REACHING THE 95% WORKGROUP

A. BETTER UNDERSTANDING THE 95% NOT SEEKING SERVICES?

BACKGROUND:
During the Provider Advisory Committee on May 10, 2022, Dr. Tsai presented to the PAC, alarming statistics released in SAMHSA's 2019 and 2020 NSDUH Reports (these were previously presented to the entire SAPC Network at the prior All Provider Meeting):

2019 Report: "Among the 18.9 million people aged 12 or older in 2019 with an SUD in the past year who did not receive treatment at a specialty facility, 95.7 percent (or 18.1 million people) did not feel that they needed treatment, 3.0 percent (or 577,000 people) felt that they needed treatment but did not make an effort to get treatment, and 1.2 percent (or 236,000 people) felt that they needed treatment and made an effort to get treatment."(www.samhsa.gov/data/report/2019-nsduh-annual-national-report)

2020 Report: "Among the 38.4 million people aged 12 or older in 2020 with an SUD in the past year who did not receive treatment at a specialty facility, 97.5 percent (or 37.5 million people) did not feel that they needed treatment, 1.9 percent (or 737,000 people) felt that they needed treatment but did not make an effort to get treatment, and 0.5 percent (or 211,000 people) felt that they needed treatment and made an effort to get treatment."(www.samhsa.gov/data/report/2020-nsduh-annual-national-report)

As a result, Dr. Tsai tasked the PAC with creating a workgroup to strategize how the current SAPC Network, may be able to address this "unreached" population. PAC Reaching the 95% Workgroup, hereto and after referred to as R95, was established and Kathy Watt, Co-Chair, encouraged PAC member participation. The PAC was presented with a preliminary framework to build from regarding serving the 95% during the prevention portion of the presentation.

Those ideas included 4 ideas to better serve the 95% (slide 8, PAC Presentation May 10, 2022):
(1) Improve understanding and access to harm reduction options;
(2) Pilot innovative prevention efforts within policy advocacy;
(3) Connect engagement efforts to connect high-risk and underserved youth;
(4) Standardize referrals from primary to secondary education.

WORKGROUP MEMBERSHIP COMPOSITION:
Membership was voluntarily and 15 of the 22 agencies represented in PAC elected to join with varying participation levels. The providers represented a variance in levels of care, treatment modalities, treatment approach viewpoints, and years of experience in the substance use disorder field. This diversity, directly contributed to some of the early struggles of the group, however later proved to be its greatest strength.

INITIAL CONVERSATIONS:
Those providers willing to participate represented a variance in levels of care, treatment modalities, treatment approach viewpoints, and years of experience in the substance use disorder field. Much of the time was spent on trying to come to an agreement of an exact definition or understanding of who the 95% actually was.
As a starting point, the group agreed to rule out who the 5% accessing services were not. Even then, there were differing views on who those "accessing services" were.

Could an individual move back and forth between 5% and 95%?
Does the 5% only makeup individuals who acknowledge their substance use disorder?
Does the 95% include individuals who know they have a problem, but don't access the system because they don't agree with current treatment approaches?

The list of questions and variable was extensive and cumbersome. The struggles in narrowing the scope of a definition, represent in essence, the wickedness of the problem. As a result, one of the first take-a-ways was the need to get a deeper understanding of who the 95% was. The workgroup agreed that in order to push forward, the 95% would represent individuals not currently accessing the SAPC network. The group agreed to disagree on the particulars or details regarding makeup of those not accessing the SAPC Network.

APPROACH:
After a few different approaches, the workgroup agreed to work via a Jamboard. Each workgroup participant submitted their idea for how to reach the 95% and Anulkah, created a virtual post-it note and placed on the board. Once the workgroup agreed that all of their ideas were represented on the screen, they decided it would be best to begin categorizing. They agreed to begin organizing the post-its into themes.

FOCUS CATEGORIES: Better Understanding the 95%, Services for the 95%, Overdose Prevention, Harm Reduction Strategies, HIV/AIDS Outreach Model. Each of the post-its were arranged to either fall under these categories or moved to the "parking lot." A sub-workgroup agreed to meet between the regular R95 meetings to organize the post-its even further.

In the end, the group created a living rough draft document that summarized each of the post-its and placed them into two distinct categories:

(A) Better Understanding the 95%
(B) Services for the 95%.

Each workgroup member was then given the task to take the rough draft and insert feedback and assign responsibility. Each member was to comment on each bullet point and determine whether it would be a SAPC provider responsibility or a SAPC responsibility. While participation on this step was scarce, some members did provide feedback. R95 met for a second to last meeting on October 10/13/22 to review all of the input and assigned responsibilities.
The group agreed to present their recommendations in a report style format with the following sections: Introduction, Body, Conclusion as well as attachments.

FINAL TAKE AWAY: The final take-away from this group was the need to dig deeper into this topic and to have future workgroups in each of the areas discussed in the report. (ie-workgroup on prevention using HIV/AIDS Outreach framework).

B. SERVICES FOR THE 95% (those not currently seeking, thinking about or dropping out of services)
   1. OVERDOSE PREVENTION STRATEGIES
      a. Primary Prevention
      b. Evidenced Based Services
      c. Harm Reduction
      d. Recovery Support

PRIMARY PREVENTION - ACTION STEPS: SAPC AND PROVIDERS

1. REQUIRED EDUCATION/TRAINING ALL PROVIDERS – OVERDOSE PREVENTION MODELS
   a. Emphasis on emerging practices
   b. Require all service providers to develop overdose prevention programs
2. REQUIRED EDUCATION/TRAINING ON MEDICATION ASSISTED TREATMENT WITH STATISTCAL AND LIFE EXPERIENCE EXAMPLES OF SUCCESS
3. SURVEY OF SAPC PROVIDER WORKFORCE ON MAT PERCEPTIONS
   a. Reviewed by Provider Leadership to enable education and training of workforce
4. WIDESPREAD COMMUNITY EDUCATION ON OVERDOSE PREVENTION
   a. Schools and PTA, Pharmacies, Emergency Departments, Family Clinics, Homeless shelters, Jails and Institutions, ODR Housing, Parks and Recreation Departments, DPSS, DCFS, DMH, AA/NA fellowship halls, Veterans Programs
5. REQUIRE ALL SERVICE PROVIDERS TO DEVELOP OVERDOSE AND PREVENTION PROGRAMS
6. INCREASED COLLABORATION WITH ALL SERVICE PROVIDERS
   a. Homeless Outreach and Shelters, Schools and Education Providers including Families Medical- Hospitals, Clinics and Pharmacies, DPSS, DMH, JAILS/PRISONS, ODR Housing, Courts, DCFS, CENS, Police/ Fire Departments and Emergency Responders

EVIDENCED BASED SERVICES - ACTION STEPS: SAPC AND PROVIDERS

1. RECOGNIZE SUBSTANCE USE AS A DISEASE IN COMPARISON TO MEDICAL OR MENTAL HEALTH DIAGNOSISES
   a. UA screening – utilize only as required by legal entities, to ensure safety and not as a sole measure of success
   b. Provide introduction to services with life saving mentality and with mindset of health/mental health diagnosis and challenges – obstacles to obtaining services, harm reduction strategies, safe usage education
2. AVOID STIGMATIZING LANGUAGE USED IN SERVICE PROVISION AND RECOGNIZE EFFECTS ON PERSONS SERVED
   a. Phone and Front office etiquette – provide a welcoming atmosphere
   b. Avoid labels such as addict or alcoholic that change a person's identity
   c. Change word use of Treatment to Services

d. Change SAGE language on UA screening from Positive/Negative to “detected” or “not detected”
e. Require provider workforce education/training on stigmatizing language use
f. Educate treatment staff on new emerging forms of therapy/counseling provided to population served – Reward small successes in lifestyle change, motivation
g. Require all provider workforce be educated/trained in trauma informed care and stages of change
h. Recognize underlying factors of brain health producing lack of motivation, lack of participation- Meet the participant where they are at – Individualized Services

HARM REDUCTION - ACTION STEPS: SAPC AND PROVIDERS

1. WORKSHOPS OF SAFE USAGE – COMMUNITY OUTREACH AND EDUCATION
2. RESEARCH FUNDING SOURCES FOR OUTREACH
3. CENS LOCATIONS IN DMH, DPSS OFFICES
4. UTILIZE MODEL OF OUTREACH USED FOR HIV
5. UTILIZE CARE COORDINATION FOR ENTRY OF SERVICE PROVISION TO BULID RAPPORT
6. EXPAND .05 LOC TO ALL POPULATIONS
7. REQUIRE TRAINING FOR ALL SERVICE PROVIDERS ON HARM REDUCTION AND SAFE USEAGE
8. PROVIDE EDUCATION/TRAINING TO ALL SERVICE PROVIDER WORKFORCE ON COUNTER TRANSFERENCE

SUPPORTING RECOVERY - ACTION STEPS: SAPC AND PROVIDERS

1. UTILIZE RECOVERY SUPPORT SERVICES AS AN ENTRY POINT FOR THOSE QUESTIONING ACCESSING SERVICES - ODR Housing/ Custody Releases, Homeless shelters, Homeless Outreach, Emergency Rooms, AA/NA fellowship halls, DUI programs, Fire/Police Department response teams, Parole/Probation, School campuses, DPSS, Medical Clinics, DMH, DCFS

2. UTILIZE RECOVERY SUPPORT SERVICES FOR THOSE LEAVING SERVICES AT ANY STAGE
   a. Engage in rapport building and welfare check ins
   b. Educating clients/ families on safe use and harm reduction strategies
   c. Providing resources for support of all services that can be acquired
   d. Ongoing support to provide services when resumption of use occurs

CONCLUSION:

Reaching the 95%, those not seeking services, those questioning accessing services or those with challenges in accessing services may need several touches until rapport can be built.

Outreach models designed and previously used with an epidemic will have ease of implementation and must incorporate safe usage education and harm reduction strategies as central themes in building rapport and preventing overdose while refraining from total abstinence as the only path to services.

Revising long used negative and shame based language or labels that affect a person's sense of identity must be eliminated to reduce stigma and create a more welcoming environment for those who are questioning accessing services.

Educating provider workforce on overdose prevention, harm reduction strategies and the latest approaches in MAT and other interventions will improve first impressions of those questioning service access.

Providing widespread education to families and all community entities on the disease model of substance use to create a better understanding that substance use is an illness and not a moral failure, creating acceptance of substance users as people instead of discrimination within services, communities and families.

Identifying touch points in all services and building rapport through a variety of service points. Create a less burdensome path of accessing services, meeting the client where they are at in their current situation and assisting at any point to provide education and a means to receive any kind of help or services when they are receptive.