Alcoholism & Drug Abuse Weekly

News for policy and program decision-makers

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In This Issue...

HHS budget proposal: Merge block grants, institutes under "behavioral health"

Under the proposed budget – which must be approved by Congress – the federal Department of Health and Human Services (HHS) would merge substance use and mental health block grants as well as federal research institutes under the "behavioral health" title. The proposal also eliminates the agency in charge of the Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) block grant, which pays for publicly funded treatment through the states.

The primary way that substance use disorder (SUD) treatment and prevention has been paid for in many states, especially states that did not expand Medicaid, is the SUPTRS block grant.

Bottom Line...
The White House has proposed eliminating the separate block grants, NIDA, and NIAAA under "behavioral health".

The merger would include SOR (State Opioid Response) grants.

Removing SUPTRS and SOR grants from SUD-specific activities would be a disaster. The reductions in opioid overdose deaths seen in the past two years would be reversed.

In the past, it has been shown that the groups which wanted to take advantage of the SUPTRS block grants – mainly the mental health field – supported such mergers (see *ADAW*

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New York lawmaker seeks to mandate coverage for problem gambling

A New York state legislator wants to make sure that state insurance parity protections for the treatment of substance use disorder also extend to care for problematic gambling. Assembly member Phil Steck has introduced legislation that would codify problem gambling services in the state's existing parity mandates.

Steck, a Democrat representing the Albany-Schenectady area, introduced Assembly Bill 8518 in this year's legislative session. The first-time proposal would add outpatient coverage for problem gambling services to the outpatient coverage for substance use detox and rehabilitation that is already spelled out in the state parity law. The law requires that insurance policies offering comprehensive medical coverage also provide outpatient coverage for substance use disorder with no more restrictive financial requirements or treatment limitations.

Bottom Line...
State legislation that has been filed in New York would require insurance plans that cover comprehensive medical care to offer coverage for problem gambling services at parity.

With this year's New York state legislative session nearing a close, Steck told *ADAW* it would be surprising to see the measure advance in this session. It has not yet

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https://onlinelibrary.wiley.com/doi/10.1002/adaw.20268). However, Congress resolutely did not go along with the proposal, and it would be surprising if it did this time. Still, we report on the proposal here.

The proposal, released the last week of May, states the following:

> "This budget introduces a new program, the Behavioral Health Innovation Block Grant. This program will provide mental health and substance use services while maximizing states' flexibilities. With the investment of $4 billion, the new block grant will consolidate the funding for the Community Mental Health Services Block Grant, Substance Use Prevention, Treatment and Recovery Support Services Block Grant, and State Opioid Response. States will have the ability to fund various activities most appropriate to the needs of their communities including addressing crisis services, serious mental illness and serious emotional disturbances; prevention, treatment, and recovery from substance use disorder, and preventing and responding to overdoses. States and local communities best know the way to serve their populations – not the federal government. Often, mental health and substance use are co-occurring conditions, and the new program is designed to foster innovative solutions at the state level instead of building administrative silos. This new program will not only increase flexibility but reduce administrative burden for states by having a single reporting mechanism. The budget also includes $80 million for a new Behavioral Health and Substance Use Disorder Resources for Native Americans Grant Program to advance mental health and substance use services at the tribal level."

The budget correctly notes that states know the best way to serve their residents. However, that is why the block grants go to the states. However, there are specific statutory requirements and accompanying regulations guiding how the block grant can be used. Now, it appears that the federal government thinks that not only do the states know best how to serve their residents, but should have to pay for it themselves (or ask their residents to). Will the states which refuse to put their own money into SUD prevention and treatment agree to this proposal? They depended on federal funding.

The budget also proposes moving the Drug-Free Communities program to HHS from the Office Of National Drug Control Policy ONDCP).

Only $11 million is set aside for Opioid Treatment Programs.

More merging

"HHS plans to combine multiple agencies— including the Health Resources and Services Administration (HRSA), Substance Abuse and Mental Health Services Administration (SAMHSA), Office of the Assistant Secretary for Health (OASH), National Institute for Environmental Health Sciences (NIEHS), and some programs from the Centers for Disease Control and Prevention (CDC)—into a new, unified entity called the Administration for a Healthy America (AHA)."

It would also merge the National Institute of Alcohol Abuse and Alcoholism (NIAAA), the National Institute on Drug Abuse (NIDA), and the National Institute of Mental Health into a new National Institute of Behavioral Health.

These are the initiatives previously in SAMHSA which would be eliminated with funding going into other – mainly "Make America Healthy Again" -- initiatives, according to the proposal:

- Mental Health Awareness Training
- Healthy Transitions
- Infant and Early Childhood Mental Health
- Mental Health Children and Family Programs
- Consumer and Family Network Grants

ALCOHOLISM & DRUG ABUSE WEEKLY
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- Mental Health System Transformation
- Project LAUNCH
- Primary and Behavioral Health Care Integration Programs
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- Homelessness Prevention
- Mental Health Criminal and Juvenile Justice Programs
- Assertive Community Treatment for Individuals with Serious Mental Health Illness
- Homelessness Technical Assistance
- Minority AIDS
- Seclusion and Restraint
- Minority Fellowship Program
- Tribal Behavioral Health Grants
- Interagency Task Force on Trauma-Informed Care
- Strategic Prevention Framework
- Sober Truth on Prevention of Underage Drinking
- Screening, Brief Intervention and Referral to Treatment
- Targeted Capacity Expansion
- Grants to Prevent Prescription Drug and Opioid Overdose-Related Deaths
- First Responder Training, Improving Access to Overdose Treatment
- Pregnant and Postpartum Women
- Recovery Community Services Program
- Substance Abuse Treatment Children and Families
- Treatment Systems for Homeless
- Building Communities of Recovery
- Substance Abuse Treatment Criminal Justice activities
- Emergency Department Alternatives to Opioids
- Treatment, Recovery, and Workforce Support
- Peer Support Technical Assistance Center

"The SUPTRS Block Grant is consistently identified by our association as our number one policy priority…. It is also important to point out that NASADAD has been on record in support of gradually transitioning SOR to the SUPTRS Block Grant in order to maintain a focus on substance use disorders but begin to move away from drug specific grants."

Rob Morrison

- Comprehensive Opioid Recovery Centers
- Youth Prevention and Recovery Initiative
- Drug Abuse Warning Network

The National Survey on Drug Use and Health (NSDUH) has already been eliminated by the firing of all its staff (see *ADAW* https://onlinelibrary.wiley.com/doi/10.1002/adaw.34474).

Funding

According to the proposal, the HHS budget "includes $5.8 billion in discretionary budget authority to provide mental health services, suicide prevention, substance use prevention, and substance use treatment. It also will increase state's flexibilities to meet behavioral health needs."

The proposed budget maintains suicide prevention programs, including $520 million for the 988 Suicide and Crisis Lifeline – which is actually also for SUD crises (see *ADAW* https://onlinelibrary.wiley.com/doi/10.1002/adaw.33508). HHS is tipping its hand by leaving that out here. The likely funding target for the merged block grants and institutes is suicide – or mental health, or the contribution of food dyes to autism, or the evils of vaccination, or any other of the many possible interests of HHS Secretary Robert F. Kennedy, Jr.

"In addition to the 988 Lifeline, the budget provides suicide prevention services through National Strategy for Suicide Prevention ($28 million), Garret Lee Smith Youth Suicide Prevention programs ($63 million), and American Indian and Alaska Native Suicide Prevention Initiative ($4 million). Suicide remains a prevalent issue within the United States and this budget aims to provide the necessary resources to those in crisis. The budget also maintains support for mental health promotion including investments in Project AWARE ($121 million), the Child Traumatic Stress Network ($99 million), Children's Mental Health ($125 million), Projects for Assistance in Transition from Homelessness ($67 million) Assisted Outpatient Treatment ($21 million), Disaster Response ($2 million), and technical assistance. In addition, the budget supports coordinated, comprehensive behavioral health care services through Certified Community Behavioral Health Clinics ($385 million)."

Comments from field

We did interview stakeholders but they could not provide on-the-record comments. Suffice it to say that work is being done on Capitol Hill to fight this proposal, which would be a disaster if it were to take place.

Others did comment.

"The SUPTRS Block Grant is consistently identified by our association as our number one policy priority," said Rob Morrison, executive director of the National Association

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of State Alcohol and Drug Agency Directors. "And within this work, we have a long and established history of supporting the maintenance of the SUPTRS Block Grant as a program that specifically focuses on substance use disorder treatment, prevention, and recovery. It is also important to point out that NASADAD has been on record in support of gradually transitioning SOR to the SUPTRS Block Grant in order to maintain a focus on substance use disorders but begin to move away from drug specific grants. I see the latter issue – combining SOR with the SUPTRS Block Grant – as important common ground with the Administration."

"The HHS budget proposal to combine the mental health and substance use disorder block grants with the State Opioid Response grant is entitled to full consideration during the Congressional process," said Rob Kent, former legal counsel for ONDCP and the New York State Office of Addiction Services and Supports. "While I would be concerned if the proposal resulted in less funds being available for addiction, I look forward to a detailed review and discussion as I do support efforts that may result in more flexibility for the states in how they use these funds."

And from Richard Frank, Ph.D. of the Brookings Institution, formerly assistant secretary of HHS under President Obama: "The totals say a lot. The SAMHSA appropriated budget from the continuing resolution in FY2024 was $7.370 billion. The proposed budget for behavioral health for FY2026 is about $5.7 billion. That is a 22.6% nominal reduction. The cuts are made by eliminating a slew of programs ranging from Infant and Early childhood Mental health to Primary and behavioral health integration (an evaluated program), to the crisis response partnership to SUD criminal justice activities. The discussion of greater reliance on block grants is broad but it suggests that there would be little systematic accountability for the quality and effectiveness of state spending—something that has long been a challenge for SAMHSA."

This story is why *ADAW* has resisted using the phrase "behavioral health" throughout the years. It merges SUD and mental illness. Some politicians and many voters mistakenly consider SUD as self-inflicted and therefore not worthy of funding. There are good reasons for devoting specialized funding to SUD services, but it took brave senators – and an astronaut – to bring alcoholism to the fore just over 50 years ago. It took much longer to bring drug addiction to the fore. But in a few short years, both have been shown to be major killers. •

It Costs More to Kill Us Than to Help Us Get Back on Our Feet: *Investing in Recovery is Cheaper and Yields Dividends*

By William Stauffer

Alcohol, Tobacco and other drug mortality leads loss in America if you add it all up, which we do not. But of course, it does not end there. We also fail to consider non mortality associated carnage. It costs us billions in lost productivity, associated healthcare costs, criminal justice expenditures and innumerable other burdens. To highlight one of the myriad of such outlays, the BoatUS Foundation calculates that impaired boating costs us 240 million dollars a year. Last week in *ADAW*, the lead article cited Indivior, finding that the average case of OUD costs $695,000 a year, most in the criminal justice system. It breaks down costs per state, and it calculates in my home state of PA, Opioid Use Disorders alone cost us over 232 Billion dollars. You cannot look anywhere in our budgets without uncovering similar stats, but we do not add all these vast burdens on society up. It is either a number so large that we cannot fathom it, or that we do not care enough to add it all up because if we did, we would have to actually do more about it. The Occom's Razor of our dearth of data in respect to all the societal costs from alcohol and other substance use. We don't want to know the full scope of costs because then we would have to do more about it.

Unfortunately, we are seeing a dramatic decrease in commitment to recovery as evidenced by draconian budget cuts at the federal levels which translates to further reductions downstream across state and local governments. The cuts go into the bone. It breaks things. There is talk of reducing services to the bare minimum presented as very short stints in treatment. This is exactly like giving someone with a life-threatening infection a half dose of a weak antibiotic and doing a Hail Mary that they survive. There will be no savings here, the longer we go without an investment in getting people into sustained recovery the steeper the butcher bill will be with fewer assets to actually support these needs.

Doing something about it would invariably include significant investment in helping people heal over the long term. We have never invested much in helping people get to the point they are in stabilized recovery despite the evidence we have as to the wisdom of such an expenditure. I have written extensively about the fact that few people get care and those that do get far less than the minimum dose known to

be effective for the average person. Remember that the main focus of efforts in respect to the opioid epidemic was on naloxone availability and first aid efforts. Keeping people alive is vital, but there is much more to life than a sustained heartbeat. Yet we just did not invest in much more beyond first aid and brief treatment. People in recovery are productive, civically engaged participants in their community. We have few challenges like this one in which we can shift a cost driver into generative investment. What is stopping us?

A generation ago in 2009, the National Center on Addiction and Substance Abuse (CASA) at Columbia University released a report titled Shoveling Up II: The Impact of Substance Abuse on Federal, State and Local Budgets, which determined that roughly 96 cents of every dollar spent in respect to the costs of substance use to society is on shoveling up the devastation wrought. Focusing on getting people into sustained recovery is the way to save money across all of those line items and in 2009 is what a penny or two on the dollar, it is likely about the same now. We are not the line item to cut if savings is what is desired.

As substance use challenges have only grown more complex, it would be hard to see that this ratio that CASA calculated so long ago has improved much, if at all. With projected federal reductions in support, what is likely to occur is even greater rates of expenditure across society as the carnage increases and the complexity of the challenges become more profound. This is not the place for frugality. We will not save money here. It costs much more to ignore or delay these challenges than it does to proactively address them. The longer we ignore getting people into recovery to save a few pennies, the greater the dollars in damage. Vast sums.

What makes us so uncomfortable helping people get into recovery

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FROM THE FIELD

"I believe in Karma!"

By Robert Kent

"*When someone shows you who they are, believe them*."
— Maya Angelou

During my almost 20 years of working on drug policy, no issue has irritated me as much patient brokering.

Patient brokering is the situation where someone (usually in recovery) offers you (only if you have private insurance) the amazing opportunity to travel to a usually warm and sunny state to go to a gold star treatment program. They will also pay for your airfare to and from your home.

Let us unpack this. First, it is illegal under many state laws and the federal law to offer something of value, like airfare, for the purpose of getting someone to enter a treatment program. Second, the amazing recovery warrior who can get you into the treatment program is being paid a "reward/bounty/kickback" from the treatment program, but only if you go to their program. Third, the programs are usually pathetic by any standard. Finally, too many folks/victims do not make it home especially if your insurance stops paying as you will be kicked to the streets of a place you do not know with no way home.

I helped pass a law in NYS to try to stop this! Unfortunately, little has changed! While the COVID pandemic significantly slowed down patient brokering, like a bad infection, it has come back with a vengeance! Prosecutors do not ever seem to be interested in pursuing these types of cases.

I raise this issue now because I see patient brokering on the rise and there are so many effective treatment programs that do not play these games. When brokering occurs, folks in need do not get well, some die, and good providers lose the opportunity to provide helpful treatment. These broker/providers are usually not in insurer networks and are then able to charge outrageous prices and usually spend more on toxicology testing than on the treatment. I personally of one situation where the treatment cost $300,000 and more than $175,000 of that amount was spent on toxicology testing. Insurers do next to nothing to pursue these cases as they would rather hassle the good providers in their network!

I lost count of how many families I spoke with over the years whose loved ones did not make it back, or they got home but the "gold star" program exhausted all their insurance benefits, and they still needed help! We would find programs that would provide a scholarship because that is what good providers do, that is what we are supposed to do!

Let me end with this. Remember what our parents told us, if it sounds too good to be true, it is!

Finally, I believe in karma and that we will be held to account for the actions we take in your life. Please reach out to your local authorities if you have been the victim of patient brokering. If they will not help, reach out to me and I will do my best to help them help you! •

Robert Kent is president of Kent Strategic Advisors, LLC, and former general counsel for the Office of National Drug Control Policy and the New York Office of Addiction Services and Supports.

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that we have failed consistently over many decades at making this a priority? Drug use is the norm in our society. Those who abstain from using make a lot of people very uncomfortable. It is also in the interest of drug merchants to keep heavy use normalized, there is no money made from people who do not use or who do so in moderation. We have some kind of invisible line between people who can use, even quite heavily, and it is accepted and often even encouraged culturally, but once you cross the threshold into having a problem, things suddenly change. It is then seen as a self-inflicted condition that we offer people few ways out of. It is part of the dynamic in play here – why help people if we see it as their fault and something that does not happen to "good" people. Of course, we know that is not true, but it seems to be the operant process in play here.

If history is instructive here, we will repeat some version of the Users Are Losers chapter in American drug policy in which we shame users and fund punitive tools and so every challenge will be met with a hammer, after all, "good people" do not struggle with drug use. While most everyone knows cognitively this is not true, it is an easy emotional lever to pull in order to justify budget cuts. Right now, we poised to decimate services under the premise that they are wasteful and people who use them are lazy. It is an old and oft used ploy, but it will not remove the stark reality. It is more expensive to kill us through neglect than it is to help us, at which point we are deeply contributive members of our communities. We are killing off our assets, quite literally.

There is an alternative future, and it really is a healthier America. We know that not only is recovery possible, which was the tag line at SAMHSA for many years. The research clearly shows us that recovery is the probable outcome when people receive the requisite care and support. We know that once people are in stable recovery they are healthier, employed, they take care of their families, and they are contributive to their communities. The pathway to a healthier America must include a focus on getting more of us into sustained recovery, but like any other challenge, we must invest in that outcome in order to achieve it.

"Let's not do the thing that is most expensive in lives and resources, let's take the road of investing in long term recovery for every American who can benefit from it."

William Stauffer

Recovery is not a partisan issue. It kills Republicans and Democrats alike. I have seen PhD's end up homeless and on the flip side the trajectory of recovery persons who were once homeless get PhD's, JDs and achieve other amazing things. I have worked with thousands of people over the decades of my life and everyone has a story. It is often one that involves a promising life trajectory laid low by addiction. The more important chapter is the one in which people regain their lives and achieve what people like William White, Phil Valentine and Dr David Best term "better than well." People who are better versions of themselves through their journeys of resiliency and recovery. If America was ever about anything, it is the place of second chances. Investing in recovery as a second chance pays dividends in lives and resources. Failing to do so places immense burdens on our society. Which road do we take?

It is not often that the less expensive course of action has a better return on investment. Investing in recovery is one of those things in which this is true. Let's not do the thing that is most expensive in lives and resources, let's take the road of investing in long term recovery for every American who can benefit from it. We would reap the wisdom of that course of action. That is the road we must take. We can turn around and get back on that road, there is still time, but not much. We stand on the precipice of losing the infrastructure that can help take us there. We should take the road that yields a healthier America, one in which people have the opportunity to recover, after which we become part of the solution.

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proceeded through required committee consideration. Steck, a member of the Assembly's Insurance Committee and chair of the legislature's Standing Committee on Alcoholism and Drug Abuse, hopes the bill's introduction plants the seed for action in a future session.

He said comments he has heard from fellow state legislators inspired him to introduce the bill. "Members of the legislature came to me saying that young men in particular have gotten into a large problem with sports betting," he said.

Two reports released in the second half of 2024 suggested that online betting has fueled worldwide growth in the gambling industry, along with many of its associated societal problems (see "Reports on gambling focus on harms of online betting," *ADAW*, Nov. 4, 2024; https://doi.org/10.1002/adaw.34315).

Steck believes an insurance mandate would result in more people taking an advantage of the opportunity to address problematic gambling behaviors.

Correlation with alcohol

Support for including coverage for problem gambling services in an insurance mandate is enhanced by research that suggests today's gamblers are particularly prone to alcohol-related problems. A study published in March in *JAMA Psychiatry* found a high positive correlation between the trajectories of sports betting and alcohol-related problems, with increases in one leading to rises in the other (see "Sports betting, alcohol problems follow similar trajectories: Study," *ADAW*, March 17, 2025; https://doi.org/10.1002/adaw.34447). The study suggested that problem drinking is more prevalent among gamblers who bet on sports than gamblers who choose other avenues for betting.

> **"Members of the legislature came to me saying that young men in particular have gotten into a large problem with sports betting."**
>
> Phil Steck

Steck said the techniques that gaming interests use to attract young people to sports betting warrant a response from government. Any measures that were created to curb excessive betting at the time the state's casinos were developed are simply inadequate for addressing the challenges of a transformed gambling landscape, he suggested.

Steck said state legislators are considering other measures to enact some control over a growing problem, such as through limits on the types of ways bettors can spend online or the number of betting vehicles they can use. He said legislators are working with an academic expert on problem gambling to devise approaches.

Steck said he also sees gambling expansion as having a disproportionately adverse impact on lower-income populations. In fact, much of the recent evidence suggests that the harmful effects of problem gambling are reaching a greater diversity of groups, including women (see "Surge in betting challenges backers of help for gambling problems," *ADAW*, Feb. 20, 2023; https://doi.org/10.1002/adaw.33695).

A spokesperson for the Association for Behavioral Health and Wellness, which represents large managed care companies overseeing substance use and mental health services, did not reply to *ADAW*'s request for comment for this article.

Treatment approaches

Although some licensed substance use treatment programs will treat individuals with a gambling disorder, oftentimes these individuals will seek help from a private-practice professional such as a psychiatrist or counselor. With no approved medication treatments for gambling disorder, behavioral therapies tend to be the most commonly used approach.

A summary of treatment recommendations from the Massachusetts Department of Public Health's Office of Problem Gambling Services cites cognitive-behavioral therapy (CBT) as the most studied treatment for gambling problems. "CBT can include at least four components: correcting cognitive

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distortions about gambling, developing problem solving skills, teaching social skills and teaching relapse prevention," the document states. "There are a number of CBT trials that suggest that it is an effective form of treatment for gambling."

Other suggested approaches resemble some of the strategies used in addressing problematic drinking, including:

1. Motivational enhancement strategies that usually accompany other interventions as adjunctive treatment;
2. Personalized feedback that helps individuals compare their behaviors to norms seen in the larger population; and
3. Relapse prevention approaches that teach individuals how to develop coping methods when encountering high-risk environments. Some research has suggested that relapse prevention in combination with cognitive therapy can reduce the time and money individuals spend on gambling.

Some of the existing medications that have been studied for possible therapeutic effects on gambling behavior include naltrexone, the opioid antagonist nalmefene and the anticonvulsant topiramate.

If the proposed New York legislation were to pass, insurance language in state statute would be amended to read:

"Every policy that provides medical, major medical or similar comprehensive-type coverage shall provide outpatient coverage for the diagnosis and treatment of substance use disorder, including detoxification, rehabilitation and problem gambling services. Such coverage shall not apply financial requirements or treatment limitations to outpatient substance use disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy." •

Coming up...

The **CPDD annual meeting** will be held **June 14-18** in New Orleans. For more information, go to **https://cpdd.org/meetings/current-meeting/**

A joint **RSA/CPDD program** on polysubstance use will be held **June 19-20** in New Orleans. For more information, go to **https://smr.plnk.co/?page_id=1419**

The **RSA annual meeting** will be held **June 21-25** in New Orleans. For more information, go to **https://researchsocietyonalcohol.org/2025-meeting/**

The **National Prevention Network (NPN) Conference** will be held **August 11-13** in Washington, DC. For more information, go to **https://npnconference.org/**

The **Cape Cod Symposium** on Addictive Disorders will be held **September 4-7**. For more information, go to **https://www.hmpglobalevents.com/symposia-addictive-disorders**

Briefly Noted

Drug decriminalization associated with reductions in police arrests

In the 2 years before decriminalization in British Columbia, rates of drug possession incidents were decreasing by 2% per month in British Columbia and 1% per month in the rest of Canada. After decriminalization, there was decrease of 57% in drug possession incidents in British Columbia – and no significant change in the rest of Canada, according to a research letter published June 3 in *JAMA*. The public health data was different, however. During the first year of decriminalization, there were no significant changes in quarterly rates of stimulant or opioid deaths, or stimulant or opioid hospitalizations. Drug decriminalization is often discussed as a way to reduce drug overdoses. The researchers compared changes in outcomes between the 2 years before decriminalization and the first year of decriminalization between British Columbia and the rest of Canada. Their study evaluated changes in police-reported drug incidents as well as hospitalizations and deaths from opioids and stimulants in the first year after decriminalization. "Drug Decriminalization in British Columbia and Changes in Drug Crime and Opioid and Stimulant Harms" is by Adrienne Gaudreault and colleagues. •

In case you haven't heard...

The troubled former CEO of New Hampshire's biggest addiction treatment center was arraigned in federal court last week on charges of masterminding attacks on homes of journalists who were investigating his actions. Eric Spofford was asked to post a $1 million bond. His arrest came years after the vandalism of journalists' homes in 2022 after a reporter detailed allegations of sexual assault and harassment. The reporter's home and the homes of her parents and her editor were all vandalized as well. Spofford and the men he hired to do the vandalism have already been convicted on charges related to the vandalism. Spofford, said he sold his company, Granite Recovery Centers, in 2021 for $115 million. Spofford remains free on the bond. The investigation led to a 2023 podcast called The 13th Step, which became a finalist for the Pulitzer Price in 2024. Thanks to WBUR for this report. •