SUD Community Planning Process
Final Recommendations: Content Outline

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Part I:
Planning Process Overview

BACKGROUND

Purpose

This introduction provides brief background information on how this community planning process came about, and why having a planning structure for Substance Use Disorders (SUD) matters for our community.

Definitions: What is Substance Use Disorder (SUD)?

Behavioral Health encompasses both mental health and substance use and includes a spectrum from those with a diagnosis to those who are experiencing mental health or substance use challenges that do not meet the criteria for a clinical diagnosis.

Substance Use Disorders occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.

Substance Use Disorder (SUD) has impacts in cross-cutting areas, including but not limited to criminal justice, public health, employment, homelessness and child welfare, and the research shows that SUDs disproportionately impact people of color due to the ways systemic racism negatively impacts social determinants of health and prevents equitable services and treatment. Because SUDs are interconnected to so many other social service issues, in order to make improvements in these areas, we must take a holistic approach and have an effective community response to SUDs as an underlying issue.

History: How did we get here? Why a planning structure for SUD?

Our community has a long history with assessment and community planning efforts in SUD, including:

- 2001 CAN Community Assessment of Community Health
- 2015 Travis County Plan for Substance Use Disorders
- 2019 Alcohol, Tobacco and Other Drugs (ATOD) Needs Assessment

What all of these efforts had in common was **a clear recommendation for a shared planning structure,** i.e. an agreed-upon shared "table" where planning for Substance Use Disorders could happen in a coordinated, holistic, and effective way, including**:** Creating and stewarding an SUD community plan; better serving residents through that plan's coordination of and investments in an equitable and accessible continuum of services and supports; positioning the community to leverage more resources and collaborate effectively; and guiding future decision-making for local authorities around SUD-related issues and investment.

However, the community has been unable to agree on that shared planning structure – what it should look like and who should convene it. Without that shared planning structure, the community has not been able to garner broad community support and buy-in for its existing plans or implement strategies in a coordinated and comprehensive manner.

In 2018-2019, former County Judge Sarah Eckhardt started conversations to explore coordinating SUD services and supports through a Local Behavioral Health Authority (LBHA) designation for Integral Care. Mixed community response prompted former Judge Eckhardt to task Travis County Health and Human Services (HHS)

with leading a more inclusive community planning process to make recommendations around a future SUD planning structure.

How was this process different?

The goal of Travis County HHS's facilitated community process was: **To make recommendations for the future SUD planning structure.** (The goal was *not* to create or implement an SUD Plan, as that work would be the purview of that future planning structure.)

The vision for its ideal outcome was: **The realization of an SUD planning structure that reflects our shared agreements around: Values, an SUD continuum, the scope and use of its community plan, its structure, roles and functions, community participation, and its convening entity.**

Travis County HHS approached this task as a "Planning to Plan" effort and set out to accomplish it in a way unlike past attempts. To do this well, staff aimed to involve a wide range of stakeholders as direct participants, have those participants generate the recommendations themselves through a thoughtful facilitated process, and engage decision-makers and elected officials along the way. Key features of this approach were:

- Inclusive: Making efforts to include and inform all relevant and interested stakeholders and build broad community support and involvement.
- Comprehensive: Using a process-oriented approach to thoroughly cover all the necessary components, in the right order, to design an effective planning structure that will work for our community.
- Collaborative: A skillfully facilitated group process rooted in interest-based problem-solving principles.

This process also invested in skilled, professional equity consultation from Quantum Possibilities, LLC.

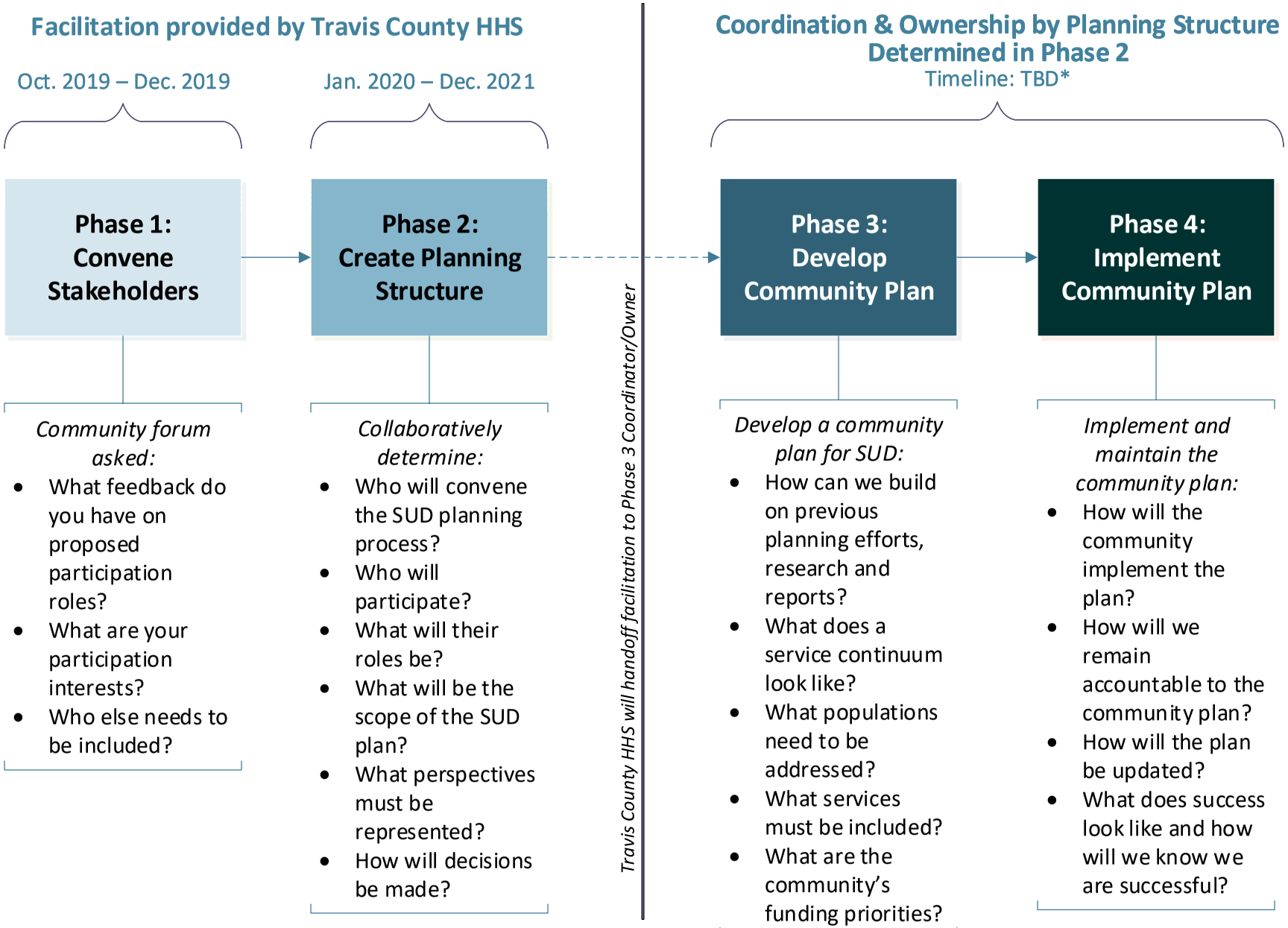
Who, what, when, how?

After some pre-work in late 2019, this community process kicked off in earnest in January 2020. It concluded in December 2021. The vast majority of the work was done virtually due to the COVID-19 pandemic.

- A Workgroup accomplished the bulk of the core work during monthly meetings, with a typical attendance of 12-16 people, with some additional ad-hoc small group and individual work.
- A Leadership Review Group of approximately 25-30 people were invited to meet every two to three months, with electronic review options.
- An Informed and Interested stakeholder list, including almost 400 unique individuals, was kept informed with regular email updates every three to four months.
- Travis County HHS staff provided all facilitation and project management.

This document compiles all the results of the community process in one final collection. It also includes detailed supporting summaries of the planning process, participation, facilitation, equity consultation, and public comment results.

Phases of Substance Use Disorder Community Planning



Future timeline projections are dependent on Approval Authority action and how the future SUD Planning Structure is implemented.

SUD Community Planning: Workplan Visualization

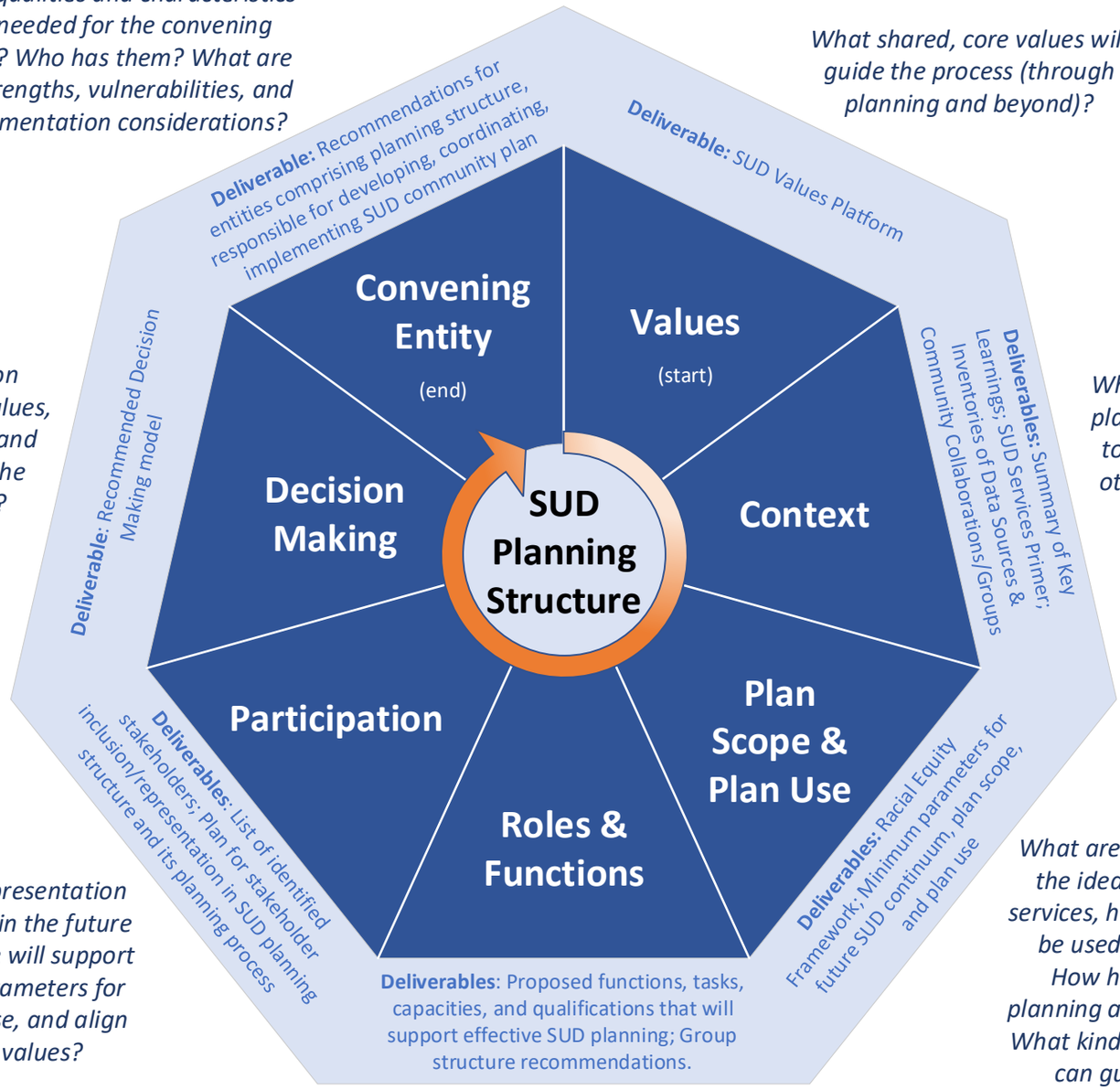
Updated 12/10/2021

What qualities and characteristics are needed for the convening entity? Who has them? What are the strengths, vulnerabilities, and implementation considerations?

What shared, core values will guide the process (through planning and beyond)?

How can future decision making align with SUD values, support identified roles and functions, and enable the desired participation?

What key learnings from past planning efforts can we apply to our work? What relevant other groups/collaborations exist?



What kinds of representation and participation in the future planning structure will support the minimum parameters for plan scope and use, and align with the SUD values?

What are minimum parameters for: the ideal continuum of local SUD services, how the future SUD plan will be used, and who it will impact? How has racism has impacted planning and service delivery to date? What kind of racial equity framework can guide and support equity accountability?

What capacities, skills, & qualifications are needed to create the SUD plan? What kind of leadership, governance, facilitation, organizational support, etc. is needed?

COMPREHENSIVE WORKPLAN: SUD COMMUNITY PLANNING PROCESS

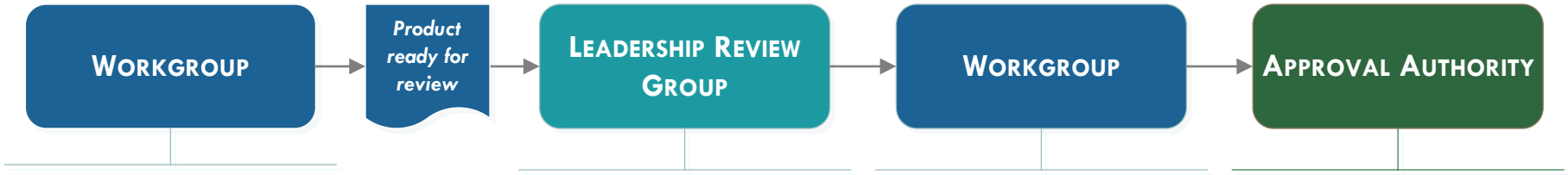
This working document was updated iteratively throughout the planning process, particularly as the pandemic impacted timelines and workflow. The workplan below represents the actual work completed.

Topic	Questions to Answer	Key Tasks	Products or Deliverables	Workgroup Timeline
0. Chartering and Workplan Development *How do we want to work together? What work do we need to accomplish?*	• What agreements do group members want to make to each other about how you will work together? • What work do we need to accomplish that will result in recommendations for a future SUD planning structure?	• Develop Group Charter for Workgroup • Develop Group Charter for Leadership Review Group • Jointly design and develop Workgroup Workplan to identify the necessary steps to complete this phase of work to develop recommendations for a future SUD planning structure	• Workgroup Charter • Leadership Review Group Charter • Workgroup Workplan	2 full group sessions (in person): Jan 2020 and Mar 2020 Small group work: Jun 2020
1. Values *What are our values?*	• What values are shared in the SUD community? • What values will guide the SUD planning process?	• Explore and identify a set of values, and definitions if needed, that can guide the work and serve as criteria for future decision-making • Travis County staff explore consultation and training for participants on anti-racism/race-equity framework	• Values platform for SUD community planning	2 full group sessions: Jul 2020 and Sep 2020 Small group work: Jul 2020
2. Context *What do we already know from past efforts, and what is happening now, that is relevant to our task to make recommendations around a future planning structure?*	• What SUD community plans already exist? • What key learnings from prior planning efforts can we apply to our work to define roles, functions, and participation for the SUD planning structure? • What other current planning efforts/collaborations may overlap with SUD services and populations? • What is the taxonomy of SUD services in Austin/Travis County? • What are the funding structures for SUD services in Austin/Travis County, and how do they impact access to care?	• Summarize key recommendations/learnings from past SUD community plans and planning efforts as they relate to the roles, functions, and participation of the future planning structure • Inventory current planning efforts/collaborations • Identify sources for relevant community conditions and data that the future planning structure should use/consider • Key informant presentations/report outs regarding prior efforts on the above • Define local SUD services and their funding landscape	• Inventory or repository of relevant data, planning efforts, etc. and associated informal analysis that can inform this planning-to-plan work • Primer on SUD services • Document illustrating funding structures for SUD services	2 full group sessions: Aug 2020 and Feb 2021 Small group work: Jan-Apr 2021

Topic	Questions to Answer	Key Tasks	Products or Deliverables	Workgroup Timeline
3. Plan Scope and Use *What will be the scope of the SUD plan that the future planning structure will create and implement?*	• What minimum specifications (i.e. components, requirements, elements, etc.) does the Workgroup want to identify for the ideal continuum of local SUD services? • What minimum specifications (i.e. components, requirements, elements, etc.) does the Workgroup want to identify for how the future SUD plan will be used and who it will impact? • How can we apply a racial equity framework to our planning?	• Consider and evaluate current models and frameworks; identify desired elements/components • Consider, evaluate, and identify a desired range of plan uses (such as: funding, service access, advocacy, collaboration/ partnership, education and awareness, and other functional uses) • Identify ways that racism has impacted problem definition, intervention planning and service delivery to date • Develop a racial equity framework to be applied to systems delivering services and coordinated response	• A document that summarizes the Workgroup's minimum parameters for the future SUD continuum, plan scope, and plan uses • A racial equity framework document that can be used as a guide to support equity accountability	3 full group sessions: Oct 2020, Feb 2021, and Apr 2021 Small group work: Jan-Mar 2021
4. Roles and Functions *What roles must be included in the SUD planning structure? What functions must be performed?*	• What kind of leadership, governance, facilitation, and organizational support is needed? • What other functions are needed to support the scope and use of the plan and meet the SUD values? • What capacities, skills, etc. are needed for all functions? • What does it mean to be the convening entity? • What communities need to be represented in leadership? • What kind of group structure would support the identified functions?	• Identify all functions and tasks needed in the SUD planning structure • Define the capacities, skills, and qualifications of key functions, including convening entity • Explore philosophy/orientation around different models for structure and how they align with the SUD values and other decisions made thus far	• List of proposed functions and tasks, including necessary capacities, skills, and qualifications, that will support effective SUD planning • Group agreement on a big picture approach to structure and/or a scenario planning/ contingency planning deliverable • Commitment to racial diversity in leadership of future planning structure	2 full group sessions: Apr-May 2021 Small group work: Feb-Mar 2021
5. Participation *Who will participate in the SUD planning structure? Whose voices must be represented?*	• What kinds of engagement, representation, and participation in the future planning structure, including from individuals across the spectrum of lived experience, will align with the SUD values? • What kinds of engagement, representation, and participation will support the minimum	• Identify all stakeholders or groups that must be included and/or represented in the SUD planning structure; crosswalk to previous continuums if appropriate • Define what is needed at a minimum from the community in order to support all of the previous decisions • Define what constitutes quality and meaningful participation	• List of identified stakeholders • Proposed participation plan for stakeholder involvement, inclusion, or representation in SUD planning structure and its planning process • Commitment to racial diversity in stakeholders and participants	1 full group session: Jun 2021 Small group work: Apr 2021

Topic	Questions to Answer	Key Tasks	Products or Deliverables	Workgroup Timeline
	parameters for the plan's intended scope and use? • What are the implications of earlier scan for "Dimensions of Diversity" and any subsequent equity discussions on the make of/participation in the future planning structure? • What is ideal? What is meaningful? What is appropriate? What is possible?	• Define the range of methods of participation • Decide what's appropriate and possible for each group and that supports the plan		
6. Decision Making *How will decisions be made in the SUD planning structure?*	• How can the future planning structure make decisions in a way that: aligns with the SUD values, supports identified roles and functions, and enables the desired participation?	• Explore power, authority, and participation in decision-making • Identify the desired qualities and features of good decision making for the future SUD planning structure • Identify how future planning structure will ensure that directly impacted people have decision making power	• Document that captures recommendations on decision-making	1 full group session: Jul 2021 Small group work: Jun 2021
7. Convening Entity *What entity will convene the SUD planning process?*	• What qualities and characteristics are needed for the convening entity? • Who has these qualities and characteristics to serve as the convening entity? • Who will the group recommend as the convening entity (or as options for convening entities) of the SUD planning process?	• Use all prior work/deliverables to evaluate options for the convening entity and other key positions • Identify recommended convening entity/entities for the SUD planning process	• Recommendation for the entity/entities (or options for convening entities) that will convene the SUD planning structure	3 full group sessions: Aug-Sep 2021
8. Close-Out	• What were the strengths and challenges of the facilitated planning process? • What are the next steps to transition to creating and implementing an SUD planning structure?	• Review and finalize all results, deliverables, and recommendations • Review and finalize process documentation • Evaluate the facilitated planning process (participant survey) • Identify next steps in transition work	• Final results and process documentation • HHS staff commitment to post/publicly share final results	1 full group session: Oct 2021 Staff follow-up work: Nov 2021 to Jan 2022

Workflow for SUD Community Planning Phase 2: Create Planning Structure



- Engage in collaborative problem solving
- Explore options and develop recommendations for the SUD planning structure
- Document decisions
- Generate draft deliverables

- Thoughtfully consider results and recommendations
- Apply "big picture" perspective as leader
- Provide substantive review and feedback to the Workgroup

- Consider all feedback
- Incorporate revisions as appropriate
- Document decisions
- Finalize deliverables

- Comprised of three taxing authorities: Travis County, City of Austin, Central Health
- Receive regular updates from Travis County staff
- Receive final results/ recommendations and take appropriate action

Part II:
Deliverables

SUD Workgroup Identity Statement: Purpose, Vision, Values

Summary of Purpose and Contents

The purpose of the Values phase was to:

- Explore and identify a set of shared values, and definitions if needed, to guide the SUD community planning process, and
- Explore training for participants on anti-racism and racial equity.[1]

The SUD Workgroup completed this work by:

- Brainstorming an expansive list of members' most important and authentic core beliefs about this work,
- Aggregating similar, interconnected, and high-frequency ideas together into broad shared values,
- Refining definitions among a small ad-hoc subset of Workgroup members, and
- Reviewing and finalizing the Purpose, Vision, and Values as a full Workgroup.

This document serves as a "values platform" to guide not only the "planning to plan" work to create an SUD Planning Structure, but also the future creation and implementation an SUD plan.

SUD Workgroup Identity Statement: Purpose, Vision, Values

Purpose of Workgroup

To make recommendations for an SUD planning structure.

Vision of Workgroup

The realization of an SUD planning structure that reflects our shared agreements around: values, plan scope and use, roles and functions, participation, and convening entity.

SUD Values

The SUD Workgroup is guided by the following values:

- **Equity:** Acknowledge that there are historically erased and systematically oppressed populations, and that fairness regarding these unbalanced conditions is necessary to offer equal opportunity for all[2]
- **Inclusion:** Commit to an ongoing collaborative process working alongside with those who are most impacted by service access barriers and those who are impacted by substance use disorders and welcoming them into the planning and decision-making processes

[1] This goal was added to the Workplan in summer 2020 in direct response to participant feedback. Travis County HHS staff researched and identified a consultant for racial equity training, and offered training to the SUD Workgroup members in 2020. HHS offered to fully subsidize and prioritize Workgroup member spots. Workgroup members were supportive of the intent but unable to commit to logistics, so this training did not move forward. However Travis County HHS did purchase consultation on equity/anti-racism for staff facilitators.

[2] Adapted from *AWAKE to WOKE to WORK: Building a Race Equity Culture, Equity in the Center*, https://www.equityinthecenter.org/wp-content/uploads/2019/04/Equity-in-Center-Awake-Woke-Work-2019-final-1.pdf.

- **An Informed Approach:** Recognize the value of diverse thinking that is both evidence-based and multiculturally driven to create space for innovation
- **Communication:** Provide a forum for open and honest communication, safety of thought, and cultivating and valuing diversity of opinions
- **Transparency:** Commit to a full and transparent process with accountability for decision-making and service delivery
- **Accessibility:** Remove barriers to accessing services for marginalized members of the community
- **Person-Centered Process:** Foster a process that values the ability of an individual to receive the type of service specific to their needs
- **Advocacy:** Accept substance use disorders as a major public health issue in order to end stigma and better understand them as treatable chronic illnesses
- **Commitment to the Process:** Commit to work for the best interests of the community, stay engaged in the process, and act with integrity, trust, compassion, and empathy
- **Comprehensive Continuum:** Provide accessible and high-quality services and supports, so that individuals can improve their quality of life
- **Resourcing What Matters:** This work deserves to be valued in every sense of the word. Resources are needed to embody these values.

Data Source and Planning Group Inventories

Summary of Purpose and Contents

The purpose of the Context phase was to:

- Summarize key recommendations/learnings from past SUD community plans and planning efforts as they relate to the roles, functions, and participation of the future SUD Planning Structure,*
- Inventory current planning efforts/collaborations that may overlap with SUD services and populations,
- Identify sources for relevant community conditions and data that the future SUD Planning Structure should use/consider, and
- Define local SUD services and their funding landscape.*

The SUD Workgroup completed this work by:

- Identifying sources for relevant community conditions and data that the future SUD Planning Structure should use or consider, and
- Identifying current local/regional planning efforts and collaborations that may overlap with/relate to SUD services and populations.

These inventories were current at the time of writing (August 2020) and likely do not reflect all relevant data sources and planning efforts/collaborations.

Data Source Inventory

Data Source Name	Brief Description	Website
County Health Rankings, a Robert Wood Johnson Foundation program	Collects data by county from public data sources and ranks the health of counties. Specific measures include drug overdose mortality rate per 100,000, percent who report excessive drinking, and alcohol-impaired driving deaths	https://www.countyhealthrankings.org/
CDC WONDER Database	Drug overdose deaths by county and state in number and as a mortality rate	https://wonder.cdc.gov/
Behavioral Risk Factor Surveillance System (BRFSS), CDC, TX HHS	Survey data of adults, including binge drinking, heavy drinking, drug use, mental health, etc.	https://www.cdc.gov/brfss/ https://dshs.texas.gov/chs/brfss/
Youth Risk Behavior Survey (YRBS), CDC and TX HHS	Drug use, alcohol use, attitudes about drugs. Note: Data is not available at the county level. This is the youth version of the BRFSS done every two years	https://dshs.texas.gov/chs/yrbs/default.shtm

* Addressed in another deliverable

Data Source Name	Brief Description	Website
Texas Health Data, TX HHS	Under category of Drugs & Alcohol: poison center calls, emergency department visits, substance use deaths, Texas Prescription Monitoring Program Data, and Texas School Survey of Drugs and Alcohol Use	http://healthdata.dshs.texas.gov/search?query=county%20data#
2018-2019 Austin ISD Substance Use and Safety Survey	Drug and alcohol use among students	https://www.austinisd.org/dre/surveys/2018-2019/2018-2019-student-substance-use-and-school-safety-survey
Austin Police Department Traffic Fatality Report, February 19, 2019	62% of the 73 fatal traffic collisions in Austin in 2018 involved a driver, pedestrian or bicyclist suspected of drug or alcohol impairment	https://data.austintexas.gov/Public-Safety/2018-APD-Traffic-Fatality-Data-021219/9jd4-zjmx
Vancouver Area Network of Drug Users	Guidance for engaging people affected by policy	https://pacificaidsnetwork.org/files/2016/05/VANDU-Manifesto-Drug-User-Liberation-Movement.doc.pdf https://vandureplace.wordpress.com/
2015 Travis County Plan for Substance Use Disorder	Former SUD community plan, September 2015	https://integralcare.org/wp-content/uploads/2017/09/150901_sud_report_6.pdf
Austin/Travis County Alcohol, Tobacco, and Other Drugs Needs Assessment, October 2019	Needs assessment based on survey data from local Alcohol, Tobacco, and Other Drugs (ATOD) service providers	https://soberingcenter.org/wp-content/uploads/2019/10/Austin-Travis-County-ATOD-Needs-Assessment-Report.pdf

Planning Group Inventory

Planning Effort / Collaboration Name	Brief Description	Website
Travis County Youth Substance Abuse Prevention Coalition (currently in process of combining efforts with Kids Living Well)	The two groups are working together to incorporate substance use issues and concerns into the 2021 Update of the Travis County Plan for Children's Mental Health and Substance Misuse	https://www.tcysapc.org/ https://kidslivingwell.org/
Austin ROSC (Recovery Oriented System of Care)	Mission: We unite the Greater Austin Area through collaboration, outreach, education and advocacy to support sustainable person-centered recovery from mental health and substance use disorders.	https://www.austinrosc.com/home
Austin Area Opioid Workgroup	The Opioid Work Group's mission will be to bring together the recovery community to identify gaps in service, best practices, needed and existing resources, and whatever else the group sees fit to assist the population that has history or presently suffers from opioid dependency. This group will welcome and include those that work with Medically Assisted Recovery Services as well as the Harm Reduction community.	https://soberaustin.com/event/austin-area-opioid-workgroup/

Planning Effort / Collaboration Name	Brief Description	Website
Bluebonnet Trails OSAR (Outreach, Screening, Assessment and Referral)	Bluebonnet Trails is designated by the State of Texas as the OSAR for the 30 counties in Region 7. OSAR is a free program to help people who have a problem with drugs or alcohol locate services in their community. Bluebonnet Trails convenes quarterly meetings of substance use providers to share information about services.	http://bbtrails.org/services/substance-use-services/

KEY LEARNINGS FROM PAST SUD COMMUNITY PLANNING EFFORTS

Summary of Purpose and Contents

The purpose of the Context phase was to:

- Summarize key recommendations/learnings from past SUD community plans and planning efforts as they relate to the roles, functions, and participation of the future SUD Planning Structure,
- Inventory current planning efforts/collaborations that may overlap with SUD services and populations,* and
- Identify sources for relevant community conditions and data that the future SUD Planning Structure should use/consider.*

The SUD Workgroup completed this work by:

- Sharing peer learning mini presentations on three planning efforts that occurred in the past 10 years: 2015 Travis County Plan for Substance Use Disorders, 2019 ATOD Needs Assessment, and 2018-19 discussions/community forums hosted by Travis County, and
- Identifying key learnings from the past to help inform the current SUD community planning effort.

This document details key learnings by theme – roles, functions, and participation – as well as pertinent discussion points that did not fit into the three thematic categories.

Roles: Key learnings about leadership, governance, facilitation, organizational support, and convening entity

- **Leadership Role**: Leadership must be engaged and committed to the planning effort. A clearly defined leadership role and consistent participation of those in leadership are needed to be successful.
  - Engagement of leadership and buy in from leadership [is important].
  - Unclear roles of leadership and governance was difficult as the plans moved into new phases.
  - Leadership need[s] consistency and commitment. Leadership gets watered down if they start to delegate or lose interest. Over time good intentions erode and it weakens the group.

- **Ownership and Support Roles**: Participants must be dedicated to the work and take ownership across roles. There must also be clear ownership of the planning structure as well as organizational support to sustain the work.
  - Ownership is a quality that needs to be clear within each of the roles. Also, accountability and responsibility [must be clear]. Making it clear what these mean before the commitment is made [is important].
  - Effort to keep leadership informed of roles [is important], but there's a hesitation to take on the ownership role.
  - Lack of one group or convening entity to keep the work on track and keep it moving [is problematic].
  - Dedicated organization support to keep the work going [is needed], not a voluntary basis by committee.
  - Having people who are dedicated to this work, rather than "on top of" their other work/job [is needed].

* Addressed in another deliverable

Functions, Capacities, & Skills: Key learnings about the capacities and skills needed to support an SUD plan

- **Facilitation**: The Planning Structure must have effective, ongoing facilitation.
  - Someone with the incentive to facilitate/work with the plan the entire time, not drop out before it's done [is needed].
  - Effective (neutrality) facilitation, especially with impassioned opinions [is needed].
  - [Planning Structure must have the] ability to negotiate ongoing role of facilitation. What entity would take that on?

- **Trust**: The community must have trust in the convening entity and there must be trust across participants.
  - What has been the role of trust in identifying [the] lead agency to move planning into implementation?
  - Capacity to trust: participants will approach things from very different viewpoints, [and there] can be mistrust across sectors and parties. [Participants] have to be able to get to trust [each other] and be able to come to consensus.

- **Time**: Participants must understand the time commitment and dedicate sufficient time to the process.
  - Knowledge of time commitment to take ownership and responsibility [is needed].
  - Time – [participants must have] dedicated time, cannot be done piecemeal.
  - Intention and ask of participation should be clear up front.

- **Additional desired capacities of planning structure as a whole**:
  - [Planning Structure must have the] ability to impact funding/make funding decisions.
  - Need for flexibility [of Planning Structure], to respond in a timely manner.

- **Additional capacities of contributing organizations or participants**:
  - Ability to provide organizational support [is needed].
  - Skill of research [is needed to understand]: what's happening across Texas and nationally (programs, policy, trends, etc.).

Participation: Key learnings about meaningful and realistic community engagement, diversity, and representation

- **Inclusive**: Participants must directly include those most impacted, those using SUD services, and those with lived experience.
  - [It's] important to have people using SUD services participate.
  - Engaging people affected by policy can be difficult, but there are successful examples [such as] Vancouver Area Network of Drug Users (VANDU).
  - Reaching out to people who are in recovery or who are struggling and "don't meet the profile" (we are "too white" in our approach, we don't represent our populations served) [is important].
  - [Planning Structure must be] intentional about [the SUD] plan including the voices of those that are the most impacted.
  - We need to *talk to people* about what people are seeing in their community (e.g., Central Health communications and community engagement).

- Concern about the right voices at the table; don't want [a Planning Structure with] one entity determining the process or have one opinion with final say versus [having] a more inclusive, community-based approach.
- Role of people utilizing services – includes everyone in the community, these people must have a role in leadership/facilitation and not just a focus group.

- **Diverse**: Participants must be diverse in professional/lived experience and include a broad range of participants across service providers/continuum.
  - Finding the mixture/intersection between professional backgrounds and skills as well as the lived experience [is important].
  - [Planning Structure must] include providers who haven't been at the table, [and those providers be] given a voice and ability to participate.
  - Aftercare resources/full continuum need to be included.
  - [Planning Structure needs to] get a broad base of participation/representation throughout these roles, not just in a single category or focus group.
  - Need a coordinated effort - must pick leaders/conveners who can have broad representation.

- **Clearly Defined:** The Planning Structure must clearly define Participation Roles, Success, and Community.
  - Need clear definitions of what these roles mean – is it going to be normative, or something different, shared, participatory? Clear definitions will help the community, however that is defined, know how to participate, and find their place in it.
  - Having a shared definition of success (is it normative, or is it deeper?) [is needed].
  - Need to have a shared definition of "the community" to know who we are serving and who we are engaging.

- **Well Resourced:** Participation has to be well resourced in order to be effective.
  - Dedicated resources [must be] applied to the engagement. It won't happen organically.

Miscellaneous: Discussion points that surfaced but did not fit within the three categories above

- The structure of the process of this planning has never been common.
- COVID has changed the landscape of who needs to be included.
- [There] has to be a clear longitudinal funding stream to attach to [the SUD Planning Structure/SUD Continuum]; could help to determine who fits in different roles.
- Is there oversight over the oversight? Ideally [there] should be, especially if money is involved.
- Texas Association of Addiction Professionals (TAAP) may be a resource in the future.

SUBSTANCE USE SERVICES PRIMER

Summary of Purpose and Contents

The purpose of the Context phase was to:

- Summarize key recommendations/learnings from past SUD community plans and planning efforts as they relate to the roles, functions, and participation of the future SUD Planning Structure,*
- Inventory current planning efforts/collaborations that may overlap with SUD services and populations,*
- Identify sources for relevant community conditions and data that the future SUD Planning Structure should use/consider,* and
- Define local SUD services and their funding landscape.

The Substance Use Services Primer, along with the Substance Use Disorders Funding Structures Primer draft, were added as deliverables to this phase by SUD Workgroup members who felt that more informational context was needed. These products were participant-driven and drafted directly by SUD Workgroup members. One member of the SUD Workgroup took the lead on this document with review support by several SUD Workgroup peers and light editorial support from Travis County HHS staff.

The purpose of this document is to demystify the complexity of substance use-related services using general descriptions of common service types and populations served within publicly funded, human service, and community-based settings. This primer should inform anyone in the position to make decisions, increase access, and diminish barriers for adults, youth, and the underinsured seeking assistance.

Introduction

What Does Recovery Look Like?

Resolution of problems related to alcohol and other drug use are often assumed to be linear, meaning there is a specific order to the process, with completion of one task preceding starting a new one. It is important to remember that there are no explicit instructions for getting better, because recovery and wellness are non-linear, very personal, and always subjective. Social norms have projected substance use and recovery as all or nothing, a fundamental assumption that is problematic for those seeking help and pervasive in the context of community service access.

What is a Continuum of Care?

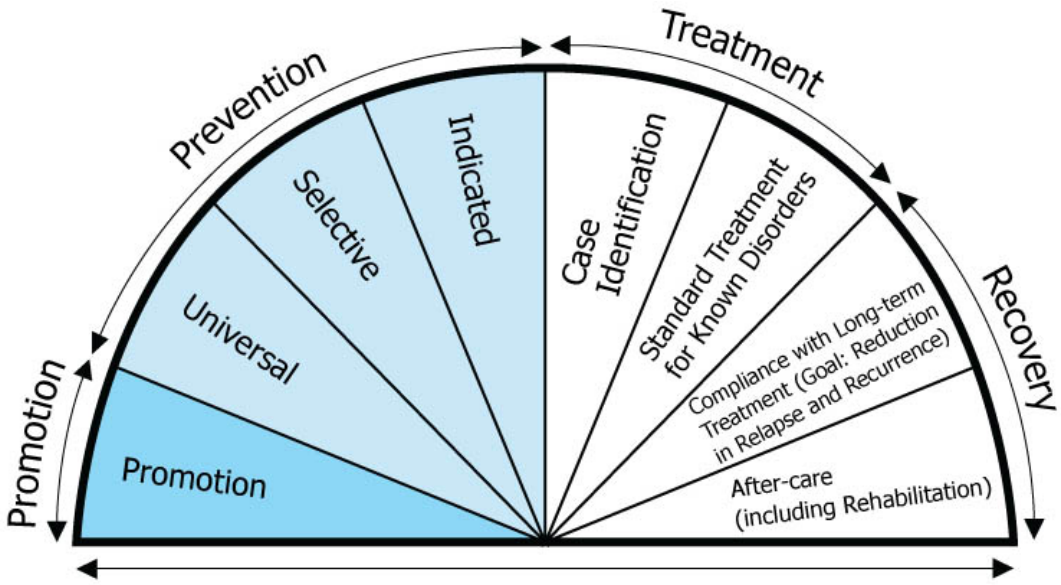
A *continuum of care* is a term that references the various services that can be accessed within a community or health system. Each continuum of care may look very different between and within communities, cities, regions, and states, depending on the funds and resources available. In general, free and reduced-fee behavioral health services within the local continuum of care are commonly funded through a combination of local and federal dollars. For more information on the funding structures for substance use, see the Substance Use Disorders Funding Structures Primer draft.

* Addressed in another deliverable

This primer focuses on services for low-income, underinsured, and uninsured individuals. These services were current at the time of writing (April 2021) and service categories are described below.

Prevention and Intervention

The continuum of care depicted in the graphic below was first established by The Institute of Medicine (IOM).[†] It has been widely used as an easy way to understand general categories of substance use services for adults and youth, with a focus on prevention.



Source: Institute of Medicine.

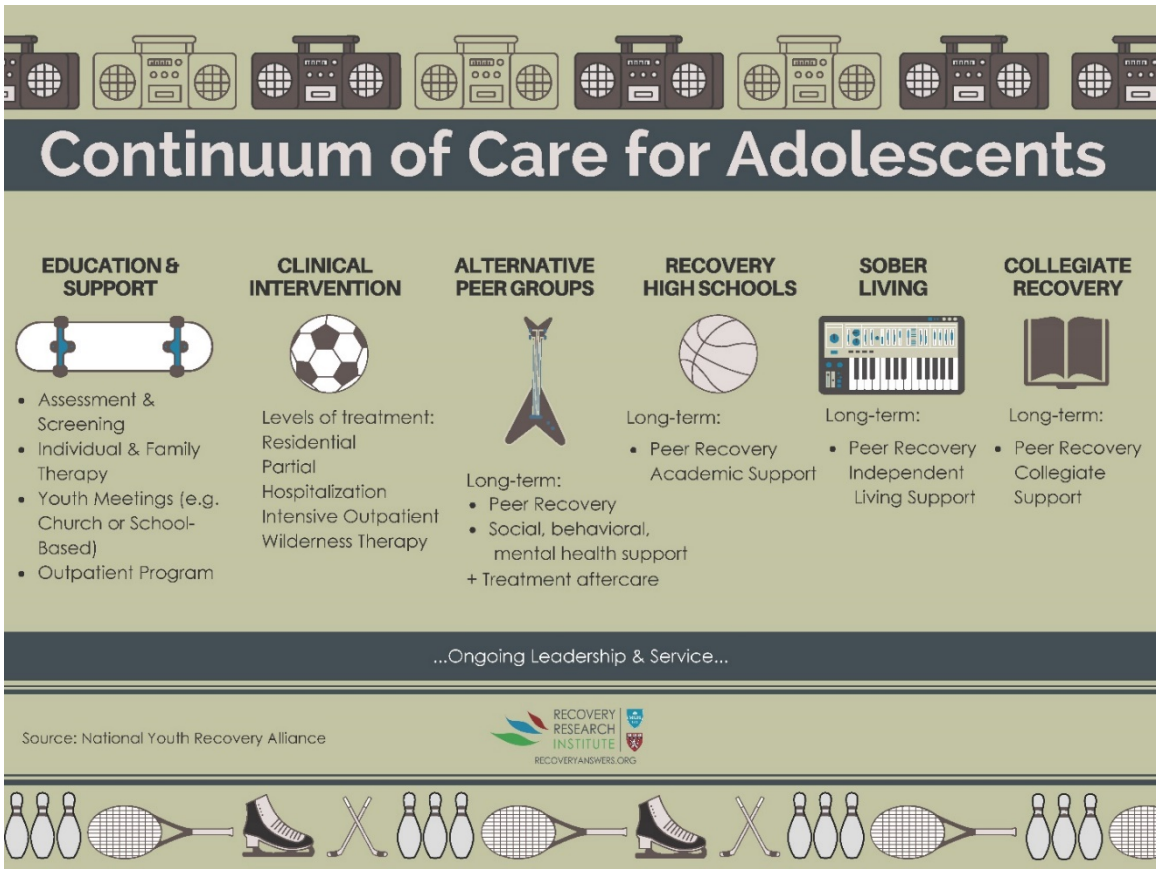
Prevention is typically considered a youth-focused category, with Universal, Selective, and Indicated[‡] programs receiving federal block grant funding for use in school settings. Prevention as a general strategy is applicable to every age group. Youth may access supports beyond prevention, such as treatment and recovery supports, in the same way adults do; however, youth are treated in facilities separate from adults, with slightly different admissions standards, as referenced in Texas Administrative Code (TAC).[§]

Since they are still developing, adolescents truly are a special population. The below graphic depicts the Continuum of Care for Adolescents, including clinical, non-clinical, formal, and informal supports and services.

[†] For more information about IOM, see http://ca-sdfsc.org/docs/resources/SDFSC_IOM_Policy.pdf.

[‡] ***Universal prevention*** refers to interventions delivered to the general population without differentiating between persons at different risk levels. ***Selective prevention*** is more targeted than universal, and these interventions would be directed towards populations identified as having a potential somewhat greater than the general population for developing the focal problem. ***Indicated prevention*** is even more targeted, delivered to populations/groups of individuals exhibiting/expressing warning signs foreshadowing development of the focal problem.

[§] See Texas Administrative Code (TAC) 448, Chapter 25 standards for service provision, including Faith Based providers. TAC 448 defers to SAMHSA TIP 21 for service delivery standards in Texas.



Source: Recovery Research Institute, https://www.recoveryanswers.org/media/continuum-of-care-for-adolescents/

This graphic does not include the youth-focused prevention aspects just discussed, which underscores how complex systems of care may be to navigate.

Harm Reduction

Harm Reduction is an intervention for risk reduction and should be considered the most fundamental access point for attaining services, whether that includes treatment or non-clinical supports. It is important to note that Harm Reduction is an assertive outreach to engage individuals in risk reduction and health promotion, with foundational roots in health equity and social justice. Harm Reduction is an evidence-based practice and does not have an end goal of abstinence. Harm Reduction:

- Provides safe means for drug user health, such as access to syringes, fentanyl test strips and other drug checking methods, wound care, naloxone for overdose prevention, condoms and more; and
- Includes intervention and prevention, but not all intervention and prevention include Harm Reduction.

Treatment

Discussions around "treatment" may often be associated with "rehab," or a 28-day intensive residential modality of care. However, there are several kinds of treatment, as well as other non-clinical recovery supports, discussed later. All substance use disorder (SUD) treatment providers in Texas are beholden to Texas Administrative Code (TAC); providers' licensure may be verified with Texas Health and Human Services Commission.

Withdrawal Management

Withdrawal Management is also commonly referred to as Detoxification Services, or simply "Detox."

- **Medically Managed Withdrawal:** While wellness and recovery are not linear, managed withdrawal is sometimes a first step for accessing some types of treatment. This should be determined by a thorough, clinical assessment. Not every treatment center has detoxification services, as they have specialized licensure and accreditation. Withdrawal from benzodiazepine and alcohol dependence should be medically managed.
- **Ambulatory Detox:** Often overlooked, this modality of care enables the person to engage in managed withdrawal at home, with physician oversight. Outpatient treatment is a requirement for this form of detoxification.

Hospitalization

We tend to think of injury, surgery, or chronic illness when we use the term hospitalization, but there are hospitals for behavioral health needs. These may be free standing businesses or units within medical hospitals. This type of hospitalization is typically available to those with mental health crisis stabilization needs, which may or may not include problematic substance use. These services are most commonly private pay or insurance-funded, although some hospitals may have contracts in place to reduce or eliminate charges for services rendered.

- **Psychiatric Hospitalization** provides mental health and substance use care, and typically requires acute criteria for admission. Not all providers are specialized or even proficient with SUD. They often take Medicaid, Medicare, and private insurance, and may or may not have contracts for indigent/emergency detention with the local mental health authority (LMHA).
- **Partial Hospitalization** is a step down from psychiatric hospitalization. Patients have more latitude to come and go but must also abide by rules and engage in clinical services. Some programs offer on-site housing for patients, while others do not, meaning patients return home in the evening.

Residential Treatment

There are many kinds of care within behavioral health which include the word "residential." Residential Treatment Centers, Intensive Residential Treatment Facilities, and Recovery Residences (discussed later), for instance, are all very different services, which we'll examine.

- **Residential Treatment Centers** (RCT) are typically long-term intensive treatment centers for children and adolescents experiencing serious emotional disturbances, who have typically been referred through state agencies or coordination groups.
- **Intensive Residential Treatment** (IRT) facilities are specialized for substance use disorder. Some do not address mental health related issues, as their scope of state licensure is typically restricted to chemical dependency. Most do not take Medicare, but many do accept insurance, with variation among facilities and accepted policies. Some facilities accept Medicaid, and some accept state (public) funding. These facilities may be accessible through independent/self-referral or through Regional Outreach Screening Assessment and Referral Counselors. There are IRT facilities for youth and adolescents, but far fewer than adult resources.
- **Supportive Residential** is less common and is considered a step down between intensive residential and recovery residences. Individuals have latitude to come and go, but they must abide by rules and engage in clinical services.

Outpatient Clinical Services

Like Partial Hospitalization, outpatient treatment is restricted to a daytime program, with a finite, recurring schedule. It is commonly utilized as a step down from higher levels of care intensity, so it may be referred to as "aftercare." However, outpatient is sometimes the only level of care needed to resolve problems with alcohol and other drugs. Sometimes people access outpatient for support while they are on a waiting list for higher intensity support, and sometimes people in outpatient return to inpatient for more support.

- **Intensive Outpatient**: Increased number of hours spent in clinical engagement. Typically covered with insurance, as such hours are often prescriptive. Less common in the state funded array; however, the state has not been known to expressly prohibit billing for intensive outpatient.
- **General Outpatient**: This modality of care enables people to live at home, and attend clinical services including groups and 1:1 counseling, typically four hours a week. The state funds outpatient, with contracted providers, stand alone as well as part of a larger provider service array.
- **Opioid Treatment Services and Medications for Opioid Use Disorder**
    - *Office Based Opioid Therapy (OBOT)*: Specialty practice prescribing buprenorphine for Opioid Use Disorder. Monthly visits after initial induction and psychosocial supports required, but not required to be provided by the practitioner.
    - *Methadone Maintenance Therapy (MMT)*: Specialty Clinic dispensing oral solutions of methadone daily, onsite, with rigorous regulations. Some patients may get take-homes after meeting no less than eight conditions. Psychosocial supports are also required.

Recovery Support Services and Recovery Oriented Systems of Care

Recovery Support Services (RSS) is a growing field of supports such as Recovery Coaching, Mutual Aid Self Help Groups, and Alternative Peer Groups, which can be found in Community Drop In Centers, Recovery Residences, Recovery High Schools, and other Recovery Community Organizations. Although typically grouped with the "aftercare" category, Recovery Support Services are not exclusive to aftercare or outpatient, and in many cases can be sought concurrent with, or in lieu of clinical care, as the person desires.

- Recovery Support Services, whether in person or delivered digitally, are more accessible than clinical services, with lower thresholds of eligibility for individuals, their families, and allies. They include peer-based service delivery that is non-clinical and leverages the shared lived experience of both peers in the relationship context. Mutuality is central, and in Texas, certification is required to deliver these services.
- Mutual Aid Self Help includes, but is not limited to, 12 Step Groups, Alumni Groups, SMART Recovery, Women for Sobriety, White Bison, Darma Recovery, and Secular Support. These groups may be formal or informal.
- Recovery Support Services honor all pathways to recovery and are not beholden to abstinence-based assumptions.

Recovery Community Organizations

One of the places offering Recovery Support Services is a recovery community organization (RCO). These are independent, non-profit organizations run for and by people in recovery. RCOs organize recovery-focused

advocacy activities, community education and outreach programs, and/or provide peer-based recovery support services.[**]

- The sole mission of an RCO is to mobilize resources within and outside of the recovery community to increase the prevalence and quality of long-term recovery from alcohol and other drug addiction.
- Public education, policy advocacy and peer-based recovery support services are the strategies through which this mission is achieved.

Recovery Residences

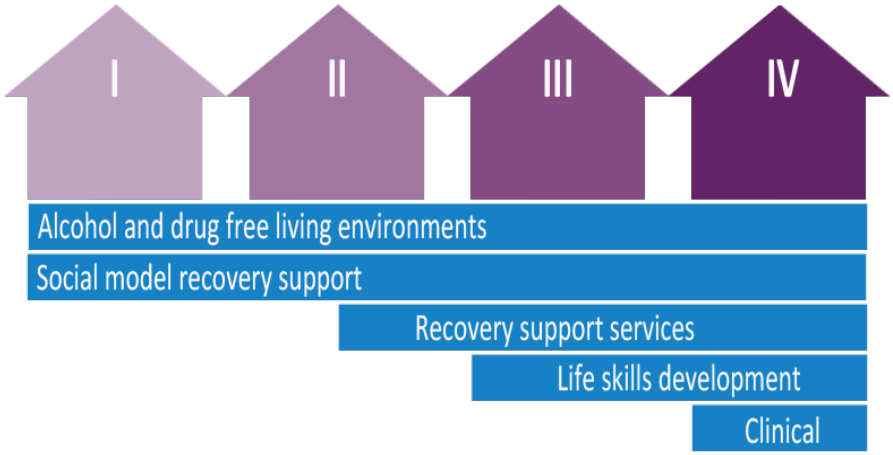
Recovery residences provide a spectrum of living environments that are free from alcohol and illicit drug use, with a focus on peer support and connection to other recovery services and supports. These homes are grounded in the social model of recovery. Recovery residences are just as diverse as any other business, with varying levels of amenities and norms. Recovery residences:

- May be referred to as sober living, recovery housing, or halfway houses. It should be noted that halfway houses are specific to the justice-involved and reentry populations, not exclusively SUD populations.
- Are not part of the Housing and Urban Development Continuum of Care
- Are protected by Americans with Disabilities Act and Fairness in Housing Act
- Are frequently subjected to scrutiny and attitudes of Not In My Backyard (NIMBY)
- Have established legal precedents for how ordinances may define family
- Are typically most effective with eight individuals in residence
- Are most often 12-Step oriented, requiring meeting attendance for residency
- Are non-discriminatory in nature, but only a handful are starting to accept residents taking medications for opioid use disorder
- Are not regulated in the state of Texas but can voluntarily certify with National Alliance of Recovery Residences Affiliate (Texas Recovery Oriented Housing Network).

The National Alliance for Recovery Residences (NARR) has developed levels of support to help standardize best practices in Recovery Residences, as depicted in the graphic below. These levels are substantiated by a rigorous set of criteria for certification.

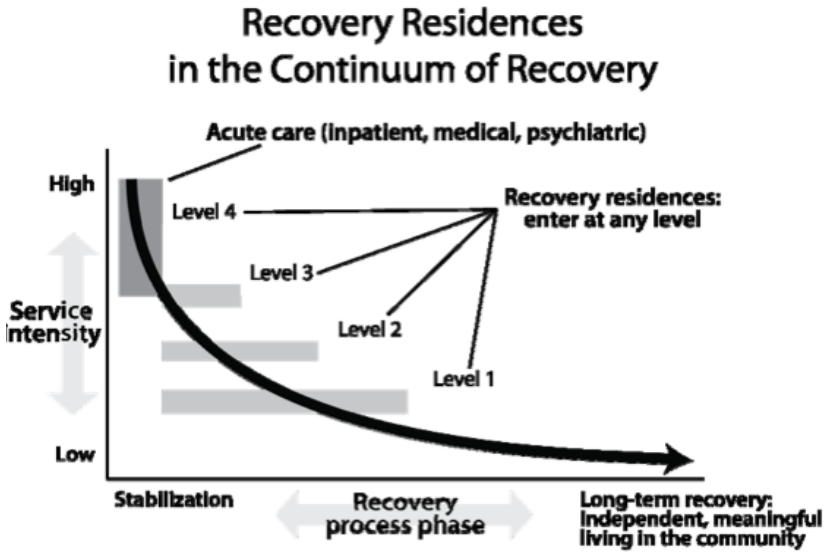
- **Level 1** is the lowest level of support. This type of residence is democratically run and does not have management but will have rules and structure for living there. Level 1 residences are best epitomized by Oxford Houses, Inc.
- **Level 2** houses typically have a lead resident or manager. These roles of oversight may or may not be directly compensated or provided a housing discount in exchange for oversight.
- **Level 3** houses also have structured internal oversight, just like Level 2, but offer or may require additional recovery supports as part of residency.
- **Level 4** homes include a clinical component. In Texas, these homes would be considered licensed treatment, but still not the same as Intensive Residential Treatment.

[**] For more information about Recovery Community Organizations, see https://facesandvoicesofrecovery.org/blog/resource/the-recovery-community-organization-toward-a-working-definition-and-description/.



Source: National Alliance for Recovery Residences (NARR), https://narronline.org/.

Entry into recovery residences should be a person-centered process, taking the recovery capital and desired goals into account as part of the admission. Certified Houses can substantiate the level of support for those who seek housing. The following graphic illustrates the intensity of need relative to the Levels of Support.



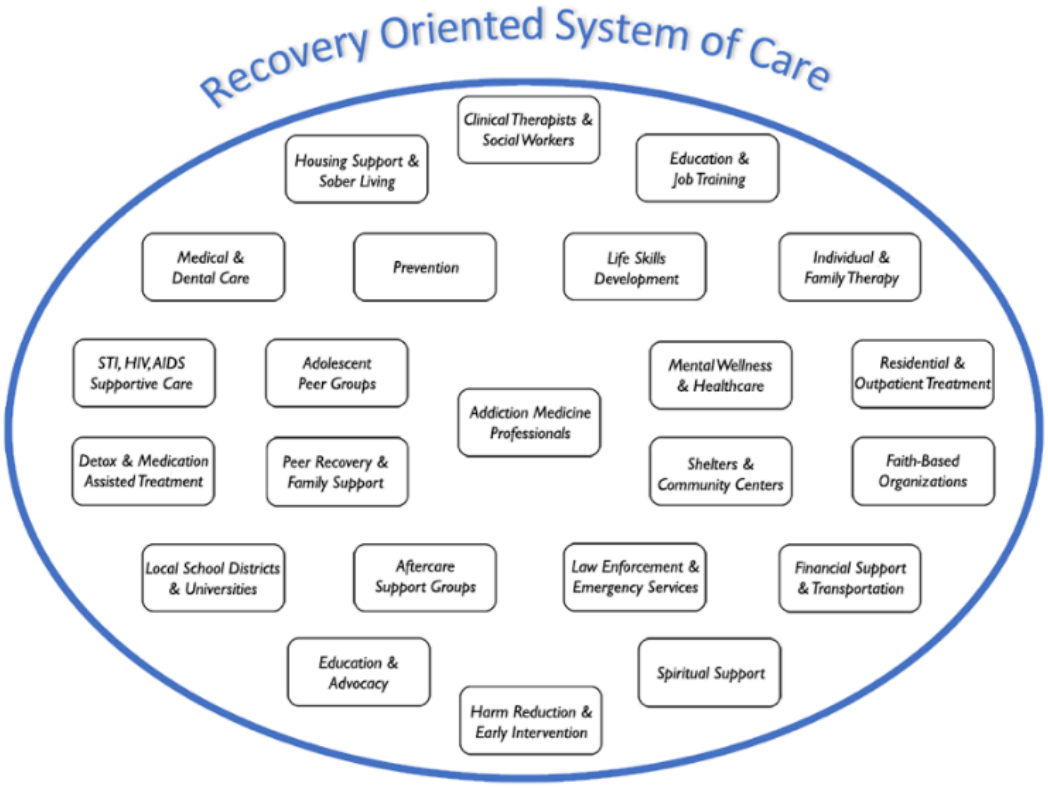
Source: Tom Hill, Substance Abuse Mental Health Services Administration, Oxford House World Convention, 2015

Recovery Oriented Systems of Care

Recovery Oriented Systems of Care (ROSC) is another way to conceptualize a continuum of care, organized by systems of community stakeholders working together within a strengths-based framework to optimize response to substance use related problems. There are no set standards for who should be members or taking part in local ROSC meetings and activities. These are grassroots, egalitarian gatherings of care providers, community members, municipalities, civic representatives, and businesses, engaging in varying degrees of collaboration.

ROSC focuses on Recovery Management theories to leverage a person's natural supports, recovery capital, and chosen menu of services, along with assertive outreach and long-term engagement to increase community recovery capital. Like a coalition, ROSC functions through community workgroups to make access to person-centered, self-directed, appropriate levels of care as streamlined as possible. In theory, a person seeking help

should be able to access care from any entry point of care, as the ROSC members work together to establish a unified system of response to SUD. The graphic below was supplied by the Greater Austin ROSC. Not every ROSC function or looks this way, but this depiction is a good general example.



Source: Greater Austin ROSC, https://www.austinrosc.com/about-us

SUBSTANCE USE DISORDERS FUNDING STRUCTURES PRIMER (DRAFT)

Summary of Purpose and Contents

The purpose of the Context phase was to:

- Summarize key recommendations/learnings from past SUD community plans and planning efforts as they relate to the roles, functions, and participation of the future SUD Planning Structure,*
- Inventory current planning efforts/collaborations that may overlap with SUD services and populations,*
- Identify sources for relevant community conditions and data that the future SUD Planning Structure should use/consider,* and
- Define local SUD services and their funding landscape.

The draft Substance Use Disorders Funding Structures Primer, along with the Substance Use Services Primer, were added as deliverables to this phase by SUD Workgroup members who felt that more informational context was needed. These products were participant-driven and drafted directly by SUD Workgroup members. One member of the SUD Workgroup took the lead on this document with review support by several SUD Workgroup peers and light editorial support from Travis County HHS staff.

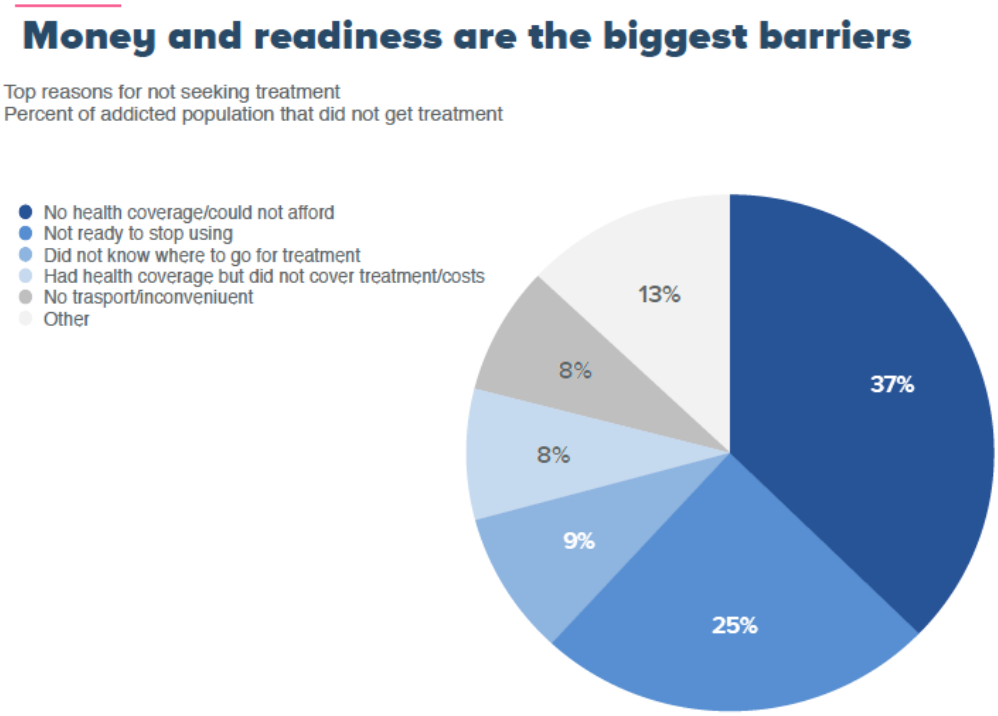
This document is intended to serve as a general starting point for understanding the complexity within the funding for behavioral health, specifically substance use services, across our community. This document also lays the groundwork for a call to action across our community for increasing awareness and participation in better coordination of care with SUD.

Unlike the rest of the final recommendations packet, this document remains in draft form. The SUD Workgroup member who initially drafted this document left their position and the Central Texas region before a final draft could be completed. Remaining SUD Workgroup members did not have the capacity to make final additions/revisions. Travis County HHS staff opted to include the draft version in the final recommendations packet because it offers valuable context. The future SUD Planning Structure could choose to build on this work, such as summarizing the local funding landscape.

Why Does This Matter?

Now, more than ever, our community members need access to care for substance use disorders (SUDs). The consequences of problematic alcohol and substance use has grown significantly through the opioid overdose crisis and made worse by the COVID-19 global health pandemic. The graphic below depicts how funding and access to services can literally be the difference between life and death.

* Addressed in another deliverable



Source: Group 17A. Addiction Recovery Primer, Spring 2018. https://group17a.com/just-health/

When it comes to SUDs, often those with the most severe circumstances either had little to begin with or have experienced a significant depletion in their resources and capital. Individual readiness for wellness and available funding are not always in alignment, and this is made more complex by the underfunding of SUD services nationally. People who are underinsured and underfunded are the most vulnerable.

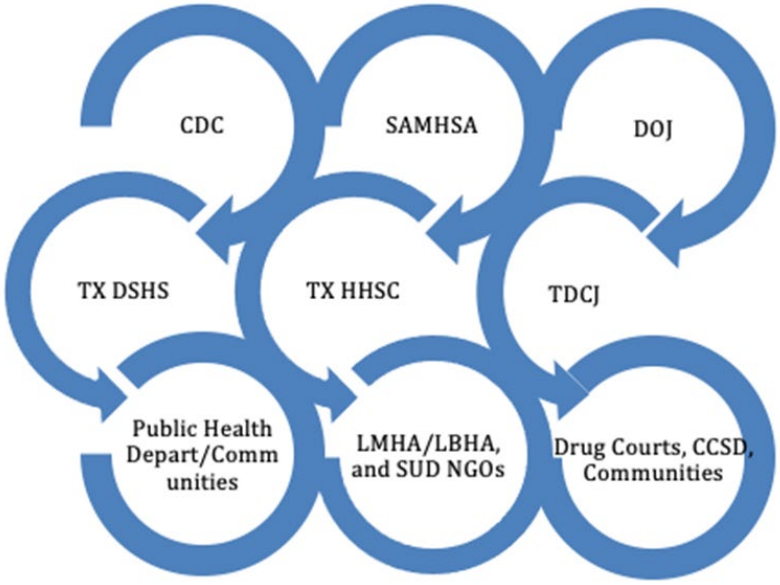
Gaps in services that negatively impact the community include uncoordinated funding systems, encompassing a variety of independent funding providers. For instance, some SUD services are funded within justice-involved settings (drug court, special dockets), while some may be accessible within larger behavioral, medical, or public health systems. There are also independent, community-based, and non-profit providers who receive SUD funding from a multitude of local, state, and federal agencies to help them survive fiscally. This reliance upon disparate funding inevitably creates inconsistent standards for eligibility for services within each agency, and across the spectrum of community providers. Additionally, the funding cycles revolve often, which is burdensome for the providers and subsequently the program participants. These gaps, silos, and barriers underscore the need for local planning to provide more effective coordination of care.

Top-Down Description of Funding Sources

Where the funding starts, and where it ends up, is sometimes called a funding stream. This is because the funds may meander through a variety of thresholds before arriving within the community. Because Texas is not a Medicaid expansion state, underinsured and underfunded populations are relegated to other federal sources or funding streams. Having many kinds of SUD funding sources does not mean we have adequate funding for accessible care. The Substance Abuse Mental Health Services Administration (SAMHSA) is the largest provider of federal funds for SUD services; utilizing special programs[†] and SAMHSA block grant dollars (SABG) which flow

[†] https://www.hhs.gov/sites/default/files/fy-2021-budget-in-brief.pdf

into Texas Health and Human Services Commission.[‡] Two other primary funding streams include The Center for Disease Control (CDC) for public health, and Department of Justice (DOJ) for justice-involved populations, all of which may be allocated into different divisions or jurisdictions.



As you can see in the above graphic, the funding streams are very close to each other, and may even have touchpoints at certain thresholds, but they remain distinct pathways. Also note that the ending points within the community are represented by separate buckets. Sometimes these funds are supplemented with state budgeted general revenues, legislative appropriations, and local or municipal funds, but not always. These three drivers have historically provided the majority of substance related services available in our community to date; however, the recent change in federal administration budget requests will re-allocate funds. Of the 5.2 billion in requested funding for Health and Human Services, SAMHSA is projected to receive 2 billion.

Funding passes through state agencies where it gets divided up, before flowing into the community where it is again divided. For instance, SAMHSA gives money to states to use as they see fit. SAMHSA block grant funds are typically divided between SUD and mental health and managed through several different divisions within the Texas Health and Human Services Commission (HHSC). With a few exceptions, the state is the payer of last resort, and is beholden to specific federal rules about targeted populations and disseminating specific dollar amounts into communities. For example, 20% of SABG funding must go to substance misuse prevention. As we continue to follow the prevention "set-aside" dollars example, we see the money spread even further across the state in different types of prevention programs within each of the 11 large regions in Texas. Prevention money is divided up regionally between tobacco prevention, universal, selective, and indicated school-based prevention programs, community coalition groups, and Prevention Resource Center/Regional Evaluation of prevention. In agencies receiving funding for all these activities, the prevention staff is around five individuals, commanding salaries typical for non-profit front-line work.

[‡] Public Health and Welfare Act, Title 42, http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/pdf/USCODE-2010-title42-chap6A- subchapXVII-partB.pdf

Local Dollars and Sense

Community Mental Health Services may also provide services for people with substance use disorder. These agencies are the largest providers of federal mental health funding after Medicaid. These centers, called Local Mental Health Authorities (LMHA) or Local Behavioral Health Authorities (LBHA), are the entry point for those without financial and health resources to obtain assistance. Broadly, LMHA/LBHA centers are responsible for providing an array of mental health related services to those with and without Medicaid, pending Uniform Assessment and other admissions criteria. Additionally, these centers are responsible for providing:

- Medication training and support services
- Psychosocial rehabilitative services
- Psychiatric diagnostic interview examination
- Routine case management
- Skills training and development
- Supported employment
- Supported housing

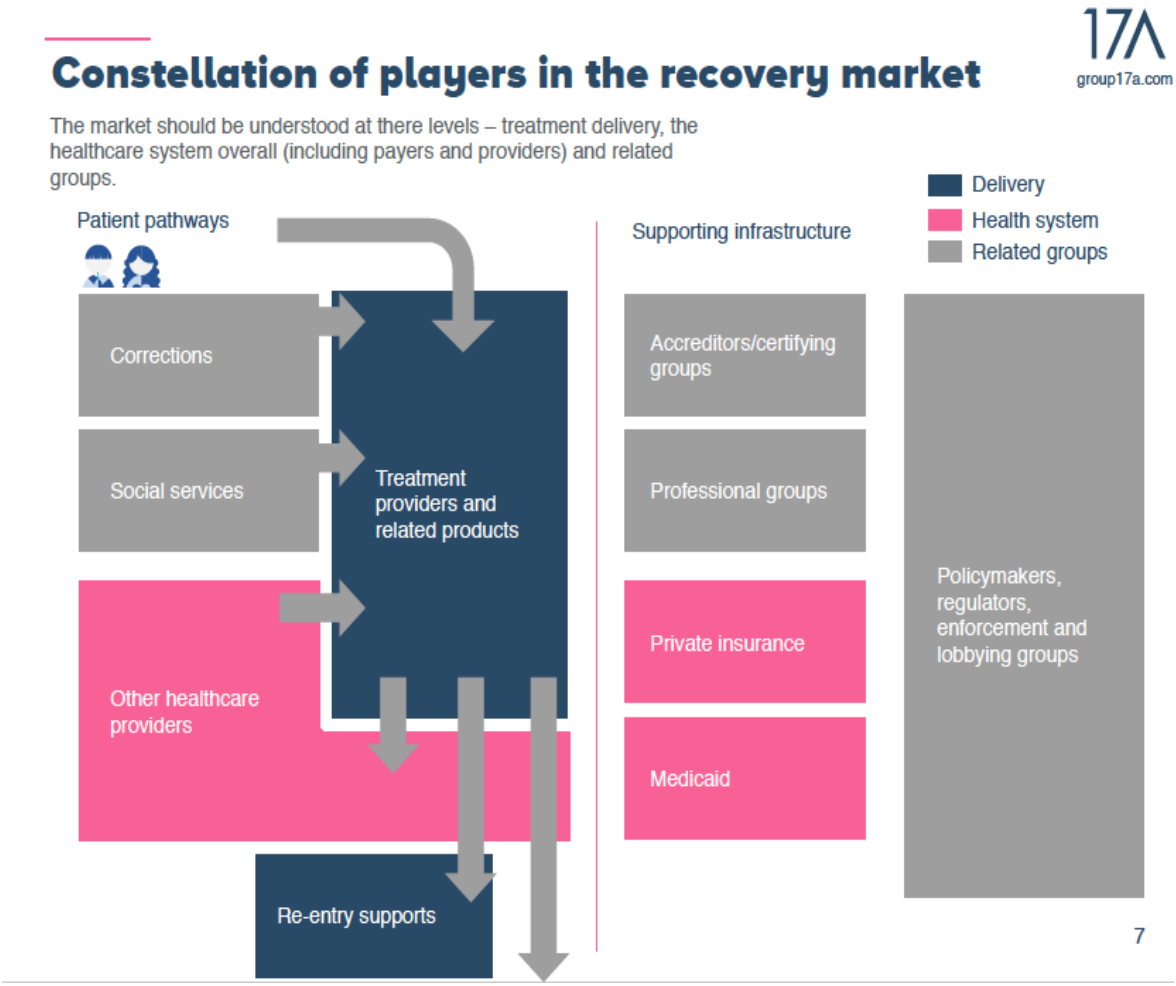
The availability of SUD services will vary from center to center, depending on the types of state contracts a center has, or if the center is an LMHA or LBHA. Some LMHAs offer SUD services, but they do not have to per SABG rules for Community Mental Health Services. By definition, LBHA centers do offer SUD services as an integral part of the service array. Eligibility for SUD services may also vary from center to center regardless of whether it is an LMHA or LBHA.

Source: Unknown, possibly SAMHSA or NASMHPD presentation

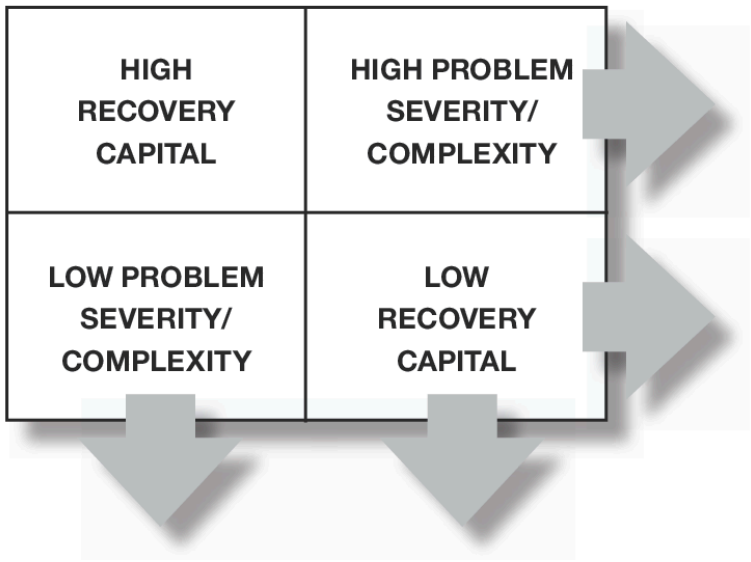
The Community of Recovery

The community compilation of services varies among all municipalities within each state. Each state is unique in the way that money flows into the community. Pennsylvania, for instance, does not have a single state authority, but single county authorities. There are other states that structure their funding streams into regional or county hubs as well, such as community boards. Texas does not have an exclusively centralized system in place. Some money flows into hubs, and some goes directly into the community via contracts or grants.

In general communities typically look like the graphic below, which was put together by a bipartisan consulting firm focusing on public health and human service delivery efficacy. As depicted here, the typical pathways are fairly narrow in scope, along with the funding sources.



As we know, people with higher recovery capital typically need less publicly funded support for access to care. Recovery capital is the total resources that a person has available to find and maintain their recovery. Individuals with acute substance related problems often end up underfunded or underinsured as part of the addiction progression. However, not all people with problematic substance use are “addicted.” Therefore, it may be easier to conceptualize appropriate services and resources from a different perspective, in the Recovery Capital Matrix seen here.



Gauging Success

Research indicates that the median number of an individual's serious recovery attempts before problem resolution is two; however, it may be more depending on intensity and duration of problem formation, as well as recovery capital. Within the current system of care, it takes an average of 15 years for a person in recovery to reach a similar quality of life as the general population *[citation needed]*. Of those who consider their substance related problems as resolved, 46% did not use any formal treatment or recovery support services *[citation needed]*. It is unknown if these individuals didn't have access to services, felt stigmatized, or had other reasons for not seeking additional support/treatment. But we do know that the current system of care has been outpaced by need. As such, there are some metrics and outcomes that communities may consider standardizing for evaluating invested dollars and determining how to allocate any new funding.

Other Sources of Federal Funding

Specific Federal Programs for SUDs

This is not a comprehensive list but does include some of the most prevalent funding sources. Sometimes funding may come from unexpected places such as the Office of Minority Health (before it was dissolved).

Centers for Disease Control and Prevention

- Injury Prevention and Control—Opioid Overdose Prevention and Surveillance
- Cooperative Agreement for Emergency Response: Public Health Crisis Response—Opioid Prevention in States
- Health Resources and Services Administration
- Expanding Access to Quality Substance Use Disorder and Mental Health Services
- Rural Health—Rural Communities Opioid Response

Administration for Children and Families

- Children and Families Services Programs—Child Abuse Prevention and Treatment Act-Infant Plans of Safe Care
- Promoting Safe and Stable Families
  - Kinship Navigator Programs

- Regional Partnership Grants

National Institutes of Health

- National Institute of Neurological Disorders and Stroke—Opioids Research
- National Institute on Drug Abuse—Opioids Research

Center for Medicare and Medicaid Services

- Medicare
- Medicaid

USDA and Food and Drug Administration

- FDA Opioid Enforcement and Surveillance
- USDA – rural housing, opioid misuse map

Department of Justice

- Comprehensive Addiction and Recovery Programs (competitive recruitment)
  - Drug Courts
  - Veterans Treatment Courts
  - Residential Substance Abuse Treatment
  - Prescription Drug Monitoring
  - Mentally Ill Offender Act (Justice and Mental Health Collaboration)
- Other Comprehensive Addiction and Recovery Act activities
  - Community Oriented Policing Services—Anti-Heroin Task Forces
  - Second Chance Act Grants
  - Reaching Youth Impacted by Opioids
  - Office for Victims of Crime—Enhancing Community Responses to the Opioid Crisis
  - Paul Coverdell Forensic Science

Office of National Drug Control Policy (ONDCP)

- High Intensity Drug Trafficking Areas (DEA collaboration)
- Drug-Free Communities (White House collaboration)

Department of Labor

- National Health Emergency Dislocated Worker Demonstration Grants
- Veterans Affairs
- Medical Care—inpatient/outpatient, pharmacy
- Medical Care—CARA opioid safety initiatives
- Medical Care—Justice Outreach and Prevention Program
- Medical Care—Office of Rural Health's Rural Health Initiative

Health Resource Services Administration

- Rural Opioids Technical Assistance (competitive procurement through HRSA and FQHC)
- Opioid Workforce Expansion Program
- Behavioral Health Workforce Expansion Program

Substance Abuse and Mental Health Services Administration

- State Targeted Response/State Opioid Response
- State Targeted Response Technical Assistance (HHSC-SABG)

- Tribal Opioid Response (competitive procurement for tribal nations)
- Provider's Clinical Support System (competitive procurement through SAMHSA)
- Targeted Capacity Expansion-General (competitive procurement)
- Medication-Assisted Treatment for Prescription Drug and Opioid Addiction (competitive procurement)
- Pregnant and Postpartum Women (HHSC-SABG and competitive procurement)
- Building Communities of Recovery (competitive procurement)
- Recovery Community Services Program (competitive procurement)
- Children and Families (competitive procurement)
- Criminal Justice Activities (competitive procurement)
- Offender Reentry Program (competitive procurement)
- Addiction Technology Transfer Centers (competitive procurement)
- Strategic Prevention Framework Rx (competitive procurement)
- Grants to Prevent Prescription Drug/Opioid Overdose (competitive procurement)
- First Responder Training (competitive procurement)
- Improving Access to Overdose Treatment (competitive procurement)
- Community-Based Coalition Enhancement Grants to Address Local Drug Crises (competitive procurement)
- Tribal Behavioral Health Grants (competitive procurement)
- Primary and Behavioral Health Integration (Technical Assistance)

Texas Substance Abuse Prevention and Treatment Block Grant (SAMHSA)
(In Texas, block grant dollars also support the following SUD services, which are most frequently accessed by those who have little to no funding.)

- Treatment and Recovery
- Outreach Screening Assessment and Referral
- Treatment (inpatient, outpatient, ambulatory)
- Pregnancy postpartum/Specialized Female programs
- Youth Recovery Support
- Opioid Treatment Services (methadone, buprenorphine and naltrexone)
- Recovery Support Services
- Recovery Housing
- Mixed: Treatment/Recovery and Prevention—Includes grant programs that are targeted to fund the continuum of care for opioid use disorders, including 80 percent of the SABG and Opioid Response; we see this present in LMHA and LBHA centers.
- Adult Mental Health which hosts several other funding types.
- Opioid Treatment Programs (HHSC)

Department of State Health Services (funded by CDC)
(Part of HHSC technically but public health arm funded by CDC, GR, and appropriations)

- HEI/HIV (formerly, moved these DSHS funded providers into the Recovery Support Services array)
- Health departments
- Infectious Disease Control
- Public Health Surveillance

DOJ (BJA) > TDCJ and CCSD pass through

- Criminal Justice
- Law Enforcement
- Interdiction

These funds are typically used in:

- Technology-Assisted Treatment—supports rural access to substance use treatment and recovery support services through remote monitoring
- System-Level Diversion—supports corrections and reentry programs, and helps connect arrestees to immediate treatment
- Statewide Planning, Coordination, and Implementation—supports initiatives jointly planned and implemented by the state criminal justice agency and the single state agency for substance use services to engage offenders who misuse opioids
- Prescription Drug Monitoring Program Implementation and Enhancement Projects
- Public Safety, Behavioral Health, and Public Health Information-Sharing Partnerships— enable state agencies to leverage information from public health and safety data

Additional Resources

- Tracking Federal Funding to Combat the Opioid Crisis https://bipartisanpolicy.org/wp-content/uploads/2019/03/Tracking-Federal-Funding-to-Combat-the-Opioid-Crisis.pdf
- Putting America's Health First FY 2021 President's Budget for HHS https://www.hhs.gov/sites/default/files/fy-2021-budget-in-brief.pdf
- Office of Justice Programs Budget Detail Worksheet https://www.ojp.gov/funding/apply/forms/ojp-budget-detail-worksheet
- Legislative Budget Board Summary of Legislative Budget Estimates 2020-21 Biennium https://www.lbb.state.tx.us/Documents/Appropriations_Bills/86/LBB_Recommended_House/5492_House_LBE_Bill_Summary.pdf
- US Department of Agriculture Budget Fiscal Year 2021 https://www.usda.gov/our-agency/about-usda/budget
- Travis County Fiscal year 2021 Budget Documents https://www.traviscountytx.gov/planning-budget/current-year
- City of Austin Fiscal Year 2020-2021 Budget https://www.austintexas.gov/news/austin-city-council-approves-fiscal-year-2020-2021-budget

SUD Community Planning Racial Equity Framework

Summary of Purpose and Contents

The purpose of the Plan Scope and Use phase was to:

- Consider and evaluate current models and frameworks and identify desired elements/components,*
- Consider, evaluate, and identify a desired range of plan uses (such as: funding, service access, advocacy, collaboration/partnership, education and awareness, and other functional uses),*
- Identify ways that racism has impacted problem definition, intervention planning and service delivery to date,* and
- Develop a racial equity framework to be applied to systems delivering services and coordinated response.

The SUD Workgroup completed this work by:

- Working with Dr. Martha Ramos Duffer, equity consultant, to identify impacts of racism on substance use disorders, and
- Building upon the Impacts of Racism document (see prior deliverable) by drafting a set of screening questions for racial equity accountability.

The intended purpose of this document is for the future SUD Planning Structure to apply these questions to any considered action, decision, process, policy, or service, in order to achieve anti-racist and anti-oppressive outcomes. The future SUD Planning Structure will need to develop its own practices to apply this equity framework to its structure, operations, plan development, and plan implementation. Regularly testing future work against these questions can integrate new ways of thinking, in order to disrupt patterns of racial inequity.

Racial Equity Framework

1. Are we creating a structure of co-creation or are we "inviting" people to existing structures? Are people of color and impacted people being included from the onset of the SUD Planning Structure's planning activities?

2. Acknowledging the long history of oppressive structures in SUD responses, how are we: nurturing environments of co-creating; supporting individuals in adopting frameworks of co-creation; allowing individuals to be creative; and learning the skills to co-create?

3. How are dominant white cultural norms reflected in the ways the SUD Planning Structure operates, including implicit and explicit norms, expectations, practices, policies, and procedures? How can we change these to include, value, and reflect multiple ways of being, showing up, communicating, processing information, and participating? In all aspects, is the SUD Planning Structure operating in a way that is consistent with the SUD Values?

* Addressed in another deliverable

4. As the SUD Planning Structure considers challenges and solutions, are the challenges understood as stemming from systemic root problems, rather than locating the problem in the individual and individual choices? Are our community responses actively interrupting the tendency to locate the problem with substances, brain chemistry and individual choices, and disrupting social/structural underlying factors that are set up to disadvantage Black, Indigenous, People of Color (BIPOC) in our systems? Are the planning processes and frameworks trauma-informed, including the understanding that racism is a source of trauma?

5. Whose experience is being centralized and whose experience is being marginalized? What data and research are we using? What narratives are we telling about SUDs? Who is made visible and invisible? Does the way in which we use data, research, and narratives reflect the complexity of the issues and reflect the issues accurately?

6. Are we fully considering history and the lasting and current impacts of the historical context? What are the power dynamics in the SUD Planning Structure's process and products, given historical and current power inequities (locally to nationally)?

7. Can the outcome or impact of any SUD Planning Structure action, decision, process, policy, service be predicted by race? If so, how do we change it, so race is no longer a predictive variable?

8. Who is in the room and who isn't and why? Who is communicating and who isn't and why? Are we allowing dissent? Is the dissenting voice heard in the structure? How are we encouraging/incorporating dissent?

The Impacts of Racism on Substance Use Disorders

Summary of Purpose and Contents

The purpose of the Plan Scope and Use phase was to:

- Consider and evaluate current models and frameworks and identify desired elements/components,[*]
- Consider, evaluate, and identify a desired range of plan uses (such as: funding, service access, advocacy, collaboration/partnership, education and awareness, and other functional uses),[*]
- Identify ways that racism has impacted problem definition, intervention planning and service delivery to date, and
- Develop a racial equity framework to be applied to systems delivering services and coordinated response.[*]

The SUD Workgroup completed this work by:

- Brainstorming the myriad ways that racism has impacted substance use disorders definition, planning, and service delivery, and
- Organizing raw responses into broad themes/impacts.

This document doesn't represent a recommendation; rather, this exercise contextualizes and bridges directly to the SUD Racial Equity Framework (see next deliverable), because "you cannot solve a problem that you cannot name."[†]

Impacts of Racism

Factors Contributing to SUD Treatment and Support	Criminal Justice System vs. Treatment
The experience of racism impacts mental health and contributes to substance use disorders (SUDs). • Research tells us there's a positive correlation between a person's experience with racial discrimination and SUD; the assumption is that substance use is used to reduce stress/stress factors such as: isolation, microaggressions, targeting, discrimination and mistreatment, and more. • Correlation of mental health challenges with SUD, as well as mental health challenges and experience with racial discrimination.	**Overarching theme: Justice system is racialized to incarcerate and criminalize people of color experiencing SUDs (versus to treat white people experiencing SUDs).** **SUDs are criminalized.** • History of how we've looked at substance use – there's been a criminal justice focus. • War on drugs is a war on people (Brown and Black people). In people of color, SUD is not seen as a response to trauma; instead, it's criminalized.

[*] Addressed in another deliverable

[†] Dr. Martha Ramos Duffer, personal communication, February 12, 2021.

Factors Contributing to SUD Treatment and Support	Criminal Justice System vs. Treatment
• People displaying symptoms of disorder may be responding to the cultural conditions placed on them; factors contributing to SUD could also be factors that are culturally derived. • Very limited access to dual diagnosis treatment which impacts effectiveness; hard to treat SUD without addressing mental health issues (with people of color more likely to have mental health issues due to impacts of racism). **Trauma: As a cause of SUDs, trauma disproportionately impacts people of color; trauma is not acknowledged for people of color as it is for people who are white.** • Trauma is overrepresented in people of color. • If drugs are the answer, what was the question in the first place? SUD could be in response to trauma, e.g., using drugs to counteract what was happening within the person, a coping mechanism to not feel what you're feeling. • White community with SUD: asked about their trauma; Black community with SUD: treated as a criminal issue, about the drugs themselves. **Race and privilege impact how SUDs are defined and treated for white people versus people of color.** • Factors contributing to how SUD is treated — race and privilege matter. • Folks in power get to define what constitutes SUD and get to define how a person responds to the program; both are racialized. (Ableism is a part of this.) • Classism: a soccer mom can drink a bottle of wine vs. someone drinking Mad Dog on a street corner. • Classism is a race story. Poor white people pitted against poor people of color. • Lack of BIPOC included in research: they are not part of the norming, so not part of the norm. **Racism impacts social determinants of health:** • Access to basic needs and environmental support: segregated living, environments with less access to resources, not feeling safe in one's own neighborhood (social determinants of health).	**The cyclical nature of racism/incarceration/SUDs engenders and reinforces racial disparities.** • Systemic racism leads to greater criminal justice involvement. • Reentry advocates report that incarceration actually promotes new or renewed use disorders. • Treatment isn't readily available to incarcerated individuals. **The Justice system is discriminatory and has racially disparate outcomes** • Sentencing guidelines are disparate (e.g., cocaine vs. crack, despite the fact that black and white people use cocaine at similar rates). • A white kid might get a warning for marijuana while a Black kid might get arrested for dealing. • People in power are more likely to be able to get their family members "out of trouble" because of access to resources and relationships. • Polarized divisions: more people of color/Black individuals are funneled into incarceration instead of treatment. • Alternatives to incarceration presented as treatment are still punitive in impact. • The punitive nature of responses overall to human challenges, distress, and problems, which then gets further racialized. • Simultaneous infantilization (adults treated as children) & perception of threat (children treated as adults) for people of color. • Criminal justice system at times treats adults as children (e.g., drug courts), potentiated by the intersection of racism and ableism.

Accessing Treatment and Supports	Factors Impacting Effectiveness of Treatment and Supports
Insurance mediates access to treatment and there is racial disproportionality in insurance coverage. • Disproportionality in lack of insurance/underinsurance. • Disparate access to health insurance and jobs that provide insurance. • Parity of insurance coverage – do all plans cover treatment and cover it equally? **Because race and privilege impact how SUDs are defined, they also impact how they are treated.** • SUDs are defined on the basis of social function: racism, class – those are social functioning issues. • Privilege in the availability of treatment, who can get it and who can't, which doors people are accessing is impacted by race. • Challenges with assessment of the need/problem – the cultural norming doesn't translate. • Systemic racism leads to reduced access to treatment and support, fewer options. **Stigma** • Interpersonal racism can lead to stigma, so many don't reach out for help. **Policy can have racist impacts.** • State-level policy decisions that disproportionately impact populations of color (e.g., Texas would look different if we had expanded Medicaid). • Significant underfunding of adequate/sufficient public systems impacts access. • Access to treatment is denied to people who continue to use drugs; insofar as POC experience other dynamics described herein (disproportionate impact, perceived with suspicion, etc.) this may impact people of color more. **Racism impacts the social determinants of health.** • Access to treatment is impacted by segregated living, environments with less access to resources, distance from services, access to transportation, and other environmental justice issues. • Under-investment in the development, enrichment, and preservation of communities of color impacts access to services.	**Because race and privilege impact how SUDs are defined and treated, they also impact effectiveness of those treatments.** • If SUDs are defined on the basis of social function (which is impacted by racism) that has an impact on what is defined as treatment and the effectiveness of treatment; we make it difficult for people of color to function socially, and SUD is defined based on lack of social functioning. • Best practices and treatment have a white-centric approach. To meet the formal definition of a "best practice," it has to be tested and measured by white culture. • Systemic racism reduces treatment efficacy, and we don't know the rubrics and baselines for efficacy for people of color because they are seldom included in samples. • Are a wide range of voices represented in the design of treatment and support, from all groups? • Practices don't have the cultural/ethnic inclusion that they need; some are dated (e.g., from the 1960s). • There is not just one pathway for treatment, it's multiple pathways/choices; however, we have a structured, white-normative way we've operated – "Here's the pathway to follow for this solution." **Individual experiences/not feeling a sense of belonging or connection** • Inability to have an affinity to a group due to racial issues. • Walking into a treatment center and not feeling a sense of belonging or connection to community (if you walk in and everyone is white, you may not feel like you belong). • Environmental cues – Who's in the room? What's on the walls? What music is being played? etc. • Are you perceived to be a threat? What behaviors are policed or punished? If you have big emotions or get angry – how are you being understood? **Racism within treatment relationships** • In mutual aid groups, interpersonal racism can lead to being told something is an outside issue, being told you aren't taking personal responsibility ("Why do you have to make everything about race?"). • Interpersonal racism can lead to an ineffective alliance in the therapy and restorative justice domains.

MINIMUM SPECIFICATIONS FOR SUD CONTINUUM, PLAN SCOPE AND USE

Summary of Purpose and Contents

The SUD Continuum and the SUD Plan were addressed under the "Plan Scope and Use" phase. The purpose of the Plan Scope and Use phase was to:

- Consider and evaluate current models and frameworks and identify desired elements/components,
- Consider, evaluate, and identify a desired range of plan uses (such as: funding, service access, advocacy, collaboration/partnership, education and awareness, and other functional uses),
- Identify ways that racism has impacted problem definition, intervention planning and service delivery to date,[*] and
- Develop a racial equity framework to be applied to systems delivering services and coordinated response.[*]

The SUD Workgroup began this task phase by evaluating four existing, available SUD continuums/models:

- Integrated Health Systems for Addictions Treatment ("Hub and Spoke" model)
- Adult Integrated Behavioral Health System in Travis County: The Desired Continuum of Care
- Austin/Travis County ATOD Asset Map
- ROSC (Recovery Oriented System of Care)

After a robust evaluation, the Workgroup determined that none of the four were an ideal fit for Austin/Travis County to fully adopt as an ideal local SUD continuum/model, although they identified some features from all four to build upon. Ultimately they decided it was the purview of the future SUD Planning Structure to construct the specific, locally-tailored SUD continuum/model as part of its work to develop an SUD plan.

However, the Workgroup did establish minimum parameters for: the future SUD Continuum for inclusion in the plan; the range of uses for the SUD plan; and other plan components and processes. For all three areas, the group identified "Minimum Specifications" which constitute all the "must do" or "must not do" items that are required for success.

This framing document outlines minimum specifications, to serve as a recommended scaffold for the future SUD Planning Structure, for:

1. **What the future plan's SUD Continuum needs to include or address;**
2. **The desired range of plan uses; and**
3. **Other necessary components or processes that must be included in the plan.**

Part 1: The SUD Continuum

This section details the parameters that the future SUD Planning Structure should meet in developing an agreed-upon continuum.[†]

[*] Addressed in another deliverable.

[†] The word "continuum" is used as a placeholder for a design that includes all relevant services, populations, systems and stakeholders required to address SUDs in our community. For the purpose of the exercise, we used the term "continuum" interchangeably with "framework" and "model." The SUD Workgroup acknowledges that it is the purview of the future Planning Structure to develop the appropriate framework, continuum or model, and to name it accordingly.

1. The future SUD Planning Structure must **develop a continuum for substance use, substance misuse, and substance use disorders** in our community.
   - This work is the purview and responsibility of the SUD Planning Structure
   - An SUD Continuum is integral to the development and implementation of an SUD plan
   - The SUD Continuum must be aligned with the SUD Values and the SUD Equity Framework which includes being explicitly anti-racist and anti-oppressive.

2. The Continuum must **not focus solely on clinical services or be purely abstinence-based**; it must also include:
   - Harm reduction strategies (such as, but not limited to: syringe services, drug checking, safe use education, controlled drinking approaches, medication assisted treatment, etc.)
   - Peer services
   - Family services (such as: AL-ANON, Community Reinforcement and Family Training)
   - Recovery support services

3. The Continuum must follow the expertise of those **who are the most impacted by SUDs** and delineate how their decision-making power will be integrated. This includes:
   - Soliciting and valuing the expertise and insights of people in recovery, people who use drugs, and those along that spectrum, as well as the perspectives of their families and allies
   - Including people who use drugs as experts on their own situation and access barriers, not just as case studies
   - Setting up information flow and decision-making processes that prioritize full participation by those most impacted by SUDs.

4. The Continuum must **center the individual goals and values of the person served**. This means:
   - Prioritizing the goals and values of the individual over the goals and values of the entity providing the service
   - Providing entry points into the continuum that meet the individual's unique needs
   - Providing access points all along the continuum that do not present bureaucratic or socio-economic barriers for marginalized populations
   - Drawing upon and responding to the person's natural recovery capital and community
   - Allowing a pathway for each person to move along their desired health promotion trajectory

5. The Continuum must **cover an expansive age range,** including:
   - Services that begin in childhood and span over a lifetime

6. The Continuum must **cover an expansive and robust range of services,** such that it:
   - Offers a diverse menu of services and supports, including those that are culturally affirming and/or multiculturally-driven
   - Is not hierarchical (implying higher and lower levels of care) or primarily linear (implying a set, directional recovery pathway) in nature
   - Integrates the social and medical models of SUD in a recovery oriented construct
   - Acknowledges social and health disparities and addresses connections to systems impacting social determinants of health

- Makes connections to systems addressing co-occurring diagnoses/issues
- Provides alternatives to criminal/juvenile justice interventions that are better addressed through other means (such as: housing, education, employment)

7. The Continuum must be **agnostic towards specific agencies/providers** in its application of resources towards services. For example:
   - Any given agency must not be a gatekeeper for resources (e.g. a sole decision maker about resource allocation, with insufficient oversight and a vested interest in funding outcomes). Any given agency or group of agencies must not drive or dominate the continuum
   - Criminal justice interests/agendas must not drive treatment

8. The Continuum must **challenge the status quo,** including:
   - Dismantling assumptions that the status quo is effective, unbiased, inclusive of our full community, and/or free of stigma
   - Actively seeking to discover what we don't know
   - Applying a critical review to our own ideas

9. The Continuum must **actively combat the role of stigma**, including:
   - Combatting the role of stigma as not just a theoretical notion, but in tangible examples of discrimination and barriers to care
   - Challenging clinical assumptions that everyone who uses drugs has a substance use disorder
   - Identifying and interrupting racist conflations of ethnicity and race with disordered substance use

Part 2: SUD Plan Use

This section details the desired range of uses for the future SUD plan.

1. The SUD Plan must ensure that **funding** is recommended to be allocated all areas of the continuum, including across different geographies (such as: rural/urban), populations (such as: youth/adult), and service types (such as: treatment, harm reduction, prevention, recovery support services, etc.) in the community and in target areas that have clearly defined, specific needs.

2. The SUD Plan must ensure that **services are accessible** across different geographies, populations, and service types in the community.

3. The SUD Plan must be used to **identify service providers/partners in order to define service access points and service gaps**.

4. The SUD Plan must **include indicators** necessary to ensure accountability, disaggregated by race and ethnicity where relevant to the indicator in question. The SUD Plan must be used in a way that **supports collaboration and partnership that is inclusive of different perspectives** that are part of this work.

5. The SUD Plan must be used to **advocate with a collective voice** for the plan's recommendations.

6. The SUD Plan must be used for awareness and education of individuals, families, and communities around substance use disorders as a public health issue.

Part 3: Other components and processes

This section addresses any other components or processes required for plan success which must be included/incorporated within the plan itself.

1. The SUD Plan must include and be informed by **relevant community indicators**:
   - The Planning Structure must collectively determine the relevant community indicators for SUD planning (including asset-based indicators, not just deficit-based indicators)
   - The Plan must outline how the Planning Structure will track or monitor those selected community indicators, being mindful of agency capacity and reasonableness

2. The SUD Plan must include **key performance indicators** for all Plan initiatives and objectives:
   - The Planning Structure must have a consistent reporting system that ensures data integrity
   - The Planning Structure must have a system to track and review performance
   - The Planning Structure must have a system to adjust the Plan based on performance
   - KPIs must include data disaggregated by race.
   - An anti-racist framework must be used to question, understand, and apply the narratives being told by the data.

3. Community and performance indicator **data must be applied in practice** to:
   - Leverage funding for the local community
   - Update/adjust the Plan

4. The SUD Plan must include **a timeline and process for regular updates**:
   - The Planning Structure must establish an appropriate timeframe for updating the Plan
   - The Planning Structure must establish a process to conduct regular review/update the Plan, including reviewing and adjusting community and/or performance indicators as needed

5. The SUD Plan must outline how the implementation of the Plan's objectives and initiatives will **include diverse voices in an ongoing and salient way**:
   - See Participation Recommendations document for more detail on the ways in which diverse voices and directly impacted individuals must be included in the process

6. The SUD Plan must outline **a decision-making process with integrity** that will be used to determine planning priorities and plan changes:
   - See Decision Making Recommendations document for more detail on how the recommended decision-making model will align with SUD Values and SUD Equity Framework and allow for the meaningful contributions of people with lived experience

Critical Functions and Tasks for the Future SUD Planning Structure

Summary of Purpose and Contents

The functions and tasks of the future SUD Planning Structure were considered as part of the Roles and Functions phase. The purpose of the Roles and Functions phase was to:

- Identify all the functions and tasks needed in the SUD Planning Structure,
- Define the capacities, skills, and qualifications of the key functions, and
- Explore philosophy/orientation around different models for structure and how they align with the SUD Values and other decisions made in prior Phases.*

A small subset of SUD Workgroup members completed this work by:

- Using a web-based mind mapping tool to brainstorm all the necessary tasks of the future SUD Planning Structure,
- Grouping the list of tasks into functional areas, and
- Identifying the required knowledge, skills, and capacities needed to carry out the tasks under each functional area.

This document outlines the future SUD Planning Structure's **recommended critical functions, related tasks, and needed capacities for those tasks**. Note that these functions do not necessarily tie to specific and discrete positions; instead, these functions could be distributed in various ways, based on the organizational structure employed by the future SUD Planning Structure and its associated positions. This table serves as a recommendation for the functions that the future SUD Planning Structure must include and perform to be successful in its work.

* The last item is addressed in another deliverable.

Recommended Critical Functions and Related Tasks

Function	Tasks	Knowledge, Skills, and Capacities
The SUD Plan *This section describes everything related to developing and creating the SUD Plan.*	• Write/create the SUD Plan as a professional document • Make the SUD Plan publicly accessible • Coordinate the design/development of the SUD Plan • Design strategy and timeline for implementation of the SUD Plan • Measure progress: gauge how we have made progress on the SUD Plan • Update the SUD Plan on some regular basis [to be determined later]	• Ability to work independently with broad guidance • Ability to pull together wide variety of perspectives and interests and present in an integrated way • Ability to analyze plan from equity and anti-racist values (applying Racial Equity Framework), ensure it addresses all disparities (from all angles) • Skilled in research design and implementing inclusive research methods that involve key informants (such as: focus groups, interviews, etc.); methods should be aligned with Participation Recommendations document • Research skills and ability to align the plan to the SUD value "An Informed Approach" with regard to quality, evidence base, and multiculturally driven approaches • Skilled in data mining, data collection, data analysis and visualization • Ability to incorporate data into the plan and present to Planning Structure leadership • Professional writing and editing • Good collaborative skill set including taking and incorporating feedback • Ability to translate high-level plan into actionable steps, measures/benchmarks, etc. • Lived experience with SUDs • Lived experience with communities most underserved by SUD services • Strong, mutual, interdependent relationships with all communities being impacted and served by the SUD Plan • *Standard for all Functions:* Time to do the tasks (especially if volunteer); Able to work well within a team; Soft skills in interacting with diverse stakeholders

Function	Tasks	Knowledge, Skills, and Capacities
Leadership *Leadership and Oversight may be connected. It will be the job of the future SUD Planning Structure to determine how these functions are distributed.* *Leadership takes action to bring the recommendations to fruition.*	• Develop operational processes for group management that align with the SUD Values and Racial Equity Framework • Maintain an environment that supports the SUD Values and Racial Equity Framework • Manage/lead meetings, including setting agenda, setting tone and expectations, supporting facilitators in their role, and keeping meetings moving forward • Manage plan development process (ensure it applies SUD Values and Racial Equity Framework) and manage plan progress • Market/promote the plan and how it can be utilized • Maintain timelines • Implement the plan in accordance with the Minimum Specifications for SUD Plan Scope and Use [this task is a placeholder for the Leadership's responsibility and represents the entirety of Phase 4 – Implement the Plan; the future SUD Planning Structure will need to revisit and expand on these tasks once the scope of that work is known] • Commit to full participation, collaborative leadership practices, and processes that include leaders from groups most impacted by SUDs and most underserved by SUD services	• Communication and collaboration skills • Skills to present the plan to various stakeholders: Travis County Commissioners Court, City Council, boards, community groups, etc. • Core understanding of the issue area • Strong understanding and application of the SUD Values and Racial Equity Framework • Value all the participants in the process • Embody a "leading to serve" approach • General organizational and project management skills • Working knowledge of the SUD Planning Structure's defined roles/responsibilities TBD • Lived experience with SUDs • Lived experience with communities most underserved by SUD services • Strong, mutual, interdependent relationships with all communities being impacted and served by the SUD Plan • *Standard for all Functions:* Time to do the tasks (especially if volunteer); Able to work well within a team; Soft skills in interacting with diverse stakeholders
Oversight *Oversight and Leadership may be connected. It will be the job of the future SUD Planning Structure to determine how these functions are distributed.* *Oversight ensures fidelity to the recommendations.*	• Ownership of the SUD Values, Racial Equity Framework, and Planning Structure • Operate with transparency and accountability throughout the process • Manage the interplay between planning structure's ongoing work and the positions of decision makers and authorities, including two-way flow of information and guidance • Ensure that the SUD Planning Structure meets the minimum recommendations that came from the SUD Workgroup (i.e., its final recommendations and all deliverables) • Establish and maintain defined roles/responsibilities for all parts of the planning structure	• Communication and collaboration skills • Core understanding of the issue area • Strong understanding and application of the SUD Values and Racial Equity Framework • Value all the participants in the process • General organizational skills • Confidence in interacting with community leadership/decision-makers • Skills in resource management (garner, develop, manage resources) • Working knowledge of policy/legislative context as it relates to the SUD Planning Structure's work (plan development, implementation, etc.) • Lived experience with SUDs

Function	Tasks	Knowledge, Skills, and Capacities
	• Ensure that the plan meets standards of the SUD Values and Racial Equity Framework and meets Minimum Specifications for Plan Scope & Plan Use • Ensure inclusion/diversity across spectrum of services/populations • Support development and maintenance of membership (including actively pursuing compensation/stipend etc. for people with lived experience, and people not working for related organizations, to participate)	• Lived experience with communities most underserved by SUD services • Strong, mutual, interdependent relationships with all communities being impacted and served by the SUD Plan • *Standard for all Functions:* Time to do the tasks (especially if volunteer); Able to work well within a team; Soft skills in interacting with diverse stakeholders
Administration *This section describes the tasks for managing the SUD Planning Structure's membership and meetings.*	• Communicate within membership about: meetings, logistics, how to participate, etc. • Organize meeting logistics (in person or virtual) • Take meeting notes • Capture attendance • Manage current and accurate participant list • Mitigate technology and transportation barriers for participation in meetings • Ensure meeting times consider challenges of shiftwork, parents, hourly workers, etc. • Ensure materials to prepare for meetings are language accessible and received with plenty of time for review • Consider and mitigate technology challenges in accessing documents	• Software skills • Hosting meetings (virtual) • Able to work with community to convene/arrange meetings • Attention to detail (for tasks such as note taking and participation tracking) • *Standard for all Functions:* Time to do the tasks (especially if volunteer); Able to work well within a team; Soft skills in interacting with diverse stakeholders
Facilitation *This section describes tasks related to facilitation of the SUD Planning Structure.*	• Design overall process that works towards the group's long-term goals and timelines • Design discussion structures/activities that are appropriate to the group's short-term goals • Ensure balanced and robust discussions • Create system to ensure equitably shared time communicating in meetings • Strive to provide discreet opportunities for: context and information sharing, discussion, and decisions, for all non-urgent matters • Provide any resulting process documentation from facilitated work (that is not part of the administrative role or the plan-related products)	• Skilled in facilitation • Skilled in creating room for diverse perspectives without privileging any particular outcome. • Not a stakeholder/participant who could directly benefit from the decisions • *Standard for all Functions:* Time to do the tasks (especially if volunteer); Able to work well within a team; Soft skills in interacting with diverse stakeholders

Function	Tasks	Knowledge, Skills, and Capacities
Funding *This section describes tasks related to securing funding.*	• Identify potential funding sources and funding obligations and limitations (either by statute, regulatory requirement, or conventional practice) • Apply for/secure funding that is aligned with/guided by the SUD Plan • Manage funding-related tasks related to the financial support of the planning structure's basic organizational functions, in alignment with the Group Structure Recommendations document	• Understanding of policy/legislative context as it relates to funding opportunities • *Standard for all Functions:* Time to do the tasks (especially if volunteer); Able to work well within a team; Soft skills in interacting with diverse stakeholders
Membership *This section identifies a role for general membership.*	• See Participation Recommendations document for more detail on the ways in which diverse voices and directly impacted individuals must be included in the process	• See Participation Recommendations document for more detail on the range of diverse voices and directly impacted individuals that must be included in the process

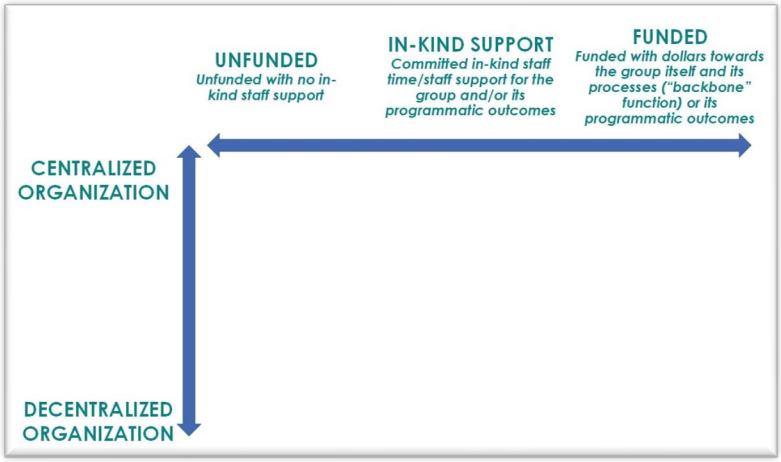
GROUP STRUCTURE RECOMMENDATIONS FOR THE FUTURE SUD PLANNING STRUCTURE

Summary of Purpose and Contents

Group structure was considered as part of the "Roles and Functions" phase. The purpose of the Roles and Functions phase was to:

- Identify all the functions and tasks needed in the SUD Planning Structure (addressed in the prior deliverable: Critical Functions and Tasks),
- Define the capacities, skills, and qualifications of the key functions (addressed in the prior deliverable: Critical Functions and Tasks), and
- Explore philosophy/orientation around different models for structure and how they align with the SUD Values and other decisions made in prior Phases.

The SUD Workgroup analyzed selected factors that influence how group structure can look: Centralized versus decentralized group organization, and whether a group is funded with dollars, provided in-kind support, or unfunded. While there are certainly other factors that impact how group structures differ, and the labels and boundaries between them are not perfectly discrete, these seemed most salient to consider in terms of identifying recommended options for the future SUD Planning Structure:



The SUD Workgroup completed this work by:

- Analyzing each possible scenario,
- Identifying key interests around group structure, and
- Coming to consensus around two possible options that could meet those interests.

This document serves as guidance for how to organize and formally support the future SUD Planning Structure.

Recommendations

The SUD Workgroup reached **a clear recommendation that the future SUD Planning Structure should be formally funded,** with dollars to support the group itself and its processes. The Workgroup also reached a clear consensus against all structure types that rely on in-kind staff support or that are entirely unfunded with no formal staff support.

The Workgroup was divided between a structure that was more centralized versus decentralized, noting benefits and vulnerabilities in both scenarios. Hypotheticals were envisioned with lead agencies, co-leading agencies, neutral third-party support, and broader power-sharing. Ultimately **the Workgroup's list of key interests around structure should guide the final decision on group structure type, as both a centralized or decentralized design could be successful if those interests are honored and incorporated.**

Recommended Structure Types

	Unfunded *Unfunded with no in-kind staff support*	**In Kind Support** *Committed in-kind staff time/staff support for the group and/or its programmatic outcomes*	**Funded** *Funded with dollars towards the group itself and its processes ("backbone" function) and/or its programmatic outcomes*
Centralized Organization	**Centralized structure, unfunded** ***Not applicable in practice***	**Centralized structure with committed in-kind staff support** ***NOT RECOMMENDED by SUD Workgroup*** Average ranking: **2.6**	**Centralized structure, funded with dollars** ***RECOMMENDED OPTION by SUD Workgroup*** Average ranking: **1.4**
Decentralized Organization	**Decentralized structure, unfunded** ***NOT RECOMMENDED, eliminated by SUD Workgroup***	**Decentralized structure with committed in-kind staff support** ***NOT RECOMMENDED by SUD Workgroup*** Average ranking: **3.9**	**Decentralized structure, funded with dollars** ***RECOMMENDED OPTION by SUD Workgroup*** Average ranking: **1.9**

**Average ranking was on a scale of 1 to 4, with 1 being most preferred, and 4 being least preferred.*

Required Interests for Group Structure

Whether the final design tends more towards centralization or decentralization, the future SUD Planning Structure **should organize around a group structure that ensures the following key interests are met**:

1. Dedicated financial resources fund the group's "backbone" operations
2. Utilize a clear and transparent structure
3. Capable of creating and implementing the SUD Plan, consistent with capacities identified in the Critical Functions & Tasks
4. Accountability for the product of an SUD Community Plan that reflects all values and recommendations of the SUD Workgroup
5. Neutral in the management of those processes
6. Has processes and mechanisms for continuity and sustainability over time
7. Includes all expertise, perspectives, lived experiences, diverse representation, and participation that is consistent with the SUD Equity Framework, Minimum Specifications for Plan Scope & Use, and Participation Recommendations
8. Utilizes decision making approaches that build collective buy-in, mitigate against any one party driving the process, and allow for power-sharing among participants (consistent with Decision Making Recommendations)

9. Honors the autonomy of all individual participants/participating entities
10. Protects against conflicts of interest specific to funding allocations/outcomes (such as an entity with a funding stake operating as the sole centralized structure)

Supporting Analysis and Evaluation

Analysis Process

For each group structure scenario, the SUD Workgroup considered:

- What familiar examples exist in our community?
- What benefits could this scenario produce?
- What are the pitfalls/vulnerabilities of this scenario?
- How could this type of structure support or not support the body of the Workgroup's recommendations (specifically: Minimum Specifications for Plan Scope & Use, Key Functions & Tasks, SUD Values, and SUD Equity Framework)?

The results of this analysis were used to move the group towards a shared understanding and consensus-based recommendations around structure options.

Note: Details of analysis are provided for context and process documentation. Where other groups are referenced, this document does not represent a researched/vetted representation of their work, but rather the group's collective understanding of where familiar examples may fall on conceptual spectrum of structure options. Naming known examples served to orient and anchor the SUD Workgroup in a shared understanding of their options for what the future SUD Planning Structure could look like

Recommended Type #1: Centralized structure, funded with dollars

Familiar examples?

- Success By Six: United Way is the backbone and convening entity, local dollars align with resulting plan/recommendations
- CHA/CHIP: City of Austin (APH) is the backbone, funded by public dollars
- Workforce Master Plan: Workforce Solutions is the backbone, local dollars fund the plan

What benefits could this scenario produce?

- There would be resources to fulfill the recommended functions and produce a quality product
- Could result in strong plan and move this work forward
- Creates legitimacy
- Sustainable over time, as it would be integrated into a designated party's work/mission (not "if you have time")
- Funding could encourage longer-term participation/mitigate against fluctuations in participation
- Less staff/volunteer burnout and turnover
- A centralized, funded structure feels "easiest" and familiar; participants may find this structure type easy to follow.
- Depending on funding source, commitment to fund backbone costs from multiple sources (e.g.: all taxing entities) would demonstrate formal support for and legitimize the shared planning table

What are the pitfalls/vulnerabilities of this scenario?

- Smaller organizations could feel like they don't have a voice in a centralized system

- If one sole agency/entity provides the centralized support, may erode community's perception of collaborative engagement and a community-driven plan: Could appear as if that entity is solely responsible for the work and directing the agenda
- Could err towards lack of inclusivity if not structured to be open and inviting
- Potential for funder interests to shift
- Potential for bias from backbone organization to influence process and results
- Potential for funding to drive the outcomes rather than vice-versa

How could this type of structure support or not support the Workgroup's body of recommendations?

- Able to implement the recommendations more effectively if funded
- Potential for longevity/continuity would support the Workgroup's long-term time horizon on recommendations.
- This type's infrastructure potential aligns with the oversight required to support the Workgroup's recommendations
- Backbone organization(s) or entity/entities providing the centralized structure must share and commit to the SUD Values and the SUD Equity Framework in order to successfully operationalize the Workgroup's recommendations

Recommended Type #2: Decentralized structure, funded with dollars

Familiar examples?

- One Voice Central Texas: Consultant provides "backbone" functions, executive and committee roles are shared between member nonprofit leaders and rotated annually, supported by member dues and a foundation grant
- Aging Services Council: Local foundations fund part-time coordinator, Council is led by two rotating co-chairs, work is driven by the membership

What benefits could this scenario produce?

- Decentralized structure could promote more community buy-in, shared responsibility, and broader leadership development by way of participation expectations
- Funding could encourage longer-term participation/mitigate against fluctuations in participation
- Smaller organizations could feel more included/like they have a voice
- Could neutralize or protect against competition and power imbalances, real or perceived
- Potential for a "teal" organizational structure1
- Depending on funding source, commitment to fund backbone costs from multiple sources (e.g.: all taxing entities) would demonstrate formal support for and legitimize the shared planning table

What are the pitfalls/vulnerabilities of this scenario?

- No one entity is responsible for the work
- Relies on community buy-in; without an agreed-upon, formally endorsed supporting entity, participants may feel more empowered to "opt out" which weakens the planning structure (due to historical fragmentation, SUD issue area may be more vulnerable to this dynamic)

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[1]A **teal organization** is an organizational theory that advocates enabling workers' self-management and to adapt as an organization grows. A Teal organization is defined by the three following ideas:

1) *Self-management* suggests a system based on peer relationships with no need for hierarchy, consensus, nor central command and control;
2) *Wholeness* is about enabling employees to present their full personas rather than just their work personas; and
3) *Evolutionary purpose* is the idea to follow the natural evolution of how the organization grows

For more information: https://en.m.wikipedia.org/wiki/Teal_organisation

- Maintaining that community buy-in requires dedicated effort, could be challenging to sustain broad engagement; if participation fluctuates, does this allow small number of voices to dominate?
- Decentralization may weaken the strength of governance and accountability: Would changes in leadership create vulnerabilities? Who provides oversight for accountability?
- Potential for complexity in funding structure (dues, grants, governmental funding, 504 status?)

How could this type of structure support or not support the Workgroup's body of recommendations?

- Able to implement the recommendations more effectively if funded
- Fidelity to SUD Equity Framework may be challenged by greater or more fluid fluctuations in leadership and participation composition

Not Recommended: Centralized structure, committed in-kind staff support

Familiar examples?

- ATC Food Policy Board and its Working Groups: City staff are assigned to support infrastructure of boards & commissions
- Children's Mental Health Plan: Integral Care staff convene/support the planning process, and write the plan with support of steering committee
- Recovery Oriented Systems of Care: Typically in-kind support, varies by community, often with a CADA or other local DSHS/HHSC affiliated agency (intended to become sustainable on their own).
- Community Resource Coordination Groups: state mandated, must have specific participation, funding varies (locally driven)

What benefits could this scenario produce?

- Someone is identified to do the organizational support work (project management, logistics, meeting setup/notes, etc.) via the in-kind support
- In the absence of formal financial support, this structure allows for any type of expertise, human resource, knowledge, participation, contributions etc. to bring value to the group and its work
- An MOU could define what in-kind support would be and could strengthen this style.

What are the pitfalls/vulnerabilities of this scenario?

- Smaller organizations could feel like they don't have a voice in a centralized system
- Having one organization volunteer resources can make it more likely for that organization to steer the work
- In-kind staff may feel like they have to "carry the weight," maybe can't focus on core job duties
- Level of in-kind support can flux or be withdrawn
- Staffing turnover in the supporting organization can result in loss of institutional knowledge
- Reliance on in-kind staff support can under-develop the skillset of the leadership team

How could this type of structure support or not support the Workgroup's body of recommendations?

- This type of structure might not have longevity; would depend on the commitment of the organization providing the in-kind support staff.
- Can you "lock in" in-kind services? Without contractual agreements, support could be time-limited, while our recommendations have a long-term view.

Not Recommended: Decentralized structure, committed in-kind staff support

Familiar examples?

- Central Texas Foodshed Collaborative (under development): City staff loosely organizing/convening an organic community process, participant interest and energy drive the activities

What benefits could this scenario produce?

- With self-selection to participate, participants will see the value of it
- An organic way to begin collaborative or community work
- Few formal constraints
- Flexibility to follow the energy and interests of participants who come to the table

What are the pitfalls/vulnerabilities of this scenario?

- Potential for attrition and movement
- Lack of accountability
- No one entity is responsible for the work
- Risk of incompletion of the Plan itself and the Planning Structure's work
- Structure itself may lack security/stability
- Potential for undue influence by individual(s) who come with high investment and energy; could influence/impact the group's projects and vision
- Self-selection may pose challenges to engaging necessary and diverse mix of participants

How could this type of structure support or not support the Workgroup's body of recommendations?

- This group structure type doesn't align well, as it will require a lot of engagement and oversight to support the Workgroup's recommendations

Not Recommended: Decentralized structure, unfunded with no in-kind staff support

Familiar examples?

- Immigrant Services Network of Austin: Informal leadership made up of participants who volunteer to coordinate and convene, with turnover on ad-hoc basis

What benefits could this scenario produce?

- None identified

What are the pitfalls/vulnerabilities of this scenario?

- This quadrant is very similar to how SUD has functioned thus far: without dedicated staff, no resources for consultant support to move the work forward, and no community planning structure
- Potential for high attrition and movement, which carries risk of incompletion of plan/work.
- No one entity is responsible; without formal funding or formal staff support, the work does not get done

How could this type of structure support or not support the Workgroup's body of recommendations?

- This will not work for the future SUD Planning Structure

Not Evaluated: Centralized structure, unfunded with no in-kind staff support

N/A in practice: If there is no formal funding, no backbone agency, and no formal or attached staff support, there won't be a way to centralize the group structure.

Participation Recommendations for Future SUD Planning Structure

Summary of Purpose and Contents

The purpose of the Participation phase was to:

- Define who will participate/be represented in the SUD Planning Structure,
- Define the range of methods of participation, and
- Decide what is appropriate and possible for each group and supports the SUD Plan.

The SUD Workgroup completed this work by:

- Exploring and identifying the stakeholders or groups that must be included and/or represented in the future SUD Planning Structure, and
- Identifying a range of participation methods as well as recommended mechanisms to share relevant information to the wider community.

This document summarizes the participation roles and methods the future SUD Planning Structure should consider, identifies methods of information sharing, and identifies the stakeholder groups that must be included as participants in the future SUD Planning Structure.

Participation Roles and Methods

This section details the participation roles and methods that the future SUD Planning Structure should consider when engaging stakeholders/groups.

Role	Descriptive Notes
Formal SUD Planning Structure involvement	Comprised of stakeholders/groups referenced below. Fill defined formal roles, committed to long term process.
Local funder involvement	Comprised of relevant local leaders, executives, elected officials, etc.
Participant in one of the other methods listed below	See below

Method	Descriptive Notes
Focus Group	To gather information
Key Informant Interviews	To gather information
Surveys	To gather information, can be ad-hoc or regular/repeated
Community Events	Community hosts and SUD Planning Structure attend and build relationships, conduct outreach, share information/education about SUD Planning Structure and problems being addressed, pass out surveys, etc. SUD Workgroup recommends hosting sessions at nontraditional times/places such as evenings, lunch, in community, and include in person and hybrid options, etc.
Community Forums	SUD Planning Structure could conduct outreach, host, gather input, build relationships, and/or share information/education about SUD Planning Structure and problems being addressed. SUD Workgroup recommends hosting sessions in convenient locations at nontraditional times/places such as evenings, lunch, in community, and include in person and hybrid options, etc. Providing food and childcare increases accessibility.
Regular Meetings	Can serve as grounding touchpoints for everyone involved in an ongoing way
Taskforces or Subcommittees	Could focus on specific topics or provide focused input; could be comprised of people with subject matter expertise ready to lead on specific action items that come out of the planning process

Method	Descriptive Notes
Community Liaison	Could be comprised of people who represent specific parts/aspects of the community, people with expertise from other places that could share what works, and people who bring/share information from existing groups through presentations or reports
Expert Consultants	Knowledge transfer from experts
Community Leaders	Leaders in the community can be utilized to engage diverse voices
Compensation	Explore stipends for volunteerism and participation

Information Sharing

This section details methods to share information, to promote transparency and engagement of the wider community.

Method	Descriptive Notes
Newsletter/Publication	To keep people informed and offer participation opportunities
Other Written Materials	For use at presentations, conferences, talks, townhalls, etc.
Social Media and Other Online Engagement	Utilizing virtual communities and electronic communication
"Virtual Home"	Examples: Online platform that includes a dashboard with work product (i.e., outputs from meetings, etc.) and online dialog option; method for accepting written comments into the process such as an online form
Engaging other entities outside of the SUD community	Advocate for planning objectives/goals to other stakeholders for SUD, outreach (for community organizations who need information and to build out membership)

Stakeholder Groups

This section details stakeholder groups that must be included as participants in the future SUD Planning Structure. The table below includes examples of each type of stakeholder group but is not an exhaustive list. Examples provide some context, and some examples may fit into more than one group. The future SUD Planning Structure is advised to refine this list further for implementation.

Stakeholder Group	Examples (not an inclusive list)
SUD service types, continuum, models	• Screening and assessment • Detox – inpatient and ambulatory • Supportive outpatient treatment • Medication Assisted Treatment (MAT) • Residential treatment centers • Intensive Outpatient (IOP) • Partial Hospitalization (PHP) • Dual diagnosis – mental health and substance use disorders • Outpatient aftercare • Harm reduction specialists • Abstinence-based recovery groups and programs • Sober Living/Recovery Residence • Recovery Community Centers and Recovery Community Organizations • Peer recovery support services (PRSS) providers
Medical providers whose scope includes SUD	• Medical professionals • Federally Qualified Health Centers (FQHCs) • Behavioral health hospitals

Stakeholder Group	Examples (not an inclusive list)
	• Local hospital systems • Primary care • Board certified addiction medicine • Emergency Medical Services (EMS) • Mental health providers
Direct front line workers serving people with SUDs	• Community healthcare workers • Front line service providers (i.e., people who are working directly with persons on a recovery path) • Community care workers • Peer workers • Community counselors
Advocates (for people with SUDs and SUD services)	• Advocacy organizations • Community members
Funders	• Government funders: City, County, Integral Care Substance Abuse Managed Services Organization (SAMSO) • Corporate funders • Private philanthropy
SUD planning bodies	• Recovery Oriented System of Care (ROSC) • Other planning bodies in behavioral health with SUD objectives, e.g., Kids Living Well, Travis County Behavioral Health/Criminal Justice Advisory Committee (BHCJAC), SUD subgroups like Opioid Workgroup
People with lived experience	• People who use drugs • MAT clients • Recovering addicts/alcoholics • People who are actively using substances • People with lived experiences • Families of people with SUDs
People who have been historically or systematically erased or oppressed	• Criminal justice involved individuals (e.g., people on probation or with a criminal record) • Black people • Indigenous people • Latine people • Asian American Pacific Islander (AAPI) people • Other people of color • Trans and non-binary people • Lesbian, gay, and bisexual people • People with disabilities • Representation from groups with unique experiences (homelessness, veterans) • Representation from various age groups – children, adolescents, young adults to aging adults • People who identify as women
Related social service systems	• Education (e.g., schools/ISD's in Travis County, higher education, parent support specialists) • Housing • Workforce • Family support • Prevention services • Etc.

Stakeholder Group	Examples (not an inclusive list)
Criminal justice and child welfare systems	• Criminal justice • Juvenile justice • Probation and parole • Reentry • Legal (Courts, District Attorney, County Attorney, Private Attorney) • Child Protective Services (CPS)
Faith-based sector	• Clergy/faith leaders • Churches • Mosques • Temples • Synagogues • Etc.
Other recovery supports	• Recovery coaches • Yoga and mindfulness

DECISION MAKING RECOMMENDATIONS FOR THE FUTURE SUD PLANNING STRUCTURE

Summary of Purpose and Contents

The purpose of the Decision Making phase was to:

- Explore power, authority, and participation in decision making,
- Identify the desired qualities and features of good decision making for the future SUD planning structure, and
- Recommend a decision-making approach for the future SUD Planning Structure that aligns with the SUD Values and Equity Framework, supports identified roles and functions, and enables the desired participation.

The SUD Workgroup completed this work by:

- Analyzing four models of group decision making,
- Rank ordering them by preference,
- Coming to concensus around one preferred decision-making approach, and
- Identifying a specific list of questions/issues for future SUD Planning Structure to further refine and define, in order to successfully implement the recommended approach.

While the SUD Workgroup was in agreement that they did not want to be overly prescriptive about detailed decision-making protocols, it was important to recommend **a scaffold for a decision-making approach that positions the future SUD Planning Structure to make decisions in alignment with its values**. Decision making matters because the Planning Structure's work will eventually culminate in making decisions,[1] which is how it will execute its power. The SUD Workgroup's task was to position the SUD Planning Structure to be accountable in its decision making, and to adopt decision-making processes for its substantive work that enable decisions that are just, equitable, and inclusive. This document outlines a recommended approach to achieve those ends.

Recommendations

The SUD Workgroup reached **a clear recommendation that the future SUD Planning Structure should use a hybrid decision-making approach, in which the SUD Planning Structure primarily uses a consensus-based process and must identify a secondary mechanism to employ in the case of gridlock**. While rankings were not unanimous, the group leaned towards approaches rooted in consensus-based processes.

The SUD Workgroup also reached a **clear and unified recommendation against using a hierarchical model of decision making** in the future SUD Planning Structure. To a somewhat lesser degree, the Workgroup likewise did not prefer a majority decision-making approach.

[1] The SUD Workgroup developed a rough list of decision types that the future SUD Planning Structure is likely to make. This list is not a definition of their authority, but rather an illustration of their possible purview, as context for this work. These examples include, but are not limited to: What the continuum will look like, what community indicators will be tracked, and how data will be managed and shared (per the Minimum Specifications for Plan Scope & Use); what data, information, and resources will inform its work; where advocacy efforts will be focused, and what gaps are identified for resource development; and how participation will be developed and maintained in the SUD Planning Structure and its activities.

Majority Decision Making	Hierarchical Decision Making
Not Recommended by SUD Workgroup Average ranking: **2.86**	***Not Recommended by SUD Workgroup*** Average ranking: **3.88**
Consensus-Based Decision Making	**Hybrid Approach (consensus basis with an "out" for gridlock)**
Moderately Recommended by SUD Workgroup Average ranking: **1.75**	***Highly recommended by SUD Workgroup*** Average ranking: **1.44**

**Ranking was on a scale of 1 to 4, with 1 being most preferred, and 4 being least preferred.*

The SUD Workgroup also determined that in order to successfully implement the Hybrid Approach, the future SUD Planning Structure must refine the process further and design deliberately around:

- What is **the definition of consensus**? How will consensus be operationalized within the future SUD Planning Structure once it is convened? How will the SUD Planning Structure educate and acclimate all participants to consensus and the hybrid approach?
- What will be **the definition of "gridlock"** that triggers the secondary decision-making mechanism, and what **agreed-upon conditions or indicators** will demonstrate that consensus cannot be reached and the group is in a gridlock;
- Which particular **secondary decision-making mechanism (or combination of mechanisms) will be employed** as the "out" (such as: Will the group default to majority decision making? Will a subset of members make a final decision? Will the leadership of the planning structure decide? Will the group appeal to an outside decision maker or authority? Etc.); and
- Given that every method has its own unique vulnerabilities (detailed in the analysis section that follows), how will the planning structure **mitigate against the identified vulnerabilities of the selected secondary decision-making mechanism**?
- For the full decision-making process, articulate how it will be operationalized in accordance with the SUD Values and the SUD Racial Equity Framework, including attention to transparency and information flow prior to, during, and following decisions.

Definitions

The following working definitions and examples were provided to inform the Workgroup's analysis.

Majority decision making: The option chosen is the one that the most people support. Examples:

- Voting
- Robert's Rules of Order

Hierarchical decision making: A person or party in a position of power or authority makes the decision. They may gather ideas or input from others, but the final decision is up to them. Examples:

- Executive decision making, with or without consultative staff input
- Boards and Commissions that inform and make recommendations to Council, and Council makes final decisions

Consensus-based approach: The decisions are made by the group as a whole. Participatory processes are used to reach group agreements. Everyone can live with the solution chosen. Example:

- This SUD Workgroup's process to create recommendations, whereby all Workgroup members had equal opportunity to participate in the process, shared in the development of the products, and came to agreements around recommendations

Hybrid approach: A consensus-based process with an "out" if you end up with a gridlock. The group collectively determines what decision mechanism will be used if consensus cannot be reached. Example:

- Travis County HHS staff provided an example of a past internal management team project: A management team worked towards consensus around a particular problem, but if consensus couldn't be reached around a solution, then their director would choose the solution.

Supporting Analysis and Evaluation

For each decision making model, the SUD Workgroup considered:

- What might be the benefits of this approach? What might this approach enable?
- What might be the unintended consequences of this approach?
- Who is likely to benefit from this approach?
- Who is likely to be harmed by this approach? Which opinions or perspectives are likely to be missed or erased?
- How does the model allow for the contributions of people with expertise, including lived experience, in the areas being considered?

The results of this analysis were used to move the group towards a shared understanding and consensus-based recommendations around their preferred decision-making approaches.

Highly Recommended Model: Hybrid-Approach (i.e., a consensus-based process with a secondary mechanism in the case of gridlock)

What might be the benefits of this approach? What might this approach enable?

- Combines strengths of multiple approaches
- Allows for full engagement of the group while still ensuring a decision is made
- Get buy-in without potential fatigue
- Would avoid the gridlock/getting stuck; can "use a lifeline" that they have chosen together

What might be the unintended consequences of this approach?

- You might give up on the consensus model too quickly in favor of the "out" (especially if under time constraints)
- Unintended consequences depend on the "out" that is selected; very important to define, understand, and control for the concerns related to that method
- Contingent upon successful consensus decision to identify the secondary mechanism

Who is likely to benefit from this approach?

- Everyone; the group at large and the population of focus

Who is likely to be harmed by this approach? Which opinions or perspectives are likely to be missed or erased?

- Harms/erasures depend on the "out" that is selected; very important to define, understand, and control for the concerns related to that method

How does the model allow for the contributions of people with expertise, including lived experience, in the areas being considered?

- Same as consensus-based approach to decision making

Moderately Recommended: Consensus-Based Approach

What might be the benefits of this approach? What might this approach enable?

- Everyone is involved, has a voice, can participate, people feel heard
- Generates buy-in
- Generates informed decision making because it allows the chance to vet information
- Promotes negotiation and discourse
- Variety of voices and perspectives are incorporated into decision making process

What might be the unintended consequences of this approach?

- Time: Can create a lengthy process, especially if it's hard to get one or more stakeholders on board; can take too long to make a decision; drawback if you need to make a decision on a timeline
- Stagnation if unable to move forward, circular conversations with no decision making
- Stakeholder engagement: Individuals who struggle with a process approach may get impatient or frustrated; if it takes too long to make a decision, people give up, drop out, acquiesce without truly supporting the decision, may feel pressured due to perceived lack of time (negatively impacting decisions made)
- Potential for "group think" in this model as you spend a lot of time together moving towards consensus

Who is likely to benefit from this approach?

- Individuals who have strong opinions and are open to voicing those opinions have a platform for their perspective
- Expectation of everyone's involvement may benefit community members, individuals with lived experience
- Minority perspectives have a voice and influence
- The underserved community

Who is likely to be harmed by this approach? Which opinions or perspectives are likely to be missed or erased?

- Leadership and high-level decision makers who can't make the time commitment
- The collective group, if multiple participants drop out or reduce engagement, then decisions might not include everyone as intended
- Those who aren't process-oriented and desire more action-oriented decision making
- People who may not be comfortable voicing their interests/concerns (due to participation preferences or newness to the process)

How does the model allow for the contributions of people with expertise, including lived experience, in the areas being considered?

- Designed to allow for contribution from all stakeholders, including experts, impacted individuals, and individuals with lived experience
- This model allows for a larger decision-making body/group of people

Not Recommended: Majority Decision Making

What might be the benefits of this approach? What might this approach enable?

- Most people understand it, it's easy, people are comfortable with it
- Facilitates quick decision making (expeditious, streamlined)
- Creates movement, for better or worse

What might be the unintended consequences of this approach?

- Whoever shows up is the majority; decisions will vary depending on who is there in the moment; the decision could be perceived to represent a faction
- Minority opinions/dissenting voices can be lost or discarded; could lead them to question the decisions being made, impact their participation
- Decisions would only reflect the values and perspectives of the majority (becomes greater vulnerability if the group tends towards homogeneity)
- Doesn't correct for lack of understanding
- Doesn't promote innovative thinking or problem solving
- In practice could lead to a small group making the decision, depending on group size, quorum, and threshold required for the majority (Ex: If for a group of 20 the quorum is 11, and only the quorum of 11 are actually voting, in reality 6 people make the decision for 20.)
- Group members moving towards the perceived positions of power, which relates to equity, political dynamics, funding considerations etc.
- All above factors could cause inequity

Who is likely to benefit from this approach?

- Whoever is present
- Those who have like minds/a shared perception on the decision or topic
- "Status quo": continuation of prevailing ideas; this approach makes it hard to dislodge ingrained thoughts; when decisions are made quickly, who benefits may be the status quo (e.g. if you are not thinking about the decision through an equity framework)

Who is likely to be harmed by this approach? Which opinions or perspectives are likely to be missed or erased?

- Those who disagree with the majority; the minority opinions would not be represented in the decision, their thoughts would be lost, they are disempowered
- The group/community as a whole: results negatively impacted because we might be missing the value of what minority opinions would bring to the process
- People with lived experience, who may not always be present to vote

How does the model allow for the contributions of people with expertise, including lived experience, in the areas being considered?

- Does create space for those with professional expertise
- Regardless of expertise, everyone gets to vote, but the weighting of expertise is not always there
- Would have to be built into the model explicitly and with intention (either into the Planning Structure itself or into a subgroup)

Not Recommended: Hierarchical Decision Making

What might be the benefits of this approach? What might this approach enable?

- Results in definitive decision making
- Easy and quick ("a person decides and it's done")
- Easier to maintain control over the decision-making process
- Prevents immobility, stagnation: When an authority is in place to make decisions, avoids gridlock
- If there is a person who is determined to be the hierarchical decision maker, there would hopefully be thought and consideration put into that designation; they would presumably have the authority and power (which we give them) to make decisions and institute change quickly

What might be the unintended consequences of this approach?

- One person can discard input if they want to; participants could be resentful if their ideas/thoughts are discarded, could create a sense of futility (people feel not heard, not included, oppressed)
- Doesn't protect against biases. Factors that can have an impact include: term limits for the authority, recruitment process for this position, etc.
- Doesn't support community buy in
- Could lack diversity and/or equity, may not align with the SUD Values or the SUD Equity Framework
- With changing roles, the decisions can change when people change in those role(s)
- Counterproductive to a group process for decisions that involve diverse thought
- One person's decisions could conceivably impact thousands of people (how do you know if you have the right person making this decision?)

Who is likely to benefit from this approach?

- People in power, people with power
- The people who have the most access to the decision makers
- The people who are the most vocal; the "squeaky wheel"
- People who want quick decisions

Who is likely to be harmed by this approach? Which opinions or perspectives are likely to be missed or erased?

- Those who don't have access to decision makers
- The community at large: Planning Structure won't get diversity of approach in decision making that ensures all impacted persons are heard
- Those who fall outside of the focus of the hierarchical decision maker
- People who feel they are not heard, not included, feel a sense of oppression in this approach

How does the model allow for the contributions of people with expertise, including lived experience, in the areas being considered?

- We may lose the voice of individuals with lived experience due to stigma and/or lack of ability to speak to/of the hierarchy
- The person/party making the decisions would have to explicitly consult with people with expertise (for example, a community oversight committee to review decisions made)
- Would be minimal: only if there are members with lived experience and they have an ability to contribute
- Unclear how or if this model does allow for contributions from diverse group of people including lived experience, and something that is authentically representative of our community

CONVENING ENTITY RECOMMENDATIONS FOR THE FUTURE SUD PLANNING STRUCTURE

Summary of Purpose and Contents

The purpose of the Convening Entity phase was to:

- Identify the desired qualities and characteristics needed for the convening entity;
- Explore what entity has these qualities and characteristics to serve as the convening entity; and
- Make a recommendation around the convening entity of the future SUD Planning Structure, that will be responsible for developing, coordinating, and implementing an SUD community plan

The SUD Workgroup completed this work by:

- Using all of its 2020-2021 work and products, identifying the criteria to use to evaluate options;
- Generating a list of options for convener(s);
- Evaluating all of the options against its criteria; and
- Aiming for consensus around recommended convener(s) to be conveyed to Approval Authorities, along with all final deliverables.

This document conveys the **final menu of recommended SUD Planning Structure Convener options for Approval Authority consideration and decision**, a detailed supporting analysis of all options considered, and process documentation of how the Workgroup arrived at these final recommendations.

Key Recommendations

Two Final Options

About a dozen potential convening entities were analyzed in full by the SUD Workgroup. The Workgroup's draft recommendations were vetted by the SUD Leadership Review Group, and facilitators integrated their input into the final recommended options. (The complete analysis and recommendations process is detailed in next section of this document.) **Ultimately, two choices are presented to the Approval Authorities as viable options for the convening entity of the SUD Planning Structure**:

	Create a New Collaboration: SUD Consortium	Existing Single Entity: LBHA Designation for Integral Care
"Take-Away"	*A fresh new start, but we have to build it from ground zero. High risk, high reward.*	*Infrastructure and expertise are the strengths; trust is the challenge.*
Description	Form a new collaboration to serve as the convener of the SUD Planning Structure. Build the new collaboration on the collected	Seek a Local Behavioral Health Authority (LBHA)[1] designation for Integral Care, which is currently the Local Mental Health Authority (LMHA); the

[1] The Texas Health and Safety Code (Sec. 533.0356) notes that the Local Behavioral Health Authority (LBHA) has all the responsibilities and duties of a local mental health authority and the responsibility and duty to ensure that chemical dependency services are provided in the service area as described by the statewide service delivery plan. Section 533.0356 further states that the department may delegate to an LBHA the authority and responsibility for planning, policy development, coordination, resource allocation, and resource development for and oversight of mental health and chemical dependency services in that service area. An LBHA designated by Texas Health and Human Services Commission would include the Local Mental Health Authority (LMHA) responsibilities. Integral Care is currently our community's designated LMHA. If another organization were to be designated as an LBHA, they would have to take on all the responsibilities, including service delivery, of the LMHA. A scenario in which Integral Care no longer functions as the LMHA because another entity is designated as the LBHA was not explored by the Workgroup, because it was not offered/brainstormed as a practical option for consideration.

	Create a New Collaboration: SUD Consortium	Existing Single Entity: LBHA Designation for Integral Care
	recommendations from this planning process and to the specifications of its deliverables.	LBHA would serve as the convener of the SUD Planning Structure.
Strengths, opportunities, rewards	• A new start means the ability to build a new system • Could design to closely embody the scaffold of Workgroup recommendations • Unique opportunity for robust application of racial equity framework • Offers opportunity for inclusive participation of those with lived experience • Bring in community members on equal footing, reduce unequal power dynamics • Chance to create diverse ownership	• Accountability: HHSC oversight, designated rules and responsibilities would have to be followed • Existing infrastructure in place • May result in faster timeline • Track record and experience, proven ability in planning • Alignment with realities of implementation • Well resourced
Weaknesses, challenges, risks	• Will take time to build; delays getting the planning started while needs are urgent • No track record, no existing infrastructure to build/sustain it • Startup entity; needs a lot more work to become operational • "It all depends on how it's built"	• Community may not perceive this different from Integral Care • Trust concerns; Will SUD community: see it as neutral? feel their voices are valued? Rebuilding trust requires a lot. • Perceptions of IC may erode community buy-in in planning process • Potential/perceived conflict of interest (could benefit directly from the plan by receiving additional resources)
Preliminary implementation considerations	• Who establishes the governance structure, and who governs the consortium? • To whom is the consortium accountable? • Who will be the fiscal agent? • How long will it take to launch a brand new consortium? • If this option is selected, a subset of this Workgroup may need to sketch out/mockup a fuller proposal and/or a process to solicit proposals	• Integral Care's three appointing authorities (Travis County, City of Austin, and Central Health) make the request to HHSC, and then HHSC designates • Who takes the lead in creating the infrastructure, HHSC or Integral Care? • What will trust building look like? How does the LBHA achieve buy-in across the community? What safeguards will need to be in place for community to support it? • Perceived expedience on front end may be offset by time required to garner public support • Could LBHA have a governance structure outside of Integral Care to address potential conflicts of interest?
	For both: • Who will fund it, and how much will it cost to support the backbone functions? (Answers depend on which structure is operationalized) • Timeline concerns: Community is in a "holding pattern" while SUD needs are urgent. What will the timeline be?	

The Workgroup concluded that **both of these Convener options – forming a new SUD Consortium, or seeking an LBHA designation for Integral Care – would be a "heavy lift," but for different reasons**: the new Consortium due to start-up requirements, and the LBHA designation because of community buy-in hurdles. Those who most favored the SUD Consortium did so for its "blank slate" quality, and felt it offered the greatest opportunity for collaboration, inclusive participation for those with lived experience, and designing for the ideal; those who most favored the LBHA designation felt it would be fastest and most practical to resource and implement. While

a few Workgroup members expressed a strong preference for one over the other, the majority clustered their top rankings around these two options.

The Workgroup did reach **a clear consensus to rule out local existing collaborations as Conveners,** as none were well matched to the group's criteria for the future SUD Planning Structure Convener, although existing collaborations and their members could easily participate in the future SUD Planning Structure (but not as the convener). While the Workgroup did identify several existing single entities with various strengths for this work, ultimately **none of those existing entities emerged as a best fit for the Convener role** and were not evaluated as highly as the two options submitted for final consideration.

The Leadership Review Group was invited to vet the Workgroup's analysis and recommendations. Respondents were equally split in their rankings of the final two options, and their supporting rationale for their rankings was aligned with the analysis generated by the Workgroup.

Operational and Funding Considerations

As the Workgroup determined in its Group Structure Recommendations, **the backbone functions of the future SUD Planning Structure must be funded,** for the structure itself to be viable and sustainable. This funding would support the operations of the Planning Structure to convene participants and develop and implement the SUD Plan; this is distinct from any potential future investment in programming or services. Therefore, **either option will carry some resource implications.**

Travis County Health & Human Services planning staff offer the following resource considerations, based on our collective experience in community planning/community collaboration:

- **Staffing:** The structural scaffold that comprises the Workgroup's full recommendations likely requires the equivalent of several full time staff to cover and/or coordinate the Critical Functions and Tasks [link] for the future SUD Planning Structure. The nature of the work likely requires some or most of those human resources to be highly skilled in planning and convening, while some could support administrative/organizational tasks and stakeholder management. Additionally, discrete tasks could be contracted or subcontracted.
- **Space, equipment, technology:** While work practices continue to shift and resettle into new patterns as a result of the pandemic, it is difficult to prescribe the specific logistical arrangements required. However, it would be prudent to account for office space to physically house staff. Regardless of whether staff are located remote or on-site, technology will be critical, including hardware and software, online tools/subscriptions, an online home for sharing information and engaging participants, provision of hotspots and devices for participants, etc.
- **Participation:** The Planning Structure recommendations are predicated on strong community participation, the inclusion of lived experience and diverse voices, and the embodiment of a Racial Equity Framework; this work must be resourced. To fully realize the Workgroup's recommendations, the budget must include sufficient resources for meaningful and sustained community engagement efforts (such as: stipends, food, childcare, space rentals, translation and interpretation, online interfaces for participation, etc.), as well as training and professional development in all relevant areas (such as: community-based approaches to public participation, racial equity, effective meetings and group communication, generative conflict).

- **Joint funding approach:** Joint funding by the three local taxing authorities (Travis County, City of Austin, and Central Health) would not only ensure the pragmatic sustainability of the Planning Structure, but it would imbue the Planning Structure with broad institutional support and ensure that all local policy makers are oriented to the same planning table. This shared institutional support would also build its credibility and encourage community participation in the Planning Structure's work. If funding for backbone operations is distributed between the three authorities, the ongoing costs could be modest relative to the benefits. Specific funding models could be examined further once a convening entity option is selected.
- **Funding level:** Exact funding level would require further exploration to itemize and refine all costs. A fixed amount could be identified for ongoing funding, with the first year requiring additional start-up resources/costs. Once established, the Planning Structure may seek additional funding, particularly for services, however the backbone functions should continue to be funded by stable local dollars.

A more detailed cost proposal could be developed during transition work, to include all of the above components, depending on which Convener option is selected by Approval Authorities.

Supporting Process Notes and Analysis Results

The work of developing convener recommendations was accomplished across three work sessions. The first meeting focused on level setting and criteria development; the second, on analysis of options against selected criteria; and the third, on evaluating and ranking final options to create recommendations.

Level Setting and Developing Convener Criteria

Peer presentations and criteria generation: Facilitators wanted evaluative conversations about the potential Planning Structure convener to be rooted in all the foundational work that came before. For each deliverable to date, facilitators identified a Workgroup member who was integral to its development and invited them to provide a brief summary in the meeting of: *What is the purpose of the product? What are its key recommendations? And what does this product tell us about the convener of the future SUD Planning Structure?* Following each peer summary, the full group was invited to add to the brainstormed criteria list.

Facilitator aggregation: After the meeting, Facilitators reviewed and consolidated the list of criteria for each deliverable, ranging from two to five concise bullet points for each. We combined like content, streamlined wording, and retained the most salient points; when an idea was replicated across deliverables, we listed that idea only once under the deliverable that fit best.

Final Criteria List

The final criteria list informed us of what the convener entity must be, do, or have. Importantly, the group refined a shared understanding that the criteria list represents an ideal state; that the convener does not have to possess every quality, characteristic, or skill themselves, but must be trusted to develop them or convene them; and that the convener may not have to conduct all of the work themselves, but must be trusted to convene the necessary participants to do so collectively.

Values Criteria:

What do our SUD Values [link] tell us that the Convener of the future SUD Planning structure must be, do, or have?

- Accept and embody the Values as guiding principles
- Must use Values as the guiding lights for decision making and to anchor the group's direction

Past Key Learnings Criteria

What do our Past Key Learnings [link] tell us that the Convener of the future SUD Planning structure must be, do, or have?

- Trusted
- Neutral
- Effective
- Committed to long-term process
- Committed to inclusion of people with lived experience

Racial Equity Framework Criteria

What does our Racial Equity Framework tell us that the Convener of the future SUD Planning structure must be, do, or have?

- Willing to apply Racial Equity Framework to disrupt patterns of racial inequity
- Have experience/history of integrating Racial Equity Frameworks
- Capable of developing practices to apply Racial Equity Framework to its structure, operations, plan development, plan implementation, and to test its work against the Racial Equity Framework

Minimum Specifications for Plan Scope & Use Criteria

What do our Minimum Specifications for Plan Scope & Use tell us that the Convener of the future SUD Planning structure must be, do, or have?

- Attitudinal disposition to follow the evidence, measure interventions, revise beliefs and practices
- Elevate/empower those who are most directly impacted
- Committed to fighting stigma and structural systems of oppression
- Commit to non-hierarchical practices and equity in power structure

Critical Functions and Tasks Criteria

What do our Critical Functions and Tasks tell us that the Convener of the future SUD Planning structure must be, do, or have?

- Have ways to ensure that all critical functions and tasks are managed/covered
- Possess high level of hard and soft skills and abilities needed by the convener

Group Structure Criteria

What do our Group Structure Recommendations tell us that the Convener of the future SUD Planning structure must be, do, or have?

- Capable of managing a formally funded collaboration
- Must demonstrate (or be capable of developing) skills/abilities to organize the planning body around a group structure in a way that fulfills the Key Interests list

Participation Criteria

What do our Participation Recommendations tell us that the Convener of the future SUD Planning structure must be, do, or have?

- Has (or can build) capacity to use full variety of methods
- Capable of meaningfully integrating participation into the Planning Structure's work
- Committed to inclusion, accessibility, removing barriers to participation, and addressing gaps in representation

Decision Making Criteria

What do our Decision Making Recommendations tell us that the Convener of the future SUD Planning structure must be, do, or have?

- Experienced in collaborative decision making
- Committed to process that is inclusive of all voices
- Leads to informed decisions
- Committed to transparency in decision making

Identifying Options for Consideration

To generate our list of options for consideration, we:

- Reviewed the list of previously identified planning groups or collaborations that addressed or overlapped with SUD-related issues or populations (generated during phase 2);
- Invited the group to add any relevant existing groups/collaborations that were not already on the list;
- Invited the group to add any existing single organizations/entities that might be considered for the convener role;
- Invited the group to add any new ideas for entities that don't already exist; and
- Removed one option because it did not fall within the geographic scope of Austin-Travis County.

The full list of options for consideration included:

- Four existing local collaborations:
  - Austin Area Opioid Workgroup
  - Greater Austin Recovery Oriented System of Care (ROSC)
  - Travis County Behavioral Health & Criminal Justice Advisory Committee (BHCJAC)
  - Travis County Youth Substance Abuse Prevention Coalition (YSAPC)
    - *Note: At the time of writing, YSAPC is in the process of combining efforts with Kids Living Well.*
- Five existing local single entities:
  - Addiction Research Institute at the University of Texas at Austin School of Social Work
  - Bluebonnet Trails Community Services, providing OSAR (Outreach, Screening, Assessment and Referral) services to our region
  - Dell Medical School
  - Integral Care (as a convening entity without the LBHA designation)
  - Travis County Health & Human Services
- One idea for a new single entity as convener:
  - LBHA designation for Integral Care
- One idea for a new collaboration as convener:
  - Create a new collaboration, an SUD Consortium

Applying Criteria to Options

Process: Using an interactive virtual tool, the Workgroup conducted a detailed analysis on every option, assessing how well it met the identified Convener criteria (assuming backbone operational functions were funded). They also shared substantive rationale, and generated considerations and questions where applicable. The following screenshot illustrates the exercise, which was repeated for all options considered:

Criteria	*Move your dot to your selection*	How well does this option meet the criteria? ☹ Not at All/Very Little	😐 Somewhat	☺ Mostly or Fully	? Unknown/Unsure
Values Criteria: ● Accept and embody the Values as guiding principles ● Must use Values as the guiding lights for decision making and to anchor the group's direction					
Past Key Learnings Criteria: ● Trusted ● Neutral ● Effective ● Committed to long-term process ● Committed to inclusion of people with lived experience					
Racial Equity Framework (REF) Criteria: ● Willing to apply REF to disrupt patterns of racial inequity ● Have experience/history of integrating REFs ● Capable of developing practices to apply REF to its structure, operations, plan development, plan implementation, and to test its work against the REF					
Min Specs for Plan Scope & Use Criteria: ● Attitudinal disposition to follow the evidence, measure interventions, revise beliefs and practices ● Elevate/empower those who are most directly impacted ● Committed to fighting stigma & structural systems of oppression ● Commit to non-hierarchical practices & equity in power structure					
Critical Functions and Tasks Criteria: ● Have ways to ensure that all critical functions and tasks are managed/covered ● Possess high level of hard and soft skills and abilities needed by the convener					
Group Structure Criteria: ● Capable of managing a formally funded collaboration ● Must demonstrate (or be capable of developing) skills/abilities to organize the planning body around a group structure in a way that fulfills the Key Interests list					
Participation Criteria: ● Has (or can build) capacity to use full variety of methods ● Capable of meaningfully integrating participation into the planning structure's work ● Committed to inclusion, accessibility, removing barriers to participation, and addressing gaps in representation					
Decision Making Criteria: ● Experienced in collaborative decision making ● Committed to process that is inclusive of all voices ● Leads to informed decisions ● Committed to transparency in decision making					

After the work session, facilitators quantified results by calculating weighted total scores and average scores for all options, as well as the average response count (N) for each option (excluding non-response or unknown/unsure responses). Salient substantive observations were carried over into Evaluation work in the next meeting.

Detailed Results: The following table details the full analysis results. (Note on scoring scale: 1 = meets criteria not at all/very little, 2 = meets criteria somewhat, 3 = meets criteria mostly or fully.)

	New Collab-oration	New Single Entity	Existing Single Entities					Existing Collaborations			
Criteria	*SUD Consortium*	*LBHA designation for Integral Care*	*Integral Care (no LBHA)*	*Dell Med School*	*Bluebonnet Trails*	*Addiction Research Institute @ UTSSW*	*Travis County Health & Human Services*	*Austin ROSC*	*Austin Area Opioid Workgroup*	*Travis County BHCJAC*	*Travis County YSAPC*
Values	3.0	2.6	3.0	2.7	2.8	2.8	2.9	2.8	3.0	2.7	3.0
Past Key Learnings	2.7	2.4	2.6	2.5	2.9	2.8	2.9	2.9	2.6	2.1	2.6
Racial Equity Framework	2.7	2.8	2.8	2.8	2.5	2.6	2.7	2.8	2.0	1.9	2.5
Min Specs for Plan Scope & Use	2.9	2.2	2.7	2.3	2.8	2.7	2.8	2.7	2.8	2.2	2.7
Critical Functions & Tasks	2.9	2.8	2.9	2.6	0	2.8	2.9	1.4	1.5	2.2	2.1
Group Structure	2.8	3.0	2.9	3.0	3.0	2.8	2.9	2.0	2.1	2.1	2.0
Participation	2.8	2.6	2.7	2.7	3.0	2.7	2.9	2.4	2.4	2.3	2.3
Decision Making	2.8	3.0	2.6	1.5	1.5	2.7	2.8	2.4	2.5	2.1	2.5
Average score (overall)	**2.83**	**2.63**	**2.75**	**2.57**	**2.89**	**2.71**	**2.85**	**2.39**	**2.47**	**2.20**	**2.50**
Average N of scored responses	**10.4**	**9.4**	**10.5**	**4.5**	**2.375**	**8**	**8.125**	**7.5**	**4.5**	**8.6**	**4.5**

"Funneling" Down to Final Options

Using the full analysis results above, facilitators removed four options with a small number of scored responses, i.e., less than half of the Workgroup evaluated the option [see first four lines of the below table].

Options analyzed	Score	N
Bluebonnet Trails	*2.89*	*2.38*
Austin Area Opioid Workgroup	*2.47*	*4.50*
Travis County YSAPC	*2.50*	*4.50*
Dell Medical School	*2.57*	*4.50*
Greater Austin ROSC	2.39	7.50
Addiction Research Institute at UT School of Social Work	2.71	8.00
Travis County Health & Human Services	2.85	8.13
Travis County BHCJAC	2.20	8.63
LBHA designation for Integral Care	2.63	9.38
SUD Consortium	2.83	10.38
Integral Care (without LBHA designation)	2.75	10.50

Next, facilitators removed one option with a low score [see first line of the below table]. While the Greater Austin ROSC score was lower than the cutoff (less than 2.50, i.e., below a score between "Somewhat" and "Mostly or Fully" overall), facilitators opted to keep it in the final list of options as the only potential Existing Collaboration that could serve as the Convener.

Options analyzed	Score	N
Travis County BHCJAC	*2.20*	*8.63*
Greater Austin ROSC	2.39	7.50
LBHA designation for Integral Care	2.63	9.38
Addiction Research Institute at UT School of Social Work	2.71	8.00
Integral Care (without LBHA designation)	2.75	10.50
SUD Consortium	2.83	10.38
Travis County Health & Human Services	2.85	8.13

The final options list that moved forward to the SWOC-Lite Evaluation step included at least one option from each category.

Category	Final Option	Score	N
New Collaboration	SUD Consortium	2.83	10.38
New Single Entity	LBHA designation for Integral Care	2.63	9.38
Existing Single Entity	Addiction Research Institute at UT School of Social Work	2.71	8.00
	Integral Care (without LBHA designation)	2.75	10.50
	Travis County Health & Human Services	2.85	8.13
Existing Collaboration	Greater Austin ROSC	2.39	7.50

SWOC-Lite Evaluation on Final Options

For each option, the group considered:

- *What are the strengths, opportunities, and potential reward?*
- *What are the weaknesses, challenges, and potential risks?*

Aggregated results of this evaluation are summarized in the following tables.

(Also as part of this exercise, the group did some preliminary brainstorming around hypothetical implementation planning for each option, in order to better inform their final rankings. Selected implementation considerations for top recommended options appear at the end of this document.)

Category: New Collaboration **SUD Consortium**	
Takeaway: A fresh new start, but we have to build it from ground zero. High risk, high reward.	
Strengths, opportunities, rewards	**Weaknesses, challenges, risks**
• A new start means the ability to build a new system • Could design to closely embody the scaffold of Workgroup recommendations • Unique opportunity for robust application of racial equity framework • Offers opportunity for inclusive participation of those with lived experience • Bring in community members on equal footing, reduce unequal power dynamics • Chance to create diverse and shared ownership	• Will take time to build; delays getting the planning started, when needs are urgent • No track record • No existing infrastructure to build/sustain it • Start-up entity; needs a lot more work and potentially more resources to become operational

Category: New Single Entity **LBHA Designation for Integral Care**	
Takeaway: Infrastructure and expertise are the strengths; trust is the challenge.	
Strengths, opportunities, rewards	**Weaknesses, challenges, risks**
• Accountability: HHSC oversight, designated rules and responsibilities would have to be followed • Existing infrastructure in place • Well organized and well resourced • May result in faster timeline • Track record and experience, proven ability in planning • Committed professionals who care about this issue • Alignment with realities of implementation	• Community may not perceive this as different from Integral Care • Trust concerns; Will SUD community see it as neutral? Will they feel their voices are valued? Rebuilding trust requires a lot. • Perceptions of Integral Care may erode community buy-in in planning process; unclear how to overcome these negative perceptions • Could subsume/prevent progress on a community-wide strategy for SUDs as public health issue • Potential or perceived conflict of interest (could benefit directly from the plan by receiving additional resources); "messy." • Concern with a "single voice" with high control

Category: Existing Collaboration **Greater Austin ROSC**	
Takeaway: Diverse membership and shared values, but lacking infrastructure and consistency.	
Strengths, opportunities, rewards	**Weaknesses, challenges, risks**
• Diverse membership, broad representation across SUD community • Mission, values, commitment to inclusion and equity are in strong alignment with values identified by SUD Workgroup • Established, long history in the community • Expertise in field of substance use • Despite being unfunded, under-resourced, and lacking infrastructure, has produced some quality programming	• Not experienced with planning, not formed to do this type of work • Lack of infrastructure to do long term or large scale planning work • Historically inconsistent membership • Concerns about sustainability • Under-resources

and collaborations: what would it look like if it were funded?	

Category: Existing Single Entity **Integral Care (without LBHA designation)**	
Takeaway: Has the infrastructure, but trust is the challenge.	
Strengths, opportunities, rewards	**Weaknesses, challenges, risks**
• Established knowledge and planning experience • Subject matter experts • Existing infrastructure to support community planning	• If Integral Care is in this role, want the oversight and protection that the LBHA requires; better safeguards in place • Trust challenges with some organizations/community members • Is a provider of services; potential or perceived conflict of interest (could benefit directly from the plan by receiving additional resources) • Could be confusing to community • Weaknesses/challenges (current and past) listed for Integral Care as an LBHA may also apply here to Integral Care without LBHA designation

Category: Existing Single Entity **Travis County Health & Human Services**	
Takeaway: Has the skills, but politics/neutrality could be a barrier.	
Strengths, opportunities, rewards	**Weaknesses, challenges, risks**
• Accountability • Shown ability to act as convener/facilitator • Committed staff well-attuned to SUD issues • Existing infrastructure • Established and ongoing partnerships • Planning experience • Public entity may enhance public accountability • Some of the community perceives as neutral	• Lacking specific SUD expertise • Can be influenced by politics • Community may not see as neutral if also a funder; perception of neutrality also impacted by partnership with Integral Care • Infrastructure is limited

Category: Existing Single Entity **Addiction Research Institute at UT School of Social Work**	
Takeaway: Research and resources, but not connected to this work.	
Strengths, opportunities, rewards	**Weaknesses, challenges, risks**
• Subject matter experts • Access to university resources and knowledge • Research oriented • Neutrality, trust • Opportunity for researchers to understand community-level dynamics of SUD planning and coalition-building	• Not engaged in this work; not connected to current or past community planning efforts in SUD • Research often disconnected from direct service or those directly impacted • UT departments can be influenced by politics and financial drivers

Ranking Results

Workgroup Rankings:

- High scores clustered clearly around a top tier of two options, the LBHA and the new SUD Consortium. These two rankings should be considered roughly equivalent (given an N of 12).
- After the top tier, scores drop significantly, with clear second and third tier clusters. None of these options can be interpreted as recommended.

	Total Score (sum of weighted scores)	Average Rank (1 = highest, 6 = lowest)
LBHA designation for Integral Care	23	1.92
New SUD Consortium	25	2.08
Travis County Health & Human Services	42	3.50
Integral Care (not as LBHA)	44	3.67
Addiction Research Institute at UTSSW	53	4.42
Austin ROSC	65	5.42

**N=12*

Leadership Review Group Rankings:

- The Leadership Review Group had an opportunity to vet the final analysis and provide a ranking among the final two options identified by the Workgroup.
- Of those who responded to the input opportunity, respondents were equally divided in their preference among the final two options.

	Total Score (sum of weighted scores)	Average Rank (1 = highest, 2 = lowest)
LBHA designation for Integral Care	12	1.5
New SUD Consortium	12	1.5

**N=8*

"What Would It Take?"

The last exercise the Workgroup completed in this Phase was some preliminary thinking about "What would it take?" We acknowledged that any of the possible options would take some transitional work and tasks to "get off the ground," in that no option was immediately "shovel ready." We asked the group to think about what transitional questions and steps would be required to take an option from a recommendation on paper to a functioning Planning Structure.

Preliminary Implementation Considerations for All Options

- Who/which entities will fund the SUD Planning Structure?
- How much will it cost to support the backbone functions of the Planning Structure?
- Answers will depend on which structure is being operationalized
- Timeline concerns: Community has been in a "holding pattern" as we plan, while SUD needs are urgent. How long will it take to get the planning process going?

Preliminary Implementation Considerations for a New SUD Consortium

- Who will be the fiscal agent?
- Who establishes the governance structure? Who governs the consortium?
- To whom is the consortium accountable?
- Can it be designed so that all other organizations/entities under consideration could be participants in the consortium?
- How is the new structure going to be accountable to people with lived experience and PWUD [people who use drugs]?

- Approval Authorities likely need a sketch/mockup to react to, understand, approve. A subset of this workgroup may need to continue working on that proposal, if selected.

Preliminary Implementation Considerations for an LBHA designation for Integral Care

- Request to HHSC comes from Integral Care's three appointing authorities (Travis County, City of Austin, and Central Health), and then HHSC has to designate
- Who takes the lead in creating the infrastructure? HHSC or Integral Care?
- What will trust building look like? How does the LBHA achieve buy-in and support from across community?
- What safeguards will need to be in place for the community to achieve this buy-in? Who creates the safeguards? How long will that take?
- Could LBHA have a governance structure outside of Integral Care to address potential conflicts of interest? Could also offer additional participation opportunities (to historically underrepresented participants)

Part III:
Participation and Facilitation Overview

Participation Summary

Purpose

This document provides a descriptive summary of participation in the SUD Community Planning Process, including:

- How participants were identified, and groups established,
- Participation roles,
- Rosters and attendance in the Workgroup and Leadership Review Group, and
- Inclusion and engagement efforts.

Participation Process

Process Kick-off

In late 2019, staff from Travis County Health and Human Services, Research & Planning Division, did extensive planning and preparatory work to launch this community planning effort. As part of this work, staff identified four general participation roles outlining the various ways that stakeholders could engage in the process: Workgroup, Leadership Review Group, Content Experts, and Informed & Interested. At the Substance Use Disorder Community Forum held on October 16, 2019, forum attendees were asked to consider and give feedback on the proposed participation roles and make preliminary commitments around personal and/or organizational participation. Staff incorporated attendee feedback into a final Participation Roles table (see below).

Targeted Engagement and Follow-Up

HHS facilitators also engaged in a tailored participant engagement process, to:

- Connect individually with every person who expressed interest (either at a forum, via email, or by referral) in the planning process,
- Clarify participation commitments required at each level, to match people to the roles that fit their interests and availability,
- Invite well-rounded representation from key sectors and services where it was missing, and
- Confirm group rosters (see below) and schedule kick-off meetings.

Participants self-selected their preferred participation role, and no participant was refused the opportunity to participate.

Participation Roles

The participation roles fell into three groups, and the following role descriptions were communicated during engagement and onboarding activities.

	Workgroup	Leadership Review Group	Informed & Interested

Give (commitment)	• *Time commitment:* At least 3-4 hours/month in monthly meetings and "homework" in between; intermittent participation in ad-hoc task-specific sub-groups
	• *Participation:* Consistent, regular attendance
	• *Be ready to:*
	  ○ Engage in collaborative, labor-intensive process focused on creating a planning structure for SUD
	  ○ Share your knowledge, expertise, and experience to that end
	• *Connect:* Serve in a representative/liaison function to your organization or community (formal or informal)
		• *Time commitment:* Bi-monthly participation in virtual meetings, plus ad-hoc electronic review
		• *Participation:* Consistent, regular engagement
		• *Be ready* to*:*
		  ○ Apply your leadership and system-wide perspective
		  ○ Review and evaluate the work
		  ○ Provide constructive feedback to Workgroup
		  ○ Give technical assistance in addressing your feedback
		  ○ Actively support the process moving forward
		• *Connect:* Seek, bring to consensus, and represent all leadership input for your organization
			• *Time commitment:* Occasional
			• *Participation:* No direct participation. Provide your email address to be on the stakeholder list.

Get (influence)	• Highest level of influence in creating the planning structure for next phases • Make collaborative decisions • Provide recommendations • Quality facilitated process	• Direct input into recommendations/results that will be considered by approval authorities • Quality facilitated process	• Limited or no opportunities to give feedback in Phase 2; may increase in later phases. • Timely updates through stakeholder list
Design Guidelines	• Diversity in composition[*] • Group size limit of 20 maximum total participants, to keep working processes manageable. • Single representative per organization[†]	• Diversity in composition[*] • Leadership role in a formal organization or in the community (with influence and ability to drive change in the community) • No limit on number of participants • Time limits on feedback opportunities • Single representative per organization[†]	• Communication will be done through email • No limit on number of stakeholders

[*]Original footnote on this item: Diversity design guidelines represent aspirational values and serve to invite and encourage diverse participation. This could include: SUD professionals/practitioners, and people with lived experience; formal and informal leaders; representatives across a spectrum of SUD services; underrepresented racial/cultural groups; faith-based communities/organizations, in addition to public and provider agencies. Members can identify assets and gaps and decide together what strategies could address them.

[†]Original footnote on this item: Ideally these groups will have no more than one representative per participating organization. However, organizations with complex structures, diversity of functions, and multiple siloed areas of expertise may require further exploration by the groups themselves around how those organizations will be represented.

Travis County HHS Staff Role	Approval Authority

Travis County HHS Research & Planning (R&P) Division Facilitators:
• Trained, neutral facilitators
• Process role only (no content role)
• Timeline management
• Documentation of work and agreements
• Logistical support
 	
Travis County HHS Sponsoring Directors:
• Workgroup participant in content role
• Support and project supervision to R&P staff
	• High-level representatives of three taxing authorities:
	  ○ Travis County
	  ○ City of Austin
	  ○ Central Health
	• Receive regular updates from Travis County staff
	• Set expectations around:
	  ○ Desired qualities in a community process
	  ○ Any non-negotiable parameters around recommendations they can consider
	  ○ Conditions under which authorities will honor the results of the community process to the greatest extent possible

Note: The initially proposed Content Experts role, which was intended to serve a community advisory function and/or to provide topical expertise at the request of the Workgroup, was not convened, due to the following factors. As the Workgroup moved through its workplan, Workgroup members did not identify missing content expertise; Workgroup members had a good range of experiences and perspectives. Further, the workplan and resulting deliverables were process focused and didn't require specific SUD-related content outside of what existed in the Workgroup and Leadership Review Group. Finally, the pandemic challenged both facilitators and community members, greatly limiting bandwidth and participation. Facilitators reached their capacity to manage the directly facilitated groups the Department had committed to, particularly as these groups moved to virtual formats.

Workgroup Roster and Attendance

Membership Roster

Organization	Primary Attendee	Role
A New Entry, Inc.	Soleece Watson	Associate Director
ASHwell	Moe Lujan	Linkage and Retention Specialist
Austin Public Health	Laura Enderle *Formerly Michelle Myles*	Planner for Behavioral Health and PSH
Austin Recovery Network	Julie McElrath	Executive Director
Building Promise USA	Carl Hunter	Executive Director
Central Health	JP Eichmiller *Formerly Alanna Boulton & Sarah Cook*	Senior Director Strategy
Changing How I Live Life	Lori Wilson	Program Director
Communities for Recovery	Darrin Acker	Executive Director
Community Medical Services Austin	Aaron Ferguson	Regional Impact Manager

Organization	Primary Attendee	Role
Dell Seton Medical Center & Dell Medical School at The University of Texas at Austin	Richard Bottner, DHA, PA-C *Proxy: Alanna Boulton*	Division of Hospital Medicine & Affiliate Faculty, Internal Medicine
Downtown Austin Community Court	Pete Valdez	Court Administrator
Dutton House LLC Sober Living	Tim Warp	Founder/Owner
Integral Care	Ellen Richards *Proxy: Mary Dodd*	Chief Strategy Officer
LifeWorks	VACANT *Formerly Beth Hutchinson*	
Phoenix House	VACANT *Formerly Kelly Aubry & Meredith Mullens*	
RecoveryATX	LaNisha Jiles *Formerly Joseph Hogan-Sanchez & Jenna Neasbitt*	Program Director
SIMS Foundation	Patsy Dolan Bouressa	Executive Director
Texas Harm Reduction Alliance	Cate Graziani	Co-Executive Director
Travis County Health and Human Services	Laura Peveto *Proxy: Brook Son*	Division Director, Office of Children Services
Travis County Justice Planning	Cathy Mcclaugherty	Planning Manager

Attendance

Attendance below does not reflect participation in small, ad-hoc groups or distinguish between full meeting versus partial meeting attendance. When members provided advanced notice of an expected absence, and the activity allowed, they were given the opportunity to provide contributions in advance. Absent members always had access to meeting materials and notes if they chose to review and add content after missed meetings; members varied in their likelihood to participate in this option. These activities are not recorded in the table below.

Organization	1/23/20	3/3/20	6/2/20	7/7/20	8/4/20	9/1/20	10/6/20	11/4/20	12/1/20	2/2/21	4/6/21	5/4/21	6/8/21	7/13/21	8/3/21	8/24/21	9/7/21	10/5/21
A New Entry, Inc.	x	x	x		x				x									
ASHwell											x	x				x		x
Austin Public Health	x	x	x		x		x	x	x	x	x	x	x	x		x	x	
Austin Recovery Network	x	x	x	x		x	x		x		x	x	x	x	x		x	
Building Promise USA	x	x	x	x	x	x	x	x		x		x	x	x	x		x	
Central Health	x				x	x		x	x	x	x	x	x		x	x	x	x
Changing How I Live Life	x	x	x		x				x	x	x	x	x		x	x		
Communities for Recovery	x	x	x	x	x	x	x	x	x	x		x	x	x	x		x	x
Community Medical Services Austin		x	x	x	x		x	x	x	x		x	x		x	x		x

Organization	1/23/20	3/3/20	6/2/20	7/7/20	8/4/20	9/1/20	10/6/20	11/4/20	12/1/20	2/2/21	4/6/21	5/4/21	6/8/21	7/13/21	8/3/21	8/24/21	9/7/21	10/5/21
Dell Seton Medical Center & Dell Medical School at The University of Texas at Austin							x	x	x	x	x			x	x	x	x	x
Downtown Austin Community Court	x	x	x		x		x	x	x	x	x					x	x	
Dutton House LLC Sober Living	x	x	x	x	x	x	x	x	x		x	x	x	x	x	x	x	
Integral Care	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
LifeWorks	x	x																
Phoenix House	x	x	x	x	x	x	x	x										
RecoveryATX		x	x	x		x	x	x	x		x	x		x		x		
SIMS Foundation			x	x	x	x						x		x			x	x
Texas Harm Reduction Alliance			x	x	x		x	x	x									
Travis County Health and Human Services	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Travis County Justice Planning	x		x		x													

Leadership Review Group Roster and Attendance

Membership Roster

Organization	Primary Attendee	Role
Ascension Seton Shoal Creek	VACANT *Formerly Brandy Hart*	
ASHwell	Sandra Chavez	Director of Outreach
Austin Public Health	VACANT *Formerly Hailey de Anda*	
Austin Recovery Network	Lynn Sherman	Chair
Austin-Travis County EMS	Andy Hofmeister	Assistant Chief
Central Health	Mike Geeslin	President & CEO
City of Austin	Stephanie Hayden-Howard	Assistant City Manager
Communities for Recovery	Sierra Castedo de Martell	Board Member
CommUnityCare	John Weems, MD *Formerly Heather Hart*	Associate Director of Addiction Recovery
ECHO	Niki Kozak	Housing for Health Systems Manager
Greater Austin ROSC	Chelsea Biggerstaff *Formerly Elizabeth Henry*	Co-Chair
Grassroots Leadership	David Johnson	Criminal Justice and Public Health Policy Analyst
Integral Care	Louise Lynch	Provider Network Authority Officer

Organization	Primary Attendee	Role
LifeWorks	VACANT *Formerly Danielle Owens*	
Oxford	VACANT *Formerly Brittany Schultz*	
Sobering Center	Laura Elmore	Executive Director
Superior HealthPlan	Daniel Crowe	Senior Medical Director
Travis County District Attorney's Office	José Garza	District Attorney
Travis County Health and Human Services	Sherri Fleming	County Executive
Travis County Health and Human Services	Lawrence Lyman	Division Director, Research & Planning *Proxy for Sherri Fleming*
Travis County Justice Planning	Roger Jefferies	County Executive
Travis County Juvenile Probation	Maya Lujan, PhD	Psychologist
Travis County Sheriff's Office	Danny Smith *Formerly Jennifer Hernandez*	Inmate Mental Health & CES Director
Travis County Underage Drinking Prevention Program	Sarah Martinez *Formerly Gloria Souhami*	Director, UDPP
N/A	Robin Peyson	Community Member

Attendance

Attendance does not reflect participation in electronic review or distinguish between full meeting versus partial meeting attendance. Whenever possible, members were provided advance copies of materials. Absent members always had access to meeting materials and notes if they chose to review and add content after missed meetings; a minority of members participated in electronic review outside of meetings. These activities are not recorded in the table below.

Organization	2/27/20	6/24/20	10/28/20	4/29/21	9/24/21	11/8/21
Ascension Seton Shoal Creek	x		x			
ASHwell	x			x	x	
Austin Harm Reduction Coalition (merged with Vivent Health)		x				
Austin Public Health	x	x	x			
Austin Recovery Network	x					
Austin-Travis County EMS				x	x	
Central Health				x	x	x
City of Austin					x	x
Communities for Recovery	x	x		x	x	x
CommUnityCare	x			x		

Organization	2/27/20	6/24/20	10/28/20	4/29/21	9/24/21	11/8/21
ECHO		x		x		
Grassroots Leadership	x	x	x	x	x	x
Greater Austin ROSC		x	x	x		
Integral Care	x	x	x	x	x	x
LifeWorks		x	x			
Oxford	x		x			
Sobering Center		x			x	x
Superior HealthPlan		x				
Travis County District Attorney's Office					x	x
Travis County Health and Human Services	x	x	x	x	x	x
Travis County Justice Planning	x	x	x	x		x
Travis County Juvenile Probation	x	x				
Travis County Sheriff's Office	x			x	x	x
Travis County Underage Drinking Prevention Program	x			x	x	x
No Affiliation, Community Member			x			

Inclusion and Engagement: Workgroup Focus Areas

Workgroup Early Orientation to Diversity and the Inclusion of Lived Experience

In the Workgroup's second meeting (and last meeting in-person), in March 2020, group members explored the diversity of experience and representation that they brought to the group. These dimensions included:

- Lived experience with substance use disorders: 100% of participants indicated having lived experience with SUDs, for themselves (about half) and/or in their family/personal network (large majority).
- Individual professional role: The group was fairly evenly and well-represented among the areas of program management, policy/planning, and upper/executive management. Practitioner, direct service, and peer support were represented, but to a lesser degree.
- Organization on service model continuum: Having not yet defined the service model continuum, Workgroup members used a working model that included treatment, intervention, harm reduction, prevention, and an "other" category. The continuum was broadly and almost evenly covered, with slightly higher representation in harm reduction.
- Populations served: Members used age groups of 9 and under, 10-17, 18-24, 25-50, and 50+. The age groups were broadly and almost evenly covered, with somewhat lower representation for the youngest age group.
- Organization's sector and role in SUD system: There was a healthy representation of providers and advocacy, but only a handful of organizations that identified under the roles of funder, policy, or planning. Most organizations identified with more than one role.
- Race: This element of the activity invited members to self-identify, with the results leading to more in-depth discussions and preliminary strategies to address (see below).

This value-driven exploration of diversity was followed by a discussion on the purpose and meaning of diversity and the way in which this diversity could impact the work, noting gaps in representation and capturing initial thoughts on how gaps could be addressed in future.

- The group observed that their membership was well represented in SUD lived experience.
- The group observed that a lot of participants in the room self-identified as white. They asked themselves "who is most impacted that needs to be in the conversation" and determined that the answer included "Black and Brown people" as well as people who use substances.
- The group wrestled with the question of whether these observed gaps required a full stop, or acknowledgement of the gaps and concerted efforts to find a path forward that ensured that these perspectives and experiences were included in the future planning work.
- The group identified the lack of equitable racial representation of Black and Brown people in the group as a major concern, and acknowledged it as a significant limitation. They also recognized the importance of moving forward with "planning to plan" the future SUD Planning Structure, in order to support all people impacted by SUDs sooner rather than later, including communities of color who are disproportionately impacted by SUDs due to systemic racism.
- The group began a conversation about the participation of people who use drugs. They observed that the Workgroup did not include people who are "actively/currently using drugs" and had a spirited conversation about their inclusion in this phase of the work. While agreement was not 100% unanimous, the group ultimately decided that at this point in the process (i.e. during the "Planning to Plan" work to make recommendations for a future planning structure) it was not a practical expectation, but the

inclusion of people who use drugs was important for that future planning structure's participation, to inform the development of the SUD Plan.

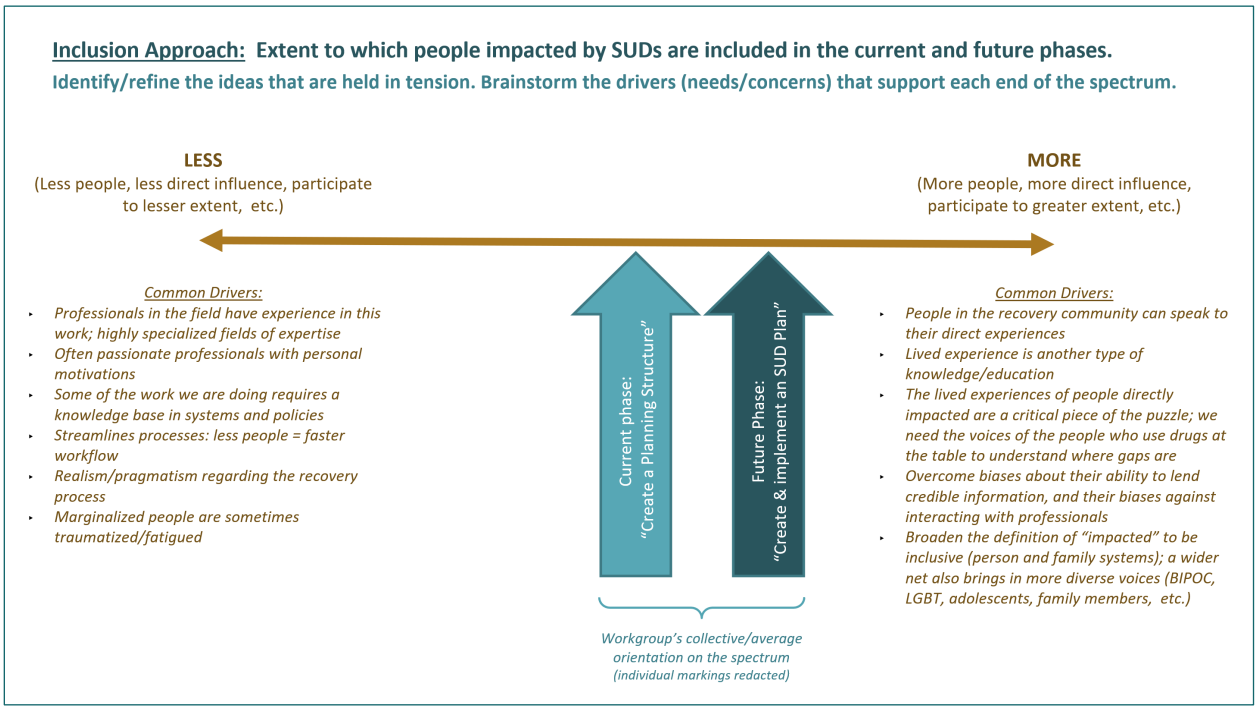
- Other areas they observed to be lacking and that should be expanded upon in the future SUD Planning Structure's participation included direct service and the private and faith-based sectors. They also noted that it would be important in the future to ensure that all services on the spectrum are represented.

Continued Conversation and Evolution of Orientation

Regarding the inclusion of lived experience in SUD planning, the Workgroup revisited the topic again in September 2020 while finalizing its SUD Values. A meeting was devoted to an in-depth, targeted conversation about:

1) The extent to which people impacted by SUD are included in the current phase, "Create a Planning Structure," that will result in recommendations for a planning body; and
2) Extent to which people impacted by SUD are included in the future phases to "Create and Implement an SUD Plan."

The results of this conversation, which used a spectrum activity (see Facilitation Summary for background on this method), are pictured below. Members' individual orientations varied, but they were able to refine a general approach. In summary, the group coalesced around a centrist orientation for the immediate "Create a Planning Structure" task, and articulated a clear stake in expanded inclusion and participation in the future Planning Structure's work to "Create an Implement an SUD Plan." This represented a commitment on the part of the Workgroup to ensure that, as it moved through its workplan, its subsequent deliverables would incorporate explicit, actionable recommendations for the Future Planning Structure's inclusion of people impacted by substance use disorders.



Note: In a heterogeneous group with mixed perspectives, participants typically demonstrate a range of individual positions, therefore it is unlikely for the zone of the group's overall orientation to be located far towards either end of a spectrum. Likewise, in the SUD Workgroup, there were individuals who advocated strongly for positions further

towards one pole or the other, but in general, members' responses clustered almost fully within a modest range (representing approximately 30-40% of the total spectrum); the arrows represent the general center of that range. One person had a strongly dissenting view in favor of maximum inclusion in all phases.

Regarding gaps in representation and the importance of diversity, the Workgroup revisited this topic during several meetings in early 2021, to develop targeted deliverables for equity accountability (see next section).

Commitments Articulated in Deliverables

The Workgroup identified the lack of equitable racial representation of Black and Brown people as a concern, and recognized the way that systemic racism functions in systems and society to create higher barriers for people of color to participate. As a result, they prioritized equitable participation in the future SUD Planning Structure in the following ways:

The Workgroup's commitment to diversity, equity, and inclusion is reflected in its final SUD Values (see deliverables section).

With the direct support of Travis County HHS's equity consultant, the Workgroup developed a strong pair of deliverables to ensure anti-racism and anti-oppression focused processes:

- A Racial Equity Framework for SUD Planning (see deliverables section)
- The Impacts of Racism on Substance Use Disorders (see deliverables section)

Finally, the SUD Values and Racial Equity Framework both helped to ground and enhance subsequent deliverables, with references to specific requirements and actionable recommendations, including:

- Minimum Specifications for SUD Continuum, Plan Scope and Use (see deliverables section)
- Critical Functions and Tasks (see deliverables section)
- Participation Recommendations (see deliverables section)
- Decision Making Recommendations (see deliverables section)

Inclusion and Engagement: Additional Process Elements

Quarterly Stakeholder Updates

Facilitators provide regular email updates to the "Informed & Interested" stakeholder list. These updates provided a status description for each group of work completed, current work, and what was coming up next. The pace of communications was dictated by the readiness of the deliverables, and roughly translated to every three to four months. This stakeholder list (which also included Workgroup and Leadership Review Group members) included approximately 400 unique individuals.

Personalized Onboarding

Whenever there was turnover or a new participant was identified to HHS facilitators, staff reached out and offered a personalized onboarding to the process. This usually looked like sending materials and providing a 1:1 meeting via Zoom to review, discuss, and answer questions.

Individualized Engagement of Approval Authorities

When the planning process resumed virtually in June 2020, facilitators shifted their engagement strategy for Approval Authorities to individualized briefings. The following were provided 1:1 overviews of the process and invited to participate as appropriate to their role:

- Travis County: All five members of the Travis County Commissioners Court, Travis County District Attorney
- City of Austin: Assistant City Manager and two Council Members
- Central Health: President & CEO

Public Comment Process

A public comment period (December 27, 2021 to January 31, 2022) provided all interested community members an opportunity to review the results of this community planning process and submit their feedback. Travis County HHS staff compiled all public comments into an addendum for additional information and context.

Facilitation Summary

Purpose

This document provides a descriptive summary of the facilitation of the SUD Community Planning Process, including:

- Project timelines and logistics,
- Collaborative problem-solving approach, and
- Facilitative methods.

Project Timelines and Logistics

Initial Project Plan: January-February 2020

Following the October 16, 2019 forum, the community planning effort kicked off in earnest in January 2020. The initial project plan looked like:

- A 12-month timeline, estimated to begin in January 2020 and conclude by December 2020
- Monthly meetings of the core SUD Workgroup, with each meeting resembling a roughly half-day work session (Workgroup members were willing to commit 3 to 4 hours per month depending on content needs)
- Every-other-month meetings of the Leadership Review Group
- Meetings held at the Highland Mall Offices of Travis County Health and Human Services

The Workgroup met twice (in January and February 2020) before the start of the COVID-19 pandemic. In these early meetings, the Workgroup created a Group Charter, a working document with their collective group agreements and shared expectations for how they would work together, and cocreated an outline for a Workplan that would ultimately guide and structure their work. The Leadership Review Group had one kick-off meeting (in February 2020) during this same time frame.

COVID-19 impacts: March-May 2020

The onset of the COVID-19 had immediate impacts on this project, for the staff coordinating the effort as well as for participants whose time and energy had to shift by necessity to:

- COVID-19 outbreaks among agency staff and clients
- Mental health and economic impacts for staff and clients
- School and daycare closures and lack of childcare
- Staffing and coverage challenges
- Rapid shift to telework for remote services
- Product shortages and supply chain issues impacting basic needs for on-site services
- Priority focus on pandemic response by the identified Approval Authorities (elected officials and executives from City of Austin, Travis County, and Central Health)

As a result, this SUD Community Planning Process took a three-month pause during March, April, and May of 2020. This pause allowed participants time and space to focus on the needs of their clients, staff, and agencies, while HHS facilitators recalibrated to a new fully virtual approach.

Project Adjustments: June 2020 to December 2021

In June 2020, the community planning process resumed, with some major modifications:

- Meetings were moved to online platforms (i.e., Zoom, with supporting web-based tools) and remained virtual for the remainder of the project, in alignment with County policy and local Risk Based Guidelines.
- Meeting times were reduced to approximately 2.0-2.5 hours in length.
- Meeting frequency for the full SUD Workgroup remained monthly (more frequent meetings were not viable for staff or participants), with experimentation with ad-hoc small groups to move work forward between meetings.
- Workplan timelines were revisited: Project completion goal was extended from December 2020 to December 2021. When offered the choice in late autumn 2020 to conclude their commitment in December 2020 or continue into 2021, all active Workgroup members opted to continue into 2021.
- Approval Authorities engagement method shifted to one-on-one briefings/orientations.
- Facilitation approaches and tools were adapted to virtual (see below).

Collaborative Problem-Solving Approach

The Process

HHS facilitators use a collaborative problem-solving approach, in which collaborative techniques are utilized to help groups solve problems and make decisions together. In this context, "collaboration" is defined as working together toward a common goal in a way that supports effective decisions, processes, and relationships.

The foundation of this process is based on the five general steps of interest-based problem solving:

1. Communicate about the issues: What are the issues? What's at the heart of the matter?
2. Identify interests: What concerns underlie each person's position?
3. Generate options: What are some ways to solve the problem that will meet everyone's core interests?
4. Evaluate options: How does each alternative meet everyone's interests?
5. Develop a plan: What steps will be taken to implement the solution?

This process is the foundation of all HHS-facilitated work, scaled as needed to fit the project. Echoes of these steps are evident throughout the Workplan for the SUD Community Planning Process, in both its broad arc and its discrete tasks.

Decision Making Philosophy

Features of HHS facilitators' process-oriented approach to decision-making include:

- **Self-determination in outcomes:** HHS's third-party facilitation to support group process is outcome neutral, meaning they do not have a vested interest in the end results. Group members direct and are responsible for their outcomes; facilitators structure the conversations to support group goals and help participants communicate and work together effectively.
- **Rely on interest-based problem-solving**: HHS facilitators lean heavily on interest-based discussion and decision-making techniques (see Facilitative Methods section for examples) and avoid power-based decision-making structures such as voting or defaulting to hierarchy.
- **Move groups towards agreement:** Consensus is an ideal state. A pragmatic approach acknowledges that: agreement is a spectrum, not a binary; more stakeholders means more (and more complex)

interests; and not all interests can align. Facilitators use creative discussion structures to explore tensions, promote understanding, and where possible, move groups closer to interest-based agreements.

- **Get as close as you can using good process:** HHS facilitators do not force results. In the best case, a group reaches full agreement around a solution or a decision, and members are satisfied with the outcomes and how they arrived at them. Sometimes a group gets most or part of the way there, and sometimes groups aren't able to reach final agreements. Facilitators highly value that members leave with a shared understanding of the reasons why, and that they came to that understanding through a process that is thorough and has integrity.
- **Document results:** HHS facilitators document the process and whatever products and/or decisions result, while the outcomes are dependent on the group's progress. Notes along the way capture the group's essential work. Final products note areas and degrees of agreement, including any identified next steps to implement solutions.

The results of the SUD Community Planning Process, as captured in this document, demonstrate fidelity to this approach.

Facilitator Role

In this process, HHS facilitators were responsible for design and implementation at multiple levels:

Process design and overall project management:

- Create and maintain overarching planning documents (such as those related to informational overviews, workplans, timelines, roles, etc.)
- Maintain and adjust the workplan iteratively as the project progresses
- Design agendas for meetings to support group goals
- Design activities, and create the supporting tools, that promote interactive engagement and accommodate a variety of participation preferences and needs
- Document the work, agreements, and results
- Facilitate linkage between all stakeholder groups involved in SUD community planning
- Send regular stakeholder email updates to support transparency and information sharing

In-meeting direct facilitation:

- Steward groups through planned meeting agenda/activities
- Remain neutral regarding the substantive content of the group's work, including the group's decisions and results
- Help groups create and follow participation agreements
- Make sure everyone gets to participate (not just the most vocal or assertive members)
- Manage the pace of discussion (pushing the group to cover more ground, or slowing down to dig deeper)
- Manage conflict and disagreement productively towards greater understanding
- Check in and invite joint design when the group is stuck, or an activity isn't working
- Start and end meetings on time
- Offer structured feedback opportunities, and be open to ad-hoc feedback from group members

Operational support:

- Reserve rooms and/or create meeting links
- Send calendar appointments and meeting materials
- Store key documents (planning documents, meeting slide decks, meeting notes, working documents, final documents) on a shared Google drive
- Identify and/or onboard new participants as appropriate
- Maintain group rosters and attendance logs

In-Kind Support and Personnel

Former County Judge Sarah Eckhardt tasked Travis County Health & Human Services (HHS) with facilitating this community planning process based on demonstrated expertise over the past two decades. Staff in HHS's Research & Planning Division, who are trained and experienced in both community planning and group facilitation, have provided facilitation support to various ad-hoc, short-term, and long-term projects and planning efforts, both internal to Travis County and for external collaborations, planning groups, and other community-based efforts.

Two tenured Senior Planners were assigned to lead the project. These HHS facilitators (Rachel Coff and Courtney Bissonnet Lucas) were selected for their high level of skill and experience in project management, process design, group facilitation, and documentation. While not specialists/clinicians in the area of substance use disorders, they did bring generalist knowledge of the behavioral health issue area and social services overall. HHS facilitators devoted a high degree of care, attention, and resources to this project, which constituted about 50% of their time for the two-year duration of the planning process (every hour of active direct facilitation requires roughly 4-8 hours of related planning, preparation, and follow-up). Additionally, HHS provided a third staff facilitator to assist with most meetings of the Workgroup and Leadership Review Group (totaling approximately 4-6 hours/month of their workload).

Facilitative Methods

Unique Challenges

From its pre-pandemic beginnings, this SUD Community Planning Process was an ambitious project. The shift to fully virtual work added another layer of challenges: New platforms and tools had to be quickly adopted and technical challenges navigated; virtual meetings can induce fatigue, disconnection, and passivity; without the immersive experience of in-person meetings (including the ability to fully read affect and non-verbal inputs), participants may find it harder to build rapport; most people cannot sustain engagement through a screen for as long as they can in-person; and consistent attendance and content continuity between meetings, both perennial challenges, were exacerbated by the pandemic environment.

Completing this ambitious project during the COVID-19 pandemic required flexibility, experimentation, and adaptation from facilitators (as well as patience and grace from participants) in order to retain the desired participatory, interactive feel. In addition to converting tried-and-true "in person" methods to virtual, facilitators developed new tools and techniques, and recalibrated all aspects of facilitation design and implementation to the parameters of remote meetings.

Design Considerations

To counter the challenges listed above, facilitators used:

- A combination of structured, guided activities and open, looser facilitated discussion
- A mix of large group work in plenary sessions, small group work in breakouts, and individual work
- Occasionally utilizing "homework" or ad-hoc small group meetings in between recurring full group meetings
- Experimenting with (1) large group setting broad direction and small groups developing related content/products, vs. (2) small groups developing proposed direction and bringing content to large group for review/feedback
- Encouragement of a "video on" culture when possible
- Invitations for active dialogue via unmuting (verbal participation) and Zoom chat (written participation)
- Options for electronic pre-meeting contributions and/or post-meeting review (offered to participants with calendar conflicts for meeting times)
- More visually impactful, interactive, and engaging online tools (see next section)

Interactive Tools and Interfaces

Facilitators experimented and embraced a wide variety of web-based tools and applications as aids to virtual meetings and for real-time collaboration.

- **Slide decks:** Created as a visual aid for every meeting. Used to overview goals, agenda, participation agreements, provide necessary information, and give activity instructions.
- **Zoom:** Optimal videoconferencing software for this use case (also tried Teams, Webex, and BlueJeans). Utilized basic videoconferencing interface plus chat, breakout rooms, and annotations.
- **Google Drive:** Housed planning, working, and final documents, as well as meeting materials and notes. Selected for universal no-cost access.
- **Google Docs:** Word processing application in the Google Suite. Used for some real-time collaborative activities. Primary tool for document review and feedback/markup, during independent electronic review and in-meeting review activities.
- **Google Slides:** Slide deck application in the Google Suite. Used for: presenting information; collecting/capturing individual, small group, and large group generative work; and inviting manipulation of slide objects for interactive activities.
- **Trello:** A virtual collaboration tool that organizes work into boards, lists, and cards. Free version was used for real-time collaborative activities.
- **MindMeister:** Mind mapping web application. Free version was used for real-time collaborative activities.
- **Metro Retro:** A free collaborative web application to run retrospectives via classic templates, or to create other virtual whiteboarding activities. Used for real-time collaborative activities.
- **Mural:** A subscription-based visual collaboration and virtual whiteboarding web application with more powerful capabilities. Acquired subscription mid-2021, used for real-time collaborative activities.

Methods for Reaching Agreements

To implement an interest-based approach with the groups involved in this effort (meetings ranging from small teams of 3-5 people to large groups of 12-25 people), facilitators employed a variety of inclusive methods to move groups towards agreements, including:

- **"Chatterfall" style activities:** Using Zoom chat to generate content from large groups quickly and concisely, in response to specific discussion questions or prompts; harvesting chat responses in real-time to compile and build shared work progressively.
- **Collaborative content generation**: Using Google slides or Google docs, generative activities invited group members, either individually or in small groups, to ideate in response to a specific prompt or task, then add more ideas as they reflected on and discussed their ideas further. Facilitator reframing and direction helped groups build iteratively on each other's ideas and coalesce around shared interests.
- **Spectrums**: Where different group members' interests and/or options appear to be in opposition to one another, exploring them as a spectrum of tension, rather than as a binary, can be a helpful technique. A spectrum approach can help groups articulate the interests driving each side, place themselves individually on the spectrum, make meaning together from the results, and collectively identify a philosophical zone in the middle that everyone can live with.
- **Stoplights:** In this technique, the colors of a traffic light (red, yellow, green) correspond with varying levels of support for a given option or proposal. A stoplight exercise can quickly eliminate a non-viable option, or fast-track an agreeable one, while exploration of yellow responses can reveal modifications that refine or improve the option into a mutually agreeable proposal.
- **Annotate Rank Order and Discuss:** Using the Annotation tool in Zoom, participants can visually markup information displayed on a slide. This technique was used several times to rank order a short-list of options (typically around four, give or take). The results quickly visualized areas of agreement or disagreement, which could be explored further through targeted discussion. Annotated rankings could also be saved and compiled later as supporting quantitative information. (This activity was also replicated later using movable objects in Mural.)
- **Individual check-ins for agreement and understanding**: Sometimes an issue required an unmuted, verbal response from every participant. In these instances, a round-robin approach let everyone share their thoughts and concerns.
- **Gathering written feedback and integrating revisions**: Primary method for broad stakeholder review and feedback. Typical steps included:
    - Sharing out draft document in meetings and/or for electronic review
    - Collecting feedback, via facilitated work in meetings and/or independent electronic review (in the latter case, typically for a period of 2-3 weeks)
    - Facilitators reviewed all feedback, incorporating revisions and/or responding to every comment to document how feedback was addressed
    - Marked up "final with comments" version posted in Google drive working folders for transparency
    - Final clean copy posted in Google drive public folder for final deliverables

EQUITY CONSULTATION SUMMARY

Purpose

This document provides a summary of Travis County HHS's purchased equity consultation services for the SUD Community Planning Process.

Background

A global racial justice movement in the summer of 2020 coincided with the SUD Community Planning Process resuming (virtually) in June 2020. Participants provided feedback at multiple levels around the disproportionate negative impacts of SUDs on people of color, the intersection of race, criminalization, and substance use, and the importance of a racial equity perspective in SUD planning work. One Leadership Review Group member suggested that every participant needed to receive foundational training in racial equity as part of the planning process. The Travis County Health & Human Services Department agreed that racial equity needed to be prioritized, and acknowledged that it did not have that specialized expertise in-house. To be responsive to this need, the Department purchased consultation services from a skilled practitioner in race equity work, Dr. Martha Ramos Duffer from Quantum Possibilities, LLC.

Implementation

The original scope of purchased services included both:

1) A foundational 8-hour training for all SUD Community Planning participants ("Towards Us and Us: Creating Shared Worlds and Understandings on the Road to Equity, Inclusion, and Racial Justice"), to be offered over Zoom, divided over two days in 4-hour segments, and fully subsidized by Travis County Health and Human Services at no cost to participants; and
2) Project-specific consulting and coaching to HHS staff facilitating the SUD Community Planning process.

When HHS offered the training opportunity to participants at no cost, they affirmed its importance but were unable to commit the required time. As a result, the Department applied its purchased services with Quantum Possibilities towards consultation, including:

- **Workplan review:** Dr. Ramos Duffer's work began by doing a thorough review of the Work Plan and identifying opportunities to strengthen and/or incorporate anti-racism and anti-oppression frameworks into the research questions, tasks, and deliverables. The intention was to build equity and anti-racism into the whole process structurally, not address it as a stand-alone topic.
- **Facilitation design assistance:** In selected phases with strong tie-ins to equity, HHS facilitators consulted with Dr. Ramos Duffer in designing relevant and effective activities.
- **Direct facilitation:** HHS invited Dr. Ramos Duffer to directly facilitate Workgroup members in two working sessions, focused on identifying the impacts of racism on substance use disorders, and developing a Racial Equity Framework.
- **Direct support for selected deliverables:** Dr. Ramos Duffer provided direct support to HHS facilitators in building out the raw results from these working sessions in order to develop final deliverables (Impacts of Racism on Substance Use Disorders, and the Racial Equity Framework for SUD Community Planning).

- **Coaching:** During regular consultation sessions in every phase, Dr. Ramos Duffer provided coaching to HHS facilitators around equity-focused professional use of self, understanding positionality, racialized participation dynamics, racialized language and meanings, historical contexts, facilitative techniques from an equity framework, etc.
- **Document review:** Dr. Ramos Duffer completed an equity review of every completed deliverable, identifying any ways to incorporate anti-racist language, practices, and principles, as the last step before finalizing deliverables. HHS facilitators processed and talked through review feedback with her during consultation meetings and made appropriate revisions.

Strengths and Limitations of the Process

Purpose

This SUD Community Planning Process had its strengths and limitations, some inherent to the design and some due to unforeseen circumstances. This document provides a summary of HHS staff's assessment of those strengths and limitations.

Strengths and Limitations

	Strengths	Limitations
COVID-19 pandemic	• Raised the impacts of Substance Use Disorders (SUDs) to more mainstream, higher visibility • Underscored the need for planning and coordination in the area of SUDs	• Major impacts on project timelines: doubled project duration • Sustaining participation during extended timeline wasn't possible for all participants • Negative impacts of the pandemic on agencies, clients, workloads, and staff's professional and personal lives created challenges with bandwidth/availability • Extended "emergency" environment exacerbated challenges with focus/attention • Priority of pandemic response for all Approval Authorities for an extended period delayed their engagement in this SUD work
Fully virtual environment	• Eliminates transportation and commuting barriers to in-person meeting attendance • Some virtual tools offered unique advantages for participants over in-person meetings (such as enhanced electronic review, ability for remote contributions pre- and post- meetings) • Some virtual tools and processes offered efficiencies for facilitators • Despite challenges, HHS adapted group facilitation model to virtual environment, and many participants brought great flexibility and willingness to learn new tools	• Can induce screen fatigue • Disconnection, lacking personal interaction; can be challenging to build group rapport • Tends towards passivity without intentional design consideration around participation • Virtual meetings have slower pace, require shorter duration and more breaks • Greater attendance challenges (late arrivals, early departures, log-ons without participation) • Transition to virtual required time for staff to identify, purchase, and develop fluency with new software; often a learning curve for participants • Technology does not always work properly; technology challenges required patience, grace, and flexibility
Collaborative, interest-based problem-solving approach	• Group ownership of norms, processes, and outcomes typically leads to greater ownership of decisions and greater participant satisfaction with outcomes • Highly participatory approach means that decisions reflect the whole group, not just the most vocal, assertive, or powerful members • Can enhance working relationships and build trust through generative conflict and respectful communication	• Process oriented, "Go slow to go fast": building agreements takes dedicated time and effort. Can feel slower and more labor-intensive than other power-based approaches. Some participants may desire a faster pace. • Tension between inclusion and efficiency: maximally efficient processes are often lacking in inclusion; a collaborative approach values inclusion highly and thus may sacrifice some efficiency.

	Strengths	Limitations
	• Working towards consensus means group members rarely "lose" (compared to power-based approaches such as voting or defaulting to hierarchy)	• Not all disputes can be resolved on the basis of interests. Some participants may still be dissatisfied with the outcomes.
Facilitation	• Outcome-neutral third-party role: generalist knowledge and a pure focus on process allowed facilitators to remain fully neutral about final decisions and recommendations • Process design/project management expertise • Skilled facilitation from tenured, senior staff • Productive and generative conflict management techniques • This effort likely would have stalled due to pandemic impacts without dedicated resources/skilled facilitation from TCHHS	• One participant shared feedback that lack of clinical/specialized SUD knowledge and/or lived experience among facilitators was a limitation • Facilitators had to take a larger-than-expected role in translating Workgroup results and decisions into final deliverables due to the pandemic's impacts on participant bandwidth
Stakeholder inclusion	• Planning model adapted to achieve inclusion of multiple stakeholders with varying levels of availability across multiple formats for a more expanded participation context • High degree of inclusion (i.e., multiple stakeholders across roles and participation methods) achieved within existing resources and challenges of COVID-19 pandemic • All interested participants were accommodated at the level they desired* • Representation was diverse along some dimensions (such as lived experience with SUDs, professional roles, and organizational roles in the SUD system/continuum and populations served) • Facilitative techniques and transparency methods supported inclusivity • Despite challenges of pandemic, many participants gave enormous time and effort to the work	• Planning models rely on a degree of representative participation; one person provided feedback that an Action Research model would have been more inclusive • Higher than normal turnover (following national trends, likely fueled by the pandemic context and related social and economic impacts) created challenges for continuity in organizational involvement • Voluntary process; degree of involvement was a function of participant time and interest • Existing resources didn't accommodate meetings during non-traditional business hours or compensation for participation; bias towards people who can participate as part of their professional roles • Process was complex; limited time and bandwidth may have been a barrier for some to fully participate • Representation gaps existed around racial diversity and organizational types/sectors
Transparency	• Use of Google drive provided public access to all foundational planning documents and completed deliverables as available • Google drive provided Workgroup and Leadership Review group members full access to their notes and working documents • Reviews accomplished electronically through shared documents on Google drive; marked up facilitator copies later showed how all review feedback was addressed	• Extended timeline to produce deliverables dictated the pace of stakeholder communication, possibly making it more difficult to track process • General feeling of disconnection during a long-term virtual process may have impacted perceptions of transparency and continuity • Some people might not have had the time to review shared materials, which were comprehensive and detailed, thus might not have been aware

*Only one exception occurred: One person contacted facilitators with interest in joining the Workgroup directly prior to its final meeting; it was not possible or appropriate to add a new member at that time, but this person was added to the Informed & Interested stakeholder email list.

	Strengths	Limitations
	• "Informed and Interested" stakeholder email list (almost 400 recipients) enabled regular updates (every 3-4 months) • Public comment period at conclusion	
Equity consulting	• Local, national, and global attention to racial justice issues in summer 2020 coincided with this project's timeline • Direct consultation, coaching to facilitators, and document reviews strengthened inclusion of anti-racism and anti-oppression principles in the process and results • Resulted in several strong deliverables for equity accountability: Impacts of Racism on Substance Use Disorders, and Equity Framework for SUD Community Planning	• Participants were unable to commit the time to offered racial equity training • Uneven participation in attempts to devote Consultant's time to direct facilitation with Workgroup members

Part IV:
Public Comment Results

Public Comment Results

Summary of Public Comment Process

Following the completion of the Substance Use Disorders (SUD) Community Planning Process of 2020-2021, the Final Recommendations document was made available for public comment. Public comments were received through several avenues:

- Formal public comment was open from December 27, 2021 through January 31, 2022. The draft Final Recommendations and a link to an anonymous public comment form were posted to the Travis County website in two locations. Six responses were received.
- Caller comments were receiving following a Travis County Commissioners Court agenda item on January 27, 2022. Nine callers provided comments.
- Ad-hoc email communication providing feedback on the process is also included.

Public Comment Form Results

Summary: Written responses were generally positive and affirming about most deliverables and their recommendations, regarding Questions 1-9. Some offered suggestions for enhancements/improvements, which the future SUD Planning Structure could consider. The responses to Question 10, regarding the Convening Entity Recommendations, generated the most substantive and pointed feedback. All written responses have been included verbatim below, with only minor corrections in spelling and punctuation typos to assist with understanding.

Question 1: Please share your feedback on the SUD Workgroup Identity Statement: Purpose, Vision, and SUD Values.

1. I think this was a well executed phase of this process, and the values align with recovery values. These values are at the core of what we are trying to accomplish with this "planning to plan."
2. The purpose should be more engaging with folks who have had lived experience. Vision should be more inclusive of community leaders and less clinical ideals.
3. It's needed badly - opiate use is killing our citizens and there's not enough funding for methadone/Suboxone treatment
4. This has the basics I would like to see. However, I think mention of combatting stigma should be included, as well as deconstructing the artificial schisms between mental health and substance use disorders (not just seeing SUD as a small aspect of MH [mental health] but complex, far reaching, and beyond self medicating for trauma/mh problems). Also, I think special attention needs to be given, especially in light of the Opioid Epidemic and evidence-based solutions, a great attention to building bridges between prevention, harm reduction services, MAT, moderation pursuit, and abstinence based services.

Question 2: Please share your feedback on Key Learnings from Past SUD Community Planning Efforts.

1. As someone who was a key leader on one of the documents referred to, there is much to be learned from these past efforts. Even though we had widespread community involvement in the process, the execution of the plan was a major failure. Without a clear path for implementation of the recommendations, little of substance was achieved. It got bogged down in bureaucratic policies and procedures and a lack of commitment. Integral Care assumed the leadership for these activities, and little was accomplished.

2. The past SUD planning efforts have been really slow reacting and has not included organizations that are actually on the streets
3. Please add to the miscellaneous that the University of Texas (e.g., Steve Hicks School of Social Work, UT Opioid Response Consortium, SHIFT, CSR, etc.) is an incredible resource for partnership, data collection/analysis, trainings, etc.

Question 3: Please share your feedback on the Substance Use Disorders Services Primer and/or Substance Use Disorders Funding Primer draft.

1. This is mostly well done and a very useful description of SUD Services and Funding. However, on page 2 of 8, the graphic on Promotion, Prevention, Treatment and Recovery is problematic. In the 2015 SUD Plan, the work clearly showed that Recovery provides a context for all of the above. This visual perpetuates the linear version of recovery, even though the words do state that recovery is non-linear. Recovery happens at all levels of this model, not following treatment. And describing recovery using the words “Compliance with long-term treatment (Goal: Reduction in Relapse and Re-Occurrence)” is completely unacceptable and inappropriate. This language reflects a clinical perspective and is the opposite of recovery. Recovery is about gaining a quality of life, not an absence of use. Compliance with treatment misses the mark completely. Peers and Recovery Community Organizations are not trying to get the peers they serve to "comply with treatment." In fact, they are not providing treatment. This section needs to be re-worked!!! And this wording excludes MAT and Harm Reduction as a part of recovery. And on page 5, there is the barest of minimums given to the description of recovery community organizations. Much more information needs to be provided about RCO's.
2. Please consider a specific reference to grief and loss services due to the fact that so many families have lost people to SUD/opioid overdose of late. Also, the funding section might even reference the Opioid Abatement Funds that are coming available from the litigation settlements with pharmaceutical companies.

Question 4: Please share your feedback on the Racial Equity Framework for SUD Community Planning and/or The Impacts of Racism on Substance Use Disorders.

1. Very well done and important if we are to make progress in addressing the inequities of the system.
2. There is a lot of toxic stigmas in really clinical and bureaucratic entities like integral care
3. Excellent section -- no suggestions or additions

Question 5: Please share your feedback on the Minimum Specifications for SUD Continuum, Plan Scope and Use.

1. I think this section if very valuable. It outlines critical components of what the Plan must do if it is to be effective. In particular, the Continuum must challenge the status quo and assist in building a strong recovery eco-system.
2. It has taken too long to scope we need to push for laws and invest in entities that help folks access harm reduction supplies
3. This seems comprehensive and the emphasis on nonlinear and person-centered is critical. The word continuum conjures the linear so I suggested actually calling it a "Nonlinear Care Continuum" to constantly reiterate this point. I think there should be more emphasis on families, allies and partners in this continuum.

Question 6: Please share your feedback on the Critical Functions and Tasks for the Future SUD Planning Structure.

1. This effort grew out of the community's concerns and frustrations about the existing system to serve individuals with SUD in Travis County. Issues related to funding, accessibility, accountability, and inclusion of marginalized communities in decision making was at the heart of the objections raised. The functions and tasks are a good list of what the new structure must accomplish, or it will again be a massive waste of the time and effort of many.

Question 7: Please share your feedback on the Group Structure Recommendations for the Future SUD Planning Structure.

1. This section does a good job of describing the process and what was and was not recommended and the pros and cons of using a centralized and decentralized structure. Very glad to see that having a funding source to implement the plan was identified as critical, as well as community based accountability.
2. The decentralized approach is amorphous and not well defined, and the examples of existing decentralized structures are very weak initiatives. (p. 50-51) However, it might resemble what the folks working on the Austin Recovery Network were proposing in our discussions with Integral Care, but there is no evidence of that in the report. It might be valuable to note the existing attempt beyond coalitions, and the digital platform worked on by Dr. Kasey Claborn at UT SHSSW which could bring the group and eventually the continuum together digitally.

Question 8: Please share your feedback on the Participation Recommendations for the Future SUD Planning Structure.

1. Good outline of activities and community members/stakeholders who should be included in the planning structure and accountability system.
2. I support this model.

Question 9: Please share your feedback on the Decision Making Recommendations for the Future SUD Planning Structure.

1. Agree that the Hybrid Model is best approach. Question of who makes the final decision if there is a deadlock will be critical.
2. I support the hybrid approach recommendation.

Question 10: Please share your feedback on the Convening Entity Recommendations for the Future SUD Planning Structure.

1. As unwieldly as it may be, I much prefer the SUD Consortium as the model for the convening entity. Having Integral Care be the convening entity does have the advantages of having the internal structures to support this work, but the disadvantages FAR OUTWEIGH any advantages. A fresh start is needed.

   Having Integral Care become the convener has the appearance of having accomplished nothing by this process. I would like to see them fully support the efforts of the SUD Consortium as an active, interested, consistent member and contribute in this capacity. [Staff note: The second paragraph of this comment was provided in response to Question 11. It was moved here because it relates to Question 10.]
2. To include folks with lived experience and also consider new ways to structure these plans and not continue to feed the same toxic cycle
3. I am glad that the two models emerged and lean towards a new entity rather than Integral Care for a slew of reasons, mostly that their MH expertise far exceeds their SUD expertise and their tendency to keep services "in house" rather than partnering with others as a first instinct and practice.

4. My time is limited to be able to comment more effectively. I do NOT support having this fall under the auspices of Integral Care- and they should NOT be designated an LBHA. The convener of this effort must actively seek to achieve equity in access and this requires continued feedback from the people needing/receiving services, the people advocating for services, and the people providing services (Integral Care leadership has failed at this for years - despite claiming to provide many opportunities for feedback, with a focus on equity). [Staff note: This comment was provided in response to Question 11, as part of response #1 below. It was moved here because it relates to Question 10.]
5. I am deeply concerned about Integral Care becoming the convening body. As a large and entrenched entity, I question their ability to implement the values and expectations detailed in this report. Integral Care has a history of treating other organizations in the community as subordinates rather than as partners committed to the same goals. I'm concerned that Integral Care lacks an interest in changing the current system dynamics, and we will not see the innovation, inclusiveness, sensitivity, and responsiveness needed to develop a strong community SUD plan.

   The committee report details two choices: 1) an SUD Consortium that may take time to establish but will eventually move the community forward in providing an equitable, effective, and innovative SUD plan or 2) Integral Care as the LBHA which will be established quickly and preserve the status quo. Too many people are dying due to overdose and substance use in our community to settle for the status quo. It is time for a change. [Staff note: This comment was provided in response to Question 11, as part of response #2 below. It was moved here because it relates to Question 10.]

Question 11: Please share any additional feedback you may have. This could be related to any other sections of the document or the process overall.

1. I also think there needs to be a structured town hall - or several- for the public to have a better understanding of this process. This document is long and I am concerned that the general public is not aware of the action steps our county is considering. There must be more opportunity for feedback from the communities/community members most impacted. Thank you for the opportunity to provide comment!
2. I joined this committee to ensure that smaller organizations and people needing and utilizing SUD services had a voice in the planning and provision of SUD services in Travis County. Having participated in this planning process, I appreciate the detail and content presented. I am, however, concerned that after almost two years, we find ourselves at the same place we started. [Content originally here was moved above to Question 10, response #5.] At a minimum, I encourage the commissioners to hold community meetings in which the final report can be presented to the public and additional comments received.
3. I am grateful for the time and energy put into this and for the chance to give feedback.

Caller Comments

Travis County Health and Human Services staff provided an update to the Travis County Commissioners Court on January 27, 2022. This was not a voting item. The presentation included background on the planning process, community participation, work process and products, equity framework, and the open public comment period.

The agenda item, video, and backup documents are available here: https://traviscotx.civicclerk.com/Web/Player.aspx?id=2772&key=-1&mod=-1&mk=-1&nov=0. Caller comments were received between the times of 1:11:31 to 1:33:50.

Below is a list of callers, their organizations and the time of their call within the recording:

1. Brian Johnson – Integral Care (1:11:29)

2. Eli Cortez – Texas Harm Reduction Alliance (1:13:42)
3. Gabby Libretti – Texas Harm Reduction Alliance (1:16:19)
4. Mathew Alves – Texas Harm Reduction Alliance (1:18:15)
5. Steven Smith – Texas Harm Reduction Alliance (1:20:22)
6. Cate Graziani – Texas Harm Reduction Alliance (1:23:00)
7. Ana Rosa Granados – Texas Harm Reduction Alliance (1:25:21)
8. David Johnson – Grassroots Leadership (1:28:19)
9. Aaron Ferguson – Community Medical Services (1:30:42)

The following key interests and themes were noted by Travis County staff:

- The callers expressed their personal experiences with and professional connections to Substance Use Disorders, and strongly advocated for immediate action because people are dying of overdoses. Some noted significant recent increases in drug overdose deaths.
- Many callers expressed their frustration with the time the planning process has taken and with potential overlap with other concurrent and past SUD planning processes.
- Many callers advocated for increased access to harm reduction methods, such as Narcan and other drugs. In addition, they called for increased funding for harm reduction methods and removing barriers in complex systems that make it hard for people to receive treatment and care.
- Many callers expressed their disappointment and anger over the perceived lack of involvement of people with lived experience with SUDs in the planning process.
- Several callers expressed their concern that Integral Care should not be the main backbone organization and could not drive meaningful change.
- Several callers advocated for reducing and erasing the stigma against people who use drugs, people of color, and people who are in poverty.

Ad-hoc Email Communication

Travis County staff received two ad-hoc comments which have been included verbatim below.

1. Email received by HHS Facilitators on January 28, 2022:
   I just want to tell you again what a great job you both did in facilitating the plan to plan SUD process. We that were involved in the process should own it. Some of the feedback was critical of our need to act and I understand that. However, it is important to note that due to this process we are further along than we ever have been and this planning effort had to be deliberative and purposeful in other to bring others along to understand the urgency and need for funding.

2. Email received by HHS Facilitators on February 9, 2022:
   I was a participant in the Leadership Review Group and want to attest to the incredibly skilled work of the facilitators, leading multiple groups of diverse stakeholders through a complex and high stakes planning process completely virtually and in the middle of a pandemic amongst other crises. The process was designed to be inclusive, seek consensus, and do so through shared values and principles agreed upon by the participants themselves, many of whom were directly impacted. The goal of the project/process was to craft a set of recommendations for the court that would inform a structure for planning, resource allocation, and compliance. It is not a function that can be taken on by a small group of interested citizens or even a small organization with boots on the ground. A larger planning process is going to require infrastructure. While I completely agree that action is needed and needed quickly, what is also needed is a long term

sustainability model for this community that treats SUD as the chronic public health issue that it is, and that is a paradigm shift, not simply a narrow immediate action. The community's mistrust of Integral Care is notable and important, and yet another structure has not been identified that can operate at their scale. Perhaps it is worth reconsidering the role of Travis County HHS in partnership with Austin Public Health as a structure or at least a place to fund a structure based in the grassroots community.

Part V:
Appendix

APPENDIX

Purpose

This appendix provides excerpted language from The Texas Health and Safety Code (Sec. 533.0356), related to Local Behavioral Health Authorities.

Excerpt from the Texas Health and Safety Code (Sec. 533.0356)

Sec. 533.0356. LOCAL BEHAVIORAL HEALTH AUTHORITIES. (a) The department may designate a local behavioral health authority in a local service area to provide mental health and chemical dependency services in that area. The department may delegate to an authority designated under this section the authority and responsibility for planning, policy development, coordination, resource allocation, and resource development for and oversight of mental health and chemical dependency services in that service area. An authority designated under this section has:

(1) all the responsibilities and duties of a local mental health authority provided by Section 533.035 and by Subchapter B, Chapter 534; and

(2) the responsibility and duty to ensure that chemical dependency services are provided in the service area as described by the statewide service delivery plan adopted under Section 461A.056.

(c) In the planning and implementation of services, the authority shall give proportionate priority to mental health services and chemical dependency services that ensures that funds purchasing services are used in accordance with specific regulatory and statutory requirements that govern the respective funds.

(d) A local mental health authority may apply to the department for designation as a local behavioral health authority.

(e) The department, by contract or by a case-rate or capitated arrangement or another method of allocation, may disburse money, including federal money, to a local behavioral health authority for services.

(f) A local behavioral health authority, with the approval of the department as provided by contract, shall use money received under Subsection (e) to ensure that mental health and chemical dependency services

are provided in the local service area at the same level as the level of services previously provided through:

(1) the local mental health authority; and

(2) the department.

(g) In determining whether to designate a local behavioral health authority for a service area and in determining the functions of the authority if designated, the department shall solicit and consider written comments from any interested person including community representatives, persons who are consumers of the proposed services of the authority, and family members of those consumers.

(h) An authority designated under this section shall demonstrate to the department that services involving state funds that the authority oversees comply with relevant state standards.

(i) The executive commissioner may adopt rules to govern the operations of local behavioral health authorities. The department may assign the local behavioral health authority the duty of providing a single point of entry for mental health and chemical dependency services.

Added by Acts 1999, 76th Leg., ch. 1187, Sec. 9, eff. Sept. 1, 1999.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.1335, eff. April 2, 2015.