Creating access to equitable and meaningful substance use disorder care

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Conflict of Interest Disclosure

I have no conflicts of interest to report.

I have never received funding from pharmaceutical companies.

Current funding includes

- WA Health Care Authority DBHR (US DHHS SAMHSA)
- NIH National Institute on Drug Abuse
- King County (SAMHSA)
- Paul G. Allen Family Foundation/Premera/WA HCA/Seattle foundation

My background

- Medical clinic- health ed., HIV counseling, nursing assistant
- Social work
  - Opioid treatment program
  - Medical social work
  - National child welfare agency policy and training
- Public health/Health services research
  - Evaluations e.g. J.R. diversion, police naloxone
  - Epidemiology e.g. WA State trends, OD, PMP, statewide syringe exchange survey
  - Clinical trials e.g. OD prevention, treatment decision making + care navigation, Meds-first model of OUD care
- Implementation e.g. OUD treatment, treatment decision making, care navigation, OD prevention education & naloxone
- Training/TA/Education e.g. Community, professionals, Elected officials, Media

Creating access to

For everyone in a culturally appropriate and trauma informed manner

equitable

&

meaningful

substance use disorder care

Creating access to

For everyone in a culturally appropriate and trauma informed manner

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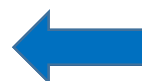

Provides connection, added value, & improves outcomes

substance use disorder care

Outline

- Brief update on drug trends
- Why are people "failing" treatment?
- New models of person-centered opioid use disorder care
- Developing a true continuum of care
- How this all relates to methamphetamine, other drugs, and mental health care
- What successes/opportunities do you see in your work for improving our services and systems?

Acknowledging reality

- This is a challenging time to do:
  - Mental health care
  - Substance use disorder care
  - Social services
  - Criminal legal system work
  - Other health care
- It's a time of opportunity, but tremendous *tension*
- Working together to provide equitable and meaningful care *we can create a future that improves the health of individuals and communities & satisfying work for everyone*

https://adai.uw.edu/wadata

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WA Data Home | By Geography ▾ | By Drug ▾ | By Indicator/Source ▾

Washington State Opioid/Major Drug Interactive Data

This site offers a series of interactive data charts and maps featuring Washington state data related to overdose deaths, treatment admissions, statewide opioid sales, and police evidence testing data for opioids and other drugs.

Find data by:

Geography

Drug Type

Indicator/Source

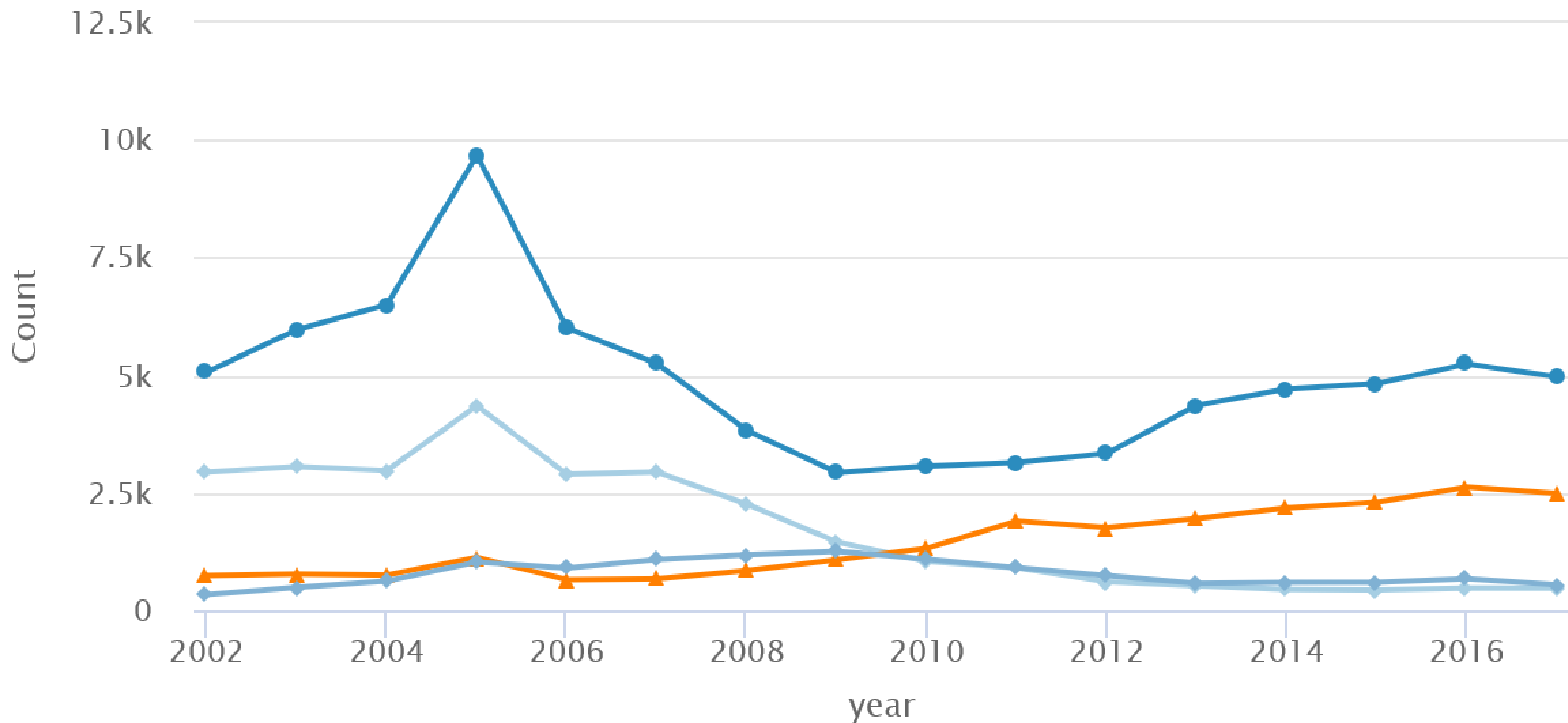
Acknowledgments

Funding from the Washington State Department of Social and Health Services, Division of Behavioral Health and Recovery. Marijuana indicators analysis was provided with support from the Washington State Dedicated Marijuana Fund for research at the University of Washington. All analysis and interpretation by ADAI.

We thank the following for data access:

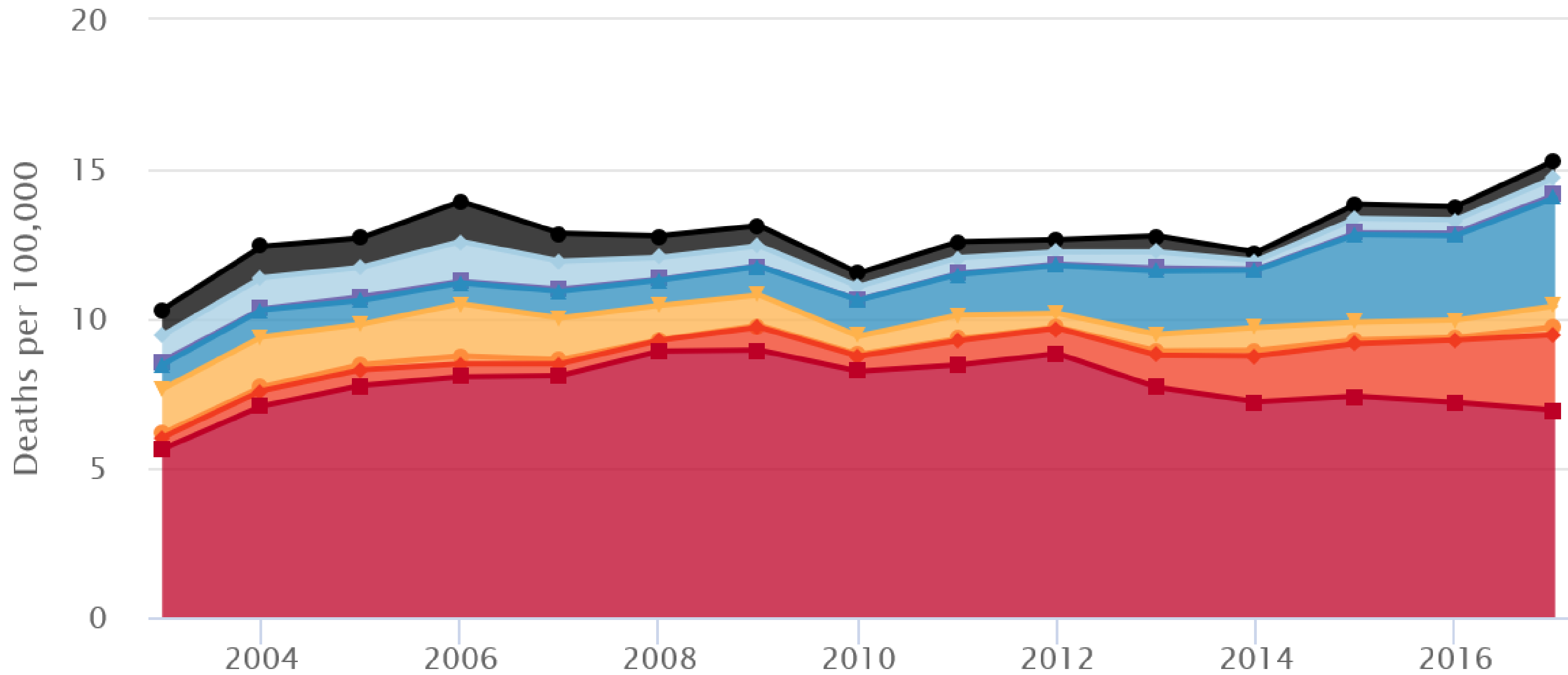
- King County Medical Examiner
- Washington State Department of Social and Health Services, Division of Behavioral Health and Recovery
- Center for Health Statistics, Washington State Department of Health
- Washington State Patrol Forensic Laboratory Services Bureau
- US Drug Enforcement Agency ARCOS database
- Washington State Office of Financial Management
- Washington State Department of Health Prescription Monitoring Program
- American Community Survey, US Census Bureau
- Looking Glass Analytics
- Washington State Liquor and Cannabis Board

Drug Trends



Analysis by UW ADAI. For data sources, see text or adai.uw.edu/WAdata

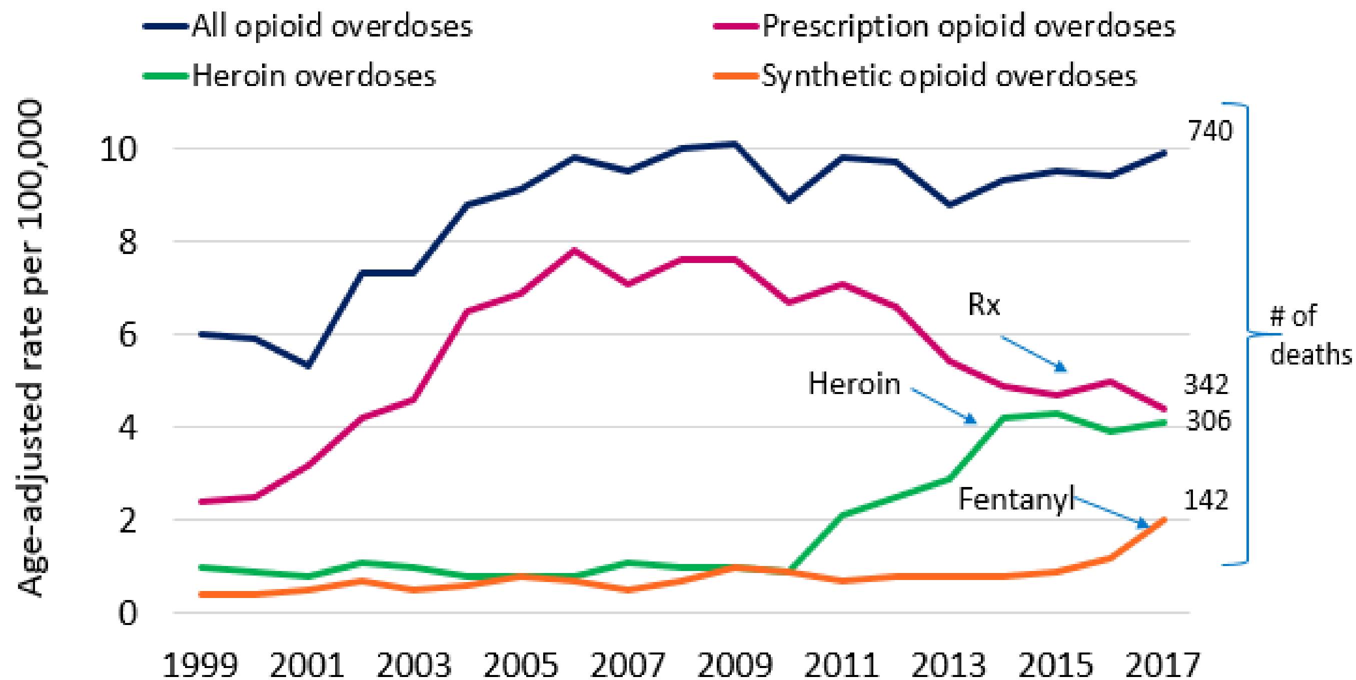
Drug Trends



All other drug poisonings
Methamphetamine & Cocaine
Opioids & Cocaine
Opioids & Methamphetamine
Cocaine (no M or O)
Methamphetamine (no C or O)
Opioids & Cocaine & Methamphetamine
Opioids (no C or M)

Analysis by UW ADAI. For data sources, see text or adai.uw.edu/WAdata

Opioid-Related Overdose Deaths 2000–2017



Source: DOH Death Certificates (Note: prescription opioid overdoses exclude synthetic opioid overdoses)
*Data for 2017 are preliminary as of 8/23/2018.

Preliminary 2019 data show continuing increases in fentanyl

- Substance use disorder and related consequences persist.
- Societal drivers persist.
- Individual factors persist.
- Substances change/evolve.

The full picture

Why are people "failing" treatment?

Some commonly cited issues:

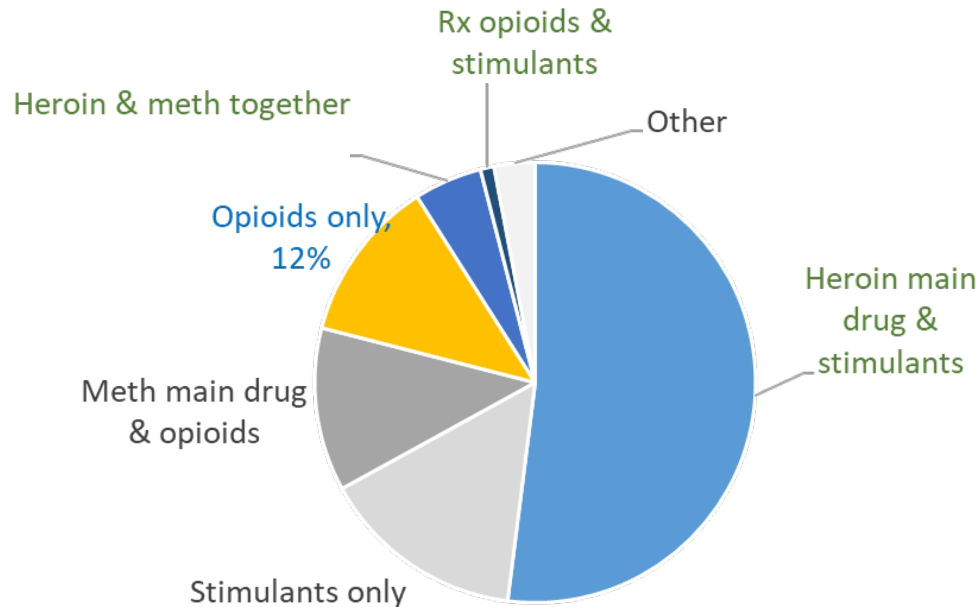
- Poly drug use and ongoing drug use
- Can't/won't make appointments
- Not "engaged" in counseling

Let's dig in…

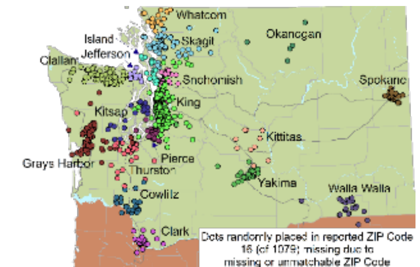
Why is *treatment* failing people?

Poly drug use and ongoing drug use

- Most people use multiple drugs & alcohol



- 78% of opioid users want to stop/reduce use



http://adai.uw.edu/pubs/pdf/2017syringeexchangehealthsurvey.pdf

Why is ***treatment*** failing people?

Poly drug use and ongoing drug use often preclude people from starting or staying in care

- Most people use multiple drugs & alcohol
- Stopping other drugs often not plausible initially or in short term
  - Benzo's/alcohol- physical/MH
  - Methamphetamine- social/MH
- By keeping people engaged in care we can eventually deal with these other substances and the underlying conditions that drive their use

Why is ***treatment*** failing people?

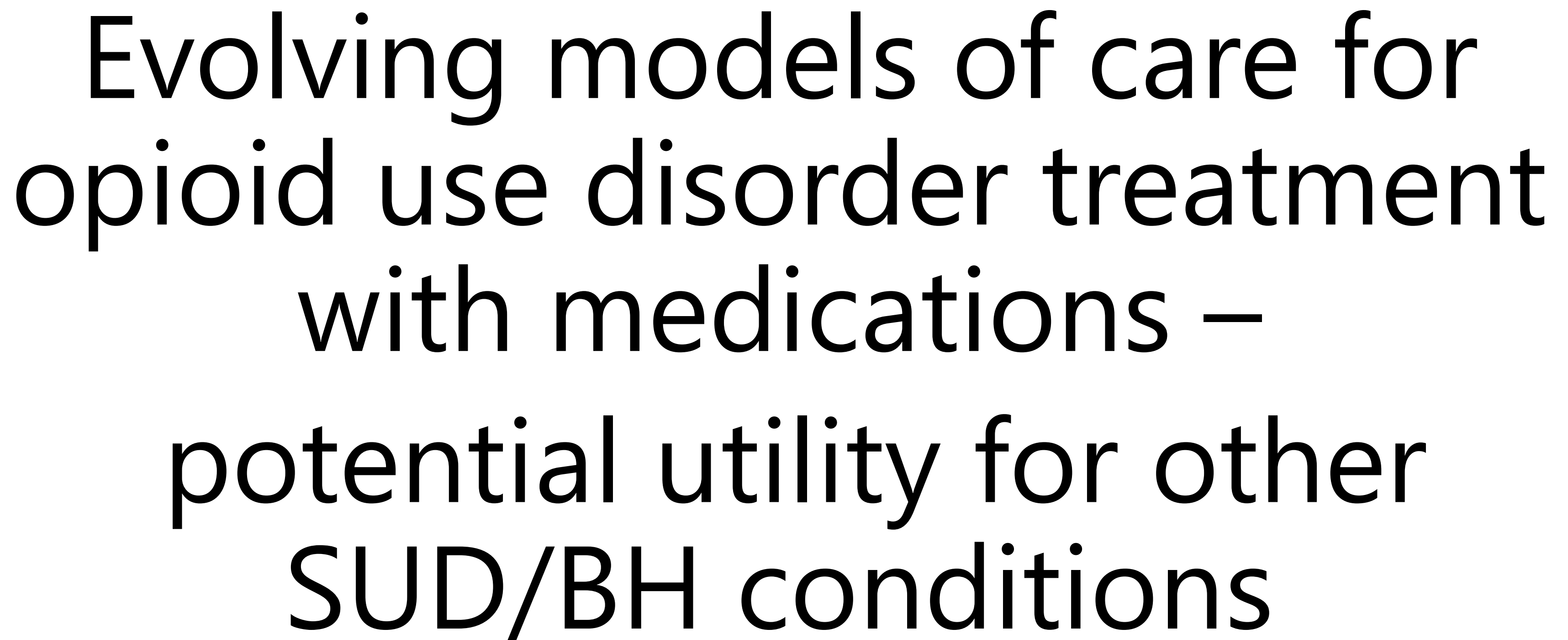
- Can’t/won’t make appointments
  - Intake
    - Not eligible- social instability, not “motivated, poly-substance use
  - Ongoing
    - Chaotic lives
    - Transportation
    - Ongoing substance use
    - Family/friends not supportive…
- Need resources and partners to deal with these issues

Why is ***treatment*** failing people?

- Not "engaged" in counseling
  - Individual or group
  - Often one size fits all-not culturally competent
    - Gender
    - Race/Ethnicity
    - Sexual orientation/identity
  - Mental health issues across the severity continuum- SMI, social anxiety…

Why is <u>*treatment*</u> failing people? Recap

- Often we are screening people out of services versus screening them *in*
- You'd think we don't want "customers"
- How can we broaden our services to allow everyone in?
- How can we create continuums of care that are person-centered and coordinated?
- Keeping people engaged in care is essential.
- The connections they have to the people and program are vital and dis-charge/ dis-connection is more trauma.


Evolving models of care for opioid use disorder treatment with medications –
potential utility for other SUD/BH conditions

Changing settings, models, populations

“TREATMENT” 1971
Specialty care

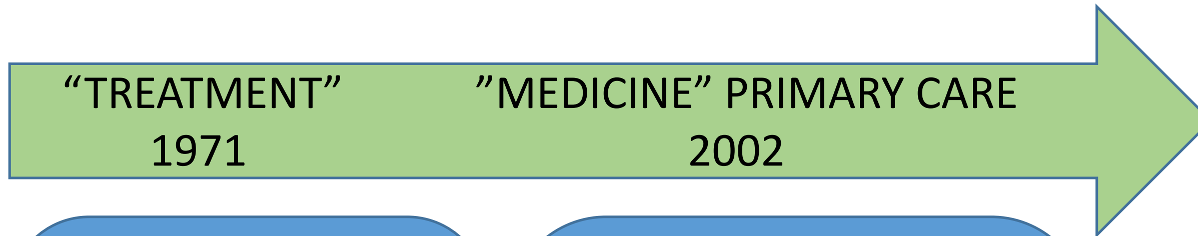
OPIOID *TREATMENT* PROGRAM

High needs* clients
High requirements
Large facilities

Counseling req.

- Model of care works great for some people, not others
- Serving 10-15% of people in need

Changing settings, models, populations



OPIOID *TREATMENT* PROGRAM

High needs* clients
High requirements
Large facilities

Counseling req.

OFFICE BASED OPIOID TREATMENT

Lower needs clients
Moderate requirements
Facilities vary

Counseling may be required somewhere
+Nurse care manager

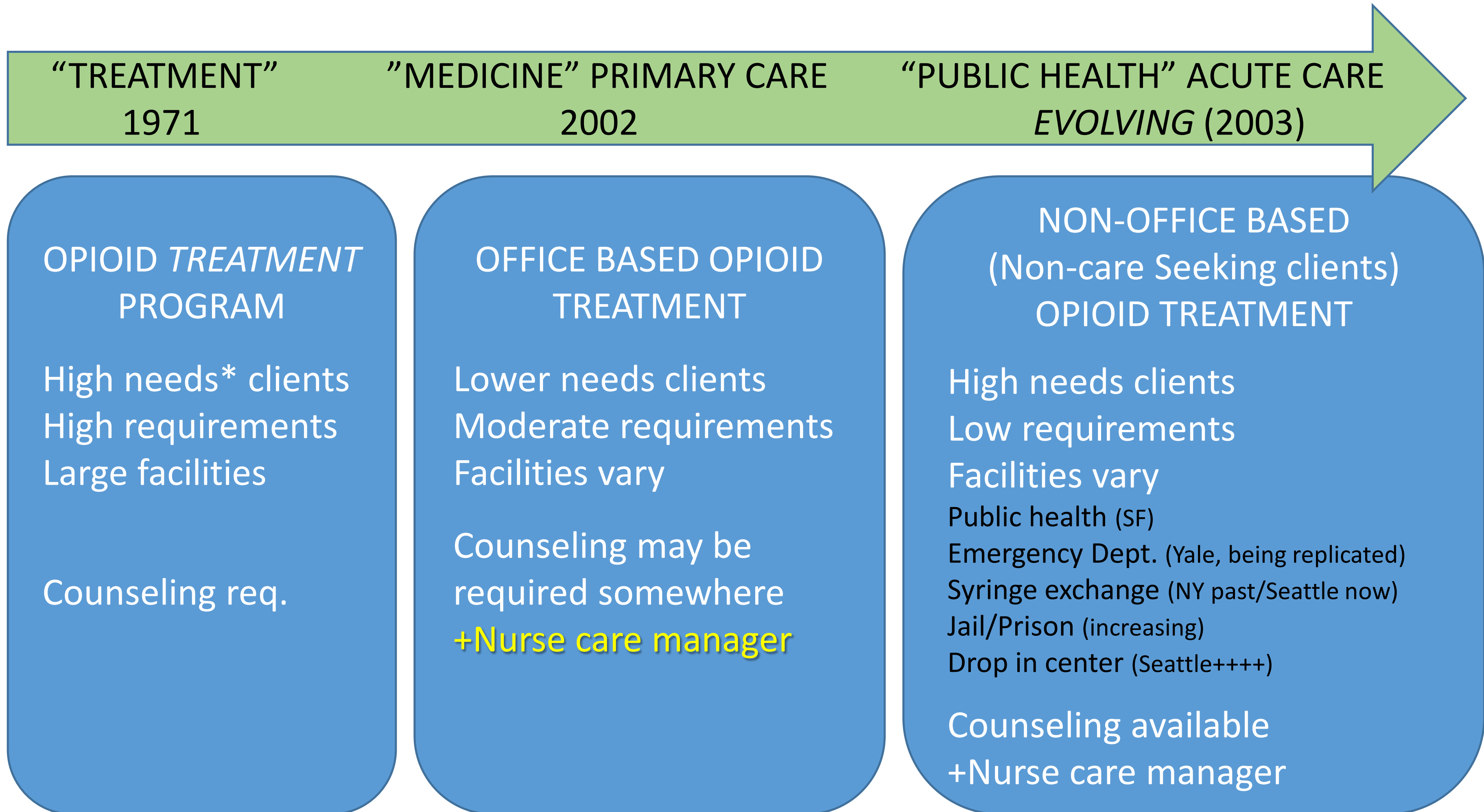
Primary care

- Model of care works great for some people, not others
- Serving 10-15% of people in need

Yellow text indicates service that may increase capacity/uptake

Treating opioid use disorder with agonist medication(s)

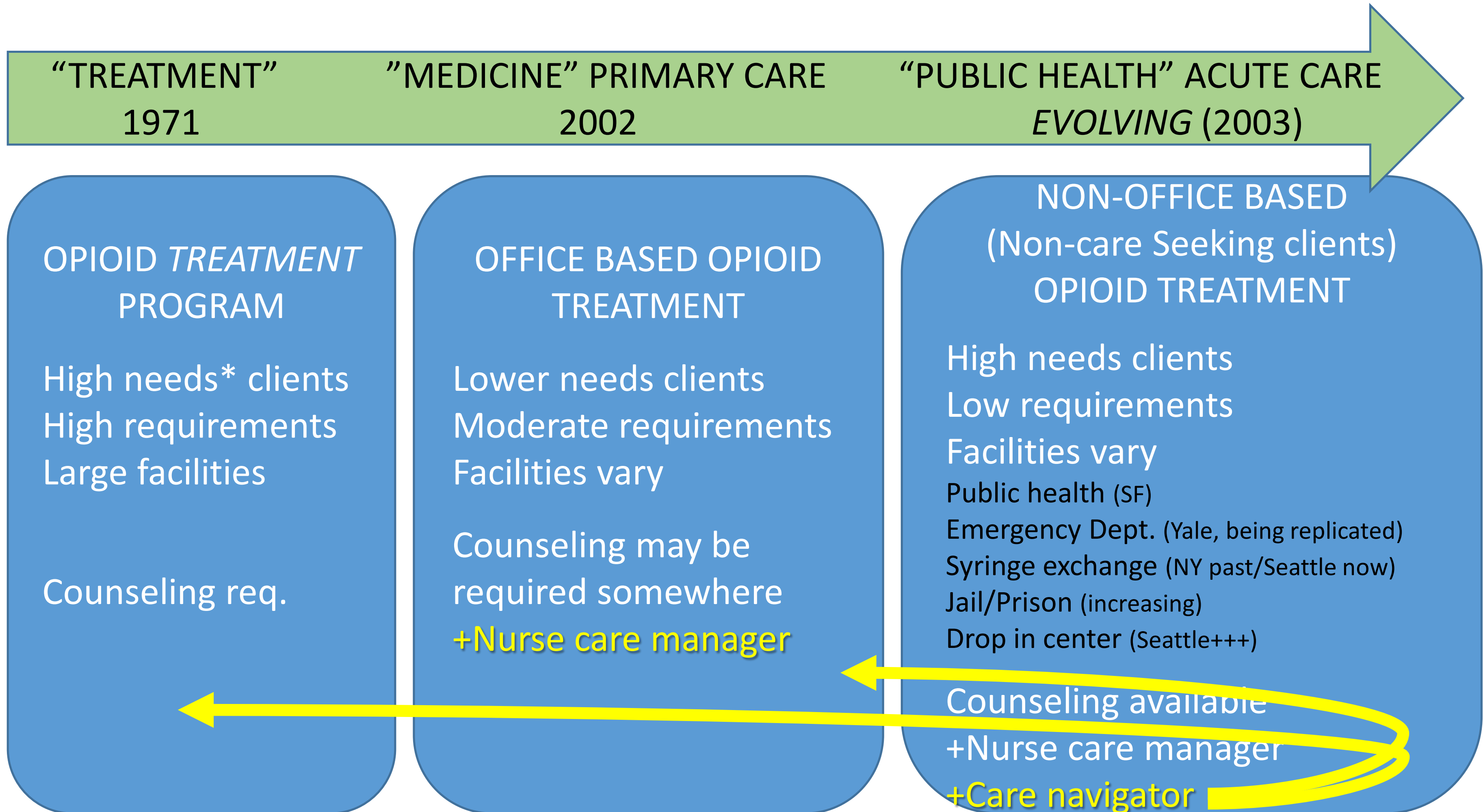
Changing settings, models, populations



Yellow text indicates service that substantially increases capacity/uptake

Treating opioid use disorder with agonist medication(s)

Changing settings, models, populations



This figure is a generalization to show the evolution of care.
Yellow text indicates service that substantially increases capacity/uptake

Pilot program- *Buprenorphine Pathways* at Downtown Seattle Public Health clinic

Initial Service Delivery Model

- Needle Exchange staff approach clients to engage and gauge interest in program
- Clients also present at clinic, requesting buprenorphine

- Nurse conducts a clinical assessment, develop a buprenorphine induction and care plan tailored to each patient's needs
- Nurse consults with DEA waivered prescriber, who orders the initial buprenorphine-naloxone prescription
- Medications dispensed at on-site pharmacy

Bup Pathways-Initial "med first" analysis

Hood, Banta-Green et al. (2019). *Engaging an unstably housed population with low-barrier buprenorphine treatment at a syringe services program: Lessons learned from Seattle, Washington.* Subst Abus. Aug 12:1-9

Number of Conversations

70
60
50
40
30
20
10
0

At Capacity,

Week 0 Week 1 Week 2 Week 3 Week 4 Week 5 Week 6 Week 7 Week 8 Week 9 Week 10 Week 11 Week 12 Week 13 Week 14 Week 15 Week 16 Week 17 Week 18 Week 19 Week 20

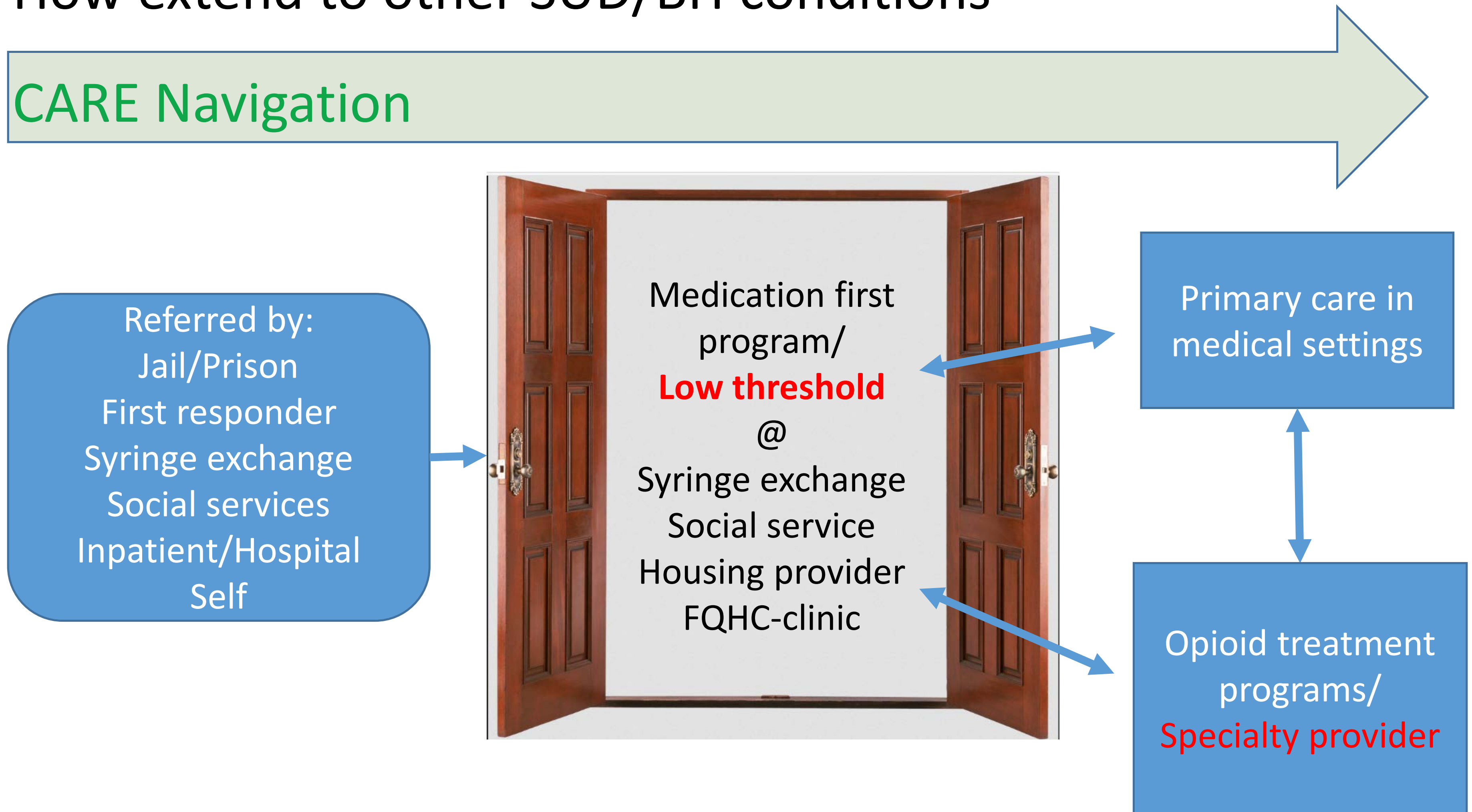
■ Conversation Initiated by Client ■ Conversation Initiated by Exchange Staff

- 82% homeless/housing insecure
- Retention rate near that of primary care
- Poly-substance use initially and ongoing
- Significant decrease in illicit opioid use
- 2% annual mortality vs 6% in similar populations

How do we support multiple care models?

- Multiple models of care are needed to ensure access to everyone
- These models are not in opposition to each other- they are complementary
- Need a big new front door out in the community

New front door to treatment network



Filling out the continuum

Dr. Emily Ashbaugh and Esther Lucero say the Seattle Indian Health Board can get people on medication-assisted treatment within a day.
CREDIT: KUOW PHOTO/AMY RADIL

Walk-in opioid treatment is about to be even more robust in downtown Seattle

OCT 02, 2019 at 10:58 AM

KUOW NEWSROOM

// PREVIOUS EPISODE

Washington state will ban flavored

"…if people start treatment in jail, they need to have a doctor when they leave. Esther Lucero said the Seattle Indian Health Board is one of the providers working with King County to take over from there. "We've been having conversations with the judicial system to be able to provide a warm handoff to a case manager or care coordinator here," she said."

Need providers within the immediate and broader care continuums to work together…

HOW

- Technology e.g WA Recovery Helpline MOUD locator, closed loop referral data systems
- Relationships- regular interdisciplinary provider meetings (many now are specialty based)
- Staff- care navigators/peers to engage and re-engage clients and help them transition between care providers

Supporting multiple care models-Recap

Need providers within the immediate and broader care continuums to know:

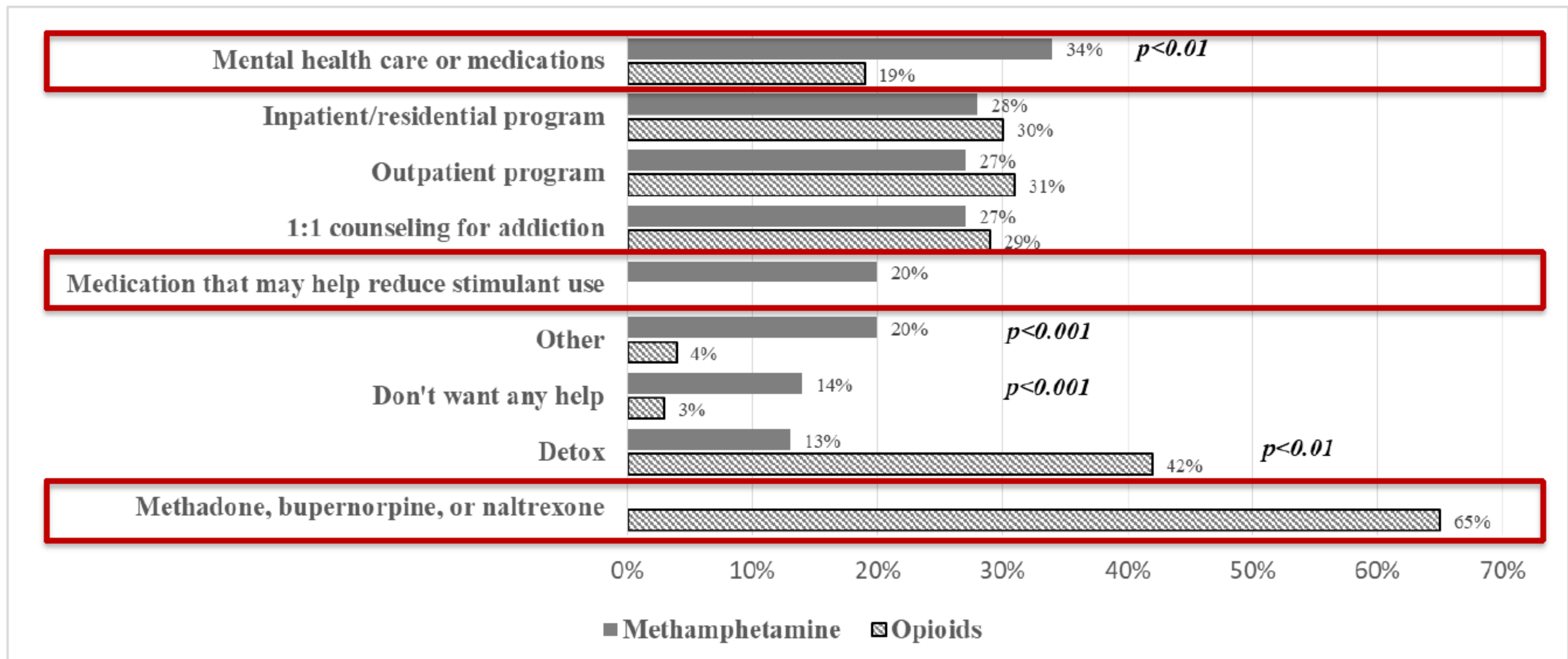
- What each other do/offer
  - How and why of program model
- How they can support other parts of continuum
  - Referrals (up and down stream)
  - Familiarity with model of care and contacts

What about methamphetamine?

Methamphetamine has re-emerged with a vengeance

- Unlike opioids only half want to stop using
- Many perceive more benefit than harm- in the context of *their* lives
- Mental health conditions co-morbid for most

Results: What Types of Help People Wanted to Reduce Use Among Those Interested (n=369)



2017 WA State Syringe Exchange Program Survey

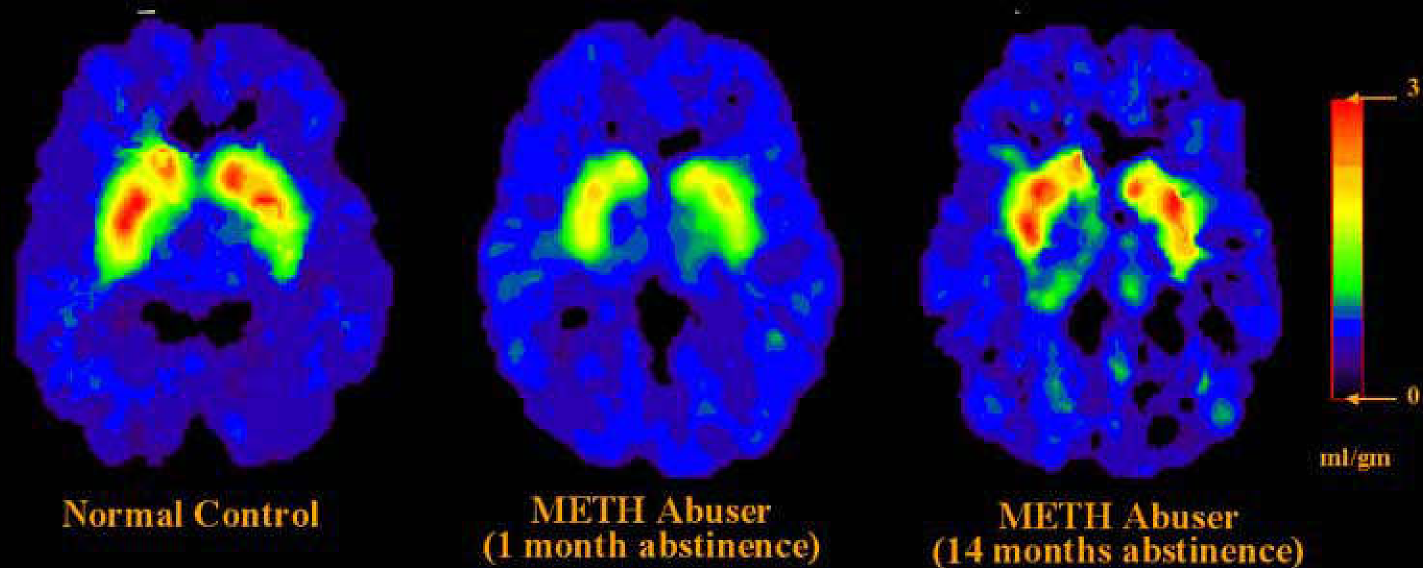


Figure 2. Partial Recovery of Brain Dopamine Transporters in Methamphetamine (METH) Abuser After Protracted Abstinence
3
0
ml/gm
Normal Control
METH Abuser
(1 month abstinence)
METH Abuser
(14 months abstinence)
Source: Volkow, ND et al., Journal of Neuroscience 21, 9414-9418, 2001.

What about methamphetamine?

- Interventions have variable and generally less impact than MOUD
- Cognitive restoration takes a long time
- Trial and error with social, psychological, behavioral, pharmacological interventions
- Need system to support people throughout this loooong process
- Need meaningful ways to engage clients in choosing interventions they want to try

What about methamphetamine?

Resources

https://adai.uw.edu/methsummit/

Methamphetamine in Washington:
Informing Policy and Research

Friday, June 28, 2019 | 9:00am-4:30pm

The University of Washington Alcohol & Drug Abuse Institute, with support from the Washington HCA Division of Behavioral Health & Recovery, hosted a symposium on **Methamphetamine in Washington: Informing Policy and Research**, in June 2019, with over 130 participants. A diverse group of speakers presented current information on the scope and impact of meth use, with a goal to address gaps in our understanding, and strategies for dealing with this large and growing issue in Washington State.

Morning Session

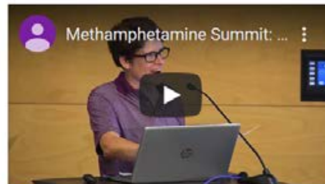
To play the videos in a separate window (with a larger viewing screen): hover over each video after it has begun playing and click the YouTube icon OR click "Open video in new tab" under each session title below.

Opening Remarks & Welcome (14 min.)
Open video in new tab

Caleb Banta-Green, PhD, MPH, MSW, UW Alcohol & Drug Abuse Institute [0:00:00 | slides]

Sally Clark, UW Regional & Community Relations [0:03:58]

Charissa Fotinos, MD, MSC, Washington State Health Care Authority [0:08:15]



What We Can Learn from People Who've Been There(30 min.)
Open video in new tab
Moderator: Susan Kingston, UW Alcohol & Drug Abuse Institute

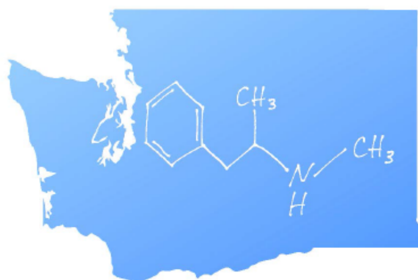
Conversation with individuals with lived experience of methamphetamine.

- **Scope and Impact of Methamphetamine Use in Washington State**
- **Basic Science and Pharmacological Interventions**
- **Cognitive, Behavioral, and Social Interventions**
- **Addressing Mental Health Needs**
- **Supportive Services (Housing, LEAD, PCAP)**
- **Harm Reduction Services**

Methamphetamine in Washington

Report to the Division of Behavioral Health and Recovery, Washington State Department of Social and Health Services

June 2018



Susan A. Stoner, PhD, Jason R. Williams, PhD, Alison Newman, MPH, Nancy Sutherland, MLS, Caleb Banta-Green, MSW, MPH, PhD

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Summary

- Huge challenges remain
- Developing and actively maintaining care networks is essential for our clients, our communities, and our effectiveness as care providers
- Reflecting on our own programs' care models, rules, and place in the continuum of care needs to be vigorously examined

What have you changed in your work that has been successful to engage and retain more clients?