# Disruption to Substance and Opioid Use Disorder among Midlife and Older Adults:

## The Deep South Integrated Care Training Program

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# Disclosures

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# Learning Outcomes

1. Describe training in one clinical graduate psychology program in a Southeastern State in the United States (training clinics, treatment approach; interprofessional clinical team).

2. Identify factors to consider when screening and treating SUD/OUD with a focus in midlife (age 40 to 49) and later life (age 50+).

3. Summarize baseline characteristics of midlife and older rural and urban adults in treatment for substance use disorder in the Deep South, USA.

4. Describe challenges in telehealth delivery with rural and urban older adults.

5. Give case examples of older adults in treatment for substance use disorder.

# Brief Career Background

- First Generation Scholar
- “Older” parents
- University of Kentucky
- Washington University in St. Louis
- The Pennsylvania State University
- The University of Alabama
  - Students
  - Colleagues
  - Community partners in Community-based participatory research

# Palliative Care Interventions: Intro to CBPR

- K01AG00943: the Legacy Efficacy Trial (Allen et al., 2008).
- R21NR11112: Legacy Intervention Family Enactment (LIFE) in collaboration with community partners and the Retired Senior Volunteer Program.

Session 1

Senior volunteers introduce Problem-Solving techniques and guide the family through Problem-Solving Steps to decide on a LIFE activity.

Session 2

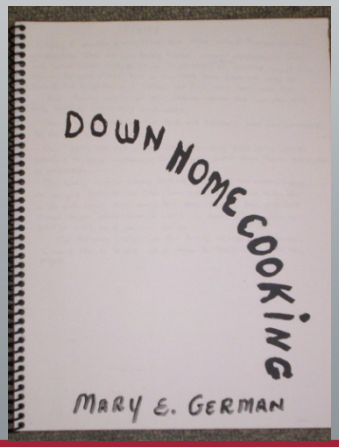
Senior volunteers work on the LIFE activity with the family (pictures, recipes, stories from other family members).

Session 3

Senior volunteers encourage the patient and caregiver to show their LIFE activity and discuss their feelings about the process and what they have learned.

# Palliative Care Interventions: Outcomes

- Patients: intervention group v. minimal contact control, though sicker, reported fewer emotional symptoms and bother, more forgiveness, less "abandonment by God". (Allen et al., 2014)
- Caregivers: intervention group v. minimal contact control reported more meaning in life (Allen et al., 2014)
- Volunteers: "It was very rewarding for me…" (Allen et al., 2016)




| COORDINATED<br>Key Element: Communication | | CO-LOCATED<br>Key Element: Physical Proximity | | INTEGRATED<br>Key Element: Practice Change | |
|---|---|---|---|---|---|
| LEVEL 1<br>Minimal Collaboration | LEVEL 2<br>Basic Collaboration at a Distance | LEVEL 3<br>Basic Collaboration Onsite | LEVEL 4<br>Close Collaboration Onsite with Some System Integration | LEVEL 5<br>Close Collaboration Approaching an Integrated Practice | LEVEL 6<br>Full Collaboration in a Transformed/ Merged Integrated Practice |
| Behavioral health, primary care, and other health care providers work: | | | | | |
| In separate facilities, where they: | In separate facilities, where they: | In same facility not necessarily same offices, where they: | In same space within the same facility, where they: | In same space within the same facility (some shared space), where they: | In same space within the same facility, sharing all practice space, where they: |
| • Have separate systems<br>• Communicate about cases only rarely and under compelling circumstances<br>• Communicate, driven by provider need<br>• May never meet in person<br>• Have limited understanding of each other's roles | • Have separate systems<br>• Communicate periodically about shared patients<br>• Communicate, driven by specific patient issues<br>• May meet as part of a larger community<br>• Appreciate each other's roles as resources | • Have separate systems<br>• Communicate regularly about share patients, by phone or e-mail<br>• Collaborate, driven by need for each other's services and more reliable referral<br>• Meet occasionally to discuss cases due to close proximity<br>• Feel part of a larger yet ill-defined team | • Share some systems, like scheduling or medical records<br>• Communicate in person as needed<br>• Collaborate, driven by need for consultation and coordinated plans for difficult patients<br>• Have regular face-to-face interactions about some patients<br>• Have a basic understanding of roles and culture | • Actively seek system solutions together or develop work-arounds<br>• Communicate frequently in person<br>• Collaborate, driven by desire to be a member of the care team<br>• Have regular team meetings to discuss overall patient care and specific patient issues<br>• Have an in-depth understanding of roles and culture | • Have resolved most or all system issues<br>• Communicate consistently at the system, team, and individual levels<br>• Collaborate, driven by shared concept of team care<br>• Have formal and informal meetings to support integrated model of care<br>• Have roles and cultures that blur or blend |

# Clinical Training Committee

Selection of Grad Student Trainees and Clinical Supervision (Hamilton and Witte with Allen)

Rebecca S. Allen, Lead PI

Martha Crowther, Co-PI

Site Coordination (with Allen and Cox [admin])

Matthew Jarrett, DCT

James Hamilton, Health

Tricia Witte, SUD/OUD

Joshua Eyer, CRHC

Robert McKinney, Dem.

Toya Burton, WHS

# Graduate Psychology Education Training Program: Environment

- Experiential and didactic training in prevention, assessment, and treatment of substance and opioid use disorder (SUD/OUD).
- Integrated care settings in rural and urban communities in AL
- Most areas in AL are Health and mental health provider shortage areas and AL is a largely rural state with poor internet access.

| Table 2 (numbers may not add to 100%; Census Data Estimates as of July 1, 2018) | | | | | | | |
|---|---|---|---|---|---|---|---|
| County | Total Pop. | NHW% | AA% | Hispanic % | Below Poverty % | Unin-sured % | Excessive Drinking % |
| Marengo (Demopolis) | 19,743 | 46 | 52 | 2 | 26 | 11 | 12 |
| Tuscaloosa (Whatley) | 208,911 | 66 | 30 | 4 | 17 | 10 | 19 |
| Walker (Capstone) | 67,023 | 91 | 6 | 2 | 22 | 13 | 14 |

# Our Integrated Care Facilities

(Federally Qualified Health Centers)

- GPE growing the workforce in our facilities:
  - Capstone Rural Health Center is located in Walker County (see AL map). Psychology services quickly integrated into MAT clinic for mental health care. Working closely with Social Work as well as nursing staff. Prevention, Assessment, Treatment.
  - Whatley Health Services (Tuscaloosa clinic) in comparison with other grants and mental health services, GPE trainees focus on SUD/OUD assessment and treatment. Only team providing long-term individual treatment and group treatment (both evidence-based).


# Phoenix House

- GPE growing the workforce in our facilities:
  - Phoenix House is located in Tuscaloosa and is a freestanding, non-profit Level III.01 Residential and Transitional Housing facility for men and women with substance use disorder. Residents receive their medical care from Whatley Health Services. Individuals receive individual and group counseling, vocational and adult education, life skills training, and job training/job placements.
  - The GPE provides mindfulness-based relapse prevention, CBT for chronic pain, and trauma group treatments within the facility.

PHOENIX HOUSE
TUSCALOOSA, AL

# Our Procedures

- Clinical champions at each site
- Program introduction and patient service options
  - —Clinical champion chart review and patient identification
  - —Phoenix House Presentation
- Consent and baseline screening
- SUD/OUD/trauma assessment & feedback
- Treatment
  - —SBIRT
  - —Individual
  - —Groups for mindfulness-based relapse prevention, literacy-adapted pain management, and trauma

# Challenges and Strengths of Our Integrated Care Facilities

(Federally Qualified Health Centers)

- Capstone Rural Health Center (2 trainees each year)
  - Challenges: Rural, high incidence of SUD/OUD, high poverty burden, transportation issues = poor access to care, high incidence of physical comorbidities (mining, logging), state-certified peer coaching program nixed volunteer-delivered MBRP peer-support
  - Strengths: Pre-existing telehealth delivery systems (pre-COVID), supportive staff (and clinical champion!) hungry for integrated behavioral healthcare, MAT clinic, EMR integration, consultation with a psychiatrist, desire for pre-peer-coaching program

# Challenges and Strengths of Our Integrated Care Facilities

(Federally Qualified Health Centers)

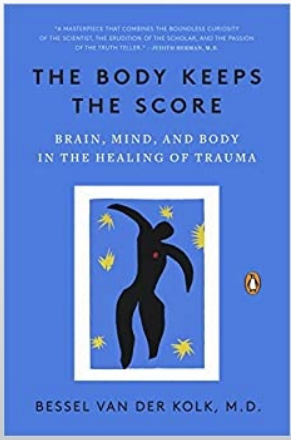
- Whatley Health Services (2 trainees each year) (Tuscaloosa clinic)
  - Challenges: many HRSA and SAMHSA projects so very busy clinic (previously had another SBIRT project), SPACE, less integrated telehealth care, no access to EMR
  - Strengths: involved interprofessional staff, large clinic for low-income adults, provides medical care for Phoenix House Residential Treatment Center and Hope Center (HIV)

# Challenges and Strengths of Our Integrated Care Facilities

- Phoenix House (WHS trainees) (Tuscaloosa residential care facilities)
  - Challenges: extremely poor web access making telehealth delivery challenging to impossible, no or minimal EMR, NOT co-located with WHS
  - Strengths: motivated staff rely on GPE for patient mental health care, extremely well-received MBRP groups ongoing (but with rolling attendance)

# Why Trauma Informed Care?

- Neuro imaging has shown no matter how many years have passed since the traumatic event, trauma survivors' brains continue to function as if they face a constant threat of danger (Body Keeps the Score, 2015)
  - State of constant arousal
  - Amygdala → stress hormones → fight or flight response




- Traumatic events or adversities during childhood
  - Increased ACE scores = negative health outcomes (Anda, et al., 2006)

- Comorbidities
  - Trauma exposure and PTSD symptoms are comorbid with mental, behavioral, and somatic conditions (SAMHSA, 2007)

- Individual trauma-focused intervention delivered alongside SUD/OUD treatment reduces severity of PTSD symptoms & drug/alcohol use (Roberts, Roberts, Jones, & Bisson, 2015)

# Principles of Trauma-Informed Care

- Operate as if all clients are survivors of trauma
- Prioritize safety
- Collaborate with and empower clients
- Show compassion and understanding
- Recognize the potential connection between trauma and present functioning
- Prevent retraumatization
- Build resiliency, highlight client strengths
- Promote agency-wide commitment to trauma-informed practice
- Train and support service delivery professionals

SAMHSA, 2014 (TIP 57)

# Trauma-Informed SUD Services in Integrated Care Settings

- Awareness of the prevalence of trauma (distant past, recent past, ongoing) among patients presenting with SUD
  - Increase compassion and maintain a nonjudgmental stance
- Awareness of age cohort and its role in trauma presentation
  - Middle-aged and older adults may present with different symptom clusters and have comorbidities
- Assessment of trauma in patients presenting with SUD
  - Be sensitive to assessment procedures
- Make trauma-related modifications to SUD services (e.g., Mindfulness RP) and provide services for co-occurring conditions (e.g., PTSD + SUD)
  - Be aware of secondary traumatization in service providers

# Examples of Trauma-Informed Care in Our Procedures

- Program introduction and patient service options
  - Educating clients about services, offering choices, respecting autonomy
- Screening
  - Screen all clients, but due to privacy/setting issues and risk for retraumatization we chose a **1 question ACE screener** -- *"How would you feel if you learned that a child you care about was growing up exactly as you did?" [Happy, Neutral, Sad/Angry, Very Sad/Angry]*
- Full Assessment
  - Feedback in private setting
- Treatment (individual and/or group)
  - Trauma-informed SUD/OUD treatments (e.g., Trauma-informed MBRP)
  - Trauma-informed chronic pain + SUD/OUD treatments
  - Trauma focused treatments (or referrals)

# Trauma-Informed Care: Modifications for COVID-19

- Telehealth!! (client, student, and provider safety, privacy, confidentiality)
  - Home environment safety (e.g., clients currently experiencing trauma may not be safe at home)
  - Access to telehealth options => possibly telephone BUT limitations to treatment options (e.g., Mindfulness via phone?)
  - Privacy and environmental issues (i.e., lessons learned from Home-based mental health care in Geropsychology Clinic)

# Trauma-Informed Care: Lessons Learned

- Challenges to date
  - Psychological Ethics and Organizational Concerns: Services provided to and through organizations (Who is the client? What information is owned and owed to whom? BAAs and MOUs)
  - We need safe/adequate space to serve clients
  - Keep the focus on the patients - We may not be able to offer each of our clinics $, but we are offering free workforce help for your patients
  - We actually HAD a third clinic site planned, but onboarding and integrating at this clinic has been interrupted by COVID-19 (HCP exhaustion and lack of bandwidth SUD/OUD)

# SUD/OUD in Later Life

- "Older adult" defined as 50+ years old (Kuerbis, 2020)
- High-risk substance use versus SUD (Barry & Blow, 2016)
- At-risk substance use and SUD/OUD are underrecognized and undertreated (Kuerbis, 2020; Yarnell et al., 2020)
  - Diagnosis can be challenging: (a) tolerance diminished with age; (b) impairment in social and work life less apparent; (c) misattribute substance-related psychological/physical disruptions to aging; (d) stigma
- "Early onset" versus "late onset" (Kuerbis, 2020)

# Prevalence of SUD/OUD in Later Life

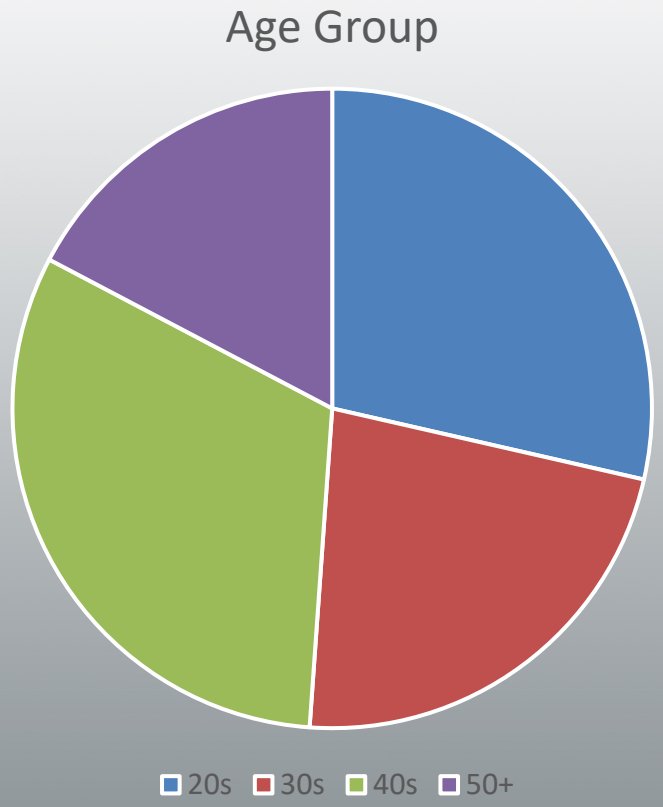
- Increase in prevalence rates over the past two decades (Kuerbis, 2020)
  - High-risk alcohol use: 15-22%
  - Tobacco use: 8.4-16.4%
  - Use of illicit substances (past-month): 6-14%
  - Cannabis use: 6%
  - Sedative/tranquilizer misuse: 16.5%
  - Opioid misuse: 1.5-3%
- Why have rates increased? (Yarnell et al., 2020; Khezrian et al., 2020)
  - Increased life expectancy
  - Aging of Baby Boomer generation
  - Cultural and attitudinal changes
  - Increase in polypharmacy

# Factors to Consider when Screening and Treating SUD/OUD in Later Life

- Stigma, particularly among older adults in rural areas (Stewart et al., 2015)
- Opioid and benzodiazepine prescribing in late life, particularly in rural areas (Maust et al., 2019; Ramachandran et al., 2021)
- Impact on physical health and wellbeing (Barry & Blow, 2016; Kuerbis, 2020)
- Association with adverse childhood experiences (Kim et al., 2021; Rhee et al., 2019)
- Association with loneliness and isolation (Day & Rosenthal, 2019; Farmer et al., 2021)
- Association with suicidal ideation (Schepis et al., 2018; Schepis & McCabe, 2021)
  - Suicide completion highest among white men age 85+ living in rural areas (El Ibrahimi et al., 2021)

# Descriptive Data

- **Total of 132 patients** to date (65 men, 67 women; 103 NHW), 39 at WHS, **42 at CRHC (rural)**, 52 at PH.
- 31% grade 11 or less; 37% GED or HS ed



# Descriptive Data (Overall)

- 79% problems with transportation, with 67% limiting activities for this reason.
- 71% early-life trauma
- 22% harmful alcohol use; 96% moderate, substantial or severe drug use
- **45% opioid use disorder**
- 32% medium or high somatic symptoms
- 70% mild or more severe depressive symptoms
- 87% mild or more severe anxiety symptoms
- 62% PTSD


# Descriptive Data Associations w Age

- No differences in substance use by age.
- Individuals in their 20s or age 50+ tend toward more severe symptoms of depression.
- Individuals in their 20s or age 50+ tend toward reporting more symptoms of PTSD.
- Older age was associated with more physical and somatic symptoms.

# Telemental Health with Older Adults

- Benefits include (Harerimana et al., 2019):
  - Reduced emergency room visits
  - Reduced hospital admissions
  - Reduced depressive symptoms
  - Improved cognitive functioning
- In 2018, an estimated 13 million were not ready for video visits and 10.8 million were not ready for telephone visits (Lam et al., 2020). Barriers include (Qian et al., 2021):
  - **Lack of access to required technologies***
  - **Low digital literacy***
  - **Poor telephone and internet connectivity***
  - Hearing, vision, communication, and cognitive impairments

***barriers reported by our student trainees and stakeholders**

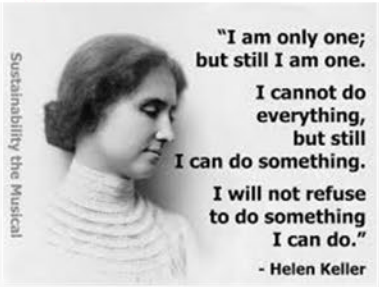
# Case Examples in Tuscaloosa (Urban)

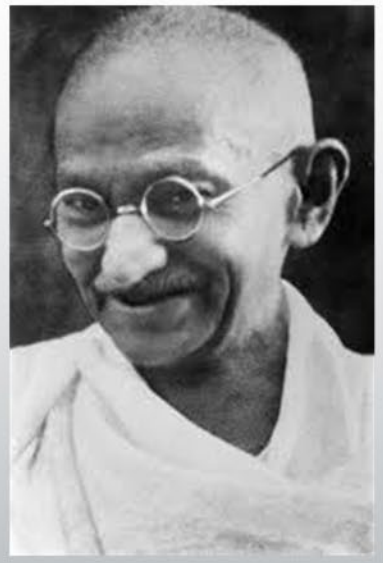
- M (Whatley client, urban):
  - 59-year-old African American female with chronic pain
  - We did brief check-in **phone calls** focused on pain management
- K (**Phoenix House** client, urban):
  - 56-year-old White male
  - History of alcohol and stimulant use
  - PTSD stemming from several past traumatic events (some which occurred while he was in prison)
  - Started working through the CPT manual but it didn't seem like a good fit so switched to **exposure-based techniques** and other CBT skills

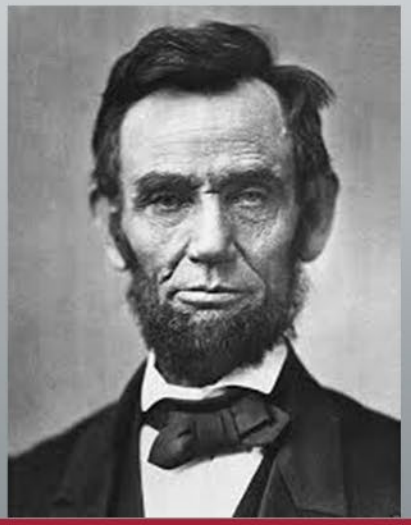
# Case Examples in Walker Co (Rural)

- Y (CRHC client, **rural**)
  - 50-year-old woman in recovery who struggled with a history of trauma but was very stable in her recovery. **MAT** program.
  - History of pain medication overuse for 3 years; on Suboxone 3 years
  - Bi-weekly telehealth/**phone calls**; some in person **accompanied**
  - Smoking reduction/cessation
  - Church as part of recovery and coping community – **cultural training**!


# It always seems impossible…
# Until it is done.



# Thank you & Questions