CAPSA
EAST TEXAS

MAY 6-7, 2021

Bridging the Gap: Challenges and Opportunities in Addressing Substance Use Disorder (SUD) in Rural Communities

Conference Proceeding

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Day 1

9:00 - 9:30 — **Networking Session**

Summary:

Day 1 began with a networking session where early arrivals were asked to use the chat window to share their information and what they hoped to learn from the conference.

9:30 - 9:45 — **Welcome and Introductions**

Yordanos Tiruneh, University of Texas Health Science Center at Tyler

Yordanos Tiruneh, University of Texas Health Science Center at Tyler, Linda Oyer, ETCADA

Dr. Tiruneh gave the welcoming remarks and as well as a brief overview of the purpose for which CAPSA-ET operates. She then introduced Dr. Julie Philley for the opening remarks.

9:45-10:00 — **Opening Remarks**

Julie Philley, University of Texas Health Science Center at Tyler

Julie Philley, University of Texas Health Science Center at Tyler

Summary: Dr Philley observed that, while the pandemic has been a challenging time for everyone, it was a particularly difficult time for people living with substance use disorders as well as healthcare workers.

Dr. Philley described the unique burden that SUDs have imposed on rural communities, which saw a 325% increase in overdose deaths between 1999 and 2015. Additionally, people living in rural communities lack ready access to healthcare providers and counselors.

Dr. Philley thanked everyone for attending and encouraged the attendees to collaborate and use CAPSA-ET's resources to help their families, friends, and communities.

Following Dr. Philley's remarks, Mrs. Linda Oyer, the co-host of the event, thanked attendees, introduced herself and the role of her organization (East Texas Council on Alcoholism and Drug Abuse) in providing services, prevention, treatment and recovery.

10:00 - 11:00

Linda Oyer, ETCADA

Mrs. Oyer thanked Dr. Philley and moved on to the Keynote speech by Mr. Joseph Hogan-Sanchez. Mrs. Oyer invited Mr. Daniel Hatcher, re recovery service specialist who is also a mentee of Mr. Hogan-Sanchez, to introduce the Keynote speaker.

Keynote Address: Bridging the Gap: Client-Provider Communication when Addressing SUD

Joseph Hogan-Sanchez, Faces & Voices of Recovery

Mr. Hogan-Sanchez admonished attendees to be mindful of the importance of people with lived experience as well as those in recovery.
Mr. Hogan-Sanchez shared that he began drinking at the age of 12 and began using drugs as an adolescent. He also struggled with his sexual identity which, coupled with religious guilt, fueled his behaviors. Despite his very public struggle with alcohol, Mr. Sanchez stated that he never saw a counselor for his substance abuse during that time.

After dropping out of college and moving to Dallas, Mr. Hogan-Sanchez was confronted by his managers at his job and given the ultimatum either to seek out outpatient treatment for his substance issues or find another job. At that point, he engaged in care for his disease.

After a crushing HIV-positive diagnosis, Mr. Hogan-Sanchez recounts how his mental health suffered. He attempted suicide and even attempted to murder his partner.

Mr. Hogan Sanchez concluded by praising the structure and support provided by recovery-oriented communities. The value of peer-recovery support services for persons living with SUD are beneficial to recovery as well. Mr. Hogan-Sanchez did not have access to these services during his adolescence and he wondered whether, of he had, he would have recovered at an earlier age.

11:00 -12:00

Community Engagement in Behavioral Health Promotion

Speakers: Jessica Yeager, Houston ER Opioid Engagement System (HEROES)

Chad Armstrong, UT Health HEROES

Ms. Yaeger and Mr. Armstrong discussed community engagement in behavioral health promotion and described what it looks like when provided by their specific program.

They noted that the population of those who are dependent on opioids has increased over the last 30 years; unsurprisingly, then, demand for treatment far exceeds capacity. They also reported that only one in 10 Texans with a substance addiction receives treatment and, consequently, the Houston area has experienced an increase the number of those addicted and overdose deaths. For this reason, the Community Connections (CC) program is integral for helping those suffering from SUDs.

The CC program has remained functional throughout the pandemic. The Heroes (the Houston ER Opioid Engagement System) model is comprehensive and first originated in the emergency department by connecting persons living with SUD to peer services and counseling.

Heroes has many referral sources that include law enforcement and specialty courts, such as Harris County Star Drug Court.

The Heroes program is research-based, which means that they collect quite a lot of data that they use to make strategic impacts on the community. Overall, the Heroes model steers participants to medication and connects them to peer services and counseling.

The Heroes peer support team provides continuous follow-up and promotes maintenance in recovery. They reported that 85% of their clients remain in long-term recovery.

12:00 - 1:00 **Opioids: Use and Misuse**

Speakers: Emanuel Elueze, University of Texas Health Science Center at Tyler

Dr. Elueze walked attendees through the clinical implications of the opioid epidemic. He discussed the importance of DSM-5 in diagnosing SUD. He spoke of the need to provide a bridge to community resources for patients. He advised practitioners to encourage patients to seek long-term care. He discussed the stigma associated with seeking such care and encouraged clinicians to be mindful of this issue. Dr. Elueze also identified the community and outpatient resources that clinicians could discuss with their patients. Finally, he discussed a mnemonic device, the 5 Ms, that are recommended by the Association of Addiction Medicine: *m*otivational counseling, *m*anage other problems, *m*edical therapy, encourage patients to attend *m*eetings and talk to patients to *m*onitor progress.

1:00 - 2:00 **Lived Experience of SUD: Panel**

Facilitator: Michael Watkins, University of Texas Health Science Center at Tyler
Panelists: Alesia Cate, Oxford House
Chelsea Collier, North Texas Region of Oxford House

Dr. Watkins facilitated a discussion with two recovery support specialists who serve in northeastern Texas. Both women shared their personal experiences with long-term recovery and their passion for helping others.

These personal stories provided participants with first-hand knowledge of the experiences of persons living with SUD and how this disease has ravaged their lives. The panelists also shared that, while serving others in sober living was not on their original career pathways, they have found the experience to be enriching and rewarding.

Both panelists shared how their lives were negatively affected by their experiences with addiction. Both were educated professionals who had experienced homelessness and had lost their previous careers. They shared their feelings of satisfaction with their new career pathways through service. They discussed their experiences with helping others who may not have had the social or family support they enjoyed.

The panelists discussed the effects of the pandemic on persons living with SUD. They confirmed anecdotally that there may have been a rise in substance use during this difficult period. Ms. Cate shared that she had lost three friends to overdoses over the past pandemic year. They explained that recovery is largely rooted in fellowship, maintaining which has been challenging during the pandemic because we are often required to socially isolate. They observed that, while online resources and meetings have been available, such occasions may not have been ideal modes for fellowship. Also, many sober-living homes may have had to restrict the number of available beds they carry to comply with social distancing requirements. Thus, timely access to care has been limited by the pandemic.

Conversely, for those persons who chose to utilize Zoom technology, the pandemic restrictions were less limiting as these persons were able to join meetings when doing so was convenient for them and they were not limited by time or location.

2:00 - 2:15 **Prize Drawing and Wrap-Up**

Day 2

8:50 – 9:00

Overview of Day 2 of Conference

Kim Elliott, University of Texas Health Science Center at Tyler

Dr. Elliott gave an overview of Day 2 schedule passed the virtual podium to Mrs. Linda Oyer to introduce the speakers.

9:00-10:00

Evidence-based SUD treatment strategies: Motivational Interviewing

Speaker: Jennifer Campbell, University of Texas Health Science Center at Tyler

Dr. Campbell presented motivational interviewing (MI) as a treatment strategy for battling SUD. MI is a client-centered counseling approach that has been shown to increase motivation to change substance use behaviors. Motivation to change is the ability, willingness, and readiness to make a change. There is evidence supporting this counseling style as a means of reducing alcohol, tobacco, and cannabis use after a brief intervention.

Dr. Campbell emphasized throughout her presentation that motivational interviewing takes time and practice. When the motivation to change is low, however, MI can be extremely helpful. That is, when ambivalence to change is high, confidence in the ability to make a change is low, desire is low, and the sense that changing a substance use disorder is important is also low, MI can be a powerful tool.

There are a range of factors that must be considered, however. Clients are often mandated to enter a treatment program and view treatment as a form of punishment. Thus, a client's anger and sense of powerlessness should be honored by at least being taken into account. Avoiding assumptions about the type of treatment needed and exploring what each client perceives as needed and useful treatment are critical steps. In addition, cultural considerations should be considered. There may be important differences in the population being treated and the cultural context should be at the forefront of the MI approach when working with clients.

Some key MI skills are based on the OARS mnemonic.

OARS

- Open questions
- Affirmation
- Reflections
- Summarizing

Open questions often lead to richer dialogue and insight into how a client is feeling about the process. Reiterating that one is listening to the client can be accomplished by openly reflecting on the client's responses to open questions and then providing a summary or focal point. Dr. Campbell closed by describing resources such as a Decision Balance Square and the MI training website's URL **www.motivationalinterviewing.org**

10:00 – 11:00 Community engagement activities fostered by a PCORI engagement award: Achievements, lessons learned, and where we are now

Brandon Brown, University of California Riverside

Brandon Brown serves on the faculty of the School of Medicine at UC Riverside with a focus on social medicine, public health, medical ethics, and community based participatory research (CBPR) in HIV. He is interested in decision-making and has 130 publications on health equity and racial justice.

Dr. Brown's community engagement activities were fostered by Patient Centered Outcomes Research Institute's (PCORI) engagement award and his talk was centered on achievements, lessons learned, and the current status of the project. He centered his presentation on the idea that there is often distrust between communities and academic researchers and academics can be seen as untrustworthy.

His research was situated in the community of Palm Springs, which suffers the highest incidence in the country of HIV among older men (12 times the national average). The likelihood of long-term survival increased in this population, and we need to know more about aging with HIV, including the higher probability of comorbidities (with depression the worst comorbidity). Dr. Brown mentioned great local interest in HIV research but inadequate capacity to facilitate research among patients and physicians and emphasized the disadvantages of following a highly siloed approach.

PCORI—which was created by ACA research—begins by talking with patients and offers a new research approach whereby researchers do not focus primarily on identifying gaps. The issue is clearly important to the community.

This work aimed to "build the foundational relationships and capacity of stakeholders needed to conduct research on aging and HIV" through:

1. Building a leadership structure with stakeholders
2. Disseminating knowledge/building relationships
3. Identifying/exploring key topics for future research
4. Building stakeholder research capacity using GPP (CBOs, Healthcare orgs, providers, caregivers, academics)

A steering committee that conducted outreach to the community helped with convening focus groups, issuing a newsletter, and identifying themes on which to

focus. The community receives research training in conducting focus groups (community members are highly diverse) and learning about health issues, resiliencies, research priorities (all led by community members), and learning its priorities (depression/isolation) directly from the community. The project's findings have been published in academic journals as well as community newsletters. An important finding was the presence of deaf patients and thus a focus group explored the challenges facing the deaf HIV community.

Dr. Brown presented a case study that involved "helicopter research/parachute science," which amounts to academic researchers coming into a community, collecting data and leaving. The case illustrated the idea that excluding community is less common in HIV research than in other areas. In the case study, however, best practices were not followed. A researcher engaged with the community for data collection but did not share important pieces of research-process materials such as informed consent or a survey that was administered. When the survey and informed-consent form were finally shared, many communities were excluded, stigmatizing language was used, no incentives were built into the process, and there were no plans to disseminate the results.

Good research principles should always be followed. Community input must be integrated into IRB applications and research protocols. Community members should be included as Co-PIs. Research projects must always account for power differentials between community members and academic researchers.

Depression and isolation were found to be major issues in this community and a new proposal was written and funded based on PCORI research. A solution that entailed halting further isolation of people aging with HIV during the COVID-19 pandemic was implemented in virtual villages that were used to keep aging people connected. This solution was centered on the following aims:

- Characterizing issues related to depression, isolation, and the basic needs of people aging with HIV during the COVID-19 pandemic
- Rank ordering of ideas about what to include in a virtual village using conjoint analysis with stakeholders involved in HIV care
- Piloting a virtual village in three regions using the results obtained by achieving the above two aims with groups of people aging with HIV in Palm Springs, Los Angeles, and Florida.

Progress to date includes an advisory board that was formed in March that reviewed materials—focus group questions, consent forms, etc. These materials were modified based on the community's recommendations. This path takes longer and more work, but it is worth it, according to Dr. Brown. All board members are aging with HIV and represent communities from across the US.

11:00 – 12:00 Behavioral Health Services Provision for SUD: The State of Texas

Speaker: Philander Moore, Former Manager SA program Services DSHS at DSHS - Central Office

Mr. Moore described the services provided for SUD by the State of Texas. He serves as the statewide opioid coordinator for HSSC, which provides him with several opportunities and responsibilities. He is the orchestrator of SUD initiatives across Texas. The state implements, funds, and conducts behavioral health services through the HHSC. Services are funded through contracts with Local Mental Health Authorities (LMHAs), Local Behavioral Health Authorities (LBHAs), substance use care providers, and universities.

The presentation included the following highlights: LMHAs have not previously engaged in SUD work or oversight (by the HHSC) in three areas: regulatory, contract oversight, or quality management (ensuring that providers comply with contract terms). Funding methodology for SUD services is based on population, poverty, and needs—RFPs, RFAs, open enrollments. SUD in Texas compared with the national situation—expanding capacity and increasing efficiency in SUD services (86th Legislature, Rider 67). Finally, attending to three key factors: Process, Approach, Results.

Florida's system is similar, with Substance Abuse Prevention and Treatment Block Grant (SABG) funds for contracting with seven managing entities that are given subcontracts.

New York provides both direct contracts and subcontracts to providers.

Through block grants in Texas, some $144 million – $4.8 million has been allocated for recovery; SABG = $51 million.

The American Rescue Plan has provided Texas with an $125 million for SUD care.

The HHSC has developed a five-year Behavioral Health Strategic Plan.

A $1.5 billion settlement paid over a timeframe similar to that of the tobacco fund: $660 million between now and 2026 (expanding funding for opioid work). A 14-member council will be created.

12:00 – 1:00

Barriers to Opioid Use Disorder (OUD) Treatment: The Gap between Current Practice and Evidence-Based Care

Speaker: Josiah Rich, Brown University

Dr. Rich spoke about the barriers to OUD treatment. His work has been centered on jail visits with HIV-positive patients who need treatment, but he found a high burden of addiction. He observed that punishment for addiction does not work but treatment does. Methadone treatment works both inside and outside the jail setting. Many factors can account for high rates of OUD—physicians and the medical field in general have not been taught how to use opioids properly and medical

students have not been adequately taught about addiction. This has made us vulnerable to the pharmaceutical industry.

Unfortunately, heroin addicts who present to an emergency department for injecting are judged harshly and, if they admit to injecting and are infected, they are often given nothing for pain. Addiction stigma is internalized by providers and addicts are characterized as "those people." If a patient presents with fever and pain and a fear of dying, is admitted with complicated medical issues, or a medical resident says to the attending physician "this person is a drug addict," a clash with the addicted patient and healthcare team occurs immediately. Patients in withdrawal or in pain are labeled "difficult" if they request medication for pain and often are treated poorly. This can be frustrating and often results in a patient's attempting to leave against medical advice. A sense of relief arises among the medical staff when such patients leave. Thus, an intern or resident learns that dealing with addicted patients (seen as bad patients) is best avoided.

OUD is poorly understood. There are two fundamental properties: tolerance and the withdrawal phenomenon. The more of an opioid a patient takes, the more they need to take and the more they ***can*** take. After days or weeks of using opioids, they begin developing tolerance. Then an abrupt cessation of treatment results in withdrawal. With opioids, that is, patients need more of the drug just to feel normal—not high. The torturous pain and bodily aches associated with withdrawal are typically accompanied by headaches, nausea, and vomiting. A patient will do anything to avoid withdrawal, although after about three days the patient begins feeling better.

Dr. Rich then noted that the underlying problem with detox as treatment—the highs and lows of tolerance, the physical withdrawal—is that the brain is hardwired for survival. The primitive brain takes over, but that portion of the brain may be damaged by OUD. Not every opioid recipient develops OUD, but we know of the following sources that predispose a patient to suffering from it:

1. Genetics – genes contribute to OUD
2. Situational – hanging with the wrong crowd, peer pressure, trauma—sexual molestation or abuse in particular—not being believed, told not to talk about it; these factors generate a psychological burden
3. Exposure –the market is flooded with opioids, pills, or heroin, and then fentanyl took off—and it is 50 times more powerful than heroin, making overdose much more likely (an example of overdosing with fentanyl in jail was offered)

Dr. Rich discussed FDA treatments –

1. Methadone – an agonist with a short half-life.
2. Buprenorphine – with a long half-life; can be prescribed by physicians
3. Naltrexone

As a potential solution for overcoming barriers to OUD treatment, storytelling—such as talking about a single case—can contribute to a solution. It is recommended that a provider ask an addict about their experience, ask them to tell their story, and ask what a provider could do differently. Make it real rather than just a presentation of data. It is important to develop a therapeutic alliance with patients—induce patients to believe you care about them by ***really*** caring about them.

Dr. Rich suggested the following course of treatment for OUD patients:

1. Work on health – Physical and mental
2. Work on your home – A place where you feel safe among people with whom you feel safe
3. Identify community – All those with whom you interact
4. Identify a purpose – What is your purpose in life? It could change from day to day; and remember . . .
5. Medications give you only breathing room to support your recovery with respect to items 1–4.

1:00 – 2:00

Stigma and Bias: Overcoming challenges in treating SUD

Speakers: Keisha Morris, CENIKOR Foundation
Daniel Hatcher, RecoveryATX

Ms. Morris and Mr. Hatcher presented the challenges posed by stigma and bias associated with SUD. Do words really matter? How do we talk about SUD? SUD is one of the most stigmatized conditions—patients and treatments are both disparaged/stigmatized. SUD is the only disease where desire is the illness.

Stigma is a barrier to treatment and leads to gaps in treatment. Treatment is seen as a negative space and discussing loss is uncomfortable. What is stigma? A mark of disgrace associated with a particular circumstance, quality, or person. Stigma discredits a person or a group; it diminishes a person's capacity to achieve their full potential; it is a visible sign or characteristic of a disease. There is also stigma associated with the word "alcoholic." What does it mean to be addicted? The context in which the word "addict" is uttered and how it is uttered can create bias and a negative connotation. Stigma can also be gendered. Stigma can be visible or invisible. For example:

1. Stigma from within—internalized, anticipated, or inactive—which form of stigma is most common among people living with SUD?
2. Stigma from clinicians and medical providers
3. Stigma from the recovery community
4. Stigma from the general public (people who use drugs have made the decision to use them; moral failing vs. disease).

The negative effects of stigma associated with SUD—stigmatized disease and treatment (guilt and shame).

1. Prejudice and discrimination are often internalized by people with SUD
2. Prejudice and discrimination cause people with SUD to "keep it a secret"

The presenters also discussed the power of positive language—using positive language can increase public support for effective SUD policies and potentially create additional funding for SUD services.

2:00 – 2:15 **Conference wrap-up, feedback, and closing remarks**

Paul McGaha, DO, Smith County Public Health Authority

Dr. McGaha summarized each speaker's talk. He then concluded the conference by emphasizing the need to address SUD in East Texas and the importance of collaboration and community engagement in addressing the problem.

Conference closed.

Presentation Slides

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UTHealth
The University of Texas Health Science Center at Tyler

Community Academic Partnership for Substance Abuse in East Texas

Yordi M. Tiruneh, MPhil, PhD
Associate Professor of Community Health
UT Health Science Center at Tyler
Project Lead: CAPSA-ET

CAPSA EAST TEXAS

UTHealth
The University of Texas Health Science Center at Tyler

- Jan 1/2020-Dec 31/2021
- Funded by Patient Centered Outcomes Research Institute (PCORI)
    - UTHSCT
    - ETCADA
- Other community partners
    - Cenikor, BHLT, Andrew Center, UT Tyler, TJC, Oxford Houses, Burgess recovery, Crossroad Treatment center, Partners in Prevention, School districts and law enforcement

Why is CAPSA-ET Here?

- Community-Academic Partnership for Public Health
- Patient centered and empowering all parties involved
- Value community input and expertise
- Develop research agenda
  - Prevention, treatment and recovery
- Get funding to advance research and service in the region

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Needs CAPSA-ET is trying to address

- Networking and collaboration among community stakeholders
- Training in research and effective collaboration
- Training in Patient Centered Outcomes Research
- Systematic gathering , sharing, and use of data

CAPSA-ET Activities

Engagement	Capacity building	Develop a research agenda	Evaluation and sustainability
• Create an infrastructure to bring academics and community stakeholders together • Conferences • Community socials • Interactive website, social media presence (FB, Instagram, You Tube)	• Workshop on SUD • Develop curricula in basic research training	• Conduct FGDs to identify a research agenda • Conduct engagement studios/community forums to prioritize a CER research agenda	• Evaluate engagement process • Devise a sustainability plan

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Capacity Building

An overview of research

Community engagement and effective collaboration

Grant writing

PCOR/CER

Data collection, use and sharing

Analysis and dissemination of results

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Looking for Community Partners

Expand engagement

Identify and recruit relevant stakeholders

Build the partnership

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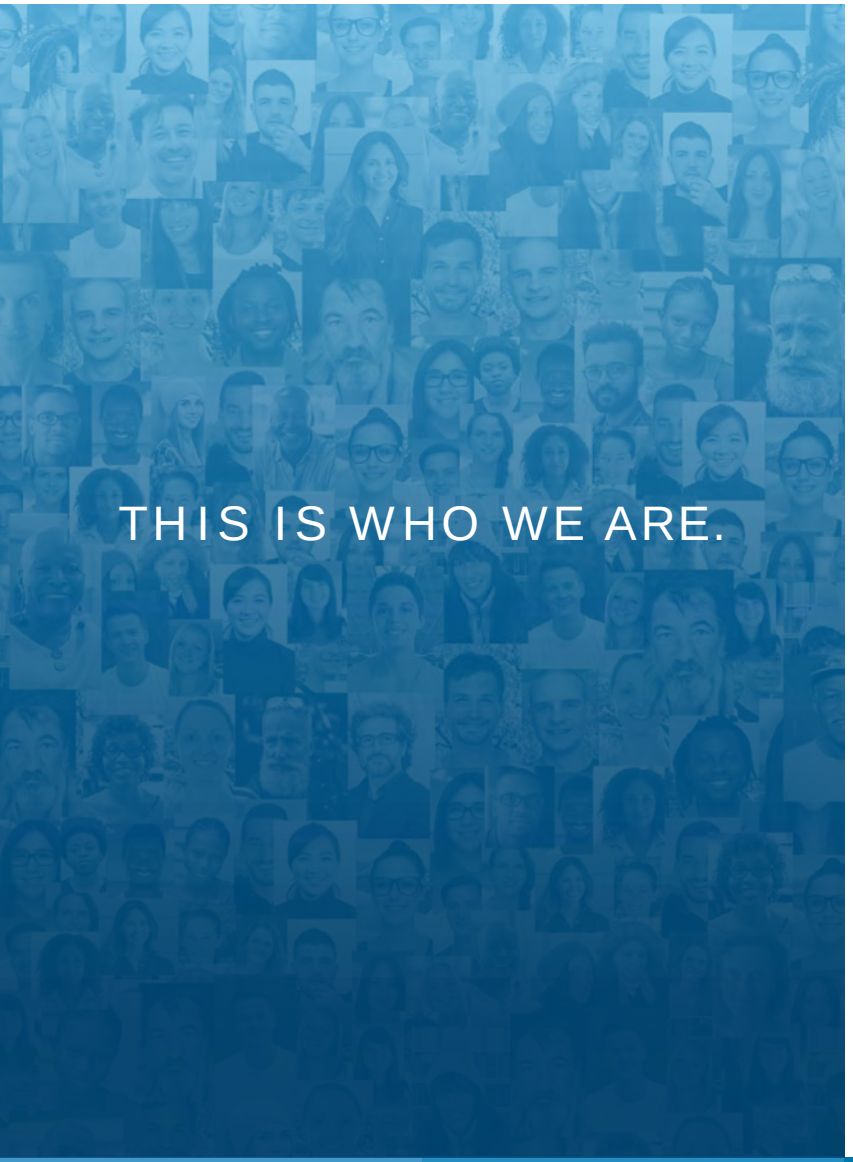
- **CAPSA-ET remains dedicated to community engagement and to working together.**
- **Let's work on this together.**
- **Thank you for your support and participation in CAPSA-ET.**



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Bridging the Gap:

Client – Provider Communication in Addressing SUD

presented by

- Joseph Hogan-Sanchez
- Director of Programs
- Faces & Voices of Recovery

Learning Objectives

- Identify the importance of people with lived experience in Recovery Oriented System of Care (ROSC)
- Implement the use of Peers in recruitment and leadership opportunities
- Recognize the need for community involvement and ownership for ROSC sustainability
- Understand a recovery-ready ecosystem model

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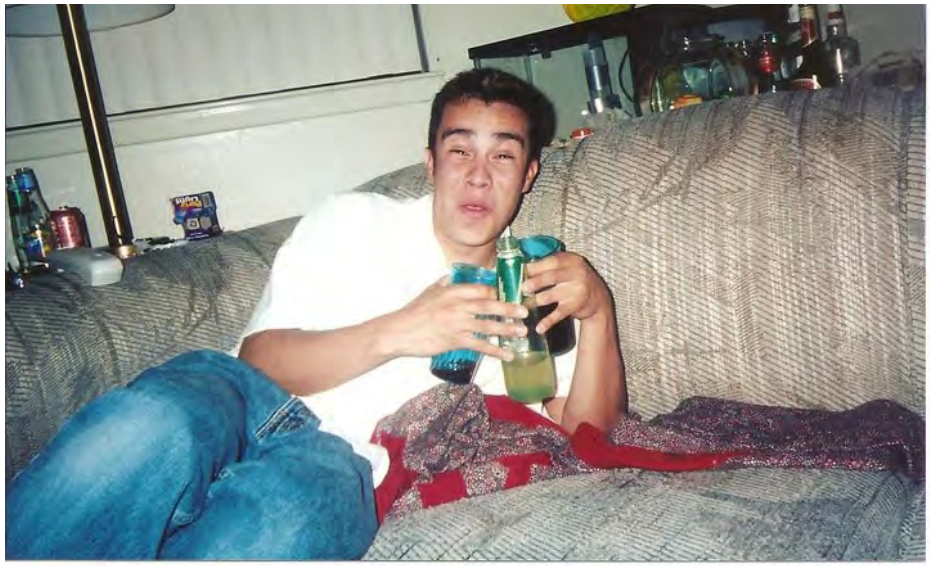
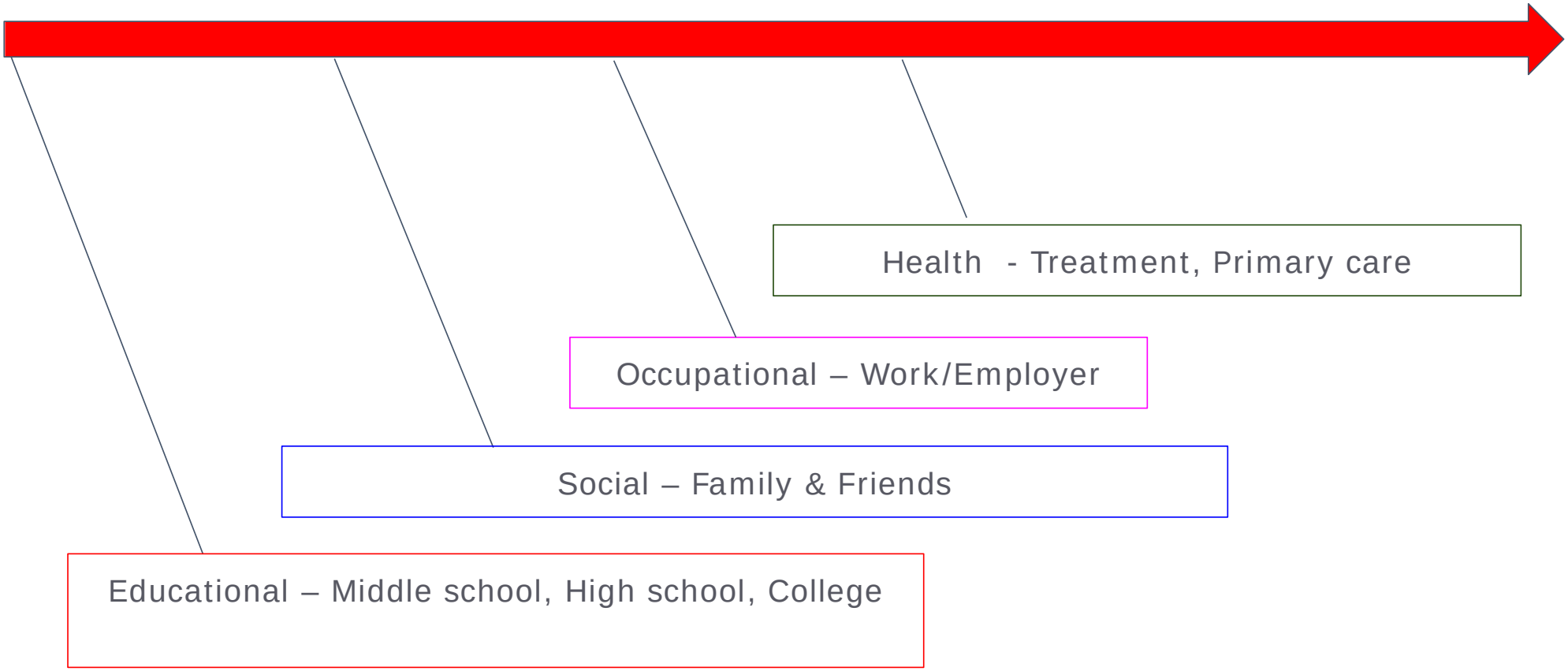
Then



- Began substance use at age 12
- Coming out exacerbated substance use and risky behaviors – age 19
- Diagnosed HIV + at age 23
- First overdose and 2nd suicide attempt– age 23

Missed Opportunities



Imagine

- A relationship with a community where you have access to organizations and people that can help fill in the gaps of service.
- A community that believes in the services that you provide and authentically feels like a stakeholder in your success.
- Having knowledge of events, activities and resources in your community.
- Having relationships across the state that support a local and statewide ROSC.
- Vested community involvement.

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It’s been happening

- 12 step communities have been connecting and linking people to services for decades
- Getting people into
  - Treatment
  - Recovery Residencies
  - Job placement
  - Social services
  - Connections in other cities/states
- Have been using personal connections and networks to help others

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Disconnect

"Recovery support roles that emerge with very close connections to communities of recovery are prone to disconnect from those communities over time as the persons filling those roles come to see the primary source of their power and authority coming from within themselves and from their professional organizations."

-White, W. (2006). Sponsor, Recovery Coach, Addiction Counselor: The Importance of Role Clarity and Role Integrity.

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White, W. (2006). *Sponsor, Recovery Coach, Addiction Counselor: The Importance of Role Clarity and Role Integrity.* Philadelphia, PA: Philadelphia Department of Behavioral Health and Mental Retardation Services.

Think about this...

What's your favorite restaurant?

- What do you recommend?
- What times are best to go?
- Do you know the manager's name?
- Can you tell me how to get there?
- Is parking easy to maneuver?

Peers have ...

- Used the same service systems
- Gone to the same meetings
- Met with the same people
- Found themselves in similar situations
- Lived in the same recovery residencies
- Know the community leaders and gate keepers

Keeping connected to the community through Peers

Peers are aware of what is happening in the community

- Events
- Activities
- Meetings
- Which meetings are appropriate
- Connection to potential sponsors or mentors
- Physicians that are recovery-friendly
- Churches and institutions of worship
- Opportunities to be of service or give back
- Job opportunities
- Recovery-friendly employers and workplaces
- How to help with living arrangements

Your referral source

Being engaged with the community, Peers are often asked how to get help for family members, friends and other members of the community.

They know:

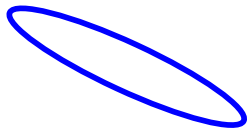
- How the process works
- Who to contact
- Funding opportunities available
- And are able to connect people directly with the resource

Peers are the connective tissue

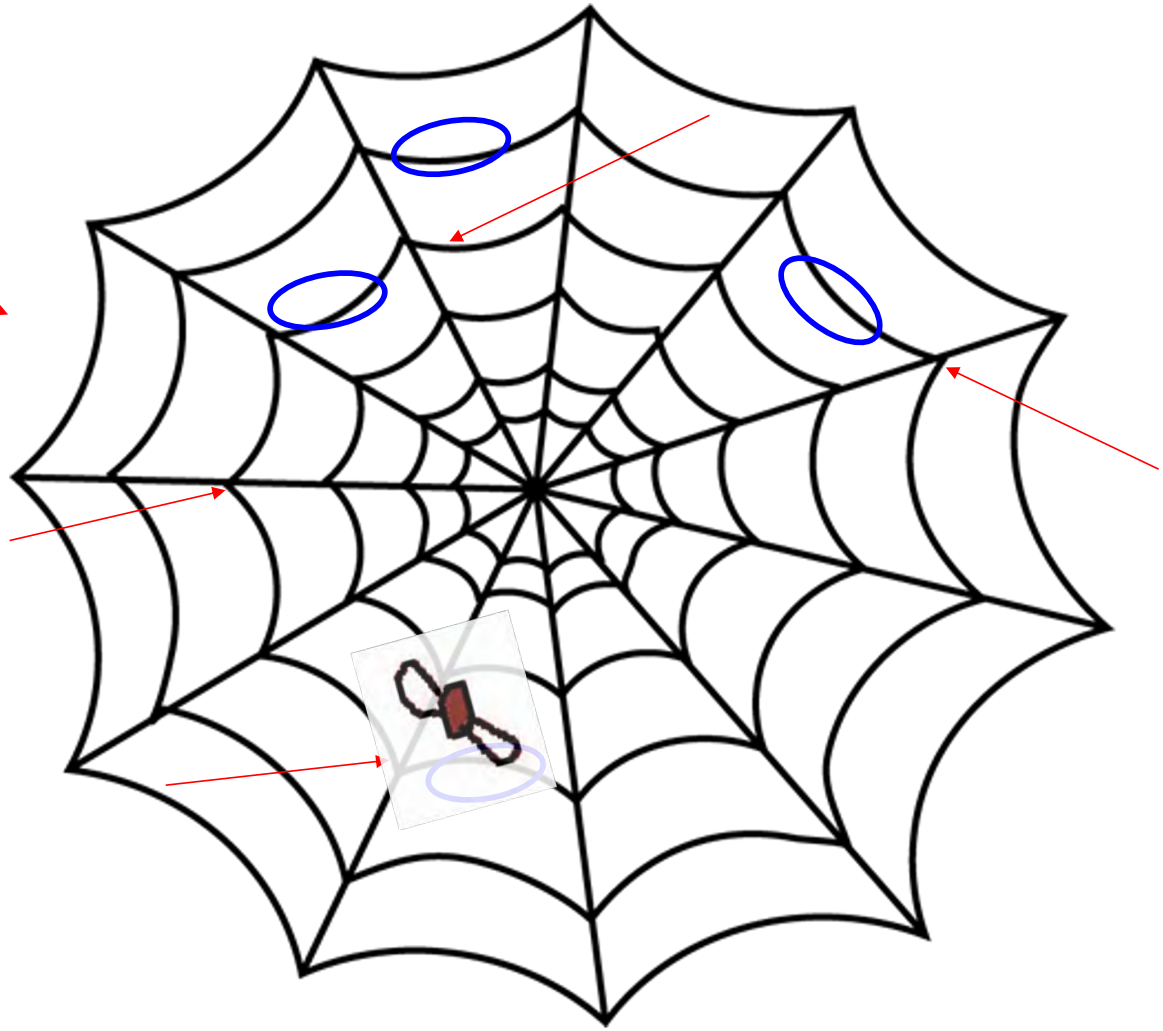
Peers in a ROSC

Organizations/Businesses -

Peer -



Person Receiving Services -



No Wrong Door

- Stop the Silos
- Through Memorandums of Understanding/Agreement/Contracts
- Build rapport with the community
- Stronger relationships with the community
- Become good stewards of resources
- Become Recovery-Oriented

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Being Recovery Oriented

Recovery values are simply tenets of being a good person

- Trustworthy
- Honest
- Integrity
- Openminded
- Compassionate
- Empathetic
- Inclusive
- Collaborative

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How to get Peers in on the action

- Coordinating events
- Team/staff meetings
- Chairing/Co-chairing committees
- Outreach and Recruitment
- Facilitation/Participation:
  - Workgroups
  - Advisory bodies
  - Focus groups

Recruiting People with Lived Experience

- Provide training and training of facilitators for ROSC 101 to Peers
- Have Peers identify leaders and gatekeepers within the community
- Peers facilitate ROSC 101 (Co-Facilitate to provide point in time information/responses)
  - Make it a small intimate group
  - Account for longer introductions – Use prompts i.e. "*One thing I feel the recovery community currently does well*"
  - Plan for tons of Q&A
- The community member is the expert on what they are seeing in the community – treat them as a valuable resource.

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Or simply...

Ask Peers!

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Nothing About Us Without Us

People with lived experience are directly impacted by…

- What does and doesn't happen in the community
- Decisions made about access, funding, options, services
- Legislation put in place around
  - Housing
  - Employment
  - Education

Have them be a part of these conversations!

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Participatory Process

- Strength-based community assessments
- Evaluation of effectiveness
- Development of plans for implementation
- Regular community process for discussion and decisions

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It Takes A Village

People recover in their Community

They live, grow and become an asset in their Community

The Community should be involved in ROSC

The Community and PLE should have investment and shared ownership

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Shared Ownership - Intentionally

- REMEMBER - Healthy relationships are intentional
- Build it in from the ground up
  - Description of the ROSC Council
  - Purpose of Committees and clearly defined expectations and terms
  - Agreements on how it operates and who should/ needs to be involved
    - Which types of SUD/MH field representation – i.e., Recovery Support, Prevention, Intervention, Treatment
    - Which types of affiliation representation – i.e., housing, food service, child services, criminal justice
    - Which types of business representation – i.e., recovery-friendly employers, businesses owned by people in recovery
    - Which types of recovery community representation – i.e., 12-step, faith based secular, diet and exercise

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Single Agency vs Shared

- Benefits one organization
- Belongs to the organization
- No investment from Council members
- Struggle to keep members
- Doesn’t feel like a community

- No one organization
- Belongs to the community
- Investment from Council members
- Keeps members
- Feels like a community effort

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Better Outcomes:
Recovery-Ready Community

- Equitable access to services
- Thriving recovery community
- More Recovery Community Centers/Organizations
- Recovery High Schools, Collegiate Recovery Programs
- Recovery Residencies
- Recovery-Friendly Workplaces
- Informed and responsive care providers
- Change in culture, change in services, change in community

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Recovery Ready Community

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Recovery Community Organizations

- Independent
- Non-profit organizations
- Led and run by representatives of local communities of recovery on behalf of the recovery community.
- The sole mission of an RCO
  - to mobilize resources to increase the prevalence and quality of long-term recovery from substance use

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https://facesandvoicesofrecovery.org/arco/rco-best-practices/

Recovery Community Organizations

- Core Strategies
  - Public education and awareness
  - Policy advocacy
  - Peer recovery support services

- Scope and Representation
  - Local
  - Statewide
  - National

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Recovery Community Centers

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Recovery Community Center

- A recovery-oriented sanctuary anchored in the heart of the community
- Offers local networks of non-medical, recovery support services
- Peer-operated
- Serve as locatable resources of community-based recovery support

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Recovery Community Center

Provide a variety of services including:

- Recovery coaching
- Medication assisted treatment/recovery (MAT/R) support
- Skills-building
- Mutual-help groups
- Employment linkages

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New kid on the block: An investigation of the physical, operational, personnel, and service characteristics of recovery community centers in the United States, Journal of Substance Abuse Treatment, Kelly, J., et al.; January 2020.

Recovery Housing

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Recovery Housing

- Safe, healthy, and substance-free living environments that support individuals in recovery from addiction.
- Vary widely in structure
- Centered on peer support and a connection to services that promote long-term recovery
- Benefits individuals in recovery by providing direct connections to other peers in recovery and recovery services and supports.

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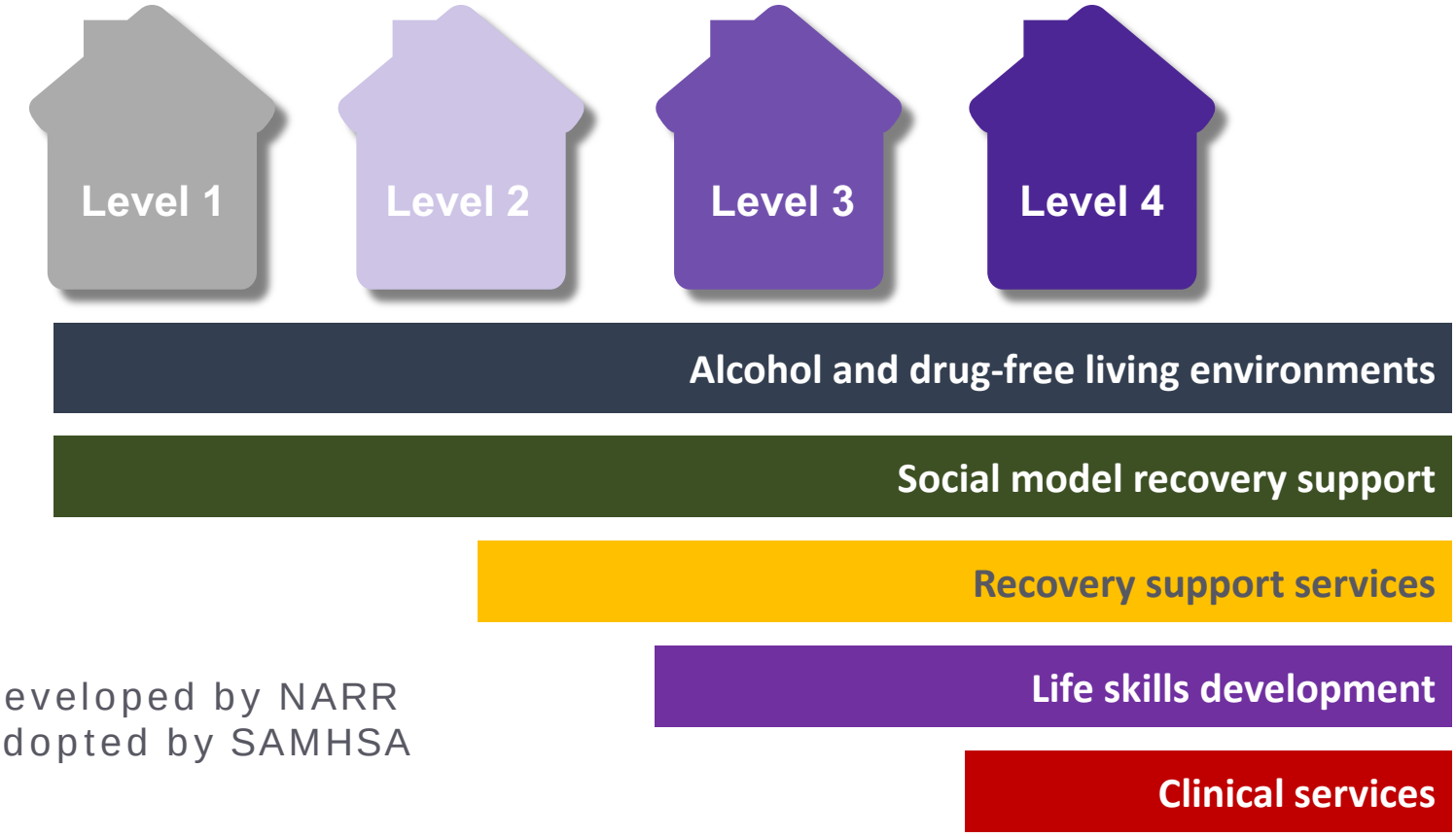
New kid on the block: An investigation of the physical, operational, personnel, and service characteristics of recovery community centers in the United States, Journal of Substance Abuse Treatment, Kelly, J., et al.; January 2020.

Residences Cover A Wide Service Spectrum



Developed by NARR
Adopted by SAMHSA

NARR Services and Programs

- Best practice standards for residences
- Code of Ethics
- Levels of recovery support
- Protocol for residence certification
- Model for state, community support
- Training, technical assistance

- Best practice standards for residences
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- Training, technical assistance

NARR
National Alliance for Recovery Residences
Community ▪ Standards ▪ Ethics ▪ Education

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For more information visit narronline.org

Collegiate Recovery

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Collegiate Recovery Basics

- University-provided addiction recovery support services
- Similar to collegiate athletes receiving specialized accommodations
- Most developed programs are Texas Tech, Augsburg University, Rutgers University, and Kennesaw State University
- Typical components include meeting space for students, dedicated staff, supportive services, housing accommodations, etc.
- Housed in a variety of areas (sometimes academic, sometimes health and wellness, etc.)

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Collegiate Recovery Research

- Key findings in Collegiate Recovery Programs (CRPs)
  - Average age of first treatment experience is 10 years earlier
  - Average age of stable recovery is 15 years earlier

- For more information on Collegiate Recovery:

ARHE
ASSOCIATION OF RECOVERY IN HIGHER EDUCATION

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For More Information Visit https://collegiaterecovery.org/

Recovery High Schools

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What is a Recovery High School?

- The primary purpose is to educate students in recovery from substance use and co-occurring disorders
- The school meets state requirements for granting a diploma
- Students in recovery are committed to working a recovery/wellness program
- The school is available to any student in recovery

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Why Do Recovery High Schools Work?

- Change of environment – people, places, and things
- Focus on academics and recovery
- Coordinated clinical supports
- Positive peer pressure

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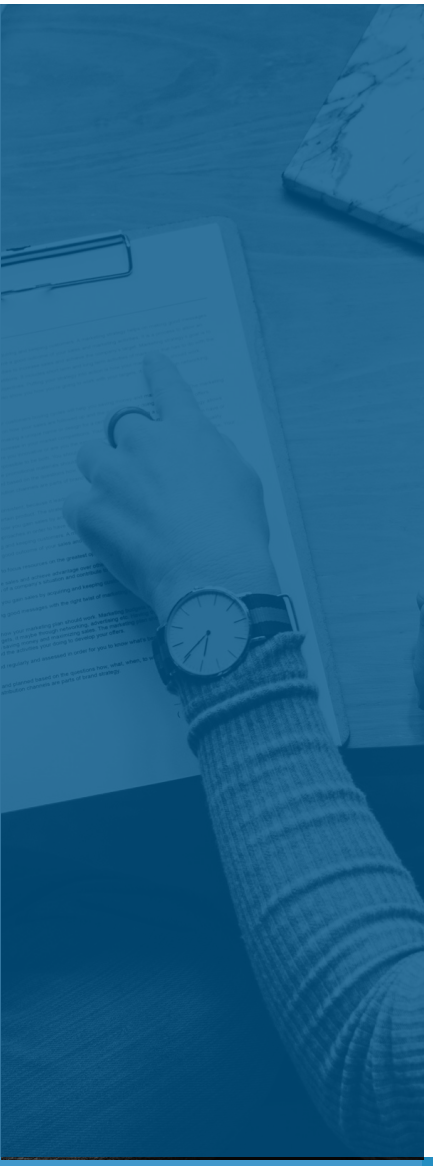

Research Outcomes

- (2017) compared students who received treatment for SUDs and attended recovery high schools for at least 28 days vs. students who received treatment and did not attend a recovery high school
- After 6 months, students attending recovery high schools were significantly more likely than non-RHS students to
  - report complete abstinence from alcohol, marijuana, and other drugs
  - exhibit lower levels of marijuana use
  - have less absenteeism from school

For more information on recovery high schools visit:

https://recoveryschools.org

Andrew J. Finch, Emily Tanner-Smith, Emily Hennessy & D. Paul Moberg (2018) Recovery high schools: Effect of schools supporting recovery from substance use disorders, The American Journal of Drug and Alcohol Abuse, 44:2, 175-184, DOI: 10.1080/00952990.2017.1354378

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Alternative Peer Groups

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Alternative Peer Groups

- Alternative Peer Groups facilitate
  - Twelve-step meetings
  - After-school programming
  - Pro-social activities
  - Educational support
  - Individual & family counseling (as a critical component)
  - Parent support services
  - Intensive outpatient therapy
- Act as a liaison between residential treatment programs, psychiatrists, school counselors and other mental health professionals

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Key Factors to the APG Model

- The Fun Factor
- Encourages recovering young people to learn how to have fun within healthy boundaries
- Rewards System
- Rewards adolescents for recovery, honesty, and integrity with fun activities
- Parent Involvement
- Parents are strongly encouraged to attend their own recovery meetings and create their own program of accountability to support their teen

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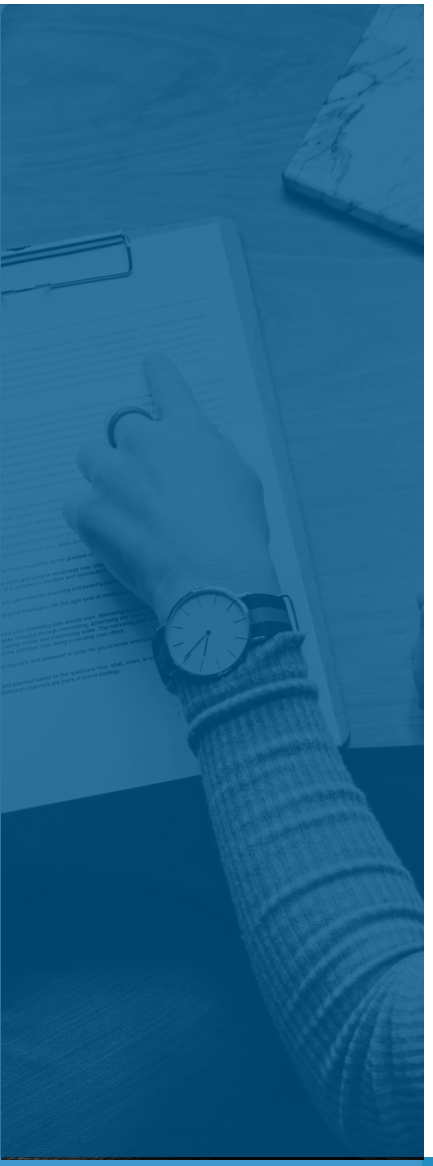

AAPG

- Association of Alternative Peer Group Programs (AAPG)
- www.aapg-recovery.com

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Harm Reduction

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Harm Reduction Programs

- Policies, programs, and practices that aim to reduce the harms associated with the use of alcohol or other drugs
- Practical strategies and ideas aimed at reducing negative consequences associated with drug use
- Movement for social justice built on a belief in, and respect for, the rights of people who use drugs
- www.harmreduction.org

https://harmreduction.org/about-us/principles-of-harm-reduction/

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Principles of Harm Reduction

- Establishes quality of individual and community life and well-being — not necessarily cessation of all drug use — as the criteria for successful interventions and policies
- Non-judgmental, non-coercive provision of services and resources to people who use drugs (PWUD) and the communities in which they live in to assist them in reducing harm
- Ensures that PWUD and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them
- Poverty, class, racism, social isolation, past trauma, sex-based discrimination, and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm

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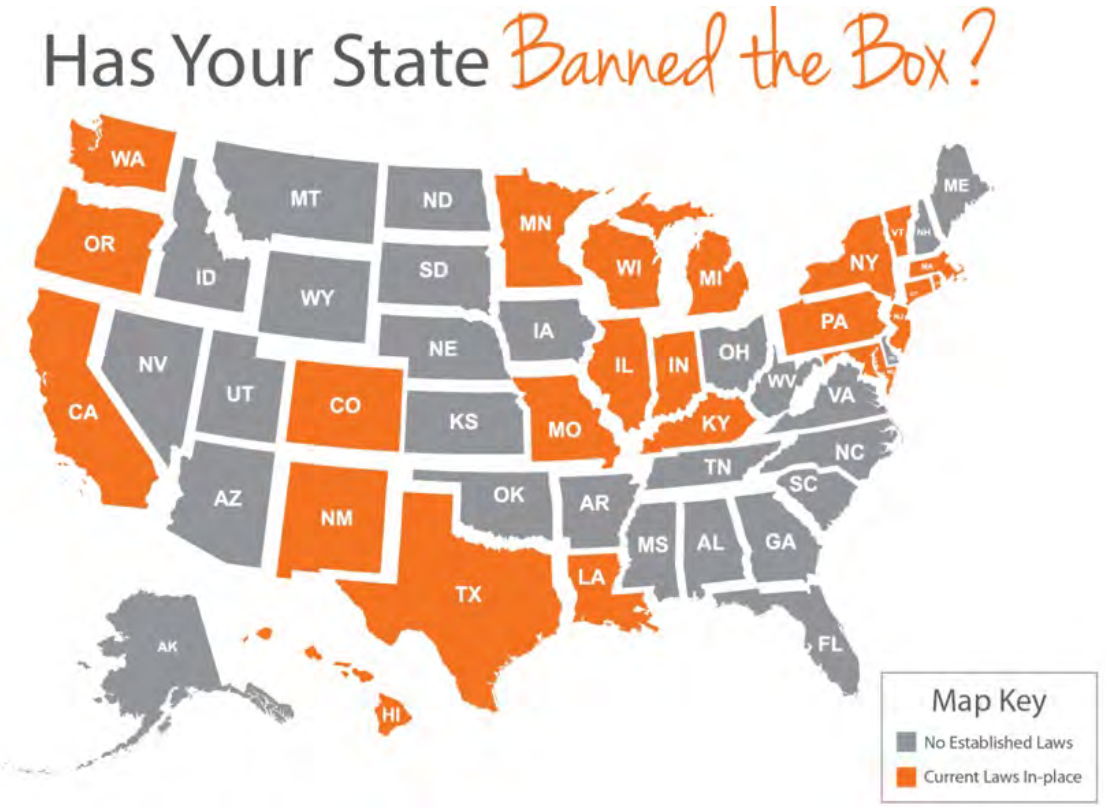
Other Elements of a Recovery-Ready Community

- Re-entry programs
- Family support programs
- Recovery-friendly employers
- Recovery-ready workplaces
- Faith based programs
- Active recovery communities
- Substance free recreation
- Online recovery community
- Recovery celebrations

Recovery Focused Policies

- Breaking down barriers to long-term recovery
- Eliminating stigma
- Eliminating discriminatory practices ar policies
- Good Samaritan law
- Ban the Box campaign



https://www.paycor.com/resource-center/ban-the-box-state-by-state

Advocacy

- Building a grassroots movement
- The voice of people with lived experience
- *Nothing about us without us*
- People in recovery on committees, councils
- We recover and we vote
- We are a constituency of consequence

What can you do right now?

10 concrete steps that local leaders can take to mobilize the recovery community

1. Bring people in recovery to the table early and often to create a shared vision of recovery.
2. Identify leaders in the recovery community
3. Identify recovery champions to support the effort and to be ambassadors for the cause.
4. Launch community visioning.
5. Assess community strengths. Where is recovery thriving?

10 concrete steps that local leaders can take to mobilize the recovery community

6. Conduct a community recovery capital assessment to identify areas where recovery support and recovery-friendly policies are most prevalent.

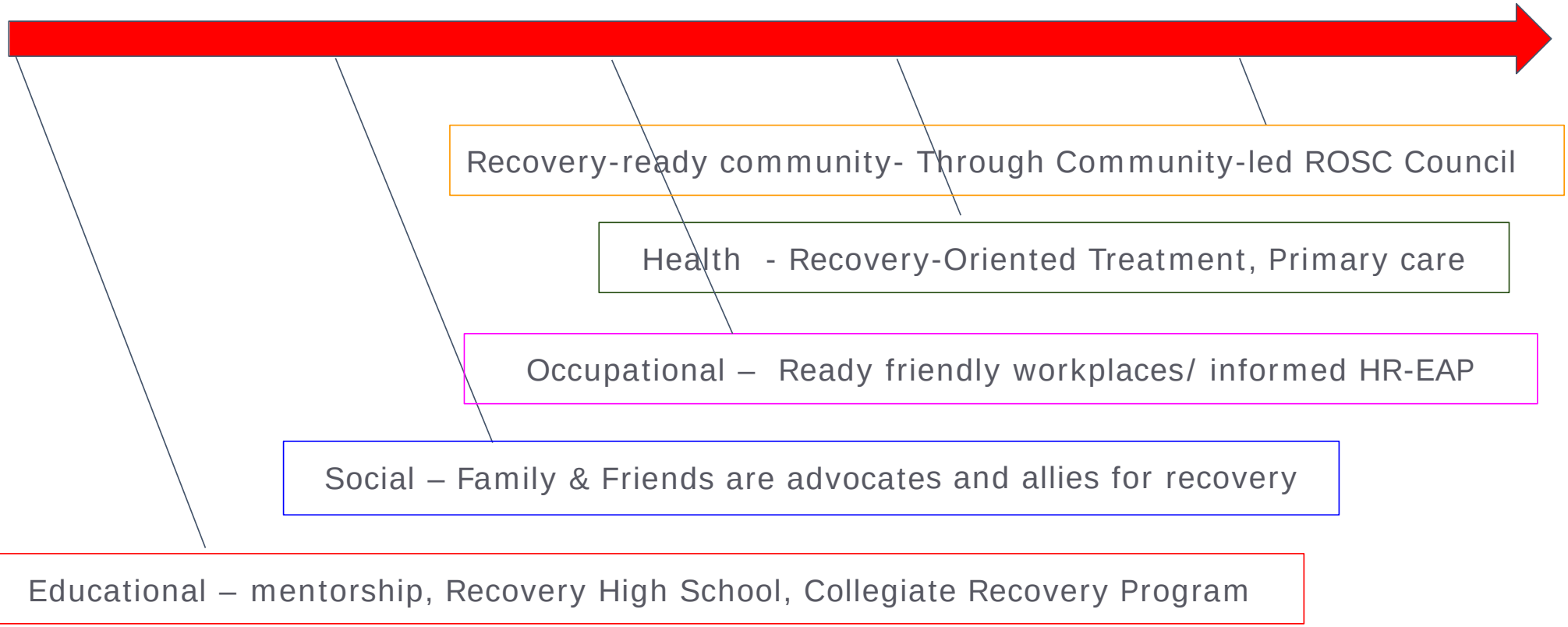
7. Get creative and innovative.

8. Encourage friends, family and colleagues to share their personal stories.

9. Create recovery community centers that make recovery visible on Main Street.

10. Celebrate recovery from addiction!

Gaps in my journey



We are here to help

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Our Programs

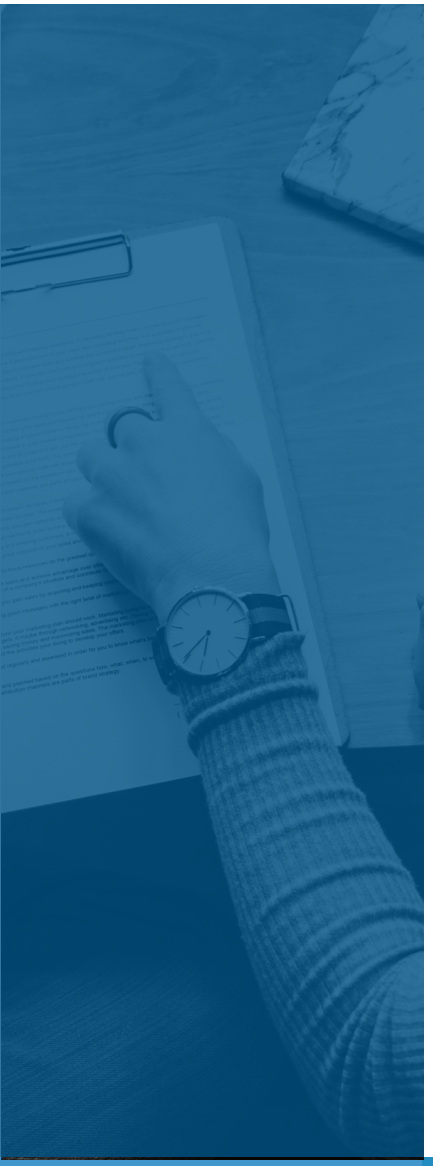
ARCO
Association of Recovery Community Organizations

CAPRSS
Council on Accreditation of Peer Recovery Support Services

NRI
National Recovery Institute

RDP
Recovery Data Platform

info@facesandvoicesofrecovery.org
facesandvoicesofrecovery.org
10 G Street, Suite 600, Washington, DC 20002



Thank you

Joseph Hogan-Sanchez

Director of Programs

jsanchez@facesandvoicesofrecovery.org

www.facesandvoicesofrecovery.org

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Community Engagement in Behavioral Health Promotion:

Houston Emergency Opioid Engagement System

Jessica Yeager, NCPRSS, PRS/ ICPR, RSPS, PM/ PRC
Chad Armstrong, RSS

CAPSA-ET SUD Conference
May 6, 2021

UTHealth
The University of Texas Health Science Center at Houston

HEROES
HOUSTON EMERGENCY OPIOID ENGAGEMENT SYSTEM

Objectives

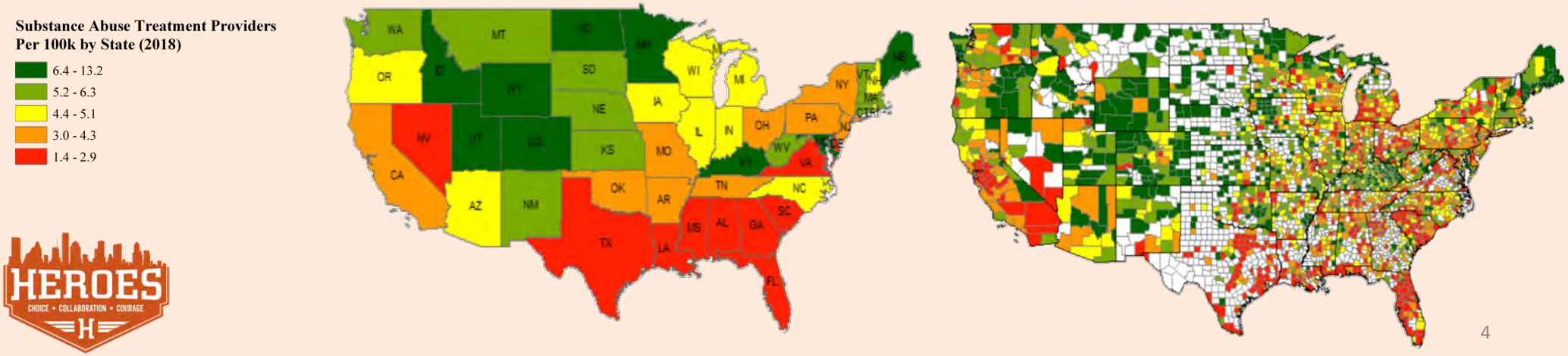
- ❑Texas data on overdoses and treatment services
- ❑Innovative Comprehensive Model
- ❑Assertive Outreach
- ❑Importance of Peers
- ❑Upcoming/ New Projects

Treatment Landscape

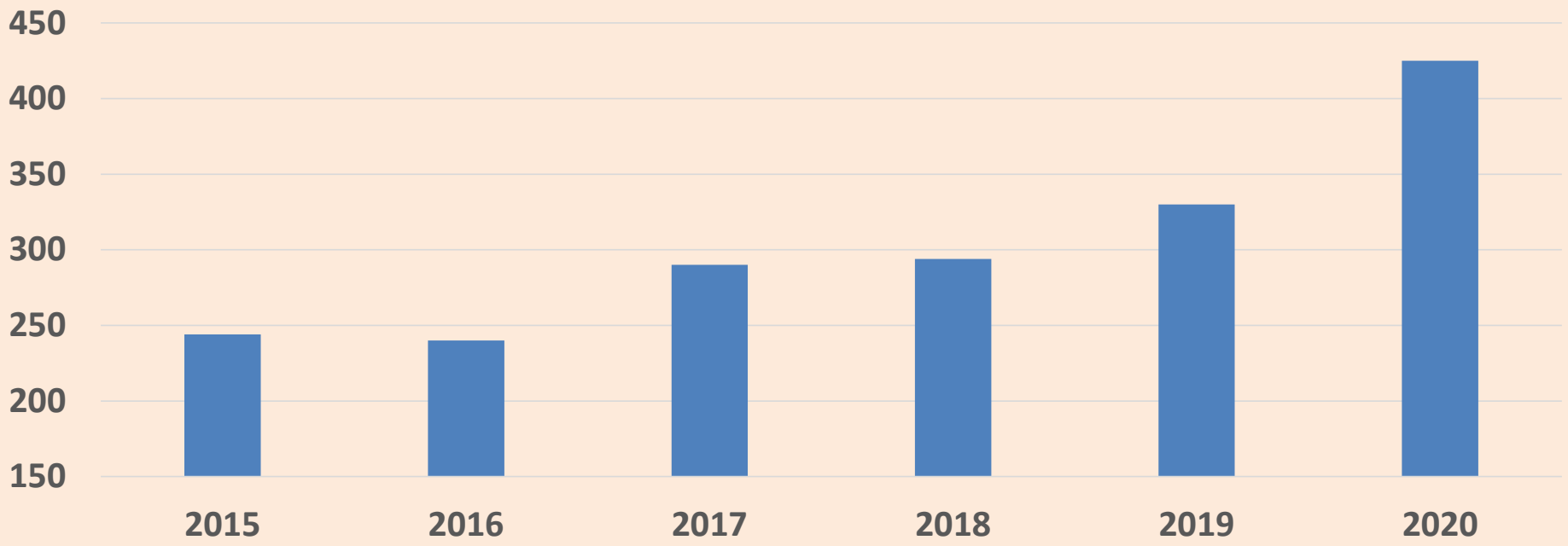
- Number of persons dependent on opioids has increased over the past 30 years
- No equivalent increase in availability of and access to treatment
- Demand for treatment far exceeds capacity
  - Nationally, only 1 in 10 people with substance addictions receive treatment
  - 93.6% of Texans who need opioid addiction treatment did not receive it (National Survey on Drug Use and Health 2016).
  - 91.2% of Texans who need opioid addiction treatment did not receive it (Texas Health and Human Services, 2020)

The National Landscape – Treatment Capacity

- Our research highlights significant treatment capacity gaps, especially in the Southeast
- 47,000+ opioid deaths
- 12,500 treatment programs



Opioid Deaths on the Rise- Houston

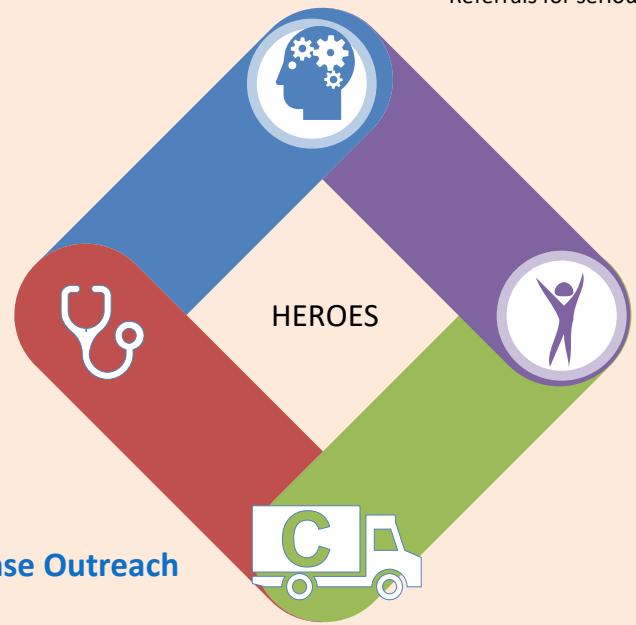


Champagne-Langabeer et al, 2019, *Substance Abuse*, Opioid Prescribing Patterns and Overdose Deaths in Texas

Towards a More Comprehensive Approach

Behavioral Counseling
- Initial and ongoing counseling
- Referrals for serious mental illness

Emergency Department
- Same-day induction into MAT via buprenorphine
- DEA "x-waivered", board-certified emergency physicians
- Consult, screening, and diagnosis for OUD
- Initial dose of Suboxone (8-12 mg)
- Rx to bridge until ongoing MAT (~2 weeks)



Peer Support Services
- Peers that can guide patients to services, motivate change, monitor progress
- Provide follow-up and outcomes

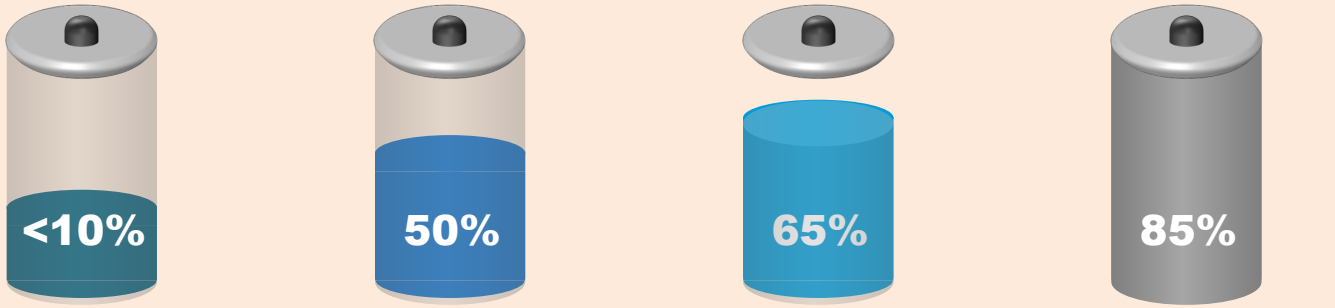
Quick Response Outreach Teams
- Led by peer recovery coach and paramedic
- Guided by data from overdose surveillance data from EMS and Police

HEROES Model

Changes in the program – COVID-19

- Substance Use Treatment has shifted to a Virtual Landscape
  - Telehealth assessments and at home initiation of MOUD (buprenorphine)
  - Two-way video counseling sessions
  - Remote attendance at virtual meetings (peer support and group counseling)
  - Phone/text/email being utilized more frequently

Odds of Successful Recovery



No Treatment

Medication For Opioid Use Disorder

MOUD + Behavioral Counseling

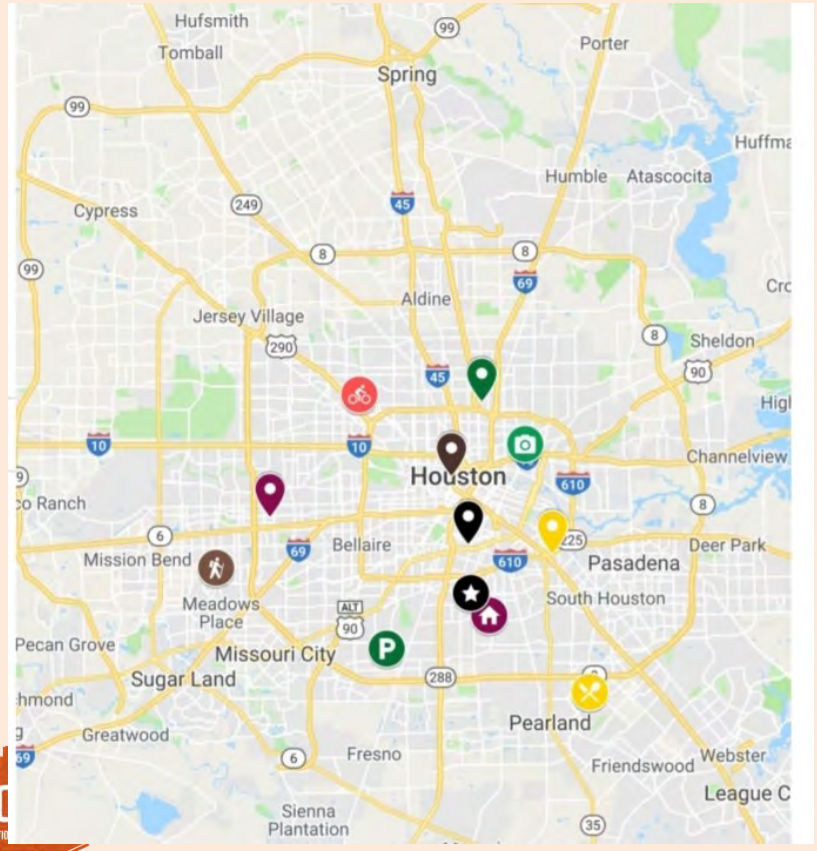
MOUD + Behavioral Counseling + Peer Support + Ongoing Follow-up

HFD Outreach

Assertive Outreach

- "Quick response team" to non-fatal OD's within 24-48 hours after report
- Paramedic and Peer Recovery Specialist
- Motivational interviewing, options, and enrollment into program

HFD Outreach Mapping



- HFD Naloxone Data from the prior week is sent to the HEROES team the day prior to outreach
- The Data is mapped, and we outreach to each address where Naloxone had a positive effect.
- Disregard addresses that are not opioid related.
- Outreach examples

Continuum of Addiction Recovery/Stages of Change

Adapted from William White

Prochaska & DiClemente

SAMHSA
Substance Abuse and Mental Health Services Administration

Peer Support and the stages of change through HEROES

- ❑Pre-contemplation – Overdose Report
- ❑Contemplation – HFD Outreach
- ❑Preparation- Making appointment to meet HEROES team and enroll in the program
- ❑Action- MOUD, counseling, peer support, & support groups
- ❑Maintenance- Staying plugged in, practice skills, and coping strategies in long-term recovery.

Importance of Peers

- Peer Recovery Support Specialists- Highly trained professionals
- Lived Experience of addiction and recovery
- Distinct from case management and treatment; non-clinical role
- Distinct from mutual aid support (i.e. 12 step groups)
- Provide links to professional treatment, health and social services, community resources
- Available outside of normal "business hours"

Relapse & Recovery Coach Rapport

- The vast majority of the individuals who experienced a relapse reached out to their recovery coach for assistance in returning to their recovery path (77%).
- Length of time between relapse and returning to the recovery path was within a month or less for 62% of the respondents with only 15% taking 4 or more months.

Source: UT Addiction Research Institute RSS 2017 Final Evaluation Report

Peer Recovery and Assertive Outreach

HFD/EMS & Peer Support

HEROES
CHOICE • COLLABORATION • COURAGE

Community Resilience

- ❑Exposure to the need and the available treatment options (awareness)
- ❑Narcan distribution (first responder and community)
- ❑Coordinated community response (other providers and stakeholders)
- ❑Family Support (assisting those impacted by addiction)
- ❑New projects to connect further into the community (mobile response)

Narcan (Naloxone)

- Approved by the FDA to prevent overdose by opioids such as heroin, morphine, and oxycodone. It blocks opioid mu receptor sites, reversing the toxic effects of the overdose.
- Administered when an individual is showing signs of opioid overdose
- Little or no effect/side effects if there are no opioids present in the body
- https://www.morenarcanplease.com/

New projects connecting the community!

Project Integra - Integrated Mobile Unit

- OUD/ HIV/ HCV/ STI's/ Prevention

Email: integrahouston@uth.tmc.edu

Young HEROES

- ❑ Between 13 and 17 years old
- ❑ Willing to attend treatment and take medication
- ❑ Have parent/ guardian consent
- ❑ For more information contact:

  Meredith O'Neal below at

  Office: 713-500-3624 or

  Email: Meredith.M.Oneal@uth.tmc.edu

Collaboration – Key to Success

Houston Recovery Center

HARRIS COUNTY CSCD

HOUSTON FIRE-EMS RESCUE 1838

Emergency Medicine
MEMORIAL HERMANN
Texas Medical Center

HOUSTON POLICE

STAR
SUCCESS THROUGH ADDICTION RECOVERY

BJA
Bureau of Justice Assistance
U.S. Department of Justice

TEXAS
Health and Human Services

UTHealth
The University of Texas
Health Science Center at Houston

Walgreens

TEXAS
EMERGENCY MEDICAL SERVICES

THE UNITED STATES
DEPARTMENT of JUSTICE

LYNDON B. JOHNSON HOSPITAL
HARRISHEALTH SYSTEM

HOPE
Galveston County Drug Court Program
Helping Ourselves with Positive Efforts

HEROES
CHOICE • COLLABORATION • COURAGE

Thank You!

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832-584-9329

Chad Armstrong
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713-702-1329

https://sbmi.uth.edu/heroes/

Opioids: Use and Misuse

05/06/2021
Substance Use Disorder Conference
UTHSC, Tyler

Emmanuel Elueze MD. PhD. MPA. FACP
Professor of Medicine
Designated Institutional Officer, GME
Vice President For Medical Education and Professional Development

UTHealth
The University of Texas Health Science Center at Tyler

Objectives

Describe Opioids and their benefits
Discuss associated risk and adverse effects with use of opioids
Discuss the key role of Medication Assisted therapy in opioid use disorder.

UTHealth
The University of Texas
Health Science Center at Tyler

What are Opioids

- Derivatives of opium alkaloids from poppy seed (Papaver Somniferum); 1st used about 3400BC, named the “joy plant”.
- Morphine extracted in 1803, named after Greek “god of dreams”
- Types of Opioids
  - Naturally occurring
    - Morphine, codeine
  - Semi Synthetic (made from natural opioids)
    - Oxycodone, hydrocodone and heroin
  - Synthetic
    - Fentanyl
    - Methadone

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The University of Texas Health Science Center at Tyler

Opioid Pharmacology: Classification

Full opioid agonist
- weak agonist (codeine, hydrocodone, oxycodone)
- strong agonist (morphine, fentanyl, hydromorphone)

Partial opioid agonist
- Buprenorphine: subutex, suboxone, butrans

Agonist-Antagonist
- butorphanol(stadol), pentazocine

Mixed opioid agonist and SNRI agents
- Tramadol, Tapentadol (Nucynta)

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The University of Texas
Health Science Center at Tyler

Opioid Pharmacology: General Properties

- Analgesia, mood alteration and respiratory depression are main CNS effects
- Drug of choice for severe acute pain and cancer pain
- Differ in potency:
  - Fentanyl > hydromorphone > oxycodone > morphine = hydrocodone >codeine = tramadol
- No ceiling for analgesic effect for pure agonist except that imposed by adverse effects

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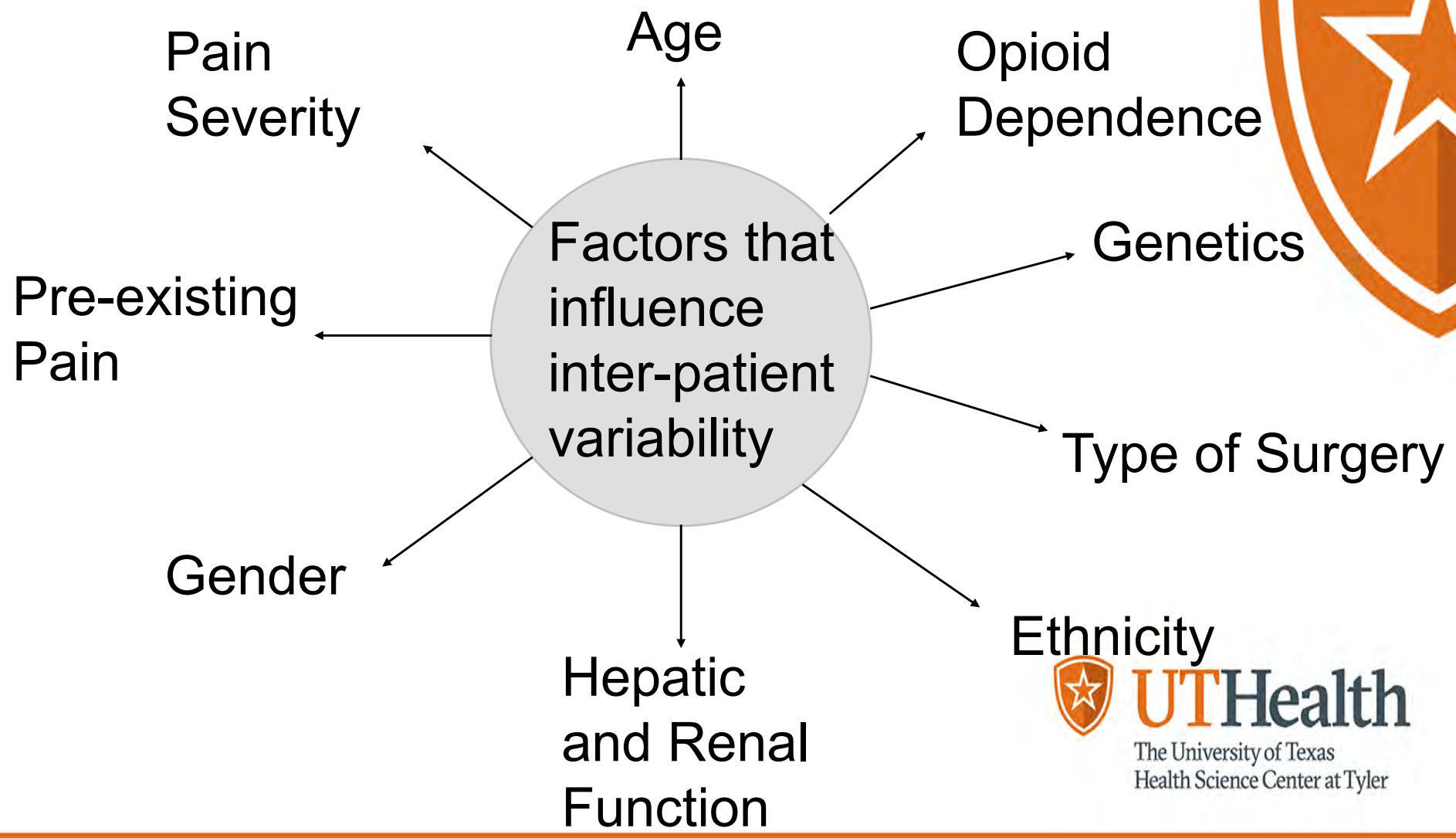
A Biological Model for Opioid Variability



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Adapted from: Seminars in Perioperative Nursing, 2001

Factors that influence choice of specific opioid

- Pain type and pathology
- Co – Morbidities
- Drug safety & toxicity profile
- Ease of administration
- Quality of life
- Overall goals of care
- Cost

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Uses of Opioids

- Acute pain
- Chronic pain with appropriate guidelines
- Dyspnea
- Diarrhea
- Cough suppressant
- Treatment of opioid use disorder

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Pain Syndromes with poor response to opioids

- Neuropathic pain
- Incident pain
- Cognitive impairment
- Psychological distress
- Psychiatric co – morbidities
- (Chronic non malignant pain)

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Health Science Center at Tyler

Routes of Opioid Delivery

Noninvasive	Invasive
Oral	Subcutaneous
Rectal	Intravenous
Transdermal	Epidural / intrathecal
Transmucosa	

Opioid Pharmacology: Preparations

- Short -Acting Drugs
- Morphine, Hydromorphone, Codeine, Oxycodone, hydrocodone
- Meperidine , Fentanyl, Buprenorphine
- Combination preparations with acetaminophen and NSAIDs (Percocet, Vicodin, Vicoprofen)
- i/v formulation: duration 2 to 4 hrs, onset 2-15 mins, peak10-30 mins
- Oral formulation: duration 2-4 hrs, onset 15-30 mins, peak 60-90 mins

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Products Covered by this REMS (Risk Evaluation and Mitigation Strategy).

Brand Name Products

Avinza® morphine sulfate ER capsules

Butrans® buprenorphine transdermal system

Dolophine® methadone hydrochloride tablets

Duragesic® fentanyl transdermal system

*Embeda® morphine sulfate/naltrexone ER capsules

Exalgo® hydromorphone hydrochloride ER tablets

Hysingla® ER (hydrocodone bitartrate) ER tablets

Kadian® morphine sulfate ER capsules

Methadose™ methadone hydrochloride tablets

MS Contin® morphine sulfate CR tablets

Nucynta® ER tapentadol ER tablets

Opana® ER oxymorphone hydrochloride ER tablets

OxyContin® oxycodone hydrochloride CR tablets

Targiniq™ oxycodone hydrochloride/naloxone hydrochloride ER tablets

Zohydro® hydrocodone bitartrate ER capsules

Generic Products

Fentanyl ER transdermal systems

Methadone hydrochloride tablets

Methadone hydrochloride oral concentrate

Methadone hydrochloride oral solution

Morphine sulfate ER tablets

Morphine sulfate ER capsules

Oxycodone hydrochloride ER tablets

* Not currently available due to voluntary recall (still approved); † No longer marketed (still approved)

Equianalgesic Dosing

POINTS TO REMEMBER

Always convert to the 24 hour morphine equivalent dose (MED) before making adjustments

IV/SQ Morphine is 3x as strong as PO Morphine

Oral breakthrough dosing should be 10% of the 24 hours does, given Q2 hours PRN

Equivalents

Hydrocodone PO 1mg = MED PO 1mg

Oxycodone PO 5mg = MED PO 5mg

Hydromorphone PO 1mg – MED PO 4mg

Oxycontin PO 20mg = MED PO 30mg

Fentanyl patch 25mcq = MED PO 50mg

Hydromorphone IV 1mg = MED 5mg IV

Fentanyl IV 100mcg = MED 10mg IV

Methadone Conversion

MS 0-60 mg	Divide by 3
MS 60-800 mg	Divide by 15 & add 15
MS 800-1000 mg	Divide 15
MS over 1000 mg	Divide by 20

Multiply by 0.6 for cross tolerance

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Choice of Opioids in Clinical Practice

- Morphine often is the first opioid of choice for parental administration
  - History, availability, various formulations
  - Knowledge of its pharmacology, cost
- In renal and liver dysfunction
  - Fentanyl; Hydromorphone
  - Methadone; Buprenorphine
- In patients with hypotension
  - Fentanyl
- In outpatient and post discharge practice
  - Hydrocodone and Oxycodone
- In Patients with substance use disorder
  - Methadone; Buprenorphine

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Adverse effects of Opioids

- Constipation
- Nausea/emesis
- Sedation
- Pruritus
- Resp depression
- Hallucination
- Cognitive dysfunction
- Seizures
- Dysphoria
- OVERDOSE
- Hyperalgesia
- Urinary retention
- Bradycardia
- Qt prolongation
- Sexual dysfunction
- Weight gain
- Hypok,HypoNa, hypomg
- Immunosuppression
- USE DISORDER

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Audience Participation
True or False

- Opioid overdose will be worsened with the use of Narcan (Naloxone). T or F
- Drowsiness, slow respiration and small pupils are the key features of opioid overdose. T or F
- COPD (Chronic Bronchitis), Sleep Apnea and Heart failure can increase your chances of having an opioid overdose. T or F
- A dose of opioid above the equivalent of 50 mg of morphine a day is considered to be high. T or F
- MAT in addiction medicine stands for Medically advanced therapy. T or F

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Spectrum of Opioid Use in the community

- Appropriate use – Medically prescribed and indicated
- Misuse – Not medically indicated and or not medical prescribed
- Use Disorder – Meets DSM-5 Criteria

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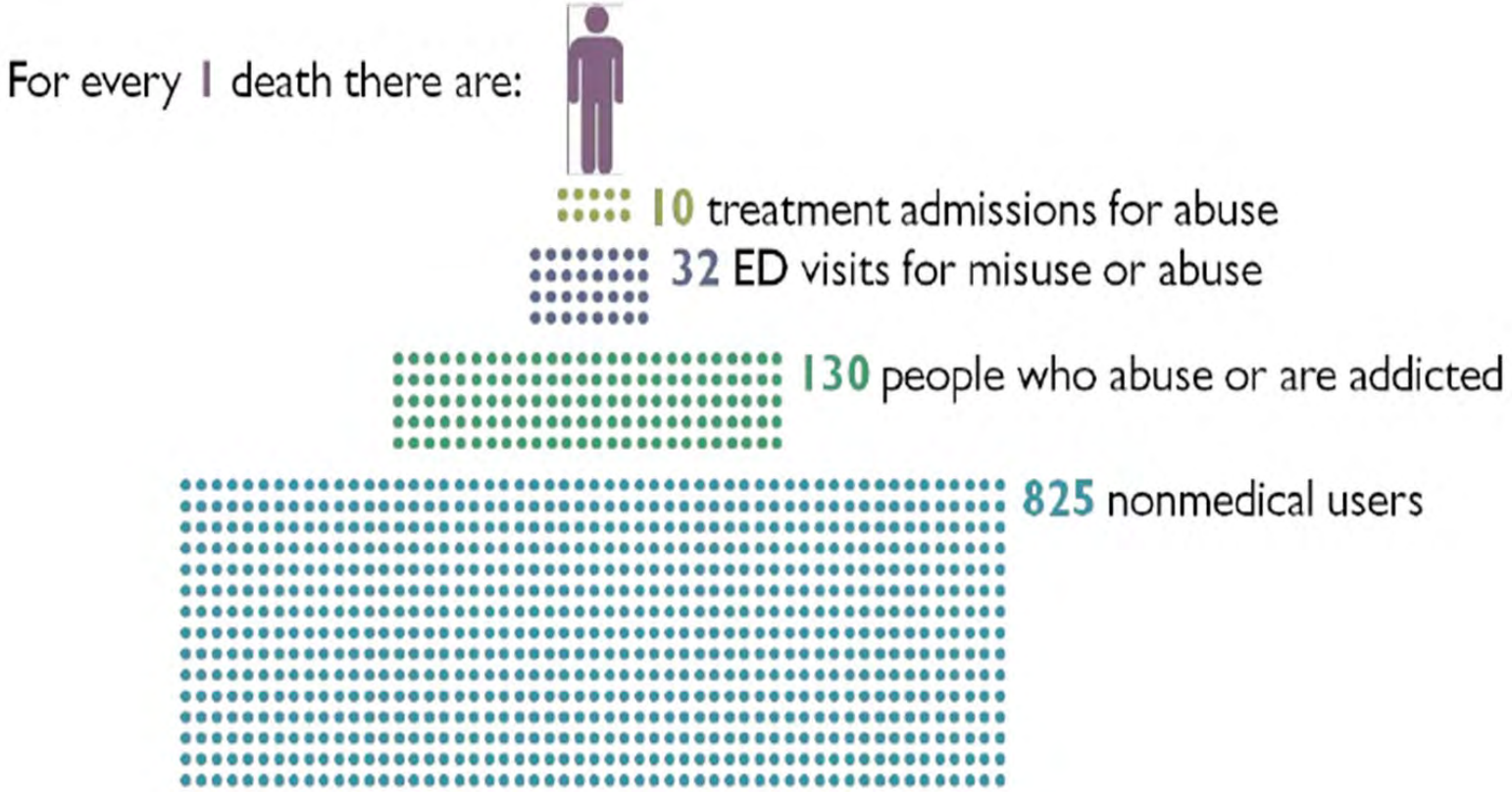
Spectrum and Extent of the Opioid use disorder



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Substance Use Continuum

TRADITIONAL

Dependence

Abuse

At- Risk Use

Non – Problem Use

Abstinence

DSM-5

Substance Use Disorders

0–1 criteria: No diagnosis

2-3 criteria: Mild

4-5 criteria: Moderate

6 or 11 criteria: Severe

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The 11 Criteria for a Substance Use Disorder (DSM-5)

1. Hazardous use
2. Social or interpersonal problems related to use
3. Neglected major roles to use
4. Withdrawal
5. Tolerance
6. Used larger amounts/longer
7. Repeated attempts to control use or quit
8. Much time spent using
9. Physical or psychological problems related to use
10. Activities given up to us
11. Craving

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Long –term Societal Effects of Chronic opioid use.

- 21-29% of patients prescribed opioids for chronic pain misuse them
- 8–12% develop an opioid use disorder
- 4-6% who misuse prescription opioids transition to heroin.
- 9.4 million Americans on long-term opioids, estimated 2.1 million are hooked.
- 80% with Opioid use disorder (OUD) are not receiving treatment

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Impact of opioid use disorder

- 500,000 deaths from Opioid overdose 1999 to 2019.
- 90,000 drug overdose death 09/2019 to 09/2020
- About 70 % from Opioids of which about 73% are from synthetic Fentanyl analogs,.

  - Fentanyl (100 times more potent than morphine)

  - Carfentanil (10,000 times more potent than morphine)

- One of the deaths of despair

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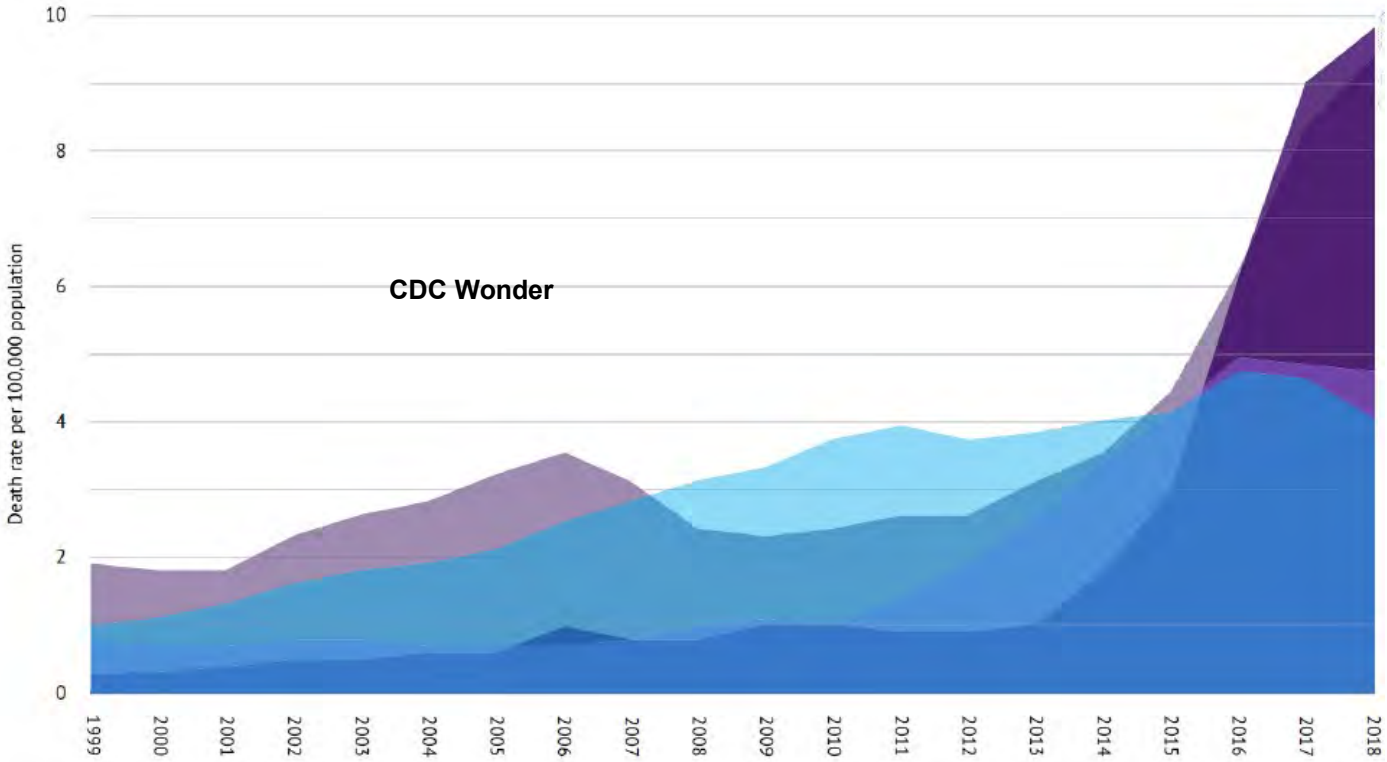
Data to Consider: Patients Continue to Die



Synthetic Opioids
(e.g., illicit fentanyl & analogues)

Stimulants
(e.g., cocaine, methamphetamine)

Heroin

Prescription Opioids

CDC Wonder

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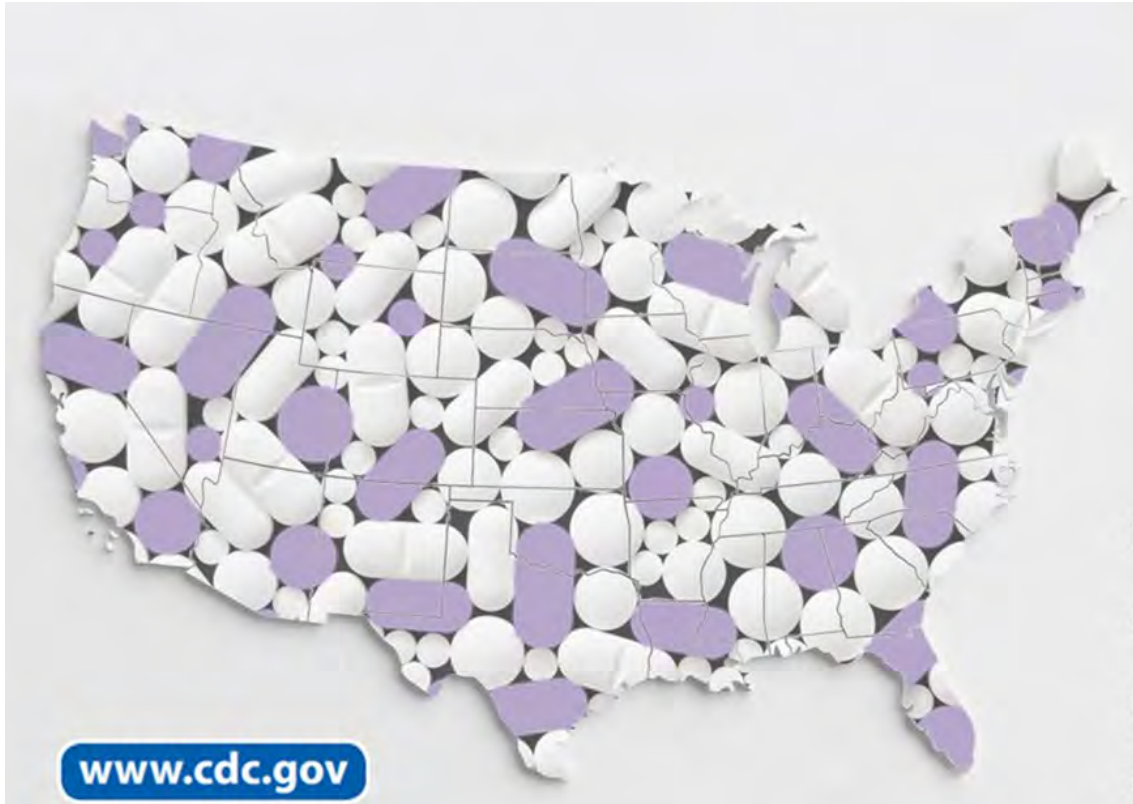

130
AMERICANS

die every day from an opioid overdose

(including Rx and illicit opioids).

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Drug Misuse in Texas – 2016 to 2017

Texas adults who used an illicit drug in the past year, by drug:

Prescription pain medication: 830,000

Heroin:67,000

Cocaine: 323,000

Methamphetamine: 125,000

15% of Texas high school students have used pain medication without a prescription.

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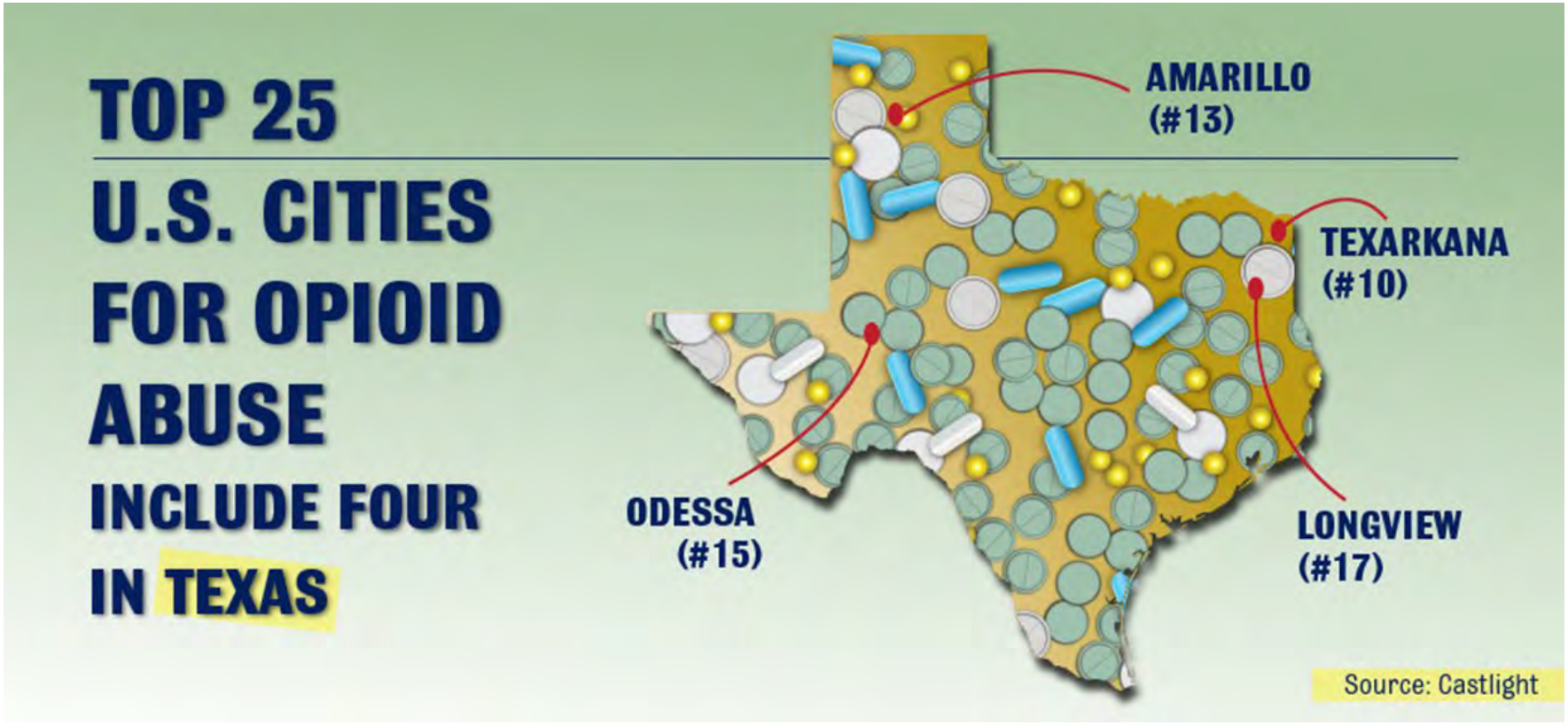
Rx Misuse & Abuse in Texas



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Risk factors for overdose

- People obtaining multiple controlled substances
- People obtaining from multiple doctors
- People taking high daily doses of opioids (>50 MME)
- Low income individuals and living in rural areas
- History of Overdose
- History of substance use disorder
- History of mental illness
- Recent decrease in opioids or loss of tolerance
- Recent release from incarceration or detoxification
- Chronic medical problems like; Liver, Kidney and Heart failures, COPD and Sleep Apnea

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How much is 50 or 90 Morphine Milligram Equivalent (MME)/DAY for commonly prescribed Opioids

50 MME/day:	90 MME/day:
• 50 mg of Hydrocodone (5 tablets of Norco (10/325) • 33mg of Oxycodone (2 tablets of Oxycodone sustained release 15mg) • 12 mg of Methadone (<3 tablets of Methadone 5 mg) • 25 microgram of Fentanyl	• 90 mg of Hydrocodone (9 tablets of Norco (10/325) • 60mg of Oxycodone (2 tablets of Oxycodone sustained release 30mg) • 20mg of Methadone (4 tablets of Methadone 5 mg) • 50microgram of Fentanyl

Opioid Overdose Control in the Community

I. Prevent Opioid use disorder

II. Improve Opioid prescribing

III. Reverse Overdose

IV. Treat Opioid Use disorder

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I. Prevent Opioid Use Disorder

- **Goal is to forestall opioid use disorder and other substance use disorder**
  - Community based interventions
    - campaigns, advertisements, taxes, age limits, legislations
  - Congress passed comprehensive opioid control package – Support for patients and communities act 10/20/2018
  - School Based interventions
    - Life-Skills Training
  - Family based interventions
    - Positive family support
  - Individual based Interventions

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II. Improve Opioid Prescribing

- Appropriate pain management
  - Know and use alternatives to opioids
- Use of CDC guidelines for pain management
- Controlled Substance Stewardship
- Use of Texas State Prescription drug monitoring program
- Co prescription of Opioids and Naloxone (now required in 8 States)

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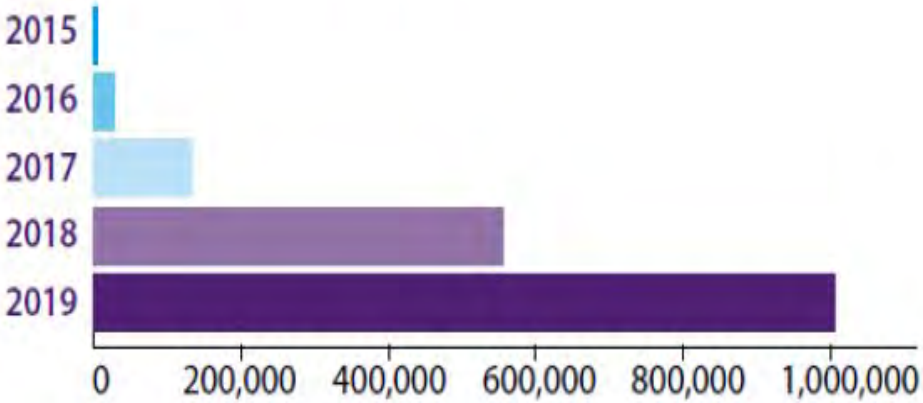
Opioid Prescribing Down 37 Percent

37.1% decrease in opioid prescriptions from 244.5M in 2014 to 153.7M in 2019[1]

1M+ naloxone prescriptions in 2019 —up from 6,588 in 2015[2]



64.4% increase in the use of state prescription drug monitoring programs in the past year—to 739M queries in 2019[3]

Hundreds of thousands of physicians accessing continuing medical education and other courses on substance use disorders, treating and managing pain, and more

85,000+ physicians and health care professionals certified to prescribe buprenorphine in-office—an increase of nearly 50,000 since 2017[4]

1. IQVIA Xponent market research services. ©IQVIA 2020. All rights reserved.
2. Emergent Biosolutions; Xponent IQVIA. Data received June 8, 2020. On file with author.
3. AMA Fact sheet: Physicians' and health care professionals' use of state PDMPs increases 64.4 percent from 2018 to 2019; 739 million queries in 2019.The state-by-state data is available at https://endoverdose-epidemic.org/wp-content/uploads/2020/07/AMA-Fact-Sheet-PDMP-use-and-registrationincrease-2014-2019-FINAL.pdf
4. 4 www.samhsa.gov/medication-assisted-treatment/training-materials-resources/practitioner-programdata, accessed June 30, 2020.

III. Reverse Opioid Overdose

Make naloxone available and use appropriately

Engage and train first responders and law enforcement in use of naloxone and features of overdose

Engage Family members / Friends on use of naloxone

Opioid Prescription take back programs

Needle Exchange and Injection sites programs

Clinicians order naloxone for appropriate patients on opioids

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Signs Of Drug Overdose: Opioid

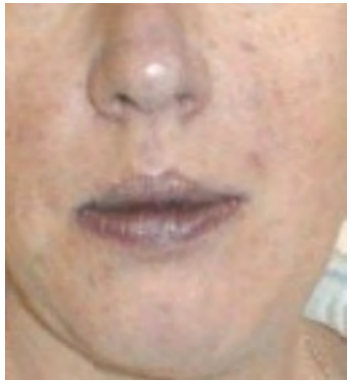
SIGNS OF AN OPIOID OVERDOSE. B.L.U.E.

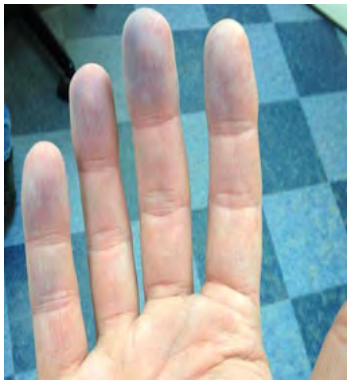
BREATHING — Breathing during an overdose is shallow, gurgling, erratic, or completely absent.

LIPS — Lips and fingertips are blue, due to decreased oxygen throughout the body.

UNRESPONSIVE — The victim will not respond to verbal or physical stimulation.

EYES — Pupils are pinpoint, as the opioids constrict the pupils to an unusally small size.





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Reversal Agent for Opioid Overdose
Naloxone (Narcan)

Benefits of Naloxone

- A complete opioid receptor antagonist
- Intranasal, Intramuscular, Intravenous forms
- Carried by EMS/Police
- Available over the counter
- Should be widely available

Intranasal

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How to respond to Overdose

- Get help immediately – CALL 911
  - Say someone is unresponsive and not breathing, give your location
- Administer naloxone if you have it and have being taught how to use it
  - Types of Naloxone available
    - Prefilled syringes
    - Autoinjector
    - Nasal Spray
- Check for fentanyl patch on the skin
- Connect them to treatment to prevent further episodes and to treat any substance use disorder
- Seek help if you overdosed

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IV. Treat Opioid use Disorder

- Be aware of local resources to treat substance use disorder
- Maintain Insurance parity laws treatment for substance use and mental health disorders
- Provide comprehensive substance use disorder treatment
  - Medication
  - Psychotherapy
  - Social support
- Make Medication Assisted Therapy widely available
  - Most effective therapy to prevent opioid overdose
- Know the options for medication Assisted Therapy
  - Methadone
  - Buprenorphine
  - Naltrexone
- Use of Drug Courts

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Treatment modalities for management of substance use disorder

- Brief Intervention
- Detoxification (inpatient and ambulatory)
- Pharmacotherapy
- Group and individual cognitive behavioral therapy
  - Hospital based
    - Inpatient / Residential / outpatient
  - Community based
    - Residential / outpatient
- Self help / 12 step programs
  - AA, NA, CA, GA
  - Family Anonymous, etc
- Management of Co-morbidities
  - Medical / psychiatric / chronic pain
- **Co-ordination / monitoring by Clinician**

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Detoxification from Opioid

- Slow taper (about 5 to 10% per month)
- Suboxone protocol or Subutex
- Methadone protocol
- Parental buprenorphine protocol
- Tramadol protocol
- Clonidine protocol

- Opioid withdrawal scales (COWS or CINA)

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What is Medication Assisted Treatment (MAT)

- Use of Medications in combination with Counselling and behavioral therapies
- To provide "whole person" approach
- Tailored to meet each patient's needs
- Goal is full recovery
- Can be part of Office Base Opioid Treatment program (OBOT)

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Benefits of MAT

- Improve patient survival
- Increase retention in treatment
- Decrease illicit opiate use and other criminal activity
- Increase patients' ability to gain and maintain employment
- Improve birth outcomes among women
- Reduce transmission of HIV and Hepatitis C
- Needs long-term use to be more Effective

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Buprenorphine

- Mu partial agonist; has ceiling effect
- Used as MAT by clinicians certified to use
- Goal is for Primary care clinicians to utilize
- Variety of Formulations for MAT
  - Combination form:
    - Buprenorphine / Naloxone (Suboxone) (oral)
  - Mono buprenorphine:
    - Oral, SC injections and Implantable rods

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Buprenorphine products approved by FDA for MAT

- Generic Buprenorphine/naloxone sublingual tablets
- Buprenorphine sublingual tablets (Subutex)
- Buprenorphine/naloxone sublingual films (Suboxone)
- Buprenorphine/naloxone) sublingual tablets (Zubsolv)
- Buprenorphine/naloxone buccal film (Bunavail)
- Buprenorphine implants (Probuphine)
- Buprenorphine extended-release injection (Sublocade)

Methadone

- Full Agonist – No ceiling effects
- Gold Standard for MAT
- Variable pharmacokinetic and pharmacodynamic and long half live
- Multiple Drug – Drug interaction
- QT prolongation
- Use as MAT only in Methadone maintenance programs

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Naltrexone

- Effective in specialized population
- Early drop out common
- Need to be off opioids for 7 days
- ? Impact on Mortality
- Good for those that do not want agonist therapy
- Oral and depot forms available
- No risk of overdose and diversion
- Can be administered in any setting
- Treats both alcohol and opioid use disorder

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Biopsychosocial Treatment Modalities for Substance Use Disorder
5 Ms by ASAM

- Motivate
- Manage
- Medication
- Meetings
- Monitor

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Impact of COVID on drug overdose deaths
CDC health Alert Network
December 17, 2020

- 18.2% increase from June 2019 to June 2020 nationally
  - > 25% in 20 states
  - 10 to 19% in 11 states
  - 0 to 9% in 10 states, including Texas
  - Decreased in 2 states

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UTHSC Goals and Plans for MAT

- Residents in primary care programs obtain certification to prescribe buprenorphine
- Begin MAT in UTHSC Psychiatry outpatient clinic
- Other primary care resident clinics begin MAT
- HRSA Grant funded programs in Pittsburg (Rural Psychiatry) and Athens (Family Medicine) will establish MAT in these communities

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Conclusion

- Opioids are very useful pharmacological agents
- Opioid overdose and use disorder continue to be an epidemic
- Seek help and or assist your loved ones to get help
- Be engaged in controlled substance stewardship in our community
- Utilize Medication Assisted Therapy in your practice

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Thank you

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Motivational Interviewing in Substance Use Disorder

Dr. Jennifer A. Campbell, PhD

Key Aspects of Presentation

Overview of MI

MI's application with SUD

MI's application beyond the therapy domain

Unique considerations

Dialog vignettes portraying provider-patient interactions will appear throughout the presentation to portray key concepts.

Introduction: Why MI?

- Motivation is key to substance use behavior change.
- Motivational approaches are based on the principles of person-centered counseling.
- Ambivalence about change is normal.
- Effective motivational approaches can be brief.
- Motivational interviewing (MI) and other motivational counseling approaches like motivational enhancement therapy are effective ways to enhance motivation throughout the Stages of Change.

MI has wide applications.

Therapist empathy, as expressed through reflective listening, is fundamental to MI.

Adaptations of MI enhance the implementation and integration of motivational interventions into standard treatment methods.

Positive outcomes: reduced alcohol, tobacco, and cannabis use; fewer alcohol-related problems; and improved client engagement and retention.

Cost effectiveness: MI can be delivered in brief interventions.

Broad dissemination: MI has been disseminated throughout the United States and internationally.

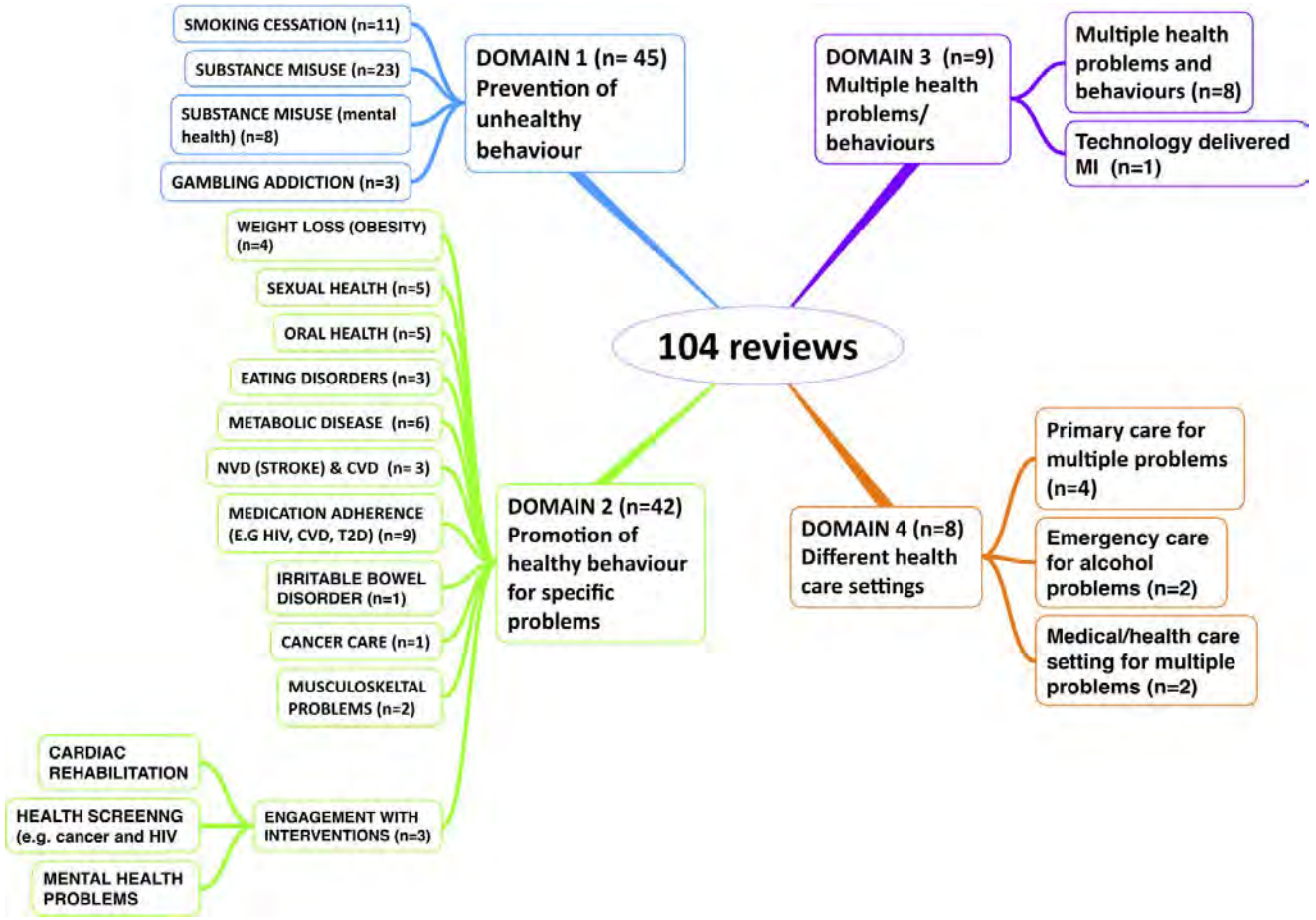
Not Limited to Substance Use

- Applicability to diverse health and behavioral health problems.
- Effective across clinical settings.
- Ability to complement other treatment approaches
- Consistent with the healthcare model of helping people learn to self-manage chronic illnesses like diabetes and heart disease.

MI has been adapted and integrated into many settings, including primary care facilities, emergency departments, behavioral health centers, and criminal justice and social service agencies.

- Primary care examples:
  - Increased of health behavior change for weight management.
  - Decreases in weight, blood pressure, and alcohol use.
  - Applicable with numerous other presenting concerns, such as health, fitness, nutrition, safe sex practices, treatment adherence, medication adherence, etc.

Applicable across various treatment formats (e.g. individual, group, telemedicine).



Frost H, Campbell P, Maxwell M, O'Carroll RE, Dombrowski SU, Williams B, et al. (2018) Effectiveness of Motivational Interviewing on adult behaviour change in health and social care settings: A systematic review of reviews. PLoS ONE 13(10)

A shift from Labels

- Person-first language in MI (e.g., a person with an SUD) is the new standard
- Separates SUD from identity
- Removes the judgmental tone that stems from the moral model of addiction

So, What is Motivational Interviewing?

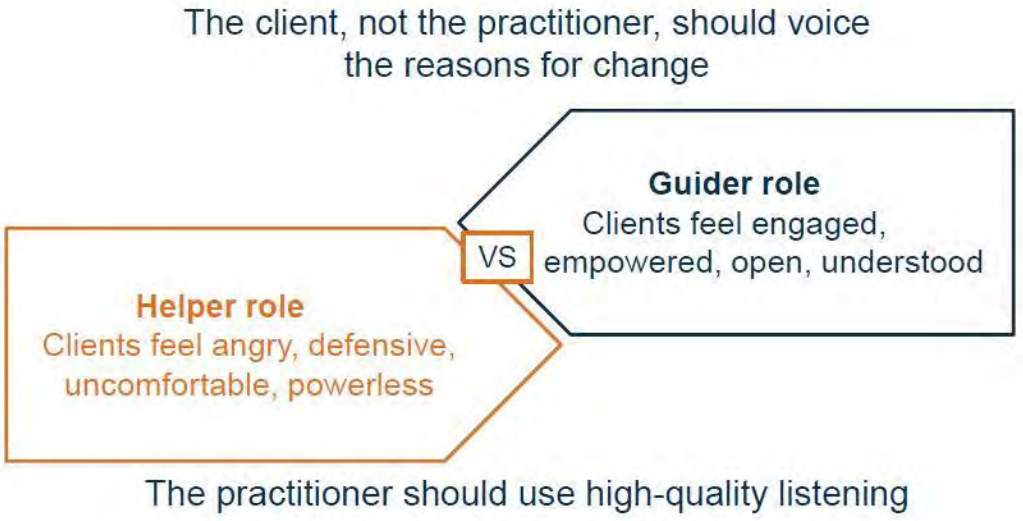
MI is a **guiding** (not directive) style of communication.

MI is designed to **empower** people to change by drawing out their own meaning, importance and capacity for change.

MI is based on a **respectful** and **curious** way of being with people that facilitates the natural process of change and honors client autonomy.

It is a humanistic approach: clinician and client engage as equals.

Guiding Vs. Directing



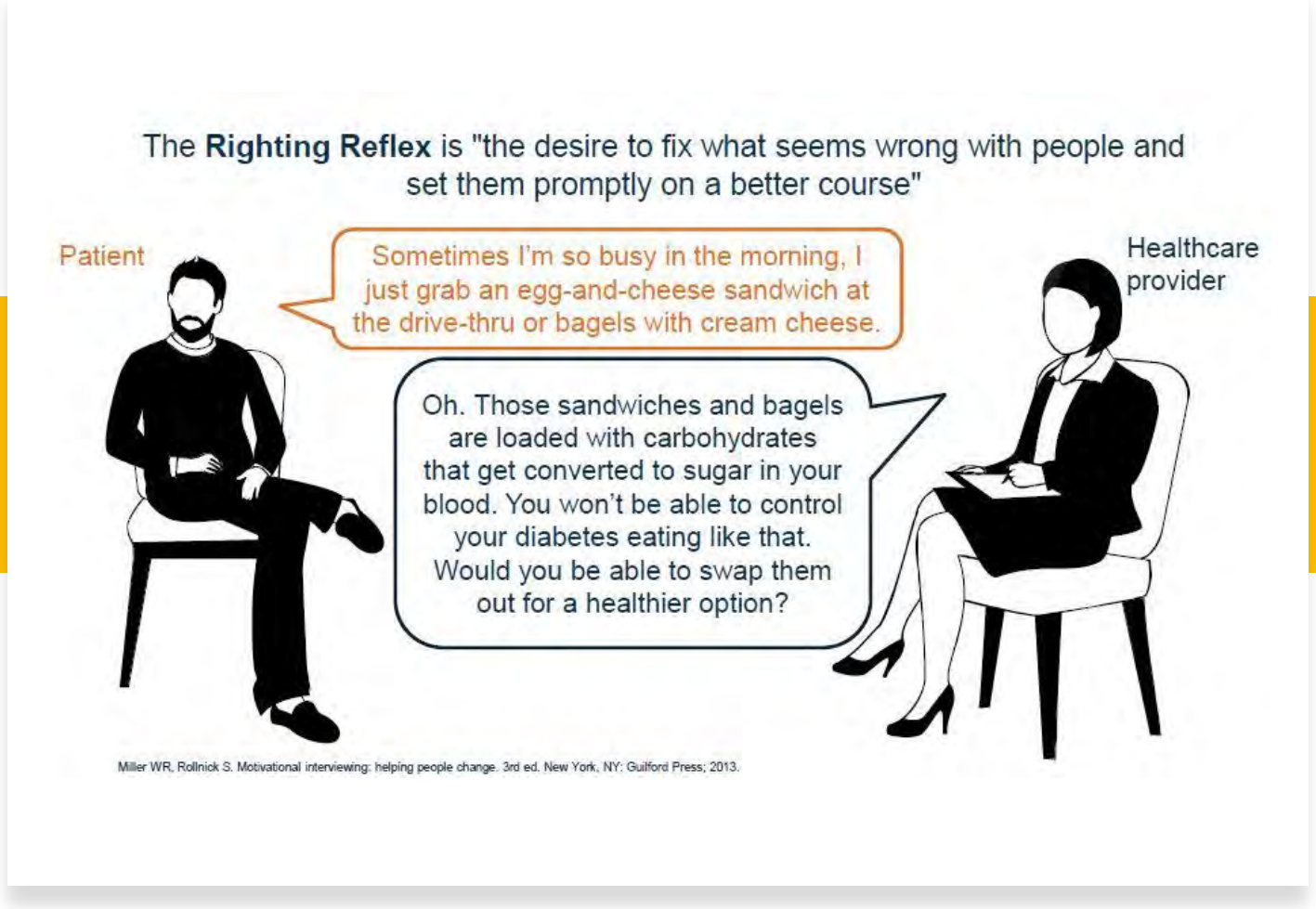
Miller WR, Rollnick S. Motivational interviewing: helping people change. 3rd ed. New York, NY: Guilford Press; 2013.

What Motivational Interviewing Is NOT

- Unsolicited advice, confronting, instructing, directing, or warning.
- It is not a way to “get people to change”.
- Not a set of techniques to impose on a conversation to force change.
- MI takes time, practice and requires self-awareness and discipline from the clinician.

The use of direct confrontation, surrendering and accepting one’s powerlessness and loss of control in the face of addiction, and emphasis on total abstinence are not consistent with MI.

- MI is not cognitive behavioral therapy (but may be complimentary/integrated within in).
- MI also is not a way of manipulating others or making them change when they don’t want to.

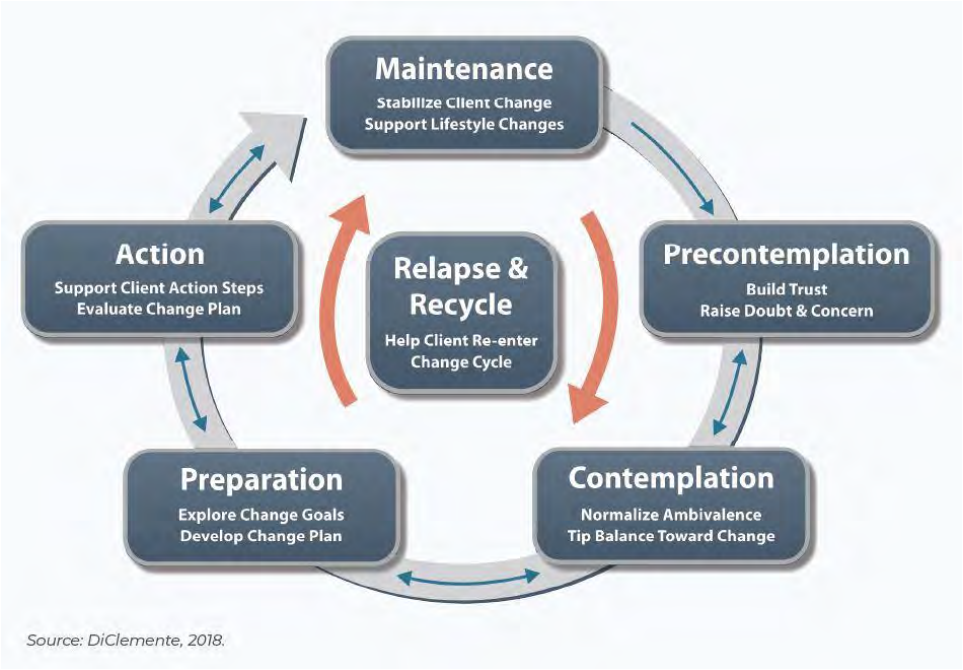


The "Righting Reflex"

What MI is NOT (A brief video)

https://youtu.be/_VlvanBFkvI

MI and the Stages of Change



Source: DiClemente, 2018.

Motivation in Context

Source: Miller & Rollnick, 2013. Motivational Interviewing: Helping People Change (3rd ed.), p. 164. Adapted with permission from Guilford Press.

Motivation is captured, in part, in the popular phrase that a person is ready, willing, and able to change:

"Ability" refers to the extent to which a person has the necessary skills, resources, and confidence to make a change.

"Willingness" is linked to the importance a person places on changing—how much a change is wanted or desired. However, even willingness and ability are not always enough.

"Ready" represents a final step in which a person finally decides to change a particular behavior.

When is MI fundamentally helpful?

Special Considerations: Mandated Treatment

Important principles to keep in mind are to:

- Honor the client's anger and sense of powerlessness in the process.
- Avoid assumptions about the type of treatment needed.
- Make it clear that you will help the client explore what he or she perceives is needed and useful from your time together.
- Clearly delineate different levels of permission. Rapport may take longer: ie, organic development in a non-organic contact scenario.

Cultural Considerations

There may be important differences among populations and cultural contexts regarding expression of motivation for change and the importance of critical life events.

Get familiar with the populations with whom you expect to establish treatment relationships, be open to listening to and learning from clients about their cultures and their own theories of change, and adapt motivational counseling approaches in consideration of specific cultural norms.

Cultural differences might be reflected in the value of health, the meaning of time, the meaning of alcohol or drug use, or responsibilities to community and family.

This requires knowledge of the influences that promote or sustain substance use and enhance motivation to change among different populations.

Motivation-enhancing strategies should be congruent with a client's cultural and social principles, standards, and expectations.

The “Spirit” of MI - PACE

Partnership. MI is a collaborative process. The MI practitioner is an expert in helping people change; people are the experts of their own lives.

Acceptance. The MI practitioner takes a nonjudgmental stance, seeks to understand the person’s perspectives and experiences, expresses empathy, highlights strengths, and respects a person’s right to make informed choices about changing or not changing.

Compassion. The MI practitioner actively promotes and prioritizes clients’ welfare and wellbeing in a selfless manner.

Evocation. People have within themselves resources and skills needed for change. MI draws out the person’s priorities, values, and wisdom to explore reasons for change and support success.

Fundamental Processes

Engaging: This is the foundation of MI. The goal is to establish a productive working relationship through careful listening to understand and accurately reflect the person's experience and perspective while affirming strengths and supporting autonomy.

Focusing: In this process an agenda is negotiated that draws on both the client and practitioner expertise to agree on a shared purpose, which gives the clinician permission to move into a directional conversation about change.

Evoking: In this process the clinician gently explores and helps the person to build their own "why" of change through eliciting the client's ideas and motivations. Ambivalence is normalized, explored without judgement and, as a result, may be resolved. This process requires skillful attention to the person's talk about change.

Planning: Planning explores the "how" of change where the MI practitioner supports the person to consolidate commitment to change and develop a plan based on the person's own insights and expertise. This process is optional and may not be required, but if it is the timing and readiness of the client for planning is important.

MI Core Skills - OARS

- **Open questions** draw out and explore the person's experiences, perspectives, and ideas.
- **Affirmation** of strengths, efforts, and past successes help to build the person's hope and confidence in their ability to change.
- **Reflections** are based on careful listening and trying to understand what the person is saying.
- **Summarizing** ensures shared understanding and reinforces key points made by the client.

Closed VS. Open Questions

“How long ago did you have your last drink?”	“Tell me about the last time you drank.”
“When do you plan to quit drinking?”	“What do you think you want to do about your drinking?”

OARS Vignette

(Emphasis on Open Questions and Reflection)

Counselor: Jerry, thanks for coming in. *(Affirmation)* What brings you here today? *(Open question)*

Client: My wife thinks I drink too much. She says that's why we argue all the time. She also thinks that my drinking is ruining my health.

Counselor: So your wife has some concerns about your drinking interfering with your relationship and harming your health. *(Reflection)*

Client: Yeah, she worries a lot.

Counselor: You wife worries a lot about the drinking. *(Reflection)* What concerns **you** about it? *(Open question)*

Client: I'm not sure I'm *concerned* about it, but I do wonder sometimes if I'm drinking too much.

Counselor: You are wondering about the drinking. *(Reflection)* Too much for…? *(Open question that invites the client to complete the sentence)*

Client: For my own good, I guess. I mean it's not like it's really serious, but sometimes when I wake up in the morning, I feel really awful, and I can't think straight most of the morning.

Summarizing

"So, one thing you hope will be different a year from now is that you will have a good job, one that you enjoy and brings you in contact with people.

You've been relating more positively to your children lately, and you would like that to continue.

You also said you might like to quit smoking.

What else, as you think of where you'd like your life to be a year from now?"

Miller WR, Rollnick S. Motivational interviewing: helping people change. 3rd ed. New York, NY: Guilford Press; 2013.

Change Talk: DARN-CAT….

- Change talk is embodied in the acronym DARN-CAT.
- DARN (Desire, Ability, Reasons, and Need)
- **CAT** (Commitment Activation, Taking steps)

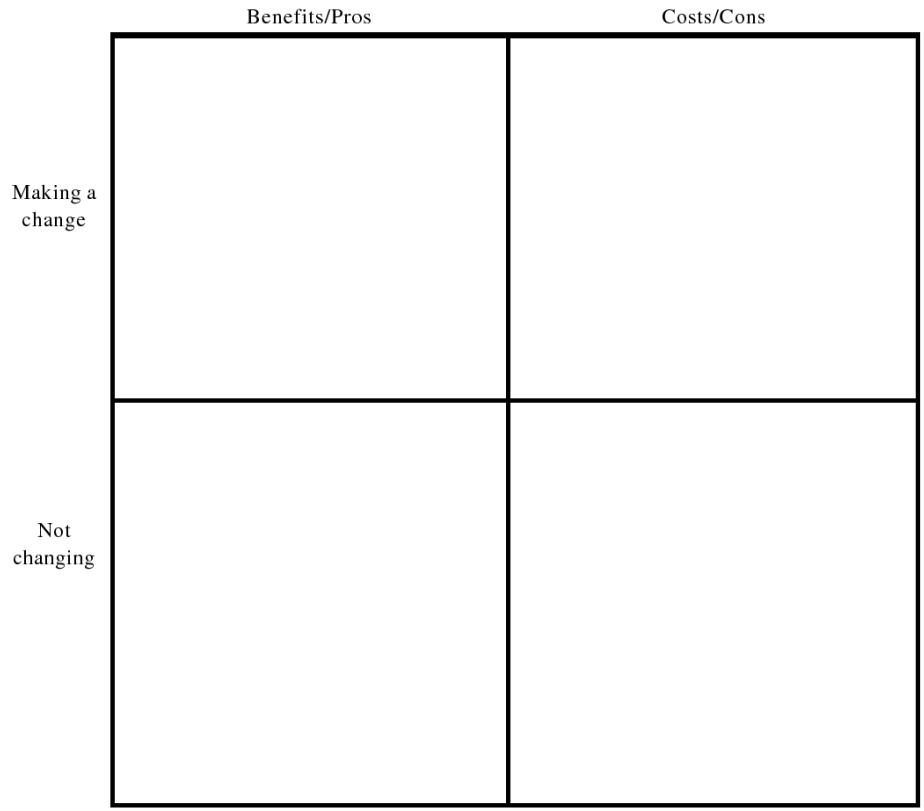
Table 3.1 Change Talk: DARN CAT

Desire	"I really want to find a way."
Ability	"I could do that."
Reasons	"My family is counting on me."
Need	"I just can't keep doing this."
Commitment	"I must—no, I will make a change."
Activation	"I set my quit date."
Taking steps	"I joined a gym last week."

MI Video

- https://youtu.be/67l6g1l7Zao

Decision Balance Square



Putting It Together

MI Overview

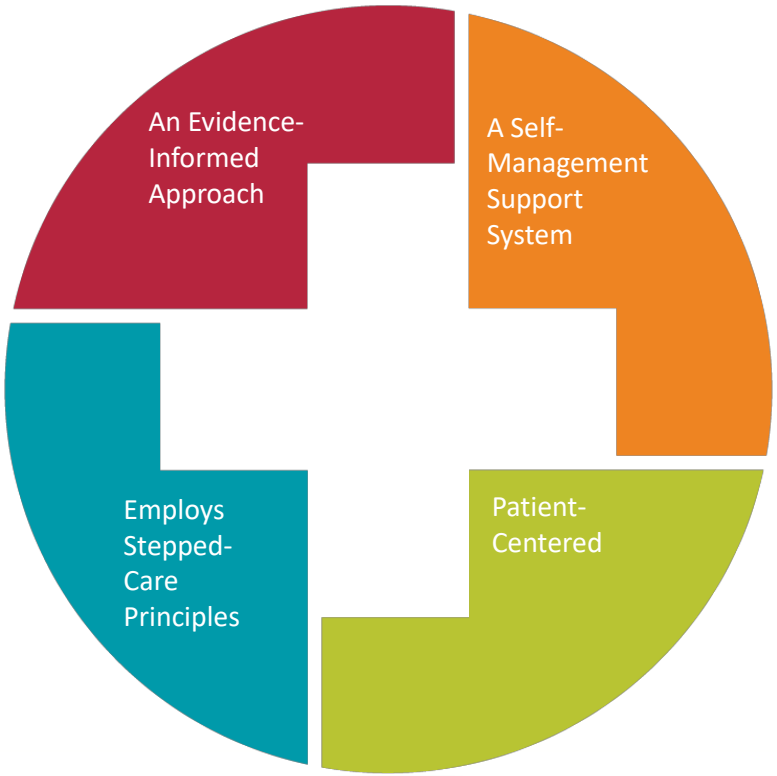
1. Spirit of MI
Partnership of Equals
Acceptance: empathy, autonomy
Compassion: Caring for them
Evocation: Use their wisdom

2. Four Processes
Engage: Establish partnership.
Focus: Clarify their agenda.
Evoke: Elicit reasons for change.
Plan: Commit to a plan of action.

3. Core Skills: OARS
Open-ended questions
Affirmations
Reflective Listening
Summaries

4. Evoke Change Talk: DARN CAT
Desire
Ability
Reasons
Need
***C**ommitment*
***A**ction Taken*
***T**ake Steps*

Brief Action Planning (BAP)



Closing Remarks

Recovery from SUDs is seen as a multidimensional process along a continuum, differs amongst individuals, and changes over time.

The effectiveness of motivational strategies are not related to the severity of the substance use pattern but the person's readiness for change.

MI involves a collaborative partnership and active collaboration between provider and client.

No matter the presenting issue, a person is more willing to express concerns when you are empathetic and show genuine curiosity about the their perspective.

Change begins with empathy and compassion; from there, dialog can begin.

MI Training

- **Motivational Interviewing Network of Trainers (MINT)** (www.motivationalinterviewing.org). This website includes links to publications, motivational interviewing (MI) assessment and coding resources, and training resources and events.

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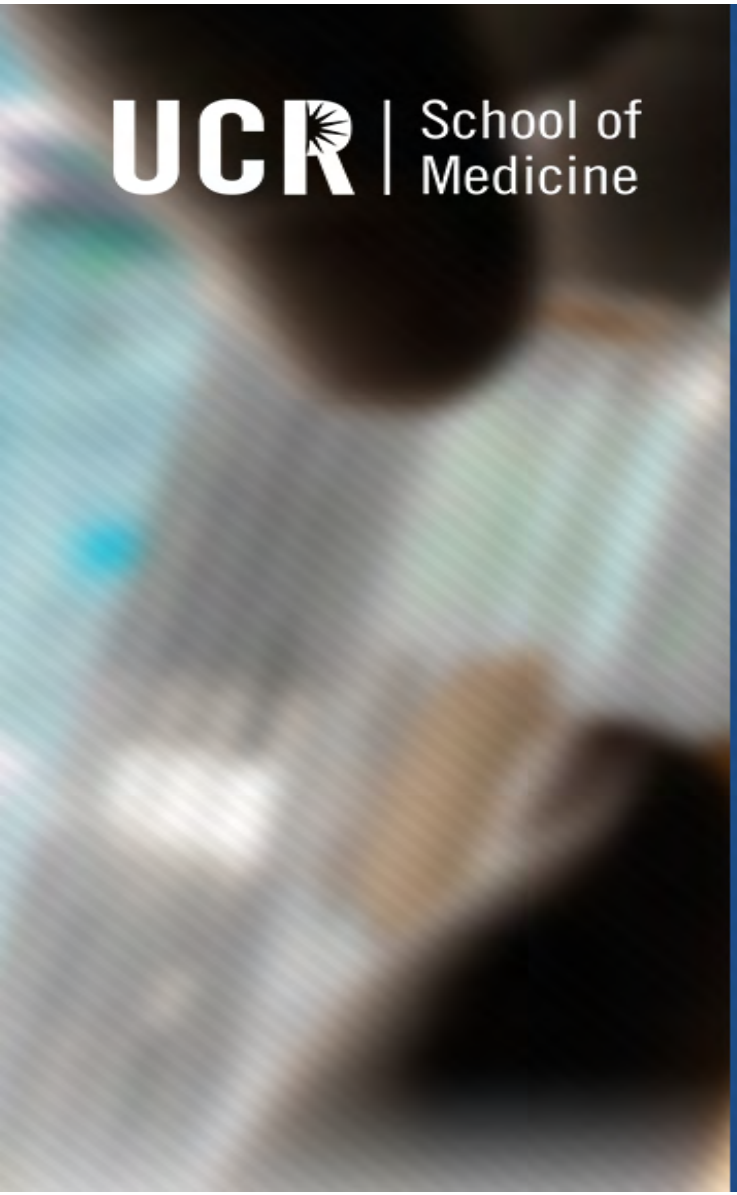


UCR | School of Medicine

Community engagement activities fostered by a PCORI engagement award: Achievements, lessons learned, and where we are now

Brandon Brown
Associate Professor
University of California
Riverside, School of Medicine

Jeff Taylor & Chris Christensen
Long-term survivors
HIV+Aging Research Project-
Palm Springs

Outline

- Background
- PCORI engagement award
- Case study
- Virtual village

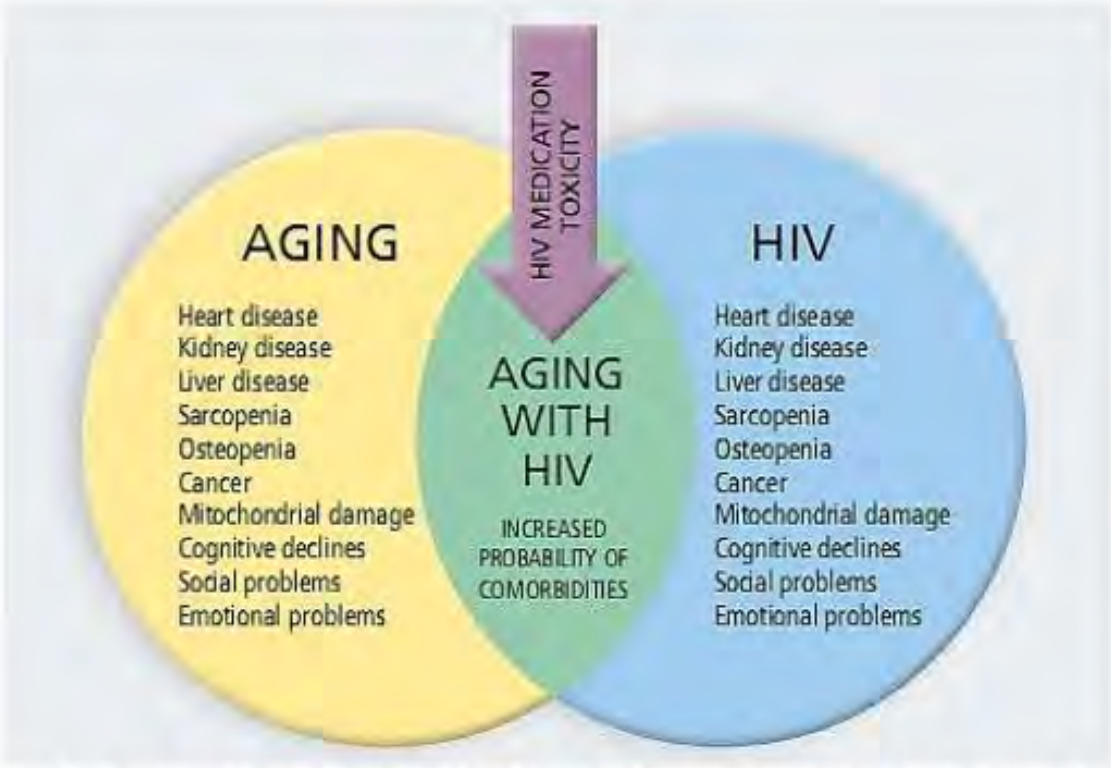
Background

- Palm Springs is a well-known retirement community, and has become a destination for older people living with HIV to retire
  - film '*Desert Migration*'

- Many survivors living with HIV needed to rebuild their lives after losing many loved ones to AIDS, and/or were priced out of due to gentrification

- Palm Springs=highest prevalence older men with HIV in the nation

Background



Interactions among aging, HIV, and HIV drugs increase the risk of comorbidities. (Vance, Am J Nurs 2010)

LOTS of local interest in HIV research!

- Patients, physicians, and others are interested to be involved in HIV and aging research

"We are often approached for research but need help to build capacity to do it"

- Lots of stakeholders, not lots of connections between them

- Working in silos, replication of work
  - Everyone is busy!

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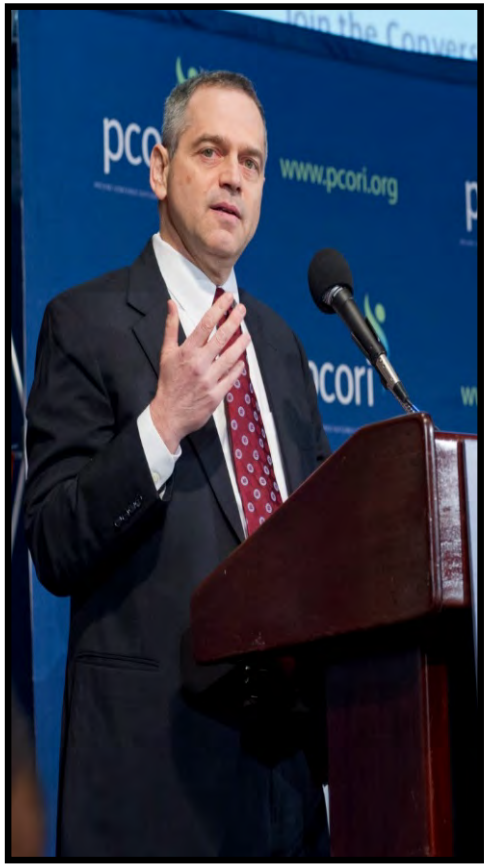
Meet PCORI



"This is going to be research <u>done</u> differently!"

PCORI Board Member **Harlan Krumholz, MD**
National Press Club, Washington, DC
February 27,2012

So what did we do?

- Build the foundational relationships and capacity of stakeholders needed to conduct research on aging and HIV

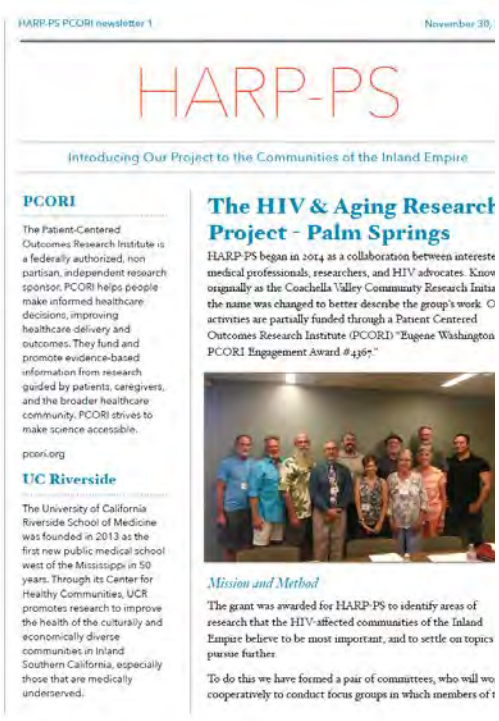
1. create a leadership structure including all stakeholders,
2. disseminate knowledge and develop relationships,
3. identify and explore key topics for future research, and
4. build stakeholder capacity to engage in research using GPP

Our major stakeholders (apart from patients)

CBOs	**Healthcare organizations**	**Individual Providers**	**Caregivers**	**Academics**
-HARC -The LGBT Center -Mizell Senior Center -HARP-PS -CVCRI -Jewish Family Service of the Desert	-Borrego Health -Desert AIDS Project -Eisenhower Medical Center -UCR Family Medicine Clinic -Desert Healthcare District	-Physicians -Nurse Practitioners -Pharmacists -Mental health	-Family -Friends -Volunteers -Partners	-Basic researchers -Applied researchers -Socio-behavioral researchers -Clinical faculty researchers

Achievements-SC and PPAB

Achievements-newsletters, focus groups, citizen panels, workshop, training activities



HARP-PS PCORI newsletter 1 November 30,

HARP-PS

Introducing Our Project to the Communities of the Inland Empire

PCORI

The Patient-Centered Outcomes Research Institute is a federally authorized, non partisan, independent research sponsor. PCORI helps people make informed healthcare decisions, improving healthcare delivery and outcomes. They fund and promote evidence-based information from research guided by patients, caregivers, and the broader healthcare community. PCORI strives to make science accessible.

pcori.org

UC Riverside

The University of California Riverside School of Medicine was founded in 2013 as the first new public medical school west of the Mississippi in 50 years. Through its Center for Healthy Communities, UCR promotes research to improve the health of the culturally and economically diverse communities in Inland Southern California, especially those that are medically underserved.

The HIV & Aging Research Project - Palm Springs

HARP-PS began in 2014 as a collaboration between intereste medical professionals, researchers, and HIV advocates. Know originally as the Coachella Valley Community Research Initia the name was changed to better describe the group's work. O activities are partially funded through a Patient Centered Outcomes Research Institute (PCORI) "Eugene Washington PCORI Engagement Award #4367."

Mission and Method

The grant was awarded for HARP-PS to identify areas of research that the HIV-affected communities of the Inland Empire believe to be most important, and to settle on topics pursue further.

To do this we have formed a pair of committees, who will wo cooperatively to conduct focus groups in which members of t

HARP-PS PCORI newsletter 1 No

UCRIVERSIDE School of Medicine Center for Healthy Communities

Palm Springs

The Coachella Valley has long been a retirement and playground destination. It has a large community of people aging with HIV, including long-term survivors and people recently infected. Community norms support research and innovative healthcare. This combination provides an ideal environment for the study of long-term HIV infection and the complications of aging with HIV.

www.HARP-PS.org

Contact us:

info@harp-ps.org

1760)904-4420

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jeff.taylor@harp-ps.org

Scientific Lead:
brandon.brown@medsch.ucr.edu

Focus Groups:
chris.christensen@harp-ps.org

Editor: Eric Janske
comms@lkaps.org

community are invited to share and discuss their HIV & Aging research. The groups will be led by Steering Committee and Patient Partner Advisor contact Chris at the sidebar address to join a foc

The Patient Partner Advisory Board is made up members of the diverse communities in the Inlan PPAB keeps focus on patient needs for all decis the project.

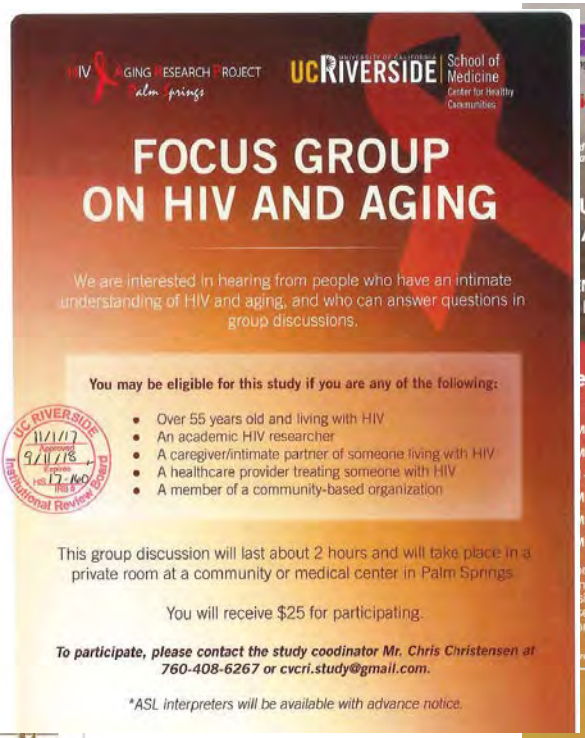
The Steering Committee (above) is composed of researchers, medical providers, people aging with and Community-Based Organizations. They will suggested topics have the strongest response, are stakeholders, and will become the topics of futur

National Stakeholders' Roundtable and Re Community Summit

To discuss research & policy needs of those aging will invite national opinion leaders to a Stakehold at the Annenberg Center for Health Sciences at Medical Center in Rancho Mirage on March 30,

This will be followed on March 31 by a daylong R summit on HIV & aging open to the entire HIV community, regardless of HIV status. The Reunic came to the Coachella Valley in November 2015 include a report from the Stakeholders' Roundtal before, followed by a town-hall type discussion fo community to provide their input about they beli research and service needs for optimal HIV care.

HIV AGING RESEARCH PROJECT Palm Springs



HIV AGING RESEARCH PROJECT Palm Springs

UCRIVERSIDE School of Medicine Center for Healthy Communities

FOCUS GROUP ON HIV AND AGING

We are interested in hearing from people who have an intimate understanding of HIV and aging, and who can answer questions in group discussions.

You may be eligible for this study if you are any of the following:

- Over 55 years old and living with HIV
- An academic HIV researcher
- A caregiver/intimate partner of someone living with HIV
- A healthcare provider treating someone with HIV
- A member of a community-based organization

UC RIVERSIDE Institutional Review Board 11/1/17 9/11/18 Expires HS 17-160

This group discussion will last about 2 hours and will take place in a private room at a community or medical center in Palm Springs.

You will receive $25 for participating.

To participate, please contact the study coodinator Mr. Chris Christensen at 760-408-6267 or cvcri.study@gmail.com.

**ASL interpreters will be available with advance notice.*

ARP Research Project | PS

ion Project 2.0 - Palm Springs
+ Aging Research Project: Thriving With HIV
d by Eisenhower Health in partnership with
and TPAN/Reunion Project

URDAY, MARCH 31, 2018
AM - 5:00PM

NBERG HEALTH SCIENCES BUILDING AT EISENHOWER
BOB HOPE DRIVE, RANCHO MIRAGE, CA 92270

edule
of events

M - Free Buffet Breakfast*
M - Free Public Sessions
- Free Buffet Lunch*
M - HIV and Aging Public Policy Presentation
M - Q&A and Public Comments
M - Cleve Jones

n Project 2.0 will include a community nference consisting of a mix of facilitated ions, panels, and presentations led by earchers, advocates, and long-term rs of HIV/AIDS.

Keynote Speaker

CLEVE JONES is an American human rights activist, author, lecturer, founder of the NAMES Project AIDS Memorial Quilt, and Co-Founder of the San Francisco AIDS Foundation.

FREE EVENT

*RSVP REQUIRED via HARP-PS.org by March 30, 2018
For more information, contact:
Jeff Taylor, HARP-PS 760.835.1926 or jeff.taylor@harp-ps.org

ersion will be available upon request.

sponsors

Supported by unrestricted educational grants from Gilead Sciences, Inc. and Bristol-Myers Squibb and was partially funded through a Patient-Centered Outcomes Research Institute (PCORI) Eugene Washington PCORI Engagement Award.

EISENHOWER HEALTH UCRIVERSIDE School of Medicine THE REUNION PROJECT TPAN

Focus groups-Top hits by all stakeholders

Question Set	Topics
Health issues	• Cognitive function, dementia, memory loss • Depression and isolation • Financial strain
Resiliencies	• Exercise/gym • Socializing/having friends • Support groups (online and in person) • CBO services (DAP, The Center)
Research Priorities	• HIV and co-morbidities • HIV and neurological function (memory loss,neuropathy)

Research Article

Journal of the Association of Nurses in AIDS Care

Community-Driven Health Priorities for Healthy Aging With HIV

Brandon Brown, MPH, PhD* • Logan Marg, MA • Alejandra Cabral, MPH • Michelle Didero, BS • Christopher Christensen • Jeff Taylor • Andrew Subica, PhD

Abstract

Palm Springs, CA, is a retirement community with the highest prevalence of gay men living with HIV older than 50 years in the United States. Through a community–academic partnership, we explored the major health issues, resiliencies, and priority research topics related to HIV and aging. We conducted five community facilitated focus groups with different stakeholders, including two focus groups with older adults living with HIV, one with their caregivers, one with HIV-focused community-based organizations, and a joint focus group with researchers and HIV care providers. Using the rigorous and accelerated data reduction technique, five major themes emerged, which included long-term side effects of medication, social determinants of health, mental health, resiliencies, and involving community in research. These data are important for developing effective interventions, conducting useful and impactful research, and providing health care providers with the tools and knowledge to provide optimal care.

Key words: aging, HIV, community, health priorities, resilience, focus groups

Journal of Women & Aging

ISSN: 0895-2841 (Print) 1540-7322 (Online) Journal homepage: https://www.tandfonline.com/loi/wjwa20

"We are becoming older women and then we have two stigmas": voicing women's biopsychosocial health issues as they age with HIV

Logan Z. Marg, Griselda Ruiz, Fidel Chagolla, Alejandra Cabral, Jeff Taylor, Chris Christensen, Marjorie Martin, Bridgette Picou & Brandon Brown

To cite this article: Logan Z. Marg, Griselda Ruiz, Fidel Chagolla, Alejandra Cabral, Jeff Taylor, Chris Christensen, Marjorie Martin, Bridgette Picou & Brandon Brown (2020): "We are becoming older women and then we have two stigmas": voicing women's biopsychosocial health issues as they age with HIV, Journal of Women & Aging

Putting participants at the centre of HIV cure research

Lancet HIV 2019
Published Online
February 13, 2019
http://dx.doi.org/10.1016/S2352-3018(19)30031-1

Curing HIV infection moved from the aspirational to the theoretically plausible with the apparent elimination of latent HIV from Timothy Ray Brown, also known as the Berlin Patient, after receipt of a stem cell transplant from a donor homozygous for the CCR5-Δ32 gene deletion.[1] As HIV cure-related research has expanded, much of the science has centred on biomedical outcomes, and less on the people for whom a cure is being sought. Specifically, there has been limited inquiry directed towards understanding the motivations, perceptions, desires, needs, and experiences of people living with HIV who are asked to participate in cure-related research. This relative lack of attention is troubling when considering trade-offs, risks, demands, and burdens accompanying many of these investigations, such as intensively monitored antiretroviral pauses in effective HIV therapy, large volume blood draws and leucapheresis, and dosing with experimental immunotherapies.

likely not be cured—in order to implement studies that are acceptable to people with HIV and reflect their priorities and concerns. This can be accomplished with the incorporation of social science research methods into clinical HIV cure investigations. For example, in clinical studies, participant-centred outcomes such as reports that are meaningful to those participating in research can be added to the typical health status and biomedical research surveys. Participant reports are useful in determining tolerance for risk over time,[4] as well as acceptable risk-benefit profiles of new interventions, and can identify heterogeneity in motivations or preferences.[5] Participant-centred outcomes supplement biological endpoints, facilitate detection of psychosocial, ethical, or practical issues, are widely accepted by HIV care providers,[6] and can enhance shared decision making.[7] Importantly, participant-centred approaches have had positive effects on

AJPH
A PUBLICATION OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

Addressing Health Disparities Through Deliberative Methods: Citizens' Panels for Health Equity

Andrew M. Subica, PhD, and Brandon J. Brown, PhD

Health disparities adversely affect millions of people living in disadvantaged communities, resisting public health interventions that do not address the specific conditions, driving forces, or health problems in these communities. Drawing from the underutilized science of deliberative methods, we introduce the innovative citizens' panels for health equity approach—a novel methodology that engages public expertise and knowledge of community health needs, risks, and priorities to tailor public health research and interventions for greater relevance and impact on disadvantaged communities.

By engaging affected residents and stakeholders in informed deliberation and decision-making about community health disparities, citizens' panels pro-

Eradicating health disparities is essential to achieving national health equity.[1] Defined as group differences in health status resulting from social, economic, or environmental disadvantage,[1] health disparities are the concrete manifestation of detrimental social factors such as racism, discrimination, and stigma that segregate individuals into disadvantaged communities laden with risk factors in the social and built environment (e.g., poverty, violence, toxic exposure). Living in these disadvantaged communities, residents are systematically denied access to health-protective and intervention models for increased relevance and effectiveness in disadvantaged communities.

Aligning with the National Institutes of Health's emphasis on engaging communities in all research phases,[5] this essay introduces citizens' panels for health equity, a novel community-based participatory research (CBPR)–oriented methodology for engaging lay members of disadvantaged communities in tailoring public health research and interventions to reduce health

THE FOUNDATION OF CITIZENS' PANELS

Grounding the methodology of our citizens' panels is the idea that persons affected by health disparities should be consulted in resolving those disparities. Supported by the World Health Organization's principle of public participation in health,[7] which holds that people have a fundamental right to participate in planning and implementing programs that affect their health,[8] our method posits that research and interventions informed by public consultation will be better

Deaf focus group data

Table 1: Representative quotes on health issues and resiliencies for Deaf PLWH	
Question	Response
What are important issues that impact people who have HIV, specifically those 55 and older?	"…**There is no direct communication**. Granted, there is communication through 3rd party, meaning, interpreters, parents or a dependent [but] within [the health care] field, we need more people trained with sign language…so they can provide direct communication to clients. That does have an impact on mental health and emotional health."
	"I have **two languages, ASL and English**. I can navigate through the Internet and type words in a search box. But many Deaf people may not be able to do this because they don't know what word to type... We have access to ASL on YouTube, but where to find the right information is hard."
	"When the doctor informs a Deaf patient that s/he has HIV, s/he usually come to my office upset and **confused about the (HIV) diagnosis**... It's an experience that happens repeatedly for them… there is a real lack of education here."
What are some resiliencies that help people age successfully with HIV?	"I have HIV, but I **mentally resist the notion of "being sic**k." I love myself, and love other people – I do my homework, eat good food, refrain from drinking and smoking too much, same for drugs. It's all about mind control. That's my perspective."
	"I think that the seeking help process involves self-awareness and having the realization that I need help for **mental health and/or psychological health**."
	"I have been on medication for 30 years and I stay on schedule, thanks to my partner who feeds me and make sure I take my medicine. We **go out for walks** as part of exercising because it helps with immune system and blood flow. It helps keeps my energy up."

Remaining active during COVID-19

Case study

- Case of ‘helicopter research’
- Excluding community is not uncommon in research (though perhaps unethical), less common in HIV
  - Denver Principles
  - GPP
  - CIOMS Guidelines

H+ARP
HIV + Aging Research Project | PS

Framing

- Present a case of what happened
  - unbiased as possible
- 4 reflections based on role
  - Community member
  - Socio-behavioral Researcher
  - Institutional Review Board (IRB) Official
  - Program Officer (Funder)

Description

- "Dr. JM" a well known researcher and professor at an established U.S. university asked a community leader in Palm Springs to collaborate on HIV and Aging research
- Community leader agreed in order to obtain important data
  - Community members completed lengthy CITI training
  - Arranged for/expended funds to set-up recruitment venue
- Dr. JM refused to share informed consent form, survey
  - Unreasonable requests, yelling over phone

Description cont.

- When materials finally shared, many excluded
  - women, trans men
  - demographic of volunteers
- Used outdated and stigmatizing language
  - “HIV Infected”
- No Incentives provided for participant time
- Key information and results not disseminated

Community Leader

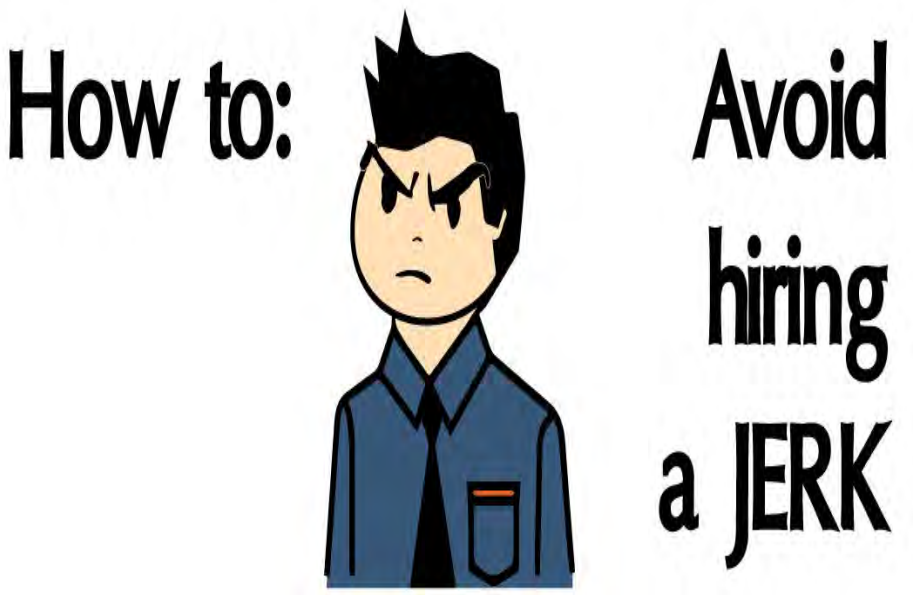
- Helicopter research leads to a "***misuse of willing community participants***"
- Have community research collaborators
- Require a Memorandum of Understanding (MOU)

Social Behavior Researcher

- Parachute science forces a research project on the community
- Belmont Report violation
  - 1) Representational Justice
  - 2) Respect for persons + communities
  - 3) Beneficence
- Use a MOU to set expectations
- Lack of community engagement

IRB Representative

- While this case is unethical in the way it failed to engage community, the **IRB can not do much**
  - small subset of issues
- Dr. JM has ability to choose who is able to see the documents and when to share them
- This case serves as a lesson to communities



Program Officer

- Researcher showed disrespect towards community members
  - Withheld key information
- Inclusion of community
  - better development of IRB materials
  - realistic recruitment
- **Suggestion**: Invite community leader as consultant to review study materials
- Provide reimbursement/incentives

Lessons Learned

- Community Members not always appreciated
- Research should benefit + respect whole community
- Researcher training needed
- Clarify expectations

Collaboration Request Template

Requester

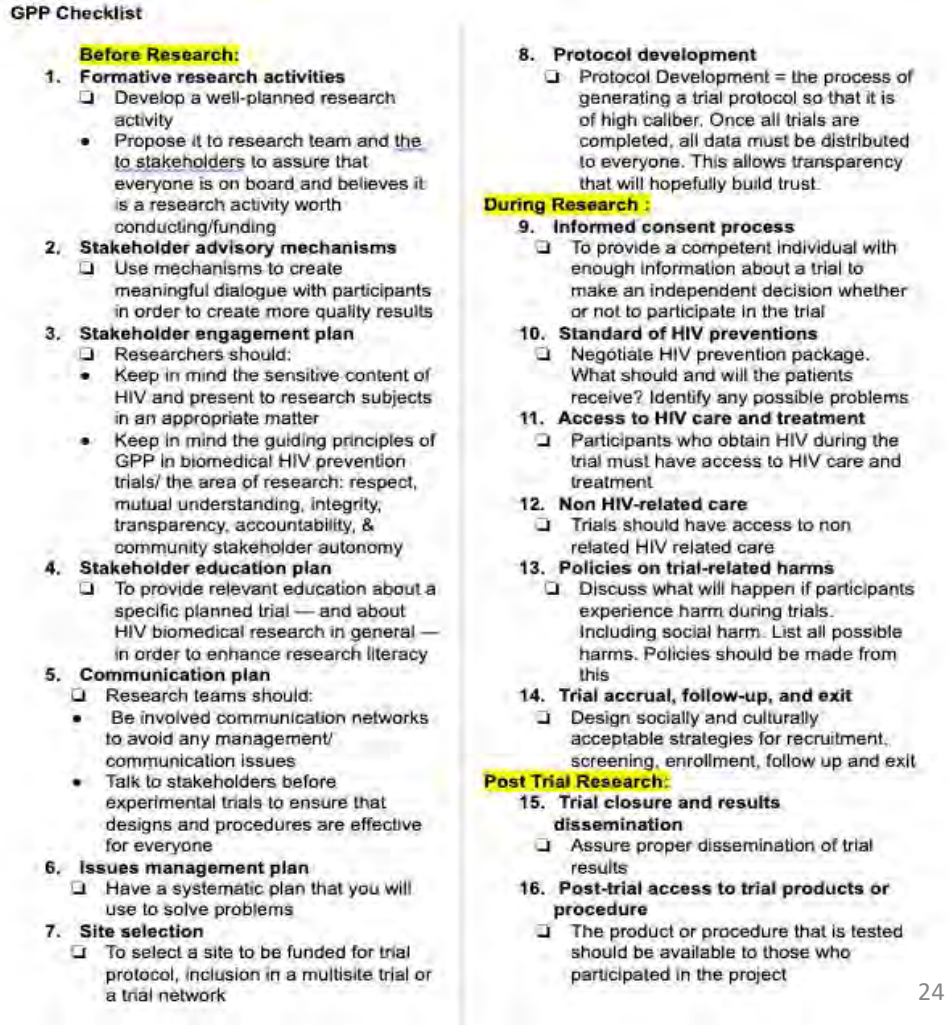
Date of request:					
Please write the individual and organization making the request:	Individuals Name and Title			Organization Name	
Type of Request (circle all that apply):	Data	Access to Patients	Letter of Support	Conference/ Meeting	Other- specify
Please tell us more about your request and the purpose:					
Describe our role be regarding your request:					
What is your timeline?					
Please tell us about the benefit of this collaboration to us. Examples are funding, salary support, publication authorship, conference registration, etc:					

Requestee (the following should be filled out by the organization receiving the request)

Approval:	Yes (list why)	No (list why)
Signature and Date:		

Recommendations

- GPP should ALWAYS be used
  - Enhance with checklist
- Community input must be integrated into IRB applications + research protocols
  - Community member Co-PIs



GPP Checklist

Before Research:

1. **Formative research activities**
   - ❑ Develop a well-planned research activity
   - Propose it to research team and the to stakeholders to assure that everyone is on board and believes it is a research activity worth conducting/funding
2. **Stakeholder advisory mechanisms**
   - ❑ Use mechanisms to create meaningful dialogue with participants in order to create more quality results
3. **Stakeholder engagement plan**
   - ❑ Researchers should:
   - Keep in mind the sensitive content of HIV and present to research subjects in an appropriate matter
   - Keep in mind the guiding principles of GPP in biomedical HIV prevention trials/ the area of research: respect, mutual understanding, integrity, transparency, accountability, & community stakeholder autonomy
4. **Stakeholder education plan**
   - ❑ To provide relevant education about a specific planned trial — and about HIV biomedical research in general — in order to enhance research literacy
5. **Communication plan**
   - ❑ Research teams should:
   - Be involved communication networks to avoid any management/ communication issues
   - Talk to stakeholders before experimental trials to ensure that designs and procedures are effective for everyone
6. **Issues management plan**
   - ❑ Have a systematic plan that you will use to solve problems
7. **Site selection**
   - ❑ To select a site to be funded for trial protocol, inclusion in a multisite trial or a trial network
8. **Protocol development**
   - ❑ Protocol Development = the process of generating a trial protocol so that it is of high caliber. Once all trials are completed, all data must be distributed to everyone. This allows transparency that will hopefully build trust.

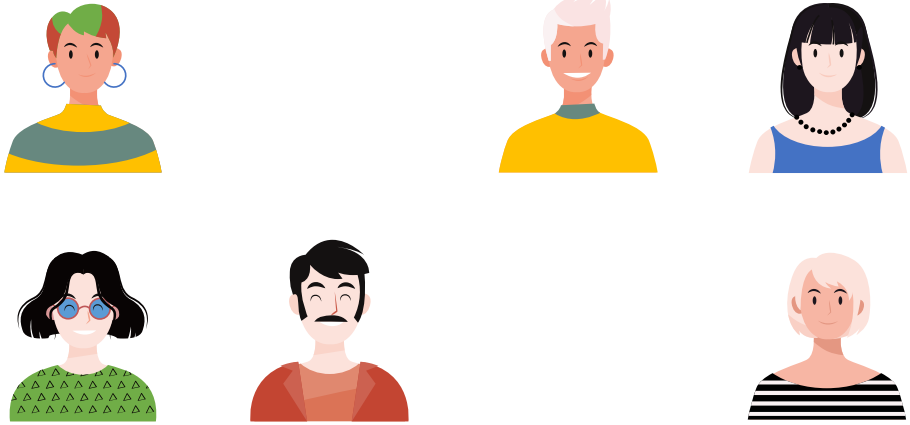
During Research :

9. **Informed consent process**
   - ❑ To provide a competent individual with enough information about a trial to make an independent decision whether or not to participate in the trial
10. **Standard of HIV preventions**
    - ❑ Negotiate HIV prevention package. What should and will the patients receive? Identify any possible problems
11. **Access to HIV care and treatment**
    - ❑ Participants who obtain HIV during the trial must have access to HIV care and treatment
12. **Non HIV-related care**
    - ❑ Trials should have access to non related HIV related care
13. **Policies on trial-related harms**
    - ❑ Discuss what will happen if participants experience harm during trials. Including social harm. List all possible harms. Policies should be made from this
14. **Trial accrual, follow-up, and exit**
    - ❑ Design socially and culturally acceptable strategies for recruitment, screening, enrollment, follow up and exit

Post Trial Research:

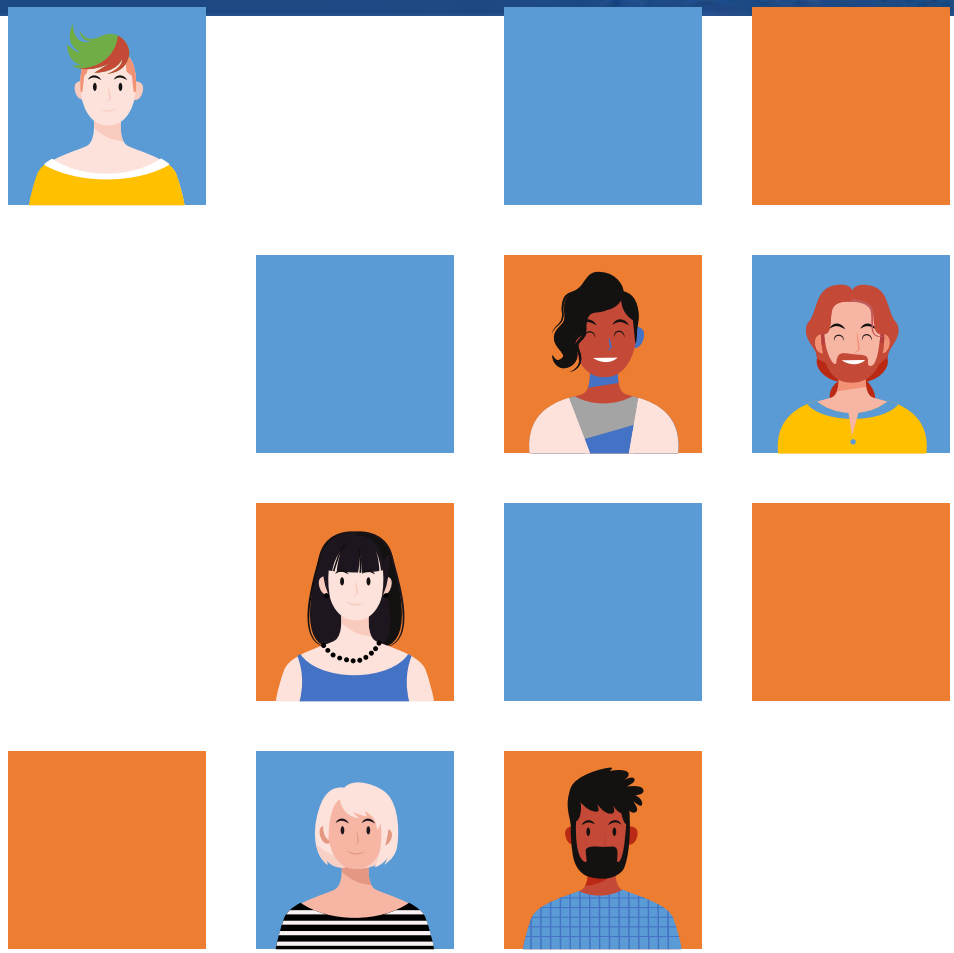
15. **Trial closure and results dissemination**
    - ❑ Assure proper dissemination of trial results
16. **Post-trial access to trial products or procedure**
    - ❑ The product or procedure that is tested should be available to those who participated in the project

Virtual Village

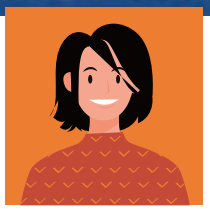


- A Solution to Halt Further Isolation of People Aging with HIV During the COVID-19 Pandemic

Research Aims



Aim #1


What?

Further characterize issues related to depression, isolation, and basic needs of people aging with HIV during the COVID-19 pandemic

How?

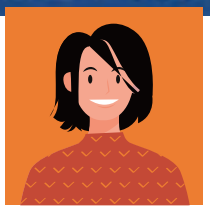
Formative Research:

12 focus groups (5-6 people each)
10 key informant interviews

With Whom?

Adults age 50+ living with HIV in Palm Springs, CA, Los Angeles, CA, and Tampa, FL

Aim #2


What?

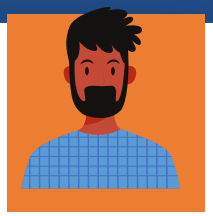
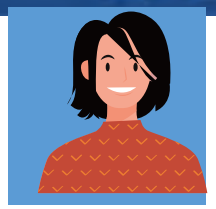
Co-develop ideas for what to include in a virtual village

How?

Conjoint analysis using Aim 1 focus group and interview data

With Whom?

Stakeholders involved in HIV care (*CAB members, HIV researchers, PLWH, HIV care providers)*


Aim #3

What?

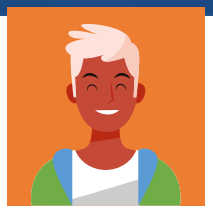
Create and pilot the virtual village in a low cost platform

How?

Use the results from Aims 1 and 2

With Whom?

A group of people aging with HIV in Palm Springs, Los Angeles, Tampa Bay region



Advisory Board




References

- PCORI engagement award
- Ethics article-case study
- Virtual village project
- Desert Migration-film
- Good Participatory Practices
- Denver Principles
- CIOMS guidelines
- This week: Public Health Reports

Thank you!

- Questions?

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TEXAS
Health and Human Services

Behavioral Health Services Provision for SUD:

The State of Texas

Philander Moore, Sr
May 7, 2021

Behavioral Health Services Provision for SUD: The State of Texas

TEXAS Health and Human Services

- The State of Texas implements, funds and conducts Behavioral Health services through the Health and Human Services Commission.
- Services are funded through contracts with LMHA's, LBHA's, Substance Use Providers, and in some cases Universities.
- Oversight

Behavioral Health Services Provision for SUD: The State of Texas

TEXAS Health and Human Services

The funding methodology for the SUD services is based on Population, Poverty and Needs.

- Request for proposals
- Request for Applications
- Open Enrollments

SUD in Texas compared to the US

TEXAS Health and Human Services

The 86th Legislature and Rider 67 requirements.

Expanding Capacity and Increasing Efficiency in Substance Use Disorder (SUD) Services

- *Process*
- *Approach*
- *Results*

SUD in Texas compared to the US

TEXAS Health and Human Services

A Review of the Texas Behavioral Health services Model of contracting and service delivery comparison. For Example

- **California:** The California Department of Health Care Services distributes state and SABG funds to each county providing substance use services for county residents, including prevention and treatment services. Counties may provide substance use services directly or may subcontract with local providers to provide substance use services.

SUD in Texas compared to the US

TEXAS
Health and Human Services

Florida: The Office of Substance Use and Mental Health within the Florida Department of Children and Families uses SABG funds to contract with seven managing entities for the administration of regional behavioral health systems of care. Managing entities then subcontract with providers for the provision of substance use services within each region

SUD in Texas compared to the US

TEXAS
Health and Human Services

New York: The Office of Addiction Services and Supports contracts both directly with substance use providers for the provision of substance use services and with local governmental entities who then subcontract with substance use providers for the provision of substance use services

Current funding for Behavioral Health

TEXAS Health and Human Services

- Block grant-$144,100,000.00
- Recovery-4,800,000.00
  - SABG-MOE/GR (General Revenue classified as Maintenance of Effort): $51.0 million

The State of Texas SUD System of Care

TEXAS Health and Human Services

The Primary source of SUD funding for HHSC (SAPT block Grant and State GR)

Funding approach for SUD services in Texas

- HHSC funds 128 SUD treatment providers
- 222 Prevention providers
- 26 Recovery Providers.

What does these funded programs look like from a structural standpoint and how does that impact the continuum of care concept in the State.

Challenges for Behavioral Health in Texas

TEXAS Health and Human Services

- Funding For Stand alone Recovery Community Centers (RCOs)
- Youth Recovery Community Centers (Similar concept to Adult RCO's)
- Expansion of Traditional Treatment Services
- Collaboration of SUD and MH Treatment services Statewide
- Review and revise current recovery Housing concepts

Strategies to address successful and sustainable services

TEXAS Health and Human Services

- HHSC 5 year behavioral Health Strategic Plan
- Develop a plan to assist Providers Statewide to in accessing funding opportunities
- Enhance Training and Technical assistance.

Statewide Opioid Coordination

TEXAS Health and Human Services

Questions and additional Thoughts

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Do Words Really Matter?

Stigma and Bias: Overcoming Challenges in Treating SUD

How Do We Talk About Addiction?

SUBSTANCE USE DISORDER

Substance Use Disorder is one of the most stigmatized conditions, where not only is the patient disparaged, but the treatment is also stigmatized.

STIGMA IS A HUGE BARRIER TO TREATMENT AND LEADS TO SIGNIFICANT GAPS IN TREATMENT.

Learning Objectives

Participants will be able to:

- Identify the words we use and how they affect individuals with SUD.
- Identify and debunk commonly held beliefs and myths
- Perform a language audit to remove stigma.

Stigma

Stigma

- a mark of disgrace associated with a particular circumstance, quality, or person.
- discredits a person or a group
- diminishes achieving full potential
- a visible sign or characteristic of a disease.

Stigma is Visible and Invisible

I. From within (Self)
- Blame self
- Feel hopeless

II. Recovery community (mutual aid culture)
- Medications vs Abstinence

III. Clinicians & medical providers (Institutional)
- Treatment is ineffective

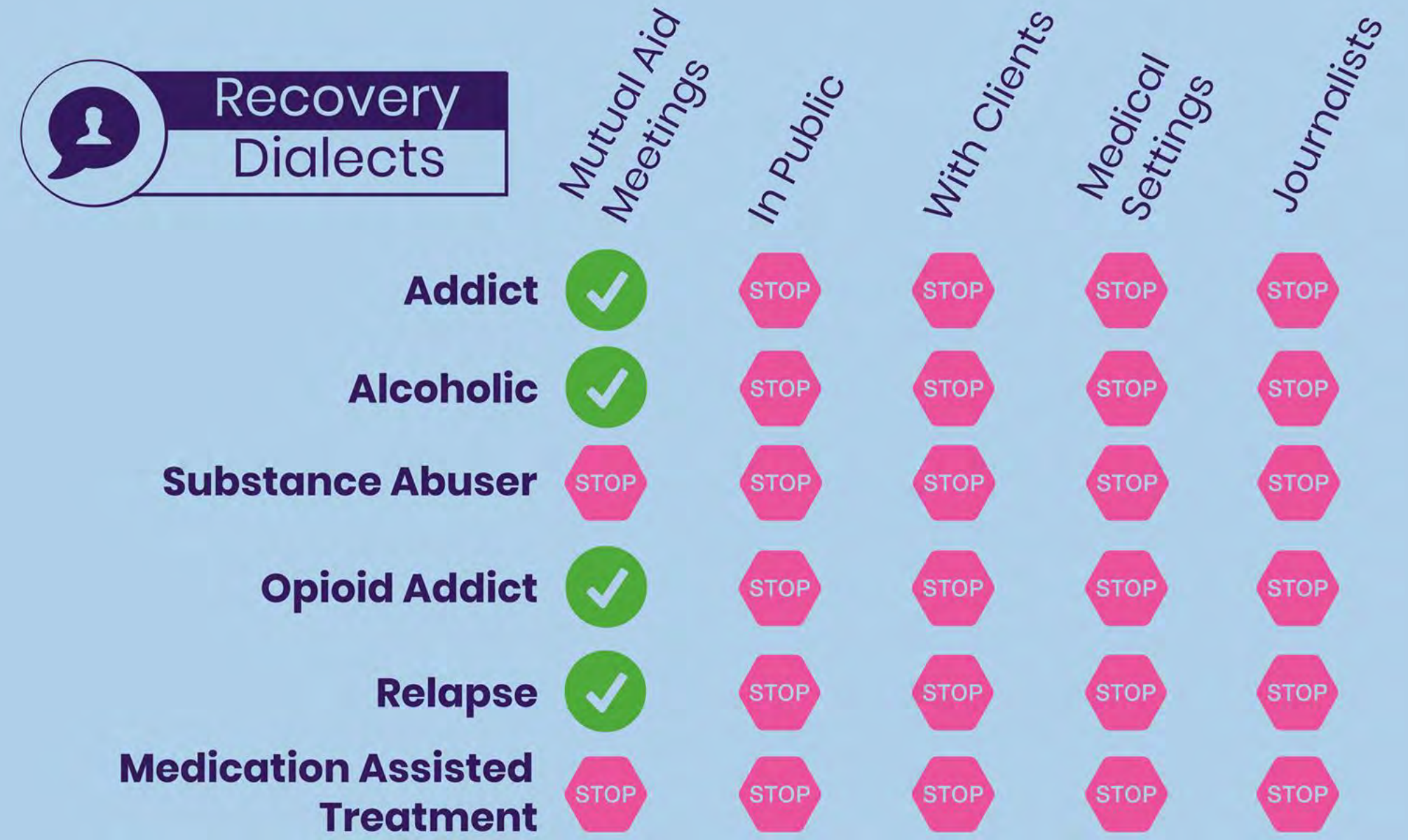
IV. From general public (Societal)
- Choice/moral failing vs Disease

The Negative Effects of Stigma in SUD

- Prejudice and discrimination often become internalized by people with SUD
  - lower self esteem because
  - guilt/shame

- Prejudice and discrimination cause people with SUD to "keep a secret"
  - avoid getting help
  - don't seek treatment
  - SUD less likely to decrease or end

When is it appropriate?



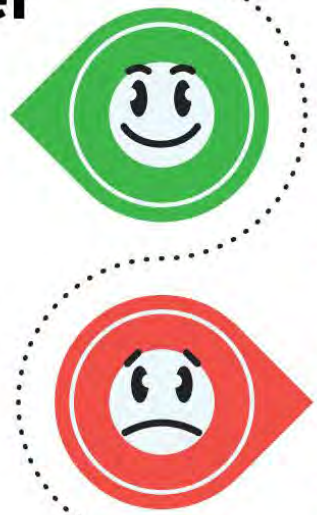
SOURCE: Ashford, R. D., Brown, A. M., & Curtis, B. (2018). Substance use, recovery, and linguistics: The impact of word choice on explicit and implicit bias. Drug and Alcohol Dependence, 189, 131–138.

The Power of Positive Language

- Using positive language increases public support for:
  - Effective substance use disorder policies.
  - Additional funding for substance use disorder services.
  - Interactions and engagements with those who are affected by substance use disorders.

Language Matters

Positive	Negative
✓ Person with a Substance Use Disorder	✗ Addict or Alcoholic
✓ Alcohol and Drug Use	✗ Alcohol and Drug Abuse
✓ Recurrence of Use	✗ Relapse
✓ Death by Suicide	✗ Committed Suicide
✓ Person in Recovery	✗ Clean/Sober
✓ Person with a Mental Health Disorder	✗ Crazy



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Audit Reflections

- Person-First language?
  - Person with SUD vs addict
- Language with clear, easily understood meanings?
  - Negative urine drug screen vs. clean UDS
- Fear-based words?
  - Unlike anything we've seen before

What else can be done?

- Reflect on the types of information you want to disseminate at work
- When developing new materials – seek input from stakeholders
- Train staff on stigma – especially negative impacts related to stigma

Resources & References

Advocacy with Anonymity brochure

- https://facesandvoicesofrecovery.org/blog/publication/advocacy-with-anonymity/

Language

- https://www.recoveryanswers.org/addiction-ary/
- http://www.changingthenarrative.news/

Your Choices, Our Lives: A Quick Guide to Fair and Accurate Media Coverage of Addiction and Mental Illness

- https://rm.facesandvoicesofrecovery.org/resource/your-choices-our-lives-a-quick-guide-to-fair-and-accurate-coverage-of-addiction-mental-illness/

Peer Recovery Center of Excellence

- https://peerrecoverynow.org/resources/resources.aspx

Faces & Voices of Recovery

- https://facesandvoicesofrecovery.org/

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