

Summary of Members' Feedback on Draft Meth Use Report

Name	Proposed Changes to Report
Amanda Consigli	<p>Charge 2: Current Barriers to treatment</p> <ul style="list-style-type: none"> • Insurance coverage of treatment for people who use meth <p>Charge 5: Intersections among stimulant use and sexual health</p> <ul style="list-style-type: none"> • The term “chemsex” is often used to describe a person using drugs as part of their sex life • Maybe also including the additional risk of HIV among people who use methamphetamine (PWUM) that also inject <p>Charge 6: Intersections between stimulant use and homelessness</p> <ul style="list-style-type: none"> • People use stimulants after becoming homeless to stay awake, cope, and for safety purposes <p>Charge 7: EMS/Law Enforcement</p> <ul style="list-style-type: none"> • Bullet two- unequipped to properly treat and recognize a patient under the influence of stimulants <ul style="list-style-type: none"> ◦ First responders have expressed difficulty discerning between a mental health and stimulant use call • Cambridge was awarded a “Combating Overdose Through Community-level Intervention” grant for December 2021- November 2022 <ul style="list-style-type: none"> ◦ Create regional training for frontline providers to bridge their knowledge gap ◦ Increase knowledge of best practices for working with people who use stimulants, and increase their capacity and confidence in working with this population • MDFS Hazardous Material Emergency Response and Special Operations does drug checking when within scope of their duties and provide results back to specific police department. This results in faster results than solely being reliant on the crime lab. However, there are barriers and restrictions. • Lack of spaces for first responders to take someone, reliant on the emergency room • Co-responder models including mental health clinicians to law enforcement responses <p>Charge 8: Source, Quantity, Potency, and Pathways</p> <ul style="list-style-type: none"> • South west border (SWB), mail, online • Mexican Drug Trafficking Organizations are the main producers and suppliers of methamphetamine which is of high purity, high potency and low cost. • Seizures sampled through the DEA Methamphetamine Profiling Program (MPP) continue to have high purity and potency, reflecting high availability of methamphetamine. In the first half of 2019, methamphetamine sampled through the MPP averaged 97.2 percent purity and 97.5 percent potency • Clandestine methamphetamine laboratory seizures continue to decrease across the United States. • Prices remain low • Data has determined an increase in methamphetamine seizures across the region, indicating that what has traditionally been a niche subculture drug, is now moving into mainstream drug use. The reasons for this are many but, among them is the

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	<p>availability of inexpensive, high quality methamphetamine coming through traditional drug trafficking routes from the southwest border (SWB).</p> <ul style="list-style-type: none"> ○ https://www.dea.gov/sites/default/files/2021-02/DIR-008-21%202020%20National%20Drug%20Threat%20Assessment WEB.pdf ○ New England has seen an increase in counterfeit pills containing methamphetamine and fentanyl. These pills mimic prescription Oxycodone and Adderall tablets <p>Recommendations</p> <ul style="list-style-type: none"> ● Establishing sobering centers (restoration centers) for PWUM to rest and access resources <ul style="list-style-type: none"> ○ These spaces should be accessible 24/7 ○ A place where first responders can bring someone to divert from the emergency room or arrest ○ Having harm reduction services and treatment providers having “come-down” or “cool-down” spaces for people to rest ● Harm Reduction tailored and targeted services for PWUM <ul style="list-style-type: none"> ○ Increasing access to safer smoking equipment, and supplies for stimulant and meth use ○ Provide meth-specific materials and training to all staff in harm reduction programs ○ Expanding access to harm reduction services across the state ○ Include behavioral health care providers in harm reduction services ● Education and trainings for health care providers, harm reduction, public safety (first responders) on methamphetamine use, overamping/overdose, de-escalation, and treatment ● Expand low-barrier mental health care settings, such as community health centers <ul style="list-style-type: none"> ○ Have treatment that addresses the full person (mental health, dental, sexual health (HIV/STIs), primary care) that is trauma informed ○ Addressing barriers to entering detox for people who don't use opioids and/or alcohol <ul style="list-style-type: none"> ▪ Removing substance requirements for admission ▪ Providing more appropriate detox services for people with SUD/MUD (protocols, length of services) ○ 24/7 access to treatment and recovery services ○ Expand access to evidence-based drug treatment (contingency management) ● Data surveillance- there is a need for more available timely, localized data that focuses on all substances not just opioids, and that also look at other data sources <ul style="list-style-type: none"> ○ Maintaining near real-time situational awareness about local use patterns and OD trends

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	<ul style="list-style-type: none"> ○ Establish state-wide data collection standards and local distribution efforts for meth use, meth-related overdoses, and other stimulant use. State and local epidemiologists need to collaborate with first responders, hospitals, and stimulant use disorder professionals to identify consistent and sustainable data collection methods that can be readily implemented. In addition to these efforts, state-owned data, such as death records or toxicology reports, need to be made accessible for local data collection and surveillance efforts. <ul style="list-style-type: none"> ▪ Data sources can include public safety (arrest, seizure, calls) ▪ Increase funding for analysts ○ Establishing Overdose Fatality Reviews (OFR) teams to identify system gaps and innovative community-specific overdose prevention and intervention strategies. That could specifically look at substance use patterns ○ Rapid response teams to respond to spikes in ODs utilizing near-real time data ● Increasing prevention efforts and enhancing community resources/supports for PWUM <ul style="list-style-type: none"> ○ Early intervention services ○ Public education around meth and stimulant use, and counterfeit pills that include pressed pills that look like Adderall and include meth or fentanyl –public campaign ○ Community support: Access to exercise/gyms recovery friendly ○ Primary prevention efforts ○ Anti-stigma campaigns ● Addressing barriers like insurance coverage of treatment for people who use meth <ul style="list-style-type: none"> ○ Insurance should be required to cover all mental health and substance use treatment, for as long as a doctor seems necessary and regardless of substance being used ○ Ending the cycle of requiring someone to go to detox before getting into another level of treatment, but can't get into detox because of limited availability or because of the substance they use ○ Expanding coverage for harm reduction, recovery coaches, etc. ● Housing and homeless services <ul style="list-style-type: none"> ○ Expand access to housing ○ Support and fund homeless services and shelters <ul style="list-style-type: none"> ▪ Non-gender specific services, so couples can stay together ▪ Allow substance use ▪ Non-restrictive access, can come and go ▪ Harm reduction model –OD prevention, HR supplies ● Expanding co-response models for first responders, where a behavioral health/mental health clinician responds to a mental health related call

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	<ul style="list-style-type: none"> • Expanding access and funding to drug checking <ul style="list-style-type: none"> ○ Further education on drug checking ○ MDFS Hazardous Material Emergency Response and Special Operations currently has the authority to respond to a situation where there is a potentially hazardous material that has the potential to be released (ex. loose powder, open container). They have an ability to test these samples. <ul style="list-style-type: none"> ▪ Need to change the definition of what a hazardous material is to include all illicit substances, currently fentanyl is only considered a hazardous material ▪ Need to allow for this team to test all illicit substances despite form ○ Increase funding for staffing <ul style="list-style-type: none"> ▪ Funding for an analyst at state crime lab, medical examiner, MDFS Hazmat, etc. to review data and provide reports <p>Additional Resources</p> <ul style="list-style-type: none"> • DEA Drug Threat Assessment • Methamphetamine Assessment and Analysis Report • National Emerging Threats Initiative –presented at the stimulant listening session last year <p>Abbreviations</p> <ul style="list-style-type: none"> • DEA- Drug Enforcement Administration • HR- harm reduction • MUD- methamphetamine use disorder • OD-overdose • PWUM- people who use methamphetamine • SUD- substance use disorder or stimulant use disorder
Chair Cyr	<p>Page 4:</p> <p>I filed language in the supplemental budget to officially extend the deadline of the Commission to April 30. Please see Section 44 of H.4650.</p> <p>Page 9:</p> <p>Suggested language in highlight:</p>

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	<p>“Recreational use of methamphetamines within the LGBTQ+ communities, particularly men who have sex with men (MSM), is of longstanding and growing concern.”</p> <p>Page 10:</p> <p>(Bullet 3) I suggest that Emergency Departments be included, along with first responders and BSAS, in the recommendation regarding development of guidance and best practices for interacting with individuals with stimulant use disorder.</p> <p>(Bullet 4) I suggest deleting the word “female”.</p> <p>(Bullet 6) In addition to stocking and distributing harm reduction supplies, emergency departments should plan for calming spaces and develop protocols for individual presenting under the influence of stimulants.</p> <p>Page 11 (Overall Recommendations) and Page 19 (Commission’s Findings Charge 5):</p> <p>I am very concerned that there are no LGBTQ- specific recommendations included in the draft. This underlines my original concern of not having an expert in the field participating in the principal conversation as a member of the Commission.</p> <p>Given the finding that methamphetamine use among MSM is ten times higher than the general population, I suggest a recommendation for increased resources for education and outreach to MSM and additional support for health care/harm reduction providers who serve the LGBTQ community.</p> <p>I would also suggest incorporating a recommendation to further explore concepts raised in Dr. Keuroghlian’s presentation, including Positive Affective Intervention. I’m disappointed that there were scant recommendations here.</p> <p>Page 13 (Commission’s Findings Charge 1) :</p> <p>(Bullet 4) I suggest deleting the word “female” — this is of concern to all sex workers, not just those who identify as female</p> <p>Page 21 (Commission Findings Charge 7) :</p> <p>Again, emergency departments should be considered for inclusion in this concept</p>

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Abby Kim	<p>Background Background– Stimulant Use Drug overdose deaths involving synthetic opioids and methamphetamine have shifted geographically (https://www.cdc.gov/drugoverdose/deaths/)</p> <ul style="list-style-type: none"> From 2018 to 2019, the largest increase in death rates involving synthetic opioids occurred in the West (67.9%) while the largest increase in death rates involving psychostimulants occurred in the Northeast (43.8%). <p>Recommendations Slide 10 –</p> <ul style="list-style-type: none"> There is a need for training, education and programming specific to populations with an increased likelihood of stimulant use disorder, including populations defined by demographic, geographic, occupational, or socioeconomic factors. This includes individuals who are homeless, the LGBTQ+ population, individuals in the construction/trade industry, individuals with a substance use disorder in Suffolk County, and Black and Latinx populations. Programming should ensure cultural and linguistic competency. <p>Slide 11 –</p> <ul style="list-style-type: none"> replace “fentanyl test strips” with “drug checking equipment” <p>Additional ABH Recommendations</p> <ul style="list-style-type: none"> State paraphernalia or Good Samaritan laws would need to be revisited in order to ensure the legal use and distribution of harm reduction supplies by individuals and non-medical entities, including safer consumption supplies. Contingency management can be funded through state dollars where federal funding is inadequate. There is a need for quiet, therapeutic spaces where people can manage symptoms of stimulant withdrawal. There is a need for increased insurance coverage of inpatient and outpatient treatment options for individuals with a primary/sole diagnosis of stimulant use disorder. There is a need for protocols, and the implementation of said protocols, for treating individuals with a stimulant use disorder in inpatient and outpatient settings. Comment - There are no recommendations addressing prevention of stimulant use/misuse. <p>Findings Slide 13 –</p>

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	<ul style="list-style-type: none"> Construction/trades industry was the industry most at risk, with 28.8% of cocaine involved overdose deaths of those surveyed coming from construction trades, followed at 18.9% by those not in the workforce, e.g. unemployed, students, homemakers (Traci Green presentation). <p>Slide 14 –</p> <ul style="list-style-type: none"> Current state paraphernalia laws hamper the use and distribution of harm reduction supplies. Access to care is positively fundamental in any aspect of harm reduction and recovery, yet there is a lack of access and insurance coverage of both inpatient and outpatient treatment programs for non dual diagnosis patients who use stimulants The current federal cap on incentives that can be paid to individuals participating in Contingency Management programs is limited to \$75 per person per year, despite evidence that higher amounts are could be more efficacious. (Lussier, Jennifer Plebani, et al. "A meta-analysis of voucher-based reinforcement therapy for substance use disorders." <i>Addiction</i> 101.2 (2006): 192-203. https://onlinelibrary.wiley.com/doi/10.1111/j.1360-0443.2006.01311.x) There is a lack of access and availability to quiet, therapeutic spaces where symptoms of stimulant withdrawal can be managed. California recently became the first state to receive federal approval to cover contingency management. Since January 1, they began funding a program with state and federal Medicaid dollars that would offer individuals a maximum of \$599 for contingency management over 6 months. (https://www.dhcs.ca.gov/formsandpubs/publications/oc/Documents/2021/21-08-CalAIM-12-29-21.pdf; https://filtermag.org/california-contingency-management-stimulants/) <p>Slide 15</p> <ul style="list-style-type: none"> Lessons learned from numerous programs , such as the need for restorative healing and compassionate care for those detoxing withdrawing from stimulant use, continue to be developed and disseminated, offering valuable insight on creating safer and more therapeutic environments for patients under the influence of stimulants. <p>Slide 22</p> <ul style="list-style-type: none"> Comment - There are no findings on the source, quantity, or pathways of illicit drugs.
Claudia Rodriguez	<p>Slide 5: ATS (and other areas where detox is mentioned would change to "medical management of withdrawal") - Management of substance/alcohol withdrawal (often referred to as detoxification)– instead of detoxification to be consistent w anti-stigmatizing language</p> <p>Instead of "non reactive" urine screen would say Urine toxicology screens negative for non prescribed substance use</p> <p>Also, under contingency management would highlight that rewards can be for urine screens consistent w recovery goals, showing up to appointments, etc. not just urine screens</p>

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Leigh Youmans	<p>I think this document looks great and is so reflective of both the commission's overall conversations and also nicely incorporates the feedback from the last meeting.</p> <ul style="list-style-type: none"> • On slide 10 – very much agree that it is best practice for providers to stock and distribute harm reduction supplies. I know we've addressed coverage of nasal naloxone, but to the extent that providers would be expected to provide other harm reduction supplies, it would be great to see language in one of the findings or a recommendation speaking to coverage and/or funding for harm reduction supplies here or on slide 17. • I was struck by some of the feedback from individuals with lived experience and providers that individuals with stimulant use disorder will use other substances so that they can access treatment. In slide 11 or 15 (or both), I think it would be helpful to include a recommendation to determine current coverage of stimulant use disorder services and a recommendation to determine if state OUD statutes should be amended to more explicitly include stimulant use disorder. • I see that reimbursement of Recovery Coaches are named in a finding related to contingency management on slide 17 and wonder if there should be a separate/explicit recommendation or finding around reimbursement of Recovery Coaches. We hear from both EDs and inpatient units (both on the medical and behavioral health sides) that Recovery Coaches are a key piece of their care teams and are critical in patient engagement and outcomes, but that due to a lack of reimbursement for Recovery Coaches generally as well as a lack of reimbursement specifically for Recovery Coaches employed by hospitals, that these positions are typically grant funded and a more sustainable funding mechanism is needed. • On slide 21, I think it would be helpful to explicitly recommend funding de-escalation training for EMS, police, ED, and others.