first portion of the question asked about how far a person is willing to travel to access a vending machine. The most common answers were "as far as needed","close", and "it depends". With the "as far as needed" responses, respondents stated that they were willing to go out of their way, whether this be a far walk or by taking public transportation, to access this resource in a different area than they spend time in. The respondents that said "close" indicated that they would like it to be within walking distance from places where they reside or spend time. The second part of this question asked about any other recommendations for the vending machine. Common answers included that it should be near MBTA stations, that it should have

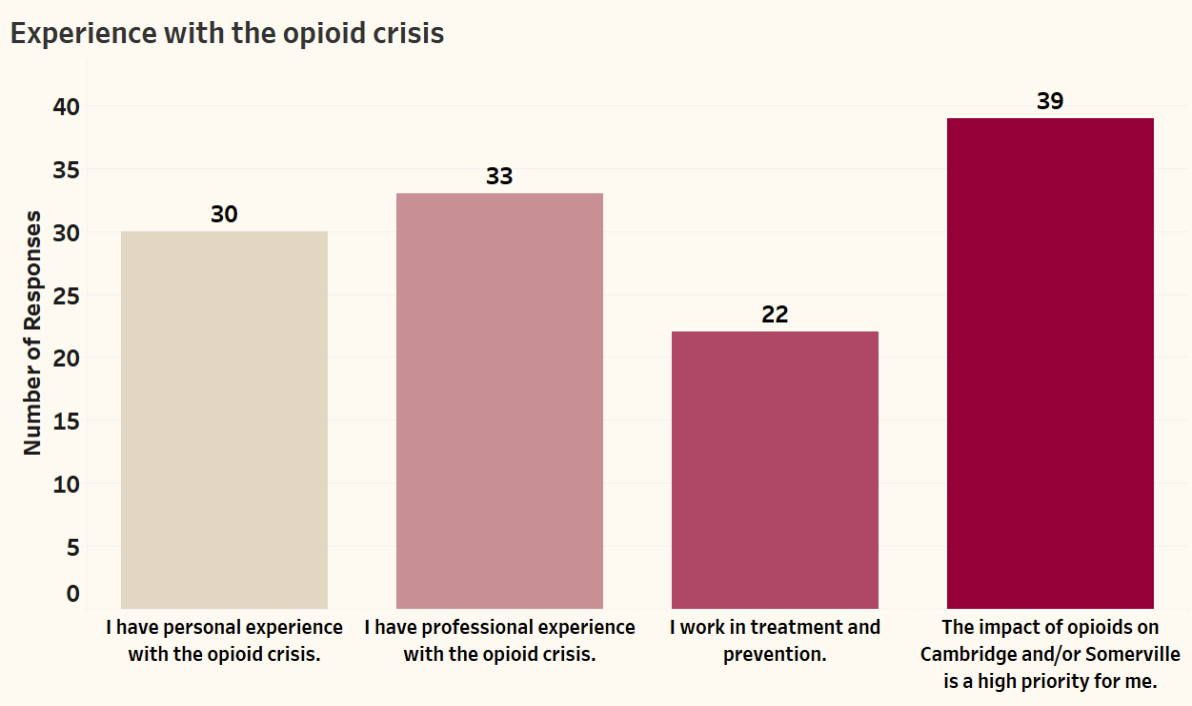
some sort of theft prevention accessory or security, that it should be near schools, and it should have 24/7 access available.

Demographic Data Summary (Phase Two)

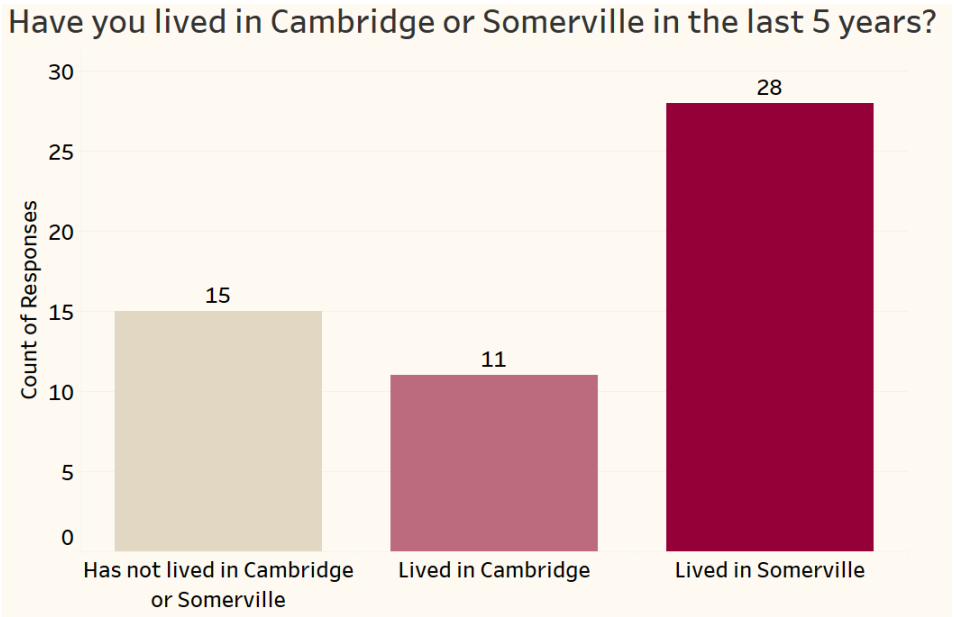
Within Phase Two of this data collection, a total of fifty people participated in interviews. The results of this data collection showed that 90% of the participants were white and between the ages of 25 and 44. 46% of participants were within this age range, followed by those aged 45 to 64, which made up 24%.



A scale from 1-4 was used to ask how much participants felt they knew about opioid settlement funds prior to this interview, with one being that the individual has no knowledge of the opioid abatement settlement funds to four being that the individual is very familiar with the opioid settlement funds. The vast majority (78%) of participants indicated that they were "somewhat" or "very familiar" with these funds. The location where an individual lived, worked, or received healthcare was not correlated with their knowledge of the funding.

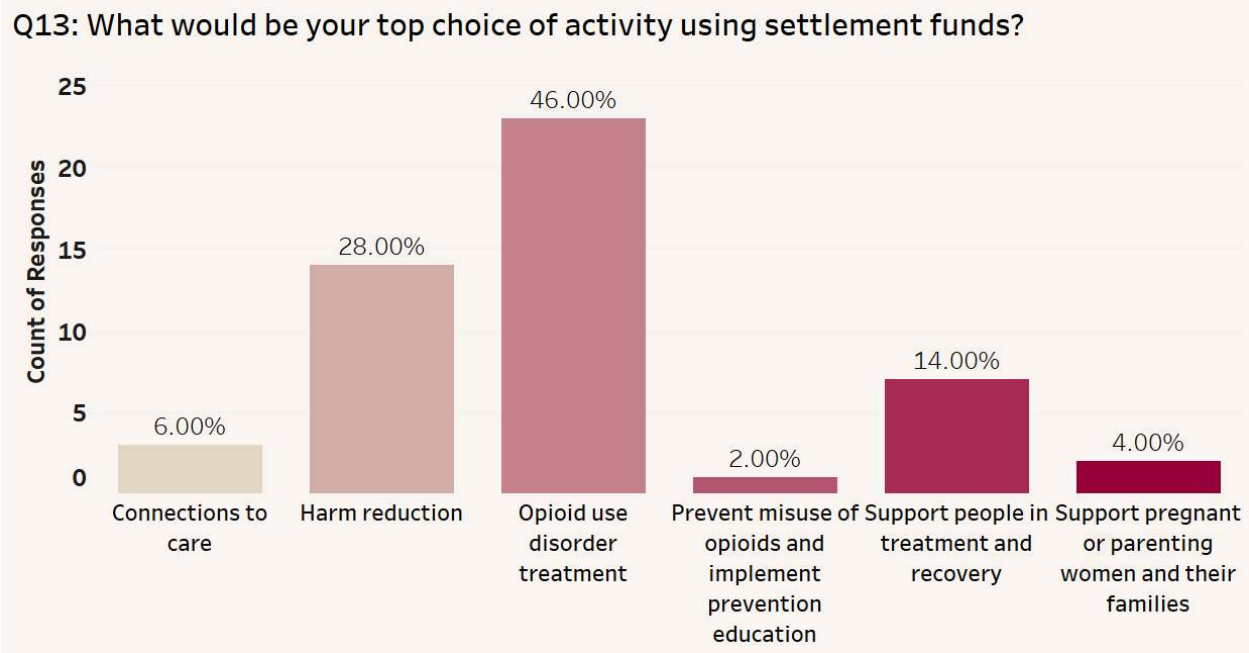


Nearly all participants (96%) considered themselves to be informed about the opioid crisis in comparison to the general public. About half of participants have had experience working with the opioid crisis, with 66% of this group having had professional experience and 44% working in treatment or recovery. Over half of the participants have been personally impacted by the opioid crisis, and most indicated that the impact of opioids is of high priority to them.

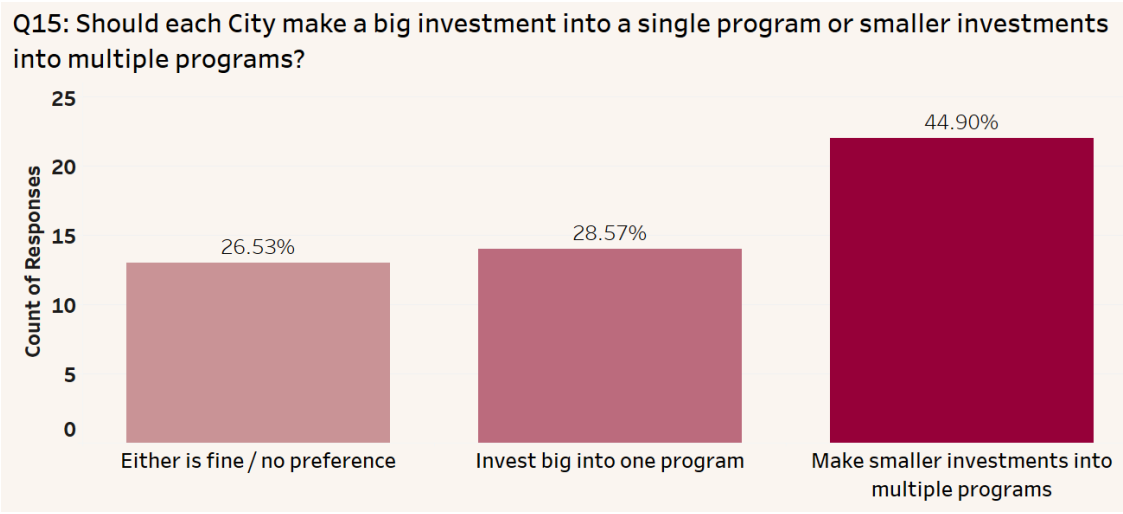


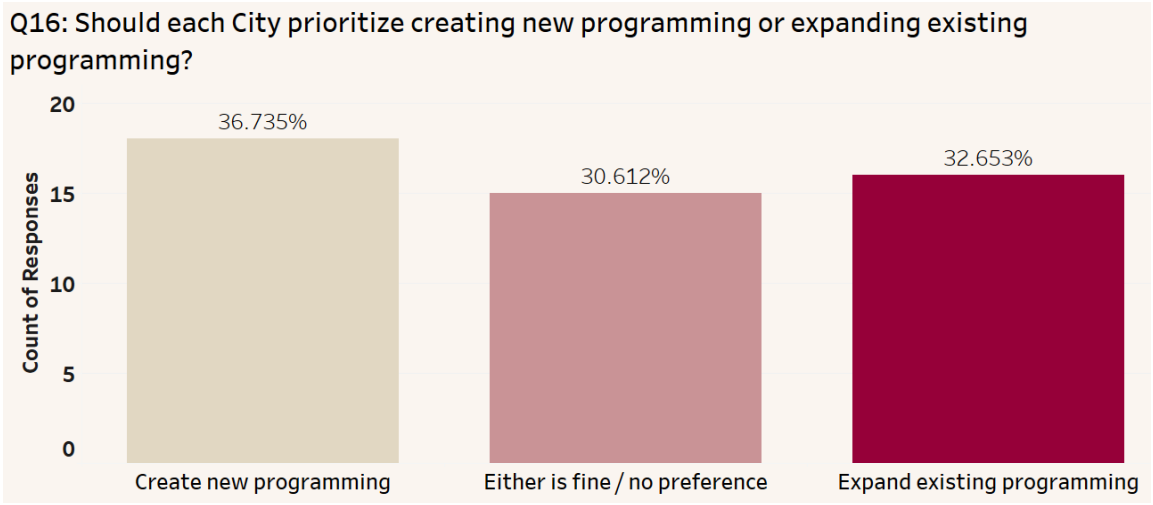
Many participants indicated that they lived, worked, or received healthcare in Cambridge and Somerville. Of the 50 participants, 28 have lived in Somerville, 11 have lived in Cambridge, and 15 have lived in neither. Of these responses, 56% of Cambridge-residing and 60% of Somerville-residing participants have received healthcare in their respective areas. Participants who have not worked, lived, or received healthcare in Somerville or Cambridge within the past five years had the most variation in their responses.

Phase Two Summary



Participants were asked which opioid use disorder treatment and harm reduction activities should be the focus of the settlement funds. 46% of participants stated that opioid use disorder treatment is the most useful way for funds to be utilized. This was followed by 28% of participants indicating harm reduction and 14% of participants suggesting support for people in treatment and recovery. Only 6% of participants identified connections to care, 4% identified supporting pregnant or parenting individuals and their families, and 2% noted preventing misuse of opioids and implementing prevention education. Harm reduction was the most important use for funds among people who have lived in Cambridge or Somerville. Opioid use disorder treatment is considered important by all groups, though data suggests that it may be more important for those who have worked in Cambridge in the last five years, have not received healthcare in Cambridge or Somerville in the past five years, and those who have personal experience with the opioid crisis or have worked in recovery.





Asked about the division of funds, participants had a slight preference for making smaller investments into more programs, although they remained split or indifferent about how funding should be divided. Participants also showed no preference between creating new programming or expanding existing programming.

When looking at the reported barriers that participants and people in their life faced when seeking substance-use related services, the most commonly-reported barrier included transportation issues. This takes many forms, including that many treatment facilities are inaccessible without a car. Respondents noted that the MBTA does not serve these locations and expecting patients to be able to seek car share services or taxis is not reasonable due to multilayered financial, accessibility, and ease of use factors. Housing is also a systemic issue that relates to transportation inaccessibility. When a person does not have a permanent address, there are difficulties with changing living accommodations while having all of their belongings in tow. A commonly reported concern was that individuals experiencing homelessness would be stripped of their belongings if they sought treatment.

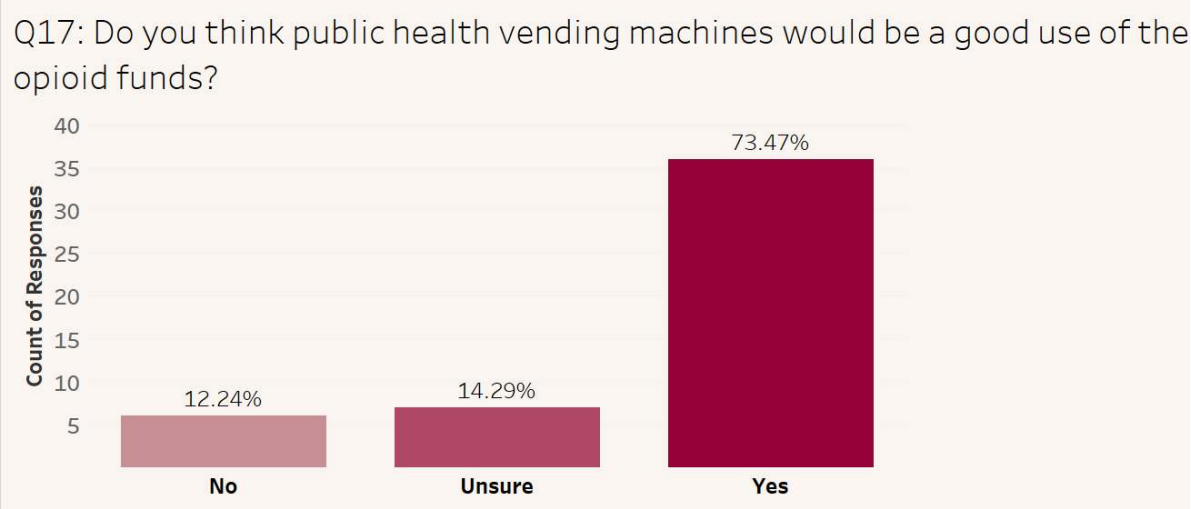
Another commonly reported barrier to access to substance-use related services includes an overall lack of available beds (particularly for MassHealth insurance holders) for both inpatient and outpatient services. Similarly, participants reported that hospitals are not helpful in aiding with next steps post-emergency room visits. When the patients are seeking help with either harm reduction or becoming sober, navigating these next steps can be an overwhelming process. The offerings of the available programs was also a reported barrier, as most are twelve-step or abstinence-based; some people felt that they would be more successful in a harm reduction program rather than an abstinence-based program.

A very common issue that was brought up in the survey was housing and homelessness. This is a complex and multi-faceted problem that would require systemic change to fully address. Main causes for concern and barriers include, but are not limited to, having proper documentation to even get on the waiting lists for affordable housing and difficulty attending the meetings that are required to join the waitlists (due to such factors as transportation, having their belongings with them, childcare, missing work, etc.). These same barriers are also applicable to individuals who have access issues to health insurance, such as MassHealth programs, as there is comparable documentation needed. Internet and phone inaccessibility are also major issues, though this was not reported by participants, as much of this paperwork typically occurs online or on the phone.

Examples of barriers impacting social service accessibility include general unaffordability of the areas where participants live and travel between; transportation challenges; getting and staying sober with the lack of inpatient and outpatient beds; and a lack of daytime sober spaces where they typically spend time.

In the free-text survey questions, many survey participants voiced a strong desire for harm reduction services to be funded by the opioid settlement funds. More specific examples included more community education classes to educate individuals on harm reduction, similar to ones that already exist in Somerville and Cambridge today, and classes to educate medical professionals as well. Many participants also called for overdose prevention centers (OPCs), with the goal of reducing opioid overdose deaths and allowing for safer use practices. Mobile treatment facilities were also proposed in popular places where people experiencing both homelessness and substance use disorder live and spend time, especially in Davis, Harvard, and Central Squares.

Other participants voiced a need for expanding medical and social support services in the free-text survey questions. This included allowing primary care doctors to prescribe Medication-Assisted Treatment (MAT) to allow for easier access; support for families, pregnant, and parenting individuals; housing assistance; and low-threshold treatment facilities.



A public health vending machine was proposed to participants; 73% were in support of this being funded. Individuals who live in Cambridge and Somerville were more supportive of a public health vending machine (91% and 82% of participants, respectively). Participants were typically indifferent about the types of items that would be included in the vending machine, though most supported harm reduction supplies when asked. 94% of participants supported harm reduction supplies, 78% supported wound care kits, 76% supported hygiene kits, and 74% supported safe sex kits.

The participants that expressed support for public health vending machines believe that the vending machines could increase access for all to these lifesaving goods. In addition, it would reduce stigma by normalizing substance use disorder. Specific items that were highlighted outside of the harm reduction products mentioned previously included free period products and Plan B pills.

Participants who expressed a hesitancy towards the vending machines were not against the idea of vending machines as a harm reduction tool. Rather, they felt that this machine would lose the sense of human connection that exists when individuals are given products by a person working at a program or distribution event. In addition, there were concerns expressed regarding people taking more than their fair share of products and the belief that the machines may not work well in an emergency and take too much time to dispense Narcan.

The participants who were against investing in these vending machines voiced concerns that accessing harm reduction products does not address the systemic issue of substance use disorder, more specifically with co-occuring conditions. The consensus in this group was that overdose prevention would be a better use of the funds, namely an OPC.

Top Themes

While collecting information through qualitative interviews with people directly and indirectly impacted by the opioid epidemic, some major themes emerged across the data collected from Phases One and Two. One such theme is a desire for funds to be allocated towards harm reduction in various different ways.

Material products being available for individuals at easily accessible or frequently visited locations, or at the proposed public health vending machines, are life-saving items for many people who use drugs. The public health vending machines were nearly unanimously supported in interviews, with placement recommended in high-traffic public spaces including MBTA stations and libraries. Examples of desired free products include Narcan; safe use kits including commonly used paraphernalia for injection, smoking, and inhalation; safe sexual health kits to reduce the spread of sexually transmitted infections and to prevent unplanned or unsafe pregnancies; and hygiene kits containing basic sanitary supplies. Many of these supplies are currently available for free in Cambridge and Somerville at various city departments and organizations, but can be difficult to access outside of their business hours. Many participants favored a vending machine for its 24/7 availability. As important as material goods and products are to the community, the nonmaterial use of the funds is just as, if not more, beneficial to the community, as expressed by interviewed participants.

Nonmaterial ways that funds can be spent, as identified by participants, include, but are not limited to, allocating funding towards education, mental health support, and stigma reduction towards individuals and communities impacted by substance use. Examples of how funds could be used for education include community-based classes educating the public on substance use and continuing Narcan training with the ultimate goal of reducing the stigma and prejudice that people impacted by substance use face. Stigma was one of the largest reported barriers to individuals seeking social services and support, which is something that can be remedied with proper education.

To reduce stigma, education should also be directed at hospital staff. A commonly-reported experience by interviewed individuals was a feeling of mistreatment when seeking both preventative and emergency healthcare. Specifically, many participants shared that they had faced stigma in the hospital or healthcare settings, such as being treated differently based on what type or specific drug an individual was experiencing a withdrawal from, as different drugs have different withdrawal symptoms, length of symptoms, and severity. These experiences with stigma extended to the staff treatment in emergency rooms during drug withdrawals. It was also reported that individuals received different treatment based on their insurance type. Many people impacted by substance use wish that people without lived experience knew that people who use drugs are more like them than different, with some of the same shared experiences and deserving of the same empathy and compassion. They also wish

that the general public knew that, for many, drug use is not a choice. Educating the general public and key groups of people that work with or otherwise regularly interact with people who use drugs can have a direct impact on ultimately reducing stigma for this community. Special attention should be given to reducing the stigma faced particularly by those living with any combination of substance use disorder, mental health challenges, and/or homelessness. People who find themselves struggling with any of these individually likely face some level of stigma, but that discrimination may feel insurmountable for those trying to manage all three at once.

Recommendations

After careful consideration of the themes that emerged from the data collection and analysis process, several key recommendations for spending the opioid abatement funds in Cambridge and Somerville have been identified. Some recommendations may require additional investments from the cities and even from the portion of abatement fund dollars allocated to the state of Massachusetts. It should be noted that these recommendations have not been formally endorsed or rejected by representatives of Cambridge and Somerville and should only be taken as recommendations coming from the participants of the data collection process outlined in this report. The following list summarizes the synthesized recommendations:

- Harm reduction services
    - Overdose prevention centers/engagement centers
    - Increased naloxone access
    - Drug testing services
    - Public health vending machines
- Substance misuse prevention
    - Youth-focused programming
    - Education for people prescribed opioids
- Treatment and recovery services
    - More availability for detox services
    - Increased accessibility to medication-assisted treatment
    - Grant funding to expand capacity at existing services
- Public awareness
    - Education campaigns for the public and for providers
    - Advocacy at city and state levels for increased funding

The clear majority of participants across all data collection phases support the public health vending machine initiative. Since March of 2023, representatives from both Cambridge and Somerville, along with those from Access and the Harvard College Overdose Prevention and Education Students (HCOPES), have met to discuss the feasibility of such an initiative. As outlined in the top themes section, these machines would contain material goods available for

free to the public, including naloxone, safe use kits, sexual health kits, and hygiene kits. Access provides many of these goods to their client base, and they highly support the vending machines as a means to close the gap that exists when their regular clients need something outside of Access' regular operating hours, as well as to hopefully reach people who may never feel comfortable coming directly to Access. These machines would also be installed outdoors in areas of high foot-traffic, making them as accessible as possible during an overdose emergency, and certainly more accessible than naloxone is when it's stored inside a locked building past business hours. This group is in the process of finalizing proposals for the respective cities, and the findings from this report show a clear support for these proposals.

Several clear recommendations emerged for creating new programming and bolstering existing services. Specific groups were identified as target audiences for various education campaigns, both new and existing. Education geared towards the general public can help reduce stigma and increase the likelihood of bystander action in the event of overdose. Because many participants with lived experience also shared their stories of feeling stigmatized and treated differently in clinical settings, person-centered education for healthcare providers and other hospital staff should be a priority. This education should also be made available for shelter and other housing providers, and other social support workers who interact regularly with people who use drugs. These educational programs should remind attendees that people who use drugs deserve care and respect, and should be treated with compassion and understanding. Additional opportunities for education should emphasize prevention - both among youth and individuals prescribed opioids - to help raise awareness of the risks of addiction and associated potential harms with substance use.

Several participants highlighted the importance of harm reduction in this work, and there are many opportunities for the opioid abatement funding to enhance the harm reduction services already available in Cambridge and Somerville. Both cities provide free naloxone, fentanyl test strips, and other harm reduction supplies to residents, businesses, organizations, and other groups within their communities. Some supplies are available readily through state subsidies, including the Community Naloxone Program and the Massachusetts Health Promotion Clearinghouse. That said, the opioid abatement funding could be used to further expand these services, as well as provide funding for more data surveillance work, such as wastewater detection, to help inform these harm reduction efforts.

The opioid abatement funds present an opportunity to expand capacity and services for many existing programs and organizations within Cambridge and Somerville that already serve people who use drugs. Participants across all data collection phases voiced support for allocating funds to organizations already working in our communities as a way to expand current services. In particular, organizations that provide services related to harm reduction, mental health support, temporary shelter and housing, detox, peer recovery, and medication-assisted treatment could likely all benefit from additional funding. Cambridge has already committed some of the opioid abatement funds to purchasing and outfitting a van for street medicine as a part of the outreach provided by FirstStep, which was specifically requested by Bay Cove. To best allocate

the opioid abatement funds to these organizations, both cities could establish their own grant programs. Allowing organizations based in each city to submit proposals outlining how they would use these grants to better serve the community reduces the burden on the cities to make all of the decisions regarding the spending of the abatement dollars. Furthermore, it puts the funding into the hands of organizations that best know where the gaps exist in their services. Due to the limited nature of the opioid abatement funds, a cap should be established for all grant awards. Consideration should be given to the fact that both cities are receiving substantially different amounts of total funding, so it should not be expected that Somerville can fund programs to the same degree as Cambridge with this funding. Such a program has been established in Boston, which is offering a pool of $1 million to support awards up to $200,000[1].

Much of the data points to a need for services that would cost more than the opioid abatement funds could feasibly cover. Many participants, particularly in the survey, called for Cambridge and Somerville to take action on overdose prevention centers. OPCs provide a space wherein people can use substances in a supervised environment and then be monitored for adverse effects and overdose. Many such centers also provide other harm reduction services, such as drug testing, and connections to care and treatment for those interested in reducing or stopping their substance use. OPCs operate globally and there have been no reported deaths from overdose at an OPC. In the United States, federal regulation of controlled substances has precluded the establishment of such services in many states; however, two currently operate in New York City and another was approved in Providence, Rhode Island as of February 2024. The Rhode Island Department of Health (RIDOH) has estimated that the net annual cost for the Providence OPC will be $783,899, well exceeding the annual allotment received by either Cambridge or Somerville[2]. RIDOH has also estimated that, compared to the current burden of emergency overdose care on Providence's health care infrastructure, the OPCs will save over $1 million a year, which speaks to the value of investing in an OPC. That said, if either Cambridge or Somerville moves to establish an OPC, additional funding will be needed to support the endeavor, particularly if the other recommendations set forth in this report are also implemented. There is also an ongoing opportunity for Cambridge and Somerville to advocate for the passage of H.1981/S.1242, a state bill to authorize OPCs in Massachusetts and thereby greatly reduce many of the barriers to establishing such centers.

If the risk of establishing an OPC against federal regulations is deemed too high, an engagement center may be a valuable first step towards supporting people who use drugs and further promoting harm reduction practices. An engagement center that would allow people who have already consumed their drugs to have a safe, comfortable space to experience their high provides many of the same benefits of an OPC without explicitly allowing substance use. An example of this kind of work is the Supportive Place for Observation and Treatment (SPOT) model developed by Boston Health Care for the Homeless[3]. SPOT provides low-threshold medical care, harm reduction services, and connections to further care and treatment. One

[1] https://www.boston.gov/bid-listings/16158966
[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10131249/
[3] https://www.bhchp.org/services/spot/

drawback of engagement centers, however, is that community members have expressed concern regarding the ability of many people who use drugs to transport themselves from where they used their drugs to an engagement center safely and successfully after using.

Additionally, when asked how this money should be spent, many participants asked for money for housing or for food, and many asked for help finding employment. Both Cambridge and Somerville currently and have historically allocated funding for social support services to help secure affordable food and housing for community members in need, as well as programming designed to help residents train and develop skills for various career paths. However, expanding access to these services may also exceed the opioid abatement dollars available. Additional funding will need to be secured in order to meet all of these goals. Avenues for this funding may become more clear if the aforementioned grant program is established, as some organizations may identify capacity needs greater than whatever the grant award cap is determined to be. Furthermore, of the total abatement funds allocated to Massachusetts, only 40% was granted to the individual cities and towns that elected to participate in the settlement, with state agencies retaining the remaining 60%. As stated above, many of the recommendations set forth by people with lived experience and those who work in the field center on expanding accessibility to detox and recovery programming, a need which may be better served with a regional approach supported by the state. Cambridge and Somerville have always been leaders in Massachusetts working to drive change, and our community members affected by substance use disorder look to city leaders to advocate for the effective spending of these dollars, both within our cities and in the state as a whole.

While the team behind this report was able to acquire a significant amount of data from those with lived experience and those who work in the field of substance use disorder, more data is needed to fully understand the needs that exist in Cambridge and Somerville and how to address those needs. Somerville completed a series of reports in 2021 assessing the needs related to and the feasibility of opening an OPC. A similar process of hiring an external consultant to assess the best use of the opioid abatement funds more broadly could help fill the gaps in this report. This could also allow for the creation of an environmental scan to better understand the broader community readiness for some of these proposed recommendations. Additionally, community advisory boards in each city should be established to solicit further input from people with lived and living experience and those affected personally or professionally by the opioid epidemic. This is a necessary component to ensuring a comprehensive and equitable approach to developing effective interventions for substance use disorder in Cambridge and Somerville.

Contributors

This report would not have been possible without many contributors from the communities of Cambridge, Somerville, and beyond. First and foremost, we would like to thank the key informant interview and survey participants. Additionally, Fenway Health Access Drug User Health Program's Dana Longobardi, Brian Sink, Grant Patch, and Jive; Somerville

Homeless Coalition's Hannah O'Halloran and Hayley Morgan; and Bay Cove's Alexis Grandberg and Johnny Gall were all instrumental in helping us coordinate our key informant interviews. Regarding data collection and analysis, generous thanks are given to HCOPES, SomerStat's Anna Gartsman and Meagan Benetti, and interns Ginjer Doherty and Jacob Gendelman. We would also like to thank Matthew Mitchell and Kelley Hiland from Somerville Health and Human Services and Danielle McPeak, Mary Kowalczuk, and Dawn Baxter from the Cambridge Public Health Department. Lastly, MAPC and the Boston Public Health Commission were crucial to survey development.

Appendices

Appendix A: Phase One Demographic Questions

1. Gender Identity:
    a. Male
    b. Female
    c. Some other way
    d. Gender identity unknown
2. Age Range:
    a. 18-20
    b. 21-24
    c. 25-44
    d. 45-64
    e. 65+
    f. Unknown
3. Racial identity:
    a. White
    b. Black/African-American
    c. Native Hawaiian/Pacific Islander
    d. Asian
    e. American Indian/Alaska Native
    f. More than one race
    g. Other race not listed above
    h. Unknown
4. Hispanic/Latinx:
    a. Yes
    b. No
    c. Unknown
5. Check all that apply:
    a. I have personal experience with the opioid crisis.
    b. I am an expert in treatment and prevention.
    c. I work for an organization that is carrying out the abatement work.
6. Would you like to participate in future discussions about substance use in our community?
    a. Yes
    b. No
7. If yes, please share your contact information below.
    a. Name
    b. Phone (if applicable)

c. Email (if applicable)

Appendix B: Phase 1A Key Informant Interview Questions

1. Where do you spend most of your time?
2. Where do you often spend time in Cambridge/Somerville?
3. Generally speaking, how do you think these funds could be spent to have the most impact on opioid prevention, harm reduction, and treatment?
4. If you had to prioritize 3-5 areas to focus on, which would they be?
5. Do you want public health vending machines? What should go into them?
6. Where would you want public health vending machines to be located?
7. These machines are designed to help us understand how people use them, which involves basic, anonymous data collection. What information would you be comfortable sharing in order to access the machine?
8. Is there anything else you would like to share with us?

Appendix C: Phase 1B Key Informant Interview Questions

1. Have you or anyone you know ever attempted to access substance-use related services? If so, what barriers did they face?
2. Have you or anyone you know ever attempted to access other social services? If so, what barriers did they face?
3. Have you ever experienced stigma when seeking any of these services? If so, would you be comfortable telling us what kinds of misconceptions were expressed?
4. Other [Access/SHC/First Step] clients we've spoken to have told us they think people who work at shelters, people who are being prescribed opioids, and the general public should be educated on opioids. Do you agree? If so, what kind of education do you think they should receive?
5. What's something you wish people knew about substance use disorder and people who use drugs?
6. How far would you be willing to travel to access a harm reduction vending machine?
7. Is there anything else you would like to share with us?

Appendix D: Phase Two Survey Questions

1. How much did you know about the opioid settlement funds before taking this survey?
    a. I had never heard of these funds or the settlement before.
    b. I was not familiar, but now know more from the state websites linked above.
    c. I am somewhat familiar with the opioid settlement funds.
    d. I am very familiar with the opioid settlement funds.

    e. Prefer not to answer
2. Have you or anyone you know ever attempted to access substance-use related services? Can you describe any barriers they faced?
3. Have you or anyone you know ever attempted to access other social services (examples: housing, food access, mental health services, etc.)? Can you describe any barriers they faced?
4. How old are you?
    a. Under 18
    b. 18-24
    c. 25-44
    d. 45-64
    e. 65+
    f. Prefer not to answer
5. How do you describe your gender identity?
    a. Woman
    b. Man
    c. Non-binary or gender non-conforming
    d. Prefer not to answer
    e. Other
6. Are you Hispanic/Latinx?
    a. Yes
    b. No
    c. Not Sure
    d. Prefer not to answer
7. What race best describes you? Please select all that apply.
    a. American Indian/Alaska Native
    b. Asian
    c. Black/African American
    d. Native Hawaiian/Pacific Islander
    e. White
    f. Not sure
    g. Prefer not to answer
    h. Other
8. Have you lived in Cambridge or Somerville in the last five years?
    a. Yes, in Cambridge only
    b. Yes, in Somerville only
    c. Yes, in both Cambridge and Somerville
    d. No, in neither Cambridge or Somerville
    e. Prefer not answer
9. Have you worked or attended school in Cambridge or Somerville in the last five years?

a. Yes, in Cambridge only
b. Yes, in Somerville only
c. Yes, in both Cambridge and Somerville
d. No, in neither Cambridge or Somerville
e. Prefer not answer

10. Have you used medical, health, emergency, or community wellness services in Cambridge or Somerville in the last five years?
    a. Yes, in Cambridge only
    b. Yes, in Somerville only
    c. Yes, in both Cambridge and Somerville
    d. No, in neither Cambridge or Somerville
    e. Prefer not answer
11. Would you consider yourself informed about and/or impacted by the opioid crisis, compared to the general public?
    a. Yes
    b. No
    c. Prefer not to answer
12. Please select all options below that apply to you:
    a. I have personal experience with the opioid crisis. This includes affecting myself, someone in my family,
    b. or someone else in my life.
    c. I work in treatment and prevention.
    d. I have professional experience with the opioid crisis.
    e. The impact of opioids on Cambridge and/or Somerville is a high priority for me.
    f. Prefer not to answer
    g. None of the above
13. What would be your top choice of activity using settlement funds?
    a. Opioid use disorder treatment
    b. Support people in treatment and recovery
    c. Connections to care
    d. Harm reduction
    e. Address the needs of criminal-justice-involved persons
    f. Support pregnant or parenting women and their families
    g. Prevent misuse of opioids and implement prevention education
14. What specific types of programs would you like to see?
15. Should each City make a big investment into a single program or smaller investments into multiple programs?
    a. Make smaller investments into multiple programs
    b. Invest big into one program
    c. Either is fine / no preference

16. Should each City prioritize creating new programming or expanding existing programming?
    a. Expand existing programming
    b. Create new programming
    c. Either is fine / no preference
17. An idea that came from our conversations with people who use drugs and/or are in recovery was public health vending machines. These vending machines could provide a variety of free materials, including Narcan and fentanyl test strips. Do you think this would be a good use of the opioid funds?
    a. Yes
    b. No
    c. Unsure
    d. Prefer not to answer
18. Please explain why or why not.
19. What materials would you put in public health vending machines? Check all that apply.
    a. Harm Reduction Supplies (Narcan, fentanyl test strips, xylazine test strips, etc.)
    b. Hygiene Kits (wipes, deodorant, toothbrush/toothpaste, hand sanitizer, etc.)
    c. Wound Care Kits (gauze, bandages, antibiotic ointment, etc.)
    d. Safe Sex Kit (internal/external condoms, lubricant)
    e. Prefer not to answer
    f. Other
20. Please use this space to share any additional comments.

CAMBRIDGE OPIOID OVERDOSE DATA REPORT 2024

INTRODUCTION

Substance use disorder and its impact on individuals and communities cannot be understated. In 2023, 79,358 people in the U.S. died from an opioid overdose;[1] the deaths were largely driven by opioid misuse, including heroin, opioid-based prescription drugs, and synthetic opioids such as fentanyl. Massachusetts has the eighteenth-highest opioid overdose mortality rate in the country as of 2023.[2] At the state level, Massachusetts has responded by providing services including the Massachusetts Substance Use Helpline and education for prescribers and providers, as well as guidance and infrastructure for municipalities to receive and implement funds and programming from earmarked state funds and the Opioid Abatement Settlement. Locally, city and community partners offer a wide range of services across the continuum of care for substance use disorder prevention, intervention, harm reduction, treatment, and recovery support.

This Cambridge opioid overdose data report is a result of an ongoing multi-year surveillance effort. The report is designed to provide residents, first responders, city officials, health professionals, and the media with data to better understand how the opioid crisis is affecting Cambridge. We have used these reports in the past to inform the city's prevention and response strategies and help relevant community stakeholders monitor progress in curbing the epidemic. Currently, Cambridge is receiving funds from the Opioid Abatement Settlement to support citywide harm reduction, prevention, and recovery initiatives. The findings in these ongoing reports may be used to guide decisions for the implementation and evaluation of the city programs and interventions that use these opioid abatement dollars. More information about the abatement funds and city efforts to incorporate lived experience feedback may be found on our website.

The Cambridge Public Health Department receives data from several sources, including Pro EMS first response services, Cambridge Health Alliance, Mount Auburn Hospital, and the Access Drug User Health Program. The data collection and analysis process is continuously reviewed for improvement opportunities.

Report Highlights

- Opioid Overdose Fatalities
    - There were 9 opioid-related overdose deaths among Cambridge residents.
    - There were 18 opioid-related overdose deaths that occurred in Cambridge, regardless of residency status.
    - The majority of fatalities involved people who were identified with at least one of the following demographic categories: White, male, and between the ages of 35-64.
- Non-Fatal Overdose Incidents
    - There were 116 documented overdose incidents that occurred in Cambridge.
    - Thirty-one percent of the people who overdosed in Cambridge were residents, according to ambulance data.

    - Demographics for these incidents were similar to those among opioid overdose fatalities.
- Naloxone Distribution and Administration
    - The Cambridge Public Health Department (CPHD) distributed 1,684 doses of naloxone with the support of the state Community Naloxone Program.
    - Instructors from CPHD and Somerville Health and Human Services partnered to deliver 21 training sessions for 175 participants.
    - Naloxone was administered in 72% of recorded opioid overdose incidents by first responders, bystanders, or other healthcare or public safety professionals to save a life in Cambridge.
    - 13% of recorded overdose reversals by naloxone were administered by bystanders.

STATE DATA

Fatal Overdoses

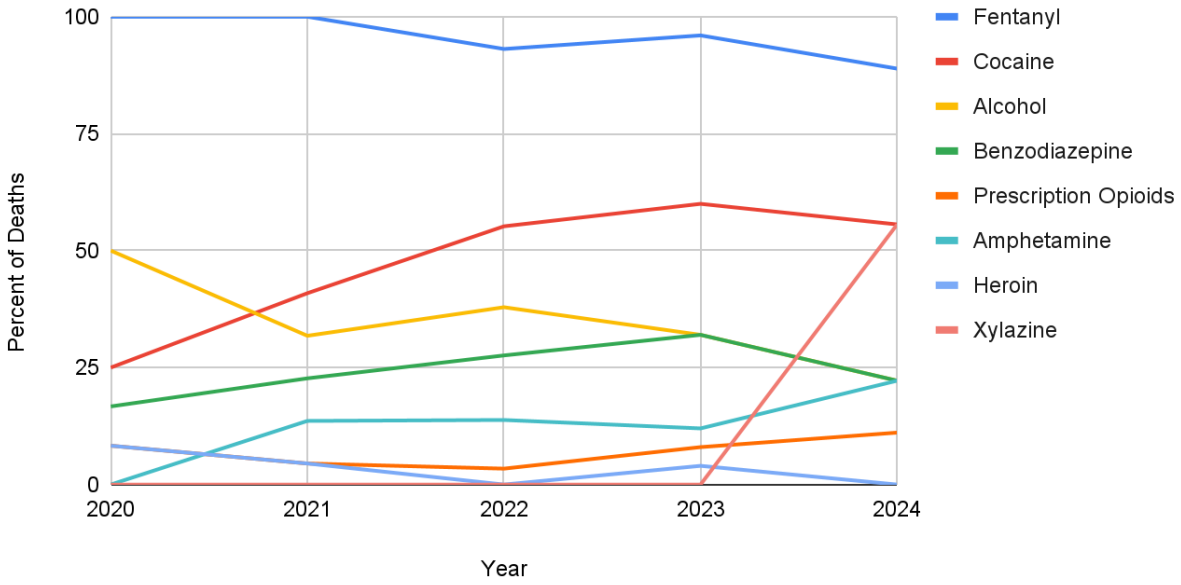
The Massachusetts Department of Public Health collects and analyzes data on opioid-related overdose deaths among all Commonwealth residents. At the time of publication for this report, 2024 state data was preliminary and may be subject to change. Currently released data reports from the state are available at mass.gov/lists/current-overdose-data.

Statewide, there were 1,336 opioid-related overdose deaths among Massachusetts residents in 2024, representing a 37.1% decrease from cases in 2023 (2,125 cases).[3] This follows national trends showing overdose declines in 2024[4]. There are many potential factors that may have contributed to this decline, including the impact of harm reduction strategies that help keep people alive in the event of an overdose.

Among Cambridge residents, there were nine opioid-related overdose deaths in 2024[5]. Compared to deaths from all causes among Cambridge residents, opioid-related overdose deaths made up 1.8% of fatalities in 2024. Eighteen people died of an opioid-related overdose in Cambridge, regardless of residency status. For both categories, most deaths were among White people and among men. All deaths occurred among people ages 25-64. Further demographic information will not be publicly disclosed by the Cambridge Public Health Department due to small numbers among some demographic categories, but will be used internally to inform program development and policy decisions as needed.

Available state data also includes toxicology data at the municipal level. All opioid-related overdose deaths among Cambridge residents in 2024 had a toxicology screen available. For eight of the nine deaths (88.9%), fentanyl was detected in the screen. Cocaine and xylazine, a sedative commonly found in the illicit opioid supply since late 2022, were each found in 55.6% of screens. Other substances present in these toxicology screens included alcohol, benzodiazepines, amphetamines, and other prescription opioids. **Figure 1** shows toxicology data for Cambridge from 2020 through 2025. In previous reports, only state-level data was readily available.

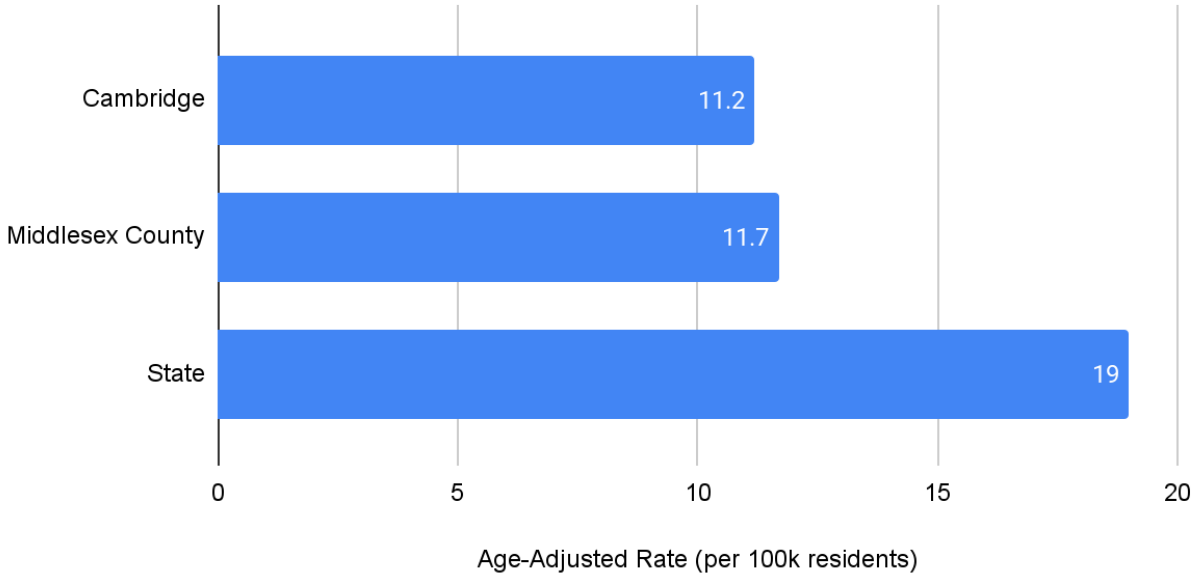
Figure 1. Percent of Opioid-Related Overdose Deaths with Specific Substances Present, 2020-2024



Data Source: Massachusetts Department of Public Health

Data on age-adjusted rates for opioid-related deaths per 100,000 residents is available at the municipal, county, and state level for 2024. As depicted in **Figure 2**, the opioid overdose-related death rate in Cambridge was below that of Massachusetts and of Middlesex County[3]. As can be seen in previous opioid reports, Cambridge usually surpasses the county-level rate, and this is the first time since 2020 that Cambridge has been below Middlesex County.

Figure 2. Age-Adjusted Opioid-Related Death Rate in Cambridge, Middlesex County, and Massachusetts, 2024



Data Source: Massachusetts Department of Public Health

Opioid-Related Emergency Events

State data also includes information on opioid-related EMS incidents, including 911 calls and emergency department visits in which opioids are involved, across the state by city and town[3]. In Cambridge, there were 296 suspected opioid-related incidents with paramedic response in 2024, and 96 Cambridge residents received care for an opioid-related incident in an emergency department.

Of note, these are different metrics compared to data reported within Cambridge. While state data includes all data from EMS services that involve a potential opioid incident (including those that do not involve a clinical overdose, such as opioid intoxication), Cambridge reporting only includes those responded to by Pro EMS and those involving a suspected overdose. For hospital-related data, the state Department of Public Health has access to data reported across all Massachusetts hospitals, while the Cambridge Public Health Department only has data-sharing agreements with Cambridge Health Alliance and Mount Auburn Hospital. Therefore, data in this section and that of the subsequent sections should not be compared.

For a more expansive picture on general substance use trends in Cambridge and across the state, including alcohol and other substances, please refer to the Bureau of Substance Addiction Services (BSAS) Dashboard.

EMERGENCY MEDICAL SERVICES DATA

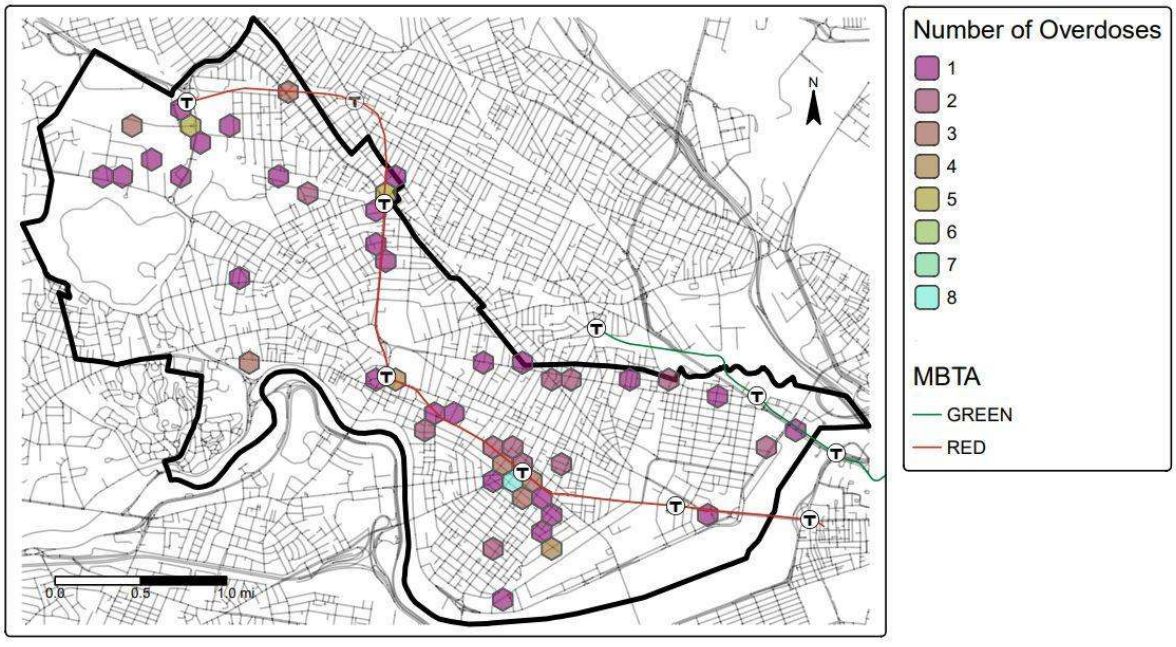
Geography of Overdoses

In Cambridge, first responders from Pro EMS ambulance service and the Cambridge Fire Department are often the first emergency personnel to arrive at the site of an overdose. Data from Pro EMS (which includes fire department data) are invaluable for pinpointing where opioid overdoses occur in the city, determining how frequently naloxone is administered, and learning what populations are at greatest risk. In 2024, Pro EMS responded to 116 overdose incidents. Of note, most of the incidents reported by Pro EMS are nonfatal overdoses, but some incidents reported below include incidents for which the patient is declared dead on arrival (DOA). In such cases, it is imperative to refrain from assuming that the death was caused by the opioid overdose and not from another cause, as this determination can only be made by the state Office of the Chief Medical Examiner.

Figure 3 shows the density of opioid-related overdoses in Cambridge in 2024, based on spatial analysis of Pro EMS data.

[How to read the maps in this report: The heat maps are primarily intended as visual tools, and exact overdose counts should not be estimated from the results. Blue and green areas indicate the highest density of overdose incidents in 2024. Color categories can be interpreted relative to one another, with pink areas having more incidents than dark orange, dark orange more than lighter orange and yellow, and so on. Dark pink areas indicate the lowest density of overdose incidents.]

Figure 3. 2024 Opioid-Related Overdoses, Cambridge, MA



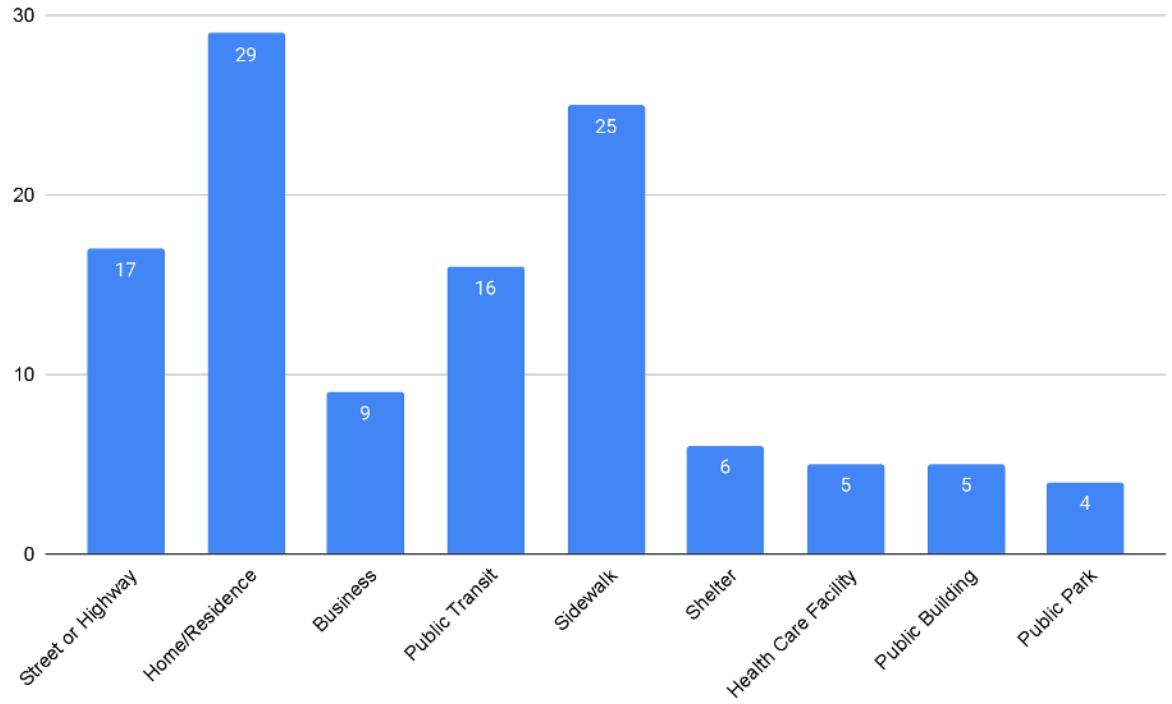
Data Source: Pro EMS Ambulance Service
Map layers sourced from: City of Cambridge, MBTA, MassGIS

Commercial districts had the highest density of opioid-related overdoses in Cambridge. These incidents were clustered primarily in Central Square, Harvard Square, Alewife, and Porter Square on the Red Line, and near Lechmere on the Green Line.

Figure 4 shows the types of places where opioid-related overdoses occurred in Cambridge in 2024, based on Pro EMS data. Of the 116 ambulance pickups for opioid-related overdoses in 2024, the majority (65.5%) occurred in public places, such as on the street, in a public building or park, at a business, or in a T station. About 5% of ambulance pickups were from a shelter.

Private residences, including houses and apartment buildings, made up a quarter of ambulance pickups. Whereas opioid-related overdoses in public spaces tended to occur repeatedly in the same locations in Cambridge, such as commercial squares with high foot traffic, overdoses in private residences occurred in homes scattered across the city.

Figure 4. Ambulance Pickups of Suspected Overdoses by Location, 2024



Data Source: Pro EMS Ambulance Service

In 2024, Pro EMS ambulance service transported the majority of opioid-related overdose cases to CHA Cambridge Hospital (57%), followed by Mount Auburn Hospital (25%) and Mass General Hospital (10%). Pro EMS typically transports people who have experienced a suspected overdose to the nearest hospital, unless the person expresses a preference for another facility (**Table 1**).

Table 1: Cambridge Opioid-Related Overdose Cases Transported by Pro EMS by Hospital Destination, 2024

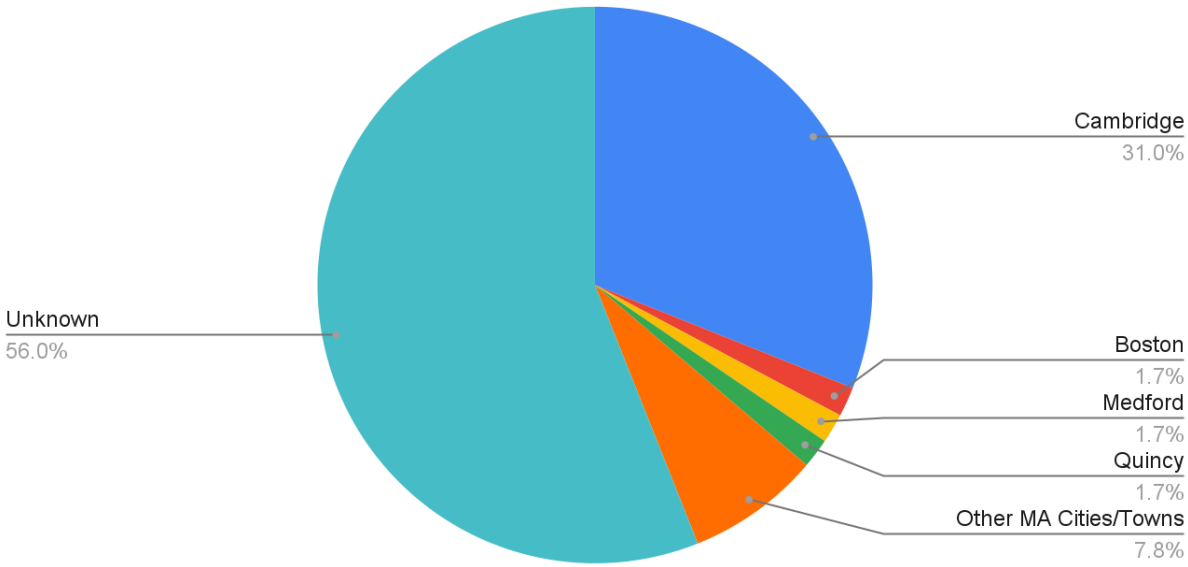
Hospital Destination	Incidents	
	Frequency	Percent
CHA Cambridge Hospital	66	56.90%
Mount Auburn Hospital	29	25.00%
Mass General Hospital	12	10.34%
Other Hospital	4	3.45%
Patient Refusal, No Transport	4	3.45%
Dead at Scene, No Transport	1	0.86%

Note: May not add up to 100% due to rounding.
Data Source: Pro EMS Ambulance Service

Cambridge Residency

Most reports of opioid-related ambulance pickups in 2024 did not include data on residence for the person who overdosed (56%). This may be due to a number of factors: the person who overdosed may be unable to provide that information due to lack of consciousness or awareness; they may be unwilling to share that information; there may be no identifying documents on the person, or; they may be experiencing homelessness at the time of the incident. Cambridge residents accounted for 31% of all opioid-related ambulance pickups in Cambridge (**Figure 5**). Of incidents that included residential data, 71% involved Cambridge residents.

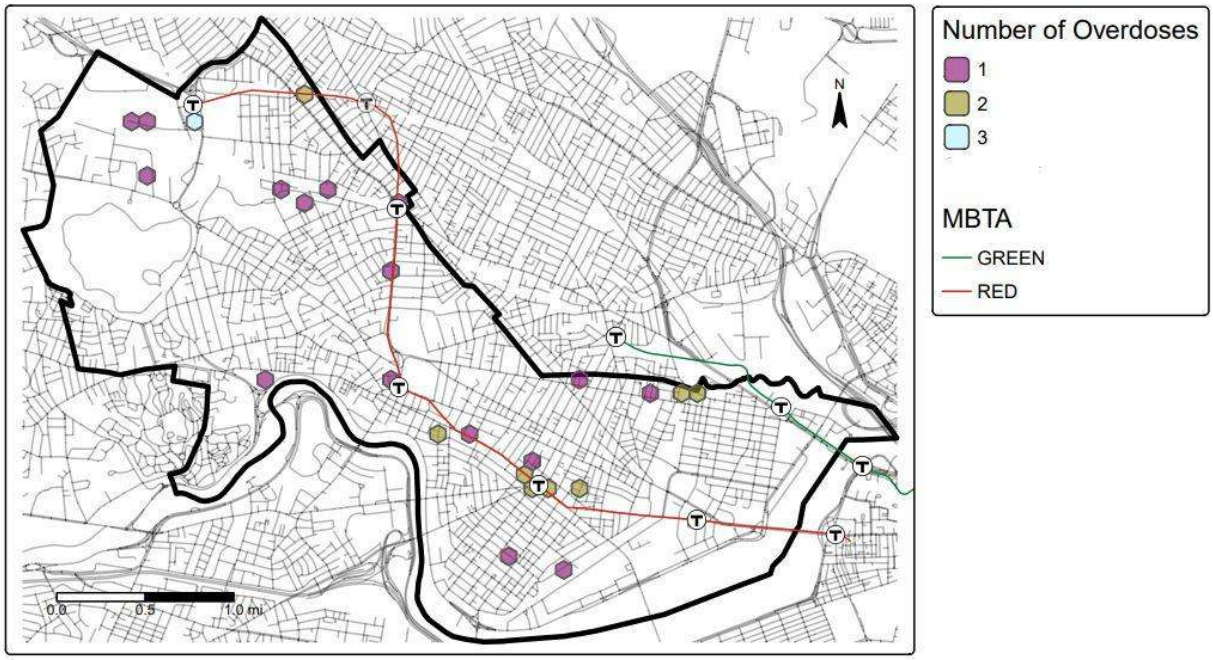
Figure 5. Opioid-Related Overdoses in Cambridge by Residence, 2024



Data Source: Pro EMS Ambulance Service

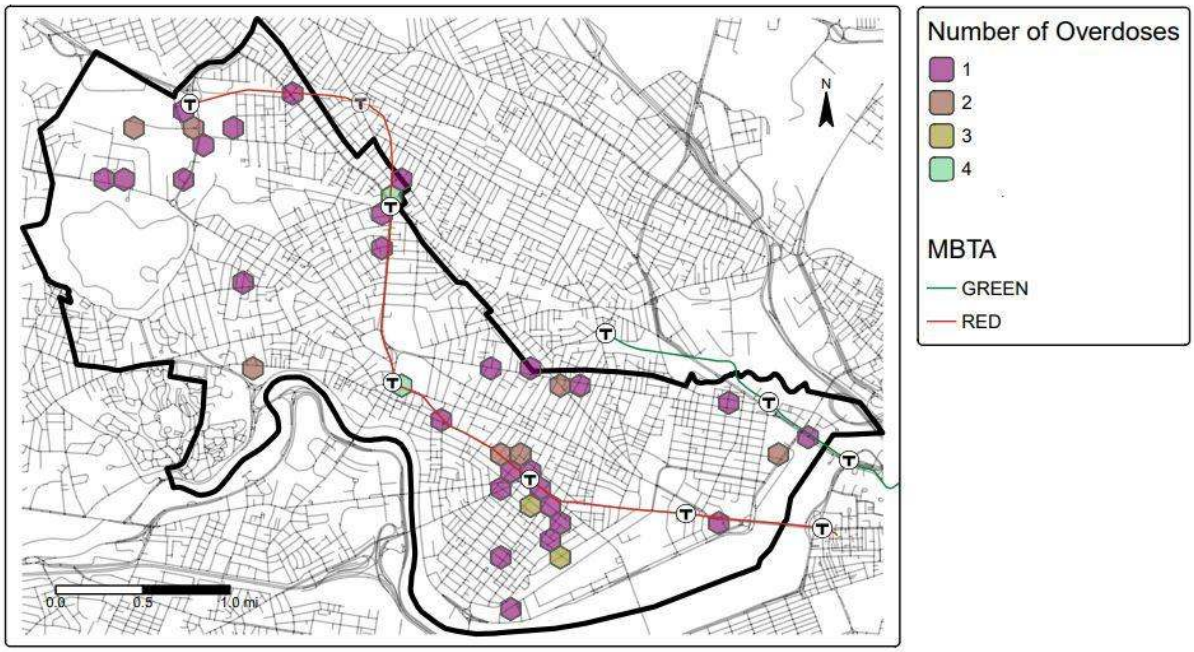
When comparing heat maps of opioid-related overdoses by Cambridge residency status, ambulance pickups for Cambridge residents covered a broader geography than non-residents (**Figure 6**). Ambulance pickups for non-residents were more concentrated in and around commercial districts, notably Alewife, Porter Square, Harvard Square, and Central Square (**Figure 7)**.

Figure 6. 2024 Opioid-Related Incidents by Cambridge Residency, Cambridge, MA



Data Source: Pro EMS Ambulance Service
Map layers sourced from: City of Cambridge, MBTA, MassGIS

Figure 7. 2024 Opioid-Related Incidents by Non-Cambridge Residency, Cambridge, MA

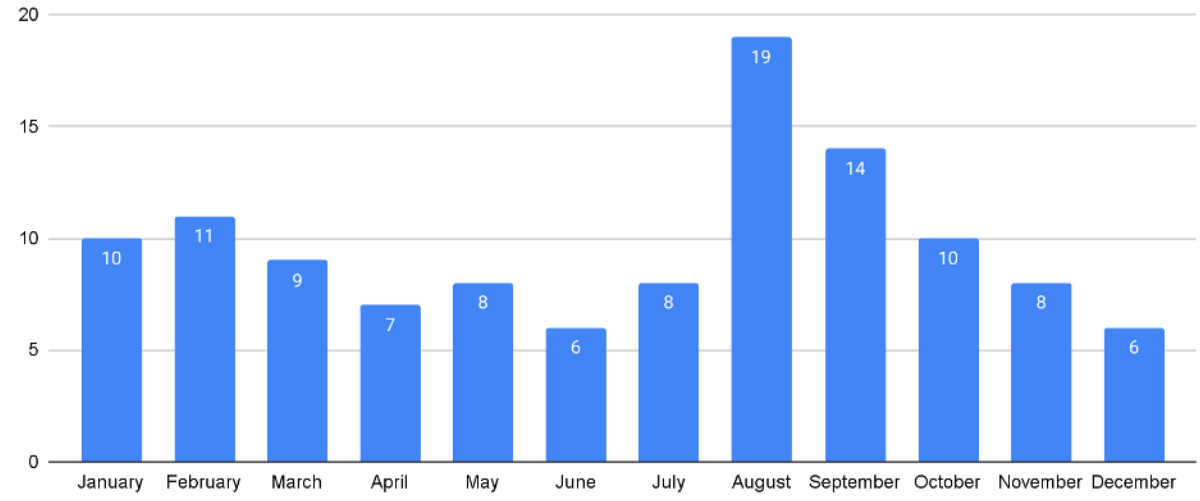


Data Source: Pro EMS Ambulance Service
Map layers sourced from: City of Cambridge, MBTA, MassGIS

Seasonality

Time trends for opioid-related pickups (**Figure 8**) show that counts varied by month across 2024. There was a peak in opioid-related incidents in August, with 19 incidents reported that month.

Figure 8. Opioid-Related Overdoses in Cambridge by Month, 2024



Data Source: Pro EMS Ambulance Service

Demographics

For the 116 opioid overdose incidents that occurred in 2024, the people who overdosed were predominately White and male (both 68.1%), with many of them being age 35-54 at the time of the incident (45.7%). Further breakdowns by race/ethnicity, sex, and age group are shown in **Table 2** below. Of note, these demographics should not be compared to similar demographics for Cambridge residents, as not all people who overdose in Cambridge are Cambridge residents. Additionally, in many overdose incidents, paramedics must make a judgement call based on physical appearance to determine an individual's race/ethnicity and sex, which may not align with how the individual would identify themselves. When comparing race and ethnicity, only incidents involving White, Black or African American, or Hispanic or Latino individuals are included, as other groups did not meet the threshold for inclusion ($n < 5$) to help protect the privacy of those individuals. Finally, it should be noted that there are likely duplicate individuals represented in this data who overdosed more than once in 2024.

Table 2: Demographics of Cambridge Opioid-Related Overdose Cases Transported by Pro EMS by Race/Ethnicity, Sex, and Age Group, 2024

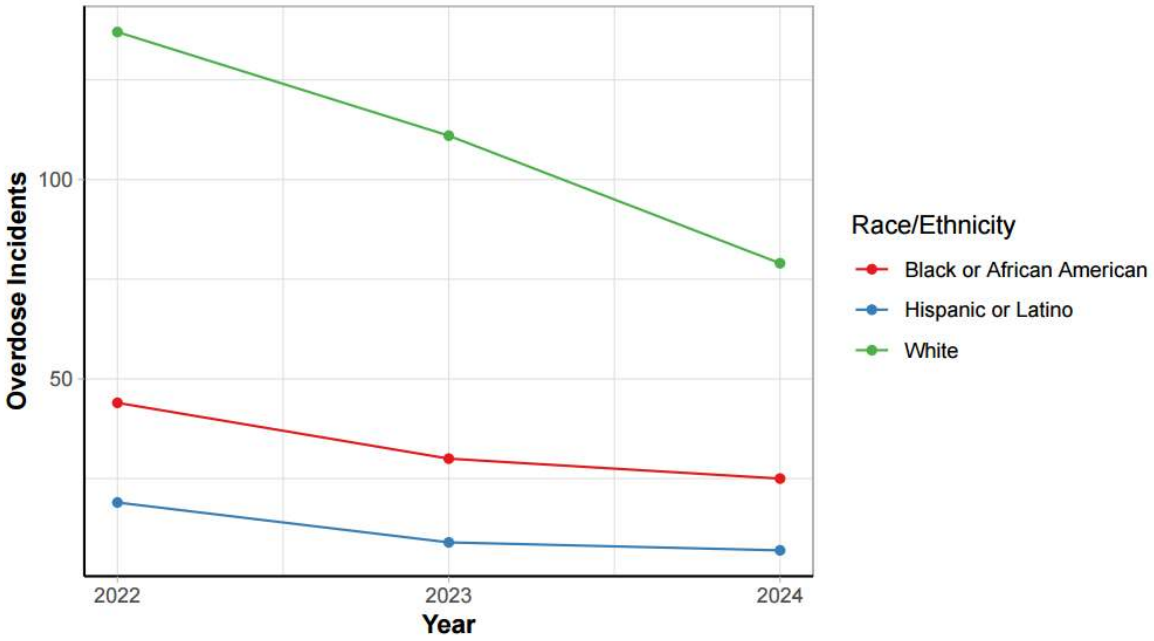
Race and Ethnicity	**Frequency**	**Percentage**
White	79	68.10%
Black or African American	25	21.55%
Hispanic or Latino	7	6.03%
Other/Unknown	5	4.31%
Sex	**Frequency**	**Percentage**
Male	79	68.10%
Female	36	31.03%
Unknown	1	0.86%
Age Group	**Frequency**	**Percentage**
0-14	0	0%
15-24	7	6.03%
25-34	16	13.79%
35-44	28	24.14%
45-54	25	21.55%
55-64	22	18.97%
65+	5	4.31%

Unknown	13	11.21%

Note: May not add up to 100% due to rounding.
Data Source: Pro EMS Ambulance Service

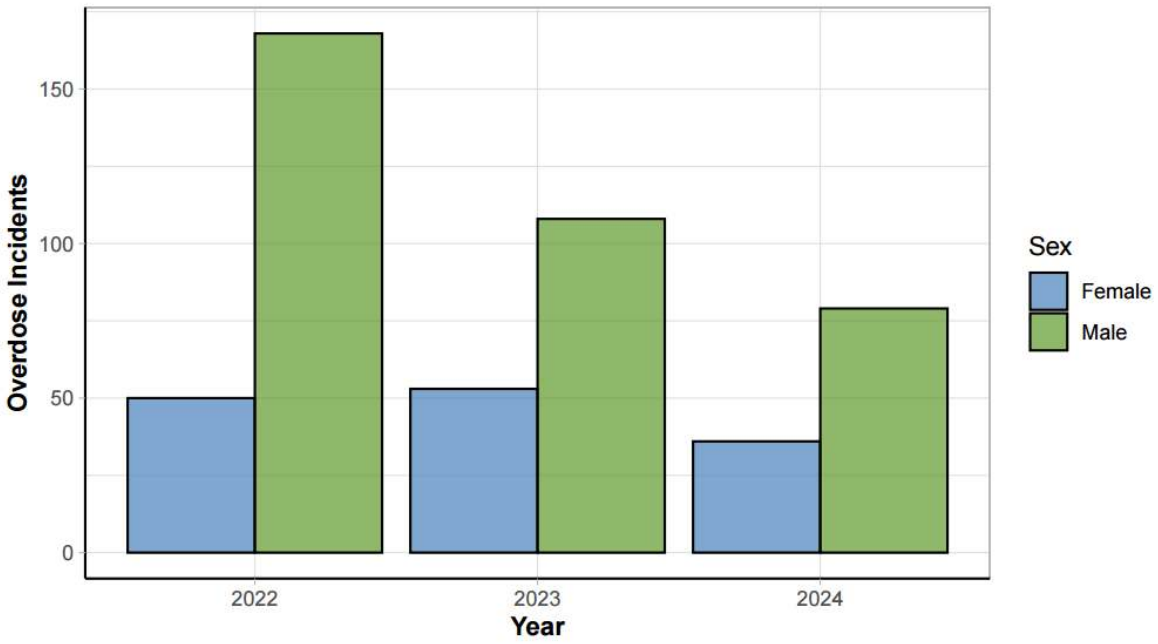
Figures 9-11 below compare overdose data by race and ethnicity, sex, and mean age from 2022 to 2024. Among these groups, all showed declines in overdose incidents over time; however, those declines were sharper for incidents involving White individuals. Overdoses by sex show variation between male and female individuals, with sharper and more consistent declines for males. From 2022 to 2024, the mean age of overdose incidents has increased.

Figure 9. Overdose by Race/Ethnicity, 2022-2024



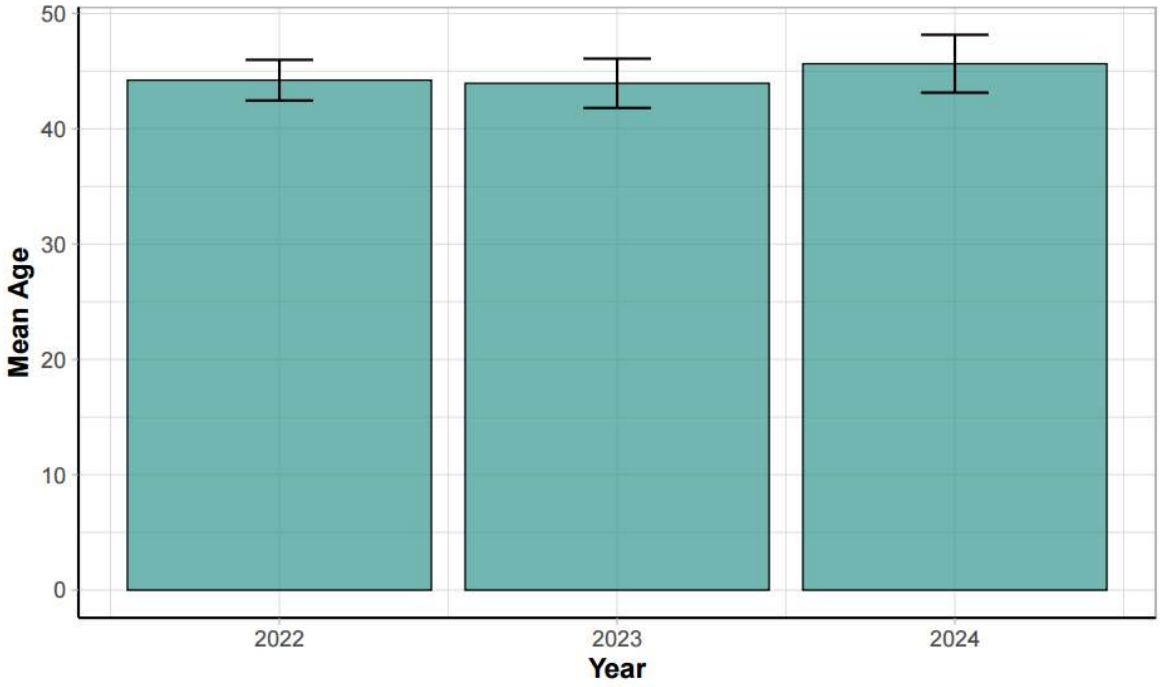
Note: Some groups have been hidden due to small numbers (n < 5)
Data Source: Pro EMS Ambulance Service

Figure 10. Overdose by Sex, 2022-2024



Data Source: Pro EMS Ambulance Service

Figure 11. Overdose by Mean Age, 2022-2024



Data Source: Pro EMS Ambulance Service

CAMBRIDGE HEALTH ALLIANCE AND MOUNT AUBURN HOSPITAL DATA

Hospital Visits

Cambridge Health Alliance (CHA) and Mount Auburn Hospital (MAH) are two of the primary health care systems that serve Cambridge. To better understand how the opioid crisis affects Cambridge residents, the health department investigated opioid-related hospital visits at MAH and CHA health care sites in Cambridge. As a disclaimer, due to inconsistencies in how hospital encounters are coded between different providers and health care sites, some over- or under-reporting is to be expected, and this report should serve as a snapshot of overdose data from hospital settings in Cambridge. Additionally, these numbers should not be compared to the Pro EMS data, which includes people who are not Cambridge residents.

In 2024, 53 Cambridge residents visited CHA or MAH health care sites for opioid-related incidents a total of 55 times (**Table 3**). Only 2, or 3.8%, of these individuals had documented multiple opioid-related visits.

Table 3: Cambridge Health Alliance and Mount Auburn Hospital Encounters for Opioid-Related Overdoses, 2024

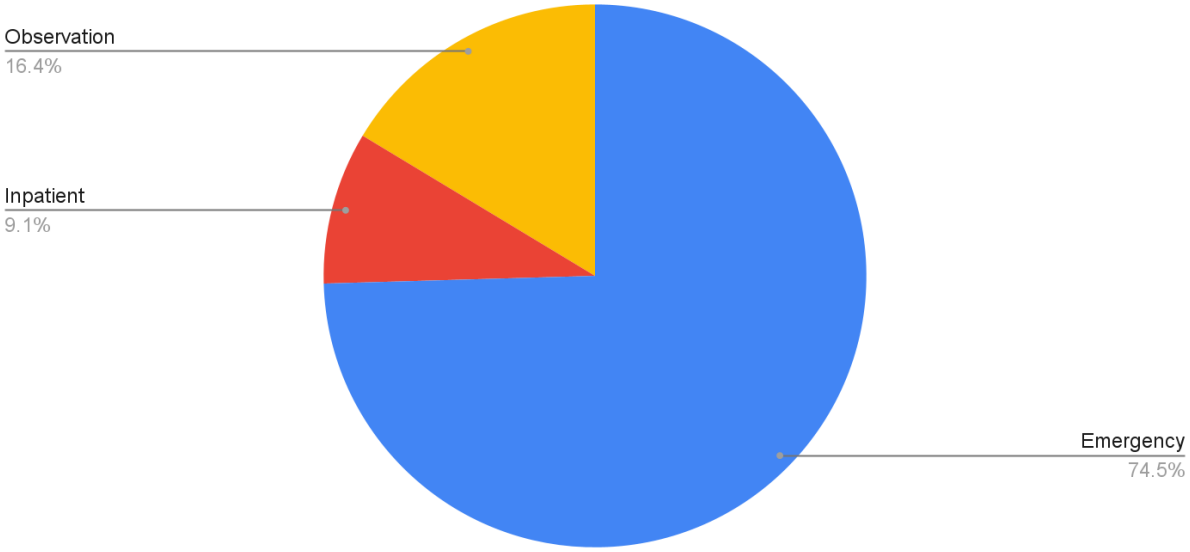
	CHA	MAH	Total
Number of Opioid-Related Overdoses	38	17	55
Number of Unique Individuals	36	17	53

Data Sources:

Cambridge Health Alliance, Business Analytics Unit, 2024
Mount Auburn Hospital, Business Intelligence Unit, 2024

In 2024, 74.5% of encounters were discharged directly from the emergency department, 9.1% were admitted to the hospital as inpatients, and 16.4% were admitted to the hospital on observation status (**Figure 12**).

Figure 12. Opioid-Related Overdoses by Encounter Type at CHA/MAH, 2024



Data Sources:

Cambridge Health Alliance, Business Analytics Unit, 2024
Mount Auburn Hospital, Business Intelligence Unit, 2024

Following an emergency department visit or hospitalization, most opioid-related visits (89%) resulted in patients being discharged to “home,” which generally refers to the patient being properly discharged (in other words, not leaving on their own before being cleared by a medical provider) without being immediately transported to another facility (**Table 4**).

Table 4: Opioid-Related Overdoses by Discharge Location from CHA/MAH, 2024

Discharge Location	**Percentage**
Home	89.09%
Left Against Medical Advice	1.82%
Left ED Without Being Seen	3.64%
Patient Death	0%
Transferred/Admitted to Other Facility	5.45%

Note: May not add up to 100% due to rounding.

Data Sources:

Cambridge Health Alliance, Business Analytics Unit, 2024
Mount Auburn Hospital, Business Intelligence Unit, 2024

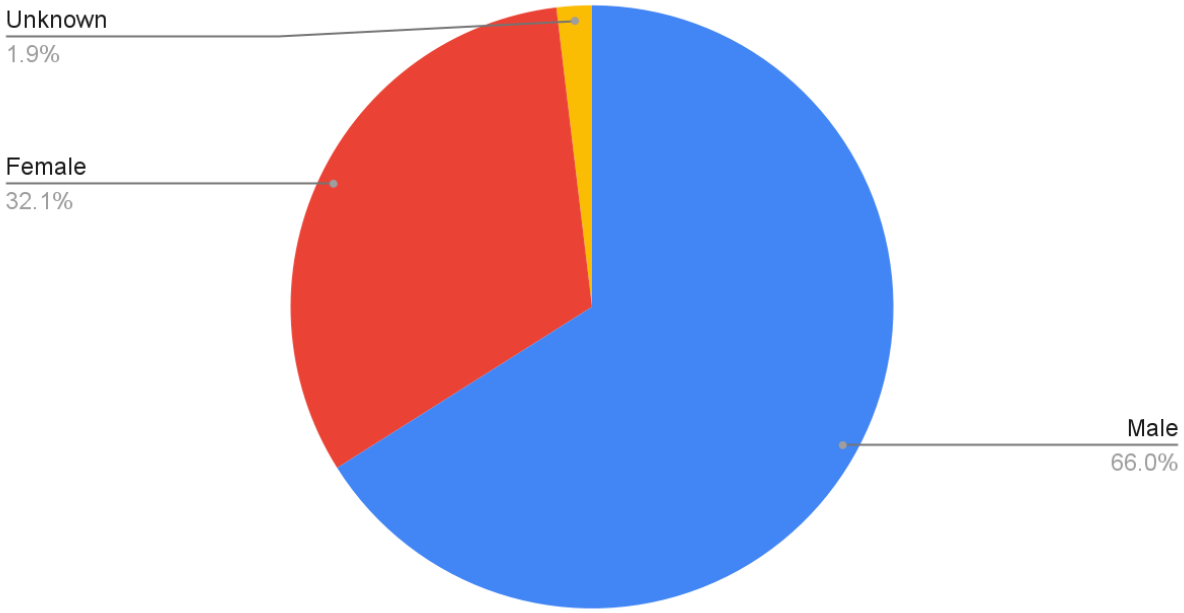
Demographics

In 2024, 53 Cambridge residents received care at CHA and MAH sites for opioid-related overdoses. This group was predominantly male (66%) and White (69.8%), and disproportionately represented residents in the 35-44 age category (37.7%).

White patients were disproportionately represented among the CHA and MAH overdose cases. In 2020, White residents comprised 57.3% of the city's population, but made up 69.8% of the overdose cases in 2024. Black residents, who comprise 10.6% of the city's population, accounted for 11.3% of the cases. Hispanic residents, who comprise 9.1% of the city's population, accounted for 5.7% of the cases.

Demographic data is further broken down and compared to similar demographics across all Cambridge residents (using data from the most recent US Census, conducted in 2020) in **Figures 13-20**[6]. These comparisons provides a visual representation of how certain demographics are disproportionately represented in the opioid overdose hospital data.

Figure 13. Opioid-Related Overdoses by Sex at CHA/MAH, 2024



Data Sources:

Cambridge Health Alliance, Business Analytics Unit, 2024
Mount Auburn Hospital, Business Intelligence Unit, 2024

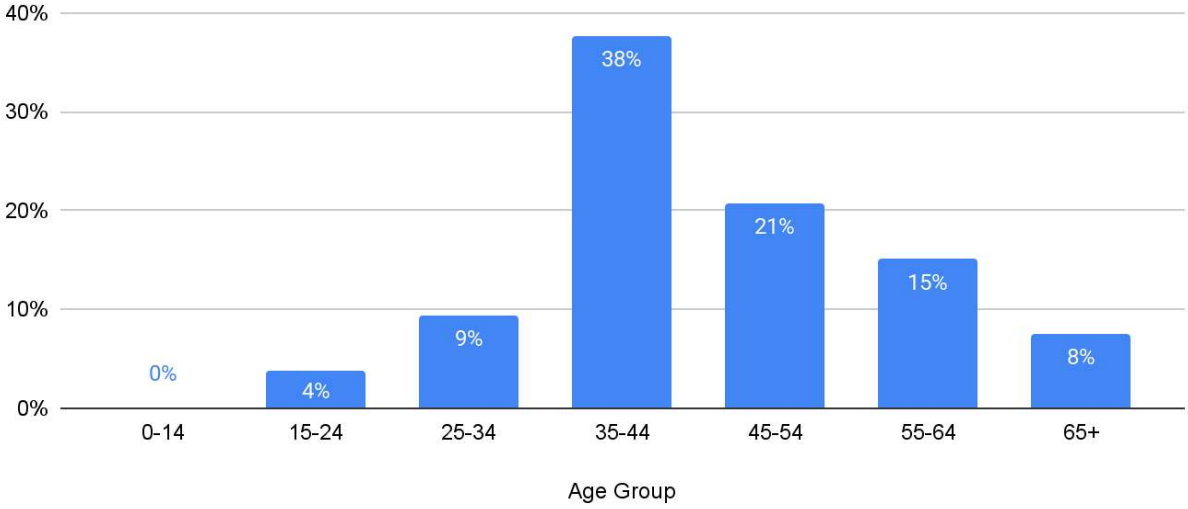
Figure 14. Cambridge Residents by Sex, 2020

Note: 50.03% of Cambridge residents are female and 49.97% are male

Data Source: United States Census, 2020

Figure 15. Opioid-Related Overdoses by Age Group at CHA/MAH, 2024

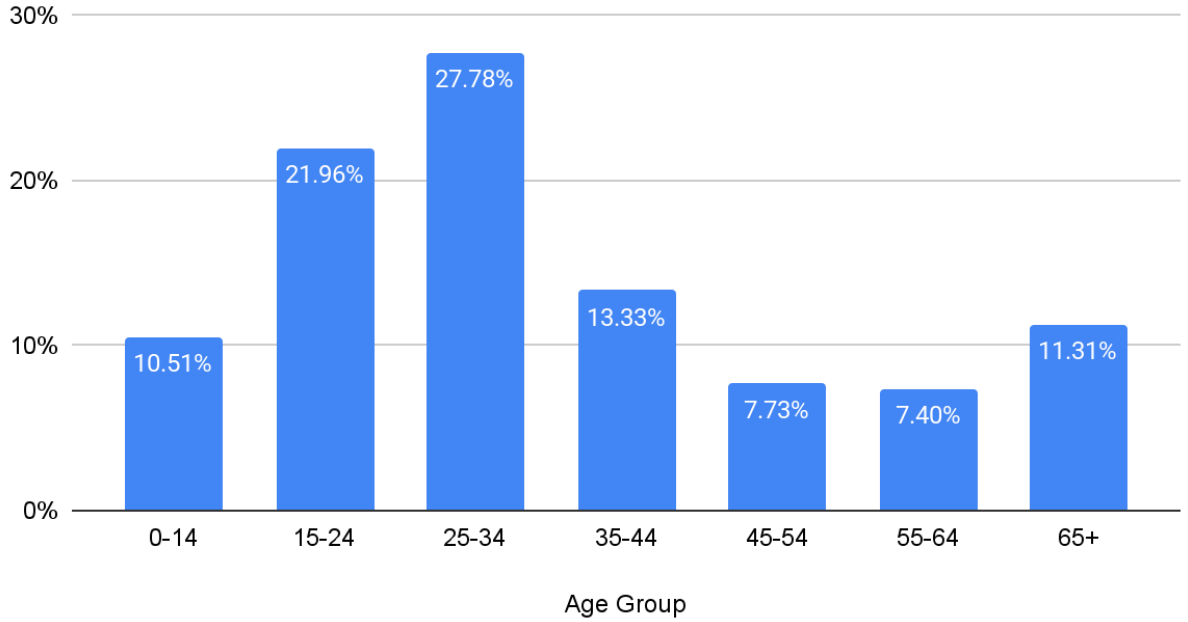
Note: 5.66% of patient ages were unknown or undocumented



Data Sources:

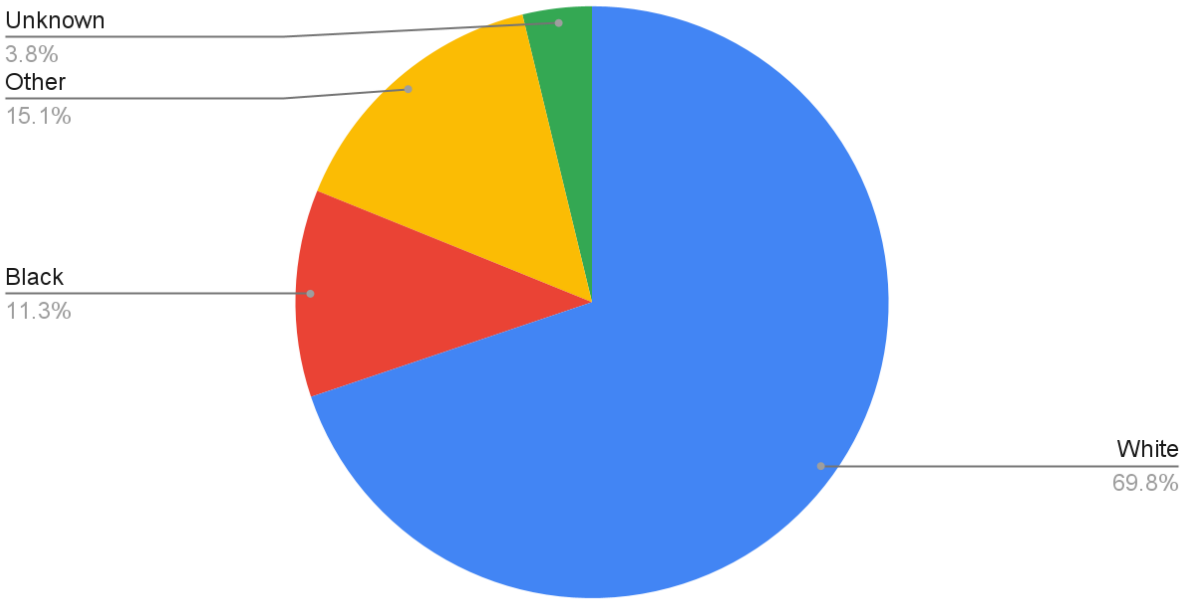
Cambridge Health Alliance, Business Analytics Unit, 2024
Mount Auburn Hospital, Business Intelligence Unit, 2024

Figure 16. Cambridge Residents by Age Group, 2020



Data Source: United States Census, 2020

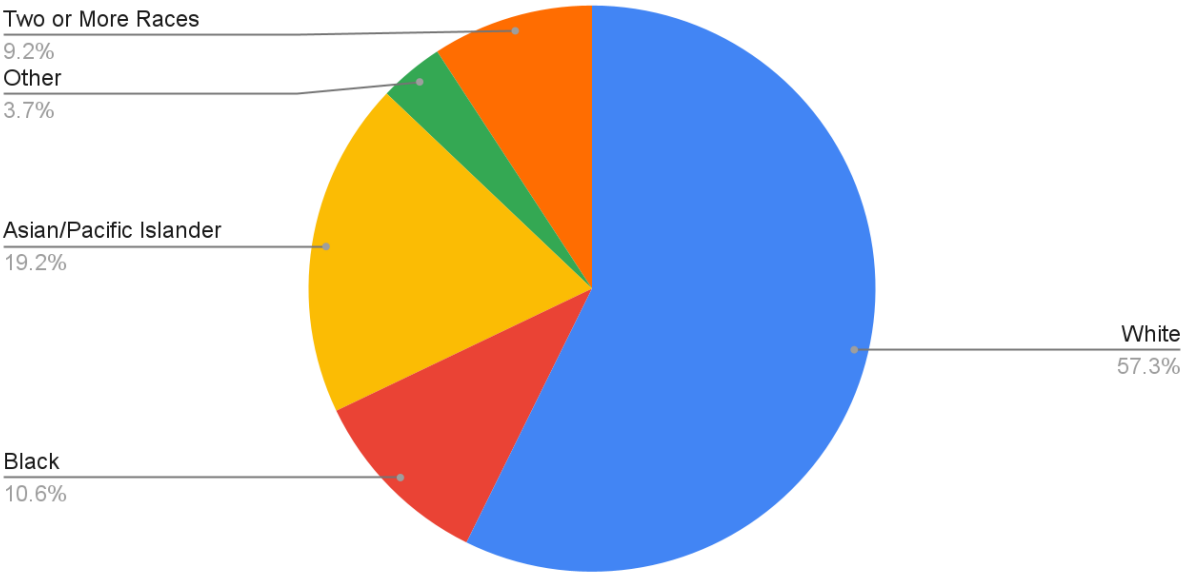
Figure 17. Opioid-Related Overdoses by Race at CHA/MAH, 2024



Data Sources:

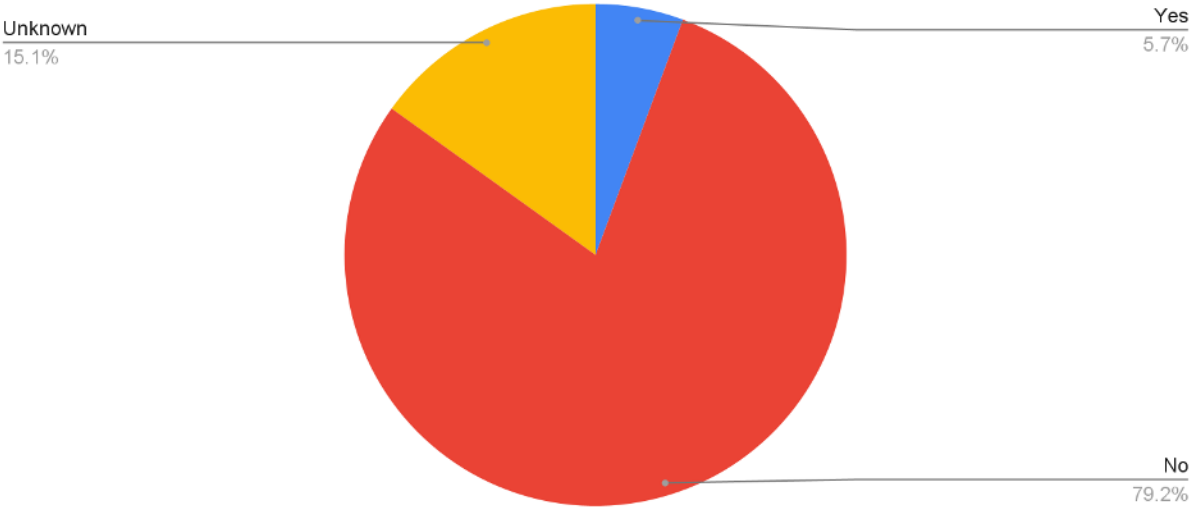
Cambridge Health Alliance, Business Analytics Unit, 2024
Mount Auburn Hospital, Business Intelligence Unit, 2024

Figure 18. Cambridge Residents by Race, 2020



Data Source: United States Census, 2020

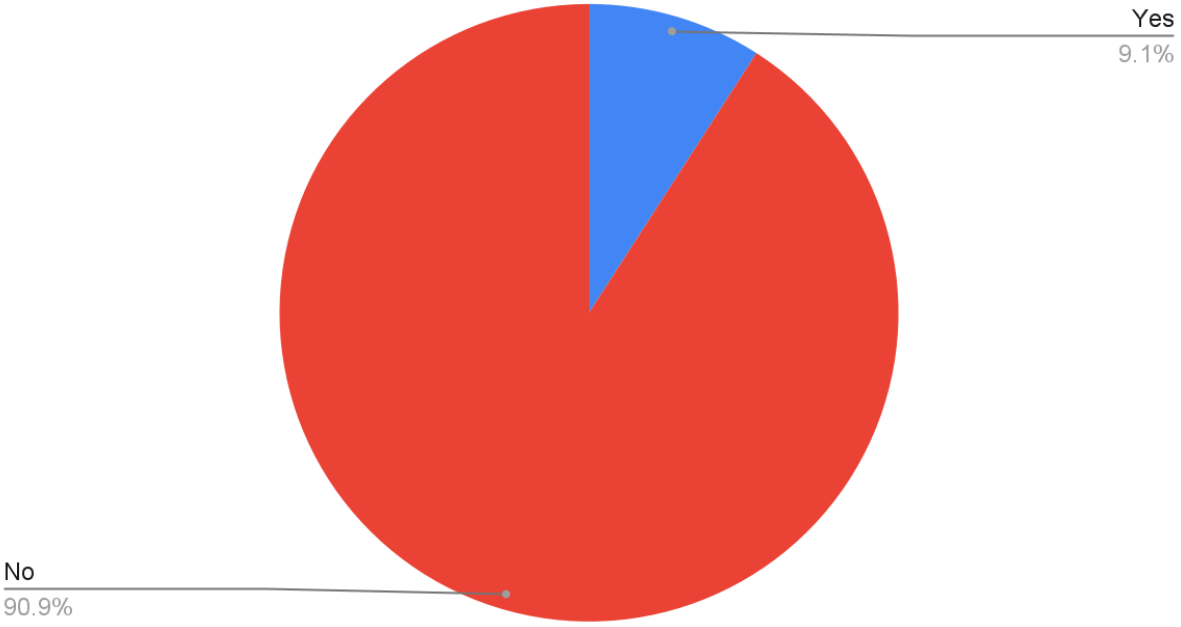
Figure 19. Opioid-Related Overdoses by Hispanic Ethnicity at CHA/MAH, 2024



Data Sources:

Cambridge Health Alliance, Business Analytics Unit, 2024
Mount Auburn Hospital, Business Intelligence Unit, 2024

Figure 20. Cambridge Residents by Hispanic Ethnicity, 2020



Data Source: United States Census, 2020

MASSACHUSETTS OVERDOSE EDUCATION AND NALOXONE DISTRIBUTION PROGRAM DATA

Naloxone (also known by the brand name Narcan) is a medication that can reverse an opioid overdose. It blocks opioids from attaching to opioid receptors in the brain. The Cambridge Public Health Department (CPHD) distributes free naloxone to community members at distribution events and upon request. CPHD is a designated Community Naloxone Program (CNP) organization. The CNP is a program of the Massachusetts Department of Public Health and provides qualifying partners with full or partially subsidized naloxone to distribute within their local communities. In 2024, CPHD distributed 1,684 doses of CNP-provided naloxone at full subsidy.

Cambridge is fortunate to also have an Overdose Education and Naloxone Distribution (OEND) site. AIDS Action Committee's Access Drug User Health Program, located in Central Square, offers a variety of services, including harm reduction tools such as naloxone, testing strips, and sterile use supplies; HIV/HCV/STI testing; and overdose response training sessions for individuals who are likely to experience or witness an overdose.

CPHD collaborates with Somerville Health and Human Services (HHS) to provide overdose prevention training across both cities. Monthly virtual training sessions are open to the general public and ad hoc sessions can be requested by any Cambridge- or Somerville-based business or organization. In 2024, CPHD and Somerville HHS instructors led 21 overdose prevention training sessions for 175 total participants. At in-person training sessions, free naloxone is provided to participants.

For more information, please visit Stop an Overdose with Naloxone on Mass.gov.

Administration of Naloxone

Table 5 lists known naloxone administrations at opioid-related incidents in Cambridge. When responding to a suspected opioid-related incident, Pro EMS records whether naloxone was administered and who administered it. If known, Pro EMS also records whether a bystander administered naloxone to someone experiencing a suspected overdose prior to EMS arrival. In 2024, 72% of opioid overdose incidents recorded by Pro EMS included documented use of naloxone. Of note, available data only records one administrator.

Table 5: Known Naloxone Administrations for Opioid-Related Overdoses in Cambridge when 911 was called, 2024

Administrator	Frequency	Percentage
Pro EMS	50	60.24%
First Responder	10	12.05%
Fire Department	10	12.05%
Bystander	11	13.25%
Other Healthcare Professional	2	2.41%

Data Source: Pro EMS Ambulance Service

RESOURCES

CPHD encourages residents to learn more about how they can help prevent death from overdose. Depending on your role in the community, there are different ways you can help stem the tide of the opioid epidemic. Below is a list of available resources at the local, state and national levels.

The Massachusetts Substance Use Helpline: Provides free, confidential information and referrals to over 600 treatment programs funded or licensed by the state. (800) 327-5050 | helplinema.org

SafeSpot: Teams of trained operators available 24/7 for people in Massachusetts who use drugs to call and have virtual supervision when using alone to help prevent overdose deaths. (800) 972-0590 | safe-spot.me

Learn to Cope: A support group for parents and other family members coping with a loved one addicted to opioids or other drugs. (508) 738-5148 | learn2cope.org

SADOD: Provides resources, information, and assistance to people who have been affected by the death of a loved one from a substance-use-related cause. sadod.org

Access Drug User Health Program: Free, safe, and confidential space for drug users to access resources and services, including free naloxone. (617) 470-6547 | fenwayhealth.org/aac/programs-services

PAATHS: One-stop shop for information about or access to addiction treatment services. (855) 494-4057 | boston.gov/government/cabinets/boston-public-health-commission/recovery-services/find-your-path-recovery

Cambridge Police Special Investigations Unit: Conducts investigations and assists overdose victims seeking treatment and recovery services. (617) 349-3360

Narcotic Anonymous: Support meetings. (866) 624-3578 | nerna.org

Alcoholics Anonymous: Support meetings. (617) 426-9444 | aaboston.org

Massachusetts Behavioral Health Help Line: Connect with qualified professionals for mental health assessments, crisis services, substance use treatment, referrals and more, with options in your own community. (833) 773-2445 | masshelpline.com

Community Behavioral Health Centers: Urgent and outpatient mental health and substance use services at more than 25 locations in Massachusetts, including at CHA Cambridge Hospital. mass.gov/community-behavioral-health-centers

SAMHSA National Helpline (800) 662-4357 | findtreatment.gov

988 Lifeline: The 988 Suicide & Crisis Lifeline provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week, across the United States and its territories. 988 | 988lifeline.org

Cambridge Public Health Department: Free overdose prevention training and harm reduction services, including free Narcan and fentanyl test strips.
cambridgepublichealth.org/services/overdose-prevention

METHODS

The Cambridge Public Health Department assessed existing community-level data sources to develop a timelier, more comprehensive overdose surveillance system.

Pro EMS Data Analysis

All EMS incidents that were likely related to opioids were pulled from the Pro EMS FirstWatch system. When this data sharing agreement was first established, epidemiologists at the Cambridge Public Health Department used narrative reports for each incident, as well as documented vital signs and naloxone response, to categorize each incident by overdose status. This method of classification was used from January 1, 2017 to May 17, 2017. From May 17, 2017 to December 2019, a machine learning algorithm was used to classify EMS incidents. Using natural language processing models in the programming language R,[7] the narrative text of new incidents were compared to previously manually classified data. In December 2019, it was discovered that data formatting changes required system revisions, prompting a return to manual labeling until February 2020. From February 2020 to present, the system revisions were completed and automatic reporting resumed.

A corpus of approximately 1,500 manually-classified incidents was used to generate a document matrix to train a Support Vector Machine (SVM), which is a type of supervised learning model.[8] New data were classified using this model. Epidemiologists at CPHD verified incidents that were not conclusively labeled. The current algorithm has an accuracy of 87.56%, a sensitivity of 68.75%, and a specificity of 95.04%. For more information, please contact the Division of Epidemiology and Data Services.

Hospital Data Analysis

CPHD received data from CHA and MAH as a set of CSV files, one for each hospital. The classification for this category included hospital visits for which a relevant diagnosis code was applied to the encounter. This classification follows the same reporting structure used by the Massachusetts Department of Public Health. Fields were matched across both hospitals to ensure standardization across the variables as the two hospitals did not always use the same designations. The data was then filtered to only include records with Cambridge-area zip codes.

A Note on Opioid-Related Fatalities

Pro EMS, CHA, and MAH datasets utilized for this report may include records of fatalities during opioid-related incidents. As such, the maps, tables, and figures in this report represent all documented opioid incidents, not just incidents without fatalities. These instances were included so that the report shows all readily-available data on where opioid incidents are occurring in Cambridge, when they are happening, and who they are happening to. Importantly, these datasets do not include all opioid-related fatalities in Cambridge or among Cambridge residents. A documented fatality during an opioid overdose does not necessarily mean that the fatality was caused by the overdose itself and not another cause. This determination can only be made by the state Office of the Chief Medical Examiner, which is why opioid-related fatalities are only reported in the State Data section of this report.

ACKNOWLEDGMENTS

We'd like to thank the following individuals and groups for their contribution to this project.

Cambridge Public Health Department
Derrick Neal, MPA
Anna Kaplan, MPH
Mary Kowalczuk, MSW
Danielle McPeak, MPH
Dawn Baxter, MBA
Rachel Heafield-Spaley, MPH

Pro EMS Ambulance
Bill Mergendahl, JD, EMT-P
Keri Cook, NRP

FirstWatch
Janet Baker

Cambridge Health Alliance
Sujin Park, MSBA

Mount Auburn Hospital
Mary DeCourcey, MS
Aliysa Rajwani, BDS, MPH, CPHQ
Christopher Cuña, MHA
Ann Turbett RN, MS, CPHQ

Access Drug User Health Program
Brian Sink

City of Somerville - Health & Human Services
Han Hogan-Rigg

ENDNOTES

1 National Institute on Drug Abuse. Drug Overdose Deaths: Facts and Figures. Retrieved October 15, 2024. https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates

2 Kaiser Family Foundation. Opioid Overdose Death Rates and All Drug Overdose Death Rates per 100,000 Population (Age-Adjusted). Retrieved October 15, 2024. https://www.kff.org/other/state-indicator/opioid-overdose-death-rates/?currentTimeframe=0&selectedDistributions=opioid-overdose-death-rate-age-adjusted&sortModel=%7B%22colId%22:%22Opioid%20Overdose%20Death%20Rate%20(Age-Adjusted)%22,%22sort%22:%22desc%22%7D

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