MONO COUNTY HEALTH DEPARTMENT
Public Health

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A Mono County Substance Use Taskforce

A group of people and agencies seeking to reduce the harmful impacts of substance use in Eastern Sierra communities

Wednesday, January 22, 2020
1:30 - 3:30pm
Sierra Center Mall
452 Old Mammoth Road
Mammoth Lakes, CA 93546

Agenda:

I. Welcome and introductions

a. Participant/stakeholder updates

Participants: Michael Ziegler (CSS), Chelsea Bertram(CSS), Amanda Hoover(CSS), Kathy Peterson (DSS), Tashina Butts(MMOH), Karen Phillips(MMOH), Connor Polcyn(MMOH), Stephen Swisher (MMOH), Keith Anderson (Inyo probation), Jazmin Barley (probation), Caroline Clotere (MMOH), Kathleen Alo (MMOH), Michelle Raust (DSS), Debre Stewart (MCBH).

- ✓ *Mammoth Hospital- building specialty clinic, still working through the logistics.*

  -Awarded for the 2019 Opioid Care Honor Roll program by voluntarily submitting data sharing their progress on implementing evidence-based practices to address the opioid crisis.

  -Total Joint Program- Decreased take home dose of opioids to 15 tablets (U.S. averages are 60-90 tabs). Program gives a basis for reaching out to patients for MAT and navigator. Working well as a hospital-wide joint effort.

  ER- Seeing more alcohol abuse. Will use AA to call a sponsor to come in the evenings to meet with patient. May also use spiritual care on call person.

-Can be referred to family Med for alcohol abuse, meeting with physician (medication), psychiatrist, warm hand off to behavioral health. Will identify resource needs and readiness of patient.

- ✓ *Mono Social Services/Child Welfare*

  -Utilizing Public Health Narcan training for all staff and reducing stigma if there is substance use. Use Narcan supply to have available to families. Narcan use has been in collaboration with behavioral health. Always have Narcan in transport vehicles when going to rehab facilities.

  -In support of MAT and would like to provide staff information about MAT

  -Gap in Spanish resources for substance use

- ✓ *Locations to obtain Narcan: Health Department, Behavioral Health, Social Services, County EMS (paramedics), and Mammoth Lakes Police Department. Probation officers carry Narcan but are not currently distributing to the public.*
- ✓ *Mono Behavioral Health- Syringe exchange program just submitted order to clearing house, will receive supplies soon. MAT is available through telemedicine providers. Staff received harm reduction training and are collaborating with Inyo County partners.*
- ✓ *Northern Inyo Hospital Rural Health Clinic is also near launching syringe exchange services*
- ✓ *General comments:*

  -Consider distributing fentanyl test strips for testing drug stimulants (see notes below about stimulant use disorder and risk of opioid overdose)

  -Al-Anon- see http://mammothlakesalanon.com/ for meeting information

- ✓ *CSS (Community Service Solutions)- CSS Board decided against staff participation in Narcan distribution, deferring to County departments as having capacity to meet distribution needs. CSS actively shares information*

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about MAT and other resources in their work implementing 8 different programs on behalf of Mono and neighboring counties.

- ✓ *Dr. Keith Anderson- Notes that in his forensic work for Mono and Inyo Counties methamphetamine is the dominant substance use problem.*
- ✓ *Jasmin, Mono County Probation- Probation staff have undergone naloxone training; decision was made to carry but not to distribute. Upcoming training for staff about MAT. Sometimes there seem to be dilemmas related to court orders mandating complete abstinence juxtaposed against potential benefits of medication-assisted therapy (MAT). Local judicial system may have some ambivalence about MAT.*
    - o *Upcoming Touch Points training, which teaches about MAT, and some officers will attend*
    - ➢ *Participant question about whether Mono Co. judges order people to participate in MAT, as happens in some other jurisdictions?*

II. Establishing and operating a Veterans Administration sober living facility; Michael Ziegler, Community Service Solutions

-Mr Ziegler described his experience running a VA sober/transitional living program in Reno for 6 years

-Ran 30 bed program for homeless male veterans for 6 years

-2 year program- Provided a safe and stable place to live at no charge, with lots of services

-new residents were free of program/treatment expectations or requirements; focused on improving health

-82% success rate in achieving independent living without substance use-related problems

-longer term 65% success rate (after 3yrs)

-Program was most successful veteran program in Reno area

-harm reduction focus

-Utilized wide variety of community programs and resources

-Transitional living program cost is approximately $1,000/person (assuming an available building)

-Would save society a lot of money!

III. "Task force" identity issues: name, mission?

- *(We didn't get to this agenda item. A survey will be distributed for feedback)*

IV. Proposed substance use website (with general information and resources)

Brief discussion about proposed website (could be hosted on Public Health website). Learned that Chelsea Bertram (CSS) has recently been working hard to compile such resources, related to her work with jail inmates preparing for release

V. Substance use related training opportunities and needs

a. Upcoming local trainings on facilitating behavioral change

-Motivational interviewing training March 17th

-Facilitating Change Talk, April 22, 2020

-Touch Point

VI. Some notes on stimulant use disorder (methamphetamine and cocaine); Tom Boo

Opioid risk/harm reduction in stimulant users*: Fentanyl (potent opioid) mixed with cocaine and methamphetamine appears to helping drive the current wave of fatal drug overdoses nationwide. Meth and cocaine users may not be aware of the risk. Recommendation to counsel stimulant-using patients or clients about risk of opioid exposure. Harm reduction programs should consider offering naloxone (aka Narcan) and fentanyl test strips to stimulant users, not just opioid users.*

Treatment of stimulant use disorder *is challenging, especially in primary care. The approach is primarily behavioral (below) but may be a role for adjunctive pharmacological therapy.*

-No FDA approved treatment; all medication treatment is off-label treatments. Shared opinion of Steven Shocktaw that while no medication has been demonstrated to improve abstinence rates, a

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number of medications appear to decrease use/dose and may decrease harm.

-Studies have shown some benefit of:

Naltrexone alone, and preliminary studies suggest that combining naltrexone with buprenorphine treatment may provide additional benefit

Stimulants- prescription stimulants (e.g. dexamphetamine) appear to decrease harmful use, and studies published too date may have used lower than optimal doses

A University of Kentucky study is evaluating a combination of phentermine (a stimulant) and topiramate (an anticonvulsant), with promising rumors of benefit (this drug combination is currently FDA approved for weight loss)

Mirtazapine, a common antidepressant, (30 mg daily) has been shown to decrease cocaine use and associated risky sexual behavior in men who have sex with men

***Behavioral therapies**: Contingency management (CM) and cognitive behavioral therapy (CBT) have greatest effect.*

Contingency management is a simple reward or incentive strategy in which substance users receive rewards for participating in program and demonstrating abstinence. Typically patients/clients present for group therapy and urine drug testing two or three times weekly. Each time they submit a urine specimen that does not contain the drug of concern they receive a retail voucher or coupon with some monetary value. The value received increases with each subsequent consecutive negative test, often with bonuses given for e.g. three negative tests in a row. Positive urine drug tests return the participant to the initial voucher level.

There are over 500 publications in PubMed on contingency management for substance use disorder and it has been shown to be beneficial in numerous and varied settings, including decreasing smoking during pregnancy and in adolescents.

CM's greatest value is in promoting early abstinence, and is as good as CBT early in treatment. CBT catches up over time, and the preferred model is combined CM and CBT.

Motivational Interviewing (MI) has also been shown to be beneficial, but with a smaller effect size (less effective than CM or CBT).

With treatment, in general 25-40% of patients achieve sustained abstinence (it is a tough disease!)