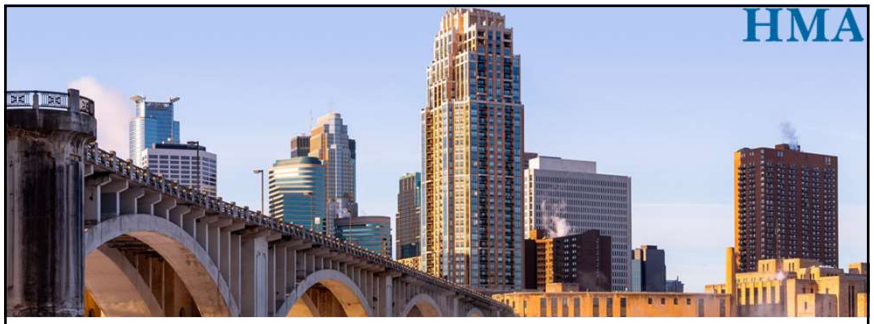


The Intersection of HIV and Substance Use:

Enhancing the Care Continuum with Evidence-Based Practices

Training Series: Day 2
May 29, 2025

HOUSEKEEPING

Today is Session 3 and 4
Please complete the evaluation for the training that will be sent out via email after each day.
You will be receiving a PDF of today's presentation.
Bio breaks at anytime. Lunch will be served between session 3 and 4.

Follow-up questions?

Contact Gabriel Velazquez:
gvelazquez@healthmanagement.com

AGENDA FOR TRAINING SERIES

Session	Topics
#1 **WEDNESDAY,** **MAY 28** 9:00 am to 12:00 pm	❑ Understanding HIV ❑ HIV Testing, Treatment and Prevention ❑ The Science of Addiction ❑ Screening and Assessment
#2 **WEDNESDAY,** **MAY 28** 12:30 pm to 4:00 pm	❑ Ethical and Legal Issues ❑ Funding and Policy Considerations ❑ HIV Risk Reduction ❑ SUD Harm Reduction ❑ HIV and Stigma ❑ Motivational Interviewing
#3 **THURSDAY,** **MAY 29** 9:00 am to 12:00 pm	❑ **Working with Legally Involved Persons** ❑ **Substance Use Disorder Treatment with Medications** ❑ **Mental Health Treatment and Counseling** ❑ **Stimulant Use** ❑ **Chem Sex**
#4 **THURSDAY,** **MAY 29** 12:30 pm to 4:00 pm	❑ **Cultural, Racial and Sexual Identities** ❑ **Pregnancy and HIV, SUD/OUD** ❑ **Accessing, Obtaining, and Integrating Services for Individuals with HIV and SUD in Minnesota**

MENTIMETER INSTRUCTIONS

1. Grab your phone

2. Go to www.menti.com

3. Enter the code **8159 4489**

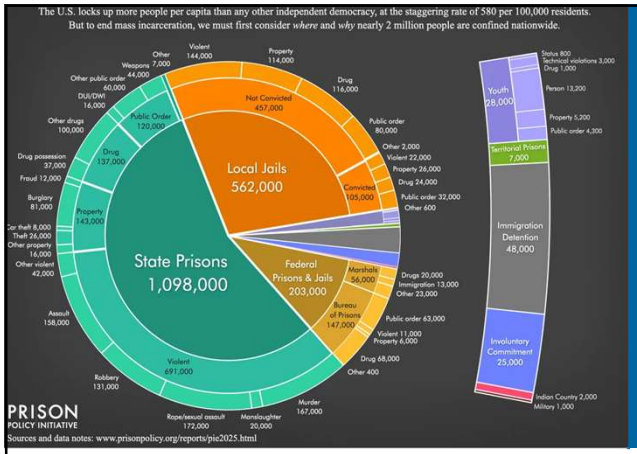
WORKING WITH LEGALLY-INVOLVED INDIVIDUALS AND MEDICATION FOR ADDICTION TREATMENT

LEARNING OBJECTIVES:

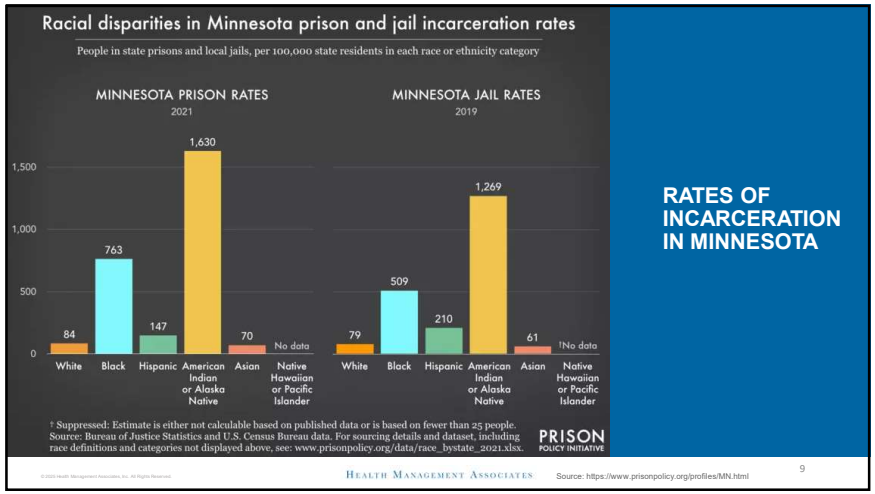
- Describe the importance of substance use disorder treatment for those who are legally involved
- List 3 actions to take to ensure continuity of care for clients upon release from incarceration
- Compare and contrast FDA approved medications for Alcohol Use Disorder (AUD), Opioid Use Disorder (OUD), and opioid reversal

WHAT IS THE DIFFERENCE?

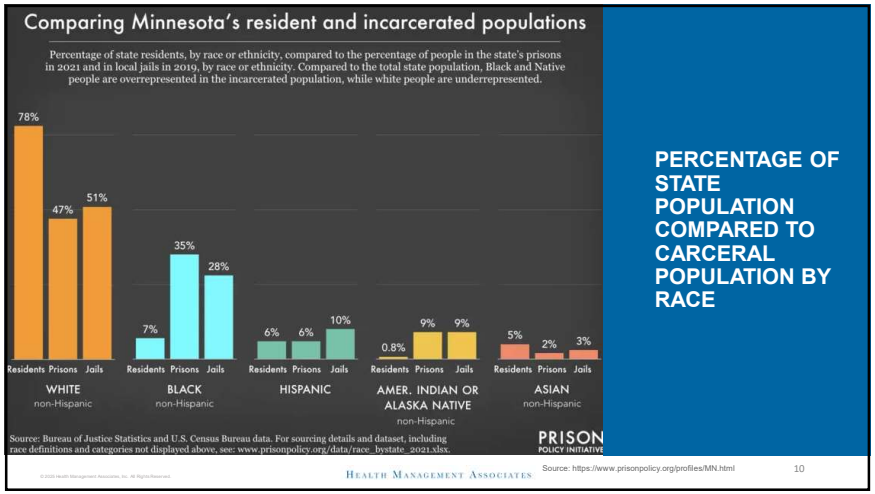
Jail	Prison
• Awaiting Trial or • Short duration of sentence • Run by County Sheriff or local government	• Convicted of a crime • Long duration of sentence • Run by state or federal governments • More education and rehabilitative programs



UNITED STATES CARCERAL POPULATION



RATES OF INCARCERATION IN MINNESOTA



PERCENTAGE OF STATE POPULATION COMPARED TO CARCERAL POPULATION BY RACE

MINNESOTA DEPARTMENT OF CORRECTIONS ADULT PRISON BY GENDER (AS OF 07/01/2024)

Total Population: 8,306

Males: 7,707 (92.8%)

Females 599 (7.2%)

Average Age 39.9

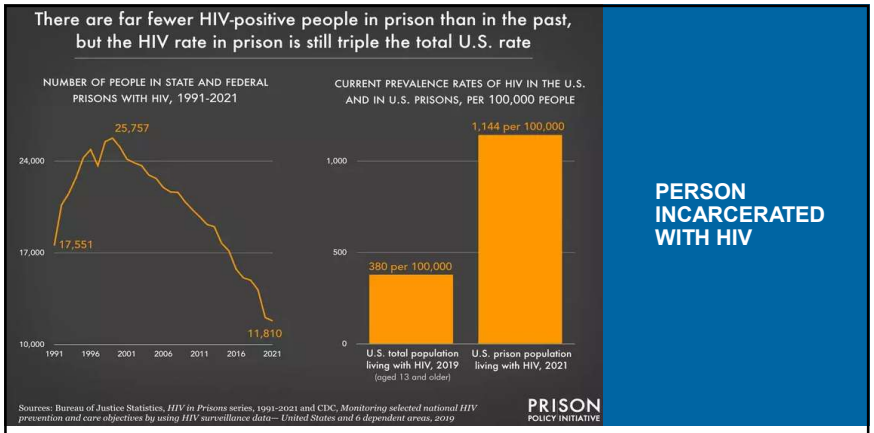
Source: https://mn.gov/doc/assets/Adult%20Prison%20Population%20Summary%207-1-2023_tcm1089-589994.pdf

Top Six Offenses	Count	Percentage (%)
Homicide	1,659	20.0%
Criminal Sexual Conduct	1,616	19.5%
Drugs	1,300	15.7%
Weapons	851	10.2%
Assault	712	8.6%
DWI	419	5.0%

Releases (FY2024)	Count	Percentage (%)
Supervised Release/Parole	3,698	78.9%
Community Programs	692	14.6%
Discharge	281	5.9%
Other	59	1.2%
Total	4,730	100.0%

MINNESOTA PRISON POPULATION 8,306 ON 7/1/2024

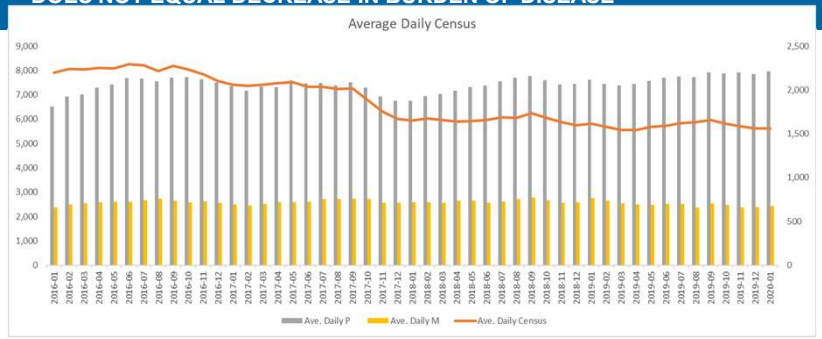
Source: Offender Statistics / Department of Corrections



PERSON INCARCERATED WITH HIV

https://www.prisonpolicy.org/blog/2023/06/01/hiv_in_prisons
Bureau of Justice Statistics, *Census of Jails*, 2019; and *Annual Survey of Jails*, 2020

DECREASE IN JAIL POPULATION DOES NOT EQUAL DECREASE IN BURDEN OF DISEASE



"Ave. Daily P"= average daily census with physical health conditions

"Ave. Daily M"= average daily census with mental health conditions.

BURDEN OF SUBSTANCE USE DISORDER (SUD) IN CARCERAL SETTINGS

- 63% of people in jail and 58% in prison have a SUD.*
- Historically jails withdrew people from medication for addiction treatment.**
- Outcomes are much better if continued on treatment.**
- 77% of deaths within 2 weeks of release are related to overdose.
- This can be decreased by 60-80% with access to medication ***

* https://www.samhsa.gov/criminal-juvenile-justice/about
**Rich 2015; **Kinlock 2007.
***Green 2018 ; Lim 2023
GUIDELINES FOR MANAGING SUBSTANCE WITHDRAWAL IN JAILS A Tool for Local Government Officials, Jail Administrators, Correctional Officers, and Health Care Professionals.
National Commission on Correctional Healthcare. (2025) Jail guidelines for the medical treatment of substance use disorders 2025.

SERVICES PROVIDED IN CARCERAL SETTINGS

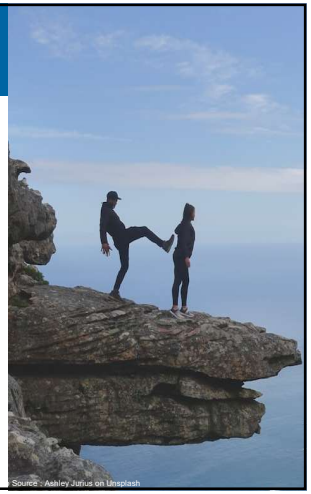
- Screening for medical, mental health, substance use disorders and dental issues
- Assessments for medical, mental health, substance use disorders and dental issues
- Acute and chronic treatment of these conditions, including
  - Overdose reversal & overdose prevention education
  - Withdrawal management
  - Medications
  - Counseling
  - Preventative care
  - Linkage to care in the community
  - Naloxone upon release

TRANSITION OF CARE

- Transition of Care – The movement of a patient from one setting of care to another.
- Actions to ensure continuity of care
  - Narcan® on release (overdose reversal agent)
  - Warm handoff to community provider
  - Medication until first community appointment
- Challenges in jails and beyond
  - No clear discharge date/time
  - Release not correlated to clinical condition
  - Housing options frequently suboptimal

Source: https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4998.pdf
https://www.ncchc.org/wp-content/uploads/2025-6/A-Guidelines-for-Substance-Use-Disorders-3-6-25.pdf

HEALTH MANAGEMENT ASSOCIATES



Source : Ashley Jurius on Unsplash

COMMUNITY OPPORTUNITIES TO MINIMIZE INCARCERATION

- Early identification of individuals with mental and substance use disorders at all points of contact with the justice system
- Diversion from the justice system to community-based treatment
- Engaging law enforcement, first responders, and crisis management teams, court personnel, and community treatment providers in diversion strategies that meet both clinical and public safety needs
- Use of validated screening and assessment tools

Source: https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4998.pdf

HEALTH MANAGEMENT ASSOCIATES

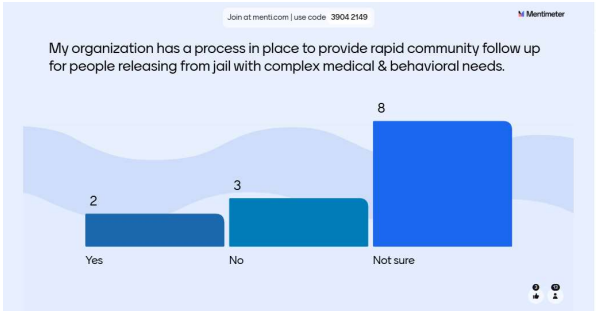
COMMUNITY OPPORTUNITIES TO MINIMIZE INCARCERATION CONT.

- Training and technical assistance for law enforcement, judges, probation officers, child welfare staff on behavioral health issues; training for behavioral health providers on criminogenic risk and the adult and juvenile legal system.
- Provide of services and supports to enable successful reentry
  - Identification
  - Insurance
  - Transportation
  - Housing
  - Education, vocational training, resume writing, interview skills and clothing
- Equitable opportunities for diversion and community services.
  - Must track data
- Collaboration to better serve those involved with behavioral health and criminal justice systems.

Source: https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4998.pdf

HEALTH MANAGEMENT ASSOCIATES

TIME FOR A POLL



INTERVENTIONS TO REDUCE HARMS RELATED TO DRUG USE AMONG PEOPLE WHO EXPERIENCE INCARCERATION

- 126 studies reviewed of 18 different interventions
  - Receiving opioid agonist treatment in first 4 weeks following release reduces risk of death in community
    - More likely to engage in treatment and take agonist treatment if it was prescribed while in prison
  - Receiving opioid agonist treatment in prison reduces risk of death in prison
  - Therapeutic communities in prison reduce rearrest

Macdonald C, Macpherson G, Leppan O, Tran LT, Cunningham EB, Hajarizadeh B, Grebely J, Farrell M, Altice FL, Degenhardt L. Interventions to reduce harms related to drug use among people who experience incarceration: systematic review and meta-analysis. Lancet Public Health. 2024 Sep;9(9):e684-e699. doi: 10.1016/S2468-2667(24)00160-9. PMID: 39214637.

COURT / PROFESSIONAL MANDATED TREATMENT

- Outcomes generally as good or better
- Important issues to consider
  - Equitable access to diversion from incarceration
  - Access to medication for addiction treatment

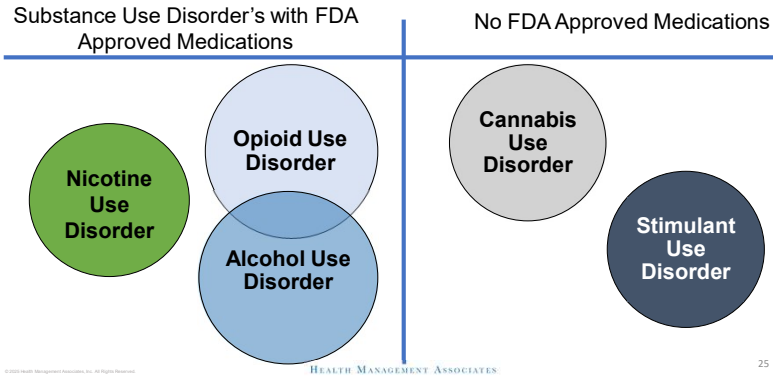
Werb D, Kamarulzaman A, Meacham MC, Rafful C, Fischer B, Strathdee SA, Wood E. The effectiveness of compulsory drug treatment: A systematic review. Int J Drug Policy. 2016 Fe
Hachtel H, Vogel T, Huber CG. Mandated Treatment and Its Impact on Therapeutic Process and Outcome Factors. Front Psychiatry. 2019 Apr 12;10:219. doi: 10.3389/fpsyt.2019.002
PMCID: PMC6474319.
Lucabeche, V. X., & Quinn, P. V. (2021). Court-Mandated Treatment Outcomes for Prescribed Opioid Use Disorder: A Gender Based Study. *Journal of Drug Issues*, *52*(1), 47-66.
https://drugpolicy.org/wp-content/uploads/2024/09/TheDrugTreatmentDebate_10.30.24-Interactive.pdf
https://opioidprinciples.jhsph.edu/what-to-know-about-mandated-treatment-programs/

SUBSTANCE USE DISORDER TREATMENT WITH MEDICATIONS

WHAT IS SUBSTANCE USE DISORDER TREATMENT WITH MEDICATIONS?

- The use of FDA-approved prescription medications, usually in combination with counseling and behavioral therapies, to provide a whole-person approach to the treatment of substance use disorders (SUD).
- When discussing medication for opioid use disorder this is frequently referred to as Medications for Opioid Use Disorder (MOUD).
- MOUD has proven clinically effective to alleviate symptoms of withdrawal & reduce cravings. MOUD maintenance has been proven to cut overdose rates in half and decrease rates of HIV and hepatitis C transmission.
- Research shows that a combination of MOUD and behavioral therapies is a successful method to treat OUD.

WHICH SUBSTANCE USE DISORDERS ARE TREATED WITH MEDICATIONS?



WHY IS MEDICATION FOR OPIOID USE DISORDER IMPORTANT?

Treat Withdrawal	Address Dopamine Depletion	Treat OUD/Achieve Results

• Muscle pain, dilated pupils, nausea, diarrhea, abdominal cramping, piloerection
• Lasts 14 days
• Methadone or buprenorphine are recommended over abrupt cessation due to risk of return to use, overdose (OD) & death
	• Reward/motivation pathway abnormalities persists for months after people stop using
	• Treated with methadone or buprenorphine
		• Without medication 85% return to opioid use within 1 year and results in more deaths than not treatment
		• MOUD decreases
		  • Use
		  • Craving
		  • Complications from IVDU
		  • Criminal behavior
		• MOUD increases retention in treatment

Sources: ASAM, (2020) National Practice Guidelines for the Treatment of OUD. Mattick, RP & Hall W (1996) Lancet 347: 8994, 97-100. Mattick, RP et al. (2008) Cochrane Systematic Review. Mattick, RP, et al. (2009) Cochrane Systematic Review. Lobmaier, P et al. (2008) Cochrane Systematic Review. Krupitsky et al. (2011) Lancet 377, 1506-13. Kakko et al. (2003) Lancet 361(9358),662-8. Rich, JD, et al. (2015) Lancet; Heimer, R (2024) Drug and Alcohol Dependence

FDA APPROVED MEDICATION FOR OUD

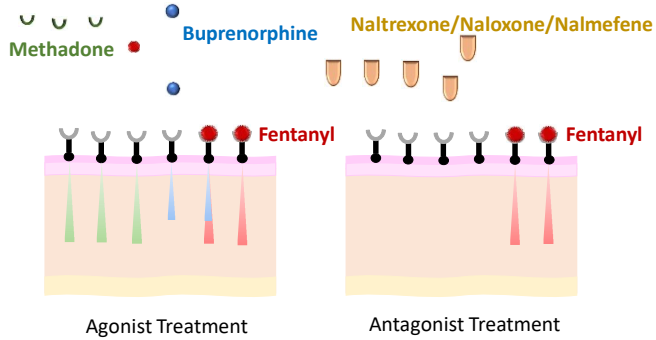
Agonist Treatment (turns on the receptor):

- Methadone- approved for cough in 1940s, for OUD 1972
- Buprenorphine (Suboxone™, Subutex™, Sublocade™ and Brixadi™)- approved in 1981 for pain; oral approved for OUD 2002, patch, implants & injection later

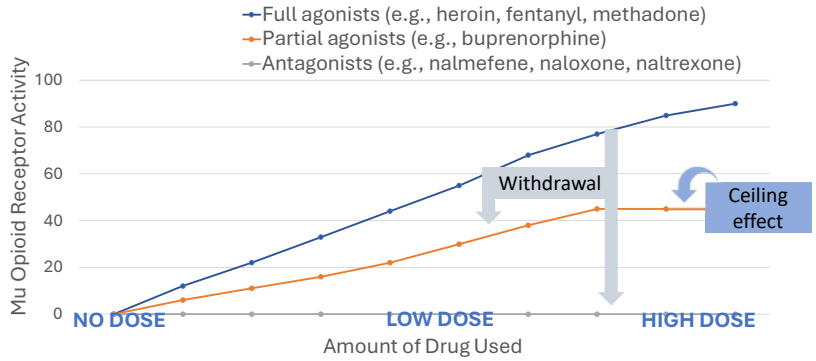
Antagonist Treatment (blocks receptor from turning on):

- Naltrexone (Revia™)- oral approved 1984; injectable (Vivitrol™) 2006 for AUD, 2010 for OUD
- Naloxone- approved 1971, autoinjector 2014, nasal spray (Narcan™) 2015
- Nalmefene (Opvee™) - injectable approved 1995; nasal spray approved 2023

HOW DO THE FDA APPROVED MEDICATIONS WORK?



FULL, PARTIAL, OR NO EFFECT



This table is an HMA-generated table compiled from numerous sources.

METHADONE: WHAT AND FOR WHOM?

- Mu opioid receptor full agonist
  - No "ceiling effect"
- Can start prior to being in withdrawal
- Reaching a therapeutic dose takes time
  - <60 mg/d is not therapeutic
  - Typical dose 60-120 mg/d
  - Increased frequency and daily dose required during pregnancy
- Several drug-drug interactions
- Illegal to write prescription for methadone to treat OUD unless:
  - Narcotic Treatment Program (NTP)
  - Covering a gap of no more than 3 days
  - Patient is in a DEA licensed clinic or hospital with another condition

Patients with a more severe OUD, such as injecting opioids

Patients who have not reached treatment goals with other MOUD

Patients who would benefit from the closest follow up at NTP

HEALTH MANAGEMENT ASSOCIATES

METHADONE: GENERAL FEDERAL REGULATIONS

Delivered via observed dosing	Once patient is stable, can be given take-home doses (varies by state)
Highly monitored in a Narcotics or Opioid Treatment Program setting (NTP/OTP)	Requirements for onsite services including therapy, toxicology…

https://www.federalregister.gov/documents/2024/02/02/2024-01693/medications-for-the-treatment-of-opioid-use-disorder

HEALTH MANAGEMENT ASSOCIATES

METHADONE: EFFICACY DATA

- Methadone resulted in 33% fewer opioid positive toxicology tests compared to those receiving no medication* when everyone receives psychosocial treatment
- 4.4x more likely to stay in treatment *
- Reduced crime *
- Reduced infectious disease*
- Reduced death**

Source:
* Mattick 2009 Cochrane Review
** Wakeman 2020 JAMA Open Network

HEALTH MANAGEMENT ASSOCIATES

BUPRENORPHINE: WHAT AND FOR WHOM?

- Partial mu opioid agonist with ceiling effect
  - Doses >32 mg don't cause greater respiratory effects
  - Available sublingually alone or in combination w/naloxone and as a long acting- weekly or monthly injections
- Greater binding affinity than full agonists
  - Start buprenorphine when client in moderate withdrawal (to avoid causing precipitated withdrawal)
  - Other opioids are not as effective when buprenorphine is present
  - Typical dose is 16-32 mg/d
  - Increased frequency and daily dose required during pregnancy
- Fewer drug-drug interactions than methadone

Opioid use disorder or withdrawal

Patient wants agonist treatment

Mattick, R. P., et al. (2014). Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. The Cochrane Database of Systematic Reviews, 2014(2), CD002207. Weimer, M. B., et al. (2023). ASAM clinical considerations: Buprenorphine treatment of opioid use disorder for individuals using high-potency synthetic opioids. Journal of Addiction Medicine, 17(6), 632–639. Bureau of Justice Assistance. (June 2022). Guidelines for managing substance withdrawal in jails. U.S. Department of Justice.

BUPRENORPHINE EFFICACY

- Rate of return to opioid use for persons taking placebo was 100% vs 25% for persons taking buprenorphine
- If taking ≥16mg buprenorphine you are 1.82 times more likely to stay in treatment than if on placebo
- Decreased crime, infectious disease and death*

Source:
NIDA Medications to Treat Opioid Use Disorder Research Report Updated December 2021
Mattick 2014 Cochrane Review
* Wakeman 2020 JAMA Open Network

NALTREXONE: WHAT AND FOR WHOM?

- Mu opioid antagonist with high, competitive binding affinity
- Does not treat withdrawal or low dopamine levels
- Must be opioid free x 14 days before starting and/or have completed withdrawal if recently using
- No evidence of decreased mortality

Patients with a high degree of motivation (dopamine)

Patients with a history of OUD and Alcohol Use Disorder (AUD): FDA approved for both

Patients who did not reach treatment goals with methadone or buprenorphine

Can be useful for occasional use or after discontinuation of methadone or buprenorphine

Source: Larochelle, et al. Medication for opioid use disorder after nonfatal opioid overdose and association with mortality. A cohort study. Annals of Internal Medicine. 169:3 (2018) 137-45. Wakeman, SE. et. al. (2020) Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder. JAMA Open Network. 3 (2).

NALTREXONE: GENERAL REGULATIONS

No Federal regulations inhibit the use

Not all BH clinics have RN to give injections

Multiple formulations:
- –Pills at 25mg and 50 mg (50-100 mg for AUD)
- –Long acting injectable 380mg (28-30 days) for AUD and OUD

NALTREXONE: EFFICACY DATA

- Extended Release (XR) Naltrexone 90% opioid abstinent toxicology tests vs. 35% placebo*
  - Decreased incarceration**
- XR Naltrexone vs usual care in HIV clinic***
  - Fewer days of opioid use for those on XR Naltrexone

Source:
*Krupitsky 2011 Lancet
**Minozzi 2011 Cochrane Review
*** Korthuis 2022

OD REVERSAL IS HARM REDUCTION

- Mu opioid antagonists: naloxone & nalmefene
- Shorter half-life & more rapid onset of action than naltrexone
- High affinity, competitive binding & displaces agonists
- Intranasal or intramuscular by bystander
- May require more than one dose
- Opioids have longer half-life than naloxone
- Saves lives; no evidence for increasing drug use
- Good Samaritan law in MN
- MN no age restriction:
  https://www.health.state.mn.us/communities/opioids/documents/naloxonestandingorder.pdf
- Available over the counter

In 2019, 77.3% of 33,084 opioid-involved overdose deaths across 37 states + the District of Columbia had no evidence of naloxone administration.

Sources: Quinn, et. al. (2022). Naloxone administration among opioid-involved overdose deaths in 38 United States jurisdictions in the State Unintentional Drug Overdose Reporting System, 2019. Drug and alcohol dependence, 235, 109467.

With additional substances within on illicit drug supply it is imperative that we remember to provide breaths/ oxygen between doses of naloxone. Sources: Dezfulian C, et al.; American Heart Association Council on Cardiopulmonary, Critical Care, Perioperative and Resuscitation; Council on Arteriosclerosis, Thrombosis and Vascular Biology; Council on Cardiovascular and Stroke Nursing; Council on Quality of Care and Outcomes Research; and Council on Clinical Cardiology. Opioid-Associated Out-of-Hospital Cardiac Arrest: Distinctive Clinical Features and Implications for Health Care and Public Responses: A Scientific Statement From the American Heart Association. Circulation. 2021 Apr 20;143(16):e836-e870. doi: 10.1161/CIR.0000000000000958. Epub 2021 Mar 8.

NALOXONE DISTRIBUTORS IN MINNESOTA

- In response to the opioid crisis in Minnesota, the Minnesota Department of Health (MDH) developed **KnowTheDangers.com** to provide clear, fact-based information, access to recovery programs, and essential harm reduction resources.
- One key resource on the site is the Naloxone Finder, which helps locate naloxone distribution sites.

NALOXONE RESOURCES

- https://www.health.state.mn.us/communities/opioids/opioid-dashboard/resources.html#naloxone
- University of Minnesota Naloxone Resources https://www.pharmacy.umn.edu/degrees-and-programs/continuing-pharmacy-education/continuing-education-courses/naloxone
- Naloxone overdose training and kits free of charge. The following community-based organizations provide Naloxone overdose training and kits free of charge:
- Steve Rummler HOPE Network—Call 952-943-3937 or sign up for training from the Steve Rummler HOPE Network.
- Rural AIDS Action Network (RAAN)—Call 320-257-3036.
- Red Door Clinic—Call 612-543-5555.
- Indigenous Peoples Task Force—Call 612-870-1723.
- Lutheran Social Services—Call 800-582-5260.
- https://knowthedangers.com/

TIME FOR A POLL

HOW LONG TO TREAT OUD?

- Studies of all FDA approved meds for OUD indicate a risk of return to opioid use upon discontinuation of meds
- **Year(s) post sobriety**, if changes to decrease likelihood of future substance use, stable in recovery and life and wants to discontinue
  - Social Support that supports recovery
    - Active in 12 step meetings or
    - Active in Self-Management and Recovery Training (SMART) meetings
    - Active in church
    - Not living with people who are using
  - Able to handle interpersonal conflicts without returning to use
  - Avoid tapering during big life transitions such as leaving incarceration, pregnancy or delivery, moving across the country, changing jobs

HOW LONG SHOULD SOMEONE BE ON MEDICATION?

Long-term or indefinite treatment with medications for OUD is often needed to maintain outcomes

Discontinuing buprenorphine or methadone is usually only successful in about 15% of cases

Discontinuing medication without return to opioid use usually occurs, if at all, when people have been treated with MOUD for at least 3 years

National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Sciences Policy; Committee on Medication-Assisted Treatment for Opioid Use Disorder, Mancher, M., & Leshner, A. I. (Eds.). (2019). Medications for opioid use disorder save lives. National Academies Press (US).

Nosyk, B., et al. (2012). Defining dosing pattern characteristics of successful tapers following methadone maintenance treatment: results from a population-based retrospective cohort study. Addiction (Abingdon, England), 107(9), 1621–1629. https://doi.org/10.1111/j.1360-0443.2012.03870.x.

Substance Abuse and Mental Health Services Agency (SAMSHA) and the Office of the Surgeon General. (2018). Facing addiction in American: The Surgeon General's spotlight on opioids. https://www.hhs.gov/sites/default/files/OC_SpotlightOnOpioids.pdf

REFERENCES: JUSTICE INVOLVED INDIVIDUALS & MOUD

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- https://www.federalregister.gov/documents/2024/02/02/2024-01693/medications-for-the-treatment-of-opioid-use-disorder
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- www.druginserts.com

ALCOHOL

- Alcohol is the most used addictive substance.
- Alcohol-related deaths (worldwide)
  - 2.6 million alcohol-related deaths/year compared to
    - .6 million drug-related deaths/year.
  - 4.7% of all deaths are related to alcohol consumption.
  - Alcohol is the most common substance causing withdrawal related deaths in jails.

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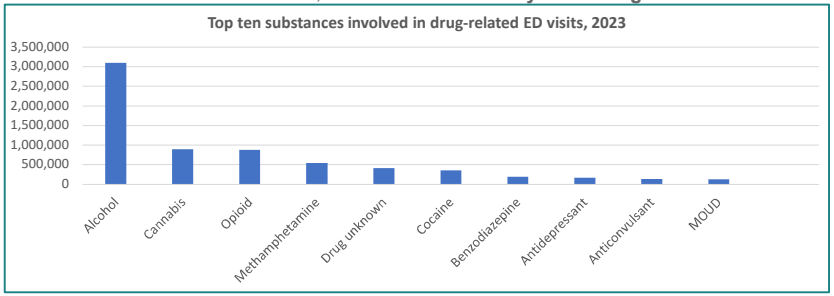
ALCOHOL AND DRUG EMERGENCY DEPARTMENT VISITS

- Alcohol-related ED visits are higher than for any other substance:
  - Exceed 3.1 million in 2023, **3 times more than any other drug class.**

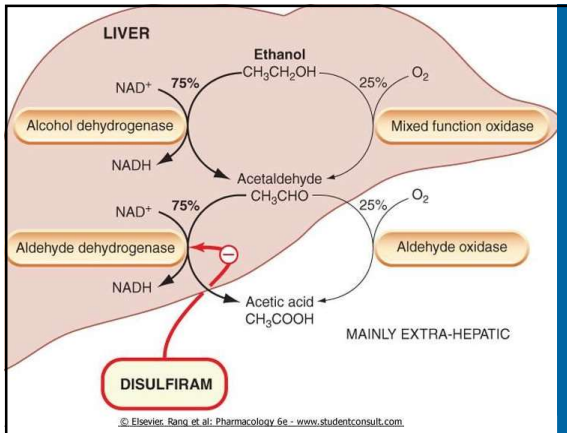


Sources: Substance Abuse and Mental Health Services Administration (SAMHSA). (2024). Drug abuse warning network: National estimates from drug-related emergency department visits, 2023. https://www.samhsa.gov/data/sites/default/files/reports/rpt53161/dawn-national-estimates-2023.pdf

WHY MEDICATIONS FOR ALCOHOL USE DISORDER IS IMPORTANT?

- Increased retention in treatment
- Decreased drinking
- Decreased cravings
- Decreased healthcare costs

- Acamprosate
- Naltrexone (oral and intramuscular)
- Disulfiram



DISULFIRAM (ANTABUSE®): MECHANISM OF ACTION

DISULFIRAM FOR ALCOHOL USE DISORDER (AUD)

- Approved decades ago; most recent data does NOT show overwhelming efficacy*
- Once per day dosing
- Inhibits multiple P450 and other liver enzymes
- Drug Interactions: benzodiazepines, phenytoin, pimozide, tricyclic antidepressants (TCAs), warfarin, sulfonylureas, metronidazole, amoxicillin, isoniazid
- Contraindications/precautions: alcohol use, hypersensitivity to rubber, severe coronary artery disease (CAD), cirrhosis, severe renal impairment, psychosis, depression, diabetes mellitus (DM), epilepsy
- Extensively metabolized
- Extensive list of side effects

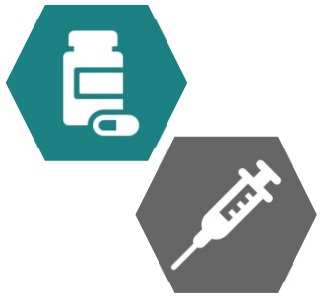
Source: * McPheeters M, O'Connor EA, Riley S, Kennedy SM, Voisin C, Kuznacic K, Coffey CP, Edlund MD, Bobashev G, Jonas DE. Pharmacotherapy for Alcohol Use Disorder: A Systematic Review and Meta-Analysis. JAMA. 2023 Nov 7;330(17):1653-1665. doi: 10.1001/jama.2023.19761. PMID: 37934220; PMCID: PMC10630900.

NALTREXONE FOR ALCOHOL USE DISORDER

- Few side effects
- Drug Interactions: opioids
- Contraindications: severe acute hepatitis
- Well studied in mild and moderate cirrhosis
- Safe in mild renal disease

NALTREXONE EFFECTIVENESS FOR ALCOHOL USE DISORDER

- Oral naltrexone:
  - Decrease return to any drinking.
  - Decrease in return to heavy drinking.
- Long-acting injectable naltrexone:
  - Greater time to first drink.
  - Lower number of heavy drinking days.



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EXTENDED RELEASE NALTREXONE COMPARED TO OTHER AGENTS FOR ALCOHOL USE DISORDER

- In multiple studies extended-release injectable naltrexone resulted in the following compared to oral naltrexone or other oral medications for alcohol use disorder:
  - Longer time on medication.
  - Decreased:
    - Emergency department visits.
    - Hospitalizations.
    - Nonpharmacy costs.

References: Bryson, W. C., et al. (2011). Extended-release naltrexone for alcohol dependence: persistence and healthcare costs and utilization. The American Journal of Managed Care, 17 Suppl 8(Suppl 8), S222–S234.
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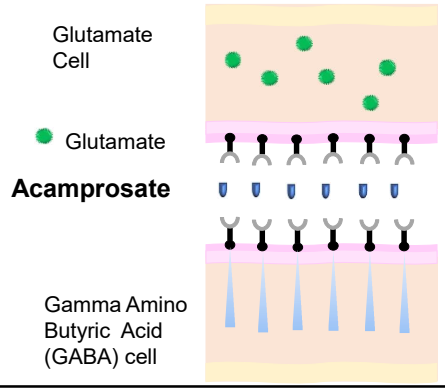
ACAMPROSATE: MECHANISM

In someone with an active alcohol use disorder acamprosate decreases glutamate



ACAMPROSATE FOR ALCOHOL USE DISORDER

- Effective
  - Decreased quantity and frequency
  - Increased retention in treatment and abstinence
- Three times per day dosing
- Drug Interactions: none
- Contraindications: severe renal impairment
  - Dose reduce if someone has moderate renal impairment
- Few side effects
- No metabolism

BEHAVIORAL HEALTH AND MEDICATION FOR ALCOHOL USE DISORDER

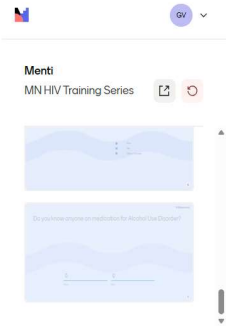
Impact of Behavioral and Medication Treatment for Alcohol Use Disorder on Changes in HIV-Related Outcomes Among Patients with HIV: A Longitudinal Analysis

Kathleen A. McGinnis[a], Melissa Skanderson[a], E. Jennifer Edelman[b,g], Adam J. Gordon[c], P. Todd Korthuis[d], Benjamin Oldfield[b], Emily C. Williams[e,f], Jessica Wyse[d], Kendall Bryant[g], David A. Fiellin[b,h], Amy C. Justice[a,b], Kevin L. Kraemer[i,j]

Medication and therapy improved HIV related outcomes

McGinnis KA, et al. Impact of behavioral and medication treatment for alcohol use disorder on changes in HIV-related outcomes among patients with HIV: A longitudinal analysis. Drug Alcohol Depend. 2020 Dec 1;217:108272.

TIME FOR A POLL



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10-MINUTE STRETCH BREAK!

COUNSELING FOR CO-OCCURRING HIV & SUD

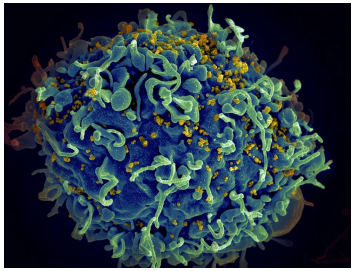
LEARNING OBJECTIVES: COUNSELING FOR CO-OCCURRING HIV & SUD

- Discuss coping with a HIV diagnosis and preparing patients for disclosure
- Identify at least 3 considerations for mental health treatment of individuals with HIV and SUD
- Distinguish acute and chronic risk of suicidality in individuals with HIV and SUD

WHY IS IT IMPORTANT TO ADDRESS SUD IN PERSONS WITH HIV?

Substance use accelerates the progression of HIV

- Increases viral load
- Increases likelihood of AIDs related morbidity (even when adherent to antiretroviral medications)
- Decreases medication adherence

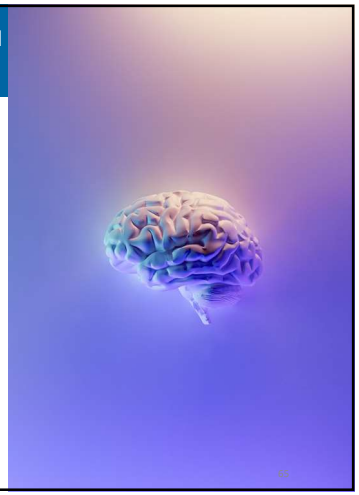


Sources: Dash, 2015; Schaffer 2017; Strazza 2011; Dahal 2015; Andriote 2012; NIDA 2021 https://www.drugabuse.gov/publications/research-reports/common-comorbidities-substance-use-disorders/
Photo Source: National Cancer Institute on Unsplash

WHY IS IT IMPORTANT TO ADDRESS SUD IN PERSONS WITH HIV?

Addictive substances weaken the blood brain barrier

- Allowing HIV to more easily enter the brain
- Allows infection and damage to nerves and supporting cells (glia)
- Triggers release of neurotoxins
- Can lead to dementia
  - 50% of people with HIV have neurocognitive disorders



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NIDA 2021 https://www.drugabuse.gov/publications/research-reports/common-comorbidities-substance-use-disorders/
Photo Source: Milad Fakurian on Unsplash

CURRENT SCREENING AND TESTING RATES

- Only 38% of adults 18-64 yo in the US report ever being tested for HIV.
- Only 76% of HIV clinics in North America reported screening HIV patients for alcohol use disorder.
- Only 36% of HIV clinics in North America screened for other SUD.
- Only 33% of SUD programs offer onsite HIV or HCV testing.
- Only 49% of people with mental illness have had an HIV test.

Sources: National Institute on Drug Abuse (NIDA). (2021). Co-occurring disorders and health conditions
Lancaster KE, et. al.; IeDEA Consortium. (2024) Availability of substance use screening and treatment within HIV clinical sites across seven geographic regions within the IeDEA consortium. Int J Drug Policy. 124:104309. doi: 10.1016/j.drugpo.2023.104309.
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Substance Abuse and Mental Health Services Administration and Center for Disease Control and Prevention. (2024) Dear Colleague Letter Title: Advancing JIV and viral hepatitis testing with point-of-care diagnostics for people with substance use disorder.
.

HIV / VIRAL HEPATITIS TESTING RECOMMENDATIONS

- SAMHSA recommends HIV/ HBV/ HCV testing:
  - All persons >15 years of age, at least once in lifetime.
  - Younger persons at increased risk.
  - Anyone at high-risk test yearly.
  - All SUD treatment programs should offer onsite same day oral fluid testing for HIV & fingerstick tests for HCV.
  - Medicare and Medicaid pay for testing.

People are at high risk if:

- They share drug injection or preparation equipment
- They have condomless sex
- They exchange sex for drugs or money

Sources: Substance Abuse and Mental Health Services Administration. (2021). Treating Substance Use Disorders Among People with HIV. Advisory. CDC: https://www.cdc.gov/hiv/basics/hiv-testing/getting-tested.html#:~:text=You%20should%20get%20tested%20at%20least%20once%20a%20year%20if%3A&text=You've%20shared%20needles%2C%20syringes,for%20another%20sexually%20transmitted%20disease
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STTR MODEL OF CARE

- Testing persons who inject drugs every 6 months is cost effective
- **Recommendation:** Inpatient and outpatient mental health settings should offer routine opt out testing to improve case finding

Chart review compared to blood samples from 2 inpatient psychiatric units:
21% of patients with HIV positive blood samples did not have documentation of infection in medical record

Sources: NIDA 2021 https://www.drugabuse.gov/publications/research-reports/common-comorbidities-substance-use-disorders
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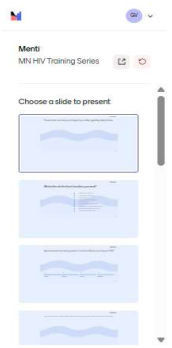
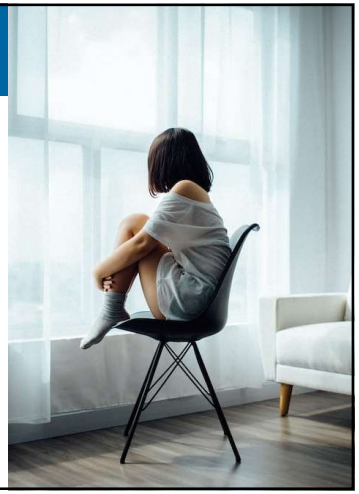
TIME FOR A POLL



EPIDEMIOLOGY- HIV & MENTAL HEALTH

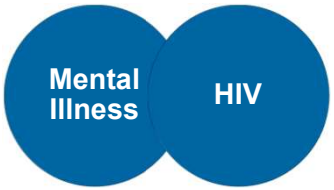
- Up to 70% of people living with HIV have a history of trauma
- 54% of people living with HIV have post-traumatic stress disorder (PTSD)
- People living with HIV are twice as likely to develop depressive symptoms compared to those at risk but who are not living with HIV
- People living with HIV experience higher rates of depression than the general population
- Key feature of depression, as compared to adjustment disorder or side effects from medication, is loss of pleasure

Sources: Kessler, R.C. 2005, Andriole, JM. 2012, Gaynes, B.N. 2008, Blank M.B.2013



EPIDEMIOLOGY- HIV & MENTAL ILLNESS

- Twenty-two percent (22%) of people with HIV have depression
  - Of those 78% **ALSO** have an anxiety disorder
  - Of those 61% **ALSO** have an SUD
- Six percent (6%) of people with HIV have schizophrenia, as compared to 1% of the general population
- Those with schizophrenia are **1.5x** as likely to contract HIV
- Those with affective disorders were **3.8x** as likely to contract HIV

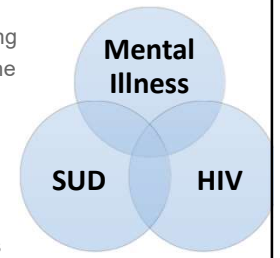


Sources: Kessler, R.C. 2005, Andriole, JM. 2012, Gaynes, B.N. 2008, Blank M.B.2013

SUD, HIV AND MENTAL ILLNESS

- 54% people with HIV report moderate to high-risk cannabis use
- 40% people with HIV report moderate to high-risk drinking
- 12% people with HIV report moderate to high-risk cocaine
- 11% people with HIV reported moderate to high risk of amphetamine use

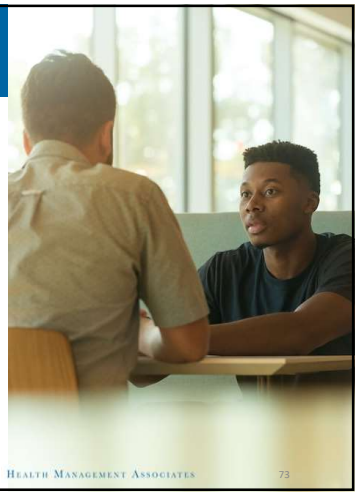
- Only 35% of people in 10 outpatient HIV clinics reported talking to primary care provider (PCP) about alcohol use
- < 50% of providers in hospital-based HIV care programs conducted recommended screening and brief interventions for reducing alcohol



Sources: Staruss, S.M. 2009
Andriole, JM. 2012
Dawson Rose 2017

COUNSELING: COPING WITH AN HIV DIAGNOSIS

- Coping with the diagnosis of HIV
  - is a form of grieving
  - is different from having a major depressive episode
  - may require treatment
    - support or psychotherapy
    - will not respond to antidepressants



Sources: Andriote, JM. 2012 http://wwwaidsmap.com/news/aug-2021/hardest-outcome-all-hiv-and-suicide
Photo Source :LinkedIn Sales Solutions on Unsplash

COUNSELING RECOMMENDATIONS

1. Don't try to solve or fix things, but….
   - Housing is important
   - Social support is important
   - Medical care is important
   - These things helps establish a sense of control over one's life
2. Don't minimize someone's feelings
3. Don't tell people to pull themselves together
4. Listen… for risks and for talk of the future

Sources: Andriote, JM. 2012 http://wwwaidsmap.com/news/aug-2021/hardest-outcome-all-hiv-and suicide

CONSIDERATIONS FOR MENTAL HEALTH TREATMENT OF INDIVIDUALS WITH HIV AND SUD

- Major Depression, among those living with HIV, responds to the same treatments:
  - Evidence-based psychotherapy
  - Evidence-based medications
  - Medication and psychotherapy
- As with other conditions, keep drug-drug interactions in mind
- Depression & bipolar disorder can make medication adherence challenging

ANTIDEPRESSANT TREATMENT OF DEPRESSION RESULTS IN LOWER HEALTHCARE COSTS

- Persons with bipolar disorder and HIV are more likely to have unprotected intercourse with HIV negative partners
- The risk of suicide is higher for those with HIV (at all stages) as compared to the general population

 Sources: McGinnis 2020, Andriote, JM. 2012 & Blank MB 2013 75

SUD TREATMENT FOR THOSE LIVING WITH HIV

- Cognitive Behavioral Therapy (CBT) & Motivational Interviewing (MI)
  - Reduce drug use
  - Reduce high risk sexual behaviors
  - Reduce viral load
  - Improve adherence to antiretrovirals

SUD Treatment is HIV Prevention!

Resources: Florida State University Center for Translational Behavioral Sciences: Tailored Motivational Interviewing and National Minority AIDS Counsel Motivational Interviewing and HIV a Guide for Navigators

Source: National Institute on Drug Abuse (NIDA). (2021) Co-occurring disorders and health conditions.
Glasner S, Patrick K, Ybarra M, Reback CJ, Ang A, Kalichman S, Bachrach K, Garneau HC, Venegas A, Rawson RA. Promising outcomes from a cognitive behavioral therapy text-messaging intervention targeting drug use, antiretroviral therapy adherence, and HIV risk behaviors among adults living with HIV and substance use disorders. Drug Alcohol Depend. 2022 Feb 1;231:109229. doi: 10.1016/j.drugalcdep.2021.109229. Epub 2021 Dec 25. PMID: 34979421.
https://www.ohtn.on.ca/rapid-response-87-effectiveness-of-motivational-interviewing-in-changing-risk-behaviours-for-people-living-with-hiv/

SUD TREATMENT FOR THOSE LIVING WITH HIV

- Opioid Use Disorder
  - Methadone and buprenorphine are associated with a 54% reduction in risk of HIV infection in persons who inject drugs
- Alcohol Use Disorder (AUD)
  - Behavioral and medication for AUD
    - Increase intensity of behavioral treatment led to greater improvements than lower intensity behavioral treatments among those with detectable viral loads
      - AUDIT C scores improved
      - Viral loads, CD4
      - Adherence
    - Medication for AUD was associated with
      - Increased CD4 among those with detectable viral loads
      - Increased adherence among those with detectable and undetectable viral loads

Source: NIDA 2021 https://www.drugabuse.gov/publications/research-reports/common-comorbidities-substance-use-disorders; McGinnis KA, et. al. Impact of behavioral and medication treatment for alcohol use disorder on changes in HIV-related outcomes among patients with HIV: A longitudinal analysis. Drug Alcohol Depend. 2020 Dec 1;217:108272..

EPIDEMIOLOGY- SUICIDALITY & HIV

Suicide

- 2nd leading cause of death in 10-14 and 25-34 y.o.
- 3rd most common cause of death in 15-24 y.o.
- 4th leading cause of death in 35-44 y.o.
- A life-threatening illness is a one of the most strongly predictive factors for completed suicide
- Suicide rate in those with HIV is at least twice the rate in the general population.
- The rates of depression & suicide are greatest in the first 2 years after diagnosis but remain elevated.

Suicide Attempt Lifetime Rate

People living with HIV: 16 to 10%

General Population: 3%

Suicidal Ideation Rate

People living with HIV: 23 to 22%

General Population: 9%

Sources: National Institute of Mental Health. (2025)Suicide is one of the leading causes of death in the U.S. Cairns, G. 2021 The hardest outcome of all: HIV and suicide. AIDSMAP. Tsai YT, et al. Suicidality Among People Living With HIV From 2010 to 2021: A Systematic Review and a Meta-regression. Psychosom Med. 2022 Oct 1;84(8):924-939.; Vollmond CV, et al. Risk of Depression in People With HIV: A Nationwide Population-based Matched Cohort Study. Clin Infect Dis. 2023 Nov 30;77(11):1569-1577.

TIME FOR A POLL

RISK FACTORS FOR SUICIDE

DEPARTMENT OF HEALTH

Suicidal Ideation Risk Assessment

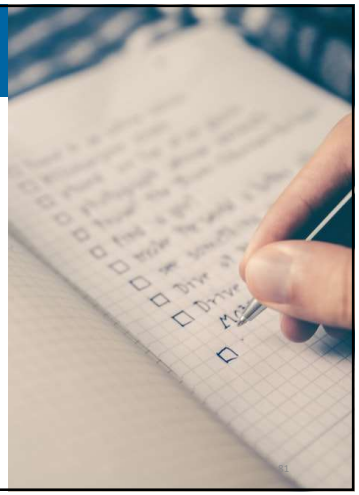
STEPS AND RESOURCES FOR EXPLORING THOUGHTS OF SUICIDE

- ❑ Trauma
- ❑ Triggering event- stressor
- ❑ Ideation & past behavior
- ❑ Health-medical, mental and substance
- ❑ Purposeless, hopeless
- ❑ Poor sleep
- ❑ Mood, anxiety, anger, withdrawal
- ❑ Reckless, impulsive

Sources: https://www.health.state.mn.us/people/syringe/suicide.pdf

ASSESSMENT FOR SUICIDALITY

- Which factors can be modified to reduce risk?
  - Opportunities for healing
  - Reduce harms
- Protective factors
  - Connectedness
  - Support
  - Skills- problem solving, coping, healing



Sources: https://www.health.state.mn.us/people/syringe/suicide.pdf
Photo Source: Glenn Carstens-Peters on Unsplash

ASSESSMENT RECOMMENDATIONS

1. Be mindful that protective factors are unique to each person
2. Use the person's language
3. Ask open ended questions such as:
   - What are things that keep you safe?
   - When this occurred in the past what has stopped you?
   - Who are the people who lift your spirits?
   - What activities lift your spirits?
   - What would you like to develop within yourself in the future?
4. Try to identify protective factors that can be enhanced

Sources: https://www.health.state.mn.us/people/syringe/suicide.pdf

INTEGRATED PRIMARY HIV & BEHAVIORAL HEALTH CARE

Benefits of Integration
- Increases likelihood of follow through on referrals
- Improve physical health outcomes
- Increased savings in healthcare cost
- Reduce emergency room use

Ryan White HIV/ AIDS Treatment Extension Act 2009
- Aligns with HHS guidelines
- Mandates include:
  1. Universal depression and SUD screening
     - MH screening rates currently are between 80%-100%
     - SUD screening rates currently are much lower
  2. Establishment of follow up plan

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STIMULANT USE

LEARNING OBJECTIVES: STIMULANT USE AND PERSONS WHO ENGAGE IN CHEMSEX

- List at least 5 risks associated with methamphetamine usage
- Define and identify at least 2 benefits of contingency management
- Identify at least 3 risk behaviors of persons who engage in Chemsex

WHAT ARE STIMULANTS?

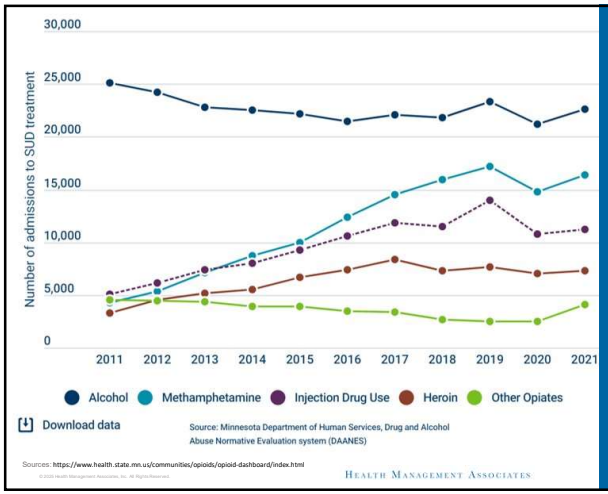
- Cocaine
- "Psychostimulants with abuse potential"
  - Mahuang, ephedra & khat- plants
  - Pseudoephedrine, ephedrine & cathinone & cathine
  - "Bath salts" (synthetic man made cathinones)
  - Amphetamine (synthetic)
    - Methamphetamine
    - Amphetamine
    - MDMA/ecstasy = Molly = methylenedioxy-methamphetamine
    - Methylphenidate = Ritalin™
  - Methylxanthines (naturally occurring)
    - Caffeine (coffee)
    - Theophylline (tea)
    - Theobromine (chocolate)

VIOLENT CRIME ENFORCEMENT TEAMS (VCET) ARRESTS 2022 IN MINNESOTA

Drug Involved in Arrest	Number of Arrests
Cocaine	207
Methamphetamine	1426
Prescription drugs	260
Heroin	155
Synthetic narcotics	106
Heroin + synthetic narcotics	261

Office of justice programs. VCET activities and data.
https://dps.mn.gov/divisions/ojp/ojp-grants/grant-programs/vcet-vcet

89



ADMISSIONS TO SUD TREATMENT MINNESOTA

AMPHETAMINE USE NATIONALLY & LOCALLY

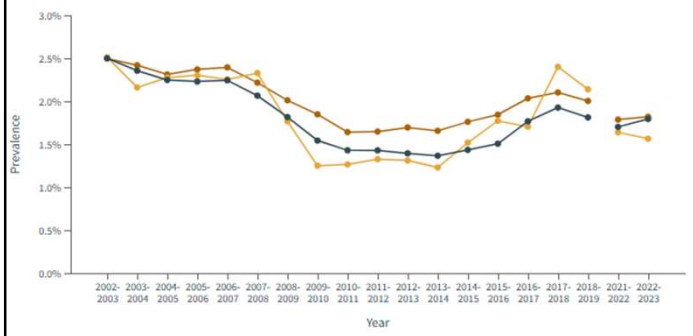
Methamphetamine Use in Past Year Among Individuals Aged 12 or Older, by Geographic Area

United States
Minnesota
Midwest

NOTE: Estimates from 2021-2022 are not comparable to estimates from previous years due to changes in NSDUH survey methodology.

COCAINE USE NATIONALLY & LOCALLY

Cocaine Use in Past Year Among Individuals Aged 12 or Older, by Geographic Area



United States
Minnesota
Midwest

HEALTH MANAGEMENT ASSOCIATES

Source: https://datatools.samhsa.gov/saes/state

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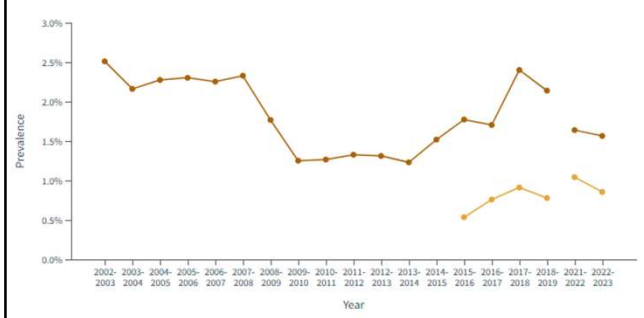
STIMULANT (COCAINE AND METHAMPHETAMINE) USE MINNESOTA

Prevalence Among Individuals Aged 12 or Older in Minnesota, by Outcome



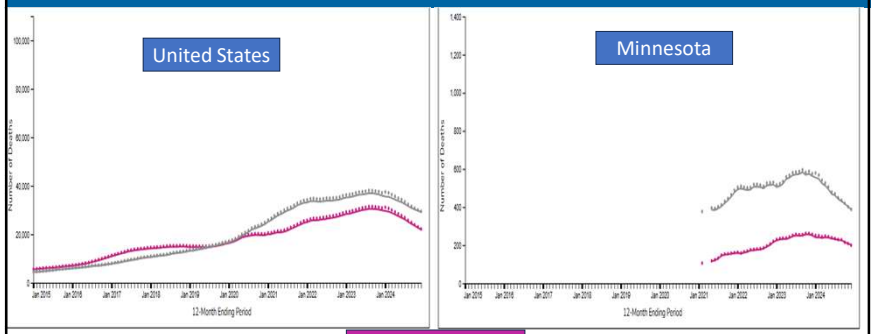
Cocaine
Methamphetamine

NOTE: Estimates from 2021-2022 are not comparable to estimates from previous years due to changes in NSDUH survey methodology.

Health Management Associates

Source: https://pdas.samhsa.gov/saes/state

STIMULANT OVERDOSE DEATHS NATIONALLY AND LOCALLY



Cocaine
Psychostimulants with Abuse Potential

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https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm#dashboard

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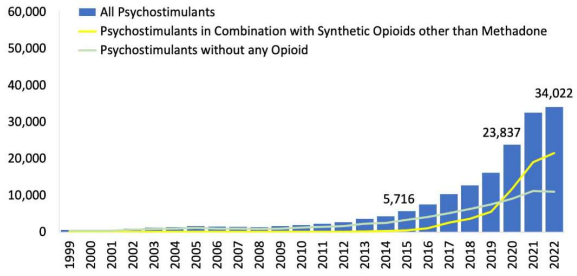
Figure 7. National Overdose Deaths Involving Psychostimulants with Abuse Potential (Primarily Methamphetamine)*, by Opioid Involvement, Number Among All Ages, 1999-2022



*Among deaths with drug overdose as the underlying cause, the psychostimulants with abuse potential (primarily methamphetamine) category was determined by the T43.6 ICD-10 multiple cause-of-death code. Abbreviated to *psychostimulants* in the bar chart above. Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2022 on CDC WONDER Online Database, released 4/2024.

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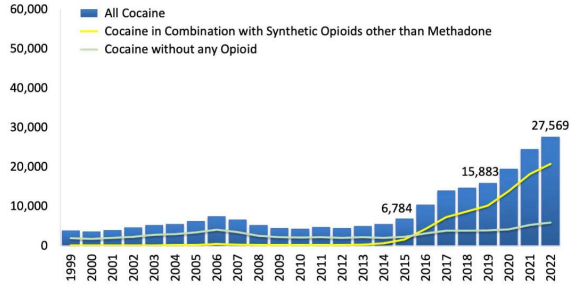
METHAMPHETAMINES OVERDOSES WITH AND WITHOUT OPIOIDS

Source: https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates#:~:text=Drug%20overdose%20deaths%20involving%20psychostimulants,to%2032%2C537%20deaths%20in%202021.

95

Figure 8. National Drug Overdose Deaths Involving Cocaine*, by Opioid Involvement, Number Among All Ages, 1999-2022



*Among deaths with drug overdose as the underlying cause, the cocaine category was determined by the T40.5 ICD-10 multiple cause-of-death code. Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2022 on CDC WONDER Online Database, released 4/2024.

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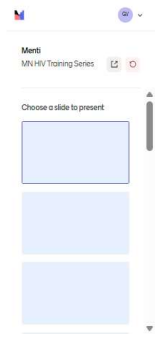
COCAINE OVERDOSES WITH AND WITHOUT OPIOIDS

Source: https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates#:~:text=Drug%20overdose%20deaths%20involving%20psychostimulants,to%2032%2C537%20deaths%20in%202021.

96

TIME FOR A POLL



MEDICINAL USES FOR STIMULANTS

- Cocaine- used as a vasoconstrictor & numbing agent
- "Psychostimulants with abuse potential"
  - Ephedra- made into pseudoephedrine and used for allergies and colds
  - Khat used for depression, obesity, fatigue in middle east
  - Amphetamines are used for obesity, narcolepsy & Attention Deficit Hyperactivity Disorder (ADHD)
  - Methylxanthines
    - Theophylline (tea) used for asthma

Amphetamine dosing:
ADHD 2.5 mg/day to 70mg/ day
Narcolepsy 5 mg/day to 60 mg/day

Methamphetamine dosing:
ADHD approved but not commonly used
5 mg/day to 25 mg/ day

Illicit use of amphetamines/ methamphetamines up to 1 g / day

SOME CONSEQUENCES ARE DUE TO MODE OF CONSUMPTION

- Smoking
  - Burned lips
  - Throat problems
  - Lung problems- acute (50% of those who smoke cocaine) and chronic
- Injection (unsafe practices)
  - Skin & heart infections
  - Hepatitis or HIV
- Snorting
  - Sinus infections
  - Holes in nasal septum
  - Nosebleeds
  - Hoarseness

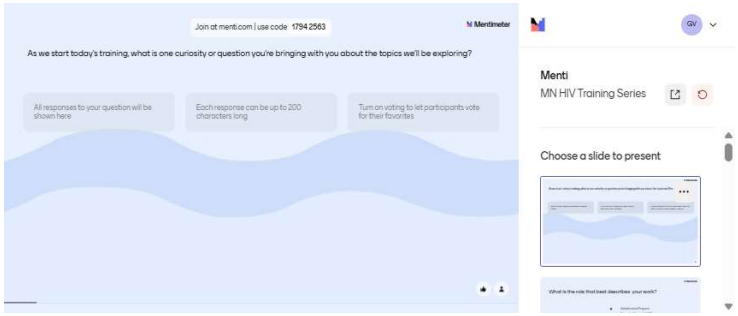
NOTE:
There is cross tolerance from one class of stimulants to another

EFFECTS DEPENDENT UPON MODE OF CONSUMPTION

Drug Reaches Brain
- Smoking- 6-8 seconds
- Injection- seconds
- Snorting- 15 minutes
- Oral-45 minutes

Half-Life
- Cocaine .75-1.5h
- Bath Salts (Cathinone) .7-2.3 hours
- Amphetamine 7-34 hours
- Methamphetamines 6-15 hours

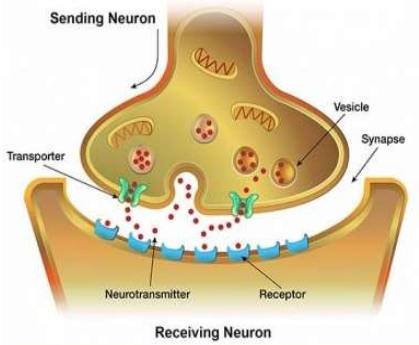
TIME FOR A POLL



STIMULANTS EFFECTS ON BRAIN CHEMISTRY

Cocaine:
Reuptake Blocker
INDIRECT agonist of
+ dopamine
+ norepinephrine
+ serotonin

BLOCKS
+ **neurotransmitters reuptake**
+ **sodium channels**



Amphetamines:
Releaser
INDIRECT agonist of
+ dopamine
+ norepinephrine
+ serotonin

INHIBITS
+ **metabolism of neurotransmitters**
+ **vesicular storage**
+ **reverses reuptake**

Photo Source: https://www.drugabuse.gov/news-events/nida-notes/2017/03/impacts-drugs-neurotransmission

ACUTE EFFECTS OF STIMULANTS

- Increased
  - Alertness/vigilance, concentration, mental acuity
  - Energy, movement
  - Sensory awareness & sexual desire
  - Self confidence, grandiosity, anxiety, irritability, paranoia
  - Heart rate & blood pressure, irregular heartbeat, vasoconstriction
  - Breathing rate, temperature, pupil size & blood sugar
  - Electrical activity, seizures
- Euphoria
- Abnormal bowel and bladder function

- Toxic effects on muscles including
  - tremors, stereotypy (i.e., ritualistic movements)
- Decreased
  - Brain blood flow & glucose metabolism
  - Appetite & sleep
  - Judgment & complex multi-tasking
- Cardiovascular effects
  - Heart attacks
  - Arrhythmias
  - Severe hypertension
  - Strokes
- Increased potential for violence and psychosis

STIMULANT INTOXICATION: TREAT THE PRESENTING SIGN/SYMPTOM

Overdose:

Seek immediate medical attention for:
- Hypertensive (HTN) crisis
- Cardiac arrythmias
- Heart attack
- Stroke – Act F.A.S.T.*
- Psychosis

* **F**acial drooping, **A**rm weakness, **S**peech difficulty, **T**ime to call 9-1-1

Treatment of Overdose

Treat HTN with alpha and/ or beta blockers

Treat arrythmias with anti-arrhythmics

Treat vasoconstriction with nitroglycerin

BH interventions for Overdose

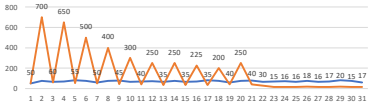
Talk down the client in a calm environment

Treat agitation with benzodiazepine

Treat psychosis with antipsychotics

LONG-TERM MENTAL EFFECTS OF ILLICIT STIMULANTS

- Tolerance to euphoria and appetite suppression
- **Loss of ability to concentrate & severe memory loss**
- Loss of ability to feel pleasure without drug
- Dopamine depletion after repeated use of addictive substances to intoxication
- Paranoia and psychosis (hallucinations & delusions)
- Insomnia and fatigue
- Irritability and anger
- **Depression (suicidal ideation)**
- Impulsive, risky sexual behavior



* Use of stimulants in doses approved by FDA for treatment of medical conditions do not result in these effects

LONG TERM PHYSICAL EFFECTS OF ILLICIT STIMULANTS

- **Dry mouth, severe dental decay and gum problems**
- **Bruxism (tooth grinding)**
- Weight loss
- Increased sweating; oily skin
- Skin lesions from injection and formication (leading to skin picking)
- Headaches
- Movement disorders and seizures
- **Strokes (bleeding into the brain) and heart attacks**
- Irregular heart beats
- Cardiomyopathy
- Kidney and liver failure
- Pulmonary hypertension
- Damaged brain cells
- Neonatal effects

Strokes & heart attacks are the leading cause of death for stimulant users, even young users

STIMULANTS AND PREGNANCY

- Pregnancy may increase risk of cardiovascular events
- Preterm labor
- Earlier gestational age at delivery
- Low birth weight
- Small for gestational age
- Strokes in utero
- Secreted in breast milk

Child:
Dysregulated behavior, growth, inhibitory control, attention and abstract reasoning, but these effects appear to be related to gestational age at delivery, psychiatric disorders, other prenatal exposures and quality of postnatal environment. *
Anxiety, depression at 3-year-old **
Worse cognitive function at 7-year-old **

Source: Gouin 2011; Kalaitzopoulos, 2018; *Smid, 2019; **Deruf, 2007

STIMULANT USE IN PREGNANT PEOPLE

- Pregnancy
  - During pregnancy stimulant use is more common than opioid use
  - Cannabis is the most used substance during pregnancy
    - Followed by stimulants
- Homelessness and sexual violence predict stimulant use in women…

If Post-traumatic Stress Disorder (PTSD) is present

- Integrated treatment is more effective for co-occurring disorder (COD)

Sources:
- Center for Behavioral Health Statistics Quality. 2015 National survey on drug use and health: Detailed tables In:2016
- Rileya, ED. Risk factors for stimulant use among homeless and unstably housed adult women. Drug Alcohol Depend. 2015 August 1; 153: 173–179. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4510017/pdf/nihms694947.pdf
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CESSATION FROM STIMULANTS

- Acute withdrawal:
  - 4 days
  - No medication recommended
- Symptoms
  - Increased appetite
  - Increased sleep & dreaming
  - Decreased activity & energy
  - Depression & anhedonia
  - Decreased concentration
  - Craving

- Protracted withdrawal
  - Up to 10 weeks
  - No medication recommended
- Lingering effects on the brain; may be permanent
  - Psychosis
  - Movement Disorders
  - Cognitive Issues

Handout: Stimulant Withdrawal: Monitoring & Treatment; available here through 5-2025
https://addictionfreeca.org/r/fpnseg8rpkgg

AMPHETAMINES AND COGNITIVE IMPAIRMENT

- Two-thirds of people with amphetamine use disorder have cognitive impairment
- Impairment is "associated" with:
  - Older age
  - Earlier onset of use
  - Longer duration of use
  - Greater frequency of use
- May limit ability to follow through on treatment

- Damage cell structures
  - Mitochondria in neurons & microglia
- Damage DNA
  - Chromosomal alterations
- Inflammation of microglia
- Disruption of blood brain barrier
  - Inflammatory markers in peripheral blood
- Cell death

Source: Paulus, M (2020) Neurobiology, clinical presentation, and treatment of methamphetamine use disorder a review. JAMA Psychiatry 77(9): 959-66.

AMPHETAMINES AND LINGERING EFFECTS ON BRAIN

- May be permanent even with prolonged abstinence
  - Attention
  - Memory
  - Learning efficiency
  - Visual- spatial processing
  - Processing speed
  - Psychomotor speed
  - Executive dysfunction

Cognitive Impairment
Impairs ability to engage in treatment due to trouble

- Sequencing events to get to treatment
- Remembering what is taught
- Applying what is taught

TREATMENT OF STIMULANT USE DISORDER

- Harm Reduction
  - Educational materials on psychological & physical effects
  - Fentanyl test strips
  - Syringe Exchange/distribution & other clean injection supplies
  - Naloxone and overdose prevention education
  - Quiet rooms to come down
  - Showers & antibiotics for infection prevention & treatment
  - Condoms & info on safer sex practices
  - Water for hydration
  - Toothpaste and toothbrush

Photo sources: Reproductive Health Supplies Coalition, Sara Groblechner, and Giorgio Trovato on Unsplash

TREATMENT OF STIMULANT USE DISORDER: SAMHSA EVIDENCE BASED RESOURCE GUIDE

- Motivational Interviewing (MI)
  - Decreased days of stimulant use & amount of stimulant used/ day
- Cognitive Behavior Therapy (CBT)
  - Decreased quantity of stimulant use & frequency/ week
  - Decreased risky sexual behaviors
- Community Reinforcement Approach- see next slide
- Contingency Management- see next slide

STRONG EVIDENCE FOR THESE AS INDIVIDUAL INTERVENTIONS OR IN COMBINATION APPROACHES

TREATMENT OF STIMULANT USE DISORDER

- Community Reinforcement Approach (CRA)
  - Decreased addiction severity
  - Decreased drug use (weeks of use, frequency/week, $/week)
  - Increased cocaine abstinence
- Contingency Management (CM): Strongest Effect Size
  - Decreased
    - days of stimulant use
    - stimulant cravings
    - HIV risk behaviors
  - Studies Veterans Administration National Rollout
    - Pre-CM: compared to 42% completed 2 sessions in 1 year
    - Post-CM Implementation: 50% completed 14 sessions in 12 week
    - 92% of >69,000 toxicology tests negative

Sources: SAMHSA
Oliva, EM (2013)
Warner & DePhilippis (2020)

TREATMENT OF STIMULANT USE DISORDER

- Select objective target behavior (ex. abstinence)
  - Define the behaviors
    - Abstinence from DOC? all illicit drugs? prescribed drugs? alcohol?
- Provide immediate, consistent, tangible, desired rewards for target behavior
- Escalate size of reward for consistent behavior
- When target behavior does not occur
  - Withhold the reward
  - Reset size of reward for next occurrence of behavior
- Example: Fishbowl Method
  - 250 good job cards/gifts
  - 209 vouchers for $1; 40 for $20; 1 for $100

Measure objectively & frequently
Don't set the bar too high or low

Reinforcement totaling $80 = treatment as usual. Reinforcements of $240 improves outcomes.
Petry 2004

SAMHSA Advisory Jan. 2025
Grant Funds up to $750/year/patient For CM for SUD.

IN THE CHAT BOX PLEASE ANSWER THIS QUESTION:

Do you have a Contingency Management Program?

Yes

No

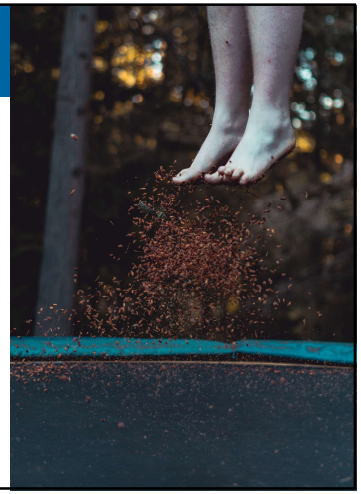

Photo Source: Jasper Garratt on Unsplash

GROUP DISCUSSION

Do you have a Contingency Management Program?

Please raise your hand if you'd like to share.

WHAT TREATMENTS HAVE BEEN TRIED FOR STIMULANT USE DISORDER?

- Cocaine & amphetamines not consistently effective
- Antidepressants: SSRIs and tricyclic antidepressants not effective
- Bupropion: risk of seizures; 5 failed trials for amphetamine use disorder *
- Mirtazapine: risk of weight gain; single small study + for amphetamine use disorder in men who have sex with men
- Treatment of co-occurring Opioid Use Disorder (OUD)
- Opioid agonists: increased dose of buprenorphine or methadone shows decreased cocaine use generally
- Naltrexone: + results in multiple small studies amphetamine use disorder and cocaine use disorder *
- Antiseizure medications: Topiramate (risks); + one or two small studies in amphetamine use disorder

* See next slide

WHAT TREATMENTS HAVE BEEN TRIED FOR STIMULANT USE DISORDER?

https://downloads.asam.org/sitefinity-production-blobs/docs/default-source/quality-science/stud_guideline_document_final.pdf?sfvrsn=71094b38_1

The ASAM/AAAP
CLINICAL PRACTICE GUIDELINE ON THE

Management of Stimulant Use Disorder

There are NO FDA approved medications for stimulant use disorders. Best Practices and Standards of Care do NOT endorse medication for stimulant disorders, by prescribers who are not experienced in addiction medicine.

WHAT'S ALL THE FUSS ABOUT?

- New England Journal of Medicine article 2021
- 400 adults with methamphetamine use disorder
- Bupropion 450mg per day + placebo or bupropion 450mg per day + extended-release naltrexone 380mg IM q 3w (XR NTX)
- Response defined as 3 of 4 toxicology tests negative for methamphetamines
- 14% of patients on Bupropion + XR NTX responded vs 3% on Bupropion + placebo
- Buprenorphine vs. placebo has a 21% difference for negative tox screen

This 6-week study has NOT been replicated yet. 11% improvement over placebo. Compare this to the EXCELLENT outcomes from psychosocial treatments.

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CHEMSEX

GROUP DISCUSSION

What does the term Chemsex mean?

Please raise your hand if you'd like to share.

CHEMSEX

Definition:

Chemsex (also known as sexualized drug use – SDU) is the **use of drugs to enhance sexual experience**.

Common drugs used include methamphetamine, gamma-hydroxybutyrate (GHB), gamma-butyrolactone (GBL), methylenedioxymethamphetamine (MDMA), cocaine, ketamine, poppers (amyl nitrite) or cannabis (the latter two gave rise to the term SDU).

CHEMSEX

What You Should Know:

- Chemsex is popular among some gay, bisexual, transgender, and queer persons, **but can be experienced by persons of any gender**
- Chemsex participants have higher odds of condomless anal sex with partners of different or unknown HIV status (bareback sex)
- Persons engaged in Chemsex have greater risk of acquiring sexually transmitted infections (STIs) and hepatitis C (HCV)
- Participants are at higher risk of HIV transmission
- The association with sexual risk indicates the importance of promoting harm reduction among this population (e.g., condoms, PrEP, PEP, drug knowledge).

COMMON TERMINOLOGY USED TO COMMUNICATE THE DESIRE TO ENGAGE IN CHEMSEX

Injecting	Meth	GHB	Ketamine	ChemSex
Pointing, slamming, darts	Blowing clouds, Cloudy, ice cream, tea, T, tina	Water, Gina, Swirling	K, Special K	Party, PNP, Party and play

Grindr sniffies S ADAM 4 ADAM

IMPACT OF CHEMSEX DRUGS

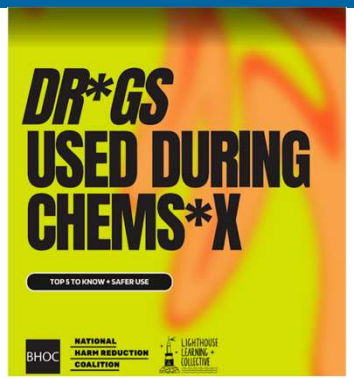
» Engaging in chemsex can be managed by some. This can mean that there is minimal impact on an individual's general wellbeing, work, relationships with partners, friends, and family.

» For others it can prove problematic, and individuals may experience:

- impaired decision making
- it dominates social life and free time
- can lead to chaotic sexual encounters
- sexual boundaries are often crossed while high
- issues around sexual consent
- impact on sexual health: Hep C, HIV, as well as other STI's
- behaviors associated with addiction

•impact on mental health
•health issues associated with injecting drugs
•being vulnerable to mental and physical harm by others
•isolation
•unmanageable comedowns
•suicidal ideation
•an impact on work performance
•a breakdown of personal relationships

SAFER CHEMSEX



POPPERS

Poppers are an inhaled depressant that relaxes muscles in the body (including anal and vaginal sphincters). The effects are short-lived but felt immediately. The most common reasons for using these during s*x are to relax (typically for bottoms) and to prevent cumming too quickly.

SAFER USE

- **TRY TO AVOID mixing with erectile meds that help you stay hard.** It can cause a lethal drop in blood pressure.
- **Avoid contact with your skin and eyes.** Put liquid on a cotton ball or get a sniff cap.
- **Don't forget lube!** Even though the muscles are relaxed, the skin around your ass or vagina can still get hurt.

SAFER CHEMSEX

GHB/GBL (G)

G is a depressant in liquid form that's usually measured with a syringe and mixed into a drink to help mask the taste. What's called "G" can refer to GHB, GBL, 1,4-BD, or other similar substances—so effects can vary depending on the type and dose. The main reason for using G during s*x is its ability to increase libido and sexual feelings.

SAFER USE

- **Use a syringe to keep track of how much you're taking.** Write it down or set an alarm.
- **TRY TO AVOID using with alcohol or other depressants** like benzos or antihistamines (like Benadryl) which increase risk of overdose and unconsciousness.
- **Try to stay awake.** Have someone put you in the recovery position if you fall asleep.
- **Be mindful of physical dependence.**

KETAMINE (K)

Ketamine is a white/off white powder that has both dissociative and depressive effects. It can be swallowed, snorted, or injected. The main reasons for using it during s*x is that it lowers your inhibitions and improves your ability to last.

SAFER USE

- **HYDRATE.** K can cause a long-term health issue called ketamine bladder syndrome. Getting your fluids helps prevent it.
- **Be mindful of how much you're taking.** Write it down. K is stronger than cocaine, so start low and go slow.
- **Plan ahead for STI + HIV prevention.** Take your condoms, PrEP, doxyPEP, and lube with you and communicate that it's important to you before using. When inhibitions are lower, we are more likely to take risks.

SAFER CHEMSEX

MDMA (MOLLY/ECSTASY)

MDMA is an empathogen, which has stimulant-like effects. It usually comes as colorful pills or capsules in a variety of shapes and designs.

While pure MDMA does exist, it's important to be cautious. What's sold as MDMA can sometimes be mixed with other substances like amphetamines, ketamine, or caffeine. Many people use it to enhance pleasure, especially through touch, connection, and sensory experiences.

- **Hydrate and get your electrolytes.** Overheating and dehydration are possible, so drink water and have salty snacks.
- **Pause between doses.** Take ¼ of a pill, wait 30 minutes, and then another if you're feeling alright.
- **Plan for aftercare.** Comedowns can last a few days.
- **Swallowing is better than snorting.**

CRYSTAL METH (TINA)

Meth is a stimulant that can be used in a variety of ways, most commonly: boofing (booty bumping), injecting, and smoking. Meth can help get you hard if you have difficulty and can boost your energy for marathon sessions.

SAFER USE

- **Injecting/slamming?** Make sure to have your own syringes and works.
- **Boofing/booty bumping?** Make sure to watch for anal tears and have your own sterile supplies to put the d*gs inside of you. **Tip:** Use a slip syringe!
- **Smoking?** Make sure your pipe is sanitized with alcohol wipes and isn't broken to avoid cuts on your mouth.
- **Be mindful of how much you're taking.** Boofing can have stronger effects than injecting or snorting.
- **TRY TO AVOID using with SSRIs or Benzos.**

RESOURCES

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METHAMPHETAMINE AND ITS IMPACT ON HIV INFECTION

Methamphetamine use:

- Increases sexual desire, impairs judgment, and provides energy and confidence to engage in sexual activity for long periods of time (hyper-sexual)
- Causes erectile dysfunction
- Causes mucosal dryness
- Decreases adherence to HIV treatment and medical follow-up
- Increases HIV replication
- Accelerates progress of HIV-related dementia

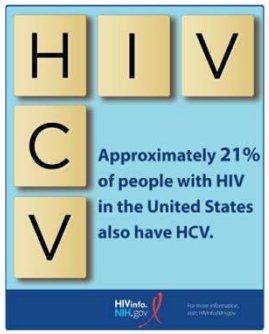
DOES METHAMPHETAMINE ACCELERATE HIV AND HCV?

- In test tube studies, when methamphetamine is added to immune cells, it significantly increases HIV replication
  - Particularly in CD4 cells and monocytes (white blood cells)
- In mouse models, methamphetamine activated a portion of the HIV genetic code (long terminal repeat – LTR), prompting cells to release a protein tied to more rapid HIV disease progression
- The Journal of Viral Hepatitis published a study indicating that methamphetamine increases Hepatitis C replication.

Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2675873/

HIV AND HEPATITIS C

HIV AND HEPATITIS C CO-INFECTIONS



- HIV may cause chronic HCV to advance more quickly.
- Impact of HCV on HIV advancement is unclear.
- In the US, between 62% - 80% of people who inject drugs who have HIV also have HCV.

Sources: HIVinfo.NIH.gov. (2021). HIV and Hepatitis C. https://hivinfo.nih.gov/understanding-hiv/fact-sheets/hiv-and-hepatitis-c#:~:text=According%20to%20the%20Centers%20for,be%20treated%20for%20both%20infections. Centers for Disease Control and Prevention (CDC). (2024). Fast Facts: HIV in the United States. https://www.cdc.gov/hiv/data-research/facts-stats/index.html#:~:text=HIV%20diagnoses%20among%20people%20who%20inject%20drugs%20(PWID),1%2C161)%20of%20new%20HIV%20diagnoses.

HIV AND HEPATITIS C CO-INFECTIONS

- In 2023 in Minnesota, there were 31,942 chronic cases of HCV
  - Approximately 6,000 Co-infected with HIV and HCV
- The U.S. Public Health Service/Infectious Diseases Society of America guidelines recommend that all HIV-infected persons be screened for HCV infection (CDC, 2014).

WHO SHOULD BE SCREENED FOR HCV?

- Universal screening of all adults ≥ 18yo, at least once.
- All pregnant women during each pregnancy.

Periodic screening while risk factors persist:

- Persons who inject drugs and/or share needles, syringes or other drug preparation equipment.
- Persons with selected medical conditions, including receipt of hemodialysis- see next slide.

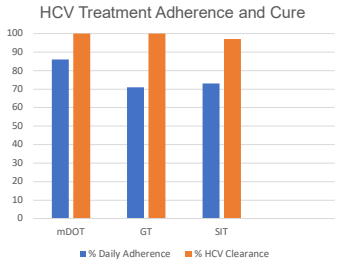
WHO SHOULD BE SCREENED FOR HCV CONTINUED

- Screening regardless of age:
  - Persons with HIV.
  - Persons who use drugs.
  - Persons with selected medical conditions (e.g., hemodialysis, persistently elevated ALT).
  - Healthcare personnel post needlesticks, sharps, or mucosal exposures.
  - Children born to mothers who are HCV+.
  - Persons receiving blood transfusion or organ transplant before July. 1992 or clotting factor concentrates before 1987.

Sources: Schillie, S., et al. (2020). CDC Recommendations for Hepatitis C Screening Among Adults - United States, 2020. MMWR. Recommendations and reports : Morbidity and mortality weekly report. Recommendations and reports, 69(2), 1–17. https://doi.org/10.15585/mmwr.rr6902a1
Debika Bhattacharya and others, Hepatitis C Guidance 2023 Update: American Association for the Study of Liver Diseases– Infectious Diseases Society of America Recommendations for Testing, Managing, and Treating Hepatitis C Virus Infection, *Clinical Infectious Diseases*, 2023;, ciad319, https://doi.org/10.1093/cid/ciad319

HCV TREATMENT IN PEOPLE WHO USE DRUGS

- Injection drug use accounts for ~ 70% of new HCV infections.
- Active or recent drug use is **NOT** a contraindication for HCV treatment.
- Cure rates ~ 95% in persons reporting drug use at start of HCV treatment.
- Opioid agonist treatment (methadone or buprenorphine) reduces rate of HCV acquisition by 50%.



mDOT = modified directly observed therapy; GT= group therapy; SIT= self-administered individual treatment

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QUESTIONS?

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SESSION 4

CONTEXT FOR SESSION 4

Previous Sessions

- HIV – Transmission, Testing, Treatment, Harm Reduction & Prevention
  - Key to ending HIV is to diagnosis, treat, prevent, respond
- Ethical and Legal Issues surrounding HIV and SUD
- Stigma Abatement and Motivational Interviewing
- SUD/OUD – Neuroscience, Substance Use Disorder Treatment with Medications, Stimulant Use, Chem Sex, Risk Reduction

Today's Session

- Populations most impacted and resources for you

DISPARITIES EXIST AMONG INDIVIDUALS AT RISK OF AND LIVING WITH HIV AS WELL AS INDIVIDUALS WHO HAVE A SUBSTANCE USE DISORDER

CULTURAL, RACIAL, AND SEXUAL IDENTITIES

LEARNING OBJECTIVES: CULTURAL, RACIAL, AND SEXUAL IDENTITIES

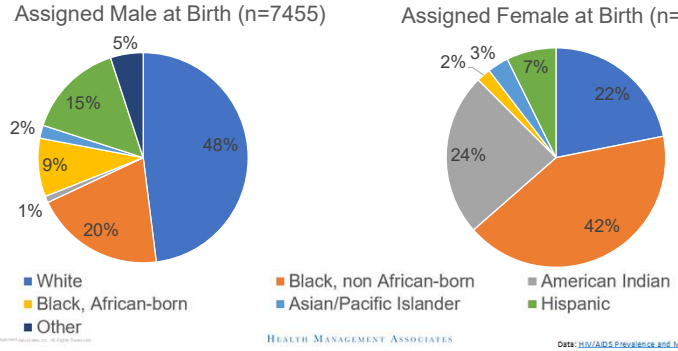
- Summarize HIV & SUD prevalence among people of color and transgender individuals compared to other populations
- Describe the connections between structural inequities and disparities in HIV
- Explain how cultural considerations can influence treatment engagement
- Identify at least three major health care challenges for this population

HEALTH DISPARITIES IN HIV

- Despite prevention efforts, some groups of people are affected by HIV, viral hepatitis, STIs, and TB more than other groups of people
- The occurrence of these diseases at greater levels among certain population groups more than among others is often referred to as a **health disparity**
- Social determinants of health like poverty, unequal access to health care, lack of education, stigma, and racism are linked to health disparities
- Differences may occur by:
  - gender
  - race or ethnicity
  - education
  - income
  - disability
  - geographic location
  - sexual orientation

HIV EPIDEMIOLOGY BY SEX ASSIGNED AT BIRTH

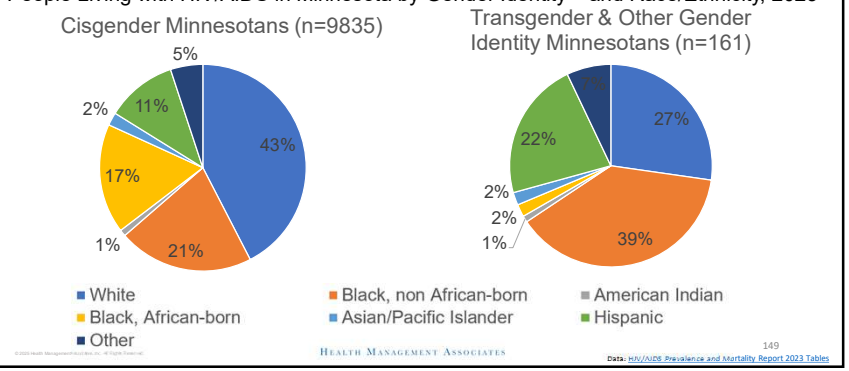
People Living with HIV/AIDS in Minnesota by Sex Assigned at Birth and Race/Ethnicity, 2023



Data: HIV/AIDS Prevalence and Mortality Report 2023 Tables

HIV EPIDEMIOLOGY BY GENDER IDENTITY

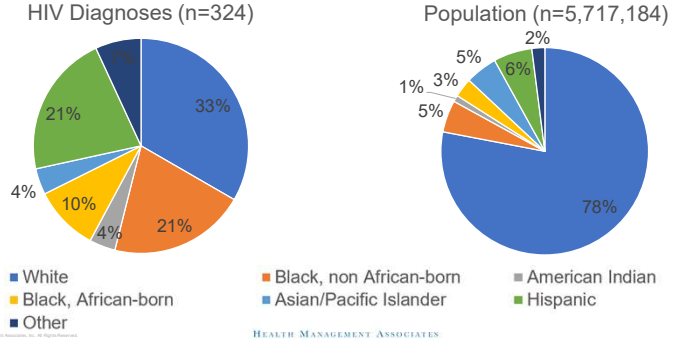
People Living with HIV/AIDS in Minnesota by Gender Identity** and Race/Ethnicity, 2023



Data: HIV/AIDS Prevalence and Mortality Report 2023 Tables

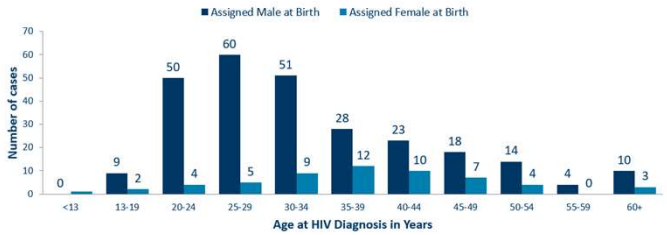
HIV INCIDENCE IN MINNESOTA BY RACE / ETHNICITY

HIV Diagnoses* in Year 2023 and General Population in Minnesota by Race/Ethnicity



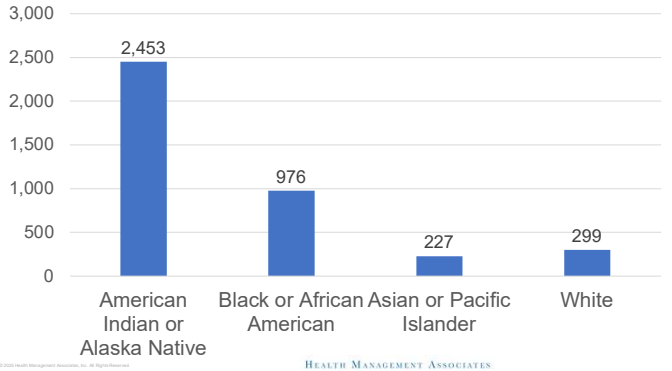
HIV INCIDENCE IN MINNESOTA BY SEX ASSIGNED AT BIRTH

HIV at HIV Diagnosis* in Year 2023 by Sex Assigned at Birth



» In 2023, there were 131 cases diagnosed under the age of 30, accounting for 40% of all cases. 119 (90%) of these were in people assigned male sex at birth. Age groups 25-29 and 30-34 had the largest number of new cases in 2023.

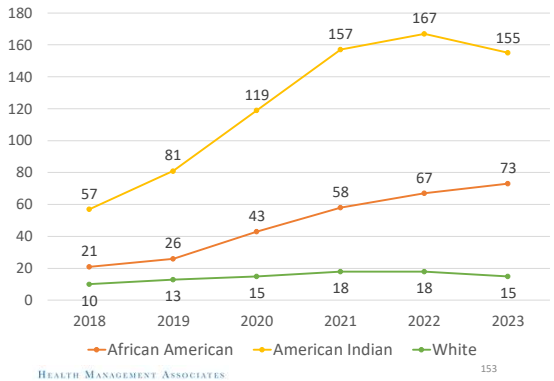
PERSONS LIVING WITH HCV IN MN BY RACE PER 100,000 (2023)



*Rates calculated using 2020 U.S. Census ACS data. Excludes persons with multiple races or unknown race, n=10,234.

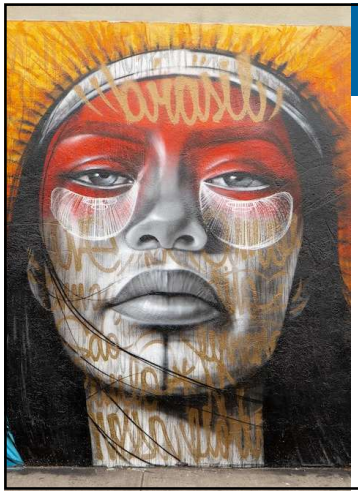
OVERDOSE RATES BY RACE

- In 2021, American Indian Minnesotans were ten times as likely to die from a drug overdose than white Minnesotans. Black Minnesotans were more than three times as likely to die from drug overdose than white Minnesotans.



SEXUAL AND GENDER MINORITIES

Sexual and gender minority (SGM) populations include, but are not limited to, individuals who identify as lesbian, gay, bisexual, asexual, transgender, Two-Spirit, queer, and/or intersex. Individuals with same-sex or -gender attractions or behaviors and those with a difference in sex development are also included.



INTERSECTIONALITY

- Compounded inequities experienced by individuals and populations who belong to two or more marginalized identities
- Impacted by systemic inequities in multiple dimensions
- Example: Black transgender women are impacted by racism, transphobia, and sexism.

Photo Source : Leo Kwan on Unsplash

SEXUAL AND GENDER MINORITIES AND SUBSTANCE USE

- National Survey on Drug Use and Health (NSDUH, 2015) indicates

Substance	Use Rates (sexual minority vs. general population)
Alcohol	12.4% vs 10.1%
Marijuana	37.6% vs 16.2%
Past year opioid use (includes misuse of prescription opioids & heroin)	9% vs 3.8%
Misuse of Prescription opioids (>26 yo)	9% vs 6.4%

- Compared to a heterosexual population, sexual and gender minorities:
  - Enter treatment with more severe SUD (i.e., persistent)
  - Have higher rates of co-occurring mental health disorders including mood disorders, self-harm behaviors (e.g., cutting), suicidality
  - Have a greater risk of HIV infection (men, women and nonbinary)
  - There are far more intervention programs designed and evaluated specifically for White Gay men than there are for other sexual or gender minorities

SEXUAL AND GENDER MINORITIES AND SUBSTANCE USE

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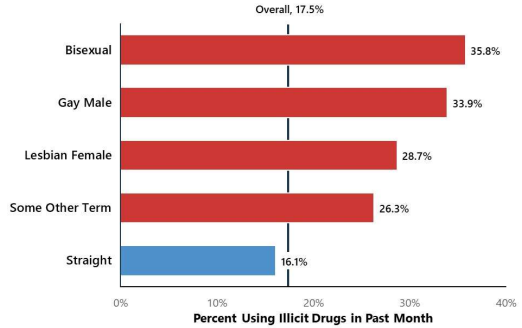
SUBSTANCE USE DISORDER BY SEXUAL MINORITY



According to SAMHSA, the LGBTQ+ people are more likely to use substance than heterosexual counterparts

https://www.samhsa.gov/data/sites/default/files/reports/rpt53159/2023-nsduh-pop-slides-lbgplus.pdf

HIV EPIDEMIOLOGY BY ETHNICITY AND GENDER IDENTITY

Racial and ethnic disparities exist among transgender women with HIV.

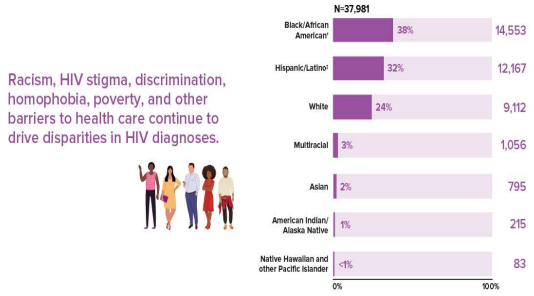
Among transgender women interviewed, 42% had HIV.

of Black/African American transgender women had HIV

of Hispanic/Latina transgender women had HIV

of White transgender women had HIV

HIV diagnoses in the US and 6 territories and freely associated states by race and ethnicity, 2022*



Racism, HIV stigma, discrimination, homophobia, poverty, and other barriers to health care continue to drive disparities in HIV diagnoses.

* Among people aged 13 and older.

† Black refers to people having origins in any of the Black racial groups of Africa. African American is a term often used for people of African descent with ancestry in North America.

‡ Hispanic/Latino people can be of any race.

Source: CDC. Diagnoses, deaths, and prevalence of HIV in the United States and 6 territories and freely associated states, 2022. *HIV Surveillance Report*, 2022;35.

HIV DIAGNOSIS BY RACE

In 2022 37,981 (13- year-old or older) received a diagnosis of HIV in the US and 6 territories

CDC (2024) HIV Surveillance Report: Diagnoses, Deaths, and Prevalence of HIV in the United States and 6 Territories and Freely Associated States, 2022

TRANSGENDER PERSONS AND SUBSTANCE USE

- Trans persons are at elevated risk for developing problems with substance use
  - Up to 72% develop problems with alcohol use
  - Up to 34% develop problems with marijuana use
  - Up to 26% develop problems with prescription drug use
- Both trans Women and people who engage in anal sex are at increased risk for HIV
  - Risky sexual behaviors and prevalence of IV drug use are often a consequence of risk and behavior stressors (violence victimization, transphobia, exchange sex, stigmatization, and stressful life events)
  - Remember that SUD treatment is associated with managing drug use and facilitating safer sex practices!

TRANSGENDER PERSONS AND SUBSTANCE USE: THEORETICAL MODELS

- The **Minority Stress Model** (Hendricks and Testa, 2012) – poses that prolonged exposure to prejudice and discrimination → adverse mental health outcomes and risk behaviors
- The **Syndemic or Multiplicative Model** – risk for a significant adverse outcome (e.g., HIV infection) is a function of multiple, co-occurring problems that multiply to increase the risk
  - We know that risky sexual behaviors can be exacerbated by substance use
  - This multiplier effect argues for a focus on the most effective ways of intervening in SUD as a vehicle for reducing HIV incidence

"Perhaps the most important conclusion of this review is that well-designed, theoretically informed culturally sensitive research focused on developing and rigorously testing interventions for substance use among transgender individuals is alarmingly scarce." – *T.R Glynn, 2017*

BARRIERS TO SUD TREATMENT FOR TRANSGENDER PERSONS

- Lack of knowledge among personnel in SUD treatment about Trans-specific realities and experiences
- SUD treatment providers who stigmatize or have negative attitudes toward Trans persons
- Victimization of Trans individuals (e.g., verbal, physical, and sexual abuse by other clients and staff),
- Discrimination (e.g., room & board, bathroom rules, being required to wear clothes judged as appropriate for their sex assigned at birth)
- Little formal/organized education for staff about the needs of Trans persons
- **False reporting of specialized treatment services for Trans population**
  - Most programs fail to even collect information on gender identity

GROUP DISCUSSION

What strategies do you have in place or are you considering to meet the SUD treatment needs of Trans women?

Please raise your hand if you'd like to share.

ADDRESSING THE TREATMENT NEEDS OF TRANSGENDER PERSONS WITH SUD

"Trans individuals (especially women) who feel they are in Trans-friendly programs are more likely to stay in treatment" – *Lyons, et al, 2017*

- Provide education and training programs for staff on the Trans-specific realities, experience and sensitivity (including health-related issues such as street hormones and needle use)
- Prevent discrimination and stigmatizing behaviors by healthcare providers
- Develop policies that address discrimination, bathrooms, sleeping arrangements, conduct in treatment and other group settings, collection of gender-identity data, name and pronouns – many of these should be posted
- For programs that are not trans-specialized, work to develop and model a culture that is affirming, inclusive, psychologically safe
- Hiring diverse staff representative of the population
- Allow continued use of hormones and encourage medical care for those using street hormones
- Be transparent about the degree of your programs' services for Trans persons

CULTURAL CONSIDERATIONS

HEALTH AND STRUCTURAL INEQUITIES

Health inequities

systematic differences in the health status of different population groups

Structural inequities

personal, interpersonal, institutional, and systemic drivers—such as, racism, sexism, classism, able-ism, xenophobia, and homophobia

THE CONNECTION

- The impact of structural inequities follows individuals "from womb to tomb."
  - Socioeconomic factors that contribute to poor health
  - Social stigma
  - Mistrust of the healthcare institution
- HIV has had a disproportionate impact on minority communities, and studies have documented a pattern of disparities in care for minorities
- This makes the issue of treatment of minorities with HIV a particularly timely and pressing one

CULTURAL CONSIDERATIONS

How do cultural considerations influence treatment engagement?

"An approach to care that uses a cultural competence framework enhances communication between minority patients and their providers, endeavors to use a more diverse array of staff members, proactively enhances the likelihood of receipt of ART, and uses an evidence-based approach to thinking about adherence will improve the likelihood that minority patients will engage in care, be satisfied with care, and have positive HIV-related outcomes".

CULTURAL CONSIDERATIONS: PROVIDE CULTURALLY HUMBLE HIV CARE

- Clinicians must be aware of the particular health-related cultural beliefs and practices of the minority groups within his or her HIV/AIDS practice
- Adopt a culturally humble framework
  - Identify the patient's core cultural issues
  - Explore the meaning of the illness to the patient – question what they think has caused the problem and how it affects their lives
  - Explore the patient's social context
  - Negotiate across the patient-physician culture to develop a treatment plan that is agreeable to both sides (ensure the key issues of the patient are heard and valued)

CULTURAL CONSIDERATIONS: ENHANCING COMMUNICATION IN CLINICAL CARE

- Research shows that minority patients are less satisfied with their HIV/AIDS care than are other patients
- Although many issues may contribute to this lower satisfaction, one issue that comes up repeatedly is ***patient-provider communication***
- Minority patients report that they needed more time to make HIV treatment decisions and more information about HIV treatment options
- Providers should endeavor to spend more time with our minority patients with HIV, and should spend more of that time listening to the patient

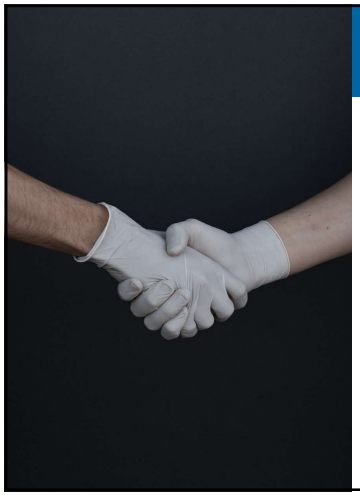
CULTURAL CONSIDERATIONS: DIVERSIFY THE CLINICAL STAFF

- Important to diversify HIV clinical staff
- Very few HIV physicians are racial/ethnic minorities
- No matter how welcoming an HIV care site is, minority patients will feel even more comfortable if at least a few clinical or peer support staff members are of their own racial/ethnic background

Photo Sources: Milad Fakurian and Mapbox on Unsplash

CULTURAL CONSIDERATIONS: OPTIMIZING THE RECEIPT OF CARE AND ART

- Minority patients have reported more problems getting the HIV care they needed and have been less likely to receive medications to treat HIV
- Disparities in receiving ART have persisted
- Medical providers should be aware of the data regarding disparities in the receipt of ART
- Should use strategies in the clinical setting to optimize the likelihood that minority patients will be ***offered, prescribed,*** and actually ***take*** antiretroviral medications.



CULTURAL CONSIDERATIONS: ENHANCE ADHERENCE TO TREATMENT

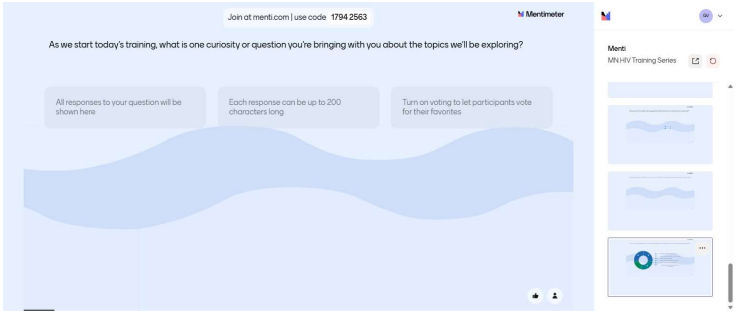
- Stereotypes among HIV care providers that minority patients were less likely to be adherent to ART than were other patients
- Because of this, ART was, at times, withheld from minority patients because of these preconceptions regarding their ability to adhere to it
- Need to eliminate bias (these biases and stereotypes affect providers' treatment decisions and result in failure to treat some minority patients)

Photo Sources: Branimir Balogović on Unsplash

CULTURAL CONSIDERATIONS: MINORITY PATIENTS WITH HIV AND CLINICAL TRIALS

- Minority patients have historically been underrepresented in HIV-related clinical trials, despite their overrepresentation among those living with HIV infection
- Legacy of abuses in past research studies, distrust of the health care system broadly, and beliefs regarding conspiracies continue to fuel the HIV epidemic in minority communities
- There is no easy answer to engaging minorities in clinical trials
- Providers can make efforts to proactively approach all patients about participation in clinical trials and answer their questions/ address any concerns they may have

TIME FOR A POLL



TRAUMA INFORMED CARE

TRAUMA INFORMED CONSIDERATIONS TO ENHANCE CARE AND SUPPORT

Trauma-Informed Care Concepts

1. A basic understanding of trauma
2. Emotional and environmental safety
3. A strengths-based approach to services

THINGS TO REMEMBER

Underlying Question	Symptoms	Healing Happens
• What happened to you?	• Response to experience & events	• Importance of relationships

EMPATHY

https://youtu.be/1Evwgu369Jw

"The sufferings of childhood can shape, and misshape, the life of an adult"
(God Help the Child, Toni Morrison, 2014)

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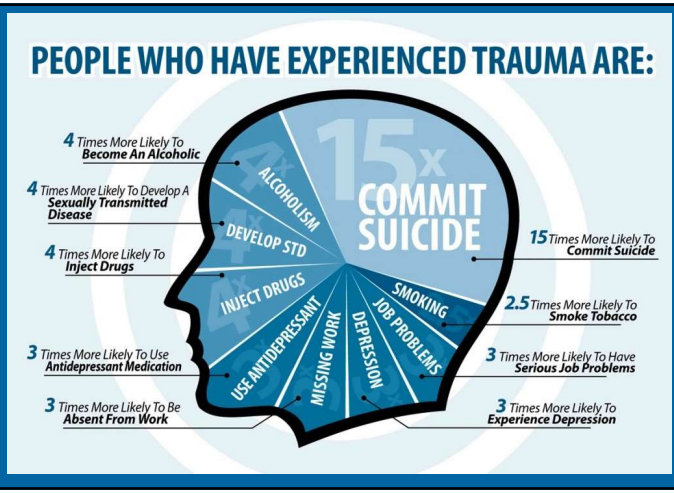
WHAT IS TRAUMA?

"Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."

https://www.integration.samhsa.gov/clinical-practice

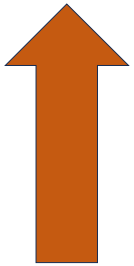
STATED IN ANOTHER WAY (SIMPLE VERSION)

"Trauma is anything that overwhelms a person's ability to cope"



PEOPLE WHO HAVE EXPERIENCED TRAUMA ARE

- 2.5 times smoke tobacco
- 3 times be absent from work
- 3 times have serious job problems
- 3 times experience depression
- 3 times take antidepressant medication
- 4 times more likely to have alcohol use disorder
- 4 times more likely to inject drugs
- 4 times more likely to have a sexually transmitted disease
- 15 times more likely to die by suicide



SPECTRUM OF TRAUMA – CONTEXT

Historical Trauma	Interpersonal Trauma	Compassion Fatigue	Vicarious Trauma
Secondary Trauma	Toxic Stress	Complex Trauma	Chronic Trauma
	Acute Trauma	ACEs	

CHALLENGES OF WORKING WITH PEOPLE WITH TRAUMA EXPERIENCES

- Stigma and implicit bias
- Prevention vs complex care
- Lack of Staff and Provider of training
- Chronicity
- Presence of mental health issues
- Co-morbid health conditions
- High need populations-takes time and people

KEY PRINCIPLES

Image Source: https://www.cdc.gov/orr/infographics/6_principles_trauma_info.htm

KEY PRINCIPLES: SAFETY

1) Safety

- Staff and the people they serve, whether children or adults, feel physically and psychologically safe
- The physical setting is safe and the interpersonal interactions promote a sense of safety.
- Understanding safety *as defined by those served* is a high priority.

KEY PRINCIPLES: TRUSTWORTHINESS AND TRANSPARENCY

2) Trustworthiness and Transparency

- Organizational operations and decisions are conducted with transparency with the goal of maintaining trust with clients and family members, among staff, and others involved in the organization.

KEY PRINCIPLES: PEER SUPPORT

3) Peer Support

- Trauma survivors or family of a child trauma survivor.
- Peer support and mutual self-help are key vehicles for establishing safety and hope, building trust, enhancing collaboration
- Utilize their stories and lived experience to promote recovery and healing

KEY PRINCIPLES: COLLABORATION AND MUTUALITY

4) Collaboration and Mutuality

Importance placed on:

- Partnering
- Leveling of power differences
  - Staff and clients
  - Organizational staff and clerical/housekeeping
  - Professional staff to administrators
- Recognize that everyone has a role to play in TIC
- One does not need to be a therapist to be therapeutic

KEY PRINCIPLES: EMPOWERMENT, VOICE AND CHOICE

5) Empowerment, Voice, and Choice

- Strengths/Experience recognized and built upon
- Organization fosters a belief in:
  - The primacy of people served
  - Resilience
  - The ability of individuals, orgs, and communities to heal and promote recovery from trauma
- Shared decision-making, choice, and goal-setting
- Cultivate self-advocacy
- Staff feel as safe as those receiving services

KEY PRINCIPLES: CULTURAL, HISOTRICAL, AND GENDER ISSUES

6) Cultural, Historical, and Gender Issues

- Moves past stereotypes and biases (race, ethnicity, sexual orientation, age, religion, gender identity, geography, etc.)
- Offers access to gender-responsive services
- Leverages the healing value of traditions cultural connections
- Incorporates policies, protocols, and processes that are responsive to the needs of individuals served
  - Racial
  - Ethnic
  - Cultural
  - Disability
- Recognizes and addresses historical trauma

TRAUMA-INFORMED SKILLS FOR RESPONSE

- **Safety Skills**
- **Emotional Management Skills**
- **Grieving and Imagination**
- **Leadership Skills**
- **Communication Skills**
- **Cognitive Skills**
- **Judgment Skills**

RESILIENCY

Resiliency is how well we cope with adversity and stress. We can build or lose resiliency throughout our lives.

GROUP DISCUSSION

Now that you have a better understanding of cultural and trauma informed considerations, what can we do as service providers to enhance care for racial and sexual minorities?

Please raise your hand if you'd like to share.

5-MINUTE STRETCH BREAK!

HIV, PREGNANCY AND SUD/OUD

*Throughout this presentation the terms mother or maternal or she or her are used in reference to the birthing person. We recognize not all birthing persons identify as mothers or women. We believe all birthing people are equally deserving of gender-specific care that helps them attain their full potential and live authentic, healthy lives.

LEARNING OBJECTIVES: HIV, PREGNANCY AND SUD/OUD

- Summarize at least 3 major considerations (important headlines) for HIV+ pregnant persons with SUD
- List 3 approaches to reduce the risk of HIV transmission from a birthing person to an infant during pregnancy, breastfeeding
- Compare the effectiveness of and considerations for using substance use disorder treatment with medications and other treatments for SUD in pregnant and parenting persons

CHATTERFALL

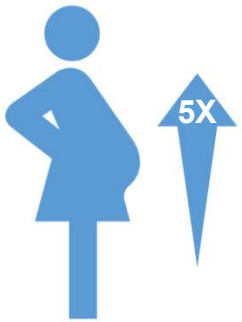
CHATTER FALL

Please take a minute to type your response in the Zoom Group Chat, but don't click enter.

What information do you need to better prepare you to care for pregnant/parenting persons with OUD, SUD, HIV and their affected children?

When instructed, please click enter.

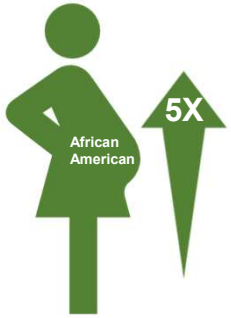
EPIDEMIOLOGY OF SUD DURING PREGNANCY



- SAMHSA data: > 400,000 infants are exposed to alcohol and other potential substance of abuse during pregnancy in the US each year
- Number of pregnant women with OUD increased from 1.5/1000 → 8.2/1000 live births (1999-2017)
- In MN the prevalence of Neonatal Abstinence Syndrome (NAS) was 10.3/1000 live births (7.3/1000 in US)
- Twenty-seven (27%) percent reported they wanted to cut down or stop using but didn't know how
- Eight percent (8%) of women with OUD/SUD receive needed treatment (most are never screened)

Sources: SAMHSA and National Survey on Drug Use and Health, 2022

EPIDEMIOLOGY OF HIV DURING PREGNANCY IN THE UNITED STATES



- Approximately 8,000 HIV+ women give birth in the US every year and fewer than 50 infants are born with HIV
- Transmission of HIV can occur throughout pregnancy, during childbirth and with breastfeeding (Perinatal Maternal to Child Transmission – PMTCT)
- While the US and Europe have experienced steep declines in perinatal HIV transmission (to <1%), African American infants have 5X the incidence of perinatal HIV transmission versus white infants
- In MN the incidence of HIV infected neonates has been ZERO since 2018
- Approaches to PMTCT prevention vs. treatment vary across the globe

POTENTIAL EFFECTS OF PERINATAL HIV AND SUD ON THE BIRTHING PERSON AND BABY

CASE: KAYLA

Kayla is 23-year-old HIV+ woman with a positive pregnancy test during a primary care visit for persistent nausea. Upon examination, Kayla is found to be 11 weeks pregnant. She states the pregnancy was not expected but she wants to keep the child. **In response to questions from an evidence-based verbal screening tool,** she indicated that she takes both oxycodone and hydrocodone for persistent back pain that resulted from a car accident when she was 19. She is still complaining of back pain and is worried that as the pregnancy goes on, her back pain will worsen. Kayla is **mostly compliant with her ART,** but occasionally skips her specialty follow-up visits. She acknowledges that she takes more than the prescribed amounts of opioids. Although concerned her pain may exacerbate during pregnancy, **she would like assistance with her opioid misuse and is concerned about the risk of HIV transmission to her infant**.

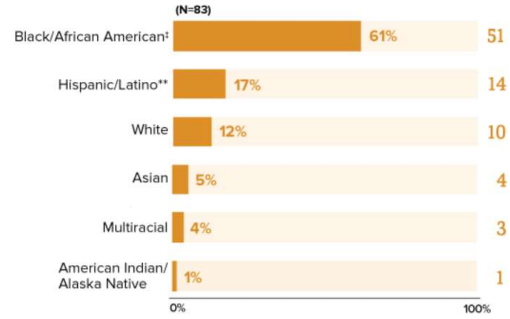
HIV POSITIVE PREGNANCIES: WHERE HAVE WE BEEN?

- By 1987 the approval for AZT (zidovudine) enabled the treatment and prophylaxis of pregnant women with HIV in the US and globally*
- By the 1990s, short course ART or single dose AZT was available across the globe
- We witnessed Perinatal Maternal to Child Transmission (PMTCT) rate decrease from 25% to less that one percent (<1%) in the US and other high-income countries

SOURCE: free.unaids.org

PERINATAL HIV INFECTIONS IN THE US AND DEPENDENT AREAS BY RACE/ETHNICITY, 2019

New perinatal HIV diagnoses disproportionately affect certain racial and ethnic groups.



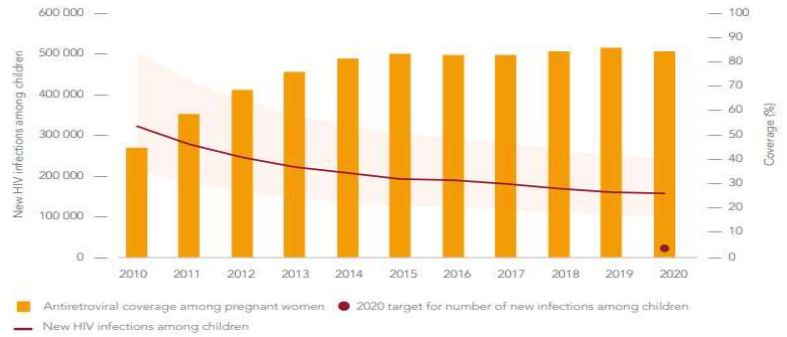
Source: CDC HIV Surveillance Report, 2021;32

WHERE HAVE WE FAILED IN ADDRESSING PERINATAL HIV/AIDS IN THE US?

- Overall, the number of infants and young children infected from perinatal transmission continues to decline: from 141 cases in 2014 to 51 cases in 2019 (and has been ZERO in MN for the past few years)
- In the United States, the overwhelming majority of new cases of HIV in children occurs among Black/African American Children
  - The racial/ethnic disparity of HIV diagnosed children under 13 years is greater than for adults (60% of children are Black/African American vs 57% of adults)

Source: CDC HIV Surveillance Report, 2021;32

NEW HIV INFECTIONS AMONG CHILDREN AND ART COVERAGE AMONG PREGNANT WOMEN WORLDWIDE



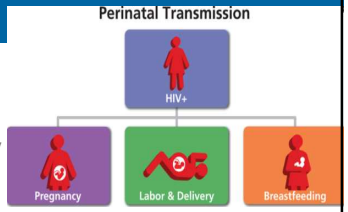
SOURCE: UNAIDS Epidemiologic Estimates 2023. aidsinfo@usaids.org

WHERE HAVE WE FAILED IN ADDRESSING PERINATAL HIV/AIDS ACROSS THE GLOBE?

- The World Health Organization (WHO) and other Global HIV/AIDs guidelines have focused for decades on the prevention of PMTCT – some would say to the exclusion of treatment
- The PMTCT cascade of tests and treatment are managed in the US and high and middle-income countries, but in low to middle-income countries, the necessary systems are immature to non-existent
- Integrating PMTCT and Maternal-Neonatal-Child Health programs and simplification for WHO guidelines has improved timely initiation of ART, but post-partum engagement of HIV infected/exposed mothers and infants is still problematic

Photo Source: Microsoft Stock Photos

IMPORTANT FACTS TO KNOW ABOUT HIV POSITIVITY DURING PREGNANCY AND PERINATAL TRANSMISSION



HIV infection can be:
- Passed vertically from mom to fetus during pregnancy
- Spread through contact with blood and bodily fluids during childbirth
- Passed through breastmilk

- Routine HIV screening of all sexually active persons with childbearing potential should occur as early as possible during pregnancy (opt-out)
- Because of disparities in access to screening, prevention and treatment, we should ensure that individuals from other countries receive information during pre-conception counseling and offered screening and treatment

CONSIDERATIONS WHEN PREGNANCY, HIV, AND SUD COEXIST

- Some substances are more detrimental to those at risk for or who have HIV than others
  - Stimulants have been associated not only with increased risky behavior, but with accelerated HIV disease progression, poor ART adherence and lack of viral suppression
  - Alcohol, benzodiazepine and opioid use all increase risky behaviors associated with HIV; cannabis does not appear to have the same significant effect
- Screening for SUD should be part of routine clinical care of persons with HIV

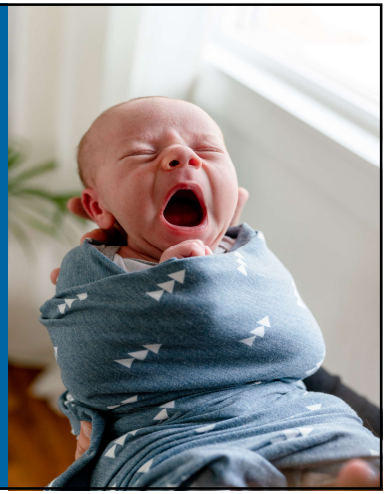
SOURCE: Ross EJ et al. Overamped: Stimulant Use and HIV Pathogenesis. Curr HIV/AIDS Rep. 2023 Dec;20(6):321-332

CONSIDERATIONS WHEN PREGNANCY, HIV AND SUD COEXIST (CONT.)

Recommendations for the Use of Antiretroviral Drugs in Pregnant Women with HIV Infection *and* Interventions to Reduce Perinatal HIV Transmission in the United States

- Individuals on substance use disorder treatment with medications are more likely to initiate and maintain ART regimens
- Ongoing SUD is NOT a contraindication to prescribing/using ART
  - Use of low risk, easy ART regimens are preferred
- ART agents that inhibit or induce the CYP system (liver enzymes) may interact with methadone and buprenorphine (no such interaction with naltrexone)
- PrEP should always be used for high-risk encounters including during pregnancy and breastfeeding for HIV negative persons

PERINATAL SUD



CHATTER FALL

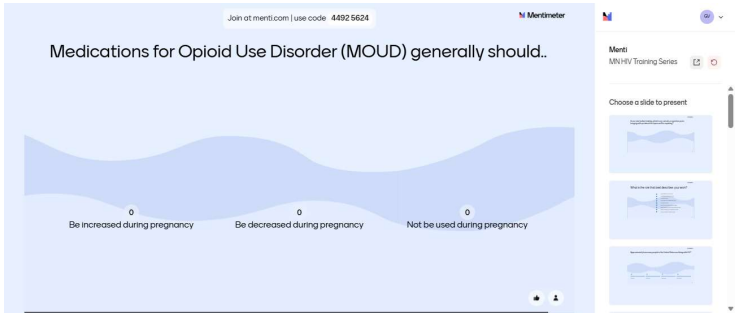
Please take a minute to type your response in the Zoom Group Chat, but don't click enter.

Medications for Opioid Use Disorder (MOUD) generally should..

A. Be increased during pregnancy
B. Be decreased during pregnancy
C. Not be used during pregnancy

When instructed, please click enter.

TIME FOR A POLL



MEDICATION FOR OPIOID USE DISORDER IS STANDARD OF CARE IN PREGNANT PERSONS WITH SUD

Treatment	Overdose Deaths	Retention in Treatment	Pregnancy Outcomes	Neonatal Abstinence Syndrome (NAS)
Detoxification/ Withdrawal				
Methadone				
Buprenorphine (Mono)				
Buprenorphine/ Naloxone				
Naltrexone				

	Research indicates use is contraindicated and/or that risks of poor outcome outweigh benefits of use
	Research is insufficient to conclude that benefits outweigh risks or benefits exceed other meds
	Research indicates that benefits do outweigh risks or that benefits do exceed those of other meds

ADDITIONAL CONSEQUENCES OF OPIOID USE DURING PREGNANCY

- Fetus exposed to unstable opioid levels
- Mother less likely to get prenatal care
- Fetus & mother more likely to be exposed to morbidity & mortality from IDU & risky behaviors
  - HIV, HCV
  - Endocarditis, cellulitis
  - Trauma

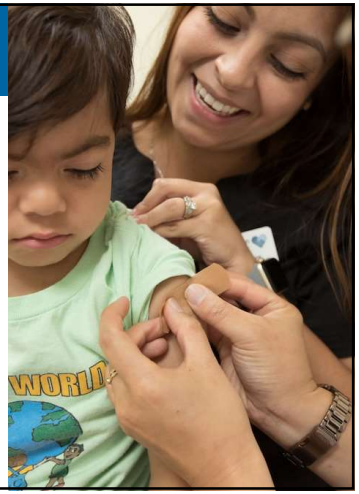


Photo Source : CDC on Unsplash

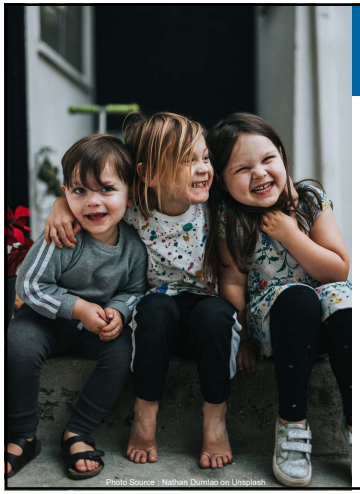


Photo Source : Nathan Dumlao on Unsplash

BENEFITS OF MOUD USE DURING PREGNANCY

- Reduced complication of IDU
- Seventy-five percent (75%) less likely to die related to their addiction
- Improves adherence to prenatal care & addiction
- Safer and healthier communities
- Reduced cravings
- Reduced illicit opioid use
- Reduced OD events
- Reduced criminal behavior
- Reduced risk of obstetric complications

CASE STUDY: KAYLA'S NEWBORN

- Baby M was born in February 2019
- Initially ambivalent, Kayla warmed to the idea of being a mom
- Mom is HIV+ (adherent on ART) with undetectable viral load 1 week prior to delivery. She has not been adherent with buprenorphine and has continued intermittently using pressed opioid pills and occasional alprazolam
- Total infant stay was 28 Days
- Total morphine need was:
  - 50.6 mg total
  - 18.7 mg/day
  - 2.3 mg/dose
- Infant stayed on 4 different hospital units
- Kayla felt judged, inadequate and powerless

CONSEQUENCES OF PERINATAL SUD

	Preterm Labor	Low Birthweight	Fetal demise	Cognitive or Developmental Effects	Other
Tobacco	X	X	X		Birth defects
Alcohol	X	X		X	Fetal Alcohol Spectrum Disorders (FASD)
Cannabis		X	X	X	Mood/ behavioral disorders
Opioids	X	X		X	Abruption, Neonatal Abstinence Syndrome (NAS)

SOURCE: See consolidation of Perinatal Outcome References at end of this presentation

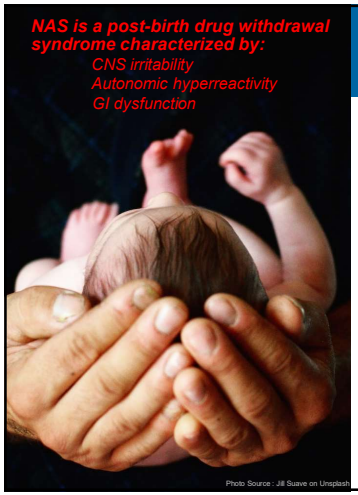
TIME FOR A POLL

Note:
Neonatal Abstinence Syndrome (NAS)

TIME FOR A POLL

Which of the following statement(s) is/are most accurate about infants exposed to opioids?

A. Infants born of mothers on substance use disorder treatment with Buprenorphine or Methadone, for more than 6 weeks during the pregnancy rarely have symptoms of neonatal abstinence syndrome (NAS).
B. The modified Finnegan score is the gold standard for monitoring infants with NAS.
C. Mothers on substance use disorder treatment with medications should never breast feed their infants.
D. Cannabis use causes fewer short and long-term effects than on exposed infants than do opioids.
E. A significant % of opioid exposed infants with NAS can be treated without pharmacotherapy.



NEONATAL ABSTINENCE SYNDROME (NAS): HOSPITAL CARE

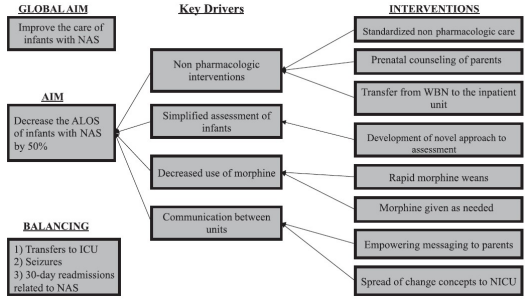
- NAS may not be recognized (occurs in 50-80% of exposed infants)
- Goals
  - Optimize growth and development
  - Minimize negative outcomes
  - Support secure attachment and post-discharge opportunity for health and wellbeing
  - Reduce lengths of stay and treatment
- Having a protocol for identification and management is critical
- Historic approaches to management are giving way to new paradigms

CHANGING PARADIGMS OF CARE FOR NEONATES WITH NAS

Eat - ≥ 1 oz or full breast-feeding session

Sleep - ≥ 1 hour between feeds

Console – Cease crying within 10 min. of being consoled



Grossman MR, et al. Pediatrics. 2017;139(6):e20163360

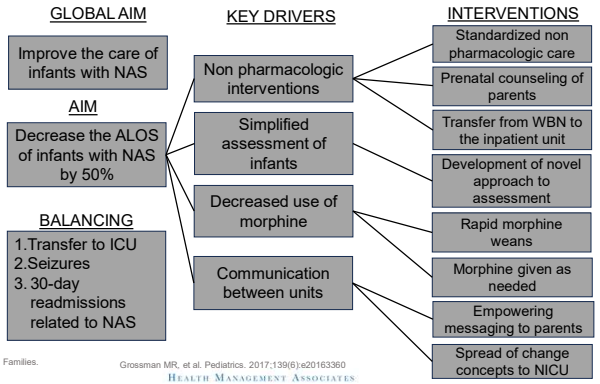
Picture from Admin of Children and Families.

CHANGING PARADIGMS OF CARE FOR NEONATES WITH NAS

Eat - ≥ 1 oz or full breastfeeding session

Sleep - ≥ 1 hour between feeds

Console – Cease crying within 10 min. of being consoled



Picture from Admin of Children and Families.

Grossman MR, et al. Pediatrics. 2017;139(6):e20163360

CHANGING PARADIGMS OF CARE FOR NEONATES WITH NAS

- **Special ward setting** (non-ICU)
- **Staffing** - dedicated, trained
- **Mom's Roles** – assessments
- **Improved communication**
- **Comprehensive care**

Prenatal Consultation

⬇

Inpatient Observation & NAS Treatment while Rooming In

⬇

Appropriate Neuro-developmental + Primary Care Follow-Up and Support

Source: *Czynski A. Family Care Support Services, Women and Infants Hosp, RI*

STANDARDIZED NON-PHARMACOLOGIC CARE BUNDLE

- Support and coaching for parents (consoling support interventions)
- Proactive skin protection
- Environmental Accommodations

- Maternal presence and Rooming-in
- Dim lights
- Reduced NICU admission
- Reduced/coordinated interventions
- Reduction in white noise/sound (location)
- Limit visitors

STANDARDIZED NON-PHARMACOLOGIC CARE BUNDLE CONT.

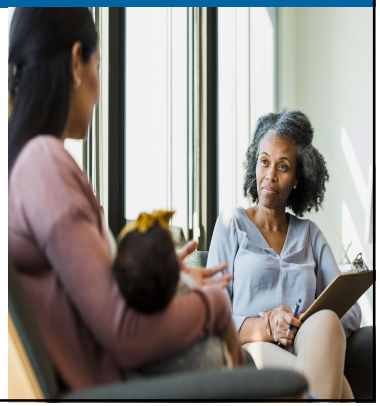
- Swaddling
- Cuddler program
- Breastfeeding promotion/On demand feeds
- Non-nutritive sucking
- Establishing policies and procedures
  - Non-pharmacologic interventions
  - As needed (PRN) vs. scheduled Morphine
  - Guidelines for assessment and monitoring
  - Methadone and adjunctive therapies
  - Rapid medication weaning protocol

Outcomes realized:

- Better engaged, more confident parents
- Reduced use and absolute dosage of medication
- Reduced length of stay
- Reduced overall costs of care

PLANS OF SAFE CARE

Plan of Safe Care is a **formalized plan established by the medical care provider** with the primary caregiver of an infant born with, and identified as being affected by, substance abuse or withdrawal symptoms resulting from prenatal drug exposure or a fetal alcohol spectrum disorder **to address the immediate needs of the affected infant** as well as the ongoing treatment needs of the affected infant and the health and substance use disorder **treatment needs of the affected family or caregiver**.



PLAN OF SAFE CARE DOMAINS

- **Primary, Obstetric and Gynecological Care**
- **Infant Health and Safety** (physical health, neurodevelopment expertise/high risk infants)
- **Prevention and Treatment of Mental Health and Substance Use Conditions**
- **Infant and Child Development** (developmental screening, early intervention, Help Me Grow)
- **Parenting and Family Support** (home visiting, classes, Road to Resilience)
- ***Other referrals** (e.g., addressing social determinants of health)

Source: ACL 20-122

* Implied but not expressly called out in the ACL

PLAN OF SAFE CARE: WHAT A POSC IS NOT

Traditional Plans completed by different disciplines:

Discharge Plans	CWS Safety Plans	SUDS & MH Treatment Plans
May focus on health and well being of the infant.	Focus on the immediate safety of a child or infant.	Usually focuses on treatment of adults.

Plans of Safe Cares are more comprehensive and include both safety and well-being factors such as:

- Safety factors
- Treatment Factors for substance use and mental health for adult but also includes broad services for the whole family including the child and the parent-child dyad.
- Include ongoing health and development of the infant as well as educational and treatment needs of family/caregiver who will be caring for the infant.

EDUCATE STAFF ABOUT NAS AND EMERGING PRACTICES

Identification, evaluation, and treatment

- Clinical providers and staff with strong foundation of knowledge can educate and support families
- Positive interactions with families of newborns with NAS contribute to better outcomes and reduced LOS
- Provider and staff interactions with families should be supportive and non-judgmental
- Families can play valuable role in care, including mothers being encouraged to breastfeed if on stable substance use disorder treatment with medications

Photo Source: Microsoft Stock Images

OPIOIDS and NAS
When reporting on mothers, babies, and substance use
LANGUAGE MATTERS

I am not an addict.
I was exposed to substances in utero. I am not addicted. Addiction is a set of behaviors associated with having a Substance Use Disorder (SUD).

I was exposed to opioids.
While I was in the womb my mother and I shared a blood supply. I was exposed to the medications and substances she used. I may have become physiologically dependent on some of those substances.

NAS is a temporary and treatable condition.
There are evidence-based pharmacological and non-pharmacological treatments for Neonatal Abstinence Syndrome.

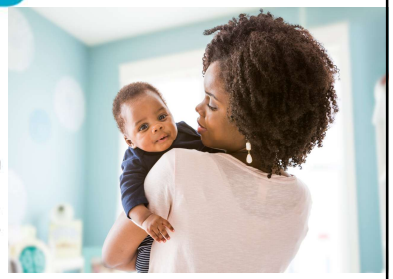


Photo Source: Microsoft Stock Images
Language Matters Information Sheet nationalperinatal.org

EMPOWERING MESSAGES TO PARTNERS

"On the inpatient unit, we explained that our first-line and most important treatment would center around measures to comfort the infant and that these should be performed by a family member. Parents were told that they were the treatment of their infants and must be present as much as possible. Nurses and physicians focused on supporting and coaching parents on the care of their infants."

Grossman MR et al. An Initiative to Improve the Quality of Care of Infants with Neonatal Abstinence Syndrome. Pediatrics. 2017;139(6):e20163360

BREASTFEEDING AND PARENTAL SUD AND HIV

BENEFITS OF BREASTFEEDING

Breastfeeding reduces the risk of:

- Respiratory infections and otitis media
- Gastrointestinal infections
- Sudden infant death syndrome
- Protection against allergic disease
- Celiac disease, inflammatory bowel disease
- Obesity, diabetes (types 1 and 2)
- Adverse neurodevelopmental outcomes

- Maternal benefits: reduced risk of breast and ovarian cancer
- Maternal bonding/decreased risk of abuse
- Breastfed infants less likely to require pharmacological intervention for NAS
- Reduced symptoms of NAS
- Shorter length of stay for NAS
- Shorter duration of pharmacologic treatment when needed for NAS

CONTRAINDICATIONS TO BREASTFEEDING

- Medical contraindications in infant (e.g., galactosemia +/- phenyl ketonuria [PKU])
- Specific Maternal infections
  - HIV*
  - Brucellosis (untreated)
  - Cracked nipples in women with HepB/C**
  - COVID-19***
  - Human T-lymphocyte virus (HTLV) I or II
  - Active, untreated tuberculosis (TB)***
  - Active herpes simplex virus (HSV) lesions (including Varicella) on nipple/breast**
- Women with SUD (including cannabis) – not stable in treatment

* Updated guidelines encourage informed consent, without actively discouraging breastfeeding
** Pump and dump
*** Pump but avoid close contact

BREASTFEEDING GUIDANCE FOR PEOPLE WITH HIV – NIH AND CDC, 2023

- Mothers who have questions about breastfeeding or who want to breastfeed should receive patient-centered, evidence-based information and counseling on infant feeding options, including ways to reduce the risk of HIV transmission through breast milk including:
  - Replacement feeding with properly prepared formula or pasteurized donor human milk from a milk bank eliminates the risk of postnatal HIV transmission to the infant.
  - Achieving and maintaining viral suppression through ART during pregnancy, delivery, and postpartum decreases risk of transmission through breastfeeding to less than 1%, but not zero.
- If mothers choose to breastfeed, providers should emphasize the importance of adherence to ART.
- Mothers with HIV who choose to breastfeed should receive close follow-up.
- Healthcare providers are encouraged to consult the National Perinatal HIV/AIDS Hotline (1-888-448-8765) if they have questions regarding mothers with HIV who want to breastfeed.

SOURCE: NIH Recommendations for ART During Pregnancy and Interventions to reduce Perinatal HIV Transmission. Jan. 2023 https://clinicalinfo.hiv.gov/en/guidelines/perinatal/whats-new

WHAT ABOUT BREASTFEEDING AND SUBSTANCE USE DISORDER TREATMENT WITH MEDICATIONS?

- Methadone (3%) and Buprenorphine (2.4%) pass thru breastmilk in clinically insignificant amounts
  - Encourage breastfeeding (especially during NAS)
- Limited information about naltrexone and breastfeeding
  - Limited transfer into breastmilk (0.86%)
- Information on long term effects of substance use disorder treatment with medications exposure is still unclear
- Benefits outweigh the risks
- Communication and "informed consent"
  - Benefits: Mothers should know the benefits of breastfeeding and of taking meds while breastfeeding
  - Risks: Considerations for breastfeeding while on any Medications (especially other psychotropic medications)
  - Risks: Mothers should know contraindications and relative contraindications
  - Risks: Mothers should know risk of relapse and risky behaviors if not on medications

Sachs et al. (2013); https://www.ncbi.nlm.nih.gov/books/NBK501922

FACTORS THAT INFLUENCE INFANT FEEDING DECISIONS AMONG PERSONS ON SUBSTANCE USE DISORDER TREATMENT WITH MEDICATIONS

- Social stigma surrounding substance use disorder treatment with medications
- Information and misinformation from healthcare personnel
  - Mixed messages from providers
  - Overt or implicit messages from nursing and other support staff
- Court or Child Protective Services "orders" to refrain from breastfeeding
- Feedback and Information from peers

SAMPLE SCRIPT FOR ADDRESSING MARIJUANA USE AND BREASTFEEDING SANTA CLARA VALLEY MEDICAL CENTER

Importance of highlighting the benefits of breastfeeding and education of families, context is in caring for the mother and baby as a whole…

Marijuana script excerpts

Marijuana, also known as "weed" or "pot" is now legal in California for adults over 21. But this doesn't mean it's safe for pregnant or breastfeeding moms or babies. THC in marijuana gets into breast milk and may affect your baby's brain and development…

Secondhand marijuana smoke is also bad for your baby. Marijuana smoke has many of the same chemicals as tobacco smoke. Some of these chemicals may cause cancer or Sudden Infant Death Syndrome (SIDS). Don't allow anyone to smoke anything in your home or around your baby…

If you choose to smoke, it is really important to have someone who is not under the influence watching your baby. And be sure to keep marijuana, including edibles, out of reach of children…

Given the concerns about possible effects on your baby's brain and development, we recommend not smoking marijuana or using marijuana edibles while you are breastfeeding.

WHICH OF THE FOLLOWING STATEMENT(S) IS/ARE MOST ACCURATE ABOUT INFANTS EXPOSED TO OPIOIDS? – THE ANSWER

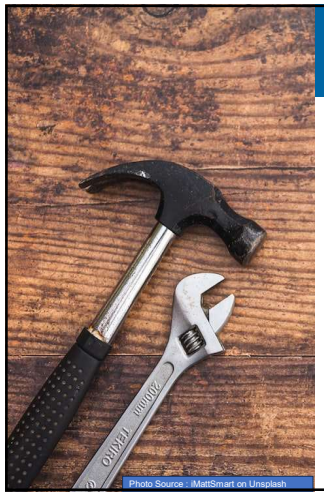
A. Infants born of mothers on substance use disorder treatment with medications, such as Buprenorphine or Methadone, for more than 6 weeks during the pregnancy are rarely born with symptoms of neonatal abstinence syndrome (NAS).

B. The modified Finnegan score is the gold standard for monitoring infants with NAS.

C. Mothers on substance use disorder treatment with medications should never breast feed their infants.

D. Cannabis use causes fewer short and long-term effects than on exposed infants than do opioids.

E. A significant % of opioid exposed infants with NAS can be treated without pharmacotherapy.



RESOURCES

- **NAS Toolkit –** 39 best practices, guidelines and protocols on perinatal SUD
  nastoolkit.org
  - Breastfeeding: Best Practice 9
  - NAS: Best Practices 16-24
  - Outcomes of exposed infants: Best Practices 28-33
  - Neurobiology of SUD: Best Practice 7, 8, 10, 13, 14, 37
- CA SUD Consultation line (UCSF): https://nccc.ucsf.edu/clinician-consultation/substance-use-management/california-substance-use-line/
- Minnesota Women's Recovery Services mn.gov/dhs/recovery
- SAMHSA: SAMHSA's National Helpline **https://www.samhsa.gov/find-help/national-helpline**

QUESTIONS?

REFERENCES: PERINATAL HIV/AIDS

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- AVERT – Global Info and Education on HIV and AIDS. https://www.avert.org/professionals/hiv-programming/prevention/prevention-mother-child
- CDC https://www.cdc.gov/hiv/group/gender/pregnantwomen/index.html
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- NIH https://hivinfo.nih.gov/understanding-hiv/fact-sheets/preventing-mother-child-transmission-hiv
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RESOURCES

The Clearinghouses for Evidence-based Practices

- The California Evidence-based Clearinghouse for Child Welfare. https://www.cebc4cw.org/
- Title IV-E Prevention and Services Clearinghouse. https://preventionservices.abtsites.com/

Home Visiting

- Maternal Infant and Early Childhood Home Visiting. https://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting-overview
- California Home Visiting Program. https://www.cdph.ca.gov/Programs/CFH/DMCAH/CHVP/Pages/default.aspx
- Evidence-based Practices and Resource Center (formerly National Center for Evidence-based Practices). https://www.samhsa.gov/ebp-resource-center
- Child Welfare Information Gateway. Strengthen Families and Education to Prevent Maltreatment. https://www.childwelfare.gov/pubpdfs/parented.pdf

CDC Opioid Prescribing Guidelines https://www.cdc.gov/opioids/providers/prescribing/index.html

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ACCESSING, OBTAINING, AND INTEGRATING SERVICES IN MN

LEARNING OBJECTIVES: ACCESSING, OBTAINING, AND INTEGRATING SERVICES IN MN

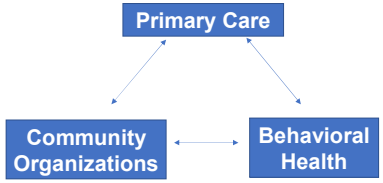
- Understand and explain the key concepts of whole-person care
- Be able to list at least 3 of the basic chemical dependency rules/regulations in Minnesota
- Describe the continuum of recovery support services for substance use and HIV treatment in Minnesota and be able to list at least 3 resources for accessing those services
- Discuss the importance of linkages, warm handoffs and case management for retention on a recovery path

WHOLE PERSON CARE

The patient centered use of diverse health care resources to deliver the physical, behavioral, emotional, and social services required to improve wholistic health.

WHOLE PERSON CARE

Involves care coordination between primary care, community-based organizations, and behavioral health providers.



CASE MANAGEMENT

Case Management is the tool that health care providers and social service organizations can use to coordinate their efforts.

A case management approach

- Recognizes that satisfying such basic needs as general health and adequate housing and food when an individual has SUD can be overwhelming
- SUD symptoms will impair a person's ability to gain access to formalized system of services
- Should be utilized in dealing with the multiple problems presented by HIV in combination with SUD
- Promotes teamwork among the various providers
- Linkages can greatly benefit the client and improve care

CASE MANAGEMENT AND COUNSELING

Counselors should be knowledgeable about the eligibility criteria, duration of service, and amount of assistance for basic financial assistance programs, including welfare, unemployment insurance, disability income, food stamps, and vocational rehabilitation.

For specific information on economic assistance available in Minnesota visit the Department of Human Services website: http://mn.gov/dhs/.

Photo Source : LinkedIn Sales Solutions on Unsplash

GROUP DISCUSSION

What successes have you experienced thinking about case management and counseling of your clients?

Please raise your hand if you'd like to share.

HEALTH CARE COVERAGE

In response to implementation of the Affordable Care Act, Minnesota's health care exchange, **MNsure** has partnered with agencies across the state to offer free enrollment assistance. Certified agents and navigators will be available to answer questions, recommend plan selection and work to help you complete your enrollment.

Whether you seek a competitively priced private health insurance plan or qualify for a public program like Medical Assistance or MinnesotaCare, you can contact an assister agency to schedule an appointment or request walk-in hours.

For more information please visit the MNSURE webpage at https://www.mnsure.org/, or contact MNSURE by phone at 1-855-366-7873.

HEALTH CARE COVERAGE

The Ryan White Care Act provides additional coverage for those living with HIV that may be uninsured or under-insured.

For information about Ryan White Programs in Minnesota please visit the Minnesota Department of Human Services webpage:

https://mn.gov/dhs/people-we-serve/seniors/health-care/hiv-aids/programs-services/

2024 MINNESOTA STATUTES – SUBSTANCE USE TREATMENT

2024 Minnesota Statues:
https://www.revisor.mn.gov/statutes/cite/245G/pdf

Service Initiation

The license holder must complete an **initial services plan within 24 hours** of the day of service initiation.

The plan must be person-centered and client-specific, address the client's immediate health and safety concerns, and identify the treatment needs of the client to be addressed during the time between the day of service initiation and development of the individual treatment plan.

2024 MINNESOTA STATUTES – SUBSTANCE USE TREATMENT

Comprehensive Assessment and Assessment Summary

A comprehensive assessment of the client's substance use disorder must be administered face-to-face by an alcohol and drug counselor **within five calendar days** from the day of service initiation for a residential program or by the end of the fifth day on which a treatment service is provided in a nonresidential program. The number of days to complete the comprehensive assessment excludes the day of service initiation. If the comprehensive assessment is not completed within the required time frame, the person-centered reason for the delay and the planned completion date must be documented in the client's file.

The comprehensive assessment is complete upon a qualified staff member's dated signature. If the client received a comprehensive assessment that authorized the treatment service, an alcohol and drug counselor may use the comprehensive assessment for requirements of this subdivision but must document a review of the comprehensive assessment and update the comprehensive assessment as clinically necessary to ensure compliance with this subdivision within applicable timelines. **An alcohol and drug counselor must sign and date the comprehensive assessment review and update**.

2024 MINNESOTA STATUTES – SUBSTANCE USE TREATMENT

Individual Treatment Plan

Each client must have a person-centered individual treatment plan developed by an alcohol and drug counselor within **ten days from the day** of service initiation for a residential program, by the end of the tenth day on which a treatment session has been provided from the day of service initiation for a client in a nonresidential program, not to exceed 30 days. Opioid treatment programs must complete the individual treatment plan within 21 days from the day of service initiation

2024 MINNESOTA STATUTES – SUBSTANCE USE TREATMENT

245G.07 Treatment Service: A licensed residential treatment program **must offer the treatment services in clauses (1) to (5) to each client**, unless clinically inappropriate and the justifying clinical rationale is documented. A **nonresidential treatment program must offer all treatment services in clauses (1) to (5)** and document in the individual treatment plan the specific services for which a client has an assessed need and the plan to provide the services:

(1) **individual and group counseling** to help the client identify and address needs related to substance use and develop strategies to avoid harmful substance use after discharge and to help the client obtain the services necessary to establish a lifestyle free of the harmful effects of substance use disorder;

(2) **client education strategies** to avoid inappropriate substance use and health problems related to substance use and the necessary lifestyle changes to regain and maintain health. Client education must include information on tuberculosis education on a form approved by the commissioner, the human immunodeficiency virus according to section 245A.19, other sexually transmitted diseases, drug and alcohol use during pregnancy, and hepatitis;

2024 MINNESOTA STATUTES – SUBSTANCE USE TREATMENT

245G.07 Treatment Service

(3) **a service to help the client integrate gains** made during treatment **into daily living** and to reduce the client's reliance on a staff member for support;

(4) a service to address issues related to **co-occurring disorders**, including client education on symptoms of mental illness, the possibility of comorbidity, and the need for continued medication compliance while recovering from substance use disorder. A group must address co-occurring disorders, as needed. When treatment for mental health problems is indicated, the treatment must be integrated into the client's individual treatment plan; and

(5) **treatment coordination provided one-to-one** by an individual who meets the staff qualifications in section 245G.11, subdivision 7.

TRANSITIONS OF CARE

Photo Source : Mark Duffel on Unsplash

CONTINUITY OF CARE-CROSS SECTOR TRANSITION

Transitions of care should happen seamlessly throughout the SUD eco-system

- Emergency Department/Hospital
- Detox / Sobering Centers
- Increase/decrease in level of care intensity (residential, intensive outpatient, outpatient)
- Psychiatric care
- Primary and specialty care (including ObGyn)
- Incarceration
  - Opportunity for in reach into incarcerated settings
    - Telehealth visits
    - In person

TRANSITIONS: WHAT IMMEDIATE NEEDS DO CLIENTS HAVE?

- Housing
- Food
- Insurance
- Medical and Behavioral Health Care

GROUP DISCUSSION

What would make the transition from one point of contact to another more successful?

Please raise your hand if you'd like to share.

TRANSITIONS: WHAT MAKES TRANSITIONS EFFECTIVE?

- Creating the relationship (engagement) with the individual pre-initiation to inform, support and educate about initiation
- Begin transition and safety planning immediately
  - Interim plan - assuming individual can leave at any time for any reason
- Supporting through initiation, including education about resources, supports and next steps
- Intentional planning for referral and linkage to resources, including treatment and resources to address social determinants of health (SDOH)
- Maintaining responsibility for core care coordination roles unless or until this responsibility is intentionally transitioned to another responsible individual with consent of patient

WARM HANDOFF: WHAT IT IS AND WHAT IT ISN'T

What is a Warm Handoff?

- A **transition of responsibility** for care coordination
- Conducted **in person** with the patient (and family/supports if applicable) and the transferring and receiving individuals responsible for care coordination
- May, through necessity, be "virtually" in person, but **must minimally include individuals noted above**
- Recommend confirmation of transition – **or the handoff is not complete**

WARM HANDOFF: WHAT IT IS AND WHAT IT ISN'T

What is NOT a Warm Handoff?

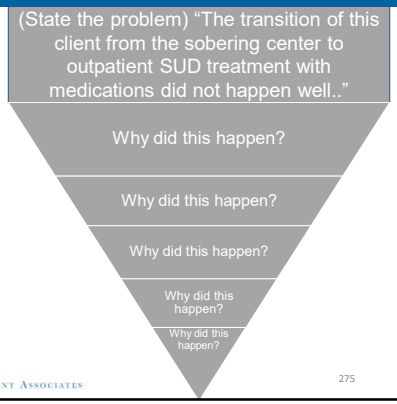
- Making a follow up appointment for the patient and telling them the time and place
- Identifying an organization vs. an Individual who is accepting responsibility for care coordination

Why is it important? Warm handoffs:

- Engage patients and families as team members (the most important team members)
- Build relationships
- Confirm accuracy of information and build safety checks

RETENTION/REFERRAL WHEN TRANSITIONS ARE DIFFICULT

- If transition has not been successful, assess why ("5 Whys" approach) it was unsuccessful and plan for how to make it successful to accomplish the transition – ideally with the patient
- Fundamentally – continuing to demonstrate commitment to the outcome: a successful transition of care



RESOURCES: MINNESOTA AND OTHER

Minnesota Department of Human Services

- HIV/AIDS Programs/Services
- Alcohol, Drug, and Other Addictions Program Overviews

AIDSLine

- AIDSLine Website
- 612-373-2437
- aidsline@aliveness.org

United Way 211

- 211 Website & Resource Directory
- Call 211 to speak with a Community Resource Specialist

Fast-Tracker Minnesota

- Find Treatment Providers

Community Partners Supporting this Work

Harm Reduction Sisters
Indigenous Peoples Task Force
Native American Community Clinic
Rural AIDS Action Network
Turning Point
The Aliveness Project

Additional Training Resources:

AIDS Education & Training Center Program

VIDEO – PRINCIPLES OF PERINATAL SUBSTANCE USE

https://vimeo.com/493418296

NEXT STEPS

Please complete the evaluation for this training using the QR code (evaluations must be completed for those seeking CEU credits).

Follow-up questions?

Contact Gabriel Velazquez at gvelazquez@healthmanagement.com

THANK YOU!

GLOSSARY OF TERMS (REVISITED)

- Sexual orientation – a person's identity in relation to the gender or genders to which they are sexually attracted (straight, gay, lesbian, asexual, bisexual, pansexual)
- Gender identity and/or expression - internal perception of one's gender; how one identifies or expresses oneself.
  - Cisgender – a term used to describe a person whose gender identity aligns with those typically associated with the sex assigned to them at birth
  - Transgender – refers to an individual whose current gender identity and/or expression differs from the sex they were assigned at birth (may have transitioned or be transitioning in how they are living)
  - Gender Expansive - refers to an individual who expresses identity along the gender spectrum (genderqueer, gender nonconforming, nonbinary, agender, two spirit)
- Sexual Minority – refers to a group whose sexual identity orientation or practices differ from the majority of and are marginalized by the surrounding society.

SOURCE: Centers for Educational Justice and Community Engagement, UC Berkeley

GLOSSARY OF TERMS (REVISITED)

- Race - is usually associated with inherited physical, social and biological characteristics. In this context that means race is associated with biology. Institutionalized in a way that has profound consequences (White, African American, American Indian Alaskan Native, Native Hawaiian or Pacific Islander)"
- Ethnicity - a term used to categorize a group of people with whom you share learned characteristics and identify according to common racial, national tribal, religious, linguistic, or cultural origin or background. (Hispanic, Non-Hispanic Black, Non-Hispanic Black, etc.)

SOURCE: US Office of Management and Budget: Federal Register Vol. 62(210): 58782

GLOSSARY OF TERMS (REVISITED)

- Health Insurance Portability and Accountability Act (HIPAA) - required the creation of national standards to protect sensitive patient health information (PHI) from being disclosed without the patient's consent and includes a Privacy Rule addressing disclosure of and access to PHI; the Security Rule protects disclosure of and access to electronic PHI (e-PHI) a subset of information covered by the Privacy Rule
- Code of Federal Regulations, Title 42, Part 2 (42 CFR Part 2) – a complicated set of regulations that strengthen the privacy protections afforded to persons receiving alcohol and substance use treatment (in addition to the more general privacy protections afforded in HIPAA). The regulations restrict the disclosure and use of alcohol and drug patient records which are maintained in connection with any individual or entity that is federally assisted and holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment (42 CFR § 2.11)
- Family Education Rights Protection Act (FERPA) - protects the privacy of student education records in public or private elementary, secondary, or post-secondary school and any state or local education agency that receives funds under an applicable program of the US Department of Education.

SOURCE: Centers for Disease Control and Prevention; and the Substance Abuse and Mental Health Services Administration

COMMON ACRONYMS (REVISITED)

ASAM- American Society of Addiction Medicine
ART – Antiretroviral therapy
AUD – Alcohol use disorder
BJA- Bureau of Justice Assistance
IDU – Injection or intravenous drug use
MAUD- Medication for alcohol use disorder
MOUD- Medication for opioid use disorder
MSM – Men who have sex with men
NCCHC- National Commission on Correctional Health Care
OUD – Opioid use disorder
PEH – Person(s) experiencing homelessness
PEP – Post-exposure prophylaxis
PrEP – Pre-exposure prophylaxis
PLWH – Person(s) living with HIV
PWID – Person(s) who injects drugs
SAMHSA- Substance Abuse Services Agency
SUD – Substance use disorder