Texas Research-to-Policy Collaboration Project

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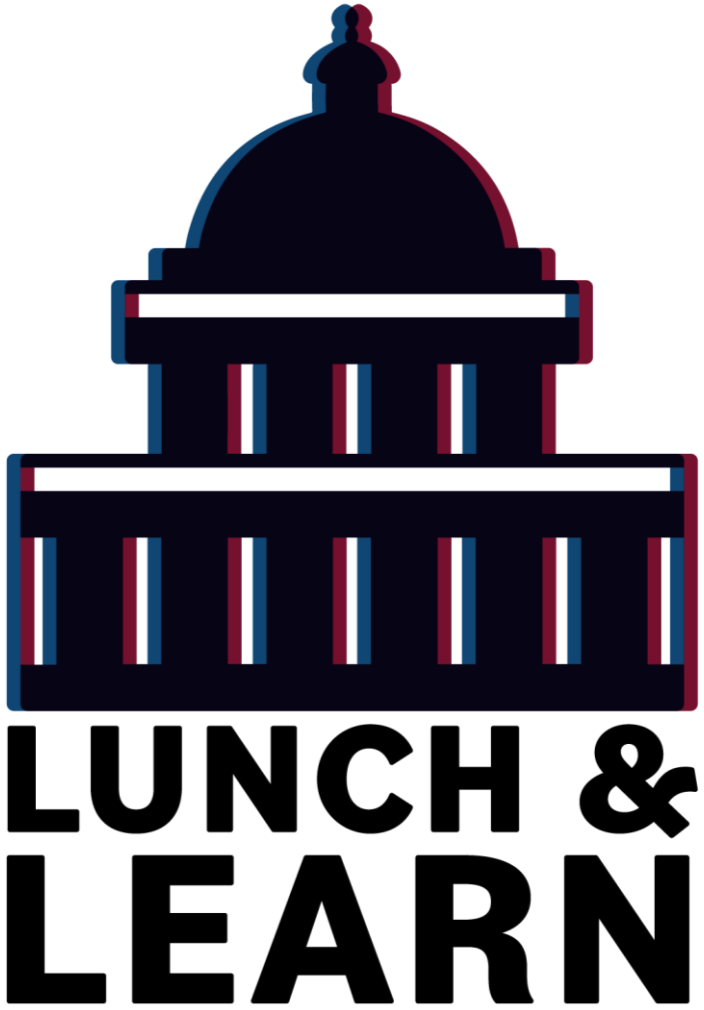
Substance Use Prevention and Treatment Programs in Texas



A Texas Research-to-Policy Collaboration (TX RPC) Project Lunch & Learn Presentation

Welcome!

- Today's room is sponsored by Senator Miles – thank you!
- Dr. Deanna Hoelscher – About the TX RPC Project
- Dr. Mike Wilkerson – Substance Use Prevention and Treatment Programs in Texas
- See you next year!

Let us know how we can support your office's legislative health policy interests in the interim and for the 2025 legislative session!

LUNCH & LEARN

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Texas Research-to-Policy Collaboration (TX RPC) Resources

Lunch & Learn Sessions

TX RPC Project Health Policy Reports

Rapid Response Requests

TX RPC Project Newsletters

Collaboration Meetings

Texas Child Health Status Reports

Center Webinars

Texas Legislative Bill Tracker

LUNCH & LEARN

Texas Research-to-Policy Collaboration Project

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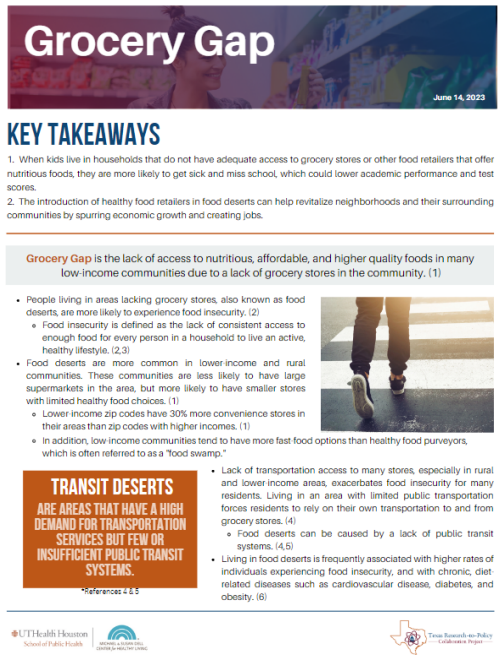
Texas Health Policy Resources



TX RPC Project
Health Policy Reports

UTHealth Houston School of Public Health
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Legislative Initiative Resources

TX RPC Project Resources
go.uth.edu/RPCresources

Texas Child Health Status Reports
go.uth.edu/TexasChildHealth

Texas Legislative Bill Tracker
go.uth.edu/LegTracker

TX RPC Project Newsletter Archive
go.uth.edu/RPCnewsletter

Michael & Susan Dell Center Webinar Series
go.uth.edu/CenterWebinars

Scan to view our Legislative Initiatives

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Rapid Request Responses

- Legislators complete the Rapid Response Form
- TX RPC Project team will conduct research and prepare report based on requested topic
  - Reports reviewed by TX RPC Project researchers, UTHealth Government Relations
- Provide requested information to legislator

College Students and SNAP Utilization

TX RPC Project Legislative Rapid-Response Request — September 28, 2022

Student Demographics [1]

Most of today's college and other post-secondary students, about 71%, are considered "non-traditional" students. They may be financially independent from their parents, work full time, are enrolled part-time, are caretakers, or do not have a traditional high school diploma. The average age of college enrollment is 21, but 26 is the average age for all college students. More than one in five (22%) college students reported being parents or caring for a child dependent, with 14% stating they are single parents.

Food Insecurity Impacts Education [1-3]

According to a 2020 survey, more than a fifth of research university students (22%) reported food insecurity. Students who are under 21 are less likely to report food insecurity, but students over 30 are more likely to be hungry. Despite these high rates of food insecurity, even before COVID-19, while more than one in six (18%) college students were eligible, only 3% of college students were receiving Supplemental Nutrition Assistance Program (SNAP) benefits.

In a 2016 study:

- Nearly a third (32%) of food insecure students believed hunger impacted their education
- More than half (55%) reported that hunger kept them from buying textbooks
- A quarter (25%) of students who reported food insecurity also reported dropping a class
- More than half (53%) of students reported missing class in 2016 due to hunger

The Policy Landscape [4]

In December 2020, the US House passed the Consolidated Appropriations Act (CAA). This act carved out an exception for higher education students enrolled at more than half time, who were previously ineligible to receive Supplemental Nutrition Assistance Program (SNAP) benefits if they met certain criteria: They must be eligible for Federal Work-Study and have an expected family contribution of $0. This exception will be in effect through the end of the declared COVID-19 Public Health Emergency (PHE), which is currently set to end on October 13, 2022, though it has been extended multiple times.

Summary of Search Results [5-8]

Based on a preliminary search for legislation related to college students and SNAP, the TX RPC project team identified four states that have proposed or passed relevant legislation. Three states (Louisiana, Connecticut, and California) enacted laws related to this issue. One state (West Virginia) had Senate and House companion bills that appear to have stalled in committee.

It is important to note that no states have made the exception permanent because the rules about SNAP eligibility and college enrollment are set at the federal level and cannot be expanded at the state level.

Rapid Response Requests

Texas Research-to-Policy Collaboration Project

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UTHealth
The University of Texas
Health Science Center at Houston
School of Public Health

Substance use recovery support services in Texas

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Agenda

About UTHealth CoLab

State of Texas Funded Projects

Priorities of Community Partners

About UTHealth CoLab

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MISSION – Our purpose:

"To improve the lives of underserved people with a history of substance use and mental health concerns."

VISION - Our Ideal:

"Interconnected social-justice community-engaged programs, training opportunities, and research initiatives that eliminate inequities and create an environment where people with a history of substance and mental health concerns can thrive. We envision being the lead research team collaborating with marginalized communities."

VALUES – What we stand for:

Respect
Responsibility
Social justice
Integrity
Equity
Fairness
Inclusiveness
Mentor and empower others
Openness
Relationships
Community connectedness
Empathy
Leading with the heart
Compassion

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Professor

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Assistant Professor

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Current Projects

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Tailored Intensive Outpatient Program

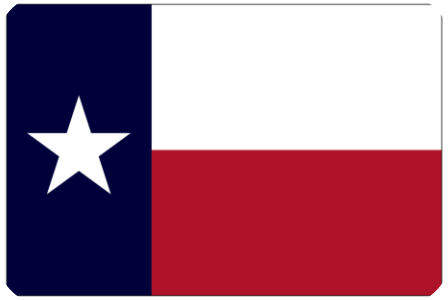
Harris County Health Worker Training

Healthy Beaumont

Recovery Support in Rural/Boarder Texas

PROJECT HOMES

Project HOMES



Density & Capacity of Substance Use Providers in Texas

Tanzanian Heroin Network

State of Texas Funded Projects

Funding

Project HOMES is supported by Texas Targeted Opioid Response, a public health initiative operated by the Texas Health and Human Services Commission through federal funding from the Substance Abuse and Mental Health Services. The administration grant award is 1H79TI083288. However, this study was not funded by TTOR. Therefore, the views expressed do not necessarily reflect the official policies of the Department of Health and Human Services or Texas Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. or Texas Government. The funder had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; and decision to submit the manuscript for publication.

The Scientific Review of Opioid Abatement Strategies is supported by the Texas Comptroller of Public Accounts. However, the views expressed do not necessarily reflect the official policies of the Texas Comptroller of Public Accounts or the Opioid Abatement Fund Council; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. or Texas Government. The funder had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; and decision to submit the manuscript for publication.

Ethics

The institutional review board of The University of Texas Health Science Center at Houston (UTHealth Houston) approved research protocols.

Conflict of interest

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this report.

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What is Project HOMES?

- We provide housing for Medication-Assisted Recovery (MAR) from opioid use (& since June 2023 in El Paso, Midland, and San Angelo residences for people in recovery from stimulant use)
- Our 14 residences are substance-free and socially supportive housing for people with a history of problematic substance use
- Recovering from opioid use is a personal experience that looks different for every person
- Learn more at https://go.uth.edu/homes

PROJECT HOMES

Locations

- Funded by Texas Health and Human Services
- 14 homes
  - 2 in Midland, TX
  - 4 in Austin, TX
  - 2 in San Angelo, TX
  - 4 in Houston, TX
  - 2 in El Paso, TX

We believe everyone should have a recovery journey built for their own unique needs without shame or judgement.

PROJECT HOMES

Demographic characteristics of residents at move-in as of December 2023

Demographic characteristics of residents as of December 2023 (N=355)		
	mean	sd
Age	35.50	9.08
	n	%
Gender		
Female	132	37.18%
Male	220	61.97%
Race/Ethnicity		
Hispanic	68	19.15%
Black Non-Hispanic	11	3.10%
White Non-Hispanic	195	54.93%
Other Non-Hispanic	81	22.82%
Employment		
Unemployed	222	62.53%
Part-time	41	11.55%
Full-time	75	21.13%
Relationship status		
Single, separated, divorced, or widowed	320	90.14%
In a committed relationship, married, or in a common law marriage	35	9.86%

Frequently reported substance use and comorbid conditions as of December 2023 (N=358)

Frequently reported substance use and comorbid conditions (N=335)

	Total n (%)
Alcohol use	323 (96.42)
Polydrug use	
Street opioids	309 (92.24)
Amphetamines	154 (45.97)
Methamphetamine	291 (86.87)
Benzodiazepines	314 (93.73)
Cannabis (marijuana, pot, hash, etc.)	324 (96.72)
Prescription opioids	319 (95.22)
Cocaine	318 (94.93)
Mental health conditions	
Depression	41 (12.24)
Anxiety	41 (12.24)
Bipolar	18 (5.37)
Post-traumatic stress disorder	17 (5.07)
Other	15 (4.48)

Frequently reported substance use and comorbid conditions (N=335)

	Total n (%)
Respiratory conditions	
Asthma	38 (11.34)
Bronchitis	35 (10.45)
Pneumonia	30 (8.96)
Other (e.g., emphysema, tuberculosis)	10 (2.99)
Neurological conditions	
Migraines	42 (12.54)
Memory loss	31 (9.25)
Other (e.g., epilepsy, traumatic brain injury)	3 (0.90)
Cardiovascular conditions	
High blood pressure	54 (16.12)
High cholesterol	10 (2.99)
Stroke and heart disease	6 (1.79)
Musculoskeletal conditions	
Bone fractures	33 (9.85)
Arthritis	26 (7.76)
Osteoporosis	5 (1.49)
Other (e.g., chronic pain, osteomyelitis)	3 (0.90)

Houston residents' service sector utilization 12 months before and 12 months after HOMES enrollment: Preliminary data as of October 2023 (N=109)

	BEFORE ENROLLMENT		AFTER ENROLLMENT		
	count	**percent**	**count**	**percent**	**p-value**
CITY EMS	73	5.4	65	3.63	0.0167
CLINICS	476	35.18	615	34.34	0.6231
HOSPITALS	166	12.27	102	5.7	<.0001
LAW ENFORCEMENT	24	1.77	2	0.11	<.0001
SOCIAL SERVICES	614	45.38	1007	56.23	<.0001

PROJECT HOMES

Houston residents' service type visits before and after HOMES enrollment as of October 2023 (N=109)

	BEFORE ENROLLMENT		AFTER ENROLLMENT		
	count	**percent**	**count**	**percent**	**p-value**
FINANCIAL PLANNING/JOB AND EDUCATION ASSISTANCE	10	0.74	54	3.02	<.0001
ANCILLARY PROCEDURES *(IMMUNIZATION, VISION, DENTAL, PHYSICAL THERAPY, ETC...)*	17	1.26	43	2.4	0.0202
INPATIENT VISITS & INVOLUNTARY COMMITS	33	2.44	14	0.78	0.0001
ER /OBSERVATION VISITS	272	20.1	165	9.21	<.0001
OTHER SOCIAL SERVICES *(MAIL, HYGIENE, TRANSPORTATION, CLOTHING, OUTREACH, BENEFITS)*	68	5.03	163	9.1	<0.0001
FELONY CASES & LEGAL ASSISTANCE	13	0.96	4	0.22	0.0052
HOUSING & SHELTER/ RENTAL ASSISTANCE	49	3.62	99	5.53	0.0125
FOOD BANK RELATED/NUTRITION ASSISTANCE	60	4.43	121	6.76	0.0057
OTHER MEDICAL RELATED VISIT *(ALLIED HEALTH, LAB APT, MEDICATION, NURSE ONLY ETC..)*	81	5.99	158	8.82	0.003
TELEMEDICINE	29	2.14	72	4.02	0.0031
OFFICE VISIT	192	14.19	274	15.3	0.3866
HEALTHCARE ASSISTANCE	68	5.03	71	3.96	0.1516
OTHER MEDICAL RELATED VISIT *(ALLIED HEALTH, LAB APT, MEDICATION, NURSE ONLY ETC..)*	80	5.91	84	4.69	0.1269
OTHER *(DAILY ATTENDANCE, SOCIAL SECURITY, ASSESSMENT, ETC..)*	234	17.29	276	15.41	0.1558
CASE MANAGEMENT	141	10.42	193	10.78	0.7492
OUTPATIENT *(OB/OBGYN, FAMILY PRACTICE/OFFICE VISITS ETC...)*	225	16.63	346	19.32	0.0528

PROJECT HOMES

Qualitative Methods and Analysis

94 interviews with residents, staff, owners and operators were conducted from 14 of the recovery residences in five cities from June 2021 to December 2021

Interviews were analyzed and then coded to develop and identify important messages and recurring ideas

PROJECT HOMES

5 Key Takeaways from the Interviews:

Structure Promotes Personal Growth

Staff as Resource Brokers

Role Boundaries for Staff (do not deviate from peer role)

Residing Amongst Peers is a Benefit for People with a Dual Diagnosis

Transition from Isolation to Community

PROJECT HOMES

Before coming here, I was a heroin addict for 25 years. I've spent about 16 years incarcerated. I've lost everything: my family, my friends, and my freedom. **To name one person here at this facility that has contributed to my eight months of sobriety would be an injustice to the entire staff that work here daily that remind us that we are still human.**

I first came to the home facing a probation revocation hearing for multiple felonies where I was sentenced to ten years deferred adjudication for multiple felonies.. I went to treatment three times, and unsuccessfully tried to live in sober living after the first two trips to treatment, making it less than a month or two each time. The third and final time, however, I ended up in House of Extra Measures…I got on MAT [medication assisted treatment; another word for MOUD], moved in, started working my steps, and built a foundation that would change my life forever… **In total, I have spent a little over 8 months at the house and can undoubtedly say that without the structure and accountability I would not be where I am today.** I have reconnected with my friends and family and for the first time since that initial arrest, I feel like I have something to live for. The feeling is indescribable.

Before I came to sober living, my life was not manageable. I was living in the streets and doing anything for my drug habit…**[N]ow that I'm living here [in my recovery residence], I'm finally able to talk to my son.** He's 4. I lost custody of him because of my addiction, and my family is talking to me more because I'm sober. They can hear in my voice that I want it this…**Also, the house keeps me accountable and is teaching me how to live without drugs.** It hasn't been easy for me because I'm so far from my son. But at the end of the day, I know I'm doing this to be in his life…I see the bigger picture of why I'm here… **I have never been sober for this long.**

Literature Review of the Evidence Supporting Opioid Abatement Strategies:

A Report to the Texas Comptroller of Public Accounts Opioid Abatement Fund Council

Citation: Rodriguez, S.A., Wilkerson, J.M., McCurdy, S.A., Gallardo, K.R., & Herrera, E.R. (2023). *Literature Review of the Evidence Supporting Opioid Abatement Strategies: A Report to the Texas Comptroller of Public Accounts Opioid Abatement Fund Council.* Dallas, Texas: The University of Texas Health Science Center Houston School of Public Health.

Workforce Development and Training Recommended Priority Area

Training to administer naloxone or other FDA-approved drugs to reverse opioid overdose:

- Tailored education and training programs for pharmacists, community members, law enforcement, and first responders have demonstrated improved outcomes suggesting these are high-impact target populations for overdose education efforts.

- Widespread implementation of overdose education and naloxone distribution in healthcare, criminal justice, and community settings is warranted based on consistently positive outcomes for increasing naloxone availability and building capacity to intervene in overdoses.

Workforce Development and Training Recommended Priority Area

Building capacity to increase access to and distribute MAT:

- Interventions at the provider- and clinic-levels using multimodal education programs, peer training, virtual case-based learning, and academic detailing were associated with increased provider knowledge, self-efficacy, and self-reported prescribing of MAT among providers.

- Directly training and educating providers on MAT effectiveness and prescribing best practices, in addition to broader clinic changes, is a promising strategy to increase MAT access for people living with OUD.

- Expanded prescriber training via policy initiatives represents a promising approach to increasing access to MAT to treat OUD.

Prevention and Public Safety Recommended Priority Area

Distribution of naloxone or other FDA-approved drugs to reverse opioid overdoses:

- Broader naloxone availability through community distribution has significant life-saving potential to prevent opioid-related mortality. Community-based naloxone education and distribution programs can effectively expand access to and use of naloxone for reversing overdoses
- Distribution of take-home naloxone kits through emergency departments (EDs) was associated with positive outcomes including later overdose reversals and participation in treatment and recovery support programs. At the community-level, a take home naloxone program helped reduce one county's opioid-related overdose death rate from 16.5 per 100,000 residents to 9.6 per 100,000 in one year.
- Novel methods to distribute naloxone in settings serving special populations, including veterans, unhoused individuals, and individuals involved with the criminal justice system, have demonstrated effectiveness.

Prevention and Public Safety Recommended Priority Area

School-based and youth-focused programs:

- Educating youth on pain management represents an effective upstream prevention strategy to equip adolescents with knowledge and skills to manage pain without medication.

Patient- and provider-focused programs:

- Multicomponent interventions combining prescriber education, guidelines, and electronic medical record changes to default prescription quantities are effective strategies to change provider prescribing behaviors.
- Studies described policies mandating prescriber participation in online training modules, mandates on participation in statewide prescription drug monitoring programs, and limitations on opioid drug prescriptions as effective strategies to reducing opioid prescriptions.
- Healthcare systems are increasingly adopting opioid stewardship programs, which include evidence-based guidelines for prescribing, policies, person-centered practices, and research to optimize treatment for patients while minimizing adverse consequences for both patients and society. There is a robust body of evidence supporting implementation of these programs and their impact on opioid prescribing and opioid use.
- Patient education programs and informational resources have the potential to influence patient expectations and behaviors around opioid use.

Prevention and Public Safety Recommended Priority Area

Drug disposal programs:

- While studies show community-based drug disposal programs are effective in encouraging safe opioid disposal, more rigorous studies are needed to determine the impact of these events on outcomes such as community overdose rates.
- Patient counseling in safe opioid disposal is an effective strategy to increase disposal behaviors. Coupled with provider-focused interventions to reduce opioid prescribing, this is a promising strategy to remove excess opioids from homes.

Treatment and Care Coordination Recommended Priority Area

Medication-assisted treatment (MAT) distribution and linkage to care :

- Across populations, evidence supports MAT, including buprenorphine, methadone, and extended-release naltrexone, as an effective first-line treatment approach for opioid use disorder given benefits on treatment retention, drug use, overdose risk, and healthcare utilization.
- Interventions initiating MAT in emergency departments (ED) with additional treatment and supportive services have demonstrated success in MAT treatment retention and engagement.
- Integrated, collaborative care models that connect individuals to wraparound services ultimately facilitate MAT access and improve treatment engagement and outcomes. Implementing such models is a promising strategy to optimize MAT delivery.
- MAT is associated with cost-saving reductions in both morbidity and mortality, particularly when combined with strategies such as overdose education, naloxone distribution, and contingency management.

Treatment and Care Coordination Recommended Priority Area

Treatment for pregnant and postpartum women:

- Perinatal MAT improves outcomes including reduced illicit drug use, better retention, lower healthcare use, and decreased neonatal abstinence syndrome further strengthening previous findings.
- Integrated models of care, which facilitate MAT access and coordinate ancillary services for pregnant and postpartum women exposed to opioids, can positively impact treatment engagement and outcomes for neonates.
- A study found supportive policies expanding MAT access increased treatment use and reduced overdoses, while punitive policies restricting access decreased psychosocial services and increased overdoses among pregnant women with opioid use disorder.

Treatment and Care Coordination Recommended Priority Area

Treatment for individuals involved with the criminal justice system:

- MAT is increasingly being adopted within the criminal justice systems, and MAT initiation among individuals involved with the criminal justice system has been associated with positive treatment outcomes. However, MAT initiation and recidivism outcomes are mixed.
- Using publicly available data from 221 counties across the US, one study found a significant effect of drug courts in reducing county overdose mortality

Treatment and Care Coordination Recommended Priority Area

People who inject drugs:

- According to reviews synthesizing 30 years of evidence, syringe service programs serve as an effective entry point to reach individuals who inject opioids and connect them to treatment and recovery services. They are also effective in linking people who inject opioids with testing services for HIV and hepatitis C.
- Statewide policies allowing SSPs also have proven effective in reducing negative outcomes associated with intravenous opioid use including population-level hepatitis B and hepatitis C transmission rates.

(Note SSPs are not permitted in Texas at the time of publication.)

Pharmacologic treatment for Neonatal Abstinence Syndrome (NAS) and coordination of care:

- Buprenorphine for neonates shows potential to reduce length of stay and treatment duration versus morphine or methadone. While morphine and methadone are commonly used as first-line pharmacotherapies for neonatal abstinence syndrome (NAS), reviews have found minimal evidence that either is superior in improving key outcomes like length of hospital stay and duration of treatment.
- Non-pharmacologic interventions such as rooming-in, swaddling, and breastfeeding when combined with pharmacologic therapies were also associated with shorter lengths of stay in hospitals for neonates with NAS.

Treatment and Care Coordination Recommended Priority Area

Nonpharmacologic treatment for NAS and coordination of care:

- Rooming in, skin-to-skin contact, breastfeeding, family education/empowerment, and infant soothing techniques can benefit neonates and infants impacted by prenatal opioid exposure. Rooming-in protocols were consistently associated with reduced pharmacotherapy, shorter hospital stays, and lower costs for newborns with NAS across multiple studies. Skin-to-skin contact via rooming-in or techniques like babywearing can lessen severity of neonatal opioid withdrawal signs and provide comfort/stability.
- Eat, Sleep, Console (ESC) approach, emphasizing function-based assessment and nonpharmacologic care (including the strategies identified above) as first-line, reduces length of stay, need for pharmacotherapy, and morphine exposure versus standard Finnegan scoring.

Treatment and Care Coordination Recommended Priority Area

Coordination of care through warm handoffs:

- Warm handoffs include the transfer of care between two members of a patient's healthcare team that occurs in front of the patient enabling patient engagement and communication in the process. Multicomponent warm handoff programs are effective in linking patients with opioid dependence to treatment and recovery services.
- Bridge clinics include initiation of MAT, stabilization during high-risk transitions in care, harm reduction services, and direct linkages to long-term providers. While the research around bridge clinics continues to grow, these clinics represent a promising strategy to link individuals with OUD to treatment and recovery services.
- The Houston Emergency Opioid Engagement System (HEROES) included first responders conducting outreach to initiate contact with high-risk individuals, provide buprenorphine/naloxone to those agreeing to treatment, and linking the individuals to behavioral support. While studies examining how first responders can proactively link individuals to treatment and recovery services are limited, this is a promising strategy to treat and support individuals with OUD.

Recovery Support Services Recommended Priority Area

Mutual help and self-help groups:

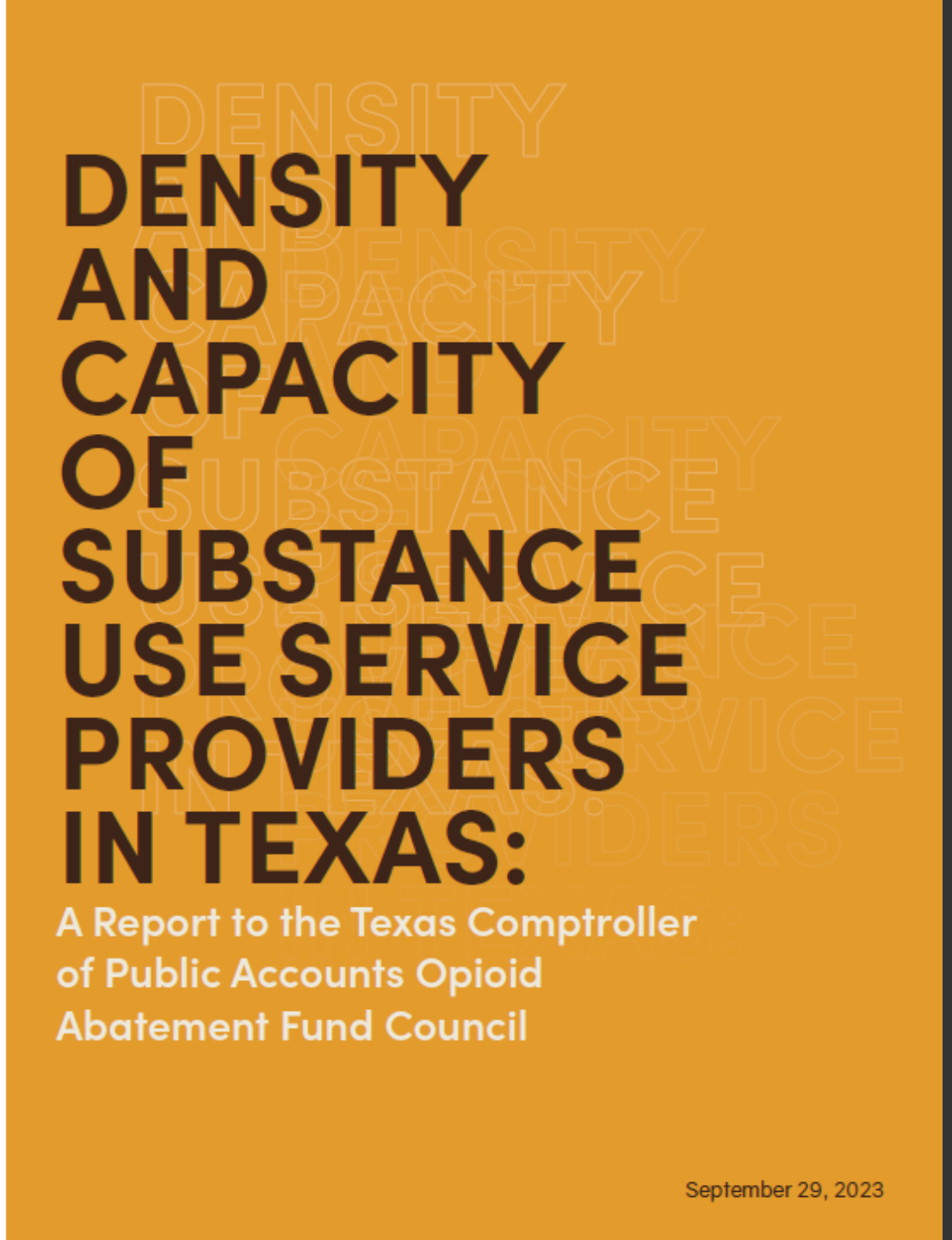
- Engagement with mutual help and self-help groups such as group counseling and 12-step programs significantly predicted abstinence from illicit drugs at follow-up in a secondary analysis of a randomized control trial. While this review does not include a large body of research focused on these mutual support, self-help, and community-based recovery support services, they are effective strategies to support individuals in recovery.

Recovery Support Services Recommended Priority Area

Support for special populations:

- While the number of facilities offering programs for pregnant and postpartum women is increasing nationally, the lowest number of programs are in the south, including Texas. There is a need to increase inpatient and outpatient treatment and services for this important population.
- Research strongly supports parent-focused, family-based interventions emphasizing contingency management as an effective approach for parents with opioid use disorders involved in the child welfare system.
- Multicomponent initiatives such as staff training in motivational interviewing, policy expansions, transportation/food provisions, and incentives lead to positive outcomes including abstinence from opioids for adolescents and young adults in treatment.

Citation: Wilkerson, J. M., Rodriguez, S. A., McCurdy, S. A., Gallardo, K. R., & Herrera, E. R. (2023). (rep.). *Density and Capacity of Substance Use Service Providers in Texas: A Report to the Texas Comptroller of Public Accounts Opioid Abatement Fund Council.* Houston, Texas: The University of Texas Health Science Center at Houston, School of Public Health.



Data analysis

Summary statistics and rates were calculated.

For count data, we used chi-squared tests of independence to identify proportional differences between regional healthcare partnership regions.

We calculated rates using the count variable of interest and the statewide or RHP region population size.

Figure 1. Texas Regional Healthcare Partnership Regions.

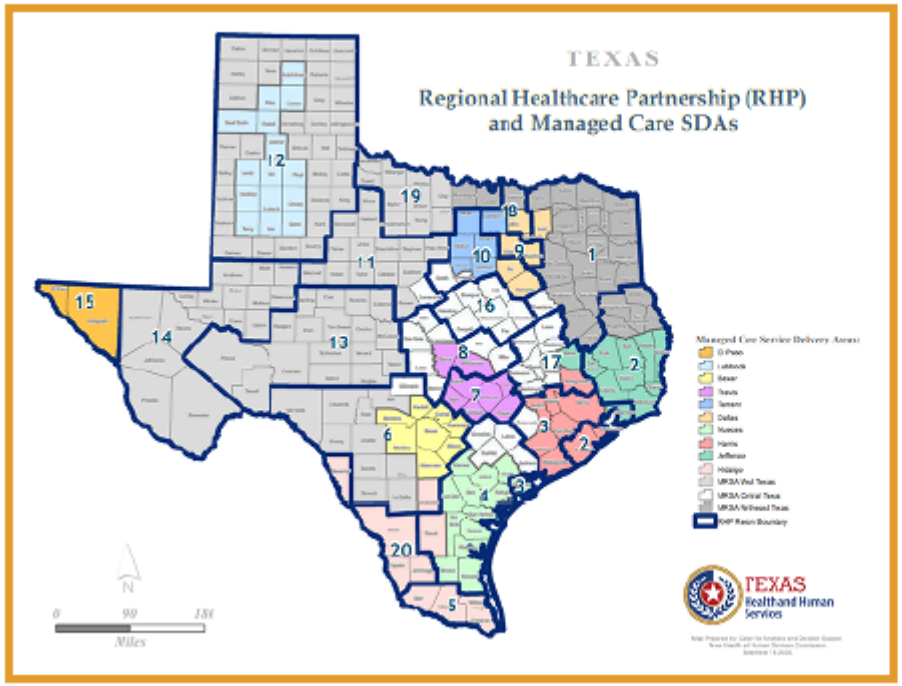


Table 1. Population estimates in 2021 according to the Texas Demographic Center.

RHP Regions	Population
Region 1	1,388,846
Region 2	1,580,910
Region 3	5,932,747
Region 4	1,727,242
Region 5	1,399,446
Region 6	2,859,255
Region 7	1,792,564
Region 8	1,206,001
Region 9	2,778,612
Region 10	2,977,673
Region 11	328,214
Region 12	926,046
Region 13	191,170
Region 14	449,519
Region 15	872,195
Region 16	455,519
Region 17	1,131,967
Region 18	1,425,035
Region 19	262,376
Region 20	344,235
Statewide	30,029,572

Table 5: Rate of services by substance use service facilities provided in Texas (N=1050).

	State-wide	RHP Region (rate)																				
Service		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	p-value
Primary Prevention																						
Community outreach/training	0.3	0.1	0.1	0.6	0.2	0.4	0.4	0.6	0.2	0.3	0.1	0.6	0.5	1.0	0.4	0.1	0.4	0.3	0.1	0.0	0.0	0.12
K-12 substance use education	0.2	0.1	0.1	0.4	0.2	0.0	0.2	0.1	0.1	0.1	0.1	0.6	0.2	1.0	0.2	0.0	0.0	0.4	0.1	0.0	0.0	0.1
Health communication/social marketing campaigns	0.1	0.0	0.0	0.2	0.0	0.0	0.1	0.3	0.1	0.1	0.0	0.3	0.1	0.0	0.0	0.1	0.2	0.0	0.1	0.0	0.0	0.56
CEU/CME provider	0.1	0.0	0.2	0.2	0.1	0.0	0.1	0.3	0.2	0.1	0.0	0.3	0.2	0.0	0.0	0.1	0.2	0.0	0.0	0.0	0.0	0.61
Secondary Prevention																						
Wound care kits	0.0	0.1	0.0	0.1	0.0	0.0	0.0	0.1	0.1	0.0	0.0	0.3	0.0	0.0	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.4
Narcan distribution	0.2	0.1	0.0	0.2	0.1	0.0	0.2	0.8	0.2	0.2	0.1	0.9	0.2	0.0	0.4	0.2	0.4	0.1	0.1	0.8	0.0	**0.04**
Case management/service linkage	0.8	0.1	0.6	1.1	0.7	0.8	1.1	1.4	0.6	0.4	0.2	1.2	0.3	0.5	0.2	0.7	1.8	0.3	0.3	3.4	2.3	**<0.001**
Detox and treatment																						
Detox	0.4	0.1	0.4	0.6	0.3	0.5	1.1	0.3	0.2	0.3	0.2	0.6	0.2	1.0	0.4	0.0	0.7	0.7	0.0	1.9	0.0	**<0.001**
Inpatient residential and stabilization services	0.5	0.1	0.9	0.8	0.2	1.0	0.9	0.4	0.6	0.4	0.2	0.6	0.1	1.0	0.4	0.0	0.4	0.8	0.1	2.3	0.3	**<0.001**
Intensive outpatient program	1.1	0.2	1.3	2.0	0.7	1.2	1.5	0.7	1.2	0.8	0.4	1.2	0.5	1.6	0.2	0.3	2.0	1.7	0.4	3.8	2.0	**<0.001**
Partial hospitalization program	0.3	0.0	0.4	0.7	0.0	0.0	0.6	0.3	0.5	0.3	0.0	0.0	0.2	0.0	0.0	0.1	0.7	0.4	0.1	0.4	0.0	**<0.001**
individual behavioral therapy	1.4	0.3	1.6	2.3	0.9	1.9	2.0	1.6	1.1	1.2	0.4	1.8	1.0	2.6	1.1	0.5	2.6	1.7	0.4	3.8	2.9	**<0.001**
Group behavioral therapy	1.3	0.3	1.5	2.2	0.8	1.9	1.5	1.2	1.1	1.0	0.3	1.5	0.5	2.1	0.2	0.6	2.6	1.6	0.3	3.8	2.6	**<0.001**
Recovery Support Services																						
Alternative peer groups	0.1	0.0	0.0	0.3	0.1	0.3	0.2	0.2	0.0	0.3	0.0	0.0	0.1	0.0	0.2	0.0	0.2	0.0	0.1	0.0	0.0	0.22
Mutual aid groups	0.6	0.1	0.3	0.8	0.4	0.6	0.8	0.7	0.3	1.0	0.2	1.2	0.5	0.0	0.7	0.2	0.9	0.4	0.3	0.4	2.3	**<0.001**
Recovery high schools	0.0	0.0	0.0	0.1	0.0	0.0	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.99
Collegiate recovery program	0.1	0.0	0.0	0.1	0.0	0.1	0.1	0.1	0.0	0.1	0.0	0.3	0.2	0.0	0.0	0.0	0.2	0.2	0.0	0.0	0.0	0.39
Recovery residences (level I)	0.9	0.4	0.1	0.5	0.9	0.0	1.9	2.2	0.6	2.2	0.9	1.5	0.5	1.6	0.7	0.2	1.1	0.4	0.6	1.1	0.0	**<0.001**
Recovery residences (level II)	0.3	0.3	0.0	0.4	0.1	0.1	0.2	0.1	0.0	1.0	0.1	1.2	0.1	0.0	0.2	0.1	0.2	0.1	0.5	0.0	0.0	**<0.001**
Recovery residences (level III)	0.1	0.0	0.0	0.2	0.1	0.1	0.1	0.1	0.0	0.1	0.1	0.3	0.2	1.0	0.4	0.1	0.2	0.0	0.1	0.0	0.3	0.27
Recovery community organizations	0.1	0.0	0.0	0.2	0.1	0.0	0.1	0.1	0.0	0.1	0.0	0.0	0.0	0.0	0.4	0.0	0.2	0.0	0.0	0.0	0.0	0.21
Recovery support peer specialists (recovery coach)	0.3	0.1	0.2	0.4	0.1	0.1	0.8	0.7	0.4	0.3	0.1	0.3	0.1	0.0	0.4	0.3	0.4	0.1	0.1	0.0	2.3	**<0.001**
Post-release/probation services	0.2	0.0	0.3	0.4	0.3	0.4	0.2	0.2	0.2	0.1	0.0	0.3	0.3	0.5	0.4	0.2	0.2	0.0	0.1	0.8	0.6	**0.01**
Jail/correction programs	0.2	0.1	0.0	0.2	0.3	0.4	0.2	0.1	0.1	0.1	0.1	0.0	0.0	0.0	0.0	0.1	0.7	0.0	0.1	0.8	0.0	**<0.001**
Drug court/diversion services	0.2	0.0	0.2	0.4	0.1	0.1	0.2	0.0	0.3	0.1	0.0	0.3	0.1	0.5	0.0	0.0	0.2	0.0	0.1	0.0	0.0	**0.04**

Table 5 continued. Rate of services by facilities provided in Texas (N=1050).

Job and life skills training/ integration services	0.7	0.1	0.3	1.2	0.5	1.3	0.8	0.6	0.4	0.8	0.2	0.0	0.4	0.5	0.4	0.5	1.5	0.0	0.1	2.7	2.6	<0.001
Workforce Development and Training	0.1	0.0	0.1	0.3	0.0	0.1	0.1	0.4	0.2	0.1	0.0	0.3	0.1	0.0	0.0	0.5	0.2	0.0	0.0	0.8	0.0	<0.001
MOUD provider (indicate Rx provided)	0.6	0.0	0.2	0.6	0.5	0.6	0.7	0.7	0.7	1.1	0.2	1.8	0.5	3.7	1.1	0.5	0.2	0.3	0.5	0.4	0.3	<0.001
Drug disposal	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.3	0.1	0.0	0.0	0.0	0.2	0.0	0.1	0.0	0.0	0.01
Research/Data Collection	0.1	0.0	0.1	0.1	0.0	0.0	0.1	0.3	0.0	0.1	0.0	0.3	0.2	0.0	0.0	0.0	0.2	0.1	0.0	0.0	0.0	0.37
Other†	0.6	0.0	0.4	1.0	0.6	1.1	0.7	1.3	0.3	0.3	0.1	0.6	0.2	1.6	0.2	0.2	0.7	0.4	0.3	1.5	0.3	<0.001

Note: Data based on a standardized population rate (SPR) of 100,000 residents. Data for number of residents based on 2021 population estimates provided by the Texas Demographic Center, https://demographics.texas.gov/data/tpepp/estimates/.

†Other recovery support services includes supportive outpatient programs (SOP), drug testing, aftercare planning, crisis intervention, battering intervention and prevention programs, parenting education, supportive counselling, relapse prevention, homeless support groups, outpatient competency restoration program (OCRP), alumni support groups, ambulatory detoxification treatment, family counselling, relapse prevention training (yoga/meditation workshops), aftercare coalitions, pharmacy services, transportation assistance, and religious studies/anger management.

Table 12. Rate of substance use service facilities offering services to priority populations standardized per 100,000 residents (N=1050).

	State-wide	RHP Region n (%)																				
Population		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	p-value
Youth (<18 years of age)	0.5	0.1	0.8	0.9	0.6	1.1	0.5	0.5	0.4	0.5	0.2	0.6	0.1	0.5	0.7	0	1.1	0.6	0.1	0.8	0.6	<0.001
Emerging adults (18-24)	1	0.4	1.3	1.1	0.8	0.8	1.2	1.8	0.8	1.2	0.3	1.8	0.6	1	1.1	0.3	1.1	1.4	0.6	1.1	0.3	0.01
Youth who are pregnant	0.2	0	0.3	0.2	0.5	0.4	0.5	0.3	0.5	0.1	0	0.3	0	0	0.2	0	0	0.4	0.1	0	0	<0.001
Youth with children	0.2	0	0.3	0.2	0.5	0.4	0.5	0.4	0.5	0.1	0	0.3	0	0	0	0	0	0.4	0	0	0	<0.001
Adult women (no children)	1.7	0.6	1.8	2.2	0.9	1	2.4	2.6	1.5	2.2	0.8	4	1.3	2.6	2	0.8	2.4	1.9	1	4.6	0.9	0.01
Adult women who are pregnant	0.9	0.2	1.4	1	0.6	0.9	1.6	1.5	1.2	0.5	0.3	1.5	0.6	2.1	0.7	0.3	1.5	1.2	0.2	1.5	0.6	<0.001
Adult women with children	1	0.4	1.4	1.2	0.8	0.9	1.7	1.6	1.1	0.9	0.5	1.5	0.8	2.6	0.7	0.2	1.3	1.5	0.4	1.5	0.6	<0.001
Adult men (no children)	2	0.5	2	2.2	1.4	1	3.2	3.3	1.7	2.7	1.1	4.6	1.3	3.1	1.8	1	3.3	1.9	1.2	5	2.6	<0.001
Adult men with children	0.9	0.2	1.4	1.1	0.7	0.9	1.3	1.7	1	0.4	0.3	1.5	0.8	1	0.7	0.2	1.5	1.4	0.2	1.1	2.3	<0.001
Sexual diverse people	0.5	0.1	0.3	0.7	0.2	0.2	0.7	1.3	0.7	0.5	0.1	0.9	0.4	1	0.7	0.1	0.7	0.2	0.1	1.1	0	0.03
Gender diverse people	0.5	0.1	0.3	0.8	0.2	0.2	0.7	1.3	0.7	0.5	0.1	0.9	0.4	1	0.7	0.1	0.7	0.3	0.1	1.1	0	0.01
Non-English speaking	0.4	0	0.4	0.6	0.2	0.6	0.6	0.9	0.4	0.4	0.2	0.3	0.2	0	0.7	0.6	0.2	0	0.1	0.4	0.3	<0.001
Native American	0.3	0.1	0.3	0.4	0.1	0.1	0.2	0.9	0.5	0.2	0	0.3	0.2	1	0.7	0.2	0.4	0	0.1	0.4	0	0.01
Currently incarcerated	0.2	0.1	0	0.2	0	0.4	0.2	0.4	0.7	0.1	0	0	0	0.5	0.2	0	0.7	0	0.1	1.1	0	<0.001
Previously incarcerated	0.5	0.1	0.3	0.8	0.1	0.5	0.5	1.4	0.9	0.3	0.2	1.2	0.6	2.1	0.9	0.3	0.7	0.2	0.2	1.1	0.6	<0.001
Co-occurring substance use and moderate-to-severe-mental health diagnoses	0.8	0.1	1.1	1.3	0.5	0.4	0.8	1.4	1	0.5	0.2	1.5	0.4	0.5	0.7	0.3	2	1	0.4	1.5	0	<0.001
Veterans	0.6	0.1	0.4	0.6	0.4	0.4	0.9	1.3	0.8	0.5	0.2	1.2	0.4	1	0.7	0.2	0.9	0.2	0.1	3.4	0	<0.001
First responders	0.4	0.1	0.2	0.6	0.4	0.4	0.7	1	0.7	0.4	0.1	0.6	0.4	0	0.4	0.1	0.4	0.2	0.1	1.1	0	0.05
Sexual violence survivors	0.4	0.1	0.2	0.6	0.2	0.2	0.7	1.1	0.6	0.3	0.1	0.9	0.4	1	0.7	0.1	0.4	0.2	0.3	1.1	0	0.03
Domestic violence survivors	0.4	0.1	0.2	0.6	0.2	0.2	0.6	1.1	0.6	0.3	0.1	0.9	0.4	1	0.7	0.1	0.4	0.3	0.3	0.8	0	0.14
Other†	0.1	0	0	0.1	0.1	0.1	0.1	0.4	0.1	0.1	0	0.3	0	0	0	0.1	0.2	0.1	0	0.4	0.3	0.57

Note: Data for number of residents based on 2021 population estimates provided by the Texas Demographic Center, https://demographics.texas.gov/data/tpepp/estimates/.
†Other includes older adults (HIV and AIDs afflicted), people with HIV, only students, business professionals, homeless people, families, people who do not have housing and health insurance, health professionals, homeless/HIV/HCV, open services for indigent population.

Conclusion

- Majority of Texas' substance use services were located in the RHP regions within the Dallas-Fort Worth, Houston, Austin, and San Antonio metropolitan areas.
- While these RHP regions have the majority of services, they were less resourced than other RHP regions when data are compared using a standardized population rate of 100,000 people
- Majority of Texans wanting to access substance use services are likely required to pay out of pocket or rely on sliding scale/grant programs.
- Majority of physical facilities were in regions with large metropolitan areas. Further expansion of virtual services could increase access to substance use services, especially for rural Texans
- Several service providers indicated that they served a variety of priority populations.

Recommendations

- If funds exist to add new substance use services, prioritize those RHP regions with the lowest standardized population rates for services and priority populations.
- Explore new payment options for facilities, especially those serving uninsured, poor Texans.
- Expand virtual and mobile services to increase rural and poor Texans' access to substance use services.
- Assess the extent to which providers serving diverse priority populations can provide high-quality tailored services that address social determinants of health attributed to disparate rates of substance use in youth and emerging adults, racial and ethnic minorities, sexual and gender diverse people, and veterans.
- Conduct additional research with facilities that reach capacity to identify and address contributing factors.
- Conduct a substance use workforce needs assessment that identifies the type of professionals needed, as well as the workforce development and retention needs.
- Continue funding to monitor changes in service availability, to inform distribution of future funds and establish a statewide service directory

Priorities of Community Partners

Partners' Legislative Priorities

Secondary Prevention

- Decriminalization of substance testing supplies, including fentanyl test strips (HB 362)

Treatment

- Increase reimbursement rate for residential treatment (Rider #154 to HHSC budget)
- Increase the availability of adolescent treatment services

Recovery Support Services

- 10% set aside for Recovery Support Services
- Increase the availability of adolescent recovery support services
- Exceptional item: Support implementation of HB 299, accreditation of level II and III recovery residences
  - Submitted by RecoveryPeople, TROHN, and Texas Coalition for Healthy Minds

Note: Bill numbers are from the 2023 regular legislative session. These priorities do not reflect those of the Substance Abuse and Mental Health Services Administration, the Texas Health and Human Services Commission, the Texas Comptroller of Public Accounts, or the Opioid Abatement Fund Council.

Partners' Legislative Priorities

Recovery Support Services (continued)

- Exceptional item: Increase Medicaid reimbursement rate for peer support services
  - Supported by the Texas Coalition for Healthy Minds
- Exceptional item: Appropriate funds to scale-up sustainable recovery community organizations
  - Submitted by RecoveryPeople, Network of Behavioral Health Providers, and Texas Coalition for Healthy Minds
- Expand access to medications, e.g., Vivitrol, to serve people with OUD and AUD

Cross-cutting

- Increase substance use workforce and workforce development
  - Support workforce student loan repayment plan (HB 2100 & SB 532)
- Find a Texas way to expand access to health insurance

Note: Bill numbers are from the 2023 regular legislative session. These priorities do not reflect those of the Substance Abuse and Mental Health Services Administration, the Texas Health and Human Services Commission, the Texas Comptroller of Public Accounts, or the Opioid Abatement Fund Council.

QUESTIONS?

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Texas Research-to-Policy Collaboration Project

UTHealth Houston School of Public Health

MICHAEL & SUSAN DELL CENTER for HEALTHY LIVING

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