Charting the Course

Opioid Settlement Planning: Community Engagement Summary and Opportunities for Utilizing Funds

SUMMARY REPORT

October 2022

COUNTY OF SAN DIEGO

BOARD OF SUPERVISORS

October 25, 2022

Dear San Diegans,

The nation is in the grip of an opioid crisis. Drug overdose deaths have increased year over year, with 71 percent of drug overdose deaths caused by opioids. In 2021, more than 900 San Diegans died from opioid-related accidental overdoses, a 54 percent increase from the previous year. These deaths are a result of both legally prescribed opioids and illicit opioids including heroin and fentanyl. The County of San Diego has a responsibility to respond to the opioid crisis and take all reasonable steps possible to stem the loss of life and heal those who have developed a related substance use disorder.

According to the U.S Department of Justice, the opioid crisis we face today is the result of actions by particular opioid pharmaceutical companies, manufacturers, and illegal distributors who have flooded the medical and street marketplaces with their products. In response to an epidemic of addiction and related deaths from prescribed opioids, jurisdictions throughout the nation brought forward litigation to remediate opioid addictions and harms. San Diego is a party to these lawsuits and is expected to receive tens of millions of dollars in settlement funds to address the local opioid crisis. Judicious use of these funds has the potential to stem the opioid crisis and hopefully reverse these alarming trends.

To prepare for the allocation of these funds, Supervisor Joel Anderson and I convened opioid experts and community stakeholders including representatives from the medical community, hospitals, first responders, social justice and equity advocates, drug treatment specialists, law enforcement, city officials, and others. These convenings focused on topics relating to healthcare integration in both our health systems and jail systems, harm reduction, and social supports. Key themes arose from the convenings centered around the need for care coordination, cultural competency, community-based organization and first responder support, stigma reduction, the building of housing, creating a robust workforce to treat and assist patients, and addressing health disparities.

This report provides an overview of the meetings, themes that arose from conversations, opportunities for investments, and the feedback provided by attendees.

Thank you to the community partners who brought forward their expertise, lived experience, and concern to create a framework for addressing the opioid epidemic. Only through our community standing together can we address this crisis.

Sincerely,

CHAIR NATHAN FLETCHER
Supervisor, District 4

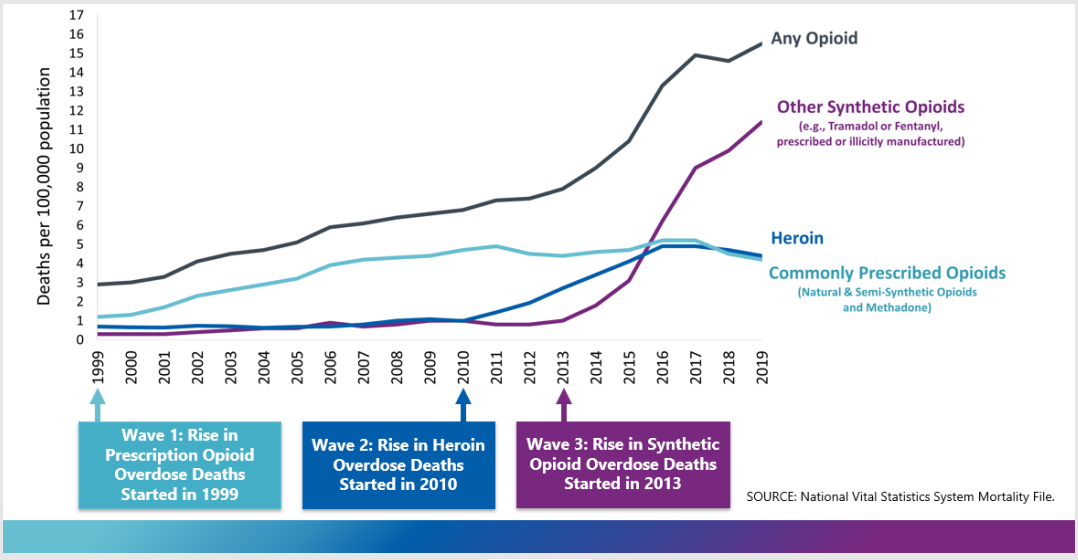
In This Summary

SECTION ONE:

Background

Understanding the Opioid Epidemic

A devastating opioid epidemic has been ongoing in the United States (U.S.) since the late 1990s. From 1999-2019, nearly 500,000 Americans died from an overdose involving prescription or illicit opioids.[1] According to the Centers for Disease Control and Prevention (CDC), this progressive and exponential rise in opioid overdose deaths in the U.S. can be linked to three distinct waves over the past two decades.



(CDC,2020)

Opioids are a class of drugs that include heroin, synthetic opioids such as fentanyl, and pain relievers available legally by prescription, such as OxyContin, hydrocodone, codeine, morphine, and many others. These drugs affect the spinal cord and brain to reduce the intensity of pain-signal perception and brain areas that control emotion. They can also affect the brain to cause euphoria or a feeling of being "high". Prolonged abuse of opioids can result in a chemical dependency that requires users to habitually use opioids to function normally and avoid withdrawal side effect symptoms that can be severe. Immediate abstinence from opioids for someone who has developed an opioid use disorder (OUD) may result in death. In many cases guidance from professionals paired with medicated-assisted therapy are necessary to help people safely wean themselves from opioids use.

Beginning in 1999, the first wave of opioid overdose deaths began as a result of **increased prescribing of opioids.**[2] In 2010, a secondary wave of this epidemic was seen with rapid increases in overdose **deaths involving heroin.**[3] Lastly, starting in 2013, significant increases in overdose deaths were observed involving **synthetic opioids**, particularly counterfeit versions involving illicitly manufactured fentanyl.[4,5,6] Presently, illicit fentanyl continues to be a significant

driver of opioid overdose-related deaths and has been found in combination with other illicit opioids, including heroin and cocaine.[7]

National Opioid Settlements

The growing supply of opioids that began in the 1990s can be directly tied to the activities of drug manufacturers and others in the drug manufacturing and distribution industry, including wholesalers and pharmacies.[8] As such, counties, cities, and states across the country have been suing manufacturers and distributors of prescription opioids and requesting billions of dollars in damages. Some industry analysts project that it would take damage payouts of $50 billion or more to settle current lawsuits related to this issue.[8]

Among existing lawsuits, there are two common allegations brought against manufacturers and distributors. First, that manufacturers of prescription opioid medications overstated the benefits and downplayed the risks associated with the use of their opioids, as well as aggressively marketing these drugs to prescribing practitioners. Secondly, distributors allegedly failed to monitor, detect, investigate, refuse, and report suspicious orders of prescription opioids. Two main classes of damages are thus seen in existing lawsuits – "compensatory damages," also known as backward-looking costs, are damages sustained due to the inappropriate prescribing or neglectful distribution, and "abatement costs," also known as forward-looking costs to address the opioid epidemic in the future.

In February 2022, four of the largest U.S. corporations agreed to pay roughly $26 billion to settle over 3,000 lawsuits linked to claims that their business practices helped fuel the deadly opioid crisis. Johnson & Johnson (J&J), a manufacturer for generic opioid medications and consumer health products, contributed $5 billion to this settlement. Wholesalers AmerisourceBergen, Cardinal Health, and McKesson, sometimes referred to as "the Big Three," contributed a combined $21 billion to this settlement. A stipulation for the majority of funds from this settlement outline that dollars must be used for healthcare and drug treatment programs designed to directly ease the current opioid crisis. Forty-six states and roughly 90 percent of eligible local governments signed on to the deal, including the State of California and San Diego County.

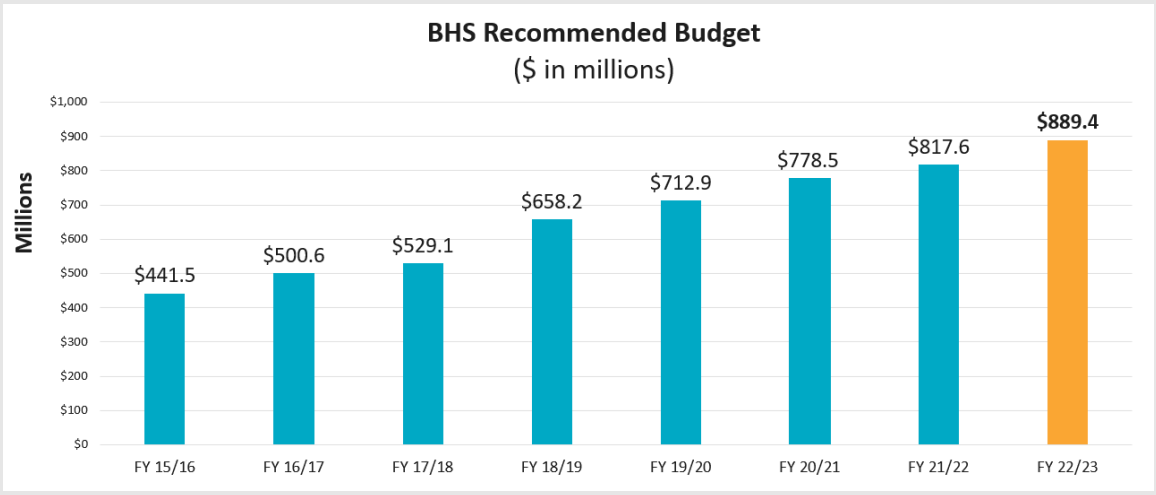
In addition to this settlement, 23 states and over 2,000 local governments, including San Diego County, have been involved in the biggest opioid case to date with drug manufacturer **Purdue Pharma**.[9] In 2019, Purdue Pharma faced thousands of lawsuits for its aggressive marketing of OxyContin, a highly addictive painkiller. Tentative settlement details related to this case involve Purdue Pharma filing for bankruptcy and paying billions in damage payouts over time, with a significant portion of settlement funds coming from the Sackler Family, the owner of the company. Similar settlements involving companies Teva, AbbVie/Allergan, and Endo are also in progress. Although payout amounts to individual government entities are still being determined and prepared for dispersal, distribution of settlement funds to jurisdictions is expected to arrive before the end of calendar year 2022.

Transforming Behavioral Health in the Region

With once-in-a-generation funding anticipated to become available in the short term, state and local government recipients are moving quickly to initiate planning discussions and activities to determine the best utilization and corresponding allocation of funds, as well as the resources and mechanisms to support implementation of interventions and strategies to address the opioid epidemic locally.

In San Diego County, over the last three years, under the leadership of Chair Nathan Fletcher, behavioral health has been progressively elevated as a key priority of the San Diego County Board of Supervisors (Board), with significant investments made to support the mental and emotional well-being of individuals impacted by mental illness and/or substance use disorders (SUD).

The recommended budget for the County of San Diego Health and Human Services Agency's Behavioral Health Services (BHS) illustrates these investments, with a dramatic budget increase observed from $441.5 million in Fiscal Year 2015-2016 to $889.4 million for the current Fiscal Year 2022-2023 (shown below). The latest budget helps continue County efforts to transform behavioral health in the region, shifting from a system driven by crisis response to one anchored in prevention and continuous care to help keep people connected and healthy.



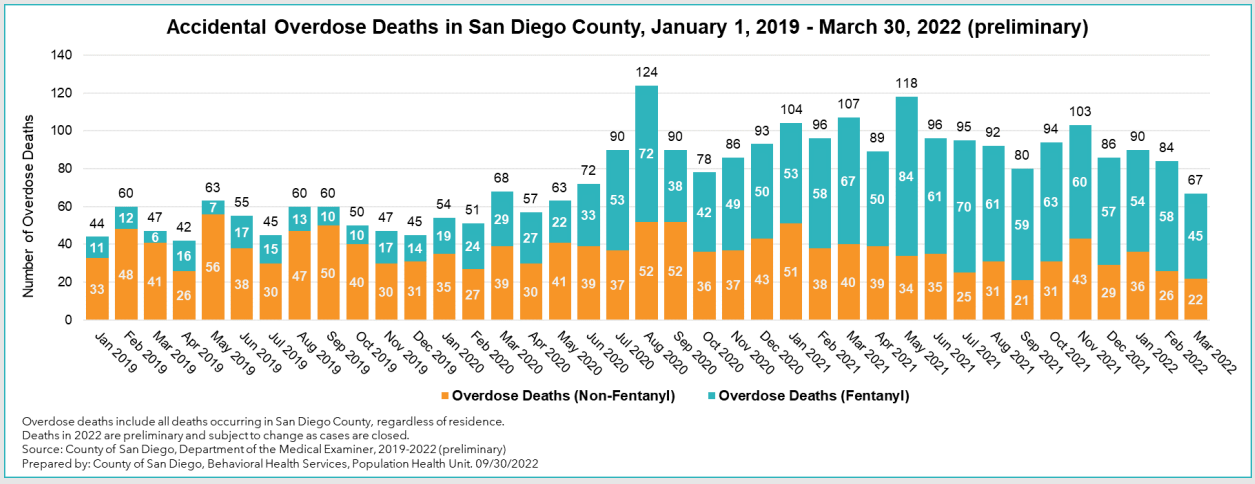
Efforts propelled by the Board in collaboration with public and private partners throughout the county have focused on the provision of a wider variety of behavioral health programs, services, and resources to match the right type of behavioral health care to an individual or family's specific needs. Providing the level of support necessary for a specific situation and embracing the importance of the premise of "meeting people where they are" when it comes to service delivery has been a core driver for this.

The Board has also prioritized improving services to help people with behavioral health challenges who have historically suffered silently, including people experiencing homelessness and youth, and focused resources to revisit, reimagine, and initiate solutions to help ensure communities and populations with unique needs receive the appropriate care they deserve and can overcome barriers preventing them from accessing necessary health supports.

The Board has moved with urgency on behavioral health issues to enable a more comprehensive system centered on the establishment of regional hubs and increased person-centered care coordination to address immediate crises. In June 2019, the Board approved a recommendation to enhance the crisis intervention options available to the community by establishing a non-law enforcement **Mobile Crisis Response Team** (MCRT) Program. The program dispatches behavioral health experts to emergency calls instead of law enforcement, when appropriate, with teams made up of clinicians, case managers, and peer support specialists.

In the last few years, the Board has also established a **Behavioral Health Impact Fund** (BHIF, February 2020) in collaboration with the City of San Diego to help community-based organizations grow their capacity to serve more clients for longer periods of time. Dollars from the BHIF serve as a catalyst for organizations to make capital investments that allow them to expand their capacity for extended treatment by providing service providers in San Diego the opportunity to buy, renovate, and expand buildings to develop into service delivery locations. The fund also encourages groups to forge new partnerships with local hospitals and other healthcare providers to develop community-based networks of support services where those suffering with behavioral health conditions can receive the appropriate level of care and be transitioned to aftercare services.

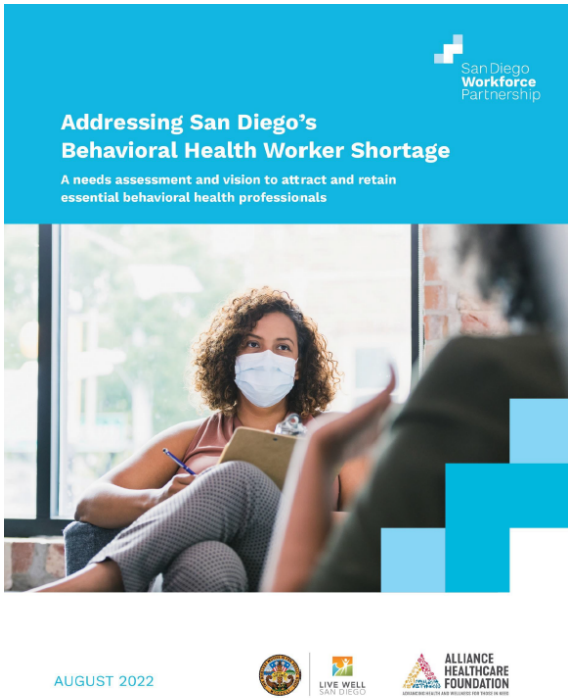
In June 2021, the Board voted to allow harm reduction programs in the unincorporated areas, overturning a previous ban. In addition, the Board directed HHSA to create a **Comprehensive Harm Reduction Strategy** for the County in response to rising substance use-related fatalities.



In San Diego County, overdose deaths in the region have steadily risen since 2019, with a sharp increase noted between 2019 and 2020, including a three-fold increase in fentanyl-related deaths. According to County records, in 2020, San Diego County saw 462 fentanyl-related overdose deaths — a 202 percent increase in one year, from 151 deaths in 2019. In 2021, more than 1,000 San Diegans died from opioid-related overdoses, a 16 percent increase from the year prior.

The Comprehensive Harm Reduction Strategy is based in multidisciplinary evidence and built upon years of foundational efforts by local regional stakeholders who have worked to mitigate the harms to residents, families, and communities related to misuse of prescribed and illicit opioids. Distribution of naloxone, a proven opioid overdose-reversing medication, and development and implementation of harm reduction programs are among the many tactics outlined in the strategy for safe and effective mitigation of harms related to substance misuse.

Additionally, in August 2022, the County of San Diego released a report developed in partnership with San Diego Workforce Partnership that detailed behavioral health workforce shortages and related challenges impacting the region. The report validated that far fewer behavioral health workers currently work within San Diego County to meet current demands. According to the report, *Addressing San Diego's Behavioral Health Worker Shortage*, the region is short an estimated 8,000 workers to meet current mental health and SUD treatment service needs. It also identified that San Diego County must educate, train, attract, employ, and retain 18,500 additional behavioral health professionals over the next five years to address current demands, replace open positions, and keep pace with population growth. Although a daunting confirmation, this assessment has now provided the region a tailored



blueprint to help focus subsequent efforts as the County and its stakeholders continue to work to build a better behavioral health system for residents. The Board has now adopted this Report (October 2022), and will be working to implement the many changes outlined in the Report to address the behavioral health worker shortage.

Poised for Action

Prescription opioid-based painkillers fueled the opioid crisis for years, propelling a persistent broader substance use crisis. Effective medications to treat opioid use disorder exist (e.g., methadone, buprenorphine), but are underutilized for multiple and complex reasons. New investments are needed to end the overdose death epidemic and improve substance use prevention, treatment, and recovery. With funding from national opioid settlements on the way and behavioral health a key priority, the region has the opportunity to effect and sustain a variety of strategies to meaningfully address the opioid epidemic in San Diego County. Furthermore, because the opioid epidemic touches nearly every aspect of county government, the County of San Diego and its partners are poised to act.

SECTION TWO:

Assessing Issues and Opportunities

Community Planning Forums

As part of the County of San Diego's planning efforts to determine how to best use anticipated opioid settlement dollars, Chair Nathan Fletcher and Supervisor Joel Anderson led three virtual community forums in August and September 2022 to begin planning discussions with stakeholders about the utilization of anticipated funds.

Forum Details

Date	Focus of Convening	Presentations
August 10th	Integration of Health Care Systems	*Overview of Opioid Health Related Data* ● Wilma Wooten MD, MPH, Public Health Officer *Healthcare and Substance Use Integration* ● Luke Bergman, PhD, Behavioral Health Services Director
September 6th	Harm Reduction and Prevention	*Principles for The Use of Funds from The Opioid Litigation: How Jurisdictions Can Leverage Settlement Funds to Save Lives* ● Sara Whaley, MPH, MSW, MA, Research Associate, Johns Hopkins Bloomberg School of Public Health, Dept. of Health Policy and Management Program Manager, Bloomberg Overdose Prevention Initiative *Federal Priorities and Opioid Settlement Funds* ● Rob Kent, General Counsel at The White House Office of National Drug Control Policy
September 7th	Housing, Workforce, and Social Services/Supports	*Opioid Solutions Initiative: A Resource for Counties* ● Samantha Karon, MPH, Senior Program Manager for Substance Use Disorder, National Association of Counties *Housing and Support Services* ● Simonne Ruff, Director, San Diego, Corporation for Supportive Housing

Each convening featured a discussion topic and brought together County and community stakeholders, including representatives of those with lived experience, for discussions on how best to plan for the use of the funds. Following speaker presentations to the full group, forum participants were randomly assigned to smaller breakout groups for facilitated discussions. These breakout groups offered participants the opportunity to share their thoughts, suggestions, and information about the topic of focus and abatement of harms from opioids. Forum participants included multidisciplinary subject matter experts from healthcare, public safety, substance use treatment and prevention providers, and harm reduction organizations.

Access to recordings of each of the convenings along with the opportunity to offer feedback and suggestions electronically was also made available to the broader community from September 16 - September 23, 2022. Over 200 stakeholders provided input.

As state and local governments begin to receive funds from opioid-related legal settlements, policymakers and leaders are looking to define processes for allocation and oversight of these dollars. In addition to considerations for how opioid abatement funds could be spent, groups are also considering the parameters and mechanisms for long-term administration, including decision-making bodies, how dollars can be requested, and how spending will be reported.

Stakeholder Feedback

Some of the stakeholders who provided feedback for this framework include, but are not limited to:

- McAlister Institute
- Association of Alcohol & Drug Services Providers
- County Behavioral Health Advisory Board
- County Health Service Advisory Board
- County Office of Equity and Racial Justice
- City of San Diego Police Department
- San Diego County Sheriff's Department
- San Diego County District Attorney
- San Diego County Superior Court
- County Probation Department
- County Emergency Medical Services
- City Emergency Medical Services
- Falck Ambulance
- California Pharmacists Association
- California Society of Health-System Pharmacists
- Center for Community Research
- San Diego County Office of Education
- Hepatitis C Elimination Initiative
- County Health and Human Services Agency
- County Public Health Services
- County Behavioral Health Services
- County Department of Homeless Solutions and Equitable Communities
- Prescription Drug Abuse Task Force
- County HIV Planning Group
- Neighborhood House Association
- Harm Reduction Coalition
- Regional Task Force on Homelessness
- City of Chula Vista
- City of El Cajon
- City of Escondido
- City of Oceanside
- Tribal Governments
- City of San Diego
- San Diego City Attorney's Office
- San Diego Housing Commission
- Corporation for Supportive Housing
- Euclid Medical Services
- Family Health Centers of San Diego
- Health Center Partners
- Healthy San Diego
- San Ysidro Health
- Borrego Health
- Imperial Beach Community Clinic
- Grossmont Healthcare District
- Rady's Children's Hospital
- Scripps Health
- UCSD Addiction and Owen Clinic
- Hospital Association of San Diego and Imperial Counties
- Institute for Public Strategies
- Mental Health Contractors Association
- Mental Health Systems Inc.
- SOAP MAT
- ARMNT Medical Specalists

- People Assisting The Homeless (PATH)
- Father Joe's Village
- Recovery International
- San Diego American Indian Health Center
- San Diego Black LGBTQ Coalition
- San Diego Black Nurses Association
- San Diego County Medical Society
- Social Advocates for Youth San Diego
- San Diego Latino Health Coalition
- Alliance Healthcare Foundation
- Acadia Healthcare
- Vista Community Clinic
- North City Prevention Coalition
- North Coastal Prevention Coalition
- San Diego Unified School District
- SDSU Public Health
- UCSD Public Health
- Freedom Ranch
- CHIP - Recovery Residence Association
- The Collective Coalition

In addition, members of the community who do not represent any organization, were given opportunities to provide feedback.

Forum Questions

The questions asked in the discussion groups at the convenings and in email surveys included:

Forum #1: Health Integration

- What is limiting comprehensivesubstance use care in mainstream healthcare?
- What would successful integration look like with emergency departments?
- What would successful integration look like with primary care?
- What would successful integration look like as it relates to medication assisted treatment?
- What is limiting comprehensive substance use care in mainstream health care?
- What recommendations do you have regarding the resources, supports, and/or tools needed to help San Diego County foster an integrated health system?

Forum #2: Harm Reduction and Prevention

- What are some specific harm reduction and prevention models that would support efforts to build a better public health infrastructure?
- What barriers or challenges might we face as we look to expand harm reduction and prevention services?
- What are the harm reduction and prevention services that have the most scientific support?
- How does scientific evidence inform how we proportionally deploy resources to prevention and harm reduction, so we are impacting the most vulnerable?

Forum #3: Housing, Workforce, and Social Services and Supports

- How do we integrate or expand services (harm reduction, recovery etc.) within housing and other support services to foster access to and sustain recovery for individuals?
- What do we need to better equip and support our workforce to meeting the complex needs of People Who Use Drugs (PWUD)?

- What is missing from our current recovery support network? What models of recovery support do we need to better meet the needs of PWUD?

As state and local governments begin to receive funds from opioid-related legal settlements, policymakers and leaders are looking to define processes for allocation and oversight of these dollars. In addition to considerations for how opioid abatement funds could be spent, groups are also considering the parameters and mechanisms for long-term administration, including decision-making bodies, how dollars can be requested, and how spending will be reported.

Key Themes

Although each community planning forum focused on a specific topic and hosted a different array of guest speakers, several key topics were identified throughout all the discussions. These themes – care coordination, stigma reduction, housing, workforce, and equity and health disparities – are discussed in greater detail below based on input received during planning forum breakout sessions.

Care Coordination

Meaningfully reducing substance use harms is an interdisciplinary, collaborative undertaking. It is built on a foundation of cross-sectoral care coordination of County of San Diego Departments, as well as health networks, community-based organizations, physical health entities, and family and community voices. A common theme of these community convenings was recognizing that care coordination exists, but not in a way that offers supportive and comprehensive care across the continuum of all social and health-related needs. The health and well-being of individuals do not exist in silos. Integration across physical health, mental health, substance use disorder (SUD) treatment services, and community-based services is a key component of addressing the well-being of People Who Use Drugs (PWUD) and managing the care of individuals in a lower-acuity, chronic care context rather than expensive episodic, acute care contexts.

SUDs can often be chronic conditions so community-based harm reduction services and services embedded in emergency departments and throughout the healthcare system can help bridge care for many clients for whom recovery is non-linear. When SUD treatment providers work in conjunction with harm reduction services and with harm reduction principles, service continuity can be optimized, and health outcomes can be improved. Treating the whole person and ensuring access to best practices in harm reduction throughout every level in the spectrum of care was a recurring theme across the community forums. There was extensive discussion about the desire to see an “army of substance use navigators with MD backup,” meaning navigators with access to and integration with outpatient community referral follow-ups so patients can be scheduled directly with providers that address all barriers, such as transportation, cost, appointments, etc.

Overall, the integration of care to ensure continuity of services is critical – low barrier housing, meeting people where they are at, recognizing and collaborating with peers who have lived

experience to “hold someone’s hand” while they navigate the complex behavioral healthcare system.

Stigma Reduction

A prominent theme throughout every discussion with community stakeholders was the stigma associated with their medical condition, an existing barrier preventing people living with substance use disorder from receiving care or seeking out tools for harm reduction in the first place. . Feelings of shame or fear of rejection can prevent people from having open conversations with their medical doctor, family, and friends. By eliminating the stigma around drug use we can create open communication with people who need help and connect them to necessary services.

Education and training for service providers, housing providers, law enforcement, first responders, emergency rooms, and community members across the spectrum of care with an emphasis on addressing stigma in the treatment process is crucial. Abstinence may not be immediately achievable by all who misuse substances; however, many smaller changes may be feasible that could bring substantial benefits, such as reducing the risk of chronic and infectious disease, lowering the rates of opioid overdose deaths, and improving overall physical and mental health outcomes. Breaking down the systemic myths and misconceptions about harm reduction and substance use treatment is paramount to providing equitable services regardless of gender, race, age, sexual orientation, ethnicity, culture, spirituality, health, or socioeconomic status.

There was significant discussion around the importance of specifically combatting stigma and disinformation involving employers, healthcare, and public safety communities with education campaigns to encompass a broader perspective on evidence-based prevention and treatment strategies including the use of medications as a part of treatment, sometimes referred to as "Medication Assisted Treatment." There is also a strong desire to see health interventions throughout the continuum of care guided by the principle of meeting people where they are, which means more than simply being tolerant and compassionate of people in crisis or addiction but acknowledging that all people are at different stages of behavior change.

The implementation of future efforts should be guided by fully leveraging the expertise of individuals with lived experiences, behavioral health professionals, public health professionals, primary care providers, first responders, clinical experts, housing experts, and other subject matter experts and stakeholders to facilitate a collaborative decision-making process for health interventions across the spectrum of care that are not influenced by stigma around substance use. In the short term, stakeholders shared the importance of anticipating and handling community concerns some of which may be driven by stigma, such as addressing “Not In My Backyard” (or NIMBY) attitudes and mistrust of people who use drugs by communicating how “controversial” programs help address the structural and root causes of substance use conditions.

Housing Support

The relationship between substance use and experience of homelessness is bidirectional, with homelessness exacerbating the harmful effects of drug use, and vice versa. Having unstable housing and being pushed to the margins increases all health risks, including those related to substance use. Yet traditionally, housing resources have not been prioritized for those with primary substance use disorders; worse, it's been customary for people with substance use to be explicitly excluded from housing services and permanent supportive housing programs. Therefore, a key pillar of the comprehensive harm reduction strategy is housing support for people living with severe substance use disorder.

Informed by a housing first approach, investing in collaborative, low-barrier bridge housing, permanent housing solutions, and resident support services that are not contingent on treatment status. Stakeholders expressed a desire to see the establishment and expansion of transitional housing sites, organized around harm reduction principles with the lowest threshold accessibility. Programs should meet people where they are at, offering variable lengths of stay and focusing on the basic elements of wellness promotion: food, hygiene, connection to healthcare and navigation to permanent housing.

Housing discussions among the breakout sessions included the overlap of various themes and the need to cross-collaborate to establish a thoroughly comprehensive system of support for people in recovery. Participants discussed the importance of supportive housing and the challenges that come along with it. If these spaces are not managed and coordinated well, there is a possibility that they can turn into hubs for illicit drug use.

Additionally, to strengthen the impact of these sites, the workforce that supports residents who live at transitional facilities need to have more extensive training, higher pay, and more overall on-site staff on a regular basis who could be available to residents. Increasing workforce retention and reducing turnover will result in a more supportive and stable environment for residents.

Participants also expressed the need to diversify the locations of transitional housing across San Diego, placing them in neighborhoods of varying socioeconomic statuses. They also acknowledged the difficulties in doing so because many folks have a "NIMBY" attitude. Suggestions were made to host town halls, workshops, or an education series in various neighborhoods to reduce stigma and understand how as a community you can support those in recovery.

Workforce

To effectively deploy and evaluate opportunities for action discussed in these community forums, a workforce that is trained and skilled in the philosophy, approaches, and interventions of harm reduction will be a necessity. Developing and supporting a workforce that employs harm reduction principles across all levels and types of services was a key point of discussion for stakeholders. In relation to this integration of people with lived experiences and community health workers into County of San Diego services is an opportunity opportunity to co-develop

equitable solutions to increase the capacity and readiness of the behavioral health workforce who can implement and evaluate the strategies and opportunities put forth by the community and this board.

Community input was clear that the existing talent attraction and retention challenges in the behavioral health industry must be addressed, and that these settlement funds could support the expansion of the size and diversity of mental health and addiction treatment professionals in San Diego, with an emphasis on retaining and increasing the capacity of the existing workforce. Community health workers and peers being integrated into the County of San Diego could be empowered with the tools and training to provide direct linkages to services tailored towards clients' readiness to engage in healthy behavior change, whatever that may be.

Looking outside of behavioral health providers, stakeholders expressed the desire to see additional supports "added to the bench" – building supportive communities of parents, family members, schools, community organizations, and businesses who are equipped to provide education on substances and treatment resources. Stakeholders also acknowledged the need to find trusted messengers in vulnerable communities, preferably with lived experience, that can more effectively reach historically underserved populations that are being disproportionately impacted by opioid overdose deaths.

Equity and Health Disparities

Also threaded throughout stakeholder conversations was the importance of equity and a desire to see services that are culturally and linguistically competent to serve the diverse population of San Diego County. Many patients struggling with substance use disorder, including opioid use disorder are unable to access treatment in the first place, due to transportation issues, stigma with treatment, and language barriers. Innovative and evidence-based solutions to address these constraints exist but must recognize that there is no one-size-fits-all approach that works for substance use disorder. Stakeholders' desire to see services that recognize and meet people where they are at and work to overcome the systemic barriers to care.

Continuity of care is critical - often when people transition from more intensive recovery programs into other supportive housing or less resourced programs, that continuity of care and trust can be lost, widening health disparities that exist in communities of color. We need to strengthen those transition supports by anticipating and planning for systemic barriers to recovery, such as transportation challenges facing rural and low-income communities. This is even more vital for those individuals transitioning into and out of incarceration—a population that tends to have higher rates of substance use disorder, mental illness, and chronic disease than the general population. Justice involved individuals, particularly those with substance use needs, too often have limited access to care both inside facilities and in the communities to which they are released. A historical lack of comprehensive coordination between justice and health agencies further impacts their health and well-being resulting in widened health disparities among this population. For this reason, it is vital to invest in expanding and

enhancing substance use treatment in correctional facilities and ensuring community supports are in place for those re-integrating into the community.

SECTION THREE:

Aligning Efforts and Opportunities

Proposed Structure for Allocating Funds

To organize and operationalize opioid settlement funds, below are examples of evidenced-based strategies connected to key themes identified from recent community planning forums. These strategies offer tangible activities that can be adopted and expanded to **effectively** reduce opioid-related harms.

Healthcare Integration

Healthcare integration is defined as actions taken in an effort to align or incorporate behavioral health services into overall healthcare to improve access, minimize stigma, lower costs, and increase overall health outcomes. In the opioid space, this integration is not happening because of a lack of investment in resources and technology, available workforce, impact of stigma on both patients and providers, and a lack of dedicated care navigation specialists. By investing in healthcare integration we can increase positive health outcomes for people experiencing an OUD. There are a number of strategies that were identified in the convenings to improve healthcare integration.

Treatment: Research supports the effectiveness of medication-assisted treatment (MAT) such as Buprenorphine or methadone, to treat substance use disorders as well as sustain recovery and prevent overdose. The prescribed medication operates to normalize brain chemistry, block the euphoric effects of opioids, relieve physiological cravings, and normalize body functions without the negative and euphoric effects of the substance used. Efforts to increase access to and engagement into MAT treatment services can lead to fewer overdoses, increased retention in treatment and improved health outcomes for PWUD. Pairing MAT with Cognitive Behavioral Therapy, Contingency Management, and Prescription Digital Therapeutics can increase health outcomes.

Emergency Department (ED) Relay Model: Recognizing the risk of overdose is much higher for those who have recently experienced an overdose, the ED relay model capitalizes on a vital setting (the ED) and time (after a nonfatal overdose) to connect a person to harm reduction and other services. This 24/7 service model dispatches a peer to hospitals to meet patients in substance use crisis. Peers stay in contact with patients for up to 90 days and connect them to appropriate support services, including overdose prevention, harm reduction, substance use disorder treatment, eligibility programs and social services.[11] New York City has implemented this model.

Justice-Involved Individuals: People who have been incarcerated are approximately 100 times more likely to die by overdose in the first two weeks after their release than the general public. Individuals entering jails should be provided MAT treatment if needed to not only help them combat their opioid use but help increase their chances of abstaining from opioid use in

the future. Doing so may not only decrease drug use in jails but may also decrease overdose deaths related to opioid use. Further, investments in medical information sharing between our jails, community-based organizations, and healthcare systems through avenues such as the Community Information Exchange and Health Information Exchange can improve the quality, safety, and efficiency of healthcare and treatment delivery.

Pregnant and Postpartum Services: Paralleling the epidemic observed in the general population, opioid use in pregnancy has escalated dramatically in recent years. Opioid exposure during pregnancy has been linked to poor health effects for both mothers and their babies. For mothers, OUD has been linked to maternal death; for babies, maternal OUD or long-term opioid use has been linked to poor fetal growth, preterm birth, stillbirth, and specific birth defects, and can cause neonatal abstinence syndrome. Special attention is needed for pregnant and postpartum women who have an OUD and may include support services, MAT, and wrap-around services postpartum.

Low-Threshold Medication Assisted Treatment Services: Low-threshold treatment is a term used to describe an alternative approach that attempts to remove as many barriers to treatment as possible. Low-threshold treatment is guided by the following principles: 1) same-day treatment entry 2) harm reduction approach 3) flexibility, and 4) wide availability in places where people with opioid use disorder are frequent. Providing low threshold services offer the potential for increased access, engagement, and retention in care for people who use drugs (PWUD). Additionally, low-threshold services are anticipated to increase the proportion of PWUD who are interested in treatment and who start and continue treatment. Low-threshold models include the integration of low-barrier services that focus on engagement, safety planning and linkage to care.

Additionally, models that include access to services such as medication-assisted treatment and preventative healthcare services offer a powerful way to provide patients with opioid use disorder access to life-saving medications. Comprehensive low-threshold models are guided by the principles of harm reduction, emphasize warm hand offs with direct referrals to social and legal services, access to safe works, and linkage to preventative care and treatment of infectious diseases.[11,]

Harm Reduction

Harm reduction is critical to keeping people who use drugs alive and as healthy as possible. Harm reduction is an approach that incorporates a spectrum of strategies that meet people "where they are" on their own terms, emphasizes safety and fosters connections to vital services. Harm reduction plays a significant role in preventing drug-related deaths and offering access to healthcare, social services, and treatment.

Harm Reduction Programs: Harm Reduction Programs are community-based prevention programs that deliver low-threshold services aimed at engaging PWUD into services that reduce risk and encourage behavior change. The first rule of harm reduction programs is that you must meet people where they are to build trust and encourage participants to return. As a result,

harm reduction programs often serve as the primary avenue to meet the health needs of PWUD and thus, are uniquely positioned to connect PWUD with support services. Harm reduction programs can provide a range of services, including access to and disposal of supplies, naloxone education and training, testing, and linkage to care.

Additionally, Harm Reduction Programs can serve as a bridge to other health services including, Hepatitis C and HIV diagnosis and treatment and MAT for substance use. Programs may differ in size, scope, geographic location, and delivery venue (e.g., mobile vs. fixed sites).

Opioid Antagonists: Opioid antagonists such as naloxone are designed to rapidly reverse the effects of opioid overdose and are an integral pillar of harm reduction and prevention of fatality. The County already distributes these medications, but we could better integrate these solutions into our harm reduction strategies to curb opioid effects and usage. This can include enhancing supply and distribution of opioid antagonist medications to individuals susceptible to using, through better equipping our peer and community health workers and healthcare facilities, our first responders, hospitals, schools, primary care, and our jail systems.

Public Health Messaging Campaigns: Public health campaigns and other programs targeted toward potential new users of opioids can help prevent a new class of users. Particularly, campaigns aimed at curbing drug use among children and college students may be beneficial if rooted in evidence-based best practices. The anti-tobacco Truth campaign was shown to significantly reduce tobacco use in youth by branding tobacco as an unhealthy lifestyle. Incorporating lessons learned from this campaign, and avoiding messaging from past campaigns that have failed to curb drug use, is essential to addressing opioid use.[12]

Addressing Stigma: Stigma is a pervasive force alienating PWUD from medical care and recovery support. Stigma increases the harm experienced and often serves as a barrier to individuals accessing care. Rates of stigma are extremely high both in the general public and within professionals who interact with PWUD. Research demonstrates that stigma damages the health and well-being of people with substance use disorder and interferes with the quality of care they receive in clinical settings. Creating robust efforts to promote public education efforts to reduce stigma and draw support for public heath interventions for OUD can drive change and eliminate stigma. Public health messaging campaigns that promote first person language, educate on opioid use disorder treatments, and avoid messaging made to villainize PWUD can be a powerful tool to ending stigma. Examples of anti-stigma campaign efforts include the application of multimedia efforts, personal stories from people impacted and messaging that emphasize that recovery is possible. For example, Michigan has developed an effective campagin.[13]

Drug Disposal: Household prescription drugs may be used improperly or abused by either the intended patient, general public, family member or children. The San Diego County Prescription Drug Abuse Task Force reported 576 unintentional prescription-related deaths in 2020 and 7,723 opioid-related emergency department visits in 2019. Drug drop-off programs are a safe and proven solution to address the hoarding of expired, unused, and unwanted prescription

drugs. Providing the community access to drug disposal systems will not only eliminate some of the supply of prescription drugs that may be abused but would raise awareness around the issue of prescription drug hoarding and abuse.[14]

Social Supports

Social Supports are defined as semi-formal, non-clinical services that help people get into or stay in recovery. These services include more than just programmatic approaches that help people enter and stay in recovery, but take into consideration a person's whole spectrum of needs. This ranges from emotional and social support to housing and workforce integration.

Peer and Community Health Worker: Peers and community health workers with lived experience are often trusted messengers in their communities that can offer valuable perspectives and input on how best to meet the needs of PWUD. Additionally, individuals with lived experience with formal training may offer an effective way to help individuals engage and continue in treatment.

Peer Services Models: Peer programs can offer a range of services, including health education, encouragement, and empathy, coping skills, recovery modeling, and concrete assistance in overcoming the situational barriers to treatment retention. Service delivery may vary based on the composition of the peer model such as those that are exclusively peer-led versus integrated peer services within clinical settings. Effective peer services leverage the lived experience of individuals but also formally train peers and establish a firm understanding of the peer's role and responsibilities.[15]

Transitional Housing: Transitional housing sites can provide programs that meet people where they are at, offering variable lengths of stay and focusing on the basic elements of wellness promotion: food, hygiene, connection to healthcare and navigation to permanent housing. These sites can be entry points to people not only having basic levels of needs met, but can also be a pathway to receiving services, treatment, and supports needed to manage their SUD.

Workforce: A workforce that employs harm reduction principles across all levels and types of services is critical to addressing the crisis. Existing talent attraction and retention challenges in the behavioral health industry must be addressed, and these settlement funds could support the expansion of the size and diversity of mental health and addiction treatment professionals in San Diego, with an emphasis on retaining and increasing the capacity of the existing workforce.

APPENDIX

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APPENDIX

Public Input

The following comments were received during three virtual forums held:

FORUM #1 Healthcare Integration

Question: What is limiting comprehensive substance use care in mainstream healthcare?

All Responses

- Lack of easy cohesive referral
- Lack of immediate access, starting care immediately when needed or open to it
- Systems operating in a silo
- Lack of comfort/time to assess for SUD issue in medical setting
- Limited resources for timely outpatient follow up for youth
- Finance, lack of financial incentive, lack of resources, integration portal
- Regarding UCSD campaign to build a SUD registry - consider incentivizing addicted people with appropriate amount of cash (e.g. Amazon credits) paid over time for participation. People want help but, they also need to live life (e.g. are consumers) and such an offer might be attractive
- Data describing the extent of the problem, especially in children/youth population. Working for a large child/youth provider, we do not have a good sense of the issue
- More data to understand the specifics of the problem
- Rural communities lack the programs, ability to access care, and education
- Stigma
- Stigma as it relates to community perceptions about addiction and behavioral health issues
- Stigma as it relates to community perceptions about SA/MH issues and community investment to welcome facilities into and/or proximity to their areas
- Barriers across the board
- I second the difficulty in accessing funding for contingency management. Hard to use if can't afford
- Making clients come to us. Harder to engage than if we can go to them
- Overwhelmed health care system, no time to make proper assessments and understand patient histories
- Access and reimbursement for FDA-cleared prescription digital therapeutics for SUD and OUD
- Access to Contingency Management and Cognitive Behavioral Therapy for patients struggling with SUD and OUD
- Was the statement that making referrals was systematically difficult speaking to a (major) technical hurdle e.g. the need for a more real time resource availability, matching most appropriate care or other factors?
- Increased accessibility to evidenced based treatments

- Workforce sustainability and enough of a workforce
- What are the challenges using the referral system which someone described being cumbersome and difficult to use
- Access to Contingency Management and Cognitive Behavioral Therapy
- Providers not knowing enough or having enough experience to feel comfortable to talk about SUD and provide care
- A major reason is the lack of knowledge about the topic by a large majority of health care providers
- Lack of understanding about current drug use patterns, including fentanyl and the evidenced based interventions available
- My assumption is that there is a lack of peer support on a long-term basis (e.g. connect addicted people with recovering peers and help sustain long term relationship) as well as integrated use of 12 step philosophies, programs and services
- Integration with 911 paramedics and community paramedics (legislative implementation of community paramedics takes place in October 2022)
- Integration of staff from peers to substance use counselors to therapists that are trained in the prospective fields
- Decreased volume- less people who are overdosing, dying etc. Saving lives is the goal
- Substance use navigators
- Also need full resources to refer people to upon discharge- MATs, IOP programs available for on-going support
- Naloxone, detox services and bed capacity
- Treatment can be accessed during a crisis when motivation to participate is high (straight from ED to treatment)
- Making sure trained staff are available and understand what specifically they need to do
- Having better communication in the MRN to systems/agencies to provide better continuity of care
- Access and reimbursements for FDA cleared prescription digital therapeutics for SUD and OUD
- Plan to install additional vending machines that dispense naloxone. Programs are expected to have them on site, but we need them all throughout the county. This will save more lives
- Access to cognitive behavioral therapy and contingency management for patients struggling with SUD and OUD
- I would think some patients would need immediate, safe housing- a sober place to go upon discharge that would also provide recovery services
- Family members of patients need to be connected to resources too- education and support and Narcan
- Getting patients to improve their condition and giving doctors bonuses/incentives based on patients' progress. Also offer virtual beds for patients to combat overcrowding hospital rooms and fast check
- Hospital rooms and fast check in

- Post-discharge follow up to ensure linkage to referrals was successful and to offer additional support/assistance as needed
- Successful care coordination for next steps
- Anonymous Narcan pick up/needle exchange
- First responders empowered with tools to prevent, educate, and treat
- Immediate points of contact for real time connection to substance use treatment resources, for access by ED and other medical providers and first responders
- Peer support/peer navigators
- Peer support/ peer navigators embedded in emergency departments and acute care hospitals
- Re: workforce incentivizing new entrants into the recovery support services workforce (to address capacity), and education and skill building for the existing workforce (to address stigma)
- Need to have educated and informed workforce
- Proactively work to decrease barriers to working with various organizations so that we can respond quickly
- Access to education and resources, specifically prevention. I have done numerous Narcan events and many people are still not aware what it is, how to use it or how to access it. Alycia Cardona, Acadia, El Cajon, CTC
- Prevention, treatment, other strategies, identify the root causes
- Waitlists - data analysis about how we can better have services readily available
- To the extent we can with all these practical suggestions it would be helpful to have a sense which recommendations can best scale without prohibitive costs... we should have some national examples of scaled approaches at a modest cost
- Destigmatize SUD
- Comprehensive care coordination across the system- recognizing care coordination exists now but not in a way that offers supportive and comprehensive care across settings
- There needs to be more consequence for drug use offenders to help stigmatize the lifestyle as undesirable and not lavish and exclusive
- There are so many roadblocks to accessing healthy opioid medication management. I am a chronic pain patient who has a degenerative connective tissue disorder. It took me three years and destroying my digestive system with NSAIDs to be able to gain access to appropriate pain management. I have successfully taken the same strength opioid prescription for 2 years now. Even so, I am constantly threatened with being dropped by my pain management provider due to a myriad of reasons that have nothing to do with my compliance with my patient agreement contract. It is an abusive, unbalanced power relationship and I know many other pain patients who have experienced the same
- Put them in a care facility
- I believe integrating healthcare can help reduce stigma
- For patients struggling with substance use disorder and/or opioid use disorder, many are unable access treatment due to the strain on the healthcare workforce, transportation issues, stigma with treatment, and language barriers. Innovative and

evidence-based technology solutions exist to address these constraints – specifically – FDA-authorized prescription digital therapeutics (PDTs). PDTs are software-based disease treatments intended to prevent or treat a disease and are regulated by the U.S. Food and Drug Administration. Specifically, there are PDTs that treat SUD and/or OUD and can help bridge care gaps while simultaneously supporting the existing behavioral health workforce infrastructure. The lack of funding for FDA-authorized, evidence-based technologies is a barrier for patient access. Data has shown these treatments give patients the best fighting chance at recovery

- Funding silos, overworked workforce, stigma, skilled employees
- It is expensive to pay psychiatric physicians. We need better availability of healthcare providers and better payout from medi-cal and other insurance policies so that we can open our
- Stigma and inappropriate behaviors and language on the part of healthcare staff; lack of awareness of treatment options or how to access them on the part of potential patients; lack of insurance or other funding to pay for services; lack of institutional support to build comprehensive care across the continuum of care for all level needs

Question: What would successful integration look like with emergency departments?

- Robust training and education by service providers made available regularly to ED staff
- We don't have the same follow up available for youth to integrate MAT
- Communication across ED platforms- so it is easy to see what has already been started and to continue the treatment path. HIE, Epic everywhere etc
- Imbedded clinical professionals from treatment facilities within Eds o assess evaluate, and enroll into treatment
- Comprehensive screening and documentation along with systemic protocols for easy immediate interventions and warm hand offs
- Potential to lower healthcare utilization of Eds when providers can prescribe FDA cleared prescription digital therapeutics for SUD and OUD
- Have EMS be able to refer into the system as well
- 12 step programs work if people actually work them. But not having that connection to the healthcare setting misses a big opportunity
- Connect addicted people with recovering peers and help sustain long term relationships as well as integrated use of 12 step philosophies, programs and services. 12 step programs work if people actually work them
- PEER WORKERS!
- You have to appropriate be able to pick them up in the ED to get the substance navigators involved…how to screen rapidly and correctly
- An army of substance use navigators to ENGAGE and evaluate patients and getting them STARTED with care immediately and referred/connected for follow up care
- Partnerships and warm hand offs with outpatient substance use treatment for youth
- In addition to good care navigation (that has engagement CENTRAL) and evaluation, there needs to be an easy to use, up to date, REFERRAL central to immediately schedule and connect patients

- Low barrier follow up street medicine teams
- Have follow up with patients after discharge for a set amount of time
- Primary care needs to move to the treatment programs our clients- clients don't like going to medical clinic. Move primary care to drug treatment
- Embedded SUD treatment staff and /or a closed referral system for direct linkage to treatment
- Routine questions and assessments regarding substance uses much like asks about alcohol and exercise; identifying individuals at risk of addiction early on
- Similar to ER, dedicated staff from SUD system who liaison with primary care, both to remind primary care that services are available and facilitate the link to SUD treatment
- After-care follow up ensuring referral linkage was successful
- Mobile clinics have been helpful in getting individuals back involved in primary care services
- Include alternative to pain management. Include yoga, acupuncture, acupressure, chiropractic, dental is imperative
- Be able to link someone to services without requiring ED clearance into treatment. Primary care like settings that can provide this services on demand without waiting days or months
- Prescribing PDTs that are FDA authorize in conjunction with a outpatient clinic. It provides 24/7 access of care
- More access to MAT (medication assisted treatment)
- Access
- We need to start with integrating the coordinators we have before we can approach integrating service systems
- Improved information sharing between substance use treatment facilities, emergency departments, and community partners (such as PERT and EMS) regarding available treatment spaces
- Having paramedic PCRs have an option to highlight/flag a potential patient with SUD to alert the ER MD. This may help to identify pts as needing help vs just a pain seeker
- Have people in ED trained to help families deal with loved one in crisis, equip them to be a support group (e.g., follow up visit, communication with loved one)
- Healthcare providers can call 24/7 to get help dealing with a potential overdose of any substance (generally not recreational drugs, admittedly). Could we update the County Access & Crisis Line to include that immediate support to healthcare providers on treatment options?
- Empower and engage families
- Not specific to ED, but education and support to families - building supportive communities of parents and family members through schools and community organizations, and providing education on substances and treatment resources
- Next step for someone who is still needing medications
- As an ED doc, I honestly don't know which programs have openings and which will take any particular insurance (or indigent patients). It makes it hard to refer folks

- Utilizing the voice of those with lived experience. Either those in recovery and/or family members. Inviting them to the table
- Communication with field providers and others across the entire continuum of care to minimize vulnerable patients "falling through the cracks"
- Looking more at data and evidence-based research to inform what works and what doesn't work - needs to be available
- Inclusion of data from encounters outside of the hospital setting
- Incorporating use of evidence-based research
- Less impact on ER services for drug related patients, less repeat offenders
- I do not have input from departments/expertise on this question
- In my experience, the emergency rooms I have interacted with are doing great
- Having a system that shows a patients history of compliance with pain management contracts allows everyone to work from a place of knowledge and safety. Where it falls short is when patients are unable to access pain management through regular clinics because they cannot jump through all the hoops to even get a pain management contract. There has to be a way to make it safe and also allow those who really need opioid medications for pain to access it safely and effectively without fear of reprisals for non-contract related "infractions"
- Peacefully getting them off the street
- Referral for comprehensive treatment to replace “band-aid” care
- The California Bridge Program uses a provider standing order for FDA authorized prescription digital therapeutics (PDT) that treat SUD and OUD at their participating EDs. The County could participate in a model with area emergency room departments (some of which may already be participating). PDTs work in a way that meet patients where they already are, on their smartphones or tablets, so they can turn screen time into therapy time. PDTs reduce ED utilization for behavioral health by having access to CBT modules when outpatient clinics are not available and further alleviate often burdened emergency departments in San Diego
- Screening and brief intervention for all patients, in-hospital connections to case managers for hand-off to treatment programs or others
- A physician on for 24 hours that can see patients and refer to services in EVERY hospital
- Many substance use navigators with MD back-up; substance use navigators with access to and integration with outpatient community referral follow-ups so patients can be scheduled directly and all barriers (transportation, cost, appointments, etc... can be addressed prior to ED discharge)
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- Utilizing the voice of those with lived experience. Either those in recovery and/or family members. Inviting them to the table
- Communication with field providers and others across the entire continuum of care to minimize vulnerable patients "falling through the cracks"
- Looking more at data and evidence-based research to inform what works and what doesn't work - needs to be available
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Question: What would successful integration look like with primary care?

- Providing access for clinicians to prescribe FDA-cleared prescription digital therapeutics for SUD and OUD
- Mobile providers who build relationships that bridge into primary care
- NTP/OTP mobile units (not specifically related o PCP)
- Discussion around person centered language
- Trained providers, front office staff nurses etc
- Also important to find a “good fit” for the participant and understand their trauma and medical mistrust
- Language being more harm reduction and less abstinence based/ stigmatizing
- Significant training would be needed to integrate this into youth/adolescent primary care
- Having identified patient meet with a SUN immediately- whether in person or via telehealth (hand the patient an IPAD) to engage the person, do an evaluation, and connect them with appropriate care
- Increased proficiency by PCPs in understanding the behavioral issues related to SUD
- Primary care needs to move to the treatment programs our clients- clients don’t like going to medical clinic. Move primary care to drug treatment
- Embedded SUD treatment staff and /or a closed referral system for direct linkage to treatment
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- Prescribing PDTs that are FDA authorize in conjunction with a outpatient clinic. It provides 24/7 access of care
- More access to MAT (medication assisted treatment)
- Access
- Care coordination and data sharing across the many different providers involved. CalAIM has opportunities but the challenge is who is the primary care coordinator. We have so many care coordinators it can be challenge for patients and families and to achieve integrated care
- Looking beyond healthcare, partner with schools, counselors, teachers, principals. Build support structures in schools in partnership with healthcare for adolescents and young adults
- Utilizing the voice of those with lived experience. Either those in recovery and/or family members. Inviting them to the table
- Communication with field providers and others across the entire continuum of care to minimize vulnerable patients "falling through the cracks"
- Looking more at data and evidence-based research to inform what works and what doesn't work - needs to be available
- Integration of comprehensive care
- Incorporating use of evidence-based research
- Primary care could include a more detailed and frequent lifestyle analysis to better identify people at risk for drug use and abuse
- I do not have input from departments/expertise on this question
- Primary care doctors should be better informed about the challenges facing chronic pain patients, how to navigate those challenges to better support their patients, and the ability to prescribe stop-gap opioid medications that have already previously been prescribed to their patient, that their patient has successfully taken without overstepping their patient contract, if patients find themselves in need of seeking a new pain management doctor
- Stigma reduction would encourage people to seek first level help from their PC docs
- FDA authorized treatments in primary care settings will expand access to behavioral health services for all populations, but specifically enhance success rates for vulnerable populations. Prescription digital therapeutics that treat substance use disorder and/or opioid use disorder will enhance care providers with tools that everyone can access. A particular focus should be given to pregnant women with co-occurring SUD and OUD, parents that have been separated from their children due to a SUD and OUD related issue, individuals who are currently incarcerated and are involved in the criminal justice, and individuals that lack stable housing or are on the verge of homelessness. If a patient does not have access to a smart phone due to financial constraints, they may be eligible for the federal Lifeline program. This program provides subscribers a discount on qualifying monthly telephone service, broadband Internet service, or bundled voice-broadband packages purchased from participating wireline or wireless providers. The discount helps ensure that low-income consumers/patients can afford 21st century broadband and the access it provides to jobs, healthcare, and educational resources

- Screening and brief intervention for all patients and immediate connections and follow up as needed (that the care providers coordinate)
- An inpatient psychiatric physician available 24 hours a day for services. A dedicated unit for psychiatric patients in every hospital. Hospitals would need funding to make units that meet current standards
- Immediate, real-time access to Addiction Consultation Services (with master's level or trained personnel doing ENGAGEMENT, assessment, and coordination of referrals) with medical back up for medication management. This can be done via iPADs/telehealth, embedded services, etc... Lots of opportunity for technology to help

Question: What would successful integration look like as it relates to medication assisted treatment?

- Site for workforce/capacity for OTPs. In particular UCSD could have an OTP to train future addiction psychiatry and addiction medicine providers and increase access to methadone
- Low barrier access to MAT. Also very important to look at the bridge from fentanyl to MAT
- Timely outpatient follow up available for youth (in addition to adults) started on MAT
- Providing access to FDA-cleared prescription digital therapeutics that complement Medication Assisted Treatment
- Uniformity of prescribing protocols between providers that ensures smooth continuity of care from one facility to the next
- Recognize we are in a crisis, but we cannot downplay the power of prevention and slowing the tide of new users
- MAT services being more readily available more readily at more sites-primary care, SUD programs etc
- Some post acute programs wont accept a person on MAT drugs. Those policies need to be updated
- Prescribing PDTs that are FDA authorize in conjunction with a outpatient clinic. It provides 24/7 access of care
- Current treatment provider (PCP, Psychiatrist) prescribing monitoring MAT rx
- Its ideal to access from anywhere but it also a bit dangerous
- Addiction is more than just use, there are behaviors that need attention as well, so monitoring is not just the medication
- Well-coordinated care with a team that includes the specialist and the addiction crew
- Address insurance/funding barriers- referrals, authorizations, copays, out of pocket costs
- Connection to ongoing MAT services beyond initial induction; warm handoff from the initial prescriber to ongoing MAT and other SU treatment services
- Higher enrollments for EDs into Bridge programs
- More education to other providers (PCP, ER) etc. to break the stigma on MAT
- Utilizing the voice of those with lived experience. Either those in recovery and/or family members. Inviting them to the table

- Communication with field providers and others across the entire continuum of care to minimize vulnerable patients "falling through the cracks"
- Incorporating use of evidence-based research
- Increased MAT for in custody individuals in the jail. Connectivity between pre-incarceration, and post incarceration records for better treatment while in custody
- Expansion of Medication Assisted Treatment in jails Transitions to community-based treatment Expand Services for Neonatal Opioid Withdrawal Syndrome:
    - Identify women in custody who have recently given birth
    - Possibly include in Healthcare Telemedicine Connectivity Hub
- I think it would look like an integrated program that supports all aspects of MAT in one place. A one stop appointment where all providers have access to the patient and eachother to best support recovery
- It would be used wisely as part of d as n overall plan
- Not only should MAT be offered by more providers across the U.S., but additional tools that complement or layer on top of MAT should also be reimbursable
- Specifically, FDA authorized prescription digital therapeutics (PDTs) for OUD are indicated by the FDA to work in tandem with MAT and increase overall retention in treatment. Data shows PDTs increase successful patient outcomes, divert emergency department usage, create system cost savings, and empower health care workers to help their patients navigate through recovery
- Incorporated into above when appropriate
- Outpatient facilities should be run by licensed teams. The teams should include mental health support/counseling, licensed practitioners or physicians for dosing, licensed nurses who perform drug testing and a care center/office for community outreach resources such as jobs, housing and additional mental health resources for theirselves and their families
- Immediate, real-time access to Addiction Consultation Services (with master's level or trained personnel doing ENGAGEMENT, assessment, and coordination of referrals) with medical back up for medication management. This can be done via iPADs/telehealth, embedded services, etc... Lots of opportunity for technology to help. The ability to start meds where-ever the person is at

Question: What is limiting comprehensive substance use care in mainstream health care?

- Lack of easy cohesive referrals
- Lack of immediate access, starting care immediately when needed or open to it
- Systems operating in a silo
- Lack of comfort/time to assess for SUD issue in medical setting
- Limited resources for timely outpatient follow up for youth
- Finance, lack of financial incentive, lack of resources, integration portal
- Regarding UCSD campaign to build a SUD registry - consider incentivizing addicted people with appropriate amount of cash (e.g. Amazon credits) paid over time for participation. People want help but, they also need to live life (e.g. are consumers) and such an offer might be attractive
- Data describing the extent of the problem, especially in children/youth population

- Working for a large child/youth provider, we do not have a good sense of the issue
- More data to understand the specifics of the problem
- Rural communities lack the programs, ability to access care, and education
- Stigma
- Need to bill services to get paid
- Lack of qualified staff
- Funding/reimbursement rates
- Anemic reimbursement from insurers
- There is provider to provider support from California warm line, NCCC. They can coach providers in individual cases with SUD. They are the same UCSF support group that helps with PEP for HIV. There is a need to be able to refer to specialist, but medical community can do more
- Access or perceived access
- More education needed on the benefits of harm reduction approach
- Not enough prevention
- Biases and presuppositions about certain communities
- Lack of physicians interested or certified
- Open funding pay rates equivalency-staff incentives
- Funding
- Access to FDA cleared Prescription digital therapeutics “PDT”
- Workforce
- Retention - ongoing case management, addressing housing security
- There is also so much that we do in health care that no matter how important the item, it's hard to find room for providers to focus on it. This is part of why specialty care is so valuable... if you can get people into that care system
- First Responders empowered with tools to prevent, educate, and treat
- I don't think we have fully embraced and exploited the various technological tools we can use to push out information and recommendations to families and others looking for guidance
- Siloed health system, inadequate care coordination between different service systems, including managed care plans, physical health providers, and the behavioral health system
- Limitations to education
- We have not developed the medical piece of SUD in the same way we have for MH
- Finding specialists in SUD
- Capacity - It's too hard to open pandora's box without the ability to actually connect someone to the services they need
- There is still so much stigma which leads to resistance to treatment or receiving education
- Related to stigma - fear of legal consequences, child welfare involvement, immigration status - hinder care-seeking and openness with health care providers
- I think there is still a huge stigma. People with SUD are "worse than" or "addicts" or "deserve it". We have to get past that

- Trained workforce with full understanding, awareness, and capacity to implement substance use care to meet the needs of patient/client
- Competent and trained workforce
- Barriers and access to care
- Poor communication across the system
- Lack of education and/or access to certain specialties
- An approximate $5 million upgrade between technologies that will integrate community health records with incarcerated individuals
- Justice partners including Sheriff should partner with HHSA & BHS on recovery and warm hand off programs for justice involved individuals
    - Procure Technology Hub (Microsoft etc./Cost ~$5M) to feed substance use disorder patients' information from Jails and Prisons to HHSA, BHS, EMS, hospitals etc. Protect Criminal Justice Information
    - Replace current Vista Jail Facility to vastly improve care to incarcerated individuals. $100-400M.
    - Create Training Facility to mimic medical response and appropriate treatment for ODs. (mimic holding cells, jail cells, medical areas etc.)
    - Standalone Correctional HealthCare Facility
    - Other Tech. (bracelets) to ID medical distress and proof of life
- I definitely think there needs to be more support for pain management patients who use opioid medications to have an easier time reporting abusive providers and having support while finding and transitioning to a new provider. When patients cannot access the pain management system adequately, there will always be a temptation to figure it out on your own. Pain changes you. How many overdoses are by people who could not access pain management and then could not live with the pain any longer? Who got tired of fighting a losing battle to get their lives back in order? We must fix things so those who need it and won't abuse it can access it and those who need help with recovery can get it
- Build facilities to house them in group homes
- Prioritize, keep up-to-date on research directives, good publicity
- To further support the existing behavioral health workforce in the County of San Diego, we believe making FDA authorized prescription digital therapeutics (PDT) that treat substance use and opioid use disorders available to providers and patients will improve overall access to healthcare, eliminate stigma, lower County healthcare costs, and increase overall health outcomes. It is important to note that these tools are not standalone solutions, but tools that complement existing outpatient addiction treatment (i.e., provider extender tools). FDA authorized PDTs for SUD and OUD offer a number of benefits to patients who need treatment for substance use and opioid use disorders: they are available in both English and Spanish; they offer "on demand" access that can be utilized day or night; they overcome transportation barriers for those who need treatment; they provide motivational incentives to avoid reoccurrences of substance use; they help remove stigma from the treatment process; and, lastly, they reduce healthcare utilization and create cost savings to the

system. These features are essential to making our addiction healthcare system more equitable, accessible, and inclusive

- SD needs to advocate for care teams run by licensed professionals. They need to provide funding for the centers and hold the centers to strict guidelines and standards like other healthcare clinics and hospitals. Our elected officials should be advocating for better payout for psychiatric services including drug addiction and rehabilitation
- Lots of opportunity for technology to help.
    - Integrated real-time scheduling with all care providers in the community, increase in same-day, in the moment access to care across all settings and levels of care
    - Fund a UCSD based corps of substance use navigators that can be available via telehealth throughout any/all points of patient contact with the system to engage and assess patients, and then facilitated connection with care

Question: What recommendations do you have regarding the resources, supports, and/or tools needed to help San Diego County foster an integrated health system

- Connect our existing diversionary programs in the courts (BH, Veterans, Drug Court, Juvenile etc.) with healthcare system. We need to connect the public safety elements with our health system. The former has a rich history of working with people with significant BH and SUD issues
- Provide access to FDA-cleared prescription digital therapeutics that treat SUD and OUD
- Multidisciplinary team
- Co-location of services (one stop shops)
- Accurate data sharing to help identify need to guide funding/resources etc
- Build upon access via better communication in medical record- access to other providers: workforce, training and pay
- Open funding-pay rates equivalency staff incentives
- No wrong door; allow MH providers to treat primary substance use disorders and be reimbursed
- Figure out how to liaison between systems--hiring individuals who can
- Properly trained staff; making sure we are at staffing capacity
- Reimbursement is a good incentive. Medical community did tobacco session education because it was reimbursed. SUD and SBIRT is “anemic” as mentioned
- An all hazards approach as complex crisis are common
- System prevalence and needs to better guide practice; Continuity of care for patient care data in universal
  MRN
- Collaboration with training programs (schools, certification programs) to help train to integrate care
- County once evaluated EDIE system- communitywide share case management. This can be used for SUD and mental health
- Training exposure
- Going virtual

- Make environment more friendly
- Eliminate stigma through clinical understanding
- Get a SU counselor on staff to have a voice at the table, include peers in staff
- Champions of health has a module on stigma
- When training and education is incorporated into workforce stigma can be reduced
- Training specific to communicating with patients/clients
- Education on the realities of substance use rather than promotion of stereotypes, rate of success, effective interventions, harm reduction
- Stigma in the community as well in the field. Need to be looked at State level
- Make sure expertise is acknowledged
- I hope that monies from this settlement will go directly to infrastructure and harm reduction needs of the incarcerated and justice involved population in San Diego County. There will be no bigger impact on our communities, families and safety than helping this population. Thank you for your time
- Support Data Collection and Research:
    - Overdose Mapping – FTE to facilitate regional participation. Fund EMS Data Analyst position (3–5-year period). Enrich Prevention Strategies:
    - Education and social media campaigns for youth and parents in multiple languages.
    - Provide age and culturally appropriate education in 42 school districts and university orientations
- I have not experience with PWUD
- Time for tough love. Enabling isn't compassion or safe for anyone
- Cannot stress enough the value and necessity of parenting support and early childhood care as prevention. Stop bullying and other demeaning practices that devalue youth and destroy their self-esteem. Pay teachers and social workers and fund schools and services adequately to put money where our mouth is
- As the County evaluates programs to fund with opioid settlement dollars, we would respectfully request that the County closely consider making available FDA-authorized prescription digital therapeutics (PDTs) for opioid use disorder to providers and patients. PDTs are software-based disease treatments intended to prevent or treat a disease and are regulated by the U.S. Food and Drug Administration. Not only do these tools provide cognitive behavioral therapy and contingency management, they also directly put care in the hands of patients that may not otherwise have access to these critical behavioral health services. We believe that by providing funding for this potential tool, PDTs will support the County's ongoing efforts to help prevent and reduce opioid use and overdoses countywide. Notably, the White House's Office of National Drug Control Policy released its 2022 National Drug Control Strategy in April. Specifically, the strategy document discusses an FDA authorized prescription digital therapeutic that treats opioid use disorder and states: "Further exploration of such digital therapeutics and other health technology in the form of digital screening, assessment and treatment could help increase services for a wide array of patients"

- Prevention is the only treatment guaranteed to work yet was not even included in your follow up email. This is extremely troubling. We need to incorporate the decades of lessons from the tobacco, alcohol, and Rx drug industries in creating a comprehensive prevention strategy for youth substance use. 90% of those with SUD started use before age 18
- Pipeline and workforce capacity development are critical. Funding academic programs to train addiction psychiatry fellows to work in all settings and levels of addiction care is critical
- If it is a fentanyl overdose, initiate them on methadone with a transfer to an OTP
- Finance, lack of financial incentive, lack of resources, integration portal
- A major reason is the lack of knowledge about the topic by a large majority of healthcare providers
- Access and reimbursement for FDA-cleared prescription digital therapeutics for SUD and OUD
- Access to Contingency Management and Cognitive Behavioral Therapy
- Stigma as it relates to community perceptions about addiction and behavioral health issues
- I support the nationally adopted Principles in the Use of the Fund from the Opioid Litigation
    1. Spend Money to Save Lives
    2. Use Evidence To Guide Spending
    3. Invest in Prevention
    4. Focus on Racial Equity
    5. Develop a Fair and Transparent Process
- Learning from Tobacco Settlement, the number one successful spending was developing the Truth Initiative that was successful in changing the smoking culture. I would recommend that prevention spending should be used in a similar way to prevent drug use before it starts. Dollars should be balanced between drug prevention and treatment
- Everyday I discharge patients from the emergency department who use drugs, may have overdosed, and desperately want treatment. Sadly, often times there are no immediate resources. Appointment at clinics can take 2 weeks. Patients go home with a prescription for naloxone and a paper with listed resources. Acute sobering and treatment capacity should be improved
- Increase funding of OTPs for staffing to provide more outreach services
- Consider monitoring sewer stations for fentanyl like we monitor for covid. Then target those areas with more extensive outreach services
- Setup opioid specific recovery homes/housing
- Setup research funds for grants to study treatment and prevention strategies
- Setup mobile van to dispense methadone. that is shared by multiple otps
- Importance of supporting families who are struggling to help family member or loved one struggling with SUD/OUD
- Partnership to end Addiction's designed and deployed family-centered programs which use "technology-rich" approaches to address a range of behavioral-health

challenges, especially in its work with counties and states in wake of the opioid and fentanyl crises

- Good ideas shared among a very diversified audience from different disciplines
- I like the interactive nature. Perhaps mix the groups more for diverse dialogue
- Presentations excellent. breakout good but biased by facilitators own top ideas
- Jam board was confusing but the person monitoring the breakout chat was great in capturing and transferring comments
- I've used jam board before and really like it. In this particular session, I was posting things on the ja board, but they were not coming up on the main jam board. It seem to work better when I was posting it in chat and the facilitator was copying and pasting it onto a jam board sticky note
- Facilitated well. I liked the remote format. I think it may have been more effective than it would have been in person?
- The break out rooms allow to hear perspectives from a range of people working in different areas. Having 3 different ways of providing feedback is good as it allows for shyer participants to share their thoughts
- Sara Whaley's presentation was very informative and appreciated the links for a deeper dive into the info provided
- Questions in breakout should be on the board so people are responding to specifics
- Let's agree on what we mean with terms like data, communication, integrated, etc. otherwise even our greatest attempts might not match expectation
- It leaned heavily on certain systems of care and I think diversity would strengthen the effort. But it was a very good meeting
- Maybe have a section about. What questions should we have asked that we haven't yet?
- I Would have liked the break out sessions and at least part of the presentations to have been led by self- identifying PWUD. Everyone did great though!
- There was no opportunity to ask questions of main speakers
- put self-identifying PWUD in lead roles
- Thank you for letting EMS participate. Great job to whoever put this together. It was flawless in format and that must have been a lot work! We appreciate what your team does
- Thanks for the opportunity to provide input to the process
- I would like to be able to share opportunities for others to share input. Will it be possible to share opening recoding and an email or link for people who were not able to attend?
- One potential issue with these fast paced breakout rooms with many participants is that they don't allow for deeper thinking. Perhaps it would be good to also have very small (2-3 people) breakout rooms in which only one question is discussed for 30 mins
- I appreciated that despite the focus of today's meeting being on harm reduction and prevention, room was made for public safety/law enforcement participation and value

FORUM #2

Question: What are some specific harm reduction and prevention models that would support efforts to build a better public health infrastructure?

- MAT being more avail. - longer times/locations
- Smoother initiation into MOUD in jails with more certainty in making connections to continued support upon release from custody
- Payor-agnostic interventions, especially for youth and in schools
- Community Health Workers focusing on Substance Use
- Greater availability of medication disposal boxes in the community and at hospitals
- Institute age limit/standard in schools to educate youth/children to be aware at an early age
- Harm reduction - street outreach. Teens that go out to provide access to services like syringe exchange programs and access to naloxone
- Expanded access and visibility - where can we go to get access to resources?
- Talk to community and engage with them - what do they need?
- Outpatient substance abuse follow-up and warm hand offs for youth to ensure secondary prevention
- Contingency Management
- Syringe exchange programs with optional connections to detox / BH/ SUD services
- Access to FTS in primary care, mental health, SUD treatment...not only at SSP
- People's concepts of recovery perhaps not including harm reduction or having a negative view of HR
- Lower barrier treatment programs (truly meeting people where they are at)
- Prevention needs to happen outside of treatment programs including in primary care, mental health clinics, pediatric providers, etc. We are missing out on the people who are not in or interested in treatment
- Low barrier detox/treatment programs
- Identify opportunities where we can intervene based on the incidents of overdose
- Wider and more robust public education campaign to address and reduce stigma surrounding addiction and addiction treatment
- Waitlist too long with county funded detox- needs to be addressed
- Contingency Management
- Correct expertise to address patient needs who are in crisis
- Syringe exchange programs with optional connections to detox / BH/ SUD services
- Those in crisis have immediate access to support/ mobile response team
- MAT induction within inpatient detox facilities
- Stronger collaboration with the ED and MAT/treatment programs is needed
- Sensitivity training and stigma work in hospitals , especially emergency rooms
- Expand naloxone/narcan distribution
- Client transportation services specific to and from MAT service providers
- Stigma and general/public misconceptions
- limits to outreach and funding

- The harm reduction strategies start entering settings that are not fully medical, thus hesitation will be seen from many inside and outside the medical community.
- Patients more familiar with MAT and harm-reduction, a living situation that's more conducive - Culture change in residential treatment facilities
- Destigmatize medical conditions, holistic approach, include family in recovery to increase success, more education for healthcare workers and doctors
- Safe consumption sites
- Insurance coverage and removal of financial barriers to all of these harm reduction options!
- Syringe Services Programs
- Distribute Naloxone in healthcare settings - Emergency Rooms and Primary Care Offices
- Naloxone distribution
- Wrap around services: hitting all social determinants of health: housing, employment, treatment services, financial assistance etc.
- Education in all languages made available for the community
- Vaccination for Hep B
- Fentanyl test strips are a critical step. Healthcare workers who recognize education to families on Narcan /naloxone is imperative Health care workers who discuss harm reduction instead of lectures
- Increased access to pre-exposure prophylaxis (PrEP) to prevent HIV
- Needle Exchange
- Education
- Medication for substance use treatment during incarceration
- Narcan access. MAT treatment
- Fentanyl test strip distribution in schools
- Simplified Buprenorphine access
- Narcan/naloxone in sober living
- For youth, mentoring curriculum for use in schools, youth programs with access for parents/guardians
- De-stigmatizing treatment and harm reduction as a whole
- Drug checking services
- Safe fentanyl distribution
- work with caregivers, schools and others who support individuals who use so they can support the individual
- Moving from an only 12 step philosophy/treatment
- Large scaling to street based AOD/MAT/SUD programs, bringing the resources to where people are. Not waiting for folks to walk through clinic doors
- Dentistry that does not use narcotics for Wisdom teeth extraction
- Healthcare workers who understand more about OUD
- CA 11550 Health & Safety Code: see more harm reduction efforts in jail settings
- Guidance and coaching to engage parents, families, caregivers to provide resources for children w/SUD

- Consider including prevention definition to be inclusive of pediatric use. Co-use of other substances prior to opioids
- Look to lessons learned from youth alcohol and tobacco prevention programs. Current trends seeing use occurring earlier and making substances seem safe
- learning lessons from alcohol and tobacco policies
- Look to replicate policy approaches from tobacco and alcohol prevention regarding advertising/marketing, sales to minors, reducing youth access, to focus on preventing use before age 21
- Broad naloxone distribution
- Low barrier housing (not requiring sobriety)
- Deeper integration of MAT program in jails
- Finding out from the people what is needed, increase/livable wage for workforce, and using funding for peer-based support
- Education and outreach in schools, social media campaigns
- Social media interventions on Snapchat, Facebook, Google, Tinder, Grinder and Instagram
- HR: Incentive MAT prescribers
- HR: Naloxone everywhere (public/healthcare)
- Needs assessment using fentanyl testing of sewer lines in different districts of SD county and then targeting these districts with harm reduction services and prevention strategies
- Better connectivity between service providers, information sharing
- There are technologies we can expand to prevent overdose deaths in the jail, i.e. more body scanners, etc.
- Drug screening and substance abuse prevention Education and intervention programs in the workplace
- More support for jails, more space for treatment is needed, better infrastructure
- Decriminalization
- Science based education for kids about drugs and body chemistry
- Many individuals in jail are aware of drug seller in the community - better ability to follow up investigations related to that information
- This is an example fentanyl sewer testing in Canada https://canadainfo.net/eng/fentanyl-detected-in-torontos-sewer-system-more-than-triples-in-pandemic-federal-survey-finds/
- Social media platforms should be allies of harm reduction
- Trauma informed and looking at CPTSD
- More available interventions
- Withdrawal support (medical, housing, financial, etc...) regardless of time frame
- Harm reduction model; Breaking the stigma around substance abuse
- Meet people where they're at (go to them) & meet their needs
- Follow-up support for those coming out of programs/incarcerations
- Continuous support/flexible funding regardless of program admission status
- Access to safer supplies/resources

- Expansion of Medication Assisted TX in jails. Nurse or Care Coordinator attached to Medical Examiner to offer Naloxone/TX/support to family and friends of people who die from overdose. Naloxone for Fire personnel
- Direct connection to treatment (MAT program, naloxone distribution)
- Increased access to services/linkages
- More readily available drug treatment programs. My sense is there is just not nearly enough easy-to-access programs that take a non-punitive/dignifying approach
- Reducing stigma for law enforcement personnel/first responder community
- Increase education/training related to MAT and other services for first responders
- Broader education across all service areas
- Educate health care providers to reduce stigma
- Other support services like housing
- Resources for those who may not have housing
- Overdose prevention
- Bridging gaps
- I would like to ask the county to look into unconventional ways of getting the messages to the people. The traditional billboards and bus stops are not effective. They do play a role but people in general are not paying attention to those. We must look into utilizing direct service awareness ideas as well as direct prevention and awareness methods that are innovative in reaching the people attention to those. We must look into utilizing direct service awareness ideas as well as direct prevention and awareness methods that are innovative in reaching the people.
- Street medicine program
- Warm handoffs (connections)
- Harm reduction over zero tolerance
- Collaboration of care

Question: What barriers or challenges might we face as we look to expand harm reduction and prevention services?

- Misunderstanding about what harm reduction means-- it's not promoting drug usage
- Misconception that harm reduction is enabling
- Stigma and politicized
- Being mindful of how we define "lived experience" and
- How we segment out different populations
- Pushback from parents on public presentations to youth
- How big the County is and how widespread it is. it's hard to get around especially to rural areas
- Admission that there is a problem
- Accessibility
- Lack of evidence-based literature or guidelines to direct primary prevention strategies
- Judgement
- Attitude that nothing can be done
- NIMBYism/finding sites
- Misinformation
- Court/probation not being aware of MATT= drug testing etc

- Limits to outreach and funding
- People's concepts of recovery perhaps not including harm reduction or having a negative view of HR
- No immediate response team to do follow ups on patients who need care
- Law enforcement are not equipped to support patients who need crisis care
- Prevention needs to happen outside of treatment programs including in primary care, mental health clinics, pediatric providers, etc. We are missing out on the people who are not in or interested in treatment
- Stigma and general/public misconceptions
- Historical challenge for providing immediate response, warm hand-offs, follow-ups after treatment
- Barriers and Challenges with training and hiring the staff needed to expand these efforts
- Reaching individuals is so challenging without motivation for treatment and recovery
- Rhe harm reduction strategies start entering settings that are not fully medical, thus hesitation will be seen from many inside and outside the medical community.
- Prevention resources that engage community as a whole in order to reduce stigma
- Lack of community support on how drug misuse effects community as a whole
- the community, the county, the police and the programs need to be working together and on the same page or the miscommunications become barriers
- Fear of prosecution from law enforcement for giving out harm reduction supplies
- Needles being considered "paraphernalia", cases of clients being charged for possessing needles obtained from county programs
- Multi-level stigma
- Insurance/financial coverage
- NIMBY = Not in my backyard
- Lack of political will
- Delivering consistent services to transient population
- Competing priorities
- Policies, Regulations, Licensing
- Fear
- Money
- perceptions / stigma
- Paraphernalia laws
- Lack of support or access to services
- Fighting between institutions for limited resources
- Workforce
- Culturally competent education/prevention materials/approaches, aimed at a variety of populations, youth in particular from a variety of backgrounds/experiences
- Social determinants of health barriers (racism; transportation; homelessness; food insecurity, etc.)
- Lack of surveillance infrastructure
- Othering of patients who seek medical treatment. Access to treatment and harm reduction- Not in my back yard old preconceived ideas of who is an addict

- Limited workforce- burnout
- HIPPA/Privacy
- Lack of will from elected officials due to outdated concepts and treatment
- Cultural Acceptance
- Messaging fatigue for the public
- Compassion fatigue for providers
- Funding
- Data - how to prove prevention was successful
- Shift policies to focus on youth use
- Barriers to naloxone distribution program is high. Getting certified to distribute naloxone is a barrier including cost and access (prescription)
- Workforce: while in SD SSP is not accessible, SSP and MAT need to be accessible when and where people need them
- Funding
- STIGMA
- Misinformation
- Shame
- Recovery language around clean an dirty
- Bias
- Fear
- Influx of new drugs
- Help parents recognize that schools/prevention intervention must be on the same team
- Resistance to treatment
- Access to services
- Focus on facts and avoid us/them and fear-based language
- Politization of the problem
- Competing interests
- Looking at the whole person and self-autonomy
- Law enforcement
- More patient centered research on new treatment solutions
- NIMBYism
- Mistrust of providers
- Changing attitudes of law enforcement
- Workforce shortage
- Hard to get parents to think it's going to happen to their child so it's difficult to get into schools.
- Public information and media
- Lack of public facing dashboards with information
- Accessible resources throughout the county
- Community resistance, need better communication/actions to see a change
- Families & youth specific challenges
- Criminal element surrounding substance abuse
- Stigma/nymbism

- Law enforcement practices might deter people from accessing services
- Limited accessibility/proximity
- Understaffed harm reduction organizations
- Lack of community trust
- Getting the message out
- Homeless population may not want to seek help due to fear/unknown risk factors
- Undocumented status affecting access
- Education
- Prevention for youth: These days it's so normalized and cool for kids to take pills and drugs even if they know the dangers. We need to get to them and have them thinking about the risks in a way that will reach them
- Finding other ways to collaborate
- After having a very conservative Board of Supervisors who did not embrace this approach, we may need broader community education to help people see the benefits and reduce lingering stigma
- Help support those who have mandates to treatment
- Where someone resides
- Evidence based programs
- Prevention programs directed at kids through music and videos
- In addition to rural communities its battling NIMBYism for treatment facilities and even prevention activities
- Limited resources
- Rural communities also include Native lands and BIPOC individuals
- Reduction in stigma in rural communities
- Fear of being stigmatized. Anonymity

Question: What are the harm reduction and prevention services that have the most scientific s*upport?*

- Screening in line with USPTF
- Prevention, education in the classroom, public messaging to community at large about SUDs, increase screening (everyone is screened at certain intervals)
- Naloxone, fentanyl strips, syringe exchange
- Bringing services TO folks (i.e. literally meeting them where they are)
- Street outreach
- Therapy
- Social media advertising/finding youth voices
- Supporting the evaluation and research of prevention (including primary) prevention strategies when there is not good evidence
- Mutual support groups
- Integrative care and team-based approach
- There is no harm in trying all of them
- Hep C treatment
- Social emotional learning to prevent engaging in risky behaviors in school settings
- Looking at gaps in the child's life (i.e. financially, housing, home issues)
- Reducing ace scores reduces risk of sud

- Kids respond better to kids their age. learning from other peers in recovery
- Contingency management coaching (e.g. here's how to say no)
- More funding for safe places for kids to go after school
- Preventing access on the supplier side
- Pre-arrest diversion
- Breaking the generational cycle of addiction - supports for the children of adults in treatment
- Subxone/Bup/MAT
- SSP's
- Overdose prevention/supervised consumption sites
- Naloxone/Narcan
- Drug checking services/test strips
- Post-overdose engagement for others who are on scene
- Contingency Management
- MAT. Specifically methadone maintenance treatment services
- Rob Kent touched on it with the fentanyl strips, testing creates opportunities for engagement
- Sublocade / vivitrol
- Primary prevention- specific care through provider leadership, lack of funding in prevention services
- Invest and Research prevention programs that are successful
- Making Fentanyl testing standard across all services and making it more affordable as it relates to testing fees
- Medications for opioid use disorder (MOUD)
- Medicated Assisted Treatment
- Cognitive Behavioral Therapy and Motivational Interviewing counseling modalities.
- Opioid Treatment Programs
- Prevention should start from a very young age, teach proper coping skills to children and youth, social emotional learning
- Targeted Naloxone Distribution
- Narcan, consumption sites, access to care
- Safe consumption sites
- Syringe Services Programs (SSPs)
- Hepatitis C treatment
- We are here now!
- Evidence base of alcohol & tobacco prevention policy approaches including marketing restriction, age restrictions are effective, reducing access, parent/family involvement
- Family engagement
- Policy and curriculum deployment and engagement with students @ middle school
- Person-centered information accessibility -- communication map including text and other modalities
- Syringe service programs
- MAT
- SSPs

- Needs based
- Contingency management
- Naloxone
- Low barrier treatment for stimulant use
- Addressing social determinants (drivers) of health
- Treatment of loneliness with services such as Papa
- Empowering PWUD to work in harm reduction for a living wage and with a career path
- Peer YES, we just published a study with 32% better results
- Papa is an online service that supplants a family member that server as a social support
- Wrap around services and connection are key
- Testing, linkage treatment for HCV/HIV
- Connection to pro-social activities
- Accessible/effective case managers
- Safe consumption sites
- Jail/prison based MOUD. Continuity of treatment
- MOUD
- Diversion from criminal justice
- Medication assisted treatments
- Needs based SSP
- Accessibility/immediate response
- Narcan
- K-12 pipeline support/teaching the correct narrative
- Structural interventions to reduce economic deprivation
- Prevention: Early identification of mental health issues
- Early, age-appropriate education - substance use and mental health
- Lived experience/peer support/community engagement
- Career assistance
- Job support for youth
- Early start prevention/treatment
- Child care services
- Prevention: support to families where parents are dealing with SUD
- CA Bridge Program
- Substance Use Navigators
- Distribute Narcan
- Getting communication out regarding Substance Use Navigators

Question: How does scientific evidence inform how we proportionally deploy resources to prevention and harm reduction, so we are impacting the most vulnerable?

- While evidence is important, need space for testing out new things and exploration
- Quantifying the size of the problem
- Emphasis on evidence and what we know is causing the most harm
- Utilizing a data driven approach to choosing and assessing the impact of interventions
- Study other communities that have successfully deployed toolkits

- Education to the community; the reality is most people are directly impacted by someone who had an OD, it is no longer something that only impacts a certain subset of the population
- Researching data to find what support is most needed
- If we had a better tracking system for overdoses so follow up could happen in the ED or pre-discharge so the person could be offered/linked to services. People have an OD and leave without linkage
- Current users but also preventing early onset
- Make harm prevention services widely available
- Narcan in the hands of people who aren't at low bottoms, it is incredibly hard to find the people in early use who are still housed and only associating in higher bottom circles that may not engage in public health services
- Or follow up with PCP, SUD programs, etc. If we had better data, we could identify gaps in services
- Mapping location data of non-fatal and fatal overdoses helps target resources (ODMAP)
- One area I think we're lacking in is cost-effectiveness analyses; however, for some programs like MOUD or SSPs we can prioritize them based on their incremental benefit
- We need to use it, with a grain of salt. There is evidence for things that work... however, we also must understand that what we have been doing, isn't working
- Look at data for substance misuse, who is most at risk and create tailored materials for those populations or look at those groups for implementing prevention strategies
- Could expand mapping related to where we see major distribution areas to also help target educational/prevention resources in schools, etc.
- New sampling methods and engagement strategies for identifying the most vulnerable
- Identify other data sources to help us understand the needs and demographic of vulnerable populations
- Collaborating with popular events to build awareness
- Identifying who is most at risk and deploying urgent information to those age groups in a way that is recognizable to the age group
- Needs assessment is crucial in the identification of most vulnerable. Resources in the past have been devoid of the identification of underserved
- How do you decide who is most vulnerable?
- New sampling methods and surveillance, better screening, analysis and comparisons of prevention efforts
- Better screening can catch early usage and better early intervention outcomes
- Earlier prevention (sectors including: school, family/community, PCP) and intervention in elementary school
- Evidence base to drive harm reduction work - e.g., Syringe Service Programs (SSPs). Provide connections to wraparound services and warm handoff safe syringes are exchanged
- Geo-mapping: Where people are who are using opioids - to target resources to those communities

- Budget for hiring peers and providing services throughout various communities that comes from current scientific numbers
- We receive 60,000-80,000 individuals into the jails every year. 82% or men and 67% of women have drugs in their system at intake. We can see if this number shifts with more treatment?
- When reliable data are available, they should dictate where the money and resources are spent
- Risk assessment models exist that can predict propensity to develop opioid use disorder. data from patients intestinal microbiome, genetics, and psychosocial history
- Emergency Department numbers and law enforcement response to overdoses in the field
- Lot's of data collection
- Drug checking with more than test strips
- Looking around the world for more, as US is behind
- There is evidence around changing of language in stigma
- Health economic evaluations
- Methods that account for health equity indicators when informing policy
- Accounting for health equity along with decision making
- Evidence can show saving costs and lives
- Scientific evidence/results go hand in hand with societal influence
- Creates transparency
- Demonstrate progress/change
- Bringing services directly to those who are most vulnerable
- cost effective methods; social influence affects these outcomes
- Data!!
- Lived experience
- Research based
- Risk assessments, new tools to evaluate & define effectiveness
- Evaluate the need
- Update evaluation/ assessment tools
- Redefine what "success" looks like

FORUM #3 Housing & Recovery Services

Question: What is missing from our current recovery support network? What models of recovery support do we need to better meet the needs of People Who Use Drugs?

- Dual diagnosis friendly housing-- understands SUD and Mental Health so often go together
- It's important to have doctor's available to provide care for those with out medical insurance with residential providers to follow their treatment and provide transportation to assist clients who need harm-reduction or MAT assistance when they are at a residential program- lower barrier on receiving treatment
- A fully integrated, real-time, active and useful referral and care transition service

- Spend money regionally. more regional hubs spread out throughout County
- Low barrier access to all forms of MAT
- More physicians
- Technology to meet people where they are at and keep them engaged (e.g. device access)
- Easy transition across the full continuum of care or level of care spectrum, independent of different organizations providing the services
- Using technology for immediate response when someone is reaching out
- Housing supports at all stages of the recovery process (e.g. recovery residences)
- Dual diagnosis friendly housing-- understands SUD and Mental Health so often go together
- A housing continuum that includes: (1) low-barrier housing supports for folks who are not engaged in treatment, (2) housing to support care transitions, (3) additional recovery residence funding to support folks in outpatient treatment, (4) longer-term/permanent housing specifically for primary SUD
- Technological solutions to enhance additional workforce around social work and engagement services
- Coordination of care and collaboration
- Funded SUD Outreach
- Education for NA/AA based sober living to lower stigma-- Stop criticism of people who choose MAT and don't go cold turkey
- "Housing Choice" model operationalized by Central City Concern (Portland) - combined approach incorporating elements of recovery housing and Housing First
- Low barrier housing/recovery options
- Housing Navigator Center as well as Housing Navigators to support with housing solutions
- Supports in place in the early stages that started during early school years as a result of trauma
- Housing is very key portion that is missing - easy access to housing
- Crisis housing for immediate needs. Shorter waitlist for accessing services
- Respite services for parents and/or childcare
- Peer models that pay a living wage
- The right housing setting that can be supportive of their recovery path
- Participant led services include housing that meets their needs
- An improved continuity of care- services working together (or a one stop shop)
- Career pathways to help people gain employment and have opportunities to be supported through the education pathway
- More than 12 step based options and more harm reduction education. More opportunities to build community and uplift program participants to work as peers
- To make purpose of their pain. Immediate access to detox beds
- Who are the peer supports offering services – training is important to support the network
- More investment in supportive services provided at Permanent Supportive Housing
- More opportunities for those with lived experience to serve as experts

- Empowerment pathways that embrace all stages of change/harm reduction goals
- Transportation and low barrier access to services
- High quality training for shelter staff and alignment with harm reduction standards
- Life skills, vocational opportunities, bring more of this in treatments, programs, and housing
- Establishing safe after school models/sites for teens in recovery
- Low barrier recovery services. "you're not poor enough, not addicted enough, not homeless enough, not in the right zip code, aren't a parent, are a parent, not on Medi-Cal, etc"
- Streamlined, singular point of entry. 211/Crisis Line too dependent on the person answering the phone
- Real-time response/referral system. How can we get peers into emergency rooms/halfway houses/etc. for warm hand-off's when needed?
- Substance use version of Clarity/HMIS software
- More realistic, data-driven promotion. so often we rely on fear-based marketing that alienates existing users
- Continuous support over time, many programs are time-limited, criteria can exclude people who still need support
- Whole person/whole family models to support families and keep them together when a parent is in recovery
- More training for parents
- Contingency Management that is region wide and not program specific.
- Immediately available treatment. There is often a small window where a user is interested in treatment and long wait lists prevent them from getting help they are seeking
- For homeless population using harm reduction support while waiting for housing - safe places to use & get medically assisted substance use support while homeless
- Providers don't always know what other supports are available in the community
- ACL can feel impersonal, how can we connect to the consumer/client in time for support services, a system that is more personable and feels more supportive
- Stronger linkages between the hospital/ED to SUD programs (not just a referral or business card) but a warm linkage to services
- More satellite/mobile clinics for service providers
- Decrease caseload expectations to provide higher quality of care (SUD is currently 25:1, Case Mgmt is 50:1)
- Short term housing options with treatment that connects to more permanent housing options and doesn't reduce eligibility for housing for homeless
- Increase training for parents, family support plays a large role for people in recovery, it can be difficult for families to know how to support
- Ask peers what their barriers are. They know, they do this work every day

Question: How do we integrate or expand services (harm reduction, recovery etc.) within housing and other support services to foster access to and sustain recovery for individuals?

- Provide peer-based and clinical training to recovery residence operators to encourage MAT and remove policy barriers limiting housing to RR tenants
- Transitional housing post RR
- NARCAN/Test Strip distribution machines (like a free vending machines)
- Peer led overdose prevention program offering supports & supplies (including test slips; safer use supplies/resources), and MAT information/resources linked to housing (e.g. a range of housing options)
- Housing that meets patients where they are at
- Work with other system partners such as CWS and Probation to provide access to housing for shared clients
- Provide anti-stigma and semi-clinical training to housing providers to understand OUD and MAT and embrace harm reduction principles to support recovery in RRs
- We need many levels of housing. For those actively using, for those new to recovery, for those in long term recovery. Meeting the people where they are at in terms of use/recovery can inform the services integrated into housing
- Expand harm reduction supplies available at/near housing to include sterile injection/smoking supplies
- There is not a one size fits all, needs are different in different stages of recovery
- Support groups for loved ones who are living with someone who is actively using
- There is a lot of family support when someone enters recovery, but more family education on SUD as a brain disease, harm reduction and building resilience
- Do we have data on the levels of housing for the clients based on the spectrum of their recovery?
- We don't have many detox centers where patients can go to safely detox
- Are there safe spaces for people to not use drugs?
- We need LGBTQ friendly sober living/detox in North County that is focused on low-income. As the one shining star has HIV contract and otherwise private pay
- Housing options that accept families with children and pets
- Opportunity to leverage funding, increase education through CalAim service providers
- True integration and support for both patients and treatment teams
- Provide a wide variety of services at intake, hub and spoke networks for MOUD and in house navigation with a low case load and fewer restrictions on reporting
- True care coordination between providers with client participation at regular intervals
- Barrier found is not enough providers for treatment options
- integrate SUD tx access and harm reduction supplies into public settings and primary care
- Need to look how we expand networks
- Allow more flexibility for people to stay enrolled in an outpatient program even if they miss multiple sessions or drop out and want to return
- Major barrier is not being able to engage all players in the field
- Recognize different stages of change apply to different areas. So a person in precontemplation in mental health but preparation for housing and more funding for

supportive networks like detox and mental health options. More access to psychiatric care to address self-medicating

- Better support and pay/reimbursement for SUD providers and peers
- More bridge services and/or care coordination for individuals presenting in EDs or with multiple inpatient admissions
- actual housing. Can we use malls and office buildings?
- More networking training and education
- Community forums and advisory boards
- Smaller range of providers with private insurance. Larger options with DMC ODS and newly Cal Aim. Participants need or must qualify for Medi-Cal to be able to fit service "rules"
- Better treatment from providers
- Looking at how people who are using substances may present in emergency services connect them to services there and stay aware of their journey
- In house MOUD
- Community based services- that can go with intake for services, someone to walk through, for example, discharge from ER and later admission to tx program or MAT
- Integrate managed care and county service spectrum more than we already have
- The need for more family respite care so they have breaks and know the children are getting taken care of
- Support groups for people like Harm Reduction Works in treatment
- Sometimes people need a break from their living situation which may not be supportive of recovery (re: respite)
- More support for families is huge
- How to engage people into support services who may have some resistance, how to meet them where they are at
- Provide support services and harm reduction services on-site. Congregate housing developments have their own subset of challenges
- We need to teach people how to live in housing and not assume people have the skills and are equipped to do so, successfully
- Repurposing old county buildings for housing/support services
- Housing in a community space, and using a community model, including peer supports
- Relaxing some of the zoning housing requirements to set up tiny home communities and tent/RV camping
- Contingency housing. if someone is kicked out of a no tolerance shelter for testing dirty for THC, where can they go that isn't the street?
- Continuity of care is critical. Oftentimes when people transition from more intensive recovery programs into other housing with supports, trust can be lost, continuity of care can be lost. We need to strengthen those transition supports
- Bring recovery services on site to supportive housing buildings (MAT, therapy, support groups, harm reduction)
- When you put people living closely together, sometimes you see and increase in behavioral issues

- We need to better understand what prevents people from wanting to be housed.
- Model communities like Baldwin City Tiny Home Community with treatment and prevention services on site
- Move up one sheltering. Eg. Tent Camping to tiny home to shared or individual housing, etc
- Managers give a Narcan Kit to tenants as they move in
- Build community participation
- Long Term supportive housing with needle exchange and supervised injection on-site. It's a big ask, but it's needed. I guarantee you'd get people housed and in treatment
- Move up one sheltering. Eg. Tent Camping to tiny home to shared or individual housing, etc., etc., etc
- More upfront harm reduction. Test strips, MAT, supervised injection, etc. Naloxone should be viewed as the last defense
- Supervised injection sites with wraparound services on site. Model One Safe Place in San Marcos, all relevant services in one place
- Purposeful housing placements considering a community approach and peer support
- Beyond training and compensation, how do we promote wellness in our own workforce, create space in their work to take down time, access both supervisory and other support & wellness resources, ensure agencies have the support of their staffs wellness in the forefront of our thoughts, decrease burnout, retain staff?
- Do this again but with more grassroots people, but don't do it invite-only, open it up to the community. They know what is needed, why aren't we including them

Question: What do we need to better equip and support our workforce to meet the complex needs of PWUD?

- Fund workforce capacity building like addiction psychiatry fellows, teaching faculty support, administration support
- Competitive compensation
- Https://workforce.org/wp-content/uploads/2022/08/San-Diego-Behavioral-Health-Workforce-Report.pdf
- More trauma informed training within all levels of staff
- Education for the SRO's and ILA's staff (from owners to persons preparing 2 meals a day)
- Issues around workforce diversity, how do we best address the importance of diversity in our addiction workforce?
- More County Homeless Case Managers
- While we build the workforce capacity, which takes time, what tools do the current people need to be more effective and efficient? What will help us retain folks now doing the hard work, help them feel supported?
- Trained counselors in housing spaces
- People working in housing have the training they need in that specific housing center
- Housing operators/landlords need training, support and operational support ($) to provide the needed housing
- Looking at barriers to obtaining higher education

- Apprenticeship programs
- Ability for housing to offer TRANSPOPTATION from housing to workforce options for clients
- Hire PWUD (and train and support and pay a living wage)
- Training on co-occurring disorders
- More support for burnout
- Provide equal pay for peers
- Creating certification programs
- Don't require/permit drug testing unless operating machinery
- More funding for paid time off
- More than 3 certification agencies- they are also short staffed and it takes too long for a response, and it approval
- Lower caseload ratios so staff can develop deep relationships of trust with clients
- More access to interns and volunteers from local educational institutions
- More technical assistance, Networking and community
- Decrease documentation standards
- Cross training in other wrap around services
- Trauma-informed care, training, and support for people in care and staff as well
- Less reporting which is a barrier for everyone, More community support
- Training surrounding cultural diversity to understand personal biases
- Consistent training across the board- all county contracted providers get the same training. That opens the door for more collaboration and coordination of care
- Continue to reduce staff administrative burdens and increase face to face time
- More regional and region or population-specific Learning Collaboratives & Alliances - better coordination amongst those coordinating care/offering support
- Ability to be more flexible and offer each other more grace in the same way we do those we meet
- Training and access to national/global experts working with PWUD
- Streamlined processes for finding treatment services and other resources for people in care, such as easier access to residential bed availability
- Education to reduce and increase confidence/empathy for service providers across the various different providers - health care, BHS contractors, housing providers, etc
- Good wages and ability to have buy in
- Mentorship - change over the last 5-6 years really really made a difference
- Hiring people with heart and passion for the people they work with (meeting people where they are). More retainment of staff that have a passion for the work
- Giving the right wages to the people who are working in this field
- Higher, competitive wages
- More development opportunities. So often you cap out around $25/hr. support for providers to seek higher education
- Support and supervision around wellness for staff, staff can experience trauma and burnout, provide resources for agencies that are working in this field
- Move away from "self-care" and use a different term, puts the responsibility of the individual vs. holding the S accountable to providing opportunities for wellness

- Most of the people employed to do this work qualify for the services they offer, work multiple jobs, etc.
- A system for people to give real time feedback for what they are seeing and/or experiencing
- More training and education for those that work. in this field
- Even the facility managers and maintenance staff need culturally relevant training
- Law enforcement training
- stop excluding a huge portion of the workforce because they are in Medication Assisted Treatment or use THC
- Less stringent requirements for treatment providers so they can spend more time with people and less time spent doing paperwork
- Flexibility in workforce. Less focus on Certified vs Registered Counselor ratios, more focus on training and development
- Evaluate whether we spend more time doing work or documenting that we're doing the work to satisfy some funder
- "nothing about us without us"
- Everyone who is in contact with people who use drugs need skills and training to work with them
- Training - trauma informed, cultural competency, SELFCARE, career planning/pathways
- More training for support in the schools for both education professionals and peers
- How to fund peer to peer support and lived experience and how to fund them correctly
- Strategically leverage peers. So often we're just slapped on top of the existing workforce
- Peer-to-peer support on how to truly practice harm reduction, significant ongoing training
- More clarity on certification processes. Multiple Peer Support Certification providers in San Diego. Most don't meet Medi-Cal requirements for Peer Support services
- Hire from clients who have had success in recovery
- Retain workers, if you want people to stay in the field, you need to pay them more
- More pipelines from schools into the workforce
- Software where you plug in qualifiers of your client and it spits out available resources
- Support for secondary trauma working with this group