

CORE REPORT 2023 PUBLIC COMMENT SUBMISSION:

Global Health Justice Partnership

Yale Law School & Yale School of Public Health

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Background

Since 2014, cities and municipalities across the United States have been litigating against major opioid manufacturers, distributors, and retailers, like Johnson & Johnson, CVS, Walgreens, who are accused of engaging in illicit practices, such as overstating the benefits of opioids, minimizing addiction risks, and employing misleading marketing strategies, which are widely understood to have precipitated the opioid crisis. As a result of these legal proceedings, states and cities across the U.S. are beginning to receive funds from these settlements that are earmarked for mitigating the ongoing impacts of the opioid crisis. According to the latest reports by CT Mirror, Connecticut (CT) is expected to receive approximately \$600 million over the next 10-18 years, of which 85% of the funds are set to go to the state government and 15% directly to cities and towns.

In 2022 state lawmakers in Connecticut voted to establish the Opioid Settlement Advisory Committee (OSAC), co-chaired by [Department of Mental Health and Services](#) (DMHAS) Commissioner Nancy Navarretta, and Mayor of the City of Waterbury, Neil O’Leary, to ensure that the proceeds received by the state as part of the opioid litigation settlement agreements are allocated appropriately.

To guide the activities of the CT OSAC, the Connecticut Opioid Response Initiative (CORE) consisting of members from the Yale Program in Addiction Medicine, was invited to provide recommendations to the CT OSAC, at the request of DMHAS and in coordination with the [Alcohol and Drug Policy Council](#) (ADPC). In September 2023, the CORE Initiative released a draft of the [Connecticut Opioid Response Initiative Report 2023](#) (henceforth, CORE Report 2023) to provide immediate guidance to the OSAC as they convene and plan for the initial disbursement of funds received by the state. This draft report, authored by faculty in the Yale Schools of Medicine and Public Health, uses current epidemiological and biomedical evidence on the overdose crisis to provide preliminary recommendations. The draft report was opened to public and expert comment in October and November 2023.

The Global Health Justice Partnership (GHJP), an initiative of the Schools of Law and Public Health at Yale that works on promoting interdisciplinary, innovative, and effective responses to key problems in health justice, read the CORE Report 2023 to provide feedback on the funding priorities outlined in the report. Our comments are detailed in the rest of this note. We find that the CORE Report 2023 represents a remarkable step forward in the state’s endeavors to bring transparency, accountability, and clarity to its opioid settlement funding decisions. The report’s guiding principles place renewed emphasis on harm

¹ This submission also pulls from research and materials developed by GHJP student RAs for our “Where is the Gender in Harm Reduction in New Haven?” workshop.

reduction strategies that empower and affirm the dignity of people who use drugs, and concerns of racial inequity that are often overlooked in conversations about drug use. We acknowledge and appreciate this constructive dialogue.

However, the CORE Report 2023, misses unsettling the traditionally masculine/male-oriented nature of harm reduction services that threaten the effectiveness and accessibility of services among women and sexual and gender minorities, especially those facing racial discrimination. It sometimes overlooks how gender-informed services for these populations remain under-prioritized, underfunded, and underutilized.

GHJP's submission highlights that there are no race-blind or gender-blind policies and interventions, and any systemic response to issues of justice must have an intersectional approach that recognizes how race, gender and sexual orientation shapes peoples' experiences. We emphasize that it is important for every policy adopted by CT to remain attentive to the differential needs of racial, sexual, and gender minorities, and that it is not enough to adopt a few gender-responsive policies or identify racial equity as an overarching principle. Gender and racial justice must be systematically central to each funding priority, goal, strategy, and tactic.

We look forward to the CORE team's updated report in February 2024 and hope to see a revised commitment to gender and racial justice in their report. We thank and commend the CORE initiative for the extensive research and hard work that went into preparing the first draft of this 2023 report.

CORE Report 2023

Overarching Principles

The draft of the CORE report released in September 2023 identifies five overarching principles that ground the recommendations made in the report:

1. Spend the Money to Save Lives
2. Use Evidence to Guide Spending
3. Invest in Youth Prevention
4. Focus on Racial Equity
5. Develop a Fair and Transparent Process for Deciding Where to Spending Funding

Funding Priorities

In keeping with these principles, the CORE Report 2023 highlights six priorities that the OSAC can support with settlement funds, namely:

1. Increase access to and support the most effective medications (methadone and buprenorphine) for opioid use disorder across diverse settings
2. Reduce overdose risk and mortality, especially among individuals at highest risk and highest need with linkage to treatment, naloxone, and harm reduction
3. Improve the use of existing data and increase data sharing across relevant agencies and organizations
4. Increase the size of the addiction-specialist workforce and improve non-specialist and community understanding of the scale and nature of OUD as well as evidence-based treatments to decrease stigma and promote treatment uptake
5. Simultaneously deploy and evaluate select primary, secondary, and tertiary prevention strategies
6. Address social determinants and needs of at-risk and impacted populations

For each funding priority, the authors identify strategies, goals targeted by each strategy, along with potential tactics for the OSAC to fund.

Component	Description
<i>Priority</i>	Overarching funding category supporting a specific goal and encompassing one or more strategies and several tactics.
<i>Goal</i>	The summary target outcome for a given funding priority.
<i>Strategy</i>	A specific approach belonging to a stated strategy to achieve a stated goal.
<i>Tactic</i>	A specific action that may be funded to implement a strategy.

The strategies and tactics discussed in the report align with [guidance from the Opioid Litigation Settlement](#), which constrains possible uses of Opioid Litigation Settlement funds, and with the [Principles for the Use of Funds from the Opioid Litigation](#) endorsed by over 60 organizations including the Yale Program in Addiction Medicine

Global Health Justice Practicum's Submission

The Global Health Justice Partnership (GHJP), an initiative of the Schools of Law and Public Health at Yale, works on promoting interdisciplinary, innovative, and effective responses to key problems in health justice, working collaboratively across the university, and with local partners.

Over the past six years, GHJP has been collaborating closely with community organizations in New Haven whose work underscores the importance of gender-responsive strategies in evidence-based harm reduction efforts. Our work has particularly engaged what (lack of) access to services looks like for criminalized populations, including drug users and sex workers, and the necessity of attention and analysis across intersections of gender, race, Indigeneity, place, class, sexuality, age, and disability.

Earlier in 2023, our team hosted 20+ dedicated harm reduction actors including service providers, people with lived experience, academics, and policymakers, for a workshop to deliberate on the barriers to and strategies and possibilities for harm reduction activities that are attentive to the broad range of experiences of people who use drugs across genders, in New Haven and surrounding areas.

GHJP's comments on the CORE Report 2023, below, are informed by comments received by GHJP from harm reduction actors during a public information sharing session organized by GHJP on 3rd November 2023, GHJP's "Where is the Gender in Harm Reduction?" workshop held in July 2023, and from our work in New Haven over the past six years.

How to read this document: GHJP's comments below are organized by funding strategy, same as the CORE REPORT 2023. We would recommend keeping a copy of the report open so you can refer to it for additional context on our comments, as needed. You can find the CORE Report 2023 [here](#).

The *text in italics* is the text from the CORE Report 2023 that GHJP is commenting on. The text below the *text in italics* is GHJP's comment. We have included page numbers and some **narrative text in bold** through this document, as guardrails, to make it easy for the reader to correlate GHJP's submission with the CORE Report 2023.

ACCESS TO MEDICINE

CORE Report 2023's funding priority #1: Increase access to and support the most effective medications (methadone and buprenorphine) for opioid use disorder across diverse settings

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GHJP recommends that CORE Report 2023 pay special attention to the needs of the populations addressed in this section include pregnant and parenting substance users; sex workers and LGBTQI+. Overall national research suggests they face unique and often unacknowledged barriers– very little research has been done in CT. Racial inequities intersect with gender, sexuality and reproductive status, exacerbating barriers to care.

Rationale

In the *Rationale* section for Funding Priority 1, the report mentions Specific population-based *Challenges with transportation to treatment settings*:

- **GHJP recommends noting:** In a peer-based needs assessment survey for people engaged in street-based sex work in New Haven, 66% of respondents were unable to afford the transportation they needed. Most respondents relied on public transportation, walking, or rides from others to reach their destinations (GHJP & SWAN, 2020).

GHJP recommends noting the following, in addition to listed barriers to *initiate or maintain treatment with MOUD*:

Specific barriers for pregnant and parenting people to treatment:

- Child abuse or neglect notification, or fear of notification
 - The *Child Abuse Prevention and Treatment Act* is a federal law requiring state notification for pregnancies “affected by substance use” at the time of delivery, and in such cases, the development of a “Plan of Safe Care” (POSC). Since 2019, Connecticut has implemented a policy to divert cases without safety concerns from notification, instead providing for de-identified public health data reporting through a portal that guides the notifier through a risk assessment. This was on the basis that under CT law substance use during pregnancy does not necessarily constitute harm or neglect of a child, and to address systemic racism and bias against people who use substances.
 - Diversion is not available where a POSC has not been completed (Ostfeld-Johns & Schiff, 2022; Sieger et al., 2022)
 - In a study of the first 28 months of policy implementation, 21% of non-diverted CAPTA notification involved opioid exposure, with Black mothers disproportionately overrepresented among notifications compared with the state population (Sieger et al., 2022), reinforcing well-documented racial disproportionality in toxicology testing at birth and maltreatment reporting (Putnam-Hornstein et al., 2016). Although 13% of all babies

born in Connecticut during the study were Black, they represented 22% of all CAPTA notifications, and all other race groups were underrepresented (Sieger et al., 2022).

- A commentary based on data in Sieger et al.'s study and the authors' experience noted also that Black non-Hispanic mothers were also less likely to have a Plan of Safe Care completed and therefore more likely for the notification to become a report to CPS. This disparity exists despite evidence affirming that substance use rates are the same across racial groups (Ostfeld-Johns & Schiff, 2022).
- CPS investigation opens families to scrutiny, including from the criminal legal system. A review of publicly available data on substance abuse treatment in the United States found the following independent variables to have a greater effect on the lack of use of MAT for pregnant women with opioid use disorders in descending order of importance: criminal justice referral, other community referral, Southern region, Medicaid coverage, drug abuse care provider referral, unknown referral, other health care provider referral, and presence of state law that permits child abuse charges (Angelotta et al., 2016).
- Policies and practices that cast women who use drugs as unfit parents have a significant negative impact on Black and Indigenous women, particularly (Boyd et al., 2022).
- In a cross-sectional study with random assignment of clinicians and simulated-patient callers, outpatient clinics that provide buprenorphine and methadone were randomly selected from publicly available treatment lists in 10 US states, and simulated patients called the clinics posing as pregnant or nonpregnant women. Callers were found to be less likely to receive an appointment if they said they were pregnant (Patrick et al., 2020).
- A study of a large cohort of pregnant women in Tennessee found that pregnant Black and Hispanic people were less likely than their non-Hispanic White peers to have received medication for opioid use disorder (Henkaus et al., 2022). Nationally, research has demonstrated that providers are also less likely to treat pregnant women with medication for opioid use disorder than non-obstetric providers (Forray et al., 2022).

The report should include specific barriers related to stigma, discrimination and violence, particularly:

- Against women, including both cis and transgender women, transgender men, gender fluid, and non-binary people
 - The 2021 Connecticut LGBTQ+ Community Survey of 3048 adult respondents across Connecticut, reported that (The Consultation Center, Inc., 2021):
 - about half (55%) of respondents reported access concerns related to access to mental health, addiction, and/or substance use services, with the top three concerns being affordability (22%), competence of providers to meet LGBTQ+ community member needs (18%), and services not being LGBTQ-friendly (17%).
 - 15% of respondents believed they had been refused mental health, addiction, and/or substance use services because of their LGBTQ identity, and transgender respondents were 20 times more likely than gender-diverse (i.e., gender queer,

nonbinary, agender, or gender non-confirming respondents who did not identify as transgender) and 12 times more likely than cisgender respondents to report refusal of mental health, addiction, and/or substance use services because of their LGBTQ+ identity.

- Black and Hispanic/Latinx respondents were less likely to identify that their needs were met all or most of the time compared to white respondents, and were also less likely to agree that providers were responsive to their needs based on their LGBTQ+ identity compared to white respondents.
- As noted in the literatures reviewed in Perri et al., 2022:
 - Nationally, trans and non-binary people also report being subjected to stigma, discrimination, and physical/sexual violence by both peers and service providers in substance use services.
 - Women often experience harassment, physical violence, sexual exploitation, and victimization by peers at in-person substance use services, which can result in the avoidance of such services.
 - Trans women may avoid substance use treatment and harm reduction services due to institutional expectations, e.g. feeling that must “pass” to be safe in those spaces.
 - Trans and non-binary people may not be represented within the limited women's substance use spaces that exist.
- Nationally, what research has been done demonstrates that many services exclude women and sexual and gender minorities, inadvertently or through discriminatory policies, violence, or gendered forms of stigma (Pinkham & Malinowska-Sempruch, 2008; Zahnow et al., 2018). Notably, “[i]ssues such as violence, the criminalization of substance use, fear of child apprehension, and limited inclusion of cultural safety contribute to reduced attendance by women and gender-diverse people in substance use services.” (Perri et al., 2022, citing Women and Harm Reduction International Network, 2020). Stigma and racism add to gendered violence as key barriers to mixed-gender health and drug treatment services (Collins, 2019).
- National research suggests that women who use drugs may also face compounded forms of gender-based stigma related to sex work, pregnancy, and motherhood that are not usually addressed by harm reduction services (Iverson et al., 2015). For these reasons, women are often put in positions in which they have to negotiate between prioritizing physical safety and substance use-related risks such as overdose death.
- Stigma takes on a particular character for reproductive-age women, pregnant individuals and mothers who use substances, leading to limited prenatal care (Wolfson et al., 2021). A 2019 scoping review highlighted the interconnectedness of stigma and related barriers across multiple levels in impacting access, retention, and outcomes of harm reduction and child welfare services for pregnant women and mothers who use substances, including: the individual level (i.e., fear and mistrust of child welfare services), interpersonal level (i.e., familial and relational influence on accessing substance use treatment), institutional

level (i.e., high organizational expectations on women), and population level (i.e., negative stereotypes and racism) (Wolfson et al., 2021).

- Against sex workers
 - In GHJP & SWAN’s peer-based needs assessment survey of self-identified people in the sex sector in New Haven, 55% of respondents reported having access to a health care provider or doctor they trust, and 40% of respondents reported feeling disrespected or stigmatized by drug treatment facility employees and doctors/nurses (GHJP & SWAN, 2020).
 - 98% of respondents indicated substance use. 96% of respondents had engaged in risky drug practices, such as using substances while alone. 66% of survey respondents reported a need for a facility/ies in New Haven to access harm reduction supplies and to otherwise help avoid risky scenarios (GHJP & SWAN, 2020).
 - 73% of respondents who were directed to a service provider by the police reported that this happened under threat of consequence. For at least one respondent, who wrote notes with additional information in the margins of their survey, police had also served as dates, suggesting law enforcement officers had exploited their positions of authority and power to arrest (GHJP & SWAN, 2020).

The report should note that specific barriers related to lack of training or capacity to address needs of specific populations are revealed in national level studies across gender diverse persons. Very little is known about CT’s capacity.

- LGBTQ+ people are systematically disadvantaged or actively excluded from supportive substance use services, which often do not have the training or capacity to address their specific needs (Corliss et al., 2010).

The report should note the specific needs for service integration and coordination in order not to exclude people across genders, races, (dis)ability, immigration status, etc.

- Recommendations drawn from existing research include integrating reproductive health approaches and resources, medication-assisted therapy, and social support services into substance use services (Baca-Atlas et al., 2023; Taylor et al., 2021).
- Appropriate and adequate child care is a significant barrier for women to engage in substance use treatment. Transportation, childcare, or other logical concerns, represent barriers, especially for single parents. Gender-specific services acknowledge gender norms, roles, and relations and include accommodations such as the provision of childcare at women's services (see cites in Perri et al., 2022, and discussion of gender-responsive and gender-transformative services).

The report should note that CT should consider innovations to reach hard-to-reach populations, including specific need for virtual and remote service delivery, including as a means to make treatment more accessible to people across genders, races, (dis)ability, immigration status, etc.

- Shifts in service delivery remote and virtual substance use services in gender-transformative ways “can better enable the engagement of women and

gender-diverse people while mitigating concerns associated with in-person services such as violence, navigating unsafe personal relationships, fears of being reported to child welfare agencies, lack of childcare and other constraints on single parents, and the limited availability of trans specific services.” (Perri et al., 2022).

The report should note that CT should take steps to address the specific barriers and impacts related to criminalization, with differential impacts across populations across race, Indigeneity, gender, sexuality, age, place (including urban/rural), class, (dis)ability, immigration status, etc.

- Criminalization of substance use and limited availability of treatment programs for pregnant individuals who use illicit substances limits access to recovery efforts for pregnant individuals and birthing parents (Polak et al., 2015).

Evidence

For Evidence, note:

Gender-specific concerns related to how *the rising number of opioid overdoses indicates there is an unmet need for these treatments in the state.*

- The percent of overdose deaths in Connecticut among women increased to 27% in 2021 from 24% in 2018 and 2019, suggesting a particular increase in gendered need for MOUD services (OCME, 2022).

Strategies

Strategy #1, Tactic #5: Fund initiatives that support linkage to ancillary support services (emphasis on transportation, insurance enrollment, vocational training, employment support, and childcare) for individuals engaged in MOUD via OTPs,

For Strategy #1, Tactic #5, the report should note the importance of transportation and child care as a means to overcome access barriers particularly faced by women and gender-diverse people who use drugs.

- See factors contributing to reduced attendance by women and gender-diverse people in substance use services, above (Perri et al., 2019).

CORE Report 2023's funding priority #2: Reduce overdose risk and mortality, especially among individuals at highest risk and highest need with linkage to treatment, naloxone, and harm reduction.

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Rationale

For the Rationale section, note:

In addition to concluding *that efforts to reduce overdoses will have the greatest impact if strategies are focused on Individuals who: have recently experienced a non-fatal overdose, use opioids alone, have a history of OUD and have lost tolerance to opioids, are opioid-naïve or have low tolerance and are purchasing illicit stimulants that include fentanyl, are unhoused or marginally housed, the report should include more attention to:*

Other key factors differentiating individuals and their risk of overdose, such as the role of factors including and across race, Indigeneity, gender, sexuality, age, place (including urban/rural), class, (dis)ability, immigration status, etc. in risk of overdose, including differences across drugs used, contexts of use, in-community responses, isolation from care.

- Attention to how specific populations are overrepresented in the categories listed, as noted in literatures around, e.g. homelessness and LGBTQ+ youth is needed in CT.
- Attention should also be made to how vulnerabilities across these different populations must be differentially addressed.

The report should discuss that research has demonstrated the necessity of an intersectional lens to understand the differential impacts of the overdose crisis across genders, including social-structural contexts, and to develop better and more ethical overdose prevention and response interventions (Collins et al., 2019). This includes not assuming heterosexuality or binary gender identity in addressing injection-related risk behaviors (Taylor et al., 2021); and recognizing that transmasculine and non-binary people work in sex industries (Jones, 2021). Any data collected by CT should include attention to these aspects of difference. In particular,

1. **Include** differential risk, and need for targeted interventions with regard to pregnant and parenting people
 - Opioid use and associated overdoses have increased across gender demographics, including among pregnant women (Cook, 2022; Tobon et al., 2019).
 - About 20% of individuals take prescription opioids while pregnant, and women experience unique vulnerabilities for opioid addiction due to higher prevalence of chronic pain and provider tendencies to prescribe higher doses to women (Cook, 2022; Sanjanwala et al., 2023).
 - PWUD have higher rates of unintended pregnancy, pregnancy-related mortality, and lower rates of contraceptive use when compared with the general population (Baca-Atlas et al., 2023).

- Many who are pregnant or who care for young children do not seek treatment or drop out of treatment early because they are unable to take care of their children, or fear that authorities will remove children from their care, with these outcomes more likely for people of color (Weber et al., 2021). Additional barriers include social stigma, and physical distance/time away from coparents, family, and other children while in treatment (Daley et al., 2000).
 - Pregnant women are more likely to stay in outpatient treatment if these programs provide childcare, parenting classes, and vocational training (Chen et al., 2004; McMurtrie et al., 1999).
 - Consistent medication assisted treatment is associated with a 47% decrease in hospitalization rate and 37-46% decrease in emergency department visits for pregnant individuals with histories of substance use disorder (Ahrens et al., 2022).
 - Concrete measures to reduce the real likelihood of CAPTA notification, and the rational fear of this occurring, is needed to ensure that services can be used, if available.
2. **Include** differential risk, and need for targeted interventions within at-risk and impacted populations, including across racial and LGBTQ+ subgroups, with attention to differences across race, Indigeneity, gender, sexuality, age, place (including urban/rural), class, (dis)ability, immigration status, etc.
- There are higher rates of relapse among women who use drugs (Fonseca et al., 2021), and the “gendered social and structural environments [that] shape women’s daily experiences using drugs” also shape “the need for culturally appropriate interventions that recognize diverse modes of consumption while attending to overdose and violence.” (Collins, 2019). Yet, there is a lack of in-patient beds for women, and attention should be made to availability across the state.
 - There is heightened risk of fatal and non-fatal overdose among sexual minority men relative to heterosexual men (Goodyear et al., 2020; Seal et al., 2001).
 - Lesbians and bisexual women are at greater risk than heterosexual women for developing substance use disorders (Iverson et al., 2015b)
 - LGBTQIA+ identifying youth, particularly those identifying as lesbian and bisexual, are at greater risk for illicit substance use compared to their heterosexual peers (Felt et al., 2020).
 - Transgender individuals report disproportionately higher rates of alcohol and substance use compared to cisgender individuals (Polak et al., 2015; Santos et al., 2014).

The report should note the dearth of services for youth, generally, in Connecticut.

The report should note the importance of ensuring funding for harm reduction services that match the needs of specific populations, including materials that match the drugs used and means of use.

Strategies

For Strategy #1: Increase linkage to naloxone, drug supply testing, and syringe service programs for people at high risk of overdose, and across all strategies, the report should note:

1. **Include** that this work should address how women, LGBTQ+ people, pregnant and parenting people, sex workers, and populations targeted by the criminalization of substance use, including as these are overlapping categories, are populations that face specific barriers in access to services
 - In data from the Global Drug Survey 2015, women reported greater difficulties accessing sterile equipment and were more likely to share injecting equipment than men, with authors conducting analysis suggesting that this and other findings reflected the broader social structure in which women are disempowered through traditional gender roles and the lack of gender appropriate harm reduction services (Zahnow et al., 2018). Yet, women tend to visit syringe exchange programs and other harm reduction services at lower proportions than men (Zierler & Kreiger, 1997). Men are overrepresented in treatment programs for substance use disorders (National Institute on Drug Abuse, 2020).
 - 59% of respondents to GHJP & SWAN’s peer-based needs assessment survey of street-based sex workers in New Haven indicated a need for clean syringes/needles, sterile water, and/or antibiotic ointment, thus suggesting an unmet need for drug use supplies, while 66% of respondents indicated a need for a facilities in New Haven to access harm reduction supplies or to otherwise avoid risk scenarios (GHJP & SWAN, 2020). This was despite the large volume of safe sex and drug supplies distributed by the city of New Haven and harm reduction providers between 2017 and 2019 (Davila, 2021). Additionally, the low uptake of healthcare, mental health care, housing, and food-related services among key underserved populations like sex workers “[does] not result from a lack of connection to or knowledge of services, but rather from shortcomings in the accessibility and acceptability of those services.” (GHJP & SWAN, 2020).
 - Note also the barriers to services, generally, listed in commentary on Funding Priority #1.

For Strategy #1, the report should note that it is important to provide leadership; decision-making power; and prioritized funds, training and institutional capacity-building to community-based individuals, collectives and organizations providing harm reduction and related services to specific populations, in order to continue critical adapted services and develop further programming based on priorities identified by them and the specific populations they work with

- Harm reduction is a movement built by and in solidarity with BIPOC groups, sex workers, and queer and trans folks, often at the intersection of all three. These groups are currently, and have historically been, leaders, providers and beneficiaries of harm reduction efforts in CT, nationally, and globally, and in building adapted harm reduction approaches that engage with the interpersonal, social, and structural factors shaping drug use, its impacts, and the impacts of coercive and punitive drug laws and policies (Roane, 2019; Jackson, 2019).

- Despite this, cis women and sexual and gender minorities (SGM) are often ignored or overlooked in the development and delivery of substance use services (Iverson et al., 2015; Boyd et al., 2020). Interventions must recognize and integrate the current and historical leadership of women and gender diverse people in harm reduction services, particularly the pathbreaking harm reduction work of Black women, which has also engaged political analysis and built legacies of Black health activism (Roane, 2019), queer communities responding to HIV/AIDS, and harm reduction as practiced by sex workers, making the concept broader and more holistic to value sex workers and their sense of self, wellness, and individual needs (Jackson, 2019).
- Providing funding via more holistic harm reduction work is essential to building trust and effectively providing harm reduction services to underserved populations.
 - A study of the Sex Workers and Allies Network (SWAN) in New Haven underscored the importance of building a supportive community for urban sex workers while employing harm reduction strategies. Almost every respondent talked about the power of relationships, community, and care that came with their interactions with SWAN and particular members of the SWAN staff. Many noted the isolation felt in their rejection by society, and how striking the different experience of care was for them. Women noted the impact of the shared lived experience they have with SWAN staff, connection to necessary legal and medical resources, and SWAN staff being consistently and dependably a part of their lives as key to the trust built in the work. Most women discussed the safety and empowerment they felt through not only basic harm reduction supplies, but also the organization's push and win for changes to policing policy, creation of bad date lists across the SWAN community, and connection to resources above and beyond basic needs (Cammisa et al., forthcoming).

For Strategy #1, the report should note that funding should be allocated to measures to engage PWUD in service feedback and decision-making

- “Effective harm reduction strategies that account for difference and diversity will only emerge with the full engagement and social inclusion of those in need of such services.” (Pauly, 2013).

For Strategy #1, the report should note that Provide funding to gender-responsive services and for the integration of attention to gender in harm reduction services:

- Recommendations in the literature for integrating attention to gender in harm reduction services include:
 - “designing services with low-threshold access for women drug users that help them to become more independent;
 - involving women in designing services and policies;
 - making programs available for mothers;
 - incorporating sexual and reproductive health into harm reduction services;
 - providing gender-sensitive drug treatment and integrated harm reduction programs for drug-using sex workers;

- connecting with domestic violence and rape prevention services; and educating mainstream providers.” (Pinkham & Malinowska-Sempruch, 2008).
- peer support workers with attention to racial, ethnic, and gender diversity at harm reduction and ancillary services;
- scaling up mobile harm reduction and ancillary support services, as they better serve women and gender diverse PWUD who do not feel safe accessing existing supports;
- additional funding to support women and gender-focused harm reduction initiatives, more generally, for tailored services and treatments (Collins et al., 2019).

For Strategy #1, the report should note that it is important to provide funding for patient advocates with lived experience that matches the communities served, to support PWUD with navigating services.

For Strategy #2: *Create harm reduction centers that provide ancillary support services for people actively using drugs,*

GHJP strongly recommends that the CORE Report and the State of Connecticut support piloting Overdose Prevention Sites (OPS) with moneys from the Opioid Settlement Funds, with attention to accessibility across populations. In this context, the state can rely on the evidence and not concede a position as to their legality or inadvertently minimize the room for legal advocacy for their implementation.²

Overdose Prevention Sites (OPS) are among the strongest evidence-based harm reduction strategies that have been successfully implemented and scaled-up around the world. Overdose prevention sites “allow people to consume pre-obtained drugs under the supervision of trained staff and are designed to reduce the health and public order problems often associated with public drug consumption.” (Drug Policy Alliance, n.d.). Currently, there are over 120 OPS operating around the world – in Australia, Canada, Denmark, Luxembourg, The Netherlands, Norway, Portugal, Germany, France, Belgium, Spain, and Switzerland (International Network of Drug Consumption Rooms, n.d.). Various models of OPS have been implemented and are inclusive of different substances, such as opioids, stimulants, and polysubstance use, and accommodate different modes of consumption, though are often primarily focused on injecting. The distribution and sustainability of OPS around the world is a testament to an intervention that has been tested, proven to reduce drug-related harms, and is scalable.

OPS have been shown to be particularly efficacious in preventing overdose deaths, with zero fatal overdoses reported within OPS (Kerr et al., 2006; Ng et al., 2017). OPS have also been shown to reduce overdose fatality in the area around the site, not just within it (Marshall et al., 2011). In addition to reduction in overdose fatality, OPS have been shown to reduce new HIV, hepatitis C, and soft tissue infections, and increase the likelihood of injection cessation (Kerr et al., 2006; Larson et al., 2017; Walley et al., 2013; Watters et al., 1994). With regard to the impact an OPS can have on the community around

² Significant portions of this section is drawn from “Responding to New Haven’s Overdose Epidemic: Progressive Harm Reduction Initiatives” submitted in May 2021 to the New Haven Board of Public Health Commissioners. On file with authors.

the site, evidence has shown that OPS lead to a decrease in public injection or drug use, a decrease in public discarding of drug use materials, and a decrease in drug related crime and violence in the neighborhoods around the site (Wood et al., 2004; 2006). OPS have been associated with an increase in PWUDs accessing other health and social services as well as a decrease in the demand for emergency and ambulance services for overdoses, effectively decreasing the burden on the healthcare system (Salmon et al., 2010; Stolz et al., 2007). Further, OPS are associated with a decrease in crime in the area surrounding a site post-implementation (Davidson et al., 2021).

We note that New York City is currently home to a city-sanctioned overdose prevention center which suggests that United States federal policy and practices may not be the barrier to the implementation of OPS in Connecticut today and in the future. Additionally, although the previous federal administration's Department of Justice acted against OPS, as seen in *United States v. Safehouse*, the current administration under President Biden has yet to take a formal stance on OPS implementation (McSwain et al., 2020). A number of sites in Connecticut can utilize local presence of medical and social scientists with experience conducting research on innovative harm reduction interventions offer crucial partnerships in the evaluation of any effort to establish and operationalize OPS.

Research suggests that appreciation for overdose prevention sites as safer spaces to consume drugs than less regulated settings integrate aspects such as peer-administered injections can play in disrupting gendered power relations and allowing women increased control over their drug use, to address concerns for the potential for them to be 'masculine' and otherwise gendered and racialized spaces (Boyd et al., 2018). Ethnographic research also points at the effectiveness of trans-inclusive women-only supervised consumption sites in addressing gender inequities that are otherwise not tackled by gender-neutral or mixed-gender services. These spaces can also provide food and other fundamental needs, and allow for information-sharing regarding drug toxicity, access to shelter and detoxification services. A key consideration for women-only spaces is to adopt inclusive gender definitions that are not essentialist and thus limited to cisgender women, but rather, expand to include transgender women and other gender-diverse people who might similarly feel unsafe in male-dominated spaces (Boyd et al., 2020).

In line with other key priorities noted in this report, critical aspects of OPS operationalization in Connecticut that require consideration, include:

- public education, especially led by and organized to the most affected communities with particular attention to historically marginalized communities, especially given CT history of racialized inequality of access to resources and inclusion;
- meaningful inclusion of PWUD leadership in design, implementation, and evaluation;
- low-barrier, non-coercive access by consumers of the service; inclusion of PWUD themselves in employment, following a peer service model, including supporting efforts to employ persons with criminal records, a practice which in turn contributes to another essential aspect of harm-reduction informed efforts to stop overdose, stable income; and
- attention to the necessity of trauma-informed care for any medical services desired.

With these issues in mind, it is essential that Connecticut consider the implementation of OPS in our communities to prevent fatal overdose—if Opioid Settlement Money is not able to be deployed for this purpose, the State should investigate other funding sources for piloting these essential programs.

DATA CHALLENGES

CORE Report 2023's funding priority #3: Improve the use of existing data and increase data sharing across relevant agencies and organizations.

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Strategies

For Strategy 1: *develop and report updated metrics pertinent to reducing overdoses and overdose mortality in the state, especially around provision of MOUD and naloxone, with special focus on at risk populations,*

The report should note the existing (limited) data on overdose deaths, including women

- Between 2012 and 2021, approximately 26% of overdose deaths in Connecticut were among women, slightly below national levels; while this proportion had decreased to 24% in 2018 and 2019, in 2021 it increased again to 27%, suggesting the need to monitor gender-related trends in coming years to determine whether the share of overdoses among women is on an upward trajectory (Davila, 2021; OCME 2022). Women represent 30% of fatal overdoses in the U.S., and the number of fatal overdoses increased 260% among women aged 30–64 years and almost 500% among women aged 55–64 years between 1999–2017 (Collins et al., 2019, citing VanHouten, Rudd, Ballesteros, & Mack, 2019).

The report should note the limited data on how gender plays a role in risk of overdose and the gaps in data about gender and harm reduction across race, age, (dis)ability, immigration status, etc.

- While epidemiological data cannot fully capture the multiple, intersecting factors that impact people across genders, more nuanced data collection, reporting, and research are needed, particularly as “overdose risks among racialized women and gender diverse persons remain poorly understood and warrant immediate attention to avoid reinforcing their exclusion in the overdose response.” (Collins et al., 2019).

The report should note the limited data on pregnancy deaths claimed to be related to substance use, and the need for further data and understanding of these cases.

- Connecticut’s Maternal Mortality Review Committee (MMRC) found that each year more than one-third of pregnancy-associated deaths in Connecticut involve the use of substances. The MMRC determined that from 2015-2019 substance use disorder contributed to 20 out of 57 pregnancy-associated deaths. Eight deaths occurred during pregnancy and 12 occurred between 43-365 days after the end of pregnancy. Over half of these deaths were accidental overdoses and all of them were determined to be preventable (Kosutic, 2020; McDowell & Kosutic, 2021).
- Data on maternal mortality and CAPTA data call for more research on the experiences of pregnant and postpartum people who use substances with a particular view toward understanding the barriers to care and gaps in services.

The report should note the need to collect new data, including:

- Disaggregated & intersectional data, with attention to differential needs within and across at-risk populations
 - National surveillance data rarely reflects the intersection of gender, sexual orientation, region, race/ethnicity, and other demographic factors that are critical to attend to substance use disparities (Barbosa-Leiker et al., 2021). The lack of disaggregated & intersectional data inhibits tailoring of interventions and program coverage, and structural responses (Iverson et al., 2015a).
 - Gaps in data obscure and flatten the lived experiences of gender-diverse populations, rendering them invisible and inhibiting systemic responses (Iverson et al., 2015b). This misses, for example, the particular relationships lesbians and bisexual women have to substance use, and both sexualized and non-sexualized drug use by gay, bisexual and other men who have sex with men (HIV Legal Network, forthcoming).
 - Elevated rates of opioid overdoses exist in both urban and rural areas in CT, with 23.7 deaths per 100,000 people in rural towns and 37.1 in Urban Core cities compared to a 22.8 death state average (Davila et al., 2020). Given these disparities, it is worth examining, as one example, how place impacts trends for ciswomen, non-binary and trans people, across race, (dis)ability, immigration status, etc.
- Substance use trends and overdose deaths among LGBTQ+ and gender diverse people, and sex workers in Connecticut, with attention to how data collection occurs to avoid required disclosure and how that may impact the accessibility of services or facilitate discrimination.
 - Results from the 2021 and 2022 National Surveys of Drug Use and Health indicate that lesbian, gay, and bisexual adults are more likely than straight adults to use substances. National data shows sexual minorities were 2-3 times more likely to have used illicit drugs, and that about one third of bisexual people and gay males and one fourth of lesbian females had a substance use disorder in the past year. This same report provides state-level data broken down by age, but not by any other categories related to identity (Daniel, 2023).
 - National research suggests that Black sexual and gender minorities, LGBTQ youth and other additionally marginalized groups have higher rates of substance use and unique outcomes (Daniel, 2023; McCurdy et al., 2023; Watson et al., 2023). No equivalent data was found for Connecticut specifically. Data that does exist that is disaggregated by sex subscribes to a gender binary that may leave out non-binary, trans, and other gender diverse people.
 - Use varies widely among and across the acronym, and in relationships with substances. For example, (cis) gay, bi and other men who have sex with men have use, whether generally or sexualized drug use, including chemsex/PnP, that is not necessarily the same as for other parts of the LGBTQ population (HIV Legal Network, forthcoming).
 - GHJP & SWAN's (2020) peer-based needs assessment of sex workers noted the underrepresentation of transgender individuals in the survey sample, and recommended

that service providers, academic researchers, and city agencies conduct “community-driven studies of needs and desires among marginalized people,” with particular attention to the “the gender- and race-specific challenges faced by cis- and transgender women subjected to policing and criminalization” in street economies.

- Qualitative data on overdose and drug use experiences and barriers to access to care, across gender, race, and other factors
 - Essential qualitative research has been done by partnerships such as between SWAN, Yale’s Community Health Van, and Quinnipiac Valley Health District to better understand overdose experiences in the region. However, survey items on barriers to access and experience with harm reduction and drug treatment services did not include gender-specific questions and were not disaggregated by gender (Davila, 2021).
 - Seniors are anecdotally noted as a particularly vulnerable population for overdose and more generally for neglect in outreach and access to care but very little data, and few groups in CT have flagged work on this population.

- Treatment admission and program use, across gender, race, and other factors
 - We were not able to find data on treatment admission by gender. This leaves significant questions on where women and LGBTQ+ people get care, how they are referred to care, and whether their needs are met at these programs.
 - DMHAS Women’s Services currently oversees a variety of programs that are designed to be gender-specific and trauma-responsive, including women’s residential addiction service beds statewide, and addiction service beds specifically for pregnant and parenting women with dependent children, with more information needed on the efficacy of these initiatives.

The report should note the need to ensure privacy protections, with attention to the higher risk and differential consequences of disclosure related to data collection on specific populations, particularly BIPOC populations across genders, including stigma, discrimination, addiction surveillance in health care settings, and criminalization

- See relevant research on CAPTA and the surveillance, regulation and punishment of Black mothers, DCF involvement, and family separation, in commentary to Funding Priority #1

For Strategy #3: *develop metrics, benchmarks, and reporting systems for programs focused on reducing overdose deaths in the state, especially those funded by opioid settlement funds,*

The report should note that it is important to address racial biases in data collection and interpretation, including through community participation in data collection and analysis, and funding decision-making about programming.

HARM REDUCTION INFRASTRUCTURE

CORE Report 2023's funding priority #4: Increase size of addiction specialist workforce and improve non-specialist clinician and community understanding of OUD and evidence-based treatments to decrease stigma and promote treatment uptake.

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Rationale

For Rationale, note:

- the particular stigma faced by those who are pregnant or have children and use drugs, sex workers, and BIPOC folks across race, gender, sexuality, (dis)ability etc. (see citations in commentary to Funding Priority #1)
- the particular need to hire PWUD and people with lived experience, across the range of experiences of people who need services, to reduce stigmatization and provide outreach and services informed by that experience
- The traditionally masculine/male-oriented nature of harm reduction services threaten the effectiveness and accessibility of services among women and sexual and gender minorities (SGM). Often ignored or overlooked in the development and delivery of substance use services, gender-informed services for these populations remain under-prioritized, underfunded, and underutilized (Boyd et al., 2020; Iverson et al, 2015a).
- Black- and BIPOC-led groups need to be particularly supported in this work, to remedy CT's long history of geographic and political exclusion. Support for the addiction focused workforce should include support for institutional capacity building and long-term sustainability for Black and people of color led groups.

Evidence

For Evidence, Workforce, the report should note:

The importance of the lived experience and expertise of people who use drugs and their critical role in providing trusted outreach and effective services to PWUD, and the need for strategies to minimize the barriers for PWUD to access professionalized roles, and specific well-paid roles for PWUD who are unable to meet these requirements.

The effective engagement of PWUD in harm reduction outreach and treatment services requires equitable and good pay and working conditions to reflect the expertise leveraged in their work, and the emotionally and physically taxing work that they perform in communities that they are often part of. This includes ensuring adequate staffing to ensure equitable workloads; the investment of time, support and training for workers, including investment in worker mental health, wellbeing, and the availability of support services for employees, other workers and volunteers. It also includes recruiting workers to ensure that people providing outreach and services share lived experience with the communities they serve, across the range of experiences present in communities served.

Provide mechanisms for worker and community decision-making and feedback in processes to meet these strategies.

Strategies

For Strategy #2- Increase the ability of non-specialist clinicians to provide screening, treatment, and linkage to evidence-based addiction treatments, include:

- **Tactic #1:** *Fund initiatives that grow the addiction specialty workforce by providing specialty training in addiction to nurses, social workers, advanced practice providers, pharmacists, psychologists, and physicians*
 - **The report should add** midwives, and labor and delivery nurses
 - **The report should add** Geriatric and family physicians

PREVENTION STRATEGIES

CORE Report 2023's funding priority #5: Simultaneously deploy and evaluate select primary, secondary, and tertiary prevention strategies.

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Evidence

For Evidence and Primary Prevention, the interventions should include more holistic services and leadership as described in commentary to Funding Priority #2, Strategy 1.

For Evidence and Primary Prevention, the interventions should address training and capacity needs to address the specific needs of populations across race, Indigeneity, gender, sexuality, age, place (including urban/rural), class, (dis)ability, immigration status, etc.

- See research listed under barriers in commentary on Funding Priority #1

For Evidence and Primary Prevention, the interventions should also include action aligned with advancing related law and policy, including equity work that advances outcomes for specific populations impacted by opioid use, and related movements

- Harm reduction strategies should include more community and structural efforts, and funding decisions should reflect and empower this approach, with particular attention to the need for diverse forms of accessible housing across CT: transitional, temporary and accessible stable housing for persons with substance use disorder, whether in treatment or not. All evidence suggests that 'sober housing' or zero-tolerance of substance use in housing is not successful in reducing death or morbidity from substance use.
- In addition to educating and deploying outreach actors and treatment providers, providing overdose prevention and response trainings, BLS certification, access to safer consumption supplies, more inclusive action also includes: public health education on drug use, overdose, sex work, and stigma, STI/STD testing, and policy work to decrease drug and sex work criminalization, or increase access and accountability for quality access to naloxone, appropriate treatment, public transportation, and social services more broadly. It also involves addressing intersections highlighted by, and acting in solidarity with, other social justice movements, such as those for racial equity, decarceration, sex work decriminalization, LGBTQIA+ health justice, housing justice, and reproductive justice (National Harm Reduction Coalition, n.d.).

CORE Report 2023's funding priority #6: Address social determinants and needs of at-risk and impacted populations

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For Strategy #3: *Provide affordable supportive and transitional housing for people with substance use disorders; increase access to "Housing First" models and other models of affordable, supportive, and transitional housing to unhoused people with and at high risk for OUD, the report should include:*

- Low-barrier and stable housing for PWUD and/or people with criminal records, with programs that cover the real cost of rent, and pay attention to specific housing needs, such as supporting housing for pregnant & birthing people, or vulnerabilities due to stigma and discrimination for specific populations, including LGBTQ+ people, particularly LGBTQ+ youth aged 18-24. Low-barrier housing means, in part, no requirements for sobriety or zero-tolerance policies regarding alcohol and substance use.
 - A national study found that comprehensive services, such as housing, transportation, education, and income support, reduces post-treatment substance use among both men and women, with gender differences in outcomes (Marsh et al., 2004).
 - A study of a transitional living center serving homeless and at-risk African American mothers and their children found that a comprehensive, community-based housing program had a positive impact on women's recovery journeys and had lasting impacts on lifetime trajectories for women who had experienced homelessness (Krueger et al., 2022).
 - A study of multi-service prevention programs in Canada found that vulnerable, marginalized pregnant and parenting women who are using substances will seek help when health and social care services are configured in such a way as to take into consideration and address their unique roles, responsibilities, and realities (Hubberstey et al., 2019)
 - A study of women and men in substance-free recovery housing completing monthly surveys over 10 months found that over the 10-month period, women averaged higher levels of depression, perceived stress, and financial strain (Sawyer-Morris et al., 2021).
 - A study of the cross-sectional California Healthy Kids Survey found that more youth living in unstable housing self-identified as LGBTQ than youth in a nationally representative sample, and that compared with heterosexual youth and youth in stable housing, LGBTQ youth in unstable housing reported higher substance use (Baams et al., 2019).
 - A study of immigrant African gay and bisexual men in NYC found current housing instability to be independently associated, among other independent factors, with current substance use (Ogunbajo et al., 2018)
- Ensure that "easier" cases are not prioritized, with the understanding that having equitable housing services requires addressing structural barriers and the commitment to supporting the most marginalized people.
- Services to ensure long-term housing stability and retention for housing for PWUD, including know-your-rights trainings, and assistance and training to manage the housing system itself, such

as through a peer advocates program of people with lived experience of drug use, such as with managing technology, documentation, payment systems, and verification processes. This should also include programs to address implicit and explicit bias, stigma and discrimination in housing services, across groups affected.

- Transitional housing for people exiting jails and prisons, including women, with attention to specific needs across race, gender, (dis)ability, etc.,
 - A study examining factors associated with anticipated post-jail homelessness among men and women found that women were twice as likely as men to anticipate post-jail homelessness (Fries et al., 2014)
- Gender-responsive alternative housing, shelters and pilot programs, including for shelters that take women with children, and shelters without strict curfew hours to allow people to maintain work hours outside of a 9-5 model.

In addition to listed strategies,

The report should expand the strategies in this section to include other social, interpersonal and structural factors, including as multiply present and compounding, for example, in pregnancy

- Case narratives reviewed by the Maternal Mortality Review Committee show the significant impact of structural and social determinants on the more than one-third of pregnancy-associated deaths in Connecticut that involve the use of substances, all of which were deemed to be preventable. There were substantial rates of homelessness, incarceration, adverse childhood experiences and intimate partner violence among this group. Approximately 35% had existing involvement with DCF. In half of the cases, the pregnant person reported to their medical provider that they had been or were currently in a substance addiction treatment program. The MMRC noted gaps in how referrals were made and missed opportunities for intervention and called for comprehensive coordinated care throughout pregnancy and the postpartum period (Kosutic, 2020; McDowell & Kosutic, 2021).

The report should expand the strategies to include compounded harm from co-occurring factors on specific populations differentially impacted by drug use

- Continually neglected overlapping social and structural factors associated with gender difference affect not only increased vulnerability to overdose, but also “reinforce the marginal status of women and gender diverse persons in ways that can render them more vulnerable to health- and drug-related harms.” This includes increased vulnerability to physical and sexual violence, HIV and hepatitis C transmission, and injection-related harms (Collins et al., 2019).
- Structural vulnerabilities related to gender and drug use, moreover, as experienced by women, both cis and transgender, transgender men, gender fluid, and non-binary people intersect with age (Barrett et al., 2022), race, Indigeneity, class, disability, and sexuality to compound vulnerability, and produce unique experiences and needs (Perri et al., 2022; Collins et al., 2019).

- Notably, “racialized persons in North America face disproportionate rates of overdose” (Collins et al., 2019), and “the impact of colonization and role of substance use need to be respected and considered.” (Pauly, 2013).
 - These factors are also mediated by gender-specific experiences of, for example, sex work, pregnancy and pre- and post-partum care, loss of child custody, and assisted injection (Collins et al., 2019).
- Co-occurring psychiatric disorders such as depression and anxiety are more common among women with substance use disorder than men (McHugh et al., 2018); and histories of trauma are more likely to trigger the onset of substance use disorder for women (Keyser-Marcus et al., 2015; McHugh et al., 2018).
- There are higher rates of co-occurring psychiatric disorders, pain, and suicide among women with Opioid Use Disorder (OUD) (Barbosa-Leike et al., 2021).
- Those identified with LGBTQ+ communities face greater risk of harassment and violence and, as a result of such stressors, also often face increased risk of various behavioral health issues such as higher rates of substance use. Sexual minority adults, for instance, report higher past-year opioid use (9%) compared to the overall population (3.8%). These disparities in substance use rates also often translate into syndemic and co-occurring disparities of mental health disorders and HIV when compared to the heterosexual population (National Institute on Drug Abuse, 2017).

ARE THERE PRIORITIES, STRATEGIES, OR MODELS NOT CAPTURED IN THIS DRAFT THAT YOU BELIEVE SHOULD BE CONSIDERED IN THIS REPORT? IF SO, PLEASE DESCRIBE BELOW AND PROVIDE DETAILED REFERENCES REFLECTING THEIR EVIDENCE IN ADDRESSING OPIOID USE DISORDER AND/OR OPIOID OVERDOSE.

For the *Background* section:

In recommending that *all funding decisions spanning all priorities incorporate a racial equity lens and that funds be allocated to address systemic racism and inclusion of diverse populations across systems designed to abate the opioid overdose crisis (page 7)* **the report should:**

- Expand the equity lens of the Report to understand racial equity as impacted by, and necessarily including, intersections across Indigeneity, gender, sexuality, age, place (including urban/rural), class, (dis)ability, immigration status, etc.
- Name Indigeneity, gender, sexuality, age, place (including urban/rural), class, (dis)ability, immigration status, and others as important equity lenses, with the understanding that attention to maximizing the likelihood of reducing overdose deaths and saving lives must not end at a global figure, but must include attention to rates of death in specific communities and recognize the impact of those deaths on those communities, including on harm reduction services led by people with (current or past) lived experience of drug use.
- Include the critical importance of the leadership of community-based individuals, collectives and organizations providing harm reduction and related services to specific populations, particularly BIPOC-led organizations and agencies. This leadership should include decision-making power in funding decisions, monitoring, evaluation, research, and feedback, and initial and ongoing decisions on priorities and shifts in funding spending. This should also involve efforts to ensure that the languages used by both community-based harm reduction providers and the communities they work with are included.
- Beyond the Background section, include specific priorities, guidance and research on how racial equity and equity lenses across Indigeneity, gender, sexuality, age, place (including urban/rural), class, (dis)ability, immigration status, etc. can be meaningfully engaged as part of each strategy, goal, and tactic, including leadership roles for affected communities and community-based outreach and service providers.

Moreover, the metrics and data collection plans outlined in the report should include review of the distribution of funds across demographic (race, place, and gender) categories, and track the extent and support for Black- and BIPOC-led organizations, with useful future metrics including: # of community-based groups, especially Black or BIPOC-led groups, providing effective harm reduction efforts 3, 5 and 7 years out across demographic groups.

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