Evaluation of the Community Opportunity, Network, Navigation, Exploration, and Connection Team (CONNECT) Year 2 Report

Submitted to the
Opioid Task Force of Franklin County and
the North Quabbin Region
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Introduction

Continued need for CONNECT

Fatal overdose attributed to opioid use has continued to worsen across the United States over the past two years (Ahmad et al., 2022). In Massachusetts, there was a 9% increase in the rate of fatal opioid overdoses from 2020 to 2021, with an estimated 2,290 people experiencing a fatal overdose in 2021. In Franklin County, MA, 36 fatal opioid overdoses were reported in 2021, representing an 80% increase from 2020 (20 reported fatal opioid overdoses) (MA Dept of Public Health, 2022). We summarize these statistics to frame the continued need for innovative interventions to address the opioid overdose crisis.

The Community Opportunity, Network, Navigation, Exploration, and Connection Team (CONNECT) is the first Franklin County/North Quabbin, Massachusetts 30-town, 24/7 opioid overdose rapid response team, using an evidence-based regional hub and spoke model, to respond to fatal and non-fatal overdoses in the only federally-designated rural county in Massachusetts. The CONNECT program is being implemented by the Opioid Task Force (OTF) of the Franklin County/North Quabbin Region. The OTF subcontracted with the University of Massachusetts Amherst (UMass) to conduct an evaluation of CONNECT. The project is funded by the Substance Abuse Mental Health Services Administration (SAMHSA) for two years starting September 1, 2020 (for context on year one of implementation, see Evans, Harrington, & Bailey, 2021).

During the second year of implementation, the CONNECT team continued programming and expanded its reach to additional communities. Operations occurred within the context of challenges that were posed by the COVID-19 pandemic and related consequences, most notably the continued use of remote work and staffing turnover and shortages that occurred within partner organizations. To meet these new challenges, CONNECT adapted program operations. For example, CONNECT focused on activities to strengthen relationships between community partners, adjusted meeting frequency and introduced workgroups to foster efficient collaborations, and developed new pathways to engage clients with services through CONNECT. In this report, we describe the experiences and lessons learned during the second year of CONNECT program implementation.

Evaluation overview

The UMass evaluation of CONNECT consists of three aims. For more detail on the proposed aims, see the CONNECT Year 1 Report (Evans, Harrington, & Bailey, 2021). In this section, we summarize the status of the UMass evaluation during the second year of program implementation.

<u>Implementation and Process Study</u>

The aim of the Implementation and Process Study is to understand how to adapt the Hub and Spoke Model for the local Franklin County/North Quabbin context. For this aim, the UMass Amherst team assessed perceptions among CONNECT staff regarding implementation barriers and facilitators, the perceived benefits of the CONNECT program, and adaptations that have been made to program operations. Qualitative data were collected through a review of meeting notes and other documents and focus group sessions with key CONNECT partners. The team also reviewed salient literature to highlight the role of community health workers and peer recovery coaches within CONNECT.

<u>Outcome Study</u>

The aim of the Outcome Study is to assess utilization of CONNECT health and social services and associated outcomes. For this aim, the UMass Amherst team examined CIMS data on overdose events and compared it with other sources of information on overdoses. The team also assessed perceptions among CONNECT staff of the CONNECT clients' use of services and outcomes through qualitative data analysis of focus groups. The focus groups identified factors perceived to be associated with health services utilization and outcomes and the extent to which these vary depending on clients' socio-demographic characteristics (e.g., age, gender, race/ethnicity, SES), comorbid physical and mental health conditions, social support, utilization of health and social services, and hub location.

Opioid Overdose Education and Naloxone Distribution (OEND) Study

The aim of the Opioid Overdose Education and Naloxone Distribution (OEND) Study will be planned for the third year of implementation, pending continuation of grant funding.

CONNECT system for tracking overdose events

By Rithika Senthilkumar, Amelia Bailey, Elizabeth Evans

The CONNECT Design Team contracted with Kelly Research and Associates to implement a Critical Incident Management System (CIMS) to track in real-time the overdose events that occur in the CONNECT communities and come to the attention of law enforcement. The Appendix shows an example of the detailed CIMS data reports that are regularly provided to the CONNECT team by Kelly Research and Associates.

Characteristics of opioid overdose events

Table 1 shows CIMS data on overdoses that occurred from July 4, 2021, to July 31, 2022. During this time period, 81 unique clients were entered into CIMS with an average of 1.2 incidents per person (total of 97 overdose incidents were recorded). Most incidents recorded were non-fatal overdoses (90.1%) and 9.9% were fatal. Most clients identified as male (69.2%) with fewer identifying as female (29.6%) or transgender (1.2%). Clients were typically 30 to 39 years old (34.6%) and 40 to 49 years old (27.2%). Clients often identified as White (77.8%) with fewer identifying as Black or African American (8.6%); most clients identified as non-Hispanic (62.9%). Few clients were recorded as unhoused (13.6%) and few children were recorded as involved in the incident (4.9%). Around half of incidents occurred at the individual's residence (53.1%). Naloxone was administered in most cases (77.8%), frequently by a first responder (44.4%) or a 3rd party person, family member, or friend (23.5%). Most clients were transported to the hospital after the incident (88.9%).

Table 1. Characteristics of Opioid Overdose Events Recorded in CIMS via the CONNECT Program, 07/04/2021 to 07/31/2022	
n= 81	
Type of overdose (%)	
Fatal (%)	9.9
Non-fatal (%)	90.1
Number of overdoses per person, mean	1.2
Gender identity (%)	
Male	69.2
Female	29.6
Transgender	1.2
Age (%)	
≤19	1.2
20-29	16.1
30-39	34.6
40-49	27.2
50-59	14.8
60-69	4.9
Unknown	1.2
Race (%)	
White	77.8
Black or African American	8.6
Unknown	13.6
Ethnicity (%)	
Hispanic	2.5
Non-Hispanic	62.9

Unknown	34.6
Unhoused (%)	13.6
Incident occurred at residence (%)	53.1
Child involved (%)	4.9
Naloxone administered (%)	77.8
3rd party, family, or friend	23.5
Police, fire, or EMS personnel	44.4
Both 3rd party and first responder	8.6
Not applicable or unknown	23.5
Transported to hospital (%)	88.9

These data show the capacity of the CIMS system to be used as a useful tool for tracking the number of overdose events and related characteristics. Such information is necessary to assess the outcomes and impact of CONNECT.

Comparing CIMS to other data sources

An ongoing topic of conversation among the CONNECT partner organizations has been the extent to which CIMS is used to track overdose events in the Franklin County/North Quabbin region. It may happen, for example, that overdose events occur and are known to partner organizations, but are not always data entered into CIMS. To examine this issue further, we identified additional datasets on overdose events that could serve as comparison data.

Here we present opioid overdose surveillance data published by the Massachusetts Department of Public Health (MDPH) in June 2022. These data were collected through the Massachusetts Ambulance Trip Reporting Information System (MATRIS), which is a statewide database for collecting emergency medical services (EMS) data. The data collected by MATRIS includes 5 severity categories of opioid-related EMS incidents: “dead on arrival” (of opioid overdose), acute opioid overdose, opioid intoxication, opioid withdrawal, and other opioid-related incidents (Bureau of Health Care Safety and Quality, MDPH). In other words, MATRIS includes information on a broader set of events, encompassing both overdose events and also other opioid related emergencies. In addition, MATRIS collects opioid-related incident data from individuals aged 11-17, a population that is not currently captured in CIMS. For these reasons, it is not possible to directly compare the data provided by CIMS and MATRIS. Instead, as shown in the next section, we extrapolated information from MATRIS data to approximate the same data parameters that are used by CIMS. These data, however, should be interpreted with caution given the assumptions that were made.

Results

Table 2 shows CIMS data on overdoses that occurred from July 4, 2021, to December 30, 2021, in the CONNECT communities of Greenfield, Montague, and Deerfield. These data are presented for the last two quarters of 2021 to facilitate comparison with the MATRIS data. During this period, overdose events recorded in the CIMS system for Greenfield, Montague, and Deerfield totaled 25, 7, and 1 respectively.

Table 2. Opioid Overdose Incidents CIMS, 07/4/21-12/30/21			
Town	Jul – Sept	Oct – Dec	Total
Greenfield	22	3	25
Montague	3	4	7
Deerfield	1	*	1

*Indicates no reported incidents

Table 3 shows the MATRIS data on all opioid-related EMS incidents that occurred in the CONNECT communities of Greenfield, Montague, and Deerfield in the last two quarters of 2021.

Table 3. All Opioid-Related EMS Incidents MDPH MATRIS, 07/21-12/21			
Town	Jul – Sept	Oct – Dec	Total
Greenfield	38	20	58
Montague	9	5	14
Deerfield	*	1-4	1-4

*Indicates no reported incidents
1-4 indicates that the value is between 1 and 4

To facilitate comparison with CIMS data, we aimed to extrapolate from MATRIS data the number of opioid overdose-related EMS incidents. MDPH reports on MATRIS data specify that of all EMS incidents in MATRIS from July to December of 2021, about 1.5% are marked as "dead on arrival" (of opioid overdose) and 57.7% are an acute opioid overdose. We used this information to estimate the number of opioid overdoses, per MATRIS data, in the relevant CONNECT communities (Table 4).

Table 4. Estimated Opioid Overdose-Related EMS Incidents MDPH MATRIS, 07/21-12/21			
Town	Jul – Sept	Oct – Dec	Total
Greenfield	22	12	34
Montague	5	3	8
Deerfield	*	1	1

*Indicates no reported incidents

Both CIMS and MATRIS data indicate that more opioid-overdose related incidents occurred in the Greenfield community, an expected trend given that Greenfield has a much larger population than the more rural communities of Montague and Deerfield. When comparing the number of overdose events for Greenfield in CIMS (Table 2) with what was estimated based on MATRIS data (Table 4), the information is similar for July to September (both sources indicate a total of 22 incidents) but different for October to December, with CIMS reporting 3 overdose

incidents and the estimate based on MATRIS data indicating 12. The information for Montague and Deerfield is mostly similar across sources.

Conclusion

The CIMS data play an instrumental role in the ability of CONNECT to track and respond to opioid overdoses in the community. However, the utility of CIMS depends on the extent to which community partners use it to report all events and in a timely and accurate manner. A comparison of CIMS data with MATRIS data provides an imperfect but useful means to assess the extent to which CIMS is being used to capture all of the opioid overdose events that should be targeted for CONNECT services. The data presented in this section suggests that CIMS is being used to capture many overdose events, albeit with apparent variation in the complete capture of events over place and time. Amid the rapidly developing opioid epidemic, there are increased calls for comprehensive and timely data on overdose incidents as necessary to identify overdose events and connect individuals with treatment and appropriately implement other life-saving interventions (Volkow et al., 2022).

Planned Program Adaptations and Future Directions

By Amelia Bailey, Rithika Senthilkumar, Elizabeth Evans

From January 2021 to July 2022 the UMass Amherst research team joined the weekly CONNECT operations meetings to learn about experiences with program implementation. In this section we document major themes from the CONNECT meetings during the second year of implementation.

CONNECT enacted several programmatic changes in the second year of implementation. At the beginning of the year, the Design Team sectioned the Implementation Meeting into *three distinct workgroups*. The purpose of the workgroups was to discuss and cultivate ideas among smaller groups of partners who were focused on the same domain of CONNECT. The workgroups were labeled At-the-Scene; Outreach; and Referrals & Training. The At-the-Scene Workgroup included first responders. The Outreach and Referrals & Training Workgroups included staff from behavioral, social, and medical service providers. The meetings rotated weekly with each distinct meeting occurring once a month. Key partners expressed appreciation for these smaller workgroups as it enabled more in-depth discussions with the ability to come together once a month as a larger group to discuss higher-level topics.

Developing pathways for secondary populations

The Design Team and key partners identified a few gaps in services where CONNECT did not reach its intended population. Key partners discussed the *mechanism to have a child affected* by overdose referred to CONNECT services. Early in 2022, the CONNECT team hired a clinician to treat children affected by overdose, widening their capacity to serve children in this population. However, the CONNECT team continued to have limited referrals for children affected by overdose in CIMS. Soon after, CONNECT team members involved the state's child protection agency to increase the number of children in the region to be referred to CONNECT. In discussion, key partners weighed the desire to access children affected by overdose with concerns over compromising the trust of people who have experienced an overdose. Key partners expressed concern about CONNECT's perception by community members as a service that would inevitably involve child protection services. There were several smaller meetings between individual organizations to clarify alternate pathways to refer children to CONNECT services. From these conversations, the team developed a pathway for direct referral from the child protection agency to the CONNECT clinician (see Appendix for release and intake forms). This pivot in client flow created a new mechanism to expand service provision to an intended population of CONNECT and removed barriers for children to access immediate trauma care. In the months of June and July of 2022, the number of referrals to CONNECT services was estimated to be between 8 – 10 children.

Relationship building, communication, and smaller group meetings between partners and child protection services were noted as key facilitators of this process. Partners also report positive feedback from parents involved in this referral process whose children are connected to a clinician. The CONNECT team continues to monitor this process while also educating agencies involved on how this new referral mechanism works. Because CONNECT is one of the first post-overdose intervention programs to offer support services for children affected by overdose (Evans, Harrington, & Bailey, 2021), the team is navigating uncertainties of confidentiality and privacy regulations (Substance Abuse and Mental Health Services Administration, 2022a). The Design Team and key partners continue to engage in discussions about privacy and confidentiality issues that arise from including children in CONNECT's client population (e.g., clarity on 51A reporting).

While CONNECT is a post-overdose intervention, the team also discussed how to expand the range of individuals who could be entered into the CIMS database to be proactively connected to CONNECT with resources. The Design Team began planning a *self-referral pathway* to include anyone who voluntarily desired services from CONNECT; and the *at-risk referral pathway* to include individuals perceived to benefit from CONNECT or to be "at-risk" for an overdose by community providers, first responders, friends, or family. The key partners discussed how to appropriately create these mechanisms while maintaining low-barrier access. Some key features of low-barrier access to care for people with opioid use disorder include a harm reduction approach (i.e., without judgement and with understanding that clients can choose their desired path), flexibility of access, and availability of services across geographic space (Jakubowski & Fox, 2020). Partners also expressed concern over confidentiality, consent, and maintaining trusting relationships with clients. In response to these concerns, the Design Team paused before moving forward with at-risk referrals from family and friends.

Outreach: CIMS data, peer recovery coaches, & collaboration

Key partners on outreach calls shared that a challenge to conducting outreach is receiving inaccurate contact information in the CIMS database which complicates the ability to connect a client with services. Several key partners mentioned the importance of police officers entering accurate, contextually rich information into CIMS. To aid this data entry, outreach workers have provided condensed trainings to police officers on how to best use the CIMS system to enter data. Outreach staff discussed how beneficial it is to work with police officers because the officers work closely in the community with some CONNECT clients and can aid in locating a client for outreach. On outreach calls, sometimes plain-clothed police officers join the outreach workers. Police partners involved with outreach shared it felt "awesome" to connect with people who have experienced an overdose with trained personnel to support them. This feedback loop may contribute to reductions in first responder compassion fatigue (Metcalf et al., 2022), which is essential to first responder endorsement of overdose interventions (Carroll et al., 2020).

The outreach team shared that during a visit they may not reach the person who experienced an overdose, but they often do reach the family of the person who experienced an overdose. Because of this reality, conversation began on *how to best support family members*. Previous literature on post-overdose interventions has lacked detail on how to support family members affected by overdose (Evans, Harrington & Bailey, 2021). To bridge this gap in knowledge, key partners generated ideas on how to best support family members, such as providing resources on local support agencies (i.e., Learn to Cope) and trainings for outreach workers that might be useful for conversations with family members (i.e., on Good Samaritan Laws, trauma, science of addiction, building resilience).

Future directions

Several next steps for CONNECT were discussed during weekly meetings. A few program adaptations that have been discussed include the services and resources offered by a mobile outreach unit, the design and purpose of branded CONNECT clothing and merchandise, and the planning, purchasing, and maintaining of Nalox-Boxes and grab-and-go naloxone throughout the community. During these conversations, key partners mentioned communicating with and listening to the CONNECT intended population (i.e., people who use drugs in the region) when developing these resources to ensure that the programs implemented would accurately reflect the needs of the population. This client-centered approach prioritizes the experiences of intended population to influence the systems that directly impact them. In addition to eliciting ideas from the CONNECT population, it is also essential for the CONNECT team to maintain transparency on the processes and outcomes of CONNECT with clients and

the community (Isom, & Balasuriya, 2021).

The Design Team also applied for and received funding, and began developing CONNECT's Cultural Humility Effort to "expand access for Black and Indigenous People of Color (BIPOC) individuals impacted by opioid use disorder." The Design Team aims to conduct staff trainings on cultural humility and identify relevant barriers to care in the region and ensure client-centered care during CONNECT's provision of outreach and support (Office of Attorney General Maura Healey, 2021). For this effort, the Design Team solicited CONNECT key partner engagement for a Cultural Humility advisory committee.

Two initiatives in the community offer opportunities for synergy between CONNECT and other related resources. The first initiative is the implementation in the region of a SAMHSA-funded program to provide trauma informed care to justice-involved individuals with opioid use disorder during incarceration and after community re-entry. A key focus of this program is increased knowledge of commercial sexual exploitation (CSE) and its relationship with opioid and other substance use. Many of the organizations that are involved in the implementation of CONNECT participated in a four-session seminar on CSE (see Appendix for highlights from these CSE seminars) with discussions currently underway on how to adapt services to incorporate lessons learned. The second initiative is the implementation of the NIH HEAL Initiative's HEALing Communities Study (HCS) in the Franklin County towns of Greenfield, Montague, and Orange and in the North Quabbin town of Athol starting in June 2022. The primary goal of HCS is to increase access to care for people with substance use disorders by reducing barriers to care (NIH HEAL Initiative, 2022). While these new initiatives are distinct from CONNECT, programmatic efforts may nevertheless benefit from the relationships, resources, and other accomplishments of CONNECT.

Lessons Learned: Insights from CONNECT Partners

By Amelia Bailey, Rithika Senthilkumar, Taylor Parduhn, Hellen Muma, Elizabeth Evans

Introduction

Post-overdose interventions have been implemented around the country over the past few years. However, these programs are under-evaluated and CONNECT incorporates unique aspects into its model for delivery of a post-overdose intervention (Evans, Harrington, & Bailey, 2021). Assessment of the factors that influence the implementation of CONNECT can inform future program design. Results may also be used to develop similar post-overdose programs elsewhere. In this section, we summarize key partners' experiences and perspectives with the implementation of CONNECT.

Methods

We used a qualitative research design to collect data from 21 community partners (i.e., behavioral health, medical, public health, and public safety personnel) who are involved in the design or implementation of CONNECT. Data were collected via semi-structured focus groups (4 groups with 2-8 participants per group). Focus groups were supplanted with individual interviews as needed, for example due to scheduling conflicts. Participants completed an Informed Consent Form and demographic questionnaire online. Discussion prompts explored key partners' perception of CONNECT client characteristics and experiences, implementation of CONNECT, collaboration between partners involved with CONNECT, and future needs and wants for continued operation of CONNECT (see Appendix for discussion prompts).

Data were collected from March 2022 to July 2022. Each discussion lasted approximately 30 minutes to 1 hour and was held on Zoom in a private, secure meeting. Interviews were digitally recorded and transcribed. Participants were assured that data would be stored confidentially and findings would be anonymized upon dissemination. All data procurement was approved by the UMass Amherst Institutional Review Board (IRB).

We used a combination of thematic analysis (Braun et al., 2006; Glaser & Strauss, 1967) and rapid qualitative analysis methods (Morgan, 1993; Nevedal et al., 2021). During live focus groups, two research staff recorded detailed notes on the content of the discussion. Immediately after the focus group, the research staff compared and reviewed their notes for accuracy. Four research staff independently summarized transcript notes, and then pairs met to compare summaries and resolve discrepancies through discussion. If discrepancies remained, the entire group discussed them to decide a resolution. We analyzed patterns within and across the responses and identified major themes, allowing the data to dictate analytical categories. We grouped common responses and pulled illustrative quotes from the transcripts. The resulting summary of themes was reviewed by the entire research team for accuracy.

Results

Participant characteristics

Focus group participants included 21 individuals from a diverse set of organizations that are involved in the design and implementation of CONNECT. These included the Recover Project, the North Quabbin Community Coalition, Tapestry, the Community Health Center of Franklin County, the Children's Advocacy Center, the Department of Children and Family, the Opioid Task Force, local Police Departments, local Fire Departments, and Kelley Research Associates. Of the participants, average age was 44.2 years and most participants identified as female (71.4%). Most participants identified as white non-Hispanic (85.7%). Most participants had

earned a graduate degree or higher (47.6%) or bachelor's degree (28.6%). Most participants were not licensed or certified (57.1%), while 23.8% were licensed and 14.3% held a certification. Participants' experience with treating OUD ranged from 0 to 35 years. Participants represented many sectors, including behavioral health (47.6%), program operation and evaluation (23.8%), medical (9.5%), harm reduction (9.5%), and first responder (9.5%).

Table 1. Participant Demographics (n = 21)		%
Age	Age, mean	44.2
Gender identity	Female	71.4%
	Male	23.8%
	Genderqueer	4.8%
Race and Ethnicity	White, non-Hispanic	85.7%
	Black or African American	4.8%
	Asian or Pacific Islander	4.8%
	American Indian or Native Alaskan	4.8%
Education	High School or Associates	19.0%
	Bachelor's Degree	28.6%
	Graduate Degree or Higher	47.6%
	Missing	4.8%
Highest Level of Training	Licensed	23.8%
	Concentration/Certification in Addiction	14.3%
	Not licensed or certified	57.1%
	Missing	4.8%
Experience with treating OUD	0 - 4 years	33.3%
	5 - 10 years	38.1%
	11+ years	28.6%
Sector	Behavioral health	47.6%
	Program operation or evaluation	23.8%
	First responder	9.5%
	Harm reduction	9.5%
	Medical care	9.5%

Participants shared their experiences and thoughts on CONNECT's implementation in response to interview prompts (see Appendix for discussion prompts). We describe these experiences in six distinct sections.

Results

CONNECT key partner structure

The key partners that comprise CONNECT represent a variety of sectors, and therefore, represent a diversity of perspectives on the implementation of CONNECT. Key partners that participated in the focus groups shared that they joined the CONNECT team through a few different channels. Most participants joined CONNECT because the leadership of CONNECT contacted them to begin a partnership for this project due to their expertise or current position. Other participants joined the CONNECT team because they heard about the work and felt a need to join the effort. CONNECT leadership brought together these partners for the purpose of

creating an interdisciplinary team with the capacity to meet a wide range of community needs.

> Our vision of what a CONNECT program looks like, how it could include components that some of our other compatriots didn't have, like reaching out to children who've been experiencing, were impacted by witnessing an overdose, how we could have harm reduction, you know, be more inter interwoven, our community health worker like we would probably do really we did create an interdisciplinary team.

Upon hearing about the concept of CONNECT, participants shared feeling excited and eager to begin the work because they perceived this project was needed in the region due to the rate of opioid overdoses and the lasting community impact of this crisis. Participants recognized that CONNECT fulfills a pressing need in their community, where support was previously not offered, in an innovative way.

> Hearing the numbers [of opioid overdose] and like it's more than numbers, those are our friends. Those are our family. Those are people that we are neighbors like people in our community and it's just devastating. And to be a part of that and try to connect people is just. Yeah, it's just needed here so. Definitely grateful to be a part of this program and having like the support of like recovery coaches and then people on this call and just you know team approach and just making sure that needs are being met right in a way that they weren't.

Since joining CONNECT, most participants continue their original role at a parent agency and are additionally contracted by CONNECT for some of their time. Other participants are compensated entirely by CONNECT and some volunteer their time for CONNECT. Participants perceived being affiliated with the CONNECT project to be an advantage because they are able to access the support, training, and mentorship of the grant, other CONNECT partners, and the task force to improve their skills and competencies.

Characteristics of the CONNECT client population

Focus group participants described that individuals who are actively using substances make up a majority of the CONNECT client population. Most CONNECT clients use opioids with a high rate of injection drug use and stimulant drug use. One participant noted that many clients also use cigarettes while fewer use alcohol. Involvement with the justice system, characterized as previous contact with law enforcement, and living in low-income areas were also identified as typical characteristics for many individuals involved with CONNECT.

Also, the CONNECT client population was reported to be mostly made up of White men, followed by White women. A few other participants shared that few people of color were identified in the CIMS database. Given the need for care in the community along with the racial and ethnic diversity within some communities in the region, participants expected that CONNECT should be engaging with more people of color. Participants valued that CONNECT leadership worked to raise awareness of these issues, for example by developing a cultural humility workgroup and by prompting discussion of racial and ethnic differences in opioid overdoses and access to care.

Participants perceived that CONNECT successfully provides access to care for those willing and able to call 9-11 after experiencing an overdose. A few participants shared that CONNECT is especially helpful in providing services for those who may be initially unaware of the

resources available in the community.

Populations that could be better served by CONNECT

Key partners also shared how “pre-overdose” populations, described as those at an elevated risk for future overdose, could benefit from the services provided by CONNECT. While individuals at elevated risk for experiencing an overdose were not in the initial intended population of CONNECT, leadership and key partners began to discuss a “preventive” mechanism for these individuals to get referred to CONNECT services. Participants identified several other populations that could be better engaged with CONNECT services. These included, in particular, unhoused individuals, individuals who use stimulants, individuals who do not call 9-11 after an overdose, and friends and family of those who experience an overdose.

Several participants identified that many CONNECT clients are *unhoused* and, without accurate physical address, phone number, or other contact information, these individuals are less likely to be successfully followed-up with and referred to CONNECT services. One participant shared that this issue was worsening, as the number of unhoused individuals in the CIMS database was increasing over time, therefore reducing the proportion of CONNECT participants who the outreach team could successfully contact.

A few participants who provide direct care to clients shared how many members of the intended population use stimulant drugs. Even when individuals intend on only using stimulants, there can often be fentanyl contamination which puts the individuals at risk of overdose. One of the participants mentioned that these individuals also do not have access to naloxone themselves or know how to utilize it. This participant emphasized the importance of distributing fentanyl test strips and naloxone as part of the harm reduction services provided to people who use stimulants. While they are at risk for an overdose and health complications related to substance use, this growing proportion of individuals are not being served well by CONNECT. Participants shared that it is more difficult to reach this population and more difficult to treat stimulant use disorder.

Additionally, participants identified that *individuals who do not call 9-11* after an overdose are missed by CONNECT. Participants speculated that individuals don’t call 9-11 due to perceived stigma surrounding substance use, fear of legal penalty after interaction with law enforcement, fear of loss of custody of children, and limited access to health insurance. Although these individuals do not interact with CONNECT’s referral system, participants shared that they often see these clients accessing harm reduction services (i.e., clean and safe supplies, naloxone) in the community; a few participants felt this population of individuals may benefit from additional CONNECT referrals to services, although there is no formal referral system in place currently.

To illustrate the barriers to care the uninsured client population faces, a participant shared that people who are immigrants to the United States without citizenship documentation will not call 9-11 not only due to fear of legal involvement but also because they do not have medical insurance so they would not be able to sustain engagement in services:

> When you’re dealing with people that are defined as undocumented in this country, when you are talking about addiction, it isn’t just the fear of outside agencies that come into play. It isn’t a fear. It’s like recovery is impossible to them because they don’t have medical insurance. So even if we give them access to the resources they get turned away so they don’t even bother. They try and do it [recovery] on their own, its like ‘what’s

> the point of calling this number because when I don't have medical insurance, I will be rejected anyway'.

To explain why some populations may have mistrust in systems like CONNECT and therefore might not engage, participants identified that the policies of organizations and systems that interact with CONNECT clients had frustrating rules and regulations that pose barriers to care and lead to poor health outcomes among certain populations:

> We're cataloging all these things [barriers] to try to figure out, or at least we hope we are. By trying to figure out how to remove some of these barriers to make it easier for people to get served been on the flip side you know. No wonder, people are upset at systems and don't trust us right… I don't know it's that's been mind boggling truly mind boggling. And at the same time, we just know there's people dying and people overdosing and people are talking about it on the streets, and you know. Sometimes it's hard not to feel helpless, even though we know a lot has happened, and a lot of good things have happened.

Aside from the primary client population, participants also identified that friends and family members impacted by a loved one's overdose were key CONNECT clients. Some challenges in reaching these "informal networks," such as the referral process and the potential distrust of CONNECT, were discussed. Several participants identified that few children were reported as affected by an overdose in the CIMS database. Participants speculated that children were underreported because parents did not want to risk loss of child custody. Because of how few cases were reported, participants felt as though CONNECT had not done enough to connect children with services. To address this gap in care, participants created an alternative pathway to receive referrals for children affected by overdose from other agencies. Setting up this referral mechanism took several meetings over months as key partners deliberated, as there were confidentiality concerns regarding the sharing of patient information between agencies.

CONNECT client engagement

Most participants discussed the importance of direct care staff in providing CONNECT services. Specifically, participants highlighted the unique role of the community health worker and the peer recovery coaches to provide interpersonal support, treatment and/or medical referrals, and direct communication with clients from a perspective of lived experience. Due to their respective skill sets, participants shared that they can specifically help those who are disenfranchised from the traditional medical systems, such as those who are unhoused or unstably housed.

Participants who provided direct outreach to clients spoke about the importance of "holding space with them and sitting with them without that agenda," to provide validation and make a connection. One participant summarized their direct approach to supporting CONNECT clients: "What do you want? What do you think that you need to help you accomplish that and how can I help with?" Participants perceive that CONNECT clients are receptive to this engagement. After the initial engagement, outreach workers shared the importance of continuous check-ins with clients to assure they have access to care and to form a relationship with clients.

A participant highlighted how the range of partners involved in CONNECT allowed potential clients to access many resource options, including peer support, medical care, support for children, harm reduction services, and counseling services, which was inherently empowering for client autonomy:

> It’s almost like presenting someone with a menu... What, what do you feel like you need right now? What could be most helpful? I think it's very person centered. It really is. Allowing the person and the family to make their own choices and sort of reach for what they think would be beneficial. It's a I think it comes through a very harm reduction approach, and I think that's sort of everyone. And in the CONNECT programming and the OTF would pretty much agree with that. We really pivoted a lot, especially during COVID kind of a way. Yes, we want folks in treatment when they're ready, but really we just want people to stay alive.

To sustain the essential role of peer recovery coaches, a few participants suggested paying peer recovery coaches involved with CONNECT to make a living wage, and legitimize their role within the program and within the greater community:

> I have to make a living right so in the future I'm hoping that our recovery coaches are paid a living wage so that we can do the work... I will do this work without pay because it it helps people, but that's my wish in the future is that the program is is robust enough where it can support and pay our people. And that and that just doesn't mean that the folks that are organizing or like the language that you use up you know that was deemed professional by society, not by how we all feel inside but by society.

Rurality of the Franklin County/North Quabbin Region

Several participants shared how the rurality of the Franklin County/North Quabbin (FCNQ) region fostered a culture of collaboration among community partners. Furthermore, participants discussed how the personal ties that many community leaders have to the FCNQ region and to one another may urge them to address community problems:

> Culture of collaboration that exists here as a value... So for me that's a huge one and then since that's an expectation that I think exists in our community, because we're rural community... It was like we have to do it ourselves no one’s going to do it for us. Like we were just so overlooked all the time... and also people who are in key leadership positions... All of these folks have worked or lived in this community, in our community, for a long time and know each other and so I think they are eager to solve problems.

Participants noted that in a rural space, “People are born here. They go to school here. They continue to work here. They raise their own families here, right? People really just stick around.” Because of how clients are embedded, participants shared how critical it is that CONNECT facilitates a “holistic” connection to multiple sources of support for individuals, their family, their children, and their community. Participants perceived this public health and person-centered focus as a facilitator to addressing substance use in the region. Conversely, participants shared that this public health focus was often met with a culture of shame and blame regarding substance use and overdose among community members in these rural areas. To address this stigma, CONNECT leadership seeks to engage with people beyond post-overdose services and normalize substance use support and services.

Participants shared how the rurality of the FCNQ region hindered access to services. In particular, many participants identified the lack of transportation as a major limitation to accessing physical services in the North Quabbin region. Alternatives, such as telehealth and mobile health units were discussed as ways to provide services. One participant specified some factors contributing to the disparity between Franklin County and the North Quabbin region in

access to harm reduction services:

> So you know if someone is sort of in Greenfield proper, most things are walkable. They could actually access services pretty easily. Tapestry has a brick and mortar site that they can get to and get you know syringe exchange and cleaner sterile needles like you know things that they could use for safer drug use... Just we haven't gotten there yet and so you know they're the people there and their ability to access harm reduction services specifically is really, really limited because there just isn't anything in that area [North Quabbin] is incredibly rural. It is incredibly poor. So lack of transportation, lack of Wi-Fi, you know, lack of cell phone service, right? Like all of the the social determinants of health, unstable housing and safe housing. I think really transportation is a big one.

A few participants speculated that the rural nature of CONNECT hindered elements of program implementation. Participants shared that few referrals recorded in the database limited the ability for CONNECT to operate as intended: “The data collection which we think is, you know, a foundation... You have to know when overdoses happen in order to respond to offer resources to people. That data needs to come from, you know, law enforcement if you're utilizing CIMS.” Participant speculated that the rurality of CONNECT contributed to this challenge due to communication across geographic space, and reduced partner bandwidth due to the part-time or volunteer workforce and staffing shortages. These staff issues were especially prevalent among first responder partners. Participants discussed the importance of buy-in in engaging key partners to combat these challenges. By increasing buy-in among all partners, participants hoped there would be more, rich data entered into CIMS for CONNECT which would generate more outreach calls with the goal of referring clients to services. Within their roles already, participants shared buy-in was tied to an understanding of the importance of CONNECT’s mission, the ability for leadership enforce CONNECT responsibilities, personal experience with friends or family with substance use disorders, and the ability to effectively “sell yourself and to sell an idea” to others.

Use of multidisciplinary partnerships

Several participants shared that effective facilitation of weekly meetings through use of structured meeting agendas, efficient flow of meetings, and by allowing everyone to speak during the meetings was something CONNECT had done well. Participants also shared that these regular meetings between partners from different sectors created a space to foster networking and collaboration of organizations. Conversely, challenges to program implementation shared by a few participants were conflicting workflows between different organizations and competing priorities from agencies that represented different sectors. These differences fostered a sense of confusion and distrust that initially halted collaboration.

> You know, like it's very complicated so. And that's the piece I don't think any of us had a good grip on when we first started. Like my perspective, I would have thought, of course people would file a report 'cause there's a child at risk, but from the [other organization] that's not what they want to do 'cause they're building a relationship. So you know, everybody's got that different lens, which I'm not sure we had all thought that through in the beginning.

When challenging conversations in the regular meetings did arise, participants felt the leadership of CONNECT responded effectively to grow and evolve the meetings to enhance collaboration through the use of an outside facilitator. This process contributed to the ability of

CONNECT partners to share knowledge on community resources to better support CONNECT clients.

> When we hit that little rough patch and we kind of had an outside facilitator come in and we went over meeting agendas and group rules and just understanding that like we all have different roles and we are here to learn and getting on the same page of like we're going to try to use non stigmatizing language. What does that mean? Folks don't know. So like we had to have that education and the assumption that we were all already at that level I don't think was a fair one. So I think when we hit the bump that was. A really good pivot instead of just continuing to let that kind of tension rise.
>
> I mean, we did hit a few hiccups at the beginning. But I feel like that's to be expected at any project, and the way that it was handled. Just it felt good. It felt right and it put everybody on a path towards teamwork and that is the goal. Continuous growth, right?

Participants also offered a few areas for CONNECT to improve upon. To improve on service delivery, a few recommendations included leaving more physical resources (e.g., cards or flyers) at client homes in the community, providing training on addiction science to all key partners, especially partners who do not specialize in addiction, and providing training on self-protection for outreach workers. Other participants shared they appreciate all CONNECT-related training, especially training that was straightforward, quick, and practice oriented. To further increase community buy-in, one participant recommended more community-based engagement, such as the outreach team visiting local high schools, another participant recommended disseminating community-specific reports on the positive work achieved by CONNECT, and two other participants suggested engaging first responder leadership around the region. Several participants also highlighted the importance of having more knowledge sharing and open communication regarding resources that different agencies offer, which can further aid the ability to offer services for clients.

Participants acknowledged that public safety officers are well trained to maintain safety of the community, however some CONNECT clients distrust police. Because of this relationship, several differing perspectives were shared regarding the role of public safety partners on outreach calls. Some participants shared that the use of police officers on outreach calls might prevent clients from further engaging with CONNECT due to their own past interactions with police. However, other participants felt it was important and essential to have plain-clothed police officers on outreach calls to ensure the safety of the outreach workers and because officers already have established rapport with individuals.

> Cops are communicators. I'm I'm, I'm sure if they're on the scene. You know family members or the person you know may engage them in a conversation and and you know, ask questions and whatnot so. So I'm sure other than security, we are helping. We are a part of the process. That's our main reason. And again, if we we may know this person much better than the team does. And you know, the officer may have a better chance of getting the person to come to the door or or or accept the services.

Aside from outreach calls, participants shared it was important for the key partners from differing sectors to maintain amiable relationships for the purpose of CONNECT's important goals:

> [Police] have their role in community health and safety. We have ours and it's important to work together collaboratively.

> We know each other and everyone knows, in a lot of ways, everyone else and a lot of people grew up together. And so you know, I think it is it is a matter, certainly from my end, and I would hope from my law enforcement colleagues end as well, that like this, is how we take care of each other... and thinking about how this is a smaller, more rural community like is this a dynamic that you think is specific to places like this.

Discussion

Populations underserved within CONNECT

Key partners involved in implementation have identified people of color as a population that CONNECT could be better engaging with. People of color tend to experience disparities in treatment access (i.e., decreased likelihood of MOUD referral, initiation, appropriate dosing); and disparities in treatment outcomes (i.e., lower treatment completion and increased repeated treatment attempts) compared to White counterparts (Entress, 2021; Faiz et al., 2022). Additionally, Black patients are less likely to receive OUD treatment and behavioral counseling in the hospital following an overdose (Faiz et al., 2022, Reddy et al., 2021). Increased diversity in the substance use disorder (SUD) workforce and health professions is detailed as an important factor in reducing interpersonal racism and dismantling structural racism (Faiz et al., 2022, Entress, 2021). Anti-racist and culturally competent practices, such as the recognition of implicit racial bases, reduction in racial microaggressions, and a non-color-blind approach, are necessary to successfully engage with and support people of color experiencing SUD. Implementation of these culturally competent practices requires training of the SUD workforce to understand and adopt an anti-racist framework for SUD treatment (Matsuzaka and Knapp, 2019).

People who are houseless or housing unstable were identified as a population CONNECT has difficulty initially contacting and maintaining contact with, thereby reducing the opportunity for those who are housing unstable to access resources. Previous interventions in emergency department settings have found that people who are housing unstable require tailored interventions to meet their needs (i.e., due to high rate of mental illness, vulnerability to injuries and assault), as compared to those who have stable housing (Sahli et al., 2018). People who are housing unstable and have a SUD also experience higher rates of stigma, compared to those without a SUD (Mejia-Lancheros et al., 2020), representing how this population may avoid interactions with institutions and systems where they had previous stigmatizing experiences. To better engage people who are housing unstable with health interventions, first their basic needs for shelter and food must be met, then, services must be offered in physically accessible, trauma-informed spaces (Omerov et al., 2020).

Children affected by parental overdose

A recurrent topic throughout the implementation of CONNECT has been the mechanism to provide support services for children who witness a family member's overdose. Children are affected by the stigma surrounding a parent's SUD or overdose, including fear of being removed from their home or being separated from their parents, making them less likely to seek support (Palumbo et al., 2022). The impact of parental SUD and overdose on children is a major one, with both acute (i.e., emotional and behavioral issues as a child) and long-term (i.e., later mental illness and SUD) effects (DiPirrio et al., 2017; Palumbo et al., 2022). These children may also experience other traumatic experiences, including poverty, domestic violence, sexual and emotional abuse, and forced separation from a parent (Palumbo et al., 2022), making it imperative to understand their specific needs and provide appropriate support services. When engaging with this population, it is essential to identify children at risk as early as possible, establish a supportive and destigmatized environment, and implement trauma-informed and

integrated services (i.e., caring for parents/caregivers and children in a single setting) (Brundage & Levine, 2019).

Stigma as a barrier

Key partners discussed community stigma and shame as barriers to healthcare access. They speculated that stigma was worse due to the rural nature of the region, which literature has supported (Ezell at al., 2021). Individuals in CONNECT's intended population have likely previously experienced stigma through public perception, acts of discrimination, and unfair or misguided structural regulations. Due to these repeated experiences of stigma, often individuals anticipate maltreatment in the future. This process leads to outcomes where individuals may be less likely to engage in medical systems (Tsai et al., 2019). Stigma is also prevalent in police overdose responses (Carroll et al., 2020). To address stigma, additional interventions that raise knowledge and normalize SUD treatment, and increase access to healthcare could be implemented. One intervention discussed by key partners that works toward this goal while also reducing the client burden of transportation is the use of a mobile health unit. Mobile health units provide resources, referrals, and general support for clients (Yu et al., 2017). Given the rurality of CONNECT, it is essential to provide a variety of services from the unit (including SUD-related and non-related resources) (Regis et al., 2020), advertise the unit with non-stigmatizing language and to the general public (Isler et al., 2012), and disseminate knowledge about the unit through word-of-mouth (Grieb et al., 2022) and use of a peer recovery coach (Marshall et al., 2015). Take altogether, use of these intervention elements have the potential to increase healthcare access for CONNECT clients.

Engaging partners

In program implementation, the nuances of rurality are often not considered. Participants in the current study shared that the reduced staff capacity of key partners, including first responders, posed as a barrier to implementing CONNECT. The workforce capacity of first responders in rural areas differs greatly from nonrural areas (i.e., hours of operation, staff per shift, funding), which must be considered when adapting an intervention such as CONNECT to a rural area (Hansen & Lory, 2020). In addition to these pre-existing challenges, COVID-19 prompted changes in organizational workflow have increased mental health issues and emotional exhaustion among first responders in rural areas (Roberts et al., 2021). In consideration of these barriers, some rural interventions have centered first responders as key leaders and developers of intervention components (Taylor et al., 2022), educated community members on the intervention prior to implementation, and obtained buy-in from well-regarded local government officials (Childs et al., 2021) to increase buy-in and engagement.

Limitations & strengths

Findings are based on a sample of 21 individuals who operate and interact with one post-overdose intervention in Western Massachusetts. Our study design is typical of qualitative research and intended to provide depth of information (Curtis et al., 2000; Creswell & Creswell, 2018). We did not collect data from clients who received intervention services which is an area for future research. As study strengths, we collected data from staff with different roles and responsibilities, representing many facets of experience within this multidisciplinary intervention.

Conclusions

CONNECT is an innovative program that collaborates with multidisciplinary partners to implement and operate one of the first known post-overdose interventions in a rural area. Key partners identified facilitators of program implementation and operation, including the ability to offer a variety of services to the intended population, and regular communication and a pre-

existing culture of collaboration among partners. Challenges also identified included complex data sharing concerns, community stigma, reduced partner bandwidth, and geographically inaccessible resources. To meet the unique and complex needs of the intended population, the CONNECT partners defined new mechanisms and expanded existing community resources.

Special Topic: Innovative role of community health workers and peer recovery coaches

By Taylor Parduhn, Amelia Bailey, Rithika Senthilkumar, Elizabeth Evans

During the focus groups, one salient perspective shared by several participants was the innovative nature of the CONNECT program to bring together a multidisciplinary team of partners and to deliver client-centered care throughout the care continuum. To further understand the specific roles involved with CONNECT, we highlight the role of community health workers and peer recovery coaches as a special topic.

Introduction

Individuals face several barriers when accessing opioid use disorder (OUD) treatment (Scott et. al. 2019). Both peer recovery coaches (PRC) and community health workers (CHW) build client-centered relationships with people with OUD to break down barriers and connect individuals with treatment and healthcare resources (Magidson et. al. 2021). Little research has compared the differences in role, training, qualifications, and supports, and effectiveness of the CHW and PRC in the treatment of OUD. CHW and PRC programs have been implemented around the United States, in rural and urban settings, and within a variety of settings such as primary care, emergency departments, and community-based care settings. There have been no empirically documented programs that included both PRCs and CHWs in an OUD treatment program. In this section, we describe the current context of PRC and CHW interventions, highlight relevant aspects of current program models, and draw inferences from the literature to the CONNECT program.

Definition of terms and usual roles

A CHW is a public health worker that is trusted and involved in the community that they are serving. Often, they have similar life experiences and sociodemographic characteristics to their client population (Hartzler et al., 2018). CHWs bridge health and social services through outreach, case management, social support, and advocacy (Stupplebeen et. al. 2019). To support their role and to support the client, CHWs are often embedded in a medical team (Hartzler et al., 2018).

A PRC, also known as a peer outreach worker or peer support worker, is someone with lived experience who is now in recovery, who works in outreach connecting people with OUD with resources for treatment and harm reduction and who provides essential mentorship and goal setting to empower people with OUD (Substance Abuse and Mental Health Services Administration, 2022b). PRCs often work independently of other medical systems. While a variety of program models exist, there is limited data on program effectiveness (Gormley et al., 2021).

Due to increased social isolation and barriers to access care during the COVID-19 pandemic, the CHW and PRC roles have been imperative to connect vulnerable individuals with services (Boyce & Katz, 2019; Kleinman, Johnson & Magidson, 2021). CHWs and PRCs can play complementary roles to reduce barriers to care. CHWs can provide preventive and treatment services and communicate public health concepts to their clients (Boyce & Katz, 2019), while PRCs can provide people with a social connection, support system, and routine schedule (Kleinman, Johnson & Magidson, 2021).

Qualifications and training

The educational requirements and training for CHW and PRC are often dependent on the employer. Across programs, CHWs must have a high school education or equivalency, while a

college education is often preferred (Osilla et. al. 2022). Although they are often working in conjunction with medical centers, CHWs are not required to have a medical degree or certification (Hartzler et al., 2018). A CHW typically has one population that they work with, for example some CHWs work with people with diabetes while others work with people with OUD. While working with people with OUD, CHWs must support clients with understanding of the complex and interwoven barriers that impact access to healthcare for their clients (Wolfe et al., 2021).

For PRC, qualifications and training differ greatly across programs and employers. Some PRCs are required to have a high school education or equivalent (Mass Gov, 2019) and some are required to have maintained their recovery for a specified period (i.e., two years) before training. In Massachusetts, many PRCs receive training from the Massachusetts Board of Substance Abuse Counselor Certification (MBSACC) which provides recovery coaches with training in ethics, boundaries, self-care, and interviewing and outreach tactics (Mass Gov, 2019).

Needs that impact roles

The formal PRC role is still relatively new to OUD treatment programs and how to best support this role is still being clarified (Magidson et al., 2021). Additional support for the PRC role, as identified in previous programs, includes adequate training and equipment; mental health support and care (i.e., supervision or direct contact with a certified mental health professional); compensation; networking with PRC and staff from other agencies (i.e., for the purpose of information sharing); formalized training resulting in certification; staff from other agencies to act as champions for PRC; and plans for program and job sustainability (Kleinman, Johnson & Magidson 2021; Staton, Watson, & Thorpe, 2021). Several of these needs were echoed by CONNECT focus group participants, including the need for compensation for PRC, and continuous training and information sharing between agencies for all partners.

In addition, the importance of initiating and maintaining interpersonal relationships with clients is essential for CHWs (Zapata et al., 2022). For CHW to be most effective, they must be empowered both personally (i.e., knowledge and training) and organizationally (i.e., equipped with available resources). Without both components, CHWs are not able to foster trust among their intended clients (John, Newtown-Lewis, & Srinivasan, 2019). CONNECT focus group participants shared fostering and maintaining trust among the client population is essential to program operation. To support their role, CHWs often meet regularly and discuss client cases with a team (i.e., physician, consultant, project supervisor), and utilize electronic medical record to comprehensively track cases (Osilla et. al. 2022). Previous program models illustrate the importance of employers providing CHWs with the proper personal and organizational support (i.e., training, knowledge, triage teams, physical resources) to be successful in building client trust.

Conclusion

CONNECT is integrating two innovative, client-centered positions in OUD care by utilizing both CHWs and PRCs within a post-overdose intervention. The roles of CHWs and PRCs are up to the program to determine, therefore, guidance from previous literature on the factors that impact roles, qualifications and training, and needs, can further clarify how to best support and integrate these roles. Future research directions should evaluate the effectiveness of this model in OUD treatment and determine the barrier and facilitators of this model from both the client and staff perspective.

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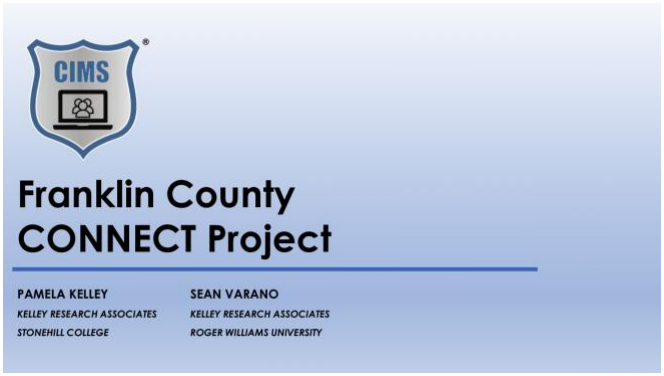
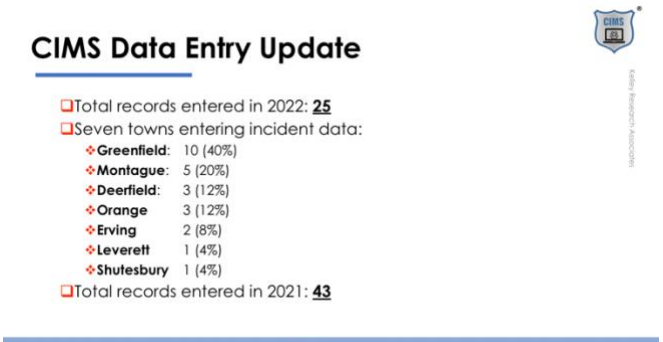
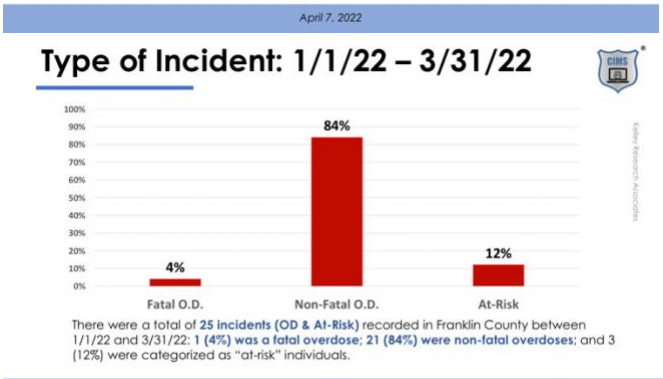
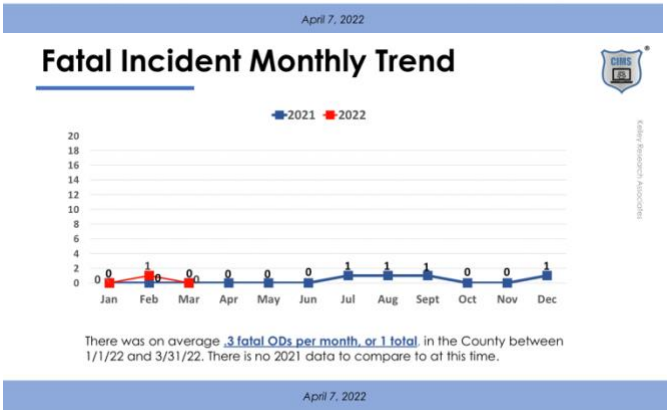
Appendix

Appendix A. Example of elements of a CIMS data report









Appendix B. Alternative pathway for children to be referred to CONNECT: Release of Information and Authorization and Intake Form

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Children and Families
www.mass.gov/dcf

RELEASE OF INFORMATION AND AUTHORIZATION

This will serve to notify the individual/agency named below that I grant permission for:

☐ The individual/agency named below to share and provide any and all information, including written documentation, to the Department of Children and Families regarding myself and/or my child(ren).

☐ The Department of Children and Families to share any and all information to the individual/agency named below regarding myself and/or my child(ren).

☐ Sharing of information as described below:

☐ The individual/agency named below to share the following information to DCF:

Children's Advocacy Center of Franklin County and the North Quabbin

56 Wisdom Way, Greenfield, MA 01301

☐ DCF to share the following information to the individual/agency named below:

Children's Advocacy Center of Franklin County and the North Quabbin

56 Wisdom Way, Greenfield, MA 01301

This authorization does not extend to any other individual/agency beyond the individual/agency named below.

This authorization will expire in 12 months from the date of signing or upon case closing, whichever occurs first, unless otherwise specified below: (Identify the date, time period or an event)

A copy/facsimile of this authorization shall be deemed as an original and shall have the same force and effect as such original.

Name of individual/agency authorized to receive/send information:

Name of Individual/Agency | Address | Telephone #

Name of Parent/Child(ren): _____

Signature of Parent/Guardian/Young Adult | Date

Revised: 7/2015

Children's Advocacy Center of Franklin County and North Quabbin, Inc. Intake Form for CONNECT

Intake Date:_____ **Referral Source:** _____
Treatment Start Date: _____ **Treatment End Date:**_____
Child's Name:_____ **DOB and age:**_____

Address:_____ **Town:**_____

Gender:_____ **Preferred Pronouns:**_____

Who has custody of the child?_____

Parent/Guardian First and Last Name:_____

Phone:_____ **Is it safe to- text : call : leave a message**

Email:_____

Person who experienced overdose occurrence:_____

Relationship of person who experienced overdose occurrence to child:_____

Child Race:

- Caucasian/White
- African American
- Asian
- Hispanic/Latino Hawaiian
- Pacific Islander
- Other

Child Ethnicity:

Special Classification:

- Deaf
- Blind
- Physical Disability
- LGBTQIA2+
- Cognitive Disability
- Limited English
- Mental Health Diagnosis
- Other

Emergency Contact:_____ **Phone:**_____
Relationship to Child:_____

Other Household Members

Name	DOB/Age	Relationship	Notes

Appendix C. Prompts for focus groups and individual interviews

Introductions and Icebreaker

1. Please briefly describe your role on CONNECT.

2. How did you become involved in CONNECT?
    a. What were your initial thoughts when you heard about CONNECT?

Target Population

3. Can you describe the CONNECT participants? What are some typical characteristics or experiences?

4. Who is being well-served by CONNECT? Why?
5. Who could be better served by CONNECT? Why?
    a. How do characteristics of the target population impact their use of services?
    b. How do factors within the Franklin-North Quabbin region impact participant use of services?
6. How do you help the target population to engage with services initially? How do you help them to stay engaged with services?

Project Development and Implementation

7. What has been useful for implementing CONNECT? Why?
    a. Any tools, trainings, protocols, prior knowledge or skills?

8. How would you describe the collaboration between community partners?
    a. What are factors that make it easy for you to collaborate with each other (with people working in other agencies and institutions)?
    b. What makes collaboration challenging?
9. How does the target population perceive you or CONNECT? How would you describe the relationship between people receiving these services and the CONNECT team?

Looking Forward

10. How has project implementation been so far?
    a. What are aspects of the project you hope will continue?
    b. What aspects of the project would you like to see changed?

11. What do you need to continue your role on CONNECT?

12. Any other things to share about CONNECT?

Appendix D. Summary of seminars on commercial sexual exploitation (CSE)

Overview

The Franklin County Sheriff's Office (FCSO), in collaboration with the Opioid Task Force (OTF) of Franklin County and the North Quabbin region, invited Abigail Judge, PhD to provide education and training on trauma-informed healthcare. Dr. Judge works as a clinical and forensic child psychologist at Massachusetts General Hospital and in private practice. She has expertise in outreach and treatment of women with histories of trauma including, in particular, commercial sexual exploitation (CSE). Dr. Judge gave a four-part seminar series via zoom in June 2022, titled "Clinical work with survivors of commercial sexual exploitation." Each seminar was attended by 60-80 individuals, including staff at FCSO and OTF and also staff in community-based health and social services organizations, the carceral-legal-justice system, advocacy group, and other institutions. Each seminar was structured to introduce terminology, core concepts, and guidelines in relation to trauma and CSE, share insights derived from firsthand outreach and treatment experiences, point to key resources for further study, and answer attendee questions. In this section, we provide a brief summary of the key lessons that were conveyed during the seminar. This information will serve as a foundation for assessing how and the extent to which FCSO designs and implements programming to address the needs of people with CSE and other trauma histories in the upcoming years.

Knowledge on how to treat people with CSE histories is limited

An important caveat to recognize is that there are few empirically-based best practices for conducting screening, assessment, and treatment of people with CSE histories. Scientific studies of trauma have largely focused on post-traumatic stress disorder (PTSD), particularly among military combat veterans. Some research has focused on human trafficking, but it has mostly sought to raise awareness of the issue, with less attention to the development of methods for treating survivors. An established gap in knowledge is that the field lacks a validated screening tool for CSE and other trauma.

It is also important to recognize that historically treatment of CSE has been unhelpful and even harmful, leading some patients to leave care and return to a cycle of re-exploitation. A challenge is that professional training and conventional psychotherapy practices have not been designed to meet the needs of people with CSE. People with trauma are often seen as being "difficult" patients. And usual treatment often enacts power dynamics that can make it hard for this population to engage with treatment. Because of this context, care providers often need to adapt therapeutic practices based on their lived experiences of engaging with this population. Also, it is critical to recognize the unique relational stance of providers when working with individuals with CSE. Providers should aim to gain patient trust and develop a therapeutic relationship by using effective and ethical techniques, which is the standard of care for all populations. Unique to the CSE population, however, clinicians also need to be "radically transparent" with patients, within therapeutic bounds, and also navigate the role of the exploiter's influence on the therapeutic relationship and especially so when the exploiter is still involved in the patient's life. A core aspect of therapeutic presence is the extent to which clinicians can establish emotional safety with interacting with a person with CSE histories.

Language matters

Language is a key factor to consider when working with individuals with CSE histories. There is a need for better common language when talking about CSE, not only so that patients, care providers, and others can understand each other, but also to avoid stigmatizing and retraumatizing patients. Power dynamics are an important concept to consider when treating

individuals with CSE. These patients often have been disempowered and trapped in an unbalanced power dynamic. Thus, when aspects of their relationship with healthcare providers perpetuate differential power dynamics, it can trigger negative thoughts or disengagement with care. The power dynamic in a clinician's relationship with patients begins with naming and language. . The power dynamic in a clinician's relationship with patients begins with naming and language.

CSE is a complex concept that exists on a continuum and is inclusive of a constellation of experiences. CSE encompasses sex trafficking, sex work, prostitution, survival/transactional sex, and CSE of children and youth. These are interrelated and not separate phenomena. Also, the definition of each of these terms is fluid and the terms have different meanings in different contexts. For example, the term "sex work" is often only used in academic settings and may be unwelcome in this population. Further, "prostitute" carries a demeaning connotation and should be replaced with person-first language such as "women in prostitution" or "prostituted women." The term "trafficking" has meanings in a legal context, but it is seldom used among individuals with CSE histories. Also, although someone may be exploited, there is not always a person actively exploiting them, as they may be engaging in prostitution as a means of survival. A core principle is that language must be chosen with care when serving this population.

Treatment settings

The setting in which clinicians meet with individuals with CSE histories dictates many aspects of their care. Again, *power dynamics* come into play. With any provider-patient relationship there is a power differential in which the patient shares much more information about themselves and the provider often has more knowledge and resources to draw on for decision making. This uneven power dynamic can be furthered in settings such as jails where patients have limited autonomy by design. If individuals with CSE histories feel powerless in their own care, they may shut down making that care ineffective. To prevent or counteract this dynamic, it is critical that providers *build relationships and garner the trust* of their patients. For example, it may be beneficial to allow patients to decide what is shared with providers and when, without rushing to diagnose the patient's condition or label them in other ways. Also, it is helpful if clinicians are calm and grounded, and then work with patients to find ways that work for that person to feel safe.

Setting also dictates how *safe* patients feel when seeking healthcare. For example, if patients are being treated in an incarcerated setting, they may be concerned that others will be aware of the care they are receiving and use that to exploit them in the future. Also, setting affects how much *time* a clinician can spend with the patient. Because progress in the therapeutic process can be slow, it is crucial to offer *different ways for patients to engage* with care. For example, Dr. Judge works in both a walk-in setting as well as having regularly scheduled therapy sessions. In the walk-in setting, the focus is on building trust so that the individual will continue to engage in care. Providers in the walk-in may only see a patient one time and never again. Thus, it is important to make this interaction of value to the patient, no matter the length of the interaction. Regularly scheduled meetings are usually longer and allow for more trust building and in-depth work. A challenge of regularly scheduled therapy sessions, however, is that this method is often too "high-barrier" to be sustained by individuals with CSE histories, especially in the early stages of treatment. Notably, incarcerated settings have aspects of both: incarcerated patients live near healthcare and have access to regular care while incarcerated but may access the healthcare may also be lost suddenly upon release.

Risk factors

Individuals with CSE histories have a much higher mortality rate than the general population.

This adverse health outcome is associated with several risk factors that are more prevalent in this population. Trauma - whether physical, sexual, or emotional - mostly begins early in life for individuals with CSE histories. *Childhood trauma* increases the risk of future trauma experiences, leading to a cycle of traumatization throughout the life course. Individuals with childhood trauma histories develop low self-worth, low self-efficacy, lack of trust in others, hypervigilance, and other symptoms. A common coping mechanism in this population is dissociation from their identity and/or body.

Substance use is also prevalent among people with CSE histories. Substance use can be used as a coping mechanism to "numb" the pain of trauma. And, among some women who use substances, particularly those with a substance use disorder (SUD) who are involved with the justice system, transactional sex is common. While the sex trade that surrounds the drug trade is relatively well-researched and policed, it is highly dangerous. Additionally, it is often omitted from media coverage on the opioid overdose epidemic. Thus it may not be commonly understood that SUD enables a cycle in which a person with CSE experiences uses substances to cope with trauma while the person who controls access to those substances is then able to further exploit the individual with CSE experiences. Access to medications to treat opioid use disorder (MOUD) can also be used to control and exploit individuals with CSE histories. When CSE and SUD are both present in an individual, they interact with compounding negative effects, and unfortunately there are few programs designed to target and treat this intersection.

Although, pimp control is less common among *LGBTQ individuals*, this group does have a disproportionate risk for CSE and sex trafficking. LGBTQ individuals often lack support systems due to familial rejection and general discrimination, which when tied with less opportunity for gainful employment, can lead to homelessness and survival sex. There are very few tailored services available to this subpopulation. For example, in shelters, when seeking care, or within incarcerated settings, people are often binarized by sex which may not line up with someone's identity. In these settings, LGBTQ individuals may feel unsafe and be at genuine risk of violence. There is a dire need for more holistic services, especially augmenting access to mental health care for this population.

A final subpopulation of interest is *incarcerated* individuals. Many aspects of CSE may lead to incarceration. There are high rates of sex exchange among incarcerated women. It can be difficult to develop trauma-informed relationships with this subpopulation, as the entire nature of incarceration is coercive. Also, correctional staff may act as buyers, exploiting their power over incarcerated individuals. Additionally, staff may be misinformed about CSE and attach stigma to individuals with CSE histories. It may appear that victims of CSE are safer while incarcerated, but this is often far from the truth. Individuals with CSE histories may be incarcerated along with victimizers or others who enact violence against them. Further, being incarcerated can make it easier for traffickers to locate victims; they might contact them during incarceration and add money to their commissary account with the goal of exploitation. When treating these individuals within correctional settings, there is a heightened need to emphasize safety and privacy, while working to minimize power imbalances.

Treatment models and practices

Multiple *theoretical models* have been used to aid understanding of how best to treat individuals with CSE histories. Of note is "phase based trauma treatment," a three-step process developed by Judy Herman. This model emphasizes the need to recognize the rungs of oppression that have led to CSE. The model is also very present-oriented, and not an excavation of the past, in recognition that exorcizing trauma does not help people to heal. The first phase in this model, known as SAFER, is focused on "self-care, safety, and stabilization," during which the provider-

patient relationship is built, skills for managing symptoms are taught, and safety planning is done. It is useful to have patients complete an acknowledgement exercise to talk about the past in a present-oriented framework. This phase may also contain treatment for SUD. Quite often, the first phase will be the only one that patients complete. The next phase is processing traumatic memory. This stage may be marked by patients connecting with other survivors, engagement with people who are not involved in CSE, or other experiences that support the goal of not feeling worse after having experienced treatment. This is followed by the third and final phase, social reconnection and moving on.

Another model is known as the “window of tolerance model.” People with PTSD or complex PTSD (cPTSD) are more prone to states of hyper-arousal and hypo-arousal. In this model, the state in between these two extremes is termed the window of tolerance, and it is the state in which victims of trauma can feel and think simultaneously. When treating these individuals, it is important that clinicians help patients to find and regulate this window of tolerance.

A third theoretical model is the “stages of change" framework, which is relevant to both CSE and SUD. This five-step model details the process of making a serious life change away from dangerous behaviors.

From her experiences, Dr. Judge shared many *strategies and practices* which she has found useful for providing effective care to this population. A theme throughout the entire seminar series was that interventions need to be individualized. It is not helpful to run through frameworks like a checklist. Instead, the provider must learn from and adapt care to each individual. Another important strategy is minimizing barriers to care when working with survivors of CSE. Providing access to low-barrier treatment can make a world of difference for people who have generally been forgotten by healthcare systems. This approach emphasizes engagement and harm reduction with no expectation of abstinence, identification as a victim, or readiness to exit CSE situations. Micro-counseling is a useful strategy during this phase. As mentioned above, building trust is another essential part of working with individuals suffering from trauma. This can take a long time, but with the use of appropriate and consistent language and actions, a relationship of trust can be achieved. While setting reasonable boundaries, a care provider can serve as a stable figure in the lives of those who tend to lack stable relationships. Furthermore, it is integral to establish a network of trusted individuals who are trauma informed, so that you may refer individuals with trauma to other forms of care. By doing this, the provider helps individuals feel more comfortable seeking care and introduces them to more professionals they can trust. Dr. Judge has found that simple things such as having conversations side by side (for example, by walking and talking together) so as not to force eye contact have been helpful in making patients feel more comfortable.

Another key practice is safety planning, which is assessing current risks of harm and how to navigate away from them. Judge emphasized the need to be curious rather than controlling when discussing a patient’s exploiter, who may still be a huge part of their daily life, come up. It is unhelpful to try and force individuals to leave situations and it is better to work on understanding their situation so you may provide them with the tools to make their own decisions.

Finally, Dr. Judge spoke on how providers can avoid compassion fatigue and other potential harms. Because of the nature of this work, it can be emotionally taxing for care providers. Dr. Judge has found that changing one’s definition of a good outcome is helpful. Since progress can be slow and setbacks can be frequent, a shift in outlook is necessary. For example, someone just coming back for a second visit can be a huge step forward. Clinicians are encouraged to

celebrate when patients seek safety in unsafe situations or show any sign of burgeoning autonomy no matter how small it may seem. Also, providers can become hyper vigilant which can be addressed by ensuring there are spaces to disengage with the work. Finally, Dr. Judge shared strategies for clinicians to be safe while working with this population, including consultation with expert advisors, use of an alert bracelet, doing street outreach in pairs, working in neighborhoods that are different from one's residence, and other techniques for safe practices.

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