

Summary of Members' Responses

Members were asked to provide feedback on the principles and metrics that might inform expenditures from the Trust Fund. Responses were received from 10 Council members. Among the varied responses, a number of themes emerged, which were bucketed into three categories (*Criteria, Services, and Structure*) with the goal of identifying actionable items for the Council to consider.

- **CRITERIA and/or principles for directing Trust Fund dollars:**
 - Support for a county/community-level approach over a broader, regional focus.
 - Support for utilizing rate of overdoses (fatal and non-fatal) and EMS incidents to guide future spending.
 - Specific demographic information, eg, age, ethnicity, should be considered to direct resources to historically underserved communities and those most impacted by the opioid crisis.
 - Increased focus on prevention, harm reduction, emergency shelter, and community outreach regarding opioid use disorder.
 - Create a standard of care that spans 60-90 days of inpatient care and the ability to then have access to housing, jobs and education.
 - Support for women and families impacted by opioids, as well as those with substance use disorder and co-occurring mental health disorders.
 - Support for justice-involved individuals with history of substance use, both currently and recently incarcerated.
- **SERVICES (new or existing) that could be supported by Trust Fund dollars:**
 - Residential programs serving Black and Latinx communities.
 - Strengthened pipelines for mental health clinicians of color and addiction care.
 - Funding for trauma-informed services associated with outreach and continued trauma-informed care accessible to those in recovery.
 - Additional funding for syringe exchange programs.
 - Advocate and legalize supervised injection sites across impacted cities.
 - Dedicate additional resources to ensure accessibility and affordability of Narcan supply for all outreach workers and recovery coaches.
 - Sober living scholarships to support those with extreme financial need.
 - Technical assistance to help organizations design and implement effective addiction prevention and treatment programs.
- **STRUCTURE of services and/or providers:**
 - No clear consensus on the length of grants or type of organizations funded, eg, well-established, comprehensive programs vs. start-ups.

ORRF Advisory Council Principles and Metrics – Member Feedback

Council Member	Response*
Council Member #1	<ol style="list-style-type: none"> 1. Suggest access to treatment and other barriers to treatment be included as one of the Principles and Metrics. <ul style="list-style-type: none"> • Based on the Distribution of Opioid Addiction Treatment providers Funded/licensed by BSAS data provided, using the data to guide expenditures from the trust fund to balance the patient geographic demand for treatment (based on the utilization of treatment center data) and the geographic distribution of Opioid Addiction Treatment providers/centers.
Council Member #2	<ol style="list-style-type: none"> 1. Incidence and prevalence of deaths and EMS incidents by a metric for location as has been shared is a great initial screen for areas of high need. 2. Layering on the social vulnerability index may be a good way to weight the areas with where the burden of social determinants will require a higher investment. This will help address the race/equity considerations. 3. Additional segmentation in these highest risk focus areas by age groups, ethnicity etc. can be used to help support local efforts and to further direct funding.
Council Member #3	<ol style="list-style-type: none"> 1. Criminal Justice Programs - BSAS Funded addiction programs for those with history of substance use while incarcerated. Also training about addiction for staff and sheriffs. 2. Fund Black and Latino serving residential programs at a higher lever taking into account level of trauma from incarceration and overall racism 3. Fund pipelines for mental health clinicians of color and addiction care 4. Fund and standardize youth programming across public schools in cities most impacted 5. Fund syringe exchange programs 6. Consider advocating and legalizing safe injections sites across impacted cities 7. More programs for diversion that divert communities of color. Show data of diversion program and impact on communities of color 8. Narcan supply for all outreach workers and recovery coaches, more easily accessible with decreased costs
Council Member #4	<ol style="list-style-type: none"> 1. Increase in funding for prevention services and family support and education in communities of residents with high OD/Death Count 2. Increase in funding for Harm Reduction/Emergency Shelter/Community Outreach in communities where high incidence of overdose and OD death occur. 3. Increase in funding for Harm Reduction/Narcan Distribution in communities with high incidence of EMS response

* Lightly edited for clarity

ORRF Advisory Council Principles and Metrics – Member Feedback

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	<ol style="list-style-type: none"> 4. Increase in funding targeted culturally appropriate outreach for communities with high incidence of OD/Deaths and EMS response in the Black/Latino community. 5. Mental health services in general are in short supply and require additional funding. 6. Focus on underserved populations and factors that contribute to the number of overdoses and overdose deaths, eg, mental health and trauma, human trafficking, and homelessness. I would like to see funds allocated to assist the following: <ul style="list-style-type: none"> • Individuals with co-occurring mental health disorders or primary mental health and secondary substance use disorder do not have access to the same services for addiction treatment or housing and employment services depending on the severity of their mental illness, as do those with solely a SUD diagnosis. 7. There is a growing population of children who have lost a parent to overdose and often grandparents or other family members that are now raising them that need mental health services and financial support, as well as prevention services directed at the children. 8. Trauma has been brought to the forefront recently as not only a contributing factor to first use but can also be a major driving force in relapse and continued use. Funding for trauma informed services associated with outreach and continued trauma-informed care that is accessible to those in recovery should be funded. 9. Programs that support prostituted woman such as LIFT in Worcester and the EVA Center in Boston need and deserve additional funded clinical support as well as the same support for all prostituted individuals. 10. Much of the re-entry support is directed at men. I would like to see an increase in re-entry support for women and additional assistance for family reunification. 11. Sober living scholarships to those with extreme financial need in order to create a continuum of care that is often not available, eg, cost of obtaining ID and some transportation and work clothes. 12. I hope that we will use this funding to create a standard of care that spans 60-90 days of inpatient care and the ability to then have access to housing, jobs and education in order to make a meaningful improvement in life.
<p>Council Member #5</p>	<ol style="list-style-type: none"> 1. Regional approach <ul style="list-style-type: none"> • Maybe even smaller than the six HHMC regions (example: Boston Quincy & Cambridge) • Focus on the areas where the highest rate of overdoses fatal and non-fatal (residence area if focusing on prevention opposed to treatment) 2. Question <ul style="list-style-type: none"> • Are we looking to focus on prevention, intervention, treatment or recovery support? • Are we creating stages of spending based of priorities? 3. Comment <ul style="list-style-type: none"> • Increase and improve the public workforce statewide

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<p>Council Member #6</p>	<ol style="list-style-type: none"> 1. Distribution across the 6 Health and Medical Coordinating Coalition regions <ul style="list-style-type: none"> • It is my hope that all pathways to recovery are considered. Medication should be accessible and affordable to all. The public would also like to see Vivitrol included and as accessible as Buprenorphine and Methadone. It seems that patients who are in recovery without medication are now stigmatized using the word "abstinence" and the impression it's not evidence based. 2. Prevalence of Opioid Use Disorder <ul style="list-style-type: none"> • Clearly the data shows we still have a long way to go and with COVID-19 there has been more fatalities and more relapse due to isolation. I hope the funds are only used to tackle Opioid use disorder. 3. Fatal and non-fatal overdose rates, include residences versus location where the overdose occurred. <ul style="list-style-type: none"> • I would also like to see gender, age and race included. There is a shortage of treatment beds for women and has been for years. 4. Race/ equity considerations <ul style="list-style-type: none"> • Although I have never seen anyone turned away from treatment due to their race or culture, I do believe there are many treatment centers that are not affordable for all communities. Each center should have to have a certain number of beds that are funded by these funds so anyone can access them, or better yet, help start up programs that will make sure all communities have the support they need 5. Additional programs for orphaned children due to opioids. <ul style="list-style-type: none"> • Maybe more programs for women and children that offer support, education and perhaps housing.
<p>Council Member #7</p>	<ol style="list-style-type: none"> 1. The Principles are generally fine but not nearly detailed or specific enough to provide guidance for decision making or assurance that the funds will prevent overdoses and deaths and support long term recovery. 2. My impression from remarks made at the last meeting is that the Secretary intends to use a competitive bid grant process to allocate funds. My comments are based on this assumption. 3. Geographic considerations that ensure attention to all areas of the State are important. In each region, however, there is large variation of both the severity of the epidemic and the availability of effective services. <ul style="list-style-type: none"> • We should develop an index at the town or small regional level that reflects the severity of the epidemic and available services. 4. Grants should be made only to organizations that have the administrative, governance and professional capacity to achieve the goals in their proposals. They should have a track record of success. As a general rule we should not fund start ups. If we do decide to make grants to small CBO's we should do so with a structured program of technical assistance and mentoring to increase their chances of success.

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	<ol style="list-style-type: none"> 5. There should be a commitment to using evidence-based practices. For treatment this means a commitment by the applicant to support medication treatment for OUD and medications as appropriate for other addictive disorders. 6. For harm reduction there should be a commitment to use naloxone and extensive continual outreach to support individuals who are using. If we decide to fund novel approaches, there must be a logic model and other evidence to show the likelihood of success. The governing body of all grantees must be required to formally agree that it will support medication treatment for OUD either by providing it or through active partnership with a medication provider. No grantee should be able to exclude individuals using medication from its programs. 7. Grantees should show evidence that the program they propose is linked to other efforts in their service area that are addressing similar issues. There should be evidence that the proposed activity fits into a community wide strategy to prevent and treat addiction and related social problems. 8. Grants should be large enough and long enough for the grantee agencies to achieve their intended results. Small one year grants are unlikely to have much impact. 9. There should be evidence that the grantee is able, through its own activities or in collaboration with others, to address the social and other barriers to successful recovery, especially housing, jobs and income support. Serious consideration should be given to making grants to organizations that focus on non-treatment barriers to successful recovery. 10. With special attention to racial and other equity priorities, grantees should be required to provide evidence they can attract and serve the identified target populations. They should have a track record of doing this. They should present a marketing and communications plan that is likely to attract the targeted individuals within their service areas. 11. Grantees should demonstrate that they have access to the technical assistance they may need to fully achieve their goals. The Task Force should consider funding one or more technical assistance groups that have the demonstrated capacity to help organizations design and implement effective addiction prevention and treatment programs. 12. All grantees should have an agreed target of the number of people they will serve during the grant period. Within the bounds of protecting individual privacy, they should be required to demonstrate they have achieved the targeted goals. This does not mean the name or other identifying information needs to be reported to the State for every service, especially harm reduction services.
<p>Council Member #8</p>	<ol style="list-style-type: none"> 1. I think these principles are the correct ones and I would endorse moving forward with precision in our approach, being data driven and having a focus on equity and anti-racism.
<p>Council Member #9</p>	<ol style="list-style-type: none"> 1. Distribution across the six Health and Medical Coordinating Coalition (HMCC) regions <ul style="list-style-type: none"> • This an opportunity to identify clusters within regions and build capacity 2. Prevalence of Opioid Use Disorder (OUD) 3. Fatal and non-fatal overdose rates, including individuals’ residences vs. location where overdose occurred

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	<ul style="list-style-type: none"> • Burden of municipal resources need to be considered, location of overdose has a higher cost to city/towns <ol style="list-style-type: none"> 4. Race / equity considerations <ul style="list-style-type: none"> • Need to define 5. Identify key area for capacity building in year 1 with a narrow focus centered on the development of a regional approach for municipalities to share and site services in a regional way. 6. Identify where this funding source will have the most impact and not duplicate other resources 7. Centralize evaluation 8. More \$ in years 2+ to implement services 9. Review how best the ORRF can be flexible with changes in the system and drug patterns, etc.
<p>Council Member #10</p>	<ol style="list-style-type: none"> 1. I want to be sure to bring light to the many prevailing issues amongst incarcerated populations with OUD, particularly Black and Brown prisoners. It's not enough to consider justice-involved individuals at the point of re-entry when the problems exist during incarceration. Equality begins with identifying and dismantling the systems and structures (policies, programs and institutional practices) that generate inequitable outcomes. Black and Latinx prisoners are arguably the most neglected and disproportionately impacted population in the country, however, they are also the most forgotten. Even in the context of criminal justice reform and mass incarceration, the discussions focus on policing, arrests, prosecutorial decisions, sentencing and re-entry; rarely does the topic include life during incarceration. The racialization of incarceration is one of the main reasons prisons and jails are allowed to be such opaque systems lacking accountability. The wholly inadequate provision of mental health care in these settings, particularly for SUD/OUD, has been a gaping hole in the fight against the opioid crisis and undeniably perpetuates and deepens health, educational and economic disparities in communities of color, especially because 96% of those incarcerated return to their communities. 2. The Covid outbreak in prisons gave the public a rare glimpse into how prisons operate. Inadequate medical care, the prioritization of security over well-being, and the disproportionate vulnerability of prisoners of color (POC) caused by structural racism, all primed prisons to become the largest clusters of Covid in the country. Covid highlighted these issues, however, Black and Latinx prisoners have long suffered disproportionately and continue to be harmed in other areas, including from untreated OUD. Although rates of drug use are similar across racial and ethnic lines, Blacks and Latinx are more likely to be incarcerated for drug use. Despite this being widely known, like most states, the Massachusetts Department of Correction (DOC) does not report race-based data regarding SUD/OUD. The problem is further compounded by racially inequitable policies such as the DOC's treatment of SUD as a criminogenic issue warranting punishment over treatment and the institution's prioritization of MAT eligibility based on the prisoners' disciplinary record, release date and prior history of community-based treatment- all of which disproportionately impact POC.

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Council Member	Response *
	3. It's not enough to fund MAT programs for incarcerated populations without policies in place to ensure equitable access to treatment for all prisoners.