Medications for Opioid Use Disorder Among Culturally Diverse People with HIV (1st Edition – 2022)

Trainer Guide

Pacific Southwest ATTC (HHS Region 9)

CDU Charles Drew University of Medicine and Science

UCLA

AETC AIDS Education & Training Center Program Pacific

Medications for Opioid Use Disorder Among Culturally Diverse People with HIV (1st Edition, 2022)

Table of Contents

Medications for Opioid Use Disorder Among Culturally Diverse People with HIV (1st Edition, 2022)

Background Information

The purpose of this introductory training is to provide HIV clinicians (including, but not limited to physicians, dentists, nurses, and other allied medical staff, therapists and social workers, and counselors, specialists, and case managers) with an overview of the challenges and strategies for change in working with individuals with HIV/AIDS and a diagnosis of an opioid use disorder. Given the potentially broad array of health disciplines, this presentation uses the terms "patient" and "client" interchangeably to refer to the individuals a training participant may be working with in their organization. The duration of the training is approximately 180 minutes (3 hours), depending on whether the trainer chooses to present all of the slides, or a selection of slides, and whether the trainer chooses to present and discuss both case studies.

Four Test Your Knowledge/What Did You Learn questions have been inserted at the beginning and end of the presentation to assess a change in the audience's level of knowledge after the information has been presented. An answer key is provided in the Trainer's notes in slides **6-9**, and slides **148-151**. Poll Everywhere, or a similar audience polling system can be utilized, if available, when facilitating the pre- and post-test question sessions. For more information, visit: https://www.polleverywhere.com/.

In addition, brief group discussions and two case studies have been inserted throughout the presentation to encourage dialogue among the training participants, and to illustrate how the information contained within the presentation can be used clinically.

The cover image credit is a purchased image from Adobe Stock, 2022.

What Does the Training Package Contain?

- PowerPoint Training Slides (with notes)
- Trainer's Guide with detailed instructions for how to convey the information and conduct the interactive exercises, and a participant handout for the "James" vignette that appears on **slides 68-70 and slides 78-82**.
- Two-Page Fact Sheet for HIV Clinicians

What Does This Trainer's Guide Contain?

- Slide-by-slide notes designed to help the trainer effectively convey the content of the slides themselves
- Supplemental information for select content to enhance the quality of instruction
- Suggestions for facilitating questions and group discussions.

How is This Trainer's Guide Organized?

For this guide, text that is shown in bold italics is a "***Note to the Trainer.***" Text that is shown in normal font relates to the "Trainer's Script" for the slide.

It is important to note that slides throughout the PowerPoint presentation may contain animation, some of which is complicated to navigate. Animations are used to call attention to particular aspects of the information or to present the information in a stepwise fashion to facilitate both the presentation of information and participant understanding. Becoming acquainted with the slides, and practicing delivering the content of the presentation are essential steps for ensuring a successful, live training experience.

General Information about Conducting the Training

The training is designed to be conducted in medium to large sized groups (25-75 people). It is possible to use these materials with larger groups, but the trainer may have to adapt the small group exercises and discussions to ensure that there is adequate time to cover all the content.

Materials Needed to Conduct the Training

- Computer with PowerPoint software installed (2010 or higher version recommended) and LCD projector to show the PowerPoint training slides.
- When making photocopies of the PowerPoint presentation to provide as a handout to training participants, it is recommended that you print the slides three slides per page with lines for notes. Select "**pure black and white**" as the color option. This will ensure that all text, graphs, tables, and images print clearly.
- Flip chart paper and easel/white board, and markers/pens to write down relevant information, including key case study discussion points.

Overall Trainer Notes

It is critical that, prior to conducting the actual training, the trainer practice using this guide while showing the slide presentation in Slideshow Mode in order to be prepared to use the slides in the most effective manner.

Icon Key

	Note to Trainer		Activity
	References		Image Credit

Medications for Opioid Use Disorder Among Culturally Diverse People with HIV
(1st Edition, 2022)

Slide-By-Slide Trainer Notes

The notes below contain information that can be presented with each slide. This information is designed as a guidepost and can be adapted to meet the needs of the local training situation. Information can be added or deleted at the discretion of the trainer(s).

Slide 1: [Title Slide]

The purpose of this introductory training is to provide HIV clinicians (including, but not limited to physicians, dentists, nurses, and other allied medical staff, therapists and social workers, and counselors, specialists, and case managers) with an overview of the challenges and strategies for change in working with individuals with HIV/AIDS and a diagnosis of an opioid use disorder. Given the potentially broad array of health disciplines, this presentation uses the terms "patient" and "client" interchangeably to refer to the individuals a training participant may be working with in their organization. The duration of the training is approximately 180 minutes (3 hours), depending on whether the trainer chooses to present all of the slides, or a selection of slides, and whether the trainer chooses to present and discuss both case studies.

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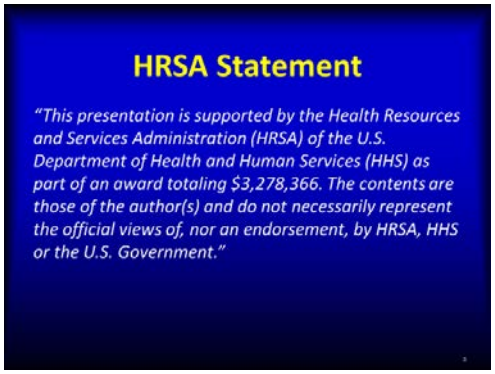
(Notes for Slide 1, continued)

Slide 1: [Title Slide]

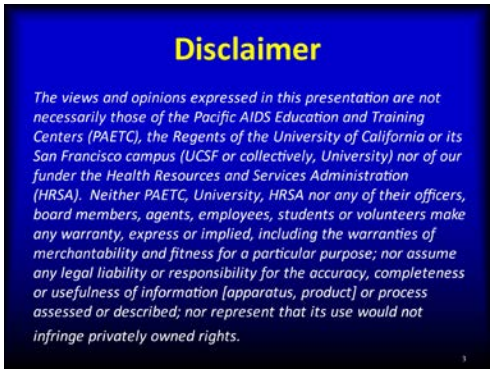
For more information, visit: https://www.polleverywhere.com/.

In addition, brief group discussions and two case studies have been inserted in the presentation to encourage dialogue among the training participants, and to illustrate how the information contained within the presentation can be used clinically.

Slide 2: HRSA Statement



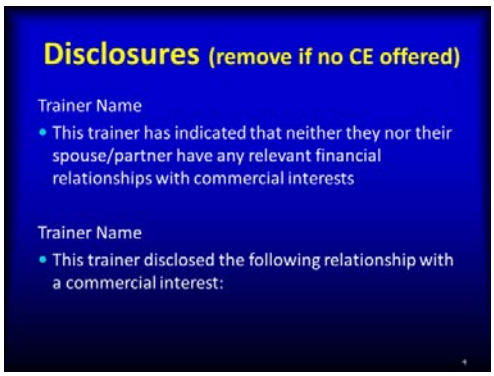
This is a statement from the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) stating that the contents of this training are those of the authors and do not necessarily represent the official views of HRSA, HHS, or the U.S. government.



Slide 3: Disclaimer

This disclaimer is provided in order to clarify funding for the project and distinguish the Pacific AIDS Education and Training Center's role in promoting view and opinions contained in the training.

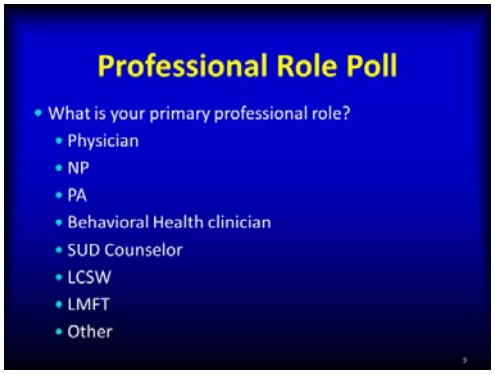
This PowerPoint presentation, Trainer Guide, and companion fact sheet was developed by James A. Peck, Psy.D. (Psychologist and Clinical Trainer at UCLA Integrated Substance Abuse Programs) and Dr. William D. King, MD, JD, through supplemental funding provided by the Pacific AIDS Education and Training Center. We wish to acknowledge Thomas E. Freese, PhD, and Beth Rutkowski, MPH, from the Pacific Southwest ATTC, and Kevin-Paul Johnson, Maya Gil Cantu, MPH, Sandra M. Cuevas, and Thomas Donohoe, MBA, from the LA Region PAETC.



Slide 4: Disclosures

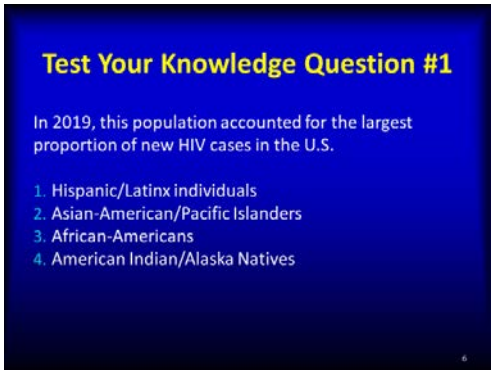
This is a slide listing relevant financial relationships of the authors.

This slide can be customized to represent the financial relationships of whoever is conducting the training or deleted if the institution is not offering Continuing Education.



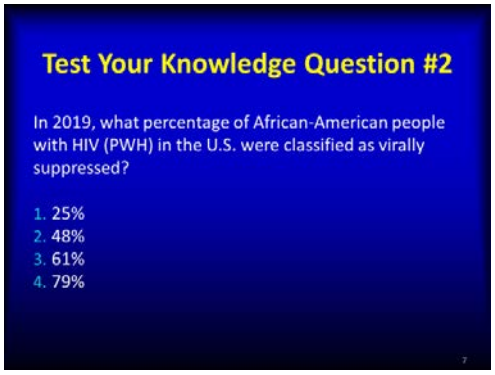
Slide 5: Professional Role Poll

If conducting the training in person, ask the question and have training participants raise their hands as you state each response. If conducting a virtual training, program the question and responses in as a poll. Give training participants approximately 30 seconds to respond, and then close the poll and display the results.



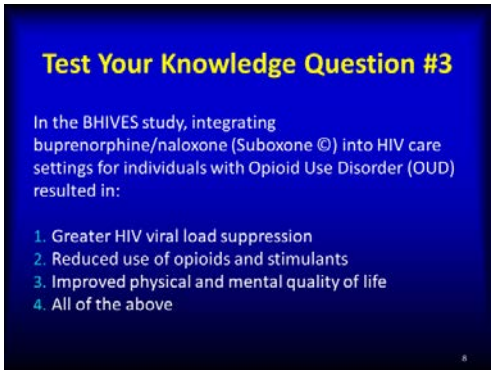
Slide 6: Test Your Knowledge – Question 1

Read the question and choices, and review audience responses out loud.



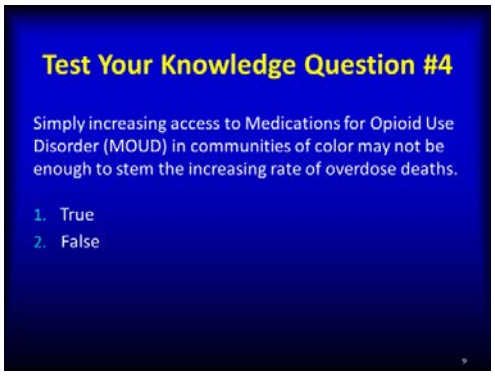
Slide 7: Test Your Knowledge – Question 2

Read the question and choices, and review audience responses out loud.



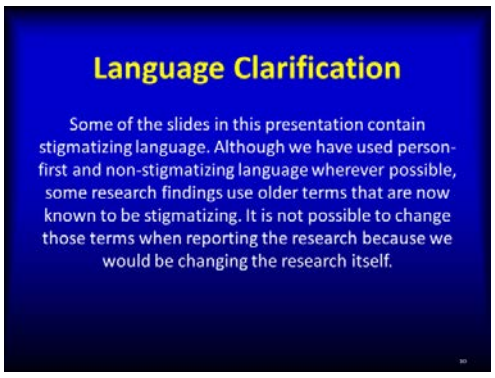
Slide 8: Test Your Knowledge – Question 3

Read the question and choices, and review audience responses out loud.



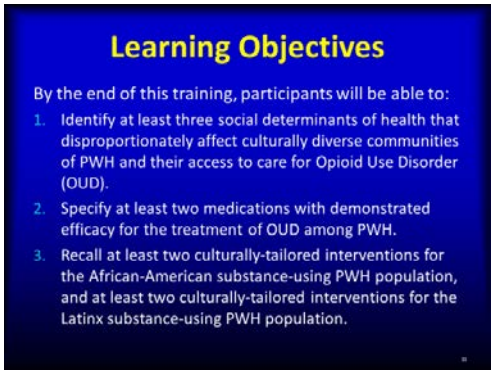
Slide 9: Test Your Knowledge – Question 4

Read the question and choices, and review audience responses out loud.



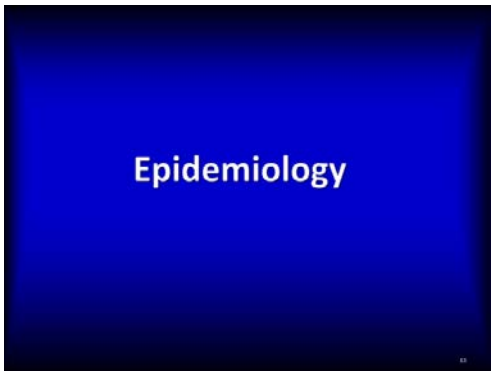
Slide 10: Language Clarification

This slide states that some of the slides in this presentation may contain older language now known to be stigmatizing. The language cannot be changed because we would then be changing the reported research.



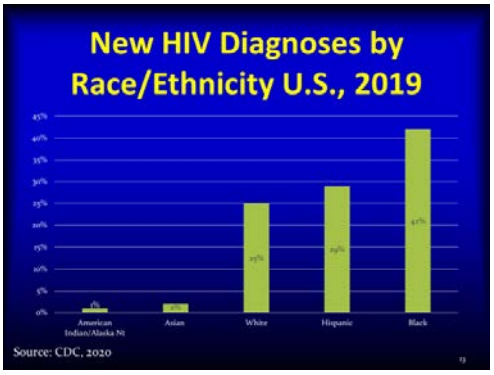
Slide 11 Learning Objectives

Briefly review each of the educational objectives with the audience.



Slide 12: [TRANSITION SLIDE] Epidemiology

This is a section header slide for the training section on epidemiology.

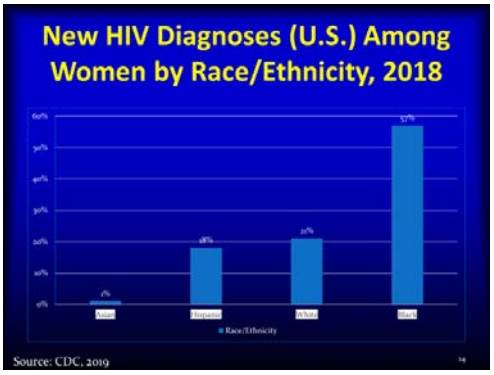


Slide 13: New HIV Diagnoses by Race/Ethnicity U.S., 2019

This slide presents a bar graph from the Centers for Disease Control and Prevention. According to the CDC, in 2019 African-Americans made up approximately 13% of the U.S. population but accounted for approximately 42% (15,340) of new HIV diagnoses.This is the first of several slides showing national data on HIV.

REFERENCE

Centers for Disease Control and Prevention. (2020). *HIV by Race/Ethnicity*. Retrieved from: https://www.cdc.gov/hiv/basics/statistics.html.

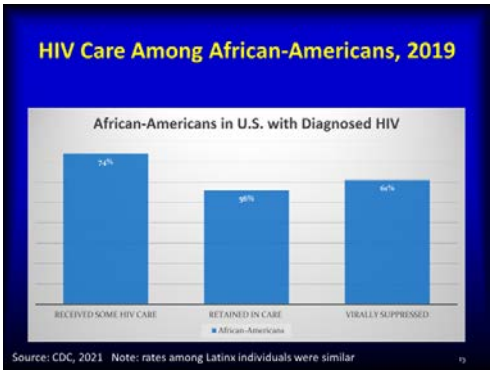


Slide 14: New HIV Diagnoses (U.S.) Among Women by Race/Ethnicity, 2018

According to the CDC, in 2018, 18% of new HIV diagnoses among women in the U.S. were in Hispanic/Latinx women, and fully 57% were among African-American women. This represents an enormous disparity.

REFERENCE

Centers for Disease Control and Prevention. (2019). *Diagnoses of HIV Infection in the U.S. and Dependent Areas, 2018*. Retrieved from: https://www.cdc.gov/hiv/group/gender/women/index.html.

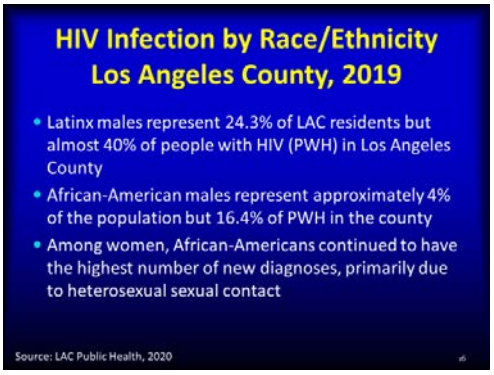


Slide 15: HIV Care Among African-Americans, 2019

Of all African-Americans diagnosed with HIV in the U.S. in 2019, 74% received some medical care, but only 56% were retained in care and only 61% were virally suppressed.

REFERENCE

Centers for Disease Control and Prevention. (2021). Monitoring selected national HIV prevention and care objectives by using HIV surveillance data-United States and six dependent areas. HIV Surveillance Supplemental Report, 26(2).



Slide 16: HIV Infection by Race/Ethnicity Los Angeles County, 2019

According to the Los Angeles County Department of Public Health, Latinx males represent approximately 24% of County residents but almost 40% of males with HIV. Black males represent approximately 4% of the population but approximately 16% of males with HIV. Both of these statistics indicate a serious disparity in terms of the race/ethnicity of people with HIV in Los Angeles County. In addition, Black women continue to have the highest number of new HIV diagnoses.

REFERENCE

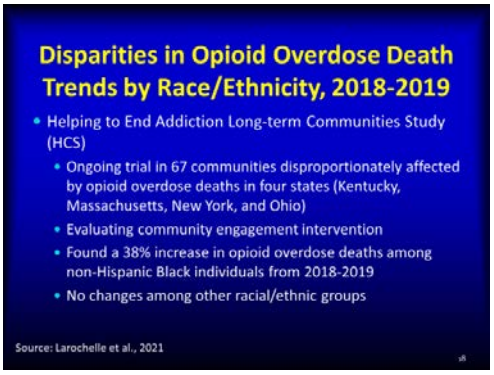
County of Los Angeles Department of Public Health. (2020). *HIV Surveillance Annual Report, 2019*. Retrieved from: http://publichealth.lacounty.gov/dhsp/Reports/HIV/2019Annual_HIV_Surveillance_Report_08202020_Final_revised_Sept2020.pdf.

Slide 17: Drug Poisoning Deaths Among African-Americans

Based on SAMHSA data, in 2015-2016 the rate of drug overdose deaths in the U.S. increased by 21%, while among African-Americans it increased by 40%. This was higher than any other racial/ethnic group. Additionally, African-Americans had the highest increase in opioid-related deaths involving synthetic opioids from 2011-2016.

REFERENCE

Substance Abuse and Mental Health Services Administration. (2020). *The Opioid Crisis and the Black/African-American population: An Urgent Issue*. Publication ID: PEP20-05-02-001. Retrieved from: https://store.samhsa.gov/product/The-Opioid-Crisis-and-the-Black-African-American-Population-An-Urgent-Issue/PEP20-05-02-001.

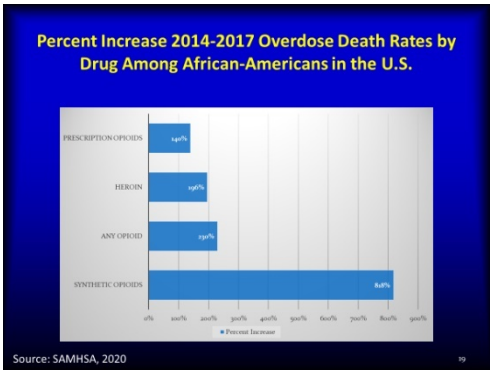


Slide 18: Disparities in Opioid Overdose Death Trends by Race/Ethnicity, 2018-2019

A study (Helping to End Addiction Long-Term Communities Study) evaluating a community engagement intervention in four states found a 38% increase in opioid overdose deaths among Black Americans from 2018-2019, but no differences among other racial/ethnic groups.

REFERENCE

Larochelle, M. R., Slavova, S., Root, E. D., Feaster, D. J., Ward, P. J., Selk, S. C., … Samet, J. H. (2021). Disparities in opioid overdose death trends by race/ethnicity, 2018-2019, from the HEALing Communities Study. *American Journal of Public Health*, e1–e4. Advance online publication. https://doi.org/10.2105/AJPH.2021.306431.

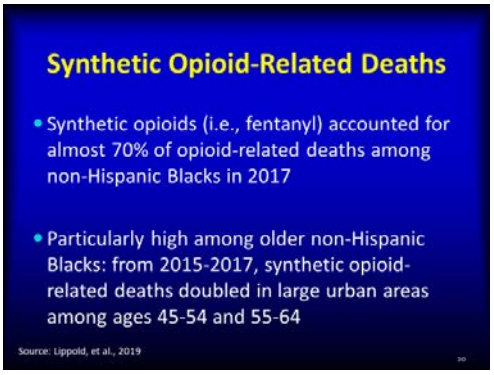


Slide 19: Percent Increase 2014-2017 Overdose Death Rates by Drug Among African-Americans in the U.S.

This chart shows that based on SAMHSA data, from 2014-2017 drug overdose rates among African-Americans in the U.S. increased by 140% for prescription opioids, almost 200% for heroin, and over 800% for synthetic opioids like fentanyl.

REFERENCE

Substance Abuse and Mental Health Services Administration. (2020). *The Opioid Crisis and the Black/African-American population: An Urgent Issue*. Publication ID: PEP20-05-02-001. Retrieved from: https://store.samhsa.gov/product/The-Opioid-Crisis-and-the-Black-African-American-Population-An-Urgent-Issue/PEP20-05-02-001.



Slide 20: Synthetic Opioid-Related Deaths

In 2017, synthetic opioids like fentanyl accounted for almost 70% of opioid-related deaths among African-Americans. Deaths attributed to synthetic opioids were particularly high among *older* African-Americans from 2015-2017: they doubled in large urban areas for African-Americans in the 45-54 and 55-64 age ranges.

REFERENCE

Lippold, K. M., Jones, C. M., Olsen, E. O., & Giroir, B. P. (2019). Racial/ethnic and age group differences in opioid and synthetic opioid– involved overdose deaths among adults aged≥ 18 years in metropolitan areas—United States, 2015–2017. *Morbidity and Mortality Weekly Report*, 68(43), 967. Atlanta, GA: Centers for Disease Control and Prevention Retrieved from: https://dx.doi.org/10.15585%2Fmmwr.mm6843a3.

Slide 21: Pathways to Opioid Misuse

One route to opioid misuse and overdose deaths is initiated through excessive prescribing and use of prescription opioids. This leads to physical dependence on these pain-killing medications. Individuals then switch to heroin when the prescription medications are no longer available. Heroin is cheaper and generally more readily available than prescription opioids. Another route is through the use of illicit drugs such as heroin and cocaine, which has a long history in low-income Black communities dating back to the drug epidemics of the 1960's and 1970's. Use of heroin is particularly dangerous now because it is frequently laced with fentanyl, a synthetic opioid approximately 25-50 times as potent as heroin.

REFERENCE

Substance Abuse and Mental Health Services Administration. (2020). *The Opioid Crisis and the Black/African-American population: An Urgent Issue*. Publication ID: PEP20-05-02-001. Retrieved from: https://store.samhsa.gov/product/The-Opioid-Crisis-and-the-Black-African-American-Population-An-Urgent-Issue/PEP20-05-02-001.

Slide 22: Pathways: Prescription Opioids

It has been proposed that African-Americans may be somewhat insulated from the fast-rising rates of opioid misuse and overdose deaths due to lack of access to these medications. Studies show that there *is* less access to prescription opioid painkillers, due to misperceptions and biases in the healthcare system. Part of that is undervaluing African-Americans' self-reports of pain severity. Also, there is stereotyping by healthcare providers i.e., Black patients are drug-seeking. However, that does not mean that African-Americans are insulated from opioid drug poisoning deaths.

REFERENCE

Meghani, S. H., Byun, E., & Gallagher, R. M. (2012). Time to take stock: A meta-analysis and systematic review of analgesic treatment disparities for pain in the United States. *Pain Medicine, 13*(2),150–74. Retrieved from: https://doi.org/10.1111/ j.1526-4637.2011.01310.x

Slide 23: Pathways: Prescription Opioids (2)

A meta-analysis found that compared to Whites, African-Americans were 29% less likely to be prescribed opioids for pain, and a study of emergency departments found that African-Americans are significantly less likely to be prescribed opioid painkillers by medical providers than White patients. Although African-Americans have higher pain scores compared to Whites, some healthcare providers believe pain levels are actually lower or that patients are drug-seeking.

REFERENCES

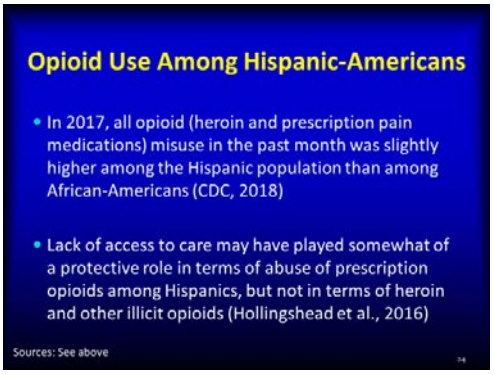
Pletcher, M. J., Kertesz, S. G., Kohn, M. A., & Gonzales, R. (2008). Trends in opioid prescribing by race/ethnicity for patients seeking care in US emergency departments. *Journal of the American Medical Association, 299*(1):70–78. Retrieved from : https://doi.org/10.1001/jama.2007.64.

(Notes for Slide 23, continued)

Slide 23: Pathways: Prescription Opioids (2)

REFERENCES

Staton, L. J., Panda, M., Chen, I., Genao, I., Kurz, J., Pasanen, M., … Rosenberg, E. (2007). When race matters: Disagreement in pain perception between patients and their physicians in primary care. *J Natl Med Assoc, 99*(5), 532. Retrieved from: https://www.ncbi.nlm.nih.gov/pubmed/17534011.



Slide 24: Opioid Use Among Hispanic-Americans

According to the CDC, all opioid misuse in the past month was slightly higher among the Hispanic population than among African-Americans in 2017. Hispanics may have an issue with lack of access to care that leads to less abuse of prescription opioids, but this does not apply to heroin and other illicit opioids.

REFERENCES

Centers for Disease Control and Prevention. (2018). *Annual Surveillance Report of Drug-Related Risks and Outcomes*. Retrieved from: https://www.cdc.gov/drugoverdose/pdf/pubs/2018-cdc-drug-surveillance-report.pdf.

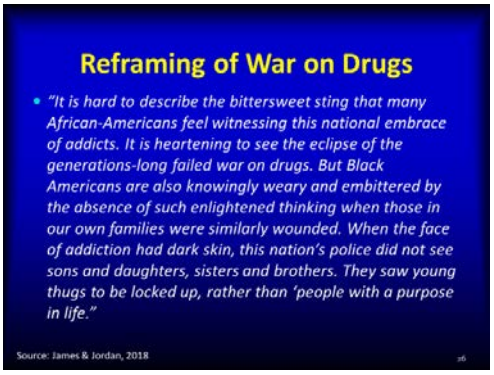
Hollingshead, N. A., Ashburn-Nardo, L., Stewart, J. S., & Hirsh, A. T. (2016). The pain experience of Hispanic Americans: A critical literature review and conceptual model. *Journal of Pain, 17*, 513–528.

Slide 25: Opioid Epidemic in Black & Latinx Communities Overlooked

Based on work by James & Jordan, the media has largely overlooked the opioid epidemic in Black and Latinx communities. This is part of a longstanding pattern of framing addiction in people of color as a pathology requiring the criminal justice system instead of treatment. Advertising and public service announcements regarding the opioid epidemic have largely featured White actors.

REFERENCE

James, K., & Jordan, A. (2018). The opioid crisis in Black communities. *Journal of Law, Medicine, and Ethics, 46*, 404–421.

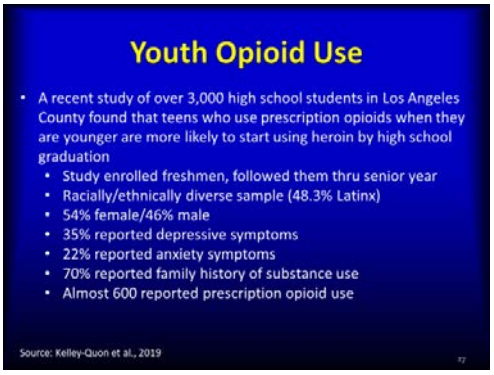


Slide 26: Reframing of the War on Drugs

This is a quote from James & Jordan, describing the "bittersweet sting" experienced by Black Americans seeing the evolution of drug addiction from a criminal justice issue to a treatment issue.

REFERENCE

James, K., & Jordan, A. (2018). The opioid crisis in Black communities. *Journal of Law, Medicine, and Ethics, 46*, 404–421.

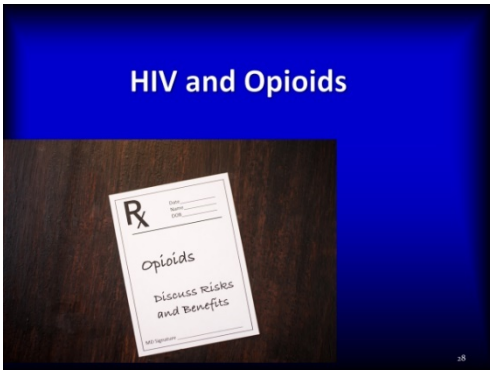


Slide 27: Youth Opioid Use

Based on a study published by Kelly-Quon and colleagues, teens in Los Angeles County who use prescription opioids when they are younger are more likely to start using heroin by high school graduation. Interesting additional findings include that over a third of the sample reported depressive symptoms, 22% reported anxiety symptoms, and nearly three quarters reported a family history of substance use. Approximately 20% of the sample reported prescription opioid use.

REFERENCE

Kelley-Quon, L., Cho, J., Strong, D., Miech, R., Barrington-Trimmis, J., Kechter, A., & Leventhal, A. M. (2019). Association of non-medical prescription opioid use with subsequent heroin use initiation in adolescents. *JAMA Pediatrics, 173*(9), e191750.

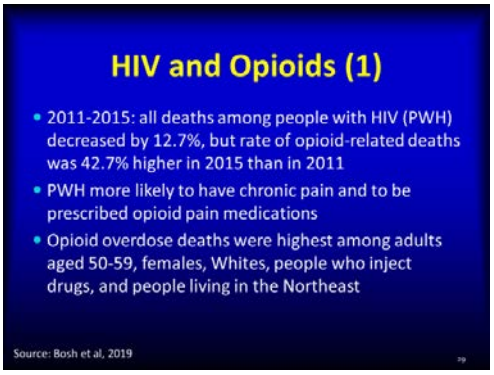


Slide 28: [TRANSITION SLIDE] HIV and Opioids

This slide serves as a transition into a section on HIV and opioids.

IMAGE CREDIT

Purchased image, Adobe Stock, 2022.

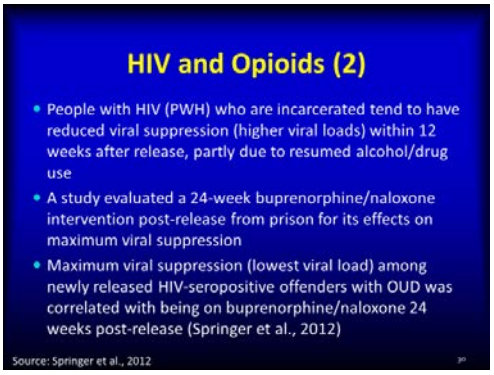


Slide 29: HIV and Opioids (1)

While all deaths among people with HIV declined by almost 13% from 2011-2015, the rate of opioid-related deaths was nearly 43% higher in 2015 than in 2011. People with HIV are more likely to have chronic pain than the general population and to be prescribed opioid medications and higher doses of opioid medications. The study found that the highest rates of opioid-related deaths were among adults in their 50's, females, Whites, people who inject drugs, and people who live in the northeast U.S.

REFERENCE

Bosh, K. A., et al. (2019). *Abstract 147 – Opioid Overdose Deaths Rising among People Living with HIV*. Presented at Conference on Retroviruses and Opportunistic Infections, Seattle, WA. Retrieved from: https://www.healio.com/news/infectious-disease/20190311/opioid-overdose-deaths-rising-in-people-living-with-hiv.

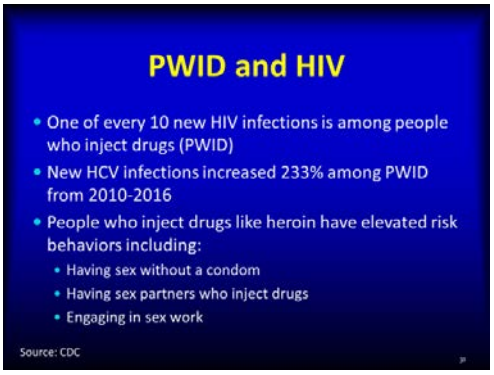


Slide 30: HIV and Opioids (2)

According to a study by Springer and colleagues, incarcerated people with HIV tend to have higher viral loads within 12 weeks of release from prison, in part due to resuming alcohol/drug use. This study evaluated a 6-month buprenorphine/naloxone (Suboxone) intervention post-release from prison to determine its effects on viral suppression. They found that maximum viral suppression (the best results) was correlated with being on buprenorphine/naloxone at 6 months after release from prison.

REFERENCE

Springer, S. A., Qiu, J., Saber-Tehrani, A. S., & Altice, F. L. (2012). Retention on buprenorphine is associated with high levels of maximal viral suppression among HIV-infected opioid dependent release prisoners. *PLoS ONE 7*(5), 1–10. Retrieved from: https://journals.plos.org/plosone/article/file?type=printable&id=10.1371/journal.pone.0038335.

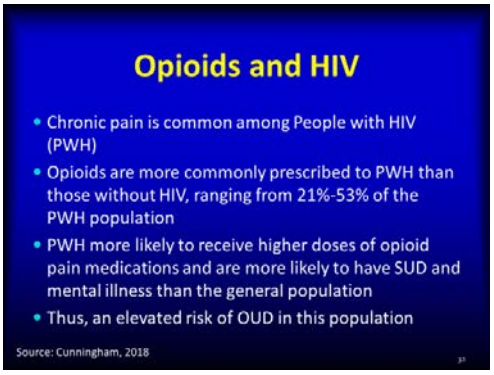


Slide 31: PWID and HIV

According to the CDC, one of every 10 new HIV infections is among people who inject drugs. New hepatitis C infections more than doubled in this group from 2010-2016. People who inject drugs like heroin have risk behaviors including having unprotected sex, having sex partners who inject drugs, and engaging in sex work.

REFERENCE

Centers for Disease Control and Prevention. (no date given). *Addressing the Infectious Disease Consequences of the U.S. Opioid Crisis*. Retrieved from: https://www.cdc.gov/nchhstp/budget/infographics/opioids.html.

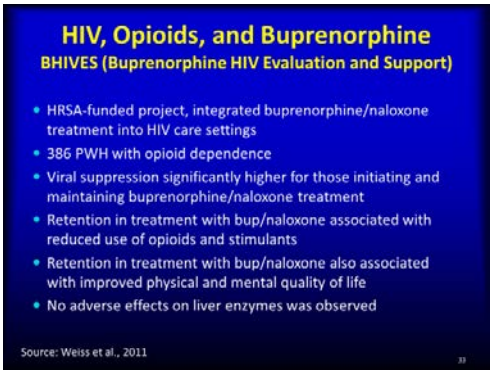


Slide 32: Opioids and HIV

There is an elevated risk of opioid use disorder among people with HIV. Despite viral suppression, chronic pain is common in this population. Opioids are more commonly prescribed to PWH than those without HIV. The rate of opioid prescriptions ranges from 21-53% of the population. PWH are also more likely to receive higher doses of opioid pain medications than the general population and are more likely to have mental health conditions and substance use disorders.

REFERENCE

Cunningham, C. (2018). Opioids and HIV infection: From pain management to addiction treatment. *Topics in Antiviral Medicine, 25*(4),143–146.



Slide 33: HIV, Opioids, and Buprenorphine

The BHIVES study (Buprenorphine HIV Evaluation and Support) was a HRSA-funded project that integrated buprenorphine/naloxone treatment into 10 HIV care settings across the country. Study outcomes were viral suppression and drug use. 303 of the 386 participants received buprenorphine/naloxone treatment; the others received methadone or other treatments. Among the participants receiving buprenorphine, those retained in treatment demonstrated significantly better HIV viral suppression, reduced use of opioids and stimulants, and improved physical and mental quality of life.

REFERENCES

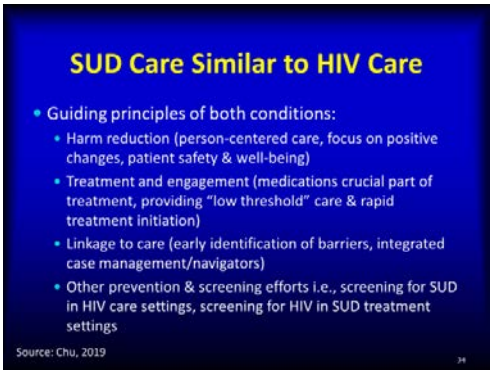
Weiss, L., Egan J. E., Botsko, M., Netherland, J., Fiellin, D. A., & Finkelstein R. (2011). The BHIVES collaborative: organization and evaluation of a multisite demonstration of integrated buprenorphine/naloxone and HIV treatment. *Journal of Acquired Immune Deficiency Syndromes, 56*(Suppl 1), S22–S32.

(Notes for Slide 33 continued)

Slide 33: HIV, Opioids, and Buprenorphine

REFERENCES

Fiellin, D., Weiss, L., Botsko, M., Egan, J., Altice, F., Bazerman, L. B., … the BHIVES Collaborative. (2011). Drug treatment outcomes among HIV-infected opioid-dependent patients receiving buprenorphine/naloxone. *Journal of Acquired Immune Deficiency Syndromes, 56*(Suppl 1), S33–38.



Slide 34: SUD Care Similar to HIV Care

This information is from a slide set from the AIDS Education and Training Center National Coordinating Resource Center. This technical assistance resource emphasizes that the guiding principles of substance use care — harm reduction, screening and other prevention interventions, treatment initiation, and linkage to ongoing medical care — are like those of viral hepatitis and HIV care. All models focus on patient safety and wellness, with effective medication being critical for the individual's health and for related public health benefits.

REFERENCE

Chu, C. (2019). *Ending the HIV & HCV Epidemics: A Critical Role for Substance Use Providers*. Newark, NJ: AIDS Education and Training Center National Coordinating Resource Center. Retrieved from: https://aidsetc.org/resource/ending-hiv-hcv-epidemics-critical-role-substance-use-providers.

Slide 35: [TRANSITION SLIDE] The Context: Social Determinants of Health

This slide serves as a transition to the section on social determinants of health. Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Resources that enhance quality of life can have a significant influence on population health outcomes. Examples of these resources include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins.

REFERENCE

HealthyPeople.Gov. (2020). [Webpage]. *Social Determinants of Health*. Retrieved from: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health.

(Notes for Slide 35 continued)

Slide 35: [TRANSITION SLIDE] The Context: Social Determinants of Health

IMAGE CREDIT

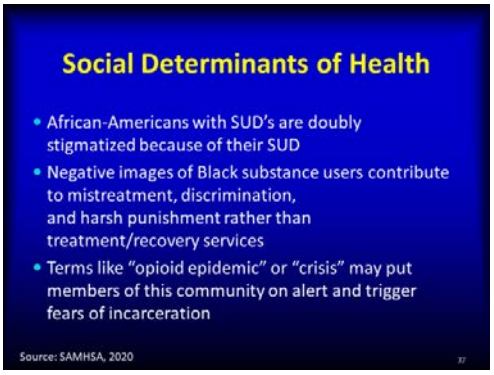
Purchased image, Adobe Stock, 2022.

Slide 36: Why Are We Talking About Social Determinants of Health?

It became clear in preparing this presentation that OUD among African-American and Latinx communities and medications for OUD in these communities cannot be discussed in terms of public health without the context of institutional racism. Cobbinah and Lewis quote Jones (2002) in defining institutional racism as "the structural and legalized system of policies, practices, and norms that results in differential access to goods and services." They argue that racism must be tackled with a sustained, multilevel, and interdisciplinary approach to empower Black communities and establish public health policies that reduce it.

REFERENCE

Cobbinah, S. & Lewis, J. (2018). Racism & health: A public health perspective on racial discrimination. *Journal of Evaluation in Clinical Practice, 24*(5), 995–998.



Slide 37: Social Determinants of Health

According to SAMHSA, African-Americans with substance use disorders are doubly stigmatized because of their SUD (and their race). We have tended to portray Black substance users negatively in the media, and that contributes to mistreatment, discrimination, and harsh punishment rather than treatment and recovery services. Although the terms "opioid epidemic" and "opioid crisis" have become common, these terms may put members of the African-American community on alert and trigger fears of incarceration.

REFERENCE

Substance Abuse and Mental Health Services Administration. (2020). *The Opioid Crisis and the Black/African-American population: An Urgent Issue*. Publication ID: PEP20-05-02-001. Retrieved from: https://store.samhsa.gov/product/The-Opioid-Crisis-and-the-Black-African-American-Population-An-Urgent-Issue/PEP20-05-02-001.

Slide 38: Social Determinants of Health: Intergenerational and Polysubstance Use

In many families in the U.S., substance misuse is passed from generation to generation. This is not unique to African-American families. In some cases, multigenerational households are misusing substances together. In high poverty communities, using and/or selling drugs is a means of coping and/or survival. In evaluating an individual's behaviors, we must examine the behaviors of their social network, often including their family. Who around them is also using substances?

REFERENCE

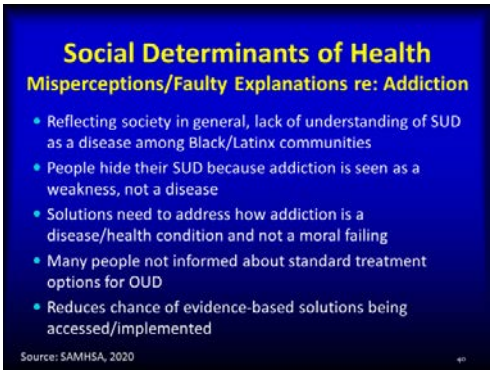
Substance Abuse and Mental Health Services Administration. (2020). *The Opioid Crisis and the Black/African-American population: An Urgent Issue*. Publication ID: PEP20-05-02-001. Retrieved from: https://store.samhsa.gov/product/The-Opioid-Crisis-and-the-Black-African-American-Population-An-Urgent-Issue/PEP20-05-02-001.

Slide 39: Social Determinants of Health: Fear of Legal Consequences

Only 10% of people with a SUD in the general population seek treatment. This is an even bigger problem in the African-American community for several reasons. One is historical mistrust of the healthcare, social services, and criminal justice systems. Another is fear of severe sentencing and incarceration policies. Another is the fear of losing children if mothers acknowledge a substance use problem and seek treatment.

REFERENCE

Substance Abuse and Mental Health Services Administration. (2020). *The Opioid Crisis and the Black/African-American population: An Urgent Issue*. Publication ID: PEP20-05-02-001. Retrieved from: https://store.samhsa.gov/product/The-Opioid-Crisis-and-the-Black-African-American-Population-An-Urgent-Issue/PEP20-05-02-001.



Slide 40: Social Determinants of Health: Misperceptions/Faulty Explanations re: Addiction

In the African-American community, as in much of society, there is a lack of understanding of conceptualizing SUD as a disease and of the high risk for opioid use disorder from prescription opioid misuse. People tend to hide their SUD because it is seen as a weakness rather than as a disease. Many people are not informed about standard treatment options, which reduces the chance of evidence-based treatments being accessed.

REFERENCE

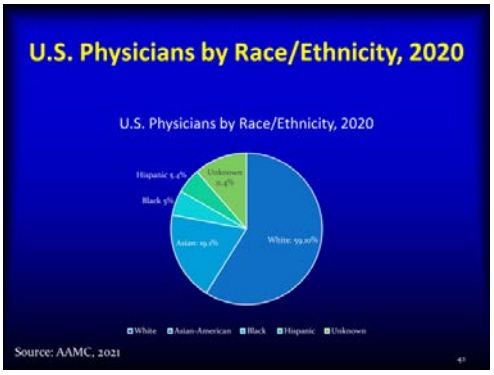
Substance Abuse and Mental Health Services Administration. (2020). *The Opioid Crisis and the Black/African-American population: An Urgent Issue*. Publication ID: PEP20-05-02-001. Retrieved from: https://store.samhsa.gov/product/The-Opioid-Crisis-and-the-Black-African-American-Population-An-Urgent-Issue/PEP20-05-02-001.

Slide 41: Social Determinants of Health: Lack of Culturally Responsive Care

There is a shortage of Black and Latinx physicians in general, and a shortage of physicians, nurse practitioners, and physician assistants waivered to prescribe buprenorphine. When people of color are unable to be treated by clinicians in their own culture, they often terminate treatment prematurely. When the cultural context is ignored, clinicians may have little respect for patients with OUD, which contributes to little hope among patients, and it becomes difficult for Black & Latinx OUD patients to engage in treatment.

REFERENCE

Lin, L. A., & Knudsen, H. K. (2019). Comparing buprenorphine-prescribing physicians across nonmetropolitan and metropolitan areas in the United States. *Annals of Family Medicine, 17*(3), 212–220. Retrieved from: https://doi.org/10.1370/afm.2384.



Slide 42: U.S. Physicians by Race/Ethnicity, 2020

According to the American Academy of Medical Colleges, as of 2021, almost 60% of physicians in the U.S. were White, approximately 19% were Asian-Americans, and approximately 11% were of unknown race/ethnicity. Only 5% were Black, and only 5.4% were Hispanic. It is not helpful for treatment engagement for Black and Brown folks to almost never see themselves represented among the physicians they see when seeking treatment.

REFERENCE

American Academy of Medical Colleges. (2021). *2021 State Physician Workforce Data Report*. Retrieved from: https://store.aamc.org/2021-state-physician-workforce-data-report.html.

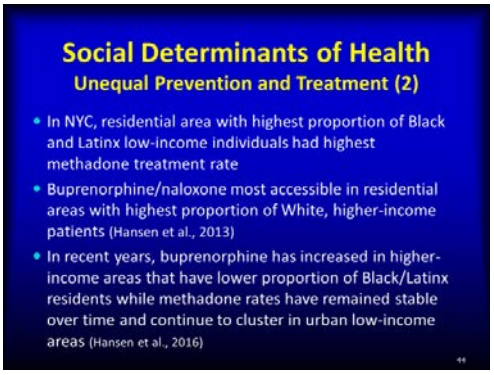
Slide 43: Social Determinants of Health: Unequal Prevention and Treatment

Standard, universal prevention campaigns may not resonate in Black and Latinx communities. Prevention messages need to be tailored to specific communities and delivered by a trusted messenger, in other words a member of that community. Access to treatment options is often more dependent on demographic factors than on individual preferences. For a variety of reasons, Black and Latinx people with OUD have limited access to the full range of MOUD options.

REFERENCES

Williams, D. R., & Wyatt, R. (2015). Racial bias in health care and health: Challenges and opportunities. *Journal of the American Medical* Association, *314*(6), 555–556. Retrieved from: https://doi.org/10.1001/jama.2015.9260.

Hansen, H. (2017). Sociocultural factors impacting access to MAT and care delivery, new qualitative data from buprenorphine prescribers in OTPs. *American Journal of Addiction, 26*(3), 236. Retrieved from: https://doi-org.ezproxyhhs.nihlibrary.nih.gov/10.1111/ajad.12545.



Slide 44: Social Determinants of Health: Unequal Prevention and Treatment (2)

One study showed that in NYC, the residential area with the highest proportion of Black and Latinx low-income people had the highest methadone treatment rate, while buprenorphine and naloxone were most accessible in residential areas with the greatest proportion of White higher-income patients. Another study showed that in recent years, the availability of buprenorphine treatment has increased in higher income areas with lower proportions of Black & Latinx residents while methadone clinics have remained relatively stable and continue to be clustered in low-income urban areas.

REFERENCES

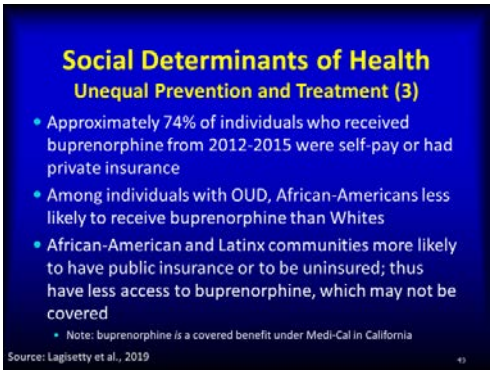
Hansen, H. B., Siegel, C. E., Case, B. G., Bertollo, D. N., DiRocco, D., & Galanter, M. (2013). Variation in use of buprenorphine and methadone treatment by racial, ethnic, and income characteristics of residential social areas in New York City. *Journal of Behavioral Health Services Research, 40*(3), 367–377. Retrieved from: https://doi.org/10.1007/s11414-013-9341-3.

(Notes for Slide 44, continued)

Slide 44: Social Determinants of Health: Unequal Prevention and Treatment (2)

REFERENCES

Hansen, H., Siegel, C., Wanderling, J., & DiRocco, D. (2016). Buprenorphine and methadone treatment for opioid dependence by income, ethnicity and race of neighborhoods in New York City. *Drug and Alcohol Dependence, 164,* 14–21. Retrieved from: https://doi.org/10.1016/j.drugalcdep.2016.03.02.

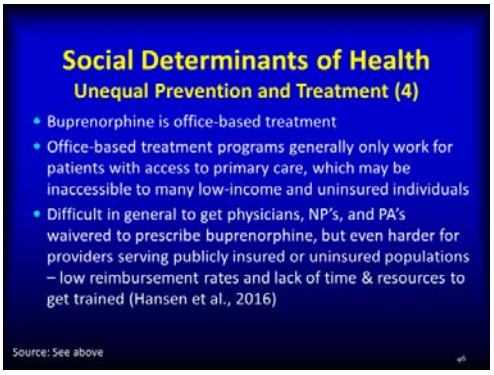


Slide 45: Social Determinants of Health: Unequal Prevention and Treatment (3)

About three-quarters of people who received buprenorphine from 2012-2015 were self-pay or had private insurance, as opposed to public insurance like Medicaid or Medicare. Among people with OUD, African-Americans are less likely to receive buprenorphine than White people. African-American and Latinx individuals are more likely to have public insurance or to be uninsured, so they have less access to buprenorphine. Buprenorphine is a covered benefit under Medi-Cal (the state's Medicaid program) in California.

REFERENCE

Lagisetty, P. A., Ross, R., Bohnert, A., Clay, M., & Maust, D. T. (2019). Buprenorphine treatment divide by race/ethnicity and payment. *JAMA Psychiatry, 76*(9), 979–981. Retrieved from: https://doi.org/10.1001/jamapsychiatry.2019.0876.



Slide 46: Social Determinants of Health: Unequal Prevention and Treatment (4)

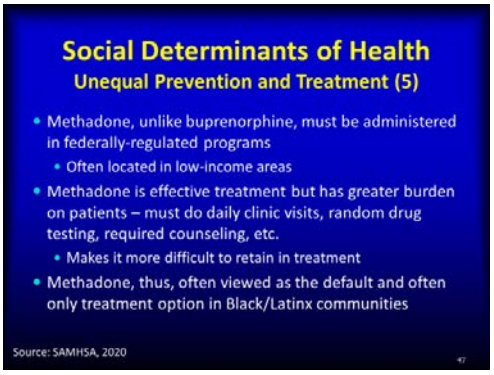
Buprenorphine is an office-based treatment, so it is easier to access instead of going to a methadone clinic. However, office-based programs only work for patients with access to primary care. Primary care is inaccessible to many low income and uninsured individuals. While it is difficult in general to get physicians, nurse practitioners, and physician assistants waivered to prescribe buprenorphine, it is even harder for providers who serve publicly insured or uninsured populations. Physicians must complete an 8-hr training course and other providers must complete 24 hrs of training. In order to treat up to 100 patients with buprenorphine in the first year, a physician must be board certified in addiction medicine or addiction psychiatry or meet a number of requirements to be considered a "qualified practice setting". After one year at the 100-patient limit, a provider can apply to treat up to 275 patients/year. (However, as of 2021, qualified prescribers can treat up to 30 patients with buprenorphine without taking the training).

(Notes for Slide 46, continued)

Slide 46: Social Determinants of Health: Unequal Prevention and Treatment (4)

REFERENCE

Hansen, H., Siegel, C., Wanderling, J., & DiRocco, D. (2016). Buprenorphine and methadone treatment for opioid dependence by income, ethnicity and race of neighborhoods in New York City. *Drug and Alcohol Dependence, 164,* 14–21. Retrieved from: https://doi.org/10.1016/j.drugalcdep.2016.03.028.



Slide 47: Social Determinants of Health: Unequal Prevention and Treatment (5)

Methadone cannot be administered in office-based settings; it must be administered in federally-regulated programs which are often located in low-income areas. Methadone is an effective treatment for OUD but places a greater burden on patients, which makes it harder to retain patients in treatment. Methadone is often viewed as the default and often only treatment option in African-American and Latinx communities.

REFERENCE

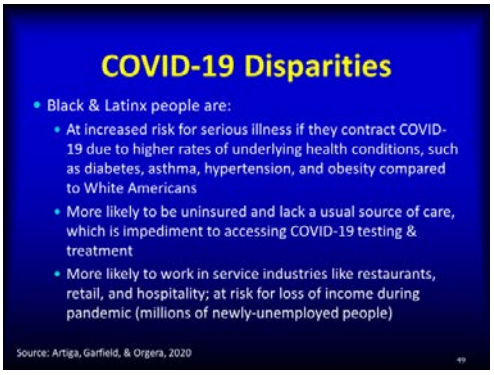
Substance Abuse and Mental Health Services Administration. (2020). *The Opioid Crisis and the Black/African-American population: An Urgent Issue*. Publication ID: PEP20-05-02-001. Retrieved from: https://store.samhsa.gov/product/The-Opioid-Crisis-and-the-Black-African-American-Population-An-Urgent-Issue/PEP20-05-02-001.

Slide 48: [TRANSITION SLIDE] Evidence of Social Determinants of Health: Disparate Impact of COVID-19

This slide serves as a transition to a section on the disparate impact of COVID-19 on communities of color.

IMAGE CREDIT

CDC Image Library, accessed at: https://www.cdc.gov/media/subtopic/images.htm.

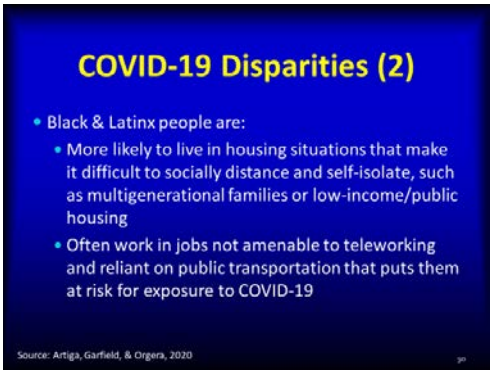


Slide 49: COVID-19 Disparities

According to a study published by the Kaiser Family Foundation, Black and Latinx people are at increased risk for severe disease if they contract COVID-19. This is due to higher rates of underlying health conditions such as diabetes and hypertension as compared to White Americans. Black and Latinx people are more likely to be uninsured and lack access to primary care. They are also more likely to work in service industries and are thus at greater risk of loss of income during the pandemic.

REFERENCE

Artiga, S., Garfield, R., & Orgera, K. (2020). *Communities of Color at Higher Risk for Health and Economic Challenges Due to COVID-19*. Oakland, CA: Kaiser Family Foundation. Retrieved from: https://www.kff.org/coronavirus-covid-19/issue-brief/communities-of-color-at-higher-risk-for-health-and-economic-challenges-due-to-covid-19/.

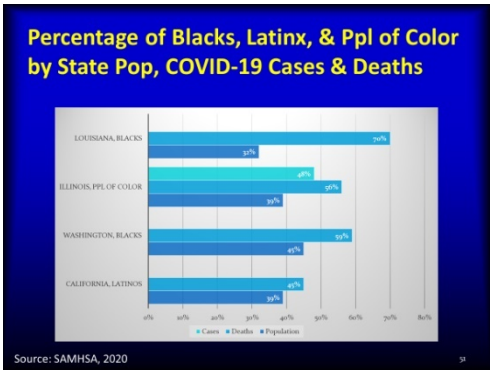


Slide 50: COVID-19 Disparities (2)

This slide continues to show information from the Kaiser Family Foundation study presented on the previous slide. Black and Latinx people are more likely to live in housing situations such as multigenerational families that make it difficult to socially distance and self-isolate. They are also more likely than White Americans to work in jobs that are not amenable to working from home and are reliant on public transportation.

REFERENCE

Artiga, S., Garfield, R., & Orgera, K. (2020). *Communities of Color at Higher Risk for Health and Economic Challenges Due to COVID-19*. Oakland, CA: Kaiser Family Foundation. Retrieved from: https://www.kff.org/coronavirus-covid-19/issue-brief/communities-of-color-at-higher-risk-for-health-and-economic-challenges-due-to-covid-19/.

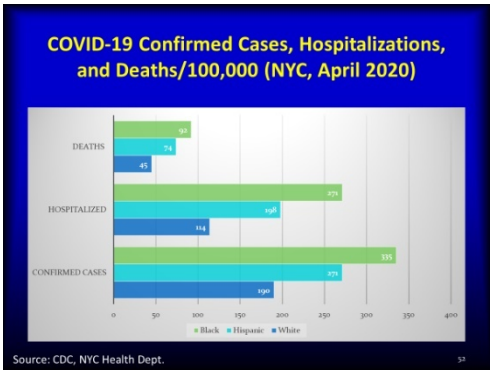


Slide 51: Percentage of Blacks, Latinx, & Ppl of Color by State Pop, COVID-19 Cases & Deaths

This graph shows that, according to SAMHSA, in 2019, African-Americans represented approximately 70% of the COVID deaths in Louisiana while only representing 32% of the population. In Illinois, people of color represented 48% of COVID cases and 56% of COVID deaths despite only representing 39% of the population. In Washington, 59% of the COVID-related deaths were among Black folks although they only represent 45% of the population, and in California, 45% of the COVID-related deaths were among the Latinx population while they represented only 39% of the population. These differences clearly illuminate the health disparities that have been magnified by the COVID pandemic.

REFERENCE

Substance Abuse and Mental Health Services Administration. (2020). *Double Jeopardy: COVID-19 and Behavioral Health Disparities for Black and Latino Communities in the U.S.* Retrieved from: https://www.samhsa.gov/sites/default/files/covid19-behavioral-health-disparities-black-latino-communities.pdf.



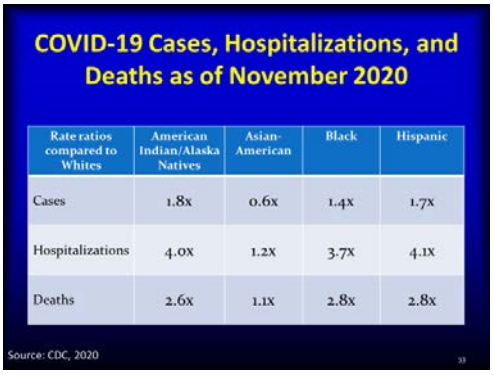
Slide 52: COVID-19 Confirmed Cases, Hospitalizations, and Deaths/100,000 (NYC, April 2020)

This graph shows that, according to the CDC and the NYC Health Department, in April of 2020, Black and Hispanic people in NYC had higher rates of COVID-19 related cases, hospitalizations, and deaths compared to White Americans.

REFERENCES

Centers for Disease Control and Prevention. [Webpage]. Retrieved from: https://www.cdc.gov/mmwr/volumes/69/wr/mm6946a2.htm.

NYC Health Department. (2020). *Age-Adjusted Rates of Lab Confirmed COVID-19*. Retrieved from: https://www1.nyc.gov/assets/doh/downloads/pdf/imm/covid-19-deaths-race-ethnicity-04162020-1.pdf.

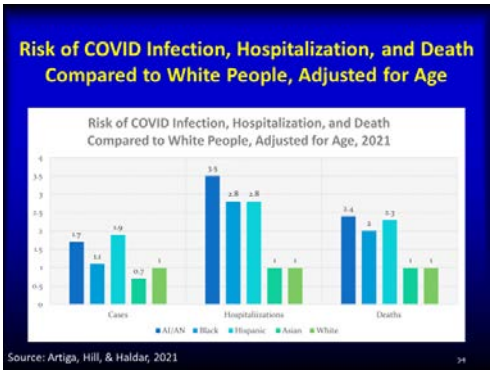


Slide 53: COVID-19 Cases, Hospitalizations, and Deaths as of November 2020

This chart shows that, according to the CDC, as of November 2020 Black, Hispanic, and American Indians/Alaska Natives had much higher rates of COVID-19 cases, hospitalizations, and deaths compared to White Americans.

REFERENCE

Centers for Disease Control and Prevention. (2020). [Webpage]. *COVID-19 Hospitalization and Death by Race/Ethnicity*. Retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html.

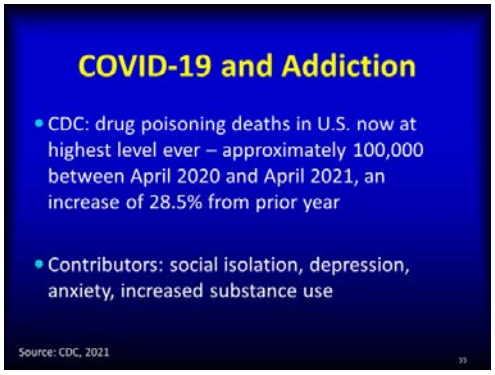


Slide 54: Risk of COVID Infection, Hospitalization, and Death Compared to White People, Adjusted for Age

After adjusting for age, American Indian and Alaska Natives, African-Americans, and Hispanic/Latino Americans have much greater risk of hospitalization and death from COVID than White people. These disparities, first identified in 2020, persisted in 2021.

REFERENCE

Artiga, S., Hill, L., & Haldar, S. (2021). [Webpage]. *COVID-19 Cases and Deaths by Race/Ethnicity: Current Data and Changes Over Time*. Retrieved from: https://www.kff.org/racial-equity-and-health-policy/issue-brief/covid-19-cases-and-deaths-by-race-ethnicity-current-data-and-changes-over-time/.

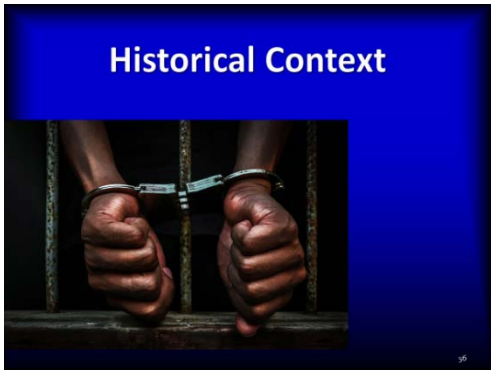


Slide 55: COVID-19 and Addiction

According to the CDC, drug overdose deaths in the U.S. are now at their highest level ever, with approximately 100,000 overdose deaths between April 2020 and April 2021. Contributing factors include social isolation, depression, anxiety, and increased substance use.

REFERENCE

Centers for Disease Control and Prevention. (2021). [Webpage]. *Drug Overdose Deaths in the U.S. Top 100,000 Annually*. Retrieved from: https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm.



Slide 56: [TRANSITION SLIDE] Historical Context

This slide serves as a transition to a section on historical context

IMAGE CREDIT

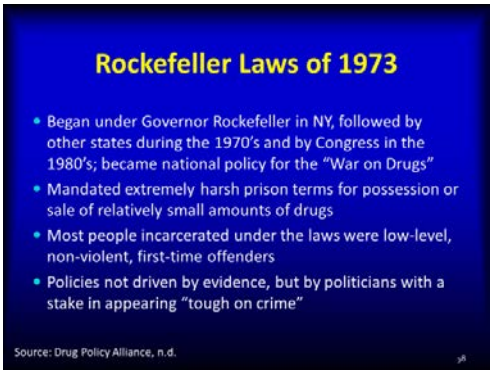
Purchased image, Adobe Stock, 2022.

Slide 57: Drug Use in the 1960's-1980's

James & Jordan discuss the opioid crisis in Black communities in their 2018 article. The article describes the heroin epidemic in the Black community in the 1960's and 1970's as being portrayed as primarily destitute Black men and women engaged in petty crimes to sustain their heroin addictions. The issue was not framed as a public health problem and little to no compassion was expressed for this population. One result of this phenomenon was passage of the Rockefeller Laws in New York in 1973.

REFERENCE

James, K., & Jordan, A. (2018). The opioid crisis in Black communities. *Journal of Law, Medicine, and Ethics, 46,* 404–421.

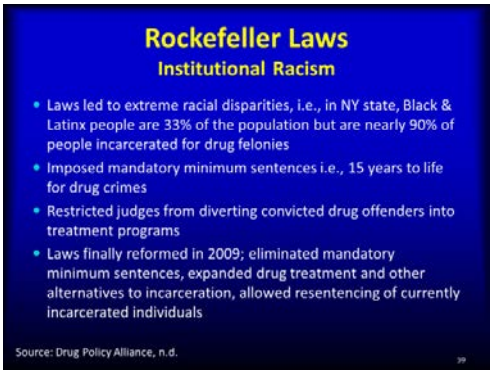


Slide 58: Rockefeller Laws of 1973

Continuing from the previous slide, according to the Drug Policy Alliance, the Rockefeller Laws were named for Governor Nelson Rockefeller in NY. They were initially enacted in New York State, then followed by other states during the decade of the 1970's and nationally by Congress in the 1980's. They eventually became the basis for the "War on Drugs". The laws mandated very harsh prison terms for possession or sale of relatively small amounts of drugs. Most individuals incarcerated under the laws were non-violent, first-time offenders. The laws were not necessarily driven by evidence, but rather by politicians invested in appearing to be tough on crime.

REFERENCE

Drug Policy Alliance. (no date given). *Background on New York's Draconian Rockefeller Drug Laws*. Retrieved from: https://www.drugpolicy.org/sites/default/files/FactSheet_NY_Background%20on%20RDL%20Reforms.pdf.

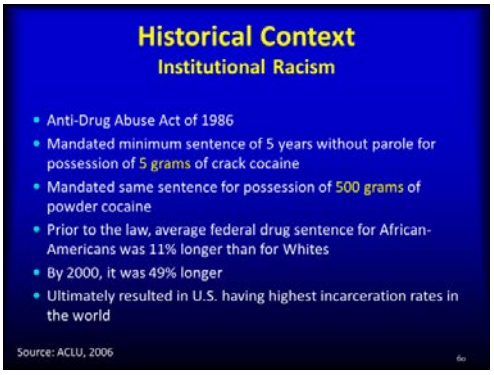


Slide 59: Rockefeller Laws: Institutional Racism

The Rockefeller Laws and the War on Drugs have led to extreme racial disparities. For instance, in New York state, Black and Latinx people represent approximately a third of the population but are nearly 90% of people incarcerated for drug felonies. The laws imposed mandatory minimum sentences such as 15 years to life in prison for drug-related crimes. They also restricted judges from diverting convicted drug offenders into treatment programs. These laws finally began to be reformed around 2009. States began eliminating mandatory minimum sentences, expanded treatment options, and allowed resentencing of currently incarcerated individuals.

REFERENCE

Drug Policy Alliance. (no date given). *Background on New York's Draconian Rockefeller Drug Laws*. Retrieved from: https://www.drugpolicy.org/sites/default/files/FactSheet_NY_Background%20on%20RDL%20Reforms.pdf.



Slide 60: Historical Context: Institutional Racism

The historical context of the harsh sentencing laws included institutional racism. For example, the Anti-Drug Abuse Act of 1986 mandated a minimum sentence of five years without the possibility of parole for possession of 5 grams of crack cocaine or 500 grams of powder cocaine. Prior to this law, the average federal drug sentence for African-Americans was 11% longer than it was for White Americans; by the year 2000, it was 49% longer. These policies ultimately resulted in the U.S. having the highest incarceration rates in the world.

REFERENCE

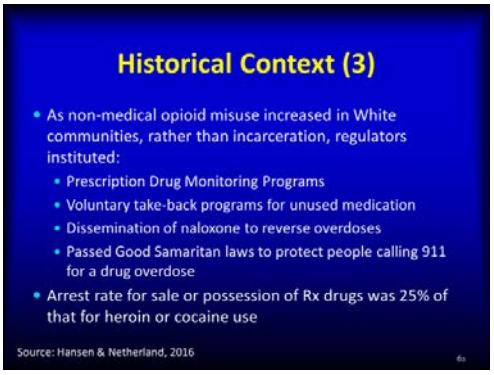
Vagins, D.J., & McCurdy, J. (2006). *Cracks in the System: Twenty Years of the Unjust Federal Crack Cocaine Law*. Washington, D.C: ACLU. Retrieved from: https://www.aclu.org/sites/default/files/pdfs/drugpolicy/cracksinsystem_20061025.pdf.

Slide 61: Historical Context (2)

Oxycontin was approved by the FDA in the 1990's as a "minimally addictive" pain reliever. In 2001, the Joint Committee on Accreditation made pain the "fifth vital sign" and encourage more assertive assessment and treatment of pain. This was partially due to the belief that pain had been undertreated. Over the next twelve years, the number of annual opioid painkiller medication prescriptions skyrocketed.

REFERENCE

Hansen, H., & Netherland, J. (2016) Is the prescription opioid epidemic a White problem? *American Journal of Public Health, 106*(12), 2127–2128.

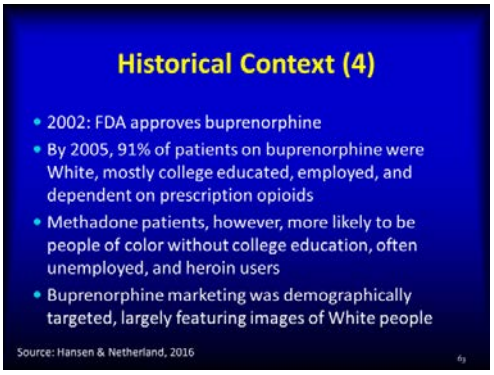


Slide 62: Historical Context (3)

As non-medical opioid use increased in White communities, regulators and policymakers instituted Prescription Drug Monitoring Programs, voluntary take-back programs for unused medications, dissemination of naloxone to reverse overdoses, and passed Good Samaritan laws to protect people calling 911 for a drug overdose from prosecution. All of these measures had the effect of reducing incarceration rates for prescription opioids; the arrest rate for sale of possession of prescription drugs was approximately 25% that of arrests for heroin or cocaine use.

REFERENCE

Hansen, H., & Netherland, J. (2016) Is the prescription opioid epidemic a White problem? *American Journal of Public Health, 106*(12), 2127–2128.

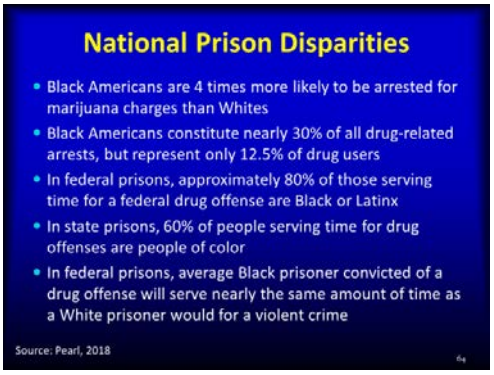


Slide 63: Historical Context (4)

In 2002, the FDA approved buprenorphine for the treatment of opioid addiction. By 2005, 91% of patients on buprenorphine were White, most were college-educated, employed, and dependent on prescription opioids rather than heroin. Methadone patients, on the other hand, were more likely to be people of color without a college education, often unemployed, and using heroin rather than prescription opioids. The marketing of buprenorphine was clearly targeted toward White Americans.

REFERENCE

Hansen, H., & Netherland, J. (2016) Is the prescription opioid epidemic a White problem? *American Journal of Public Health, 106*(12), 2127–2128.



Slide 64: National Prison Disparities

Continuing the sub-topic of incarceration rates, as of 2018 Black Americans were four times more likely to be arrested on marijuana possession/distribution charges than White Americans. Black Americans represent approximately 12.5% of drug users in the U.S. but constitute nearly 30% of all drug-related arrests. In federal prisons, approximately 80% of individuals serving time for a federal drug offense are Black or Latinx, and the average Black prisoner convicted of a drug offense will serve nearly the same amount of time as a White prisoner will for a violent crime. At the state level, approximately 60% of people serving time for drug-related offenses are people of color.

REFERENCE

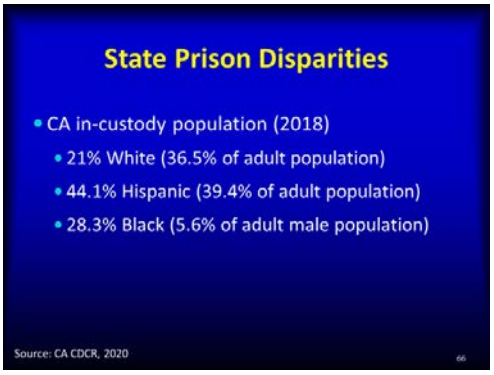
Pearl, B. (2018). [Webpage]. *Ending the War on Drugs: By the Numbers*. Retrieved from: https://www.americanprogress.org/issues/criminal-justice/reports/2018/06/27/452819/ending-war-drugs-numbers/.

Slide 65: State Prison Disparities

In California, Black and Latinx men and women continue to be over-represented in the correctional system. In 2017, approximately 28.5% of male prisoners were Black, while they represent only 5.6% of the state's adult male population. Similarly, approximately 26% of female prisoners were Black, while they represented only 5.7% of the adult female population. Approximately 60% of marijuana-related felony arrests in 2017 were Black or Latinx.

REFERENCE

Public Policy Institute of California. (2019). [Webpage]. *Just the Facts: California's Prison Population*. Retrieved from: https://www.ppic.org/publication/californias-prison-population/.



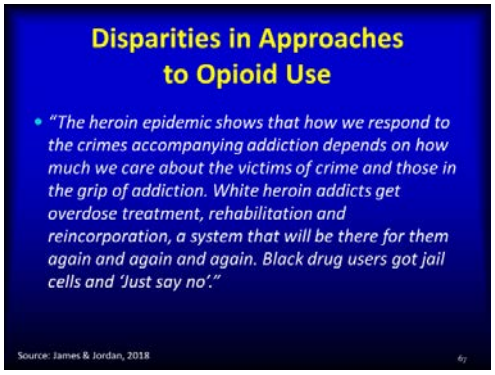
Slide 66: State Prison Disparities

According to the California Department of Corrections and Rehabilitation, in 2018 only 21% of the state prison population was White, while they represent over a third of the adult population; approximately 44% were Hispanic, while they represent approximately 39% of the adult population; and over 28% were Black, despite representing only 5.6% of the adult population of the state.

REFERENCES

California Department of Corrections & Rehabilitation, Office of Research. (2020). *Offender Data Points: Offender Demographics for the 24-Month Period Ending December 2018.* Retrieved from: https://www.cdcr.ca.gov/research/wp-content/uploads/sites/174/2020/01/201812_DataPoints.pdf.

U.S. Census Bureau. (2019). *Quick Facts California*. Retrieved from: https://www.census.gov/quickfacts/CA.

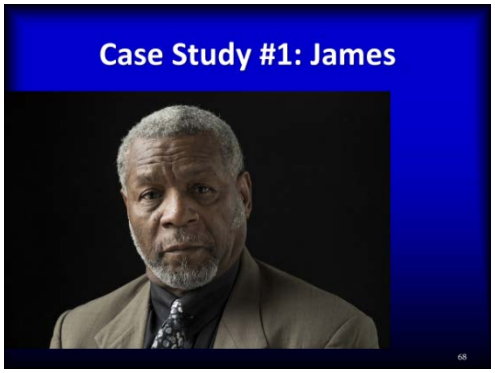


Slide 67: Disparities in Approaches to Opioid Use

This is a quote from James & Jordan's 2018 article on the opioid crisis in Black communities. It compares the treatment that White heroin users receive to the imprisonment that Black heroin users receive.

REFERENCE

James, K., & Jordan, A. (2018). The opioid crisis in Black communities. *Journal of Law, Medicine, and Ethics, 46,* 404–421.

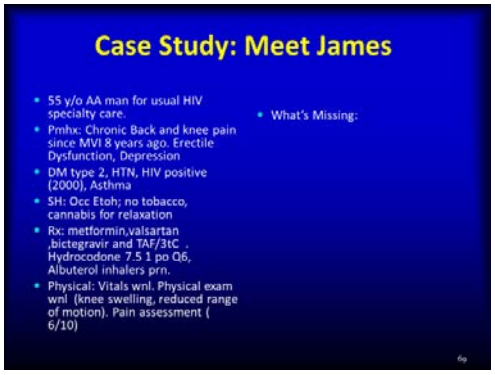


Slide 68: [TRANSITION SLIDE] Case Study: James

This slide serves as a transition into the case study to be discussed.

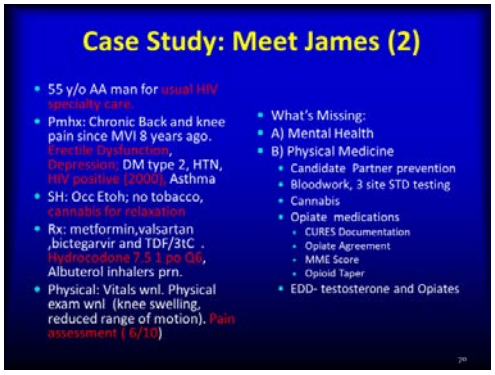
IMAGE CREDIT

Purchased image, Adobe Stock, 2022.



Slide 69: Case Study: Meet James

On this slide the first part of a multi-part vignette is presented. On some of the vignette slides the trainer will ask the audience to consider and respond to questions, and in the middle of the vignette is a breakout group activity. On this slide, first state that the picture of "James" is not an actual patient, then read the bullet points of the vignette and then pose the following question to the audience: "What are any red flags that might cause you concern as this patient's healthcare provider?" Allow 2-3 minutes for discussion.

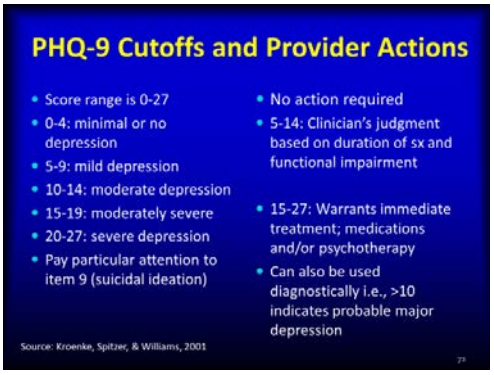


Slide 70: Case Study: Meet James (2)

This slide adds information to the previous slide and highlights some of the information in red. Ask the audience what else they might want to assess related to the red-highlighted items, i.e. "James is in 'usual' HIV specialty care – what does that mean, we would want to know his viral load and CD4 count, how long he has been in treatment with this provider, etc." Another example would be "James apparently has a diagnosis of depression. Is it current or historical? Did the provider screen for depression symptoms using the PHQ-9 or another instrument, and if so, what was the total score and what severity range was it in? Do we need to make a referral to behavioral health?" Another example is "James has a current prescription for hydrocodone. Has the provider calculated his MME score, has the provider checked the CURES database to make sure James isn't receiving hydrocodone prescriptions elsewhere, etc.?"

Slide 71: Screening for Depression and Anxiety in Primary/Specialty Care Settings

The trainer should make the point that screening for mental health conditions like depression and anxiety should take place not only in behavioral health settings; it should be integrated into primary care settings, especially when there is a suspected or diagnosed substance use disorder, because of the high rate of comorbidity of mental health and substance use disorders.



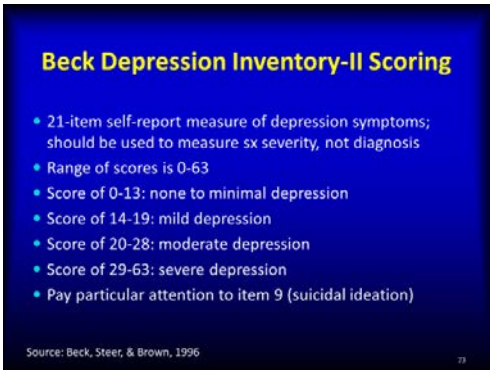
Slide 72: PHQ-9 Cutoffs and Provider Actions

This slide shows the PHQ-9 (Patient Health Questionnaire) scoring cutoffs and recommended provider actions.

Read the bullet points delineating the diagnostic ranges and the recommended clinician actions for each range. It would be helpful for the trainer to be familiar with the PHQ-9 prior to presenting this slide.

REFERENCE

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine*, *16*(9), 606–613. https://doi.org/10.1046/j.1525-1497.2001.016009606.



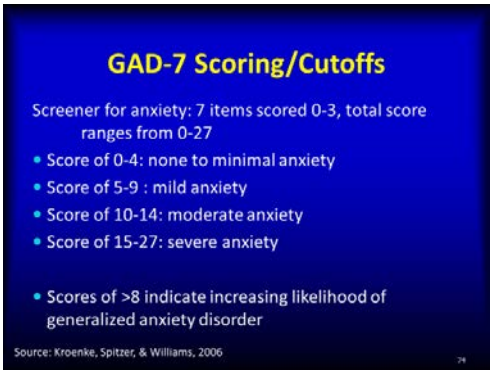
Slide 73: Beck Depression Inventory-II Scoring

This slide presents the Beck Depression Inventory-II scoring and interpretation.

Read the range of scores and concomitant severity of depressive symptoms. Emphasize that clinicians should pay particular attention to item 9, which assesses for suicidal ideation, and that total scores of 20 or higher warrant a more formal assessment for major depressive disorder by a behavioral health clinician.

REFERENCE

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for the Beck Depression Inventory-II*. San Antonio, TX: Psychological Corporation.



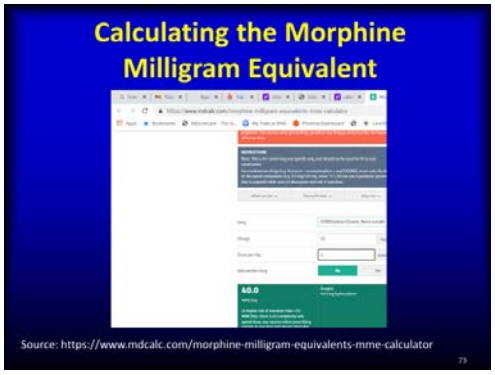
Slide 74: GAD-7 Scoring/Cutoffs

This slide shows the cutoff points and scoring for the GAD-7 anxiety screener.

Read the bullet points showing the GAD-7 scores and severity ranges. Make the point that scores greater than 8 indicate an increasing probability of generalized anxiety disorder and warrant more formal assessment for anxiety disorders by a behavioral health clinician.

REFERENCE

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. *Archives of Internal Medicine 166,* 1092–1097.



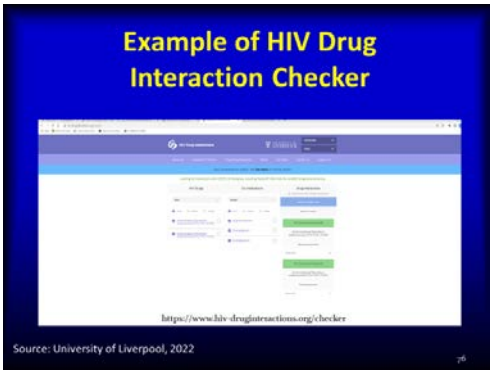
Slide 75: Calculating the Morphine Milligram Equivalent

This slide features an example of calculating the morphine milligram equivalent (MME) using an online calculator.

Explain that the purpose of the MME calculator is to obtain a standardized measure of the amount of opioid medication a patient is taking. To use the calculator, enter the name of the opioid medication the patient is taking, enter the dosage and number of daily doses. The MME will be calculated.

REFERENCE

MDcalc.com, retrieved from: https://www.mdcalc.com/morphine-milligram-equivalents-mme-calculator.



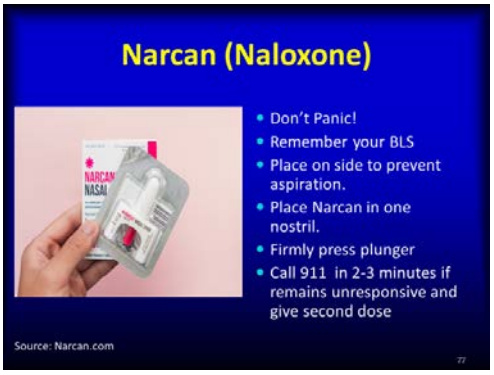
Slide 76: Example of HIV Drug Interaction Checker

This slide shows an example of the University of Liverpool Drug Interaction Checker website.

This is one example of an HIV medication interaction checker. There are others, but one of the developers of this curriculum, a physician, finds this one to be helpful and easy to use.

REFERENCE

University of Liverpool. (2022). [Webpage]. *HIV Drug Interactions*. Retrieved from: https://www.hiv-druginteractions.org/checker.



Slide 77: Narcan (Naloxone)

This slide shows a picture of Narcan (naloxone) nasal spray with instructions for its use.

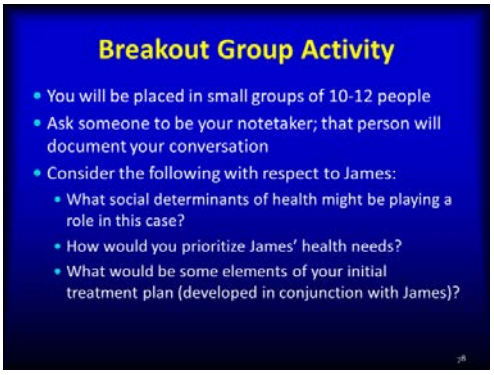
Read the bullet points on how to administer naloxone in the event of an opioid overdose. Encourage training participants to be familiar with where and how to prescribe this medication (if they are prescribers) and how to instruct patients to use it, particularly if the patient is taking a prescription opioid medication or states that they are using illicit opioids.

REFERENCE

Narcan.com. (n.d.). [Webpage]. *Narcan Nasal Spray 4mg*. Retrieved from: https://www.narcan.com/.

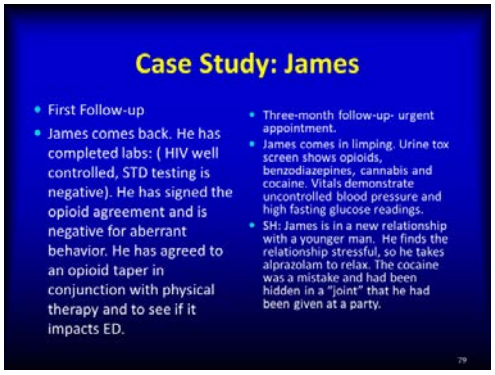
IMAGE CREDIT

Adobe Stock, purchased image, 2022.



Slide 78: Breakout Group Activity

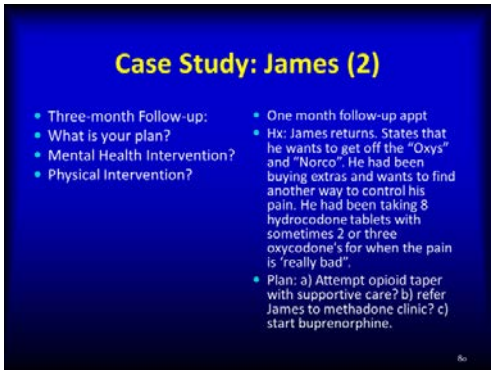
This slide provides instructions for a breakout group activity. Whether for an in-person training or a virtual training, divide the participants into small groups of approximately 6-8 people (if a small training) or 10-12 (if a larger training). If doing an in-person training, hand out the printed case vignette pdf. If doing a virtual training, the pdf handout of the case should have been emailed to participants prior to the training. Instruct participants to have the vignette and questions either printed out or open on their computer. Instruct participants to ask someone in their small group to be their notetaker/spokesperson to document their discussion of the questions. Read the bulleted questions to the participants and, if conducting the training on Zoom or another virtual platform, paste the bulleted questions into the chat before creating the breakout rooms so that participants will still be able to see them in their breakout groups. Allow approximately 10 minutes for the breakout groups to discuss the case and answer the questions, then bring the participants back together and ask for several volunteer groups to share their responses to the questions.



Slide 79: Case Study: James

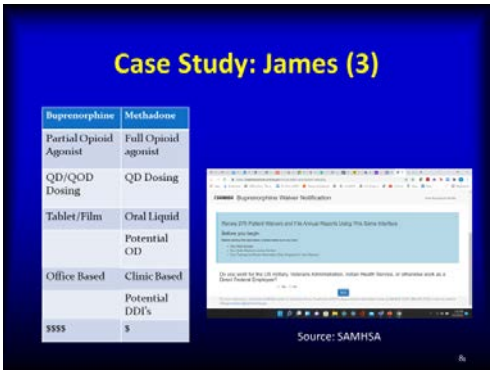
This slide presents information from follow-up visits with the James vignette.

Conduct this as a large group discussion. Read through the information on the first follow-up (left-hand column). Ask the training participants if they have any additional concerns. Read through the information on the three-month follow-up (right-hand column) and then pose the following questions to the training participants. Would you have seen James sooner than three months later? Why or why not? Urine drug screen shows use of multiple substances. When you have medications or substances not seen in prior visits, how do you handle it? Why is James limping? Is his pain not adequately controlled? Why are his blood glucose levels elevated? Where did he obtain the alprazolam? What are your thoughts about his new relationship? Should you have a discussion with James about disclosure of his HIV serostatus to sexual partners?



Slide 80: Case Study: James (2)

Continue the large group discussion from the previous slide. Pose the bulleted questions to the participants about the three-month follow-up from the previous slide. Then read the information from the next one-month follow-up visit (right hand column). Ask the participants what they think of the treatment plan options listed in the final bullet point. How would they proceed at this point?



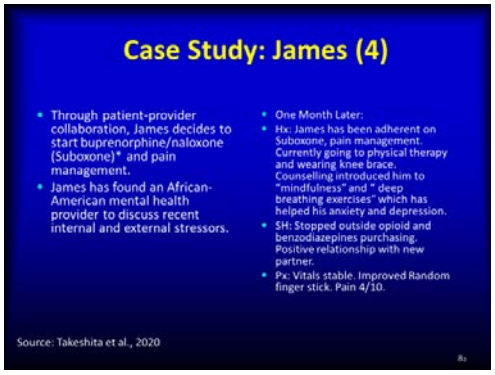
Slide 81: Case Study: James (3)

This slide compares and contrasts methadone and buprenorphine, and shows the SAMHSA Buprenorphine Waiver Notification website.

Read through the table comparing methadone and buprenorphine, pointing out the pros & cons of each. Ask the training participants whether James should be referred to a methadone clinic or possibly be prescribed buprenorphine at their office. Make the point that physicians, NP's, and PA's may now prescribe buprenorphine to up to 30 patients without obtaining the "X-Waiver."

REFERENCE

Substance Abuse and Mental Health Services Administration. (2021). [Webpage]. *Buprenorphine Waiver Notification*. Retrieved from: https://buprenorphine.samhsa.gov/forms/select-practitioner-type.php.



Slide 82: Case Study: James (4)

James comes in for one final follow-up visit one month after the last visit. Along with the bullet points, make the point that he has connected with an African-American mental health provider, and how important that is for effective, culturally competent care. Ask training participants if they have any additional thoughts/comments/questions about the case. Tell participants they can learn more about the importance of racial/ethnic concordance between patients and providers in the referenced article.

REFERENCE

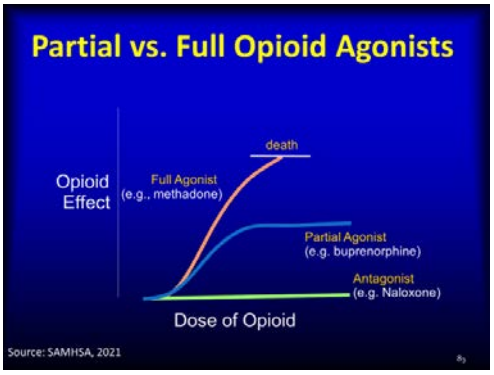
Takeshita, J., Wang, S., Loren, A. W, Mitra, N., Shults, J., Shin, D. B., & Sawinski, D. L. (2020). Association of racial/ethnic and gender concordance between patients and physicians with patient experience ratings. *JAMA Network Open, 3*(11), e2024583. doi:10.1001/jamanetworkopen.2020.24583

Slide 83: [TRANSITION SLIDE] Break

This slide indicates the point in the training where a 15-minute break should be taken (assuming you are 90 minutes or further into a three-hour training at this point).

Slide 84: [TRANSITION SLIDE] The Gold Standard for OUD: Medications for OUD (MOUD)

This is a transition slide to a section on the FDA-approved medications for the treatment of opioid use disorder (OUD).



Slide 85: Partial vs. Full Opioid Agonists

The graph on this slide depicts the differences in opioid effect between full opioid agonists such as methadone, partial agonists such as buprenorphine, and antagonists like naloxone or naltrexone. Taking too much of an opioid agonist like methadone can potentially lead to overdose and death, while partial agonists like buprenorphine have a "ceiling effect", meaning that the amount of opioid effect levels off at a certain point. Antagonists like naloxone completely block the effects of opioids by occupying the opioid receptors.

REFERENCE

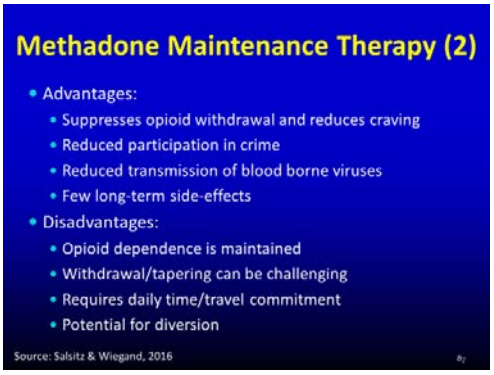
Substance Abuse and Mental Health Services Administration. (2021). *Medications for Opioid Use Disorder. Treatment Improvement Protocol (TIP).* Series 63 Publication No. PEP21-02-01-002. Rockville, MD: Author.

Slide 86: Methadone Maintenance Therapy

This slide begins to describe methadone maintenance therapy. Methadone is a full opioid agonist, so higher doses can lead to overdose and death. It is prescribed to treat severe pain and opioid use disorder. It suppresses opioid withdrawal symptoms and reduces or completely prevents opioid cravings. One of the features that makes it difficult for people to adhere to treatment is having to go to a methadone clinic every day to get their dose. There has historically been a great deal of stigma attached to methadone clinics.

REFERENCE

Mattick, R., Breen, C., Kimber, J., & Davoli, M. (2009). *Cochrane Database Systematic Reviews,* 3, rCD002209.

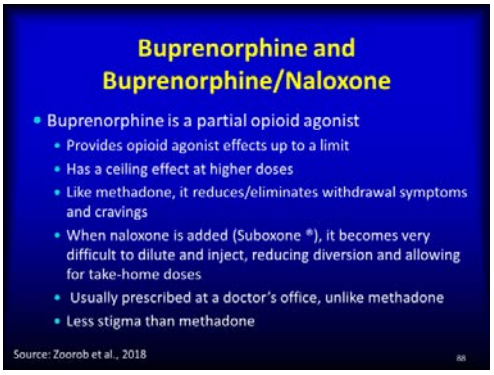


Slide 87: Methadone Maintenance (2)

This slide presents advantages and disadvantages of methadone maintenance therapy. Some of the advantages are that it suppresses opioid withdrawal symptoms and reduces cravings, thereby reducing relapses. Studies have shown that individuals on methadone maintenance are less likely to engage in criminal activity and have reduced transmission of blood-borne viruses compared to heroin users. There appear to be few long-term side effects. Some disadvantages of methadone are that dependence on an opioid is being maintained, tapering down and/or discontinuing methadone can be very difficult; it requires a daily time and travel commitment (to the clinic); and that there is the potential for diversion.

REFERENCE

Salsitz, E., & Wiegand, T. (2016). Pharmacotherapy of opioid addiction: "Putting a real face on a false demon." *Journal of Medical Toxicology, 12,* 58–63.

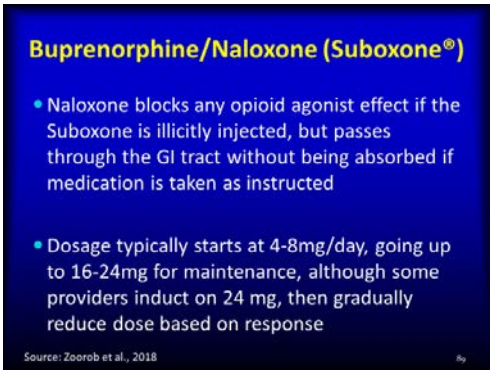


Slide 88: Buprenorphine and Buprenorphine/Naloxone

This slide explains buprenorphine treatment for opioid use disorder. Buprenorphine is a partial opioid agonist, meaning that it provides opioid effects up to a limit. It has a ceiling effect at higher doses, meaning that it is impossible to overdose on it. Similar to methadone, it reduces or eliminates withdrawal symptoms and cravings. When naloxone is added to buprenorphine (i.e., Suboxone), it becomes very difficult to dilute and inject, which reduces diversion and allows for take-home doses. Buprenorphine can be prescribed at any doctor's office (as long as the physician, NP, or PA has an FDA waiver to prescribe it, unless they are prescribing to 30 or fewer patients), which makes it easier in general to access than methadone, and there is less historical stigma around it than there is around methadone.

REFERENCE

Zoorob, R., Kowalchuk, A., & Mejia de Grubb, M. (2018). Buprenorphine therapy for opioid use disorder. *American Family Physician, 97*(5), 313–320.

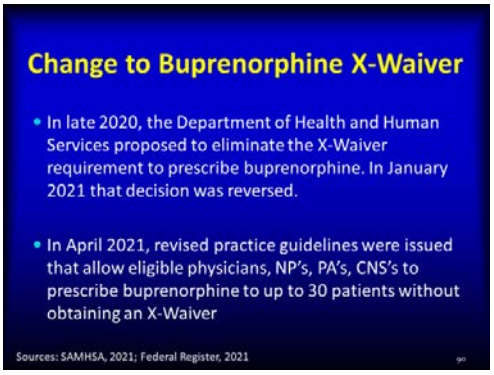


Slide 89: Buprenorphine/Naloxone (Suboxone®)

When naloxone is added to buprenorphine, the naloxone blocks the opioid agonist effect if it is illicitly injected, thereby reducing attempts to inject it. If the medication is taken as instructed, in the film or tablet forms, the naloxone passes through the GI tract without being absorbed, thus providing the desired opioid effect. Dosage may start at 4-8mg/day, escalating to 16-24mg/day for maintenance, depending on each patient's response. However, some providers choose to start patients on a 24mg dose and then gradually reduce the dose depending on the patient's response.

REFERENCE

Zoorob, R., Kowalchuk, A., & Mejia de Grubb, M. (2018). Buprenorphine therapy for opioid use disorder. *American Family Physician, 97*(5), 313–320.



Slide 90: Change to Buprenorphine X-Waiver

In order to prescribe buprenorphine for Opioid Use Disorder, physicians, nurse practitioners, physician assistants, and clinical nurse specialists are required to complete training called an X-Waiver. The required training is 8 hrs for physicians and 24 hrs for the other healthcare providers. Qualified providers can prescribe buprenorphine for up to 100 patients in the first year and can apply for an increase to 275 patients after one year. As of April 2021, eligible healthcare providers can prescribe buprenorphine to up to 30 patients *without* obtaining an X-Waiver.

REFERENCES

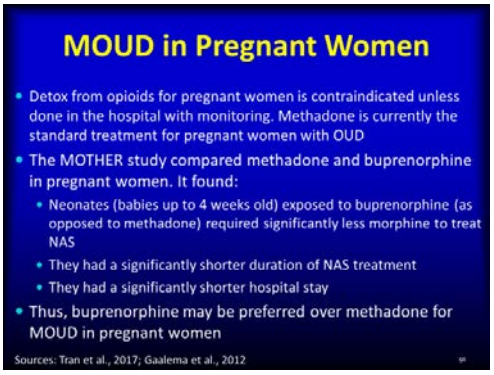
Substance Abuse and Mental Health Services Administration. (2021). [Webpage]. *Become a Buprenorphine Waivered Practitioner*. Retrieved from: https://www.samhsa.gov/medication-assisted-treatment/become-buprenorphine-waivered-practitioner.

(Notes for slide 90, continued)

Slide 90: Change to Buprenorphine X-Waiver

REFERENCES

Federal Register. (2021). [Webpage]. *Practice Guidelines for the Administration of Buprenorphine for Treating Opioid Use Disorder*. Retrieved from: https://www.federalregister.gov/documents/2021/04/28/2021-08961/practice-guidelines-for-the-administration-of-buprenorphine-for-treating-opioid-use-disorder.



Slide 91: MOUD in Pregnant Women

Detoxification from opioids is contraindicated in pregnant women unless it is done in a hospital setting with constant monitoring. Methadone is currently the standard treatment for pregnant women with opioid use disorder; however, buprenorphine can also be used. The MOTHER study compared methadone and buprenorphine treatment in pregnant women. They found that neonates exposed to buprenorphine in utero required significantly less morphine to treat neonatal abstinence syndrome. They also found that neonates of the women taking buprenorphine had a significantly shorter duration of neonatal abstinence syndrome treatment and that they required a significantly shorter hospital stay. The study provided preliminary evidence that buprenorphine may be preferred over methadone for pregnant women. Ultimately the decision is up to each woman and her doctor.

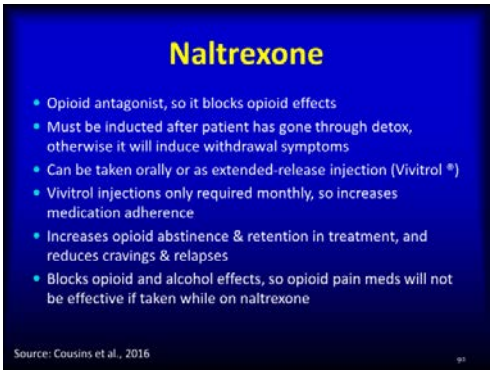
(Notes for slide 91, continued)

Slide 91: MOUD in Pregnant Women

REFERENCES

Tran, T., Griffin, B., Stone, R., Vest, K., & Todd, T. (2017). Methadone, buprenorphine, and naltrexone for the treatment of opioid use disorder in pregnant women. *Pharmacotherapy, 37*(7), 824–839.

Gaalema, D., Scott, T., Heil, S., Coyle, M., Kaltenbach, K., et al. (2012). Differences in the profile of neonatal abstinence syndrome signs in methadone- versus buprenorphine-exposed neonates. *Addiction, 107*(Suppl. 1), 53–62.

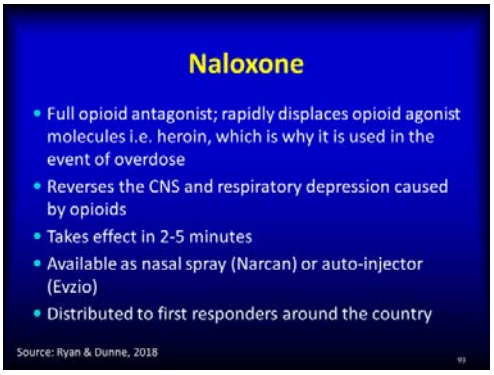


Slide 92: Naltrexone

Naltrexone is another treatment approach for opioid use disorder. It is an opioid antagonist, meaning that it blocks opioid effects. Patients must be inducted onto naltrexone after they have gone through detox; otherwise it will induce withdrawal symptoms. It can be taken orally or as an extended-release injection (i.e. Vivitrol). Vivitrol injections are only required monthly, which increases medication adherence. Naltrexone has been shown to increase opioid abstinence and retention in treatment, and to reduce cravings and relapses. Patients need to be warned that because the extended-release injection blocks all opioid and alcohol effects, opioid pain medications will not be effective while taking it.

REFERENCE

Cousins, S., Denering, L., Crevecoeur-MacPhail, D., Viernes, J., Sugita, W., Barger, J., … Rawson, R.. (2016). A demonstration project implementing extended-release naltrexone in Los Angeles County. *Substance Abuse, 37,* 54–62.



Slide 93: Naloxone

Naloxone is a full opioid antagonist and rapidly displaces opioid agonist molecules such as heroin, which is why it is used in cases of overdose. It reverses the central nervous system and respiratory depression caused by opioids. Naloxone takes effect in 2-5 minutes and is available as a nasal spray (i.e., Narcan) or as an auto-injector (i.e., Evzio). It has been distributed to first responders around the country and is generally now prescribed along with opioid painkiller medications, to be used in case of overdose.

REFERENCE

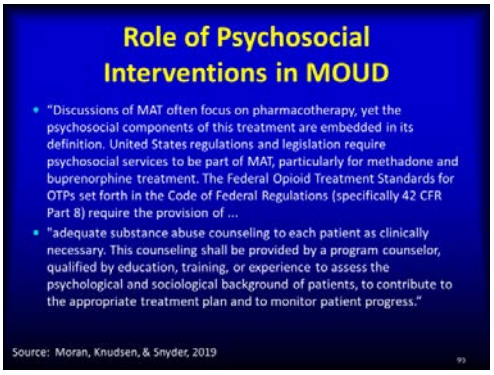
Ryan, S. & Dunne, R. (2018). Pharmacokinetic properties of intranasal and injectable formulations of naloxone for community use: A systematic review. *Pain Management, 8*(3), 231–245.

Slide 94: Naloxone/Evzio Auto-Injector

This slide contains a picture of the Evzio naloxone auto-injector, which is an alternative delivery mechanism for naloxone. As explained previously, naloxone is used to reverse opioid overdoses. The auto-injector delivers a single 2mg dose of naloxone. The auto-injector issues verbal instructions to the user, which means that no special training is needed to administer it.

IMAGE CREDIT

Kaleo Pharmaceuticals, free image.

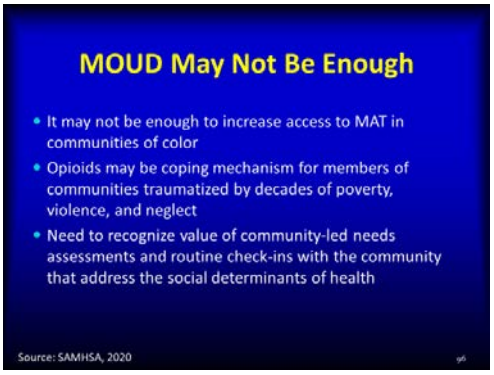


Slide 95: Role of Psychosocial Interventions in MOUD

Medication treatment for opioid use disorder is meant to include psychosocial treatment in addition to the medication. The medication is not intended to be a "cure" for OUD. The U.S. Code of Federal Regulations sets out standards for assessment and treatment of psychosocial needs of patients on MOUD.

REFERENCE

Moran, G., Knudsen, H., & Snyder, C. (2019). *Psychosocial supports in medication-assisted treatment: Site visit findings and conclusions, Appendix B. U.S. Department of Health & Human Services, Office of the Assistant Secretary for Planning and Evaluation*. Retrieved from: https://aspe.hhs.gov/basic-report/psychosocial-supports-medication-assisted-treatment-recent-evidence-and-current-practice.

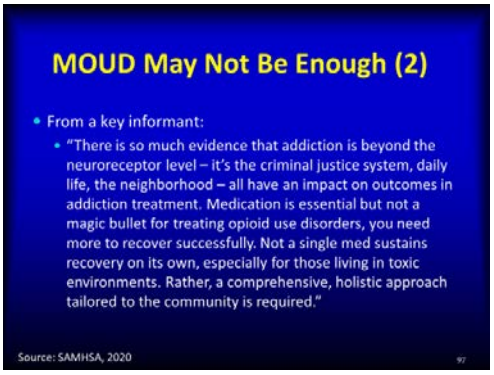


Slide 96: MOUD May Not Be Enough

According to SAMHSA, simply increasing access to MOUD in communities of color may not be enough to stem the opioid epidemic. Opioids may be a coping mechanism in communities traumatized by poverty, violence, and neglect. In order for interventions to be effective, we need to recognize the value of community-led needs assessments and routine check-ins with the community that address the social determinants of health.

REFERENCE

Substance Abuse and Mental Health Services Administration. (2020). *The Opioid Crisis and the Black/African-American population: An Urgent Issue*. Publication ID: PEP20-05-02-001. Retrieved from: https://store.samhsa.gov/product/The-Opioid-Crisis-and-the-Black-African-American-Population-An-Urgent-Issue/PEP20-05-02-001.



Slide 97: MOUD May Not Be Enough (2)

This is a quote from a key informant in the SAMHSA report on the opioid crisis in the African-American population. They make the point that medications may not be enough to treat opioid addiction; that comprehensive, holistic approaches tailored to the community are required.

REFERENCE

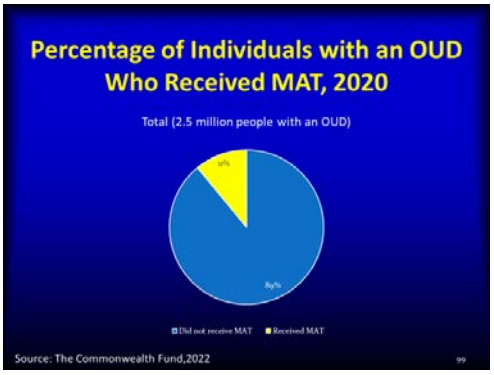
Substance Abuse and Mental Health Services Administration. (2020). *The Opioid Crisis and the Black/African-American population: An Urgent Issue*. Publication ID: PEP20-05-02-001. Retrieved from: https://store.samhsa.gov/product/The-Opioid-Crisis-and-the-Black-African-American-Population-An-Urgent-Issue/PEP20-05-02-001.

Slide 98: [TRANSITION SLIDE] Access to Care

This is a transition slide to a section on access to MOUD care issues.

IMAGE CREDIT

Adobe Stock, purchased image, 2022.



Slide 99: Percentage of Individuals with an OUD Who Received MAT, 2020

This is a chart showing that, according to the Commonwealth Fund, in 2020 of the approximately 2.5 million people with an Opioid Use Disorder in the U.S., only 11% received any type of medication-assisted treatment. This is a good place to stress that there is a disturbing lack of access to care for OUD in the U.S.

REFERENCE

Baumgartner, J. C., & Radley, D. C. (2022). [Webpage]. *Overdose Deaths Surged in the First Half of 2021, Underscoring Urgent Need for Action*. The Commonwealth Fund, Blog Feb 7, 2022. Retrieved from: https://www.commonwealthfund.org/blog/2022/overdose-deaths-surged-first-half-2021-underscoring-urgent-need-action.

Slide 100: Barriers to MAT Access in General

Barriers to MAT access in general include: insurance restrictions like prior authorization requirements for methadone or buprenorphine; many SUD treatment programs, including criminal justice settings, do not offer MAT or restrict its use (although this is changing in California, where MAT is to be made available to patients at all levels of SUD treatment); there is a dearth of buprenorphine prescribers, particularly prescribers of color; and despite a harm reduction focus at the federal level, there continues to be widespread resistance to harm reduction measures like making naloxone widely available, having syringe-service programs, and making fentanyl test strips available despite their creation in 2011. Fentanyl test strips are used to test a "batch" of drug for fentanyl, allowing the user to choose a different batch, use less of the current batch, use in the presence of other people, or make sure they have naloxone available. In 2021, the CDC and SAMHSA announced that federal funding can, for the first time, be used to purchase fentanyl test strips.

(Notes for slide 100, continued)

Slide 100: Barriers to MAT Access in General

REFERENCE

Baumgartner, J. C., & Radley, D. C. (2022). [WEbpage)]. *Overdose Deaths Surged in the First Half of 2021, Underscoring Urgent Need for Action*. The Commonwealth Fund, Blog Feb 7, 2022. Retrieved from: https://www.commonwealthfund.org/blog/2022/overdose-deaths-surged-first-half-2021-underscoring-urgent-need-action.

Slide 101: Need for Increased Access to Care

This slide begins a small section on access to care. Helena Hansen and colleagues argue that we need to reorient U.S. drug policy toward a public health approach for all Americans, not just White Americans. They state that MAT and psychosocial treatments need to be available in all communities, and that expanding access to MAT may require incentives for physicians and other healthcare providers serving low income and/or uninsured patients in settings like FQHC's to prescribe buprenorphine. They also suggest that we decriminalize personal possession of drugs and expunge arrest records, which will benefit men of color in particular. They also recommend requiring racial impact statements with any proposed public policy changes related to the opioid epidemic or the criminal justice system. Racial impact statements require legislators to evaluate if and how criminal justice reforms will affect racial disparities before voting on legislation.

(Notes for Slide 101, continued)

Slide 101: Need for Increased Access to Care

REFERENCE

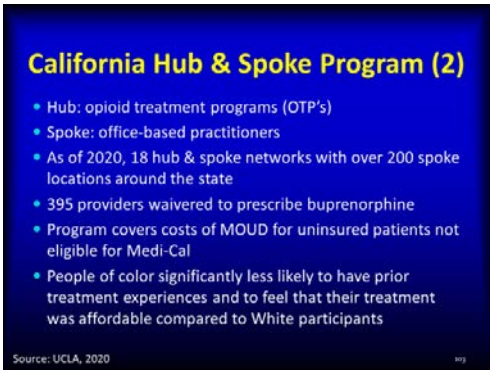
Hansen, H. & Netherland, J. (2016). Is the prescription opioid epidemic a White problem? *American Journal of Public Health, 106*(12), 2127–2128.

Slide 102: California Hub & Spoke Program

This slide and the following slide describe the California Hub and Spoke Program. The goals of the project are to implement a hub and spoke model to increase access to OUD treatment in California, to increase the availability of medications for OUD, to increase the number of healthcare providers waivered to prescribe buprenorphine, to develop prevention and recovery activities, establish learning collaboratives and provide training to hub and spoke program staff, and to improve medication access for tribal communities.

REFERENCE

Darfler, K. Santos, A., Gregorio, L., Vazquez, E., Bass, B., Joshi, V., Antonini, V., … Urada, D. (2020). *California State Targeted Response to the Opioid Crisis; Final Evaluation Report.* Los Angeles, CA: UCLA Integrated Substance Abuse Programs.

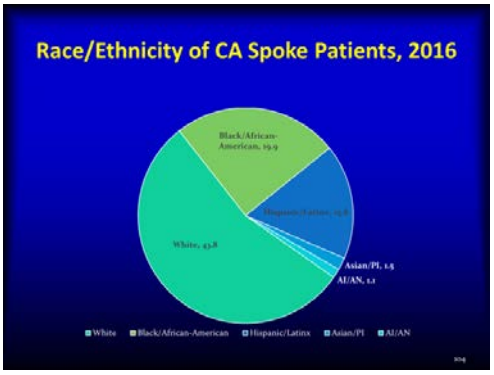


Slide 103: California Hub & Spoke Program (2)

In the California Hub and Spoke program, a hub is defined as an opioid treatment program (OTP), and a spoke is a physician's office. The idea is to connect each hub with spokes in its geographic area. As of 2019, there were 18 hub & spoke networks with over 200 spoke locations around the state, and almost 400 providers with waivers to prescribe buprenorphine. The program covers the costs of MOUD for uninsured patients who are not eligible for Medi-Cal. The 2019 evaluation report of the program noted that people of color were significantly less likely to have prior treatment experiences and to feel that their treatment was affordable compared to White participants.

REFERENCE

Darfler, K. Santos, A., Gregorio, L., Vazquez, E., Bass, B., Joshi, V., Antonini, V., … Urada, D. (2020). *California State Targeted Response to the Opioid Crisis; Final Evaluation Report.* Los Angeles, CA: UCLA Integrated Substance Abuse Programs.



Slide 104: Race/Ethnicity of CA Spoke Patients, 2016

This slide depicts the racial/ethnic breakdown of California Spoke patients (i.e., those receiving buprenorphine). Approximately 44% were White, approximately 20% were Black, and approximately 14% were Hispanic/Latinx. The point here is that spoke programs appear to have a fairly diverse mix of ethnicities that have access to buprenorphine as well as methadone.

REFERENCE

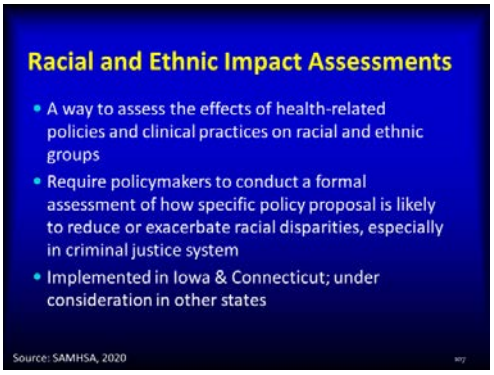
Darfler, K. Santos, A., Gregorio, L., Vazquez, E., Bass, B., Joshi, V., Antonini, V., … Urada, D. (2020). *California State Targeted Response to the Opioid Crisis; Final Evaluation Report.* Los Angeles, CA: UCLA Integrated Substance Abuse Programs.

Slide 105: Small Group Activity

This slide provides instructions for a breakout group activity. Whether for an in-person training or a virtual training, divide the participants into small groups of approximately 6-8 people (if a small training) or 10-12 (if a larger training). If doing an in-person training, leave this slide on the screen and ask participants to consider and discuss the questions on the slide. If conducting the training on Zoom, paste the questions into the chat prior to assigning the breakout rooms. Instruct the participants to ask someone to volunteer to be their notetaker/ spokesperson. That person will represent their small group when the breakout group activity is concluded and everyone returns to the main room. Allow 10-15 minutes for the activity, then bring everyone back to the main room and call on several of the breakout groups to share their responses to the questions.

Slide 106: Culturally-Tailored Interventions

State that it is vital to develop culturally-tailored interventions, and ask the participants why that might be the case. Allow a few minutes for discussion, then make the point that many "standard interventions" were evaluated and normed on White, heterosexual populations. Numerous studies have now demonstrated that having a patient see a treatment provider who shares demographic characteristics with the patient, such as race/ethnicity, yield better patient outcomes.



Slide 107: Racial and Ethnic Impact Assessments

Racial/ethnic impact statements are a way to assess the effects of health-related policies and clinical practices on racial/ethnic groups. They require policymakers to conduct a formal assessment of how a specific policy proposal is likely to reduce or exacerbate racial disparities, especially policies affecting the criminal justice system. They have been implemented in Iowa and Connecticut and are currently under consideration in other states.

REFERENCE

Substance Abuse and Mental Health Services Administration. (2020). *The Opioid Crisis and the Black/African-American population: An Urgent Issue*. Publication ID: PEP20-05-02-001. Retrieved from: https://store.samhsa.gov/product/The-Opioid-Crisis-and-the-Black-African-American-Population-An-Urgent-Issue/PEP20-05-02-001.

Slide 108: [TRANSITION SLIDE] Community-Informed Strategies to Address Opioid Use Disorder in African-American Communities

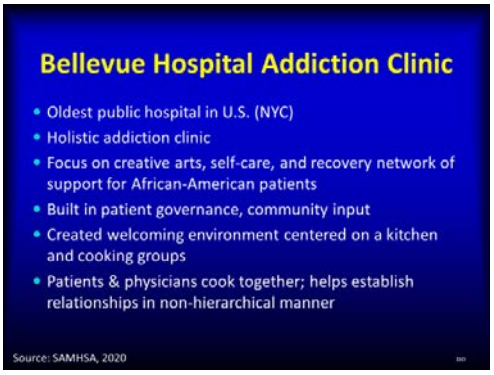
This is a transition slide to a section on culturally tailored strategies for addressing opioid use disorder in African-American communities.

Slide 109: SAMHSA/Faith-Based Community Initiatives

There is a SAMHSA task force that provides grants for faith-based community initiatives. It encourages healthcare professionals to work with faith-based organizations to deliver substance use prevention and treatment, and mental health services to underserved communities. Religious institutions have historically been very important in the Black community and are ideal vehicles to deliver culturally sensitive treatment for OUD.

REFERENCE

Substance Abuse and Mental Health Services Administration. (2020). [Webpage]. *About Faith-Based and Community Initiatives*. Retrieved from: https://www.samhsa.gov/faith-based-initiatives/about.

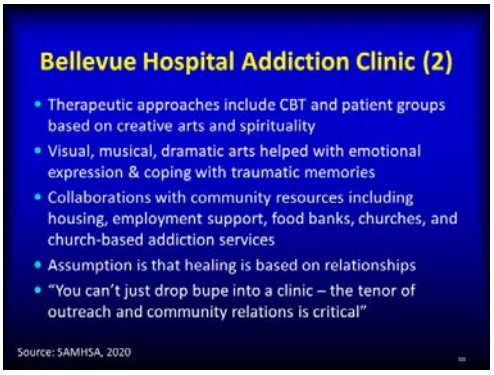


Slide 110: Bellevue Hospital Addiction Clinic

One culturally tailored program is the Bellevue Hospital Addiction Clinic. Bellevue is the oldest public hospital in the United States (in NYC). Created a holistic addiction clinic with a focus on the creative arts, self-care, and a recovery network of support for African-American patients. The clinic built in governance by the patients and community input into their programs. They created a welcoming environment centered on a kitchen and cooking groups. Patients and staff cook and eat together, which helps establish non-hierarchical relationships.

REFERENCE

Substance Abuse and Mental Health Services Administration. (2020). *The Opioid Crisis and the Black/African-American population: An Urgent Issue*. Publication ID: PEP20-05-02-001. Retrieved from: https://store.samhsa.gov/product/The-Opioid-Crisis-and-the-Black-African-American-Population-An-Urgent-Issue/PEP20-05-02-001.



Slide 111: Bellevue Hospital Addiction Clinic (2)

Therapeutic approaches at the Bellevue clinic include CBT as well as groups based on the creative arts and spirituality. Visual, musical, and dramatic arts help with emotional expression and coping with traumatic memories. They established collaborations with community resources including housing, employment, support, food banks, churches, and church-based addiction services. One of the basic assumptions is that healing is based on relationships. One participant stated "you can't just drop bupe (buprenorphine) into a clinic – the tenor of outreach and community relations is critical."

REFERENCE

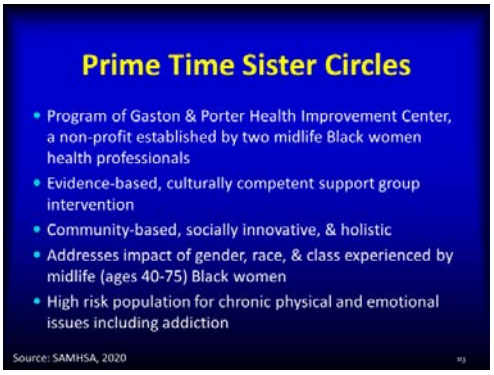
Substance Abuse and Mental Health Services Administration. (2020). *The Opioid Crisis and the Black/African-American population: An Urgent Issue*. Publication ID: PEP20-05-02-001. Retrieved from: https://store.samhsa.gov/product/The-Opioid-Crisis-and-the-Black-African-American-Population-An-Urgent-Issue/PEP20-05-02-001.

Slide 112: Employ Culturally-Specific Engagement Strategies

Work from SAMHSA indicates the importance of establishing trusting relationships. "The opposite of addiction is not abstinence, it's connection". We as healthcare providers and intervention developers need to learn from the community we're trying to serve, we need to recognize their assets, not just their deficits, and we need to acknowledge and learn from both failed and successful policies from the past.

REFERENCE

Substance Abuse and Mental Health Services Administration. (2020). *The Opioid Crisis and the Black/African-American population: An Urgent Issue*. Publication ID: PEP20-05-02-001. Retrieved from: https://store.samhsa.gov/product/The-Opioid-Crisis-and-the-Black-African-American-Population-An-Urgent-Issue/PEP20-05-02-001.

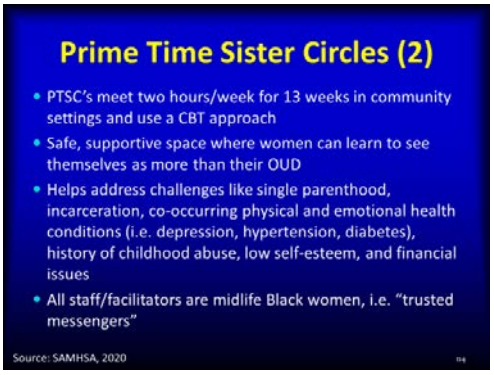


Slide 113: Prime Time Sister Circles

Prime Time Sister Circles is another example of an intervention that is culturally tailored to the Black community. It is a program of the Gaston & Porter Health Improvement Center, which is a nonprofit established by two mid-life Black women health professionals. It is an evidence-based, culturally competent support group intervention that is community-based, socially innovative, and holistic. It addresses the unique impact of gender, race, and class experienced by mid-life (age 40-75) Black women. This is a population at high risk for chronic physical health and emotional issues including opioid misuse.

REFERENCE

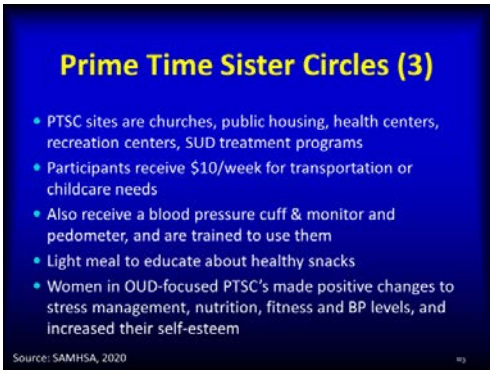
Substance Abuse and Mental Health Services Administration. (2020). *The Opioid Crisis and the Black/African-American population: An Urgent Issue*. Publication ID: PEP20-05-02-001. Retrieved from: https://store.samhsa.gov/product/The-Opioid-Crisis-and-the-Black-African-American-Population-An-Urgent-Issue/PEP20-05-02-001.



Slide 114: Prime Time Sister Circles (2)

Prime Time Sister Circle groups meet two hours per week for 13 weeks in community settings, utilizing a CBT approach. These are safe, supportive spaces where women can learn to see themselves as more than their addiction, mental health conditions, or physical health condition. The groups help to address challenges like single parenthood, incarceration, co-occurring physical and mental health conditions like depression, diabetes, or hypertension, histories of childhood abuse, low self-esteem, and financial issues. All of the staff and group facilitators are midlife Black women themselves, so the clients can see themselves reflected in the staff.

REFERENCESubstance Abuse and Mental Health Services Administration. (2020). *The Opioid Crisis and the Black/African-American population: An Urgent Issue*. Publication ID: PEP20-05-02-001. Retrieved from: https://store.samhsa.gov/product/The-Opioid-Crisis-and-the-Black-African-American-Population-An-Urgent-Issue/PEP20-05-02-001.

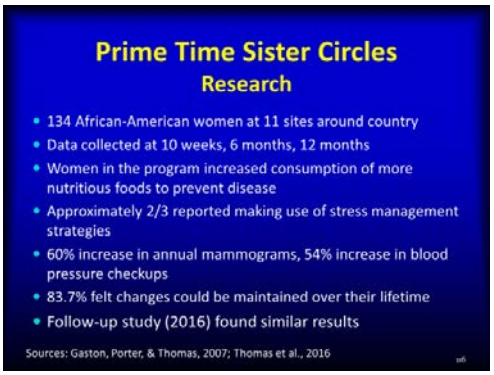


Slide 115: Prime Time Sister Circles (3)

PTSC sites include churches, public housing settings, health centers, recreation centers, and substance use disorder treatment programs. Participants receive $10 per week, if needed, for transportation or to put toward childcare. They also receive a blood pressure cuff and monitor and a pedometer, and are trained to use them correctly. A light meal is provided to help educate participants about healthy snacks. Outcomes in SUD treatment settings have included positive changes in stress management, nutrition, fitness and blood pressure levels, and increased self-esteem.

REFERENCE

Substance Abuse and Mental Health Services Administration. (2020). *The Opioid Crisis and the Black/African-American population: An Urgent Issue*. Publication ID: PEP20-05-02-001. Retrieved from: https://store.samhsa.gov/product/The-Opioid-Crisis-and-the-Black-African-American-Population-An-Urgent-Issue/PEP20-05-02-001.



Slide 116: Prime Time Sister Circles: Research

Research conducted on Prime Time Sister Circles included a study of 134 women at 11 sites around the country. Data were collected at 10 weeks, six months, and twelve months. Outcomes included: women increased consumption of healthier foods to help prevent disease, and approximately 2/3 reported making use of stress management strategies. They found an approximately 60% increase in annual mammograms, and a 54% increase in blood pressure checkups. Over three-quarters of the women felt that the changes they were making could be maintained across their lifetime. A follow-up study in 2016 found similar results.

REFERENCES

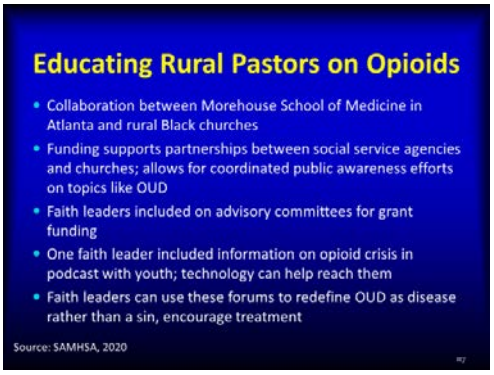
Gaston, M., Porter, G., & Thomas, V. (2007). Prime Time Sister Circles: Evaluating a gender-specific, culturally relevant health intervention to decrease major risk factors in mid-life African-American women. *Journal of the National Medical Association 99*(4), 428–438.

(Notes for Slide 116, continued)

Slide 116: Prime Time Sister Circles: Research

REFERENCES

Thomas, V., Gaston, M., Porter, G., & Anderson, A. (2016). Prime Time Sister Circles II: Evaluating a culturally relevant intervention to decreased psychological and physical risk factors for chronic disease in mid-life African-American women. *Journal of the National Medical Association 108*(1), 6–18.



Slide 117: Educating Rural Pastors on Opioids

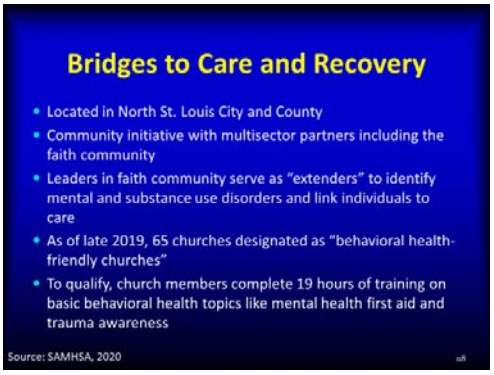
Morehouse School of Medicine has collaborated with Black churches in rural Georgia to address public health efforts including the opioid crisis. The "dual mission of the faith community to provide spiritual support as well as attend to unmet social issues and needs in the community" is the basis for the partnership. Funding has supported partnerships between social service agencies and churches, and has allowed for coordinated public awareness efforts on topics like opioid use disorder. Faith leaders are included on advisory committees that determine grant funding to provide guidance on working with the faith community. In one community, after attending a training on the opioid crisis in the community, a faith leader included the subject in a podcast with youth. Podcasts and other social media are innovative, inexpensive, easily accessible ways to discuss important but stigmatized health issues with younger generations and to redefine substance use disorders as diseases rather than sins.

(Notes for Slide 117, continued)

Slide 117: Educating Rural Pastors on Opioids

REFERENCE

Substance Abuse and Mental Health Services Administration. (2020). *The Opioid Crisis and the Black/African-American population: An Urgent Issue*. Publication ID: PEP20-05-02-001. Retrieved from: https://store.samhsa.gov/product/The-Opioid-Crisis-and-the-Black-African-American-Population-An-Urgent-Issue/PEP20-05-02-001.



Slide 118: Bridges to Care and Recovery

A program called Bridges to Care and Recovery, located in North St. Louis, a predominantly Black community, is a community initiative with partners including the faith community. Leaders among the faith community serve as healthcare extenders to identify mental health and substance use disorders and link individuals to care. As of late 2019, sixty-five churches had been designated "behavioral health-friendly churches". To qualify for this designation, church members complete nineteen hours of behavioral health training on topics like mental health first aid and trauma awareness.

REFERENCE

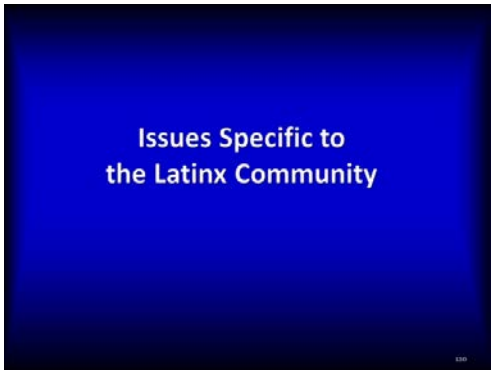
Substance Abuse and Mental Health Services Administration. (2020). *The Opioid Crisis and the Black/African-American population: An Urgent Issue*. Publication ID: PEP20-05-02-001. Retrieved from: https://store.samhsa.gov/product/The-Opioid-Crisis-and-the-Black-African-American-Population-An-Urgent-Issue/PEP20-05-02-001.

Slide 119: Bridges to Care and Recovery (2)

In the Bridges program, as part of the "behavioral health-friendly church" designation, churches hold monthly meetings and sponsor presentations on behavioral health topics. Bridges has trained 220 church leaders and volunteers as "Wellness Champions" to help reduce the stigma of mental illness. The "First Ladies Network", comprised of pastors' wives, are trained as group facilitators and peer mentors. Bridges is also working with the Missouri Opioid State Targeted Response team to facilitate "opioid crisis management training" to churches that agree to provide naloxone kits onsite, to help reverse opioid overdoses.

REFERENCE

Substance Abuse and Mental Health Services Administration. (2020). *The Opioid Crisis and the Black/African-American population: An Urgent Issue*. Publication ID: PEP20-05-02-001. Retrieved from: https://store.samhsa.gov/product/The-Opioid-Crisis-and-the-Black-African-American-Population-An-Urgent-Issue/PEP20-05-02-001.



Slide 120: [TRANSITION SLIDE] Issues Specific to the Latinx Community

This is a transition slide to a section on SUD-related issues specific to Latinx communities.

Slide 121: Misuse of Rx Pain Medications Among Latinx Individuals

According to SAMHSA, Latinx individuals have greater occupational risks for injuries than White Americans. They have a high presence in the military and are thus at greater risk for injury and need for pain medications. There is a higher proportion of Mexican-Americans in blue collar manual labor jobs than non-Hispanic Whites, also putting them at greater risk for injuries and need for pain meds. Efforts to address opioid misuse in this population need a comprehensive approach to pain management.

REFERENCE

SAMHSA (2020a). *The Opioid Crisis and the Hispanic/Latino Population: An Urgent Issue*. Publication No. PEP20-05-02-002. Office of Behavioral Health Equity. Rockville, MD: Author. Retrieved from: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-002.pdf.

Slide 122: Reasons for Misusing Prescription Pain Meds

According to SAMHSA, self-reported reasons for misusing a prescription pain reliever among the Latinx population are to relieve physical pain (53%) or to increase or decrease the effects of another drug (11%). Among Latinx youth aged 12-17, the reasons were to relieve physical pain (67%), health with unpleasant emotions (12%), or to help with sleep (8%).

REFERENCE

Substance Abuse and Mental Health Services Administration (SAMHSA). (2018). [Webpage]. *Substance Abuse and Mental Health Data Archive*. Rockville, MD: SAMHSA Center for Behavioral Health Statistics and Quality; 2019 [cited 2020 May 28]. Retrieved from: https://datafiles.samhsa.gov.

Slide 123: Familismo

The concept of "Familismo" in the Latinx community underscores the importance of family and family roles in each other's lives. It emphasizes the role of internal family dynamics, extended social networks, and the distribution of resources through those networks. Understanding this concept is crucial to prevention, treatment, and recovery from SUD in the Latinx community. Interventions that incorporate the concept of Familismo and that are based on family systems models and the involvement of family members may be more effective than traditional individual interventions.

REFERENCE

SAMHSA (2020a). *The Opioid Crisis and the Hispanic/Latino Population: An Urgent Issue*. Publication No. PEP20-05-02-002. Office of Behavioral Health Equity. Rockville, MD: Author. Retrieved from: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-002.pdf.

Slide 124: Immigration Issues in the Latinx Community

The immigration status of individuals and their family members is a chronic stressor for many Latinx individuals. The trauma associated with leaving one's native country (and potentially the trauma resulting from living conditions there) can manifest as a mental health condition and/or result in substance misuse. Migrants fleeing persecution in their country of origin have high rates of anxiety, depression, and PTSD. The constant fear of deportation for undocumented individuals is also a chronic stressor.

REFERENCE

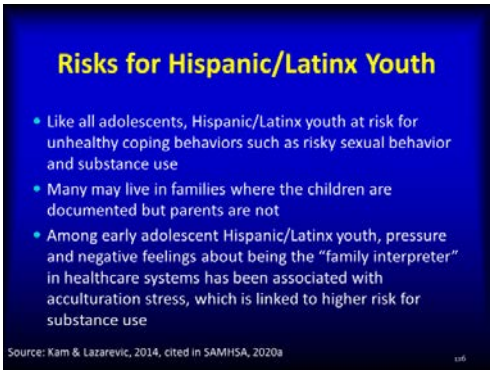
SAMHSA (2020a). *The Opioid Crisis and the Hispanic/Latino Population: An Urgent Issue*. Publication No. PEP20-05-02-002. Office of Behavioral Health Equity. Rockville, MD: Author. Retrieved from: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-002.pdf.

Slide 125: Heterogeneity of Latinx Population

There is a large amount of heterogeneity in the Hispanic/Latinx population, so combining all of them into one category is problematic. The second bullet point is a quote from a Hispanic treatment provider in the below-referenced SAMHSA publication. It makes the points that there are issues around the generation of the individual, i.e., third generation vs. recently immigrated individuals, those who are beginning to assimilate, and blended families. Many of these people don't have access to care because of language, insurance, and cultural barriers.

REFERENCE

SAMHSA (2020a). *The Opioid Crisis and the Hispanic/Latino Population: An Urgent Issue*. Publication No. PEP20-05-02-002. Office of Behavioral Health Equity. Rockville, MD: Author. Retrieved from: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-002.pdf.



Slide 126: Risks for Hispanic/Latinx Youth

Just as all adolescents are, Latinx youth are at risk for unhealthy coping behaviors such as risky sexual behavior and substance use. Many may live in families where the children are documented but the parents are not. Among early adolescent Latinx youth, the pressure and negative feelings associated with being the "family interpreter" in healthcare systems are associated with acculturation stress, which has been linked to higher risk for substance use. There is a lot of pressure on these kids.

REFERENCES

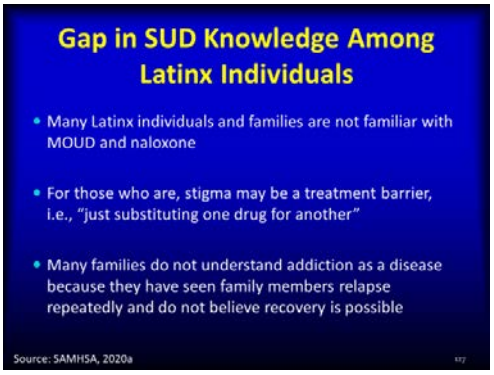
Kam J. A. & Lazarevic V. (2014). The stressful (and not so stressful) nature of language brokering: Identifying when brokering functions as a cultural stressor for Latino immigrant children in early adolescence. *Journal of Youth and Adolescence, 43*(12), 1994–2011. Retrieved from: https://doi.org/10.1007/s10964-013-0061-z.

(Notes for Slide 126, continued)

Slide 126: Risks for Hispanic/Latinx Youth

REFERENCES

SAMHSA (2020a). *The Opioid Crisis and the Hispanic/Latino Population: An Urgent Issue*. Publication No. PEP20-05-02-002. Office of Behavioral Health Equity. Rockville, MD: Author. Retrieved from: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-002.pdf.

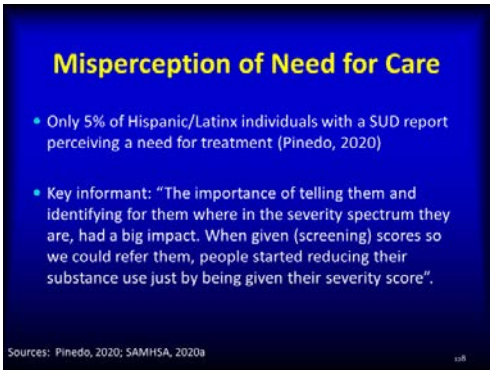


Slide 127: Gap in SUD Knowledge Among Latinx Individuals

There is a gap in knowledge about substance use disorders among Latinx individuals. Many are not familiar with medication treatment of opioid use disorder or with naloxone. For those who are familiar with them, stigma may be a treatment barrier, i.e. the belief that medication is just substituting one drug for another. Many families do not understand addiction as a disease because they have seen family members relapse repeatedly and they do not believe that recovery is possible. This leads to a type of "learned helplessness".

REFERENCE

SAMHSA (2020a). *The Opioid Crisis and the Hispanic/Latino Population: An Urgent Issue*. Publication No. PEP20-05-02-002. Office of Behavioral Health Equity. Rockville, MD: Author. Retrieved from: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-002.pdf.



Slide 128: Misperception of Need for Care

Like many in the general population, a very small percentage of Latinx individuals with a substance use disorder report perceiving a need for treatment. One key informant stated that screening individuals with a standardized screening instrument and then telling them their score and where it ranked among other people had a significant impact. When people understood their score and what it meant, many began reducing their substance use.

REFERENCES

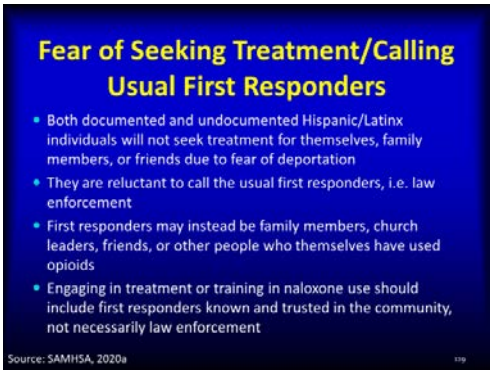
Pinedo M. (2020). Help seeking behaviors of Latinos with substance use disorders who perceive a need for treatment: Substance abuse versus mental health treatment services. *Journal of Substance Abuse Treatment,* 109, 41–45. Retrieved from: https://doi.org/10.1016/j.jsat.2019.11.006

(Notes for Slide 128, continued)

Slide 128: Misperception of Need for Care

REFERENCES

SAMHSA (2020a). *The Opioid Crisis and the Hispanic/Latino Population: An Urgent Issue*. Publication No. PEP20-05-02-002. Office of Behavioral Health Equity. Rockville, MD: Author. Retrieved from: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-002.pdf.



Slide 129: Fear of Seeking Treatment/Calling Usual First Responders

Both documented and undocumented Latinx individuals may refuse to seek treatment for themselves, family members, or friends due to fears of deportation. They are thus reluctant to call the usual first responders such as law enforcement. First responders may therefore instead be family members, church leaders, friends, or other people who have used opioids themselves. Attempts to engage these individuals in treatment or in training in the use of naloxone should include first responders who are known and trusted in the community, not necessarily law enforcement.

REFERENCE

SAMHSA (2020a). *The Opioid Crisis and the Hispanic/Latino Population: An Urgent Issue*. Publication No. PEP20-05-02-002. Office of Behavioral Health Equity. Rockville, MD: Author. Retrieved from: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-002.pdf.

Slide 130: [TRANSITION SLIDE] Community-Informed Strategies to Address Opioid Use Disorder in Latinx Communities

This slide serves as a transition to a section on community-informed strategies for addressing OUD in Latinx communities.

Slide 131: Interventions for Hispanic/Latinx Americans

According to Brenes and Henriquez, we should be utilizing culturally acceptable interventions in clinical settings. This might include some combination of non-pharmacological interventions and alternative therapies, including prayer, deep breathing techniques, meditation, herbal remedies, massage therapy, or acupressure.

REFERENCE

Brenes, F & Henriquez, F. (2020) Hispanics, Addictions, and the opioid epidemic: brief report. *Hispanic Health Care International, 18*(1), 40–43.

Slide 132: Make Treatment Holistic

SAMHSA suggests that we make treatment holistic for the Hispanic/Latinx population. A holistic approach would make use of key supports like housing, employment, and primary healthcare to promote an overall healthy lifestyle. There is a need for collaboration across service sectors to establish and maintain recovery. The approach might include a case manager for housing and employment support or resources, having a consistent primary care provider, and having a peer specialist network. An example of this type of approach is the Bellevue Hospital project mentioned earlier.

REFERENCE

SAMHSA (2020a). *The Opioid Crisis and the Hispanic/Latino Population: An Urgent Issue*. Publication No. PEP20-05-02-002. Office of Behavioral Health Equity. Rockville, MD: Author. Retrieved from: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-002.pdf.

Slide 133: Culturally-Tailored Public Awareness Campaigns in Native Languages

SAMHSA states that it is important to address prevention and treatment in campaigns like public service announcements in Spanish. One key message is that long-term recovery is possible. The 3rd bullet point is a quote from a key informant in which they suggest that we identify informal, trusted community leaders and take information to them in Spanish so that they can recognize and intervene in opioid use.

REFERENCE

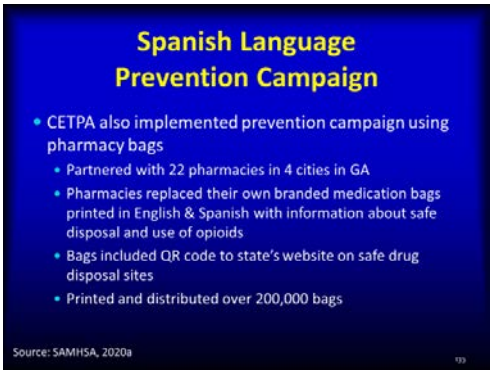
SAMHSA (2020a). *The Opioid Crisis and the Hispanic/Latino Population: An Urgent Issue*. Publication No. PEP20-05-02-002. Office of Behavioral Health Equity. Rockville, MD: Author. Retrieved from: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-002.pdf.

Slide 134: Media Campaigns in Spanish

A good example of a media campaign in Spanish is the CETPA Mental Health and Substance Abuse Services, a nonprofit agency in Georgia. They initiated a prescription drug prevention program for Hispanic communities for which they held focus groups in English and Spanish, with various age groups. They found that families with recently arrived members had the least amount of knowledge about opioids and the potential harms of misuse. Following the focus groups, they created a media campaign in Spanish to educate the population about opioid use disorder as a chronic illness as opposed to a moral failing.

REFERENCE

SAMHSA (2020a). *The Opioid Crisis and the Hispanic/Latino Population: An Urgent Issue*. Publication No. PEP20-05-02-002. Office of Behavioral Health Equity. Rockville, MD: Author. Retrieved from: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-002.pdf.



Slide 135: Spanish Language Prevention Campaign

CETPA (Clinic for Education, Treatment, and Prevention of Addiction) also implemented a prevention campaign using pharmacy bags. The agency partnered with 22 pharmacies in four cities in Georgia. The pharmacies replaced their own branded medication bags printed in English and Spanish with information about the safe use and disposal of opioids. The bags included a QR code to the state's website on safe drug disposal sites. Over the course of the project, they printed and distributed over 200,000 bags.

REFERENCE

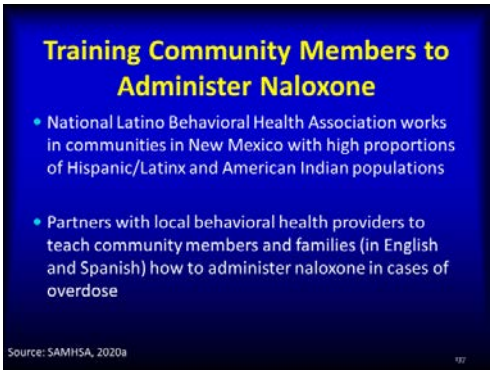
SAMHSA (2020a). *The Opioid Crisis and the Hispanic/Latino Population: An Urgent Issue*. Publication No. PEP20-05-02-002. Office of Behavioral Health Equity. Rockville, MD: Author. Retrieved from: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-002.pdf.

Slide 136: Partnering with Community-Based Organizations

Many Latinx families seek services from Hispanic-focused community-based organizations where Spanish is spoken. Behavioral health agencies have historically only been open until 4 or 5pm. Many working-class families cannot take off work to get there during business hours, which means that operating hours need to change. Ser Familia is a behavioral health CBO in Georgia that coordinates meetings between small Hispanic-serving agencies to create informal networks of CBO's. Ser Familia teaches staff at smaller CBO's to recognize opioid use, intervene, and connect individuals to treatment.

REFERENCE

SAMHSA (2020a). *The Opioid Crisis and the Hispanic/Latino Population: An Urgent Issue*. Publication No. PEP20-05-02-002. Office of Behavioral Health Equity. Rockville, MD: Author. Retrieved from: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-002.pdf.

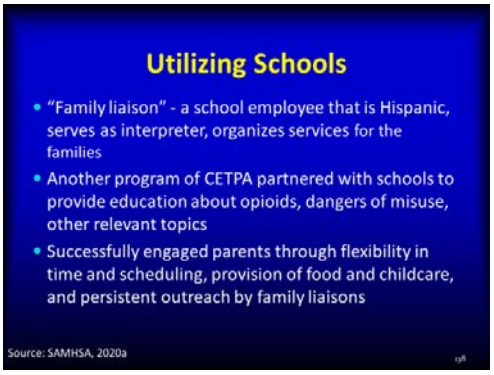


Slide 137: Training Community Members to Administer Naloxone

Another strategy in the Hispanic/Latinx community is to train community members to administer naloxone. The National Latino Behavioral Health Association works in communities in New Mexico with high proportions of Hispanic/Latinx and American Indian populations. It partners with local behavioral health providers to teach community members and families in both English and Spanish about how to administer naloxone in cases of overdose.

REFERENCE

SAMHSA (2020a). *The Opioid Crisis and the Hispanic/Latino Population: An Urgent Issue*. Publication No. PEP20-05-02-002. Office of Behavioral Health Equity. Rockville, MD: Author. Retrieved from: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-002.pdf.



Slide 138: Utilizing Schools

Another strategy is to utilize schools as a central service hub. A family liaison is a school employee that is Hispanic/Latinx and serves as an interpreter and organizes services for families. Another CETPA program partnered with schools to provide education about opioids, the dangers of misuse, and other topics relevant to the opioid crisis. They successfully engaged parents through flexibility in time and scheduling, the provision of food and childcare, and persistent outreach by the family liaisons.

REFERENCE

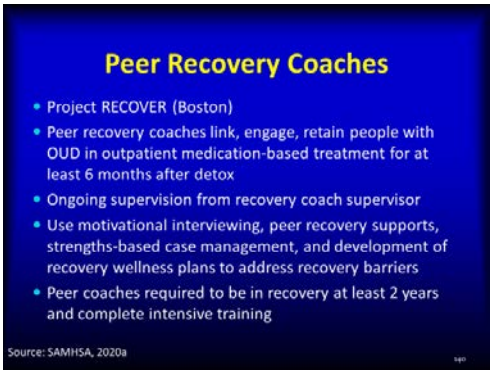
SAMHSA (2020a). *The Opioid Crisis and the Hispanic/Latino Population: An Urgent Issue*. Publication No. PEP20-05-02-002. Office of Behavioral Health Equity. Rockville, MD: Author. Retrieved from: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-002.pdf.

Slide 139: Utilizing Faith-Based Organizations

Another example of partnering with faith-based organizations is Project Hospitality in Staten Island, NY. Project Hospitality is an interfaith community-based organization. A behavioral health clinic partners with local churches to provide opioid use disorder treatment for the Hispanic/Latinx population. They contract with a physician to provide medication-assisted treatment at churches. However, they have a number of challenges: lack of funding to coordinate care between primary care and behavioral health, lack of staff to manage billing and reimbursement functions, and lack of funding for behavioral relapse prevention efforts.

REFERENCE

SAMHSA (2020a). *The Opioid Crisis and the Hispanic/Latino Population: An Urgent Issue*. Publication No. PEP20-05-02-002. Office of Behavioral Health Equity. Rockville, MD: Author. Retrieved from: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-002.pdf.



Slide 140: Peer Recovery Coaches

Project RECOVER in Boston utilizes peer recovery coaches. They link, engage, and retain people with opioid use disorders in outpatient medication-based treatment for at least six months after detox. The peer coaches are provided with ongoing supervision from a recovery coach supervisor. They utilize motivational interviewing, peer recovery supports, a strengths-based case management approach, and the development of recovery wellness plans to address barriers to recovery. To become a peer coach, an individual must be in recovery at least two years themselves and complete an intensive training process.

REFERENCE

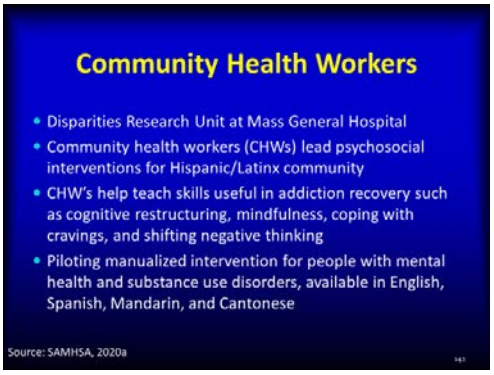
SAMHSA (2020a). *The Opioid Crisis and the Hispanic/Latino Population: An Urgent Issue*. Publication No. PEP20-05-02-002. Office of Behavioral Health Equity. Rockville, MD: Author. Retrieved from: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-002.pdf.

Slide 141: Project RECOVER

This slide contains a quote from the SAMHSA publication on the opioid crisis in the Latinx population about the peer recovery coaches in Project RECOVER. The key point is that recovery coaches can spend time and perform functions for people in recovery that professionals cannot.

REFERENCE

SAMHSA (2020a). The Opioid Crisis and the Hispanic/Latino Population: An Urgent Issue. Publication No. PEP20-05-02-002. Office of Behavioral Health Equity. Rockville, MD: Author. Retrieved from: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-002.pdf.



Slide 142: Community Health Workers

Massachusetts General Hospital has a Disparities Research Unit that utilizes community health workers. The unit is targeted to the Latinx community and the community health workers lead psychosocial interventions. The community health workers use techniques such as cognitive restructuring, mindfulness, coping with cravings, and reframing negative thinking. They are piloting a manualized intervention for people with mental health and substance use disorders and making it available in English, Spanish, Mandarin, and Cantonese.

REFERENCE

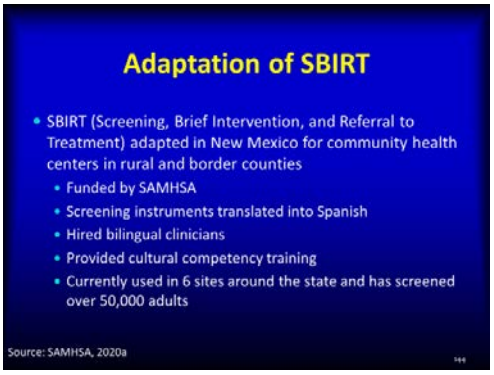
SAMHSA (2020a). *The Opioid Crisis and the Hispanic/Latino Population: An Urgent Issue*. Publication No. PEP20-05-02-002. Office of Behavioral Health Equity. Rockville, MD: Author. Retrieved from: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-002.pdf.

Slide 143: Developing Ethnicity-Specific Interventions

Another ethnicity-specific intervention is Familia Adelante, implemented by Amistades, Inc. in Tucson, Arizona. Amistades is a Latinx-staffed agency serving the Latinx community with culturally responsive services. The Familia Adelante intervention began in 2015. It is an evidence-based program offered in both English and Spanish, designed to reduce multiple risk behaviors in Latinx adolescents and their parents. Evaluations of the program have shown improved outcomes in adolescents' self-esteem, school performance, overall conduct, enhanced perception of substance misuse harms, and reductions in reported past 30 days substance use.

REFERENCE

SAMHSA (2020a). *The Opioid Crisis and the Hispanic/Latino Population: An Urgent Issue*. Publication No. PEP20-05-02-002. Office of Behavioral Health Equity. Rockville, MD: Author. Retrieved from: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-002.pdf.



Slide 144: Adaptation of SBIRT

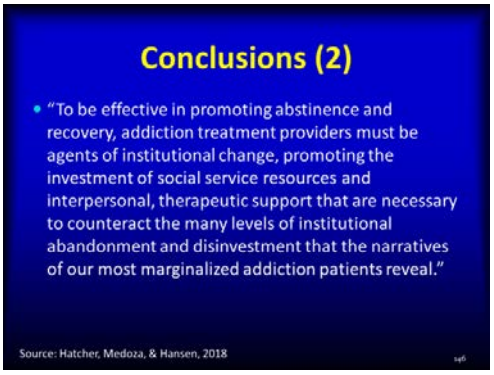
SBIRT (Screening, Brief Intervention, and Referral to Treatment), an evidence-based approach to reducing harmful substance use, has been adapted for use in community health centers in rural and border counties in New Mexico. This is a program funded by SAMHSA. The standardized screening instruments have been translated into Spanish and are administered by bilingual clinicians who have been provided cultural competency training. It is currently being implemented in six sites around the state and has screened over 50,000 adults. The goal is to reduce substance misuse in the Latinx population through the use of brief interventions and provide referrals to SUD treatment for those screening positive for a SUD.

REFERENCE

SAMHSA (2020a). *The Opioid Crisis and the Hispanic/Latino Population: An Urgent Issue*. Publication No. PEP20-05-02-002. Office of Behavioral Health Equity. Rockville, MD: Author. Retrieved from: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-002.pdf.

Slide 145: Conclusions

This slide and the next present the final conclusions of the training. Key points to make are: racial/ethnic disparities exist among people with OUD, as they do for general health issues and access to healthcare; culturally tailored interventions exist and more are under development, but much work remains to be done to reduce and eventually eliminate those disparities; and the inequities highlighted by the COVID-19 crisis may serve to accelerate the process of reform.

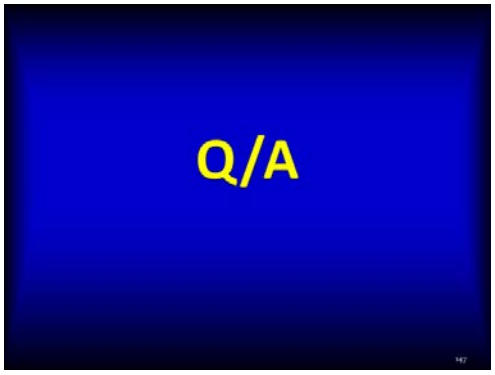


Slide 146: Conclusions (2)

This is a final quote from an article by Hatcher, Mendoza, and Hansen that provides a final summary and should be read to the training participants. Key points are that addiction treatment providers must be agents of institutional change and must promote the investment of social service resources and provide the therapeutic support necessary to counteract the institutional abandonment and disinvestment in communities of color, particularly as they relate to addiction prevention and treatment.

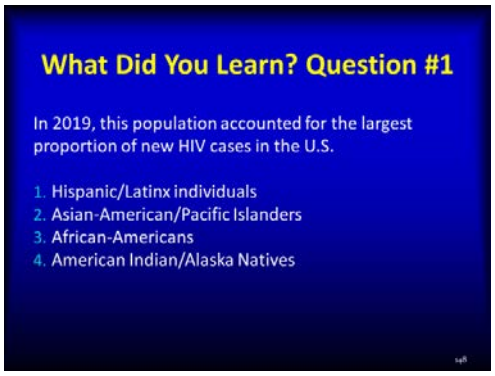
REFERENCE

Hatcher, A., Mendoza, S., & Hansen, H. (2018). At the expense of a life: Race, class, and the meaning of buprenorphine in pharmaceuticalized "care". *Substance Use & Misuse, 53*(2), 301–310.



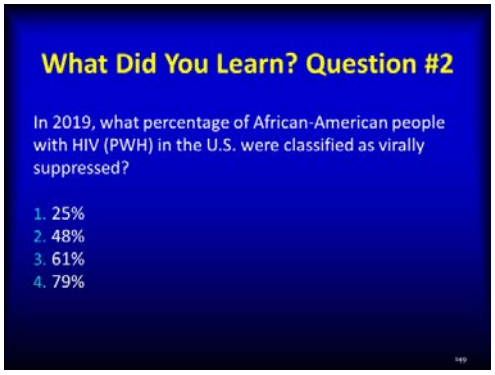
Slide 147: [TRANSITION SLIDE] Q/A

This is a transition slide to the question/answer period.



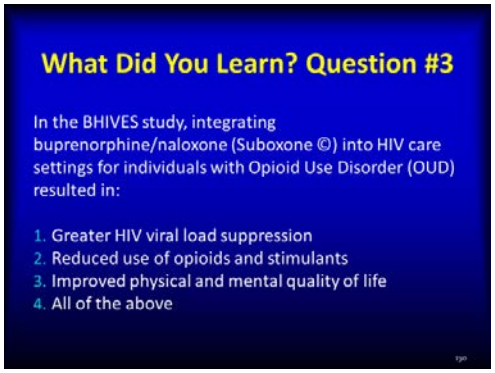
Slide 148: What Did You Learn? Question #1

This slide and the following three slides present the same four "What Did You Learn?" questions that were presented at the beginning of the training. If doing an in-person training, read the question out loud and ask participants to raise their hand for their preferred answer. If conducting a virtual training, the questions and responses can be programmed in as polls. Give participants approximately 30 seconds to respond, and then display the results and identify the correct answer (3).



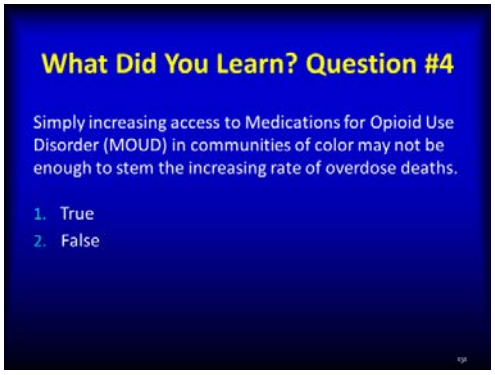
Slide 149: What Did You Learn? Question #2

If doing an in-person training, read the question out loud and ask participants to raise their hand for their preferred answer. If conducting a virtual training, the questions and responses can be programmed in as polls. Give participants approximately 30 seconds to respond, and then display the results and identify the correct answer (3).



Slide 150: What Did You Learn? Question #3

If doing an in-person training, read the question out loud and ask participants to raise their hand for their preferred answer. If conducting a virtual training, the questions and responses can be programmed in as polls. Give participants approximately 30 seconds to respond, and then display the results and identify the correct answer (4).



Slide 151: What Did You Learn? Question #4

If doing an in-person training, read the question out loud and ask participants to raise their hand for their preferred answer. If conducting a virtual training, the questions and responses can be programmed in as polls. Give participants approximately 30 seconds to respond, and then display the results and identify the correct answer (1)

Slide 152: Final Slide

This slide concludes the presentation. Add the trainer(s) name, contact information, and institutional affiliation. Thank the participants for their time and participation and address any last-minute questions about the content. Encourage participants to reach out to the Pacific Southwest ATTC or the LA Region PAETC should they have questions or concerns following the training.

Acknowledgements

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At the time of writing, Thomas E. Freese, Ph.D. served as the Principal Investigator and Director of the HHS Region 9, Pacific Southwest Addiction Technology Transfer Center, based at UCLA Integrated Substance Abuse Programs and Beth A. Rutkowski, MPH served as Co-Director of the HHS Region 9, Pacific Southwest Addiction Technology Transfer Center. Hal Zawacki, MPH, MSW, served as the ATTC Government Project Officer. Yngvild K. Olsen, MD, MPH, currently serves as Director of the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. The opinions expressed herein are the views of the authors and do not reflect the official position of the Pacific Southwest ATTC/SAMHSA-CSAT. No official support or endorsement of the Pacific Southwest ATTC/SAMHSA-CSAT for the opinions described in this document is intended or should be inferred.

Attachment #1
Case study for discussion in breakout groups (Slides 69-70 & 78-82)

- James is a 55 y/o African-American man being seen for usual HIV specialty care.
- Pmhx: Chronic back and knee pain since motor vehicle accident 8 years ago.
- Erectile Dysfunction, Depression; Diabetes type 2, hypertension, HIV positive since 2000, Asthma
- Substance use history: occasional use of alcohol; no tobacco; uses cannabis for "relaxation"
- Prescriptions: metformin, valsartan, bictegarvir and TDF/3tC. Also has prescription for Hydrocodone 7.5 1 po Q6 and Albuterol inhaler as needed.
- Physical: Vitals within normal limits. Physical exam within normal limits (knee swelling, reduced range of motion). Self-report pain assessment is 6/10.

What is missing from this case? What else do we need to know?

- Mental health history
- Physical medicine:
    - Did not ask if he is sexually active or in a relationship: is he a candidate for partner prevention?
    - Need bloodwork, 3-site STI testing
    - Assess frequency/quantity of cannabis use
    - He is on an opioid painkiller
        - CURES documentation
        - Opiate agreement
        - What is his MME score?
        - Should we consider an opioid taper?
    - Erectile dysfunction: check testosterone and consider possible confounding variables i.e., opioids, depression, hypertension, diabetes medications.

Other questions to consider in your breakout group:

- What social determinants of health might be playing a role in this case?
- How would you prioritize James' health needs?
- What would be some elements of your initial treatment plan (developed in conjunction with James)?