From Insight to Impact:
My Pathways to Sustainable Public Mental Health Progress

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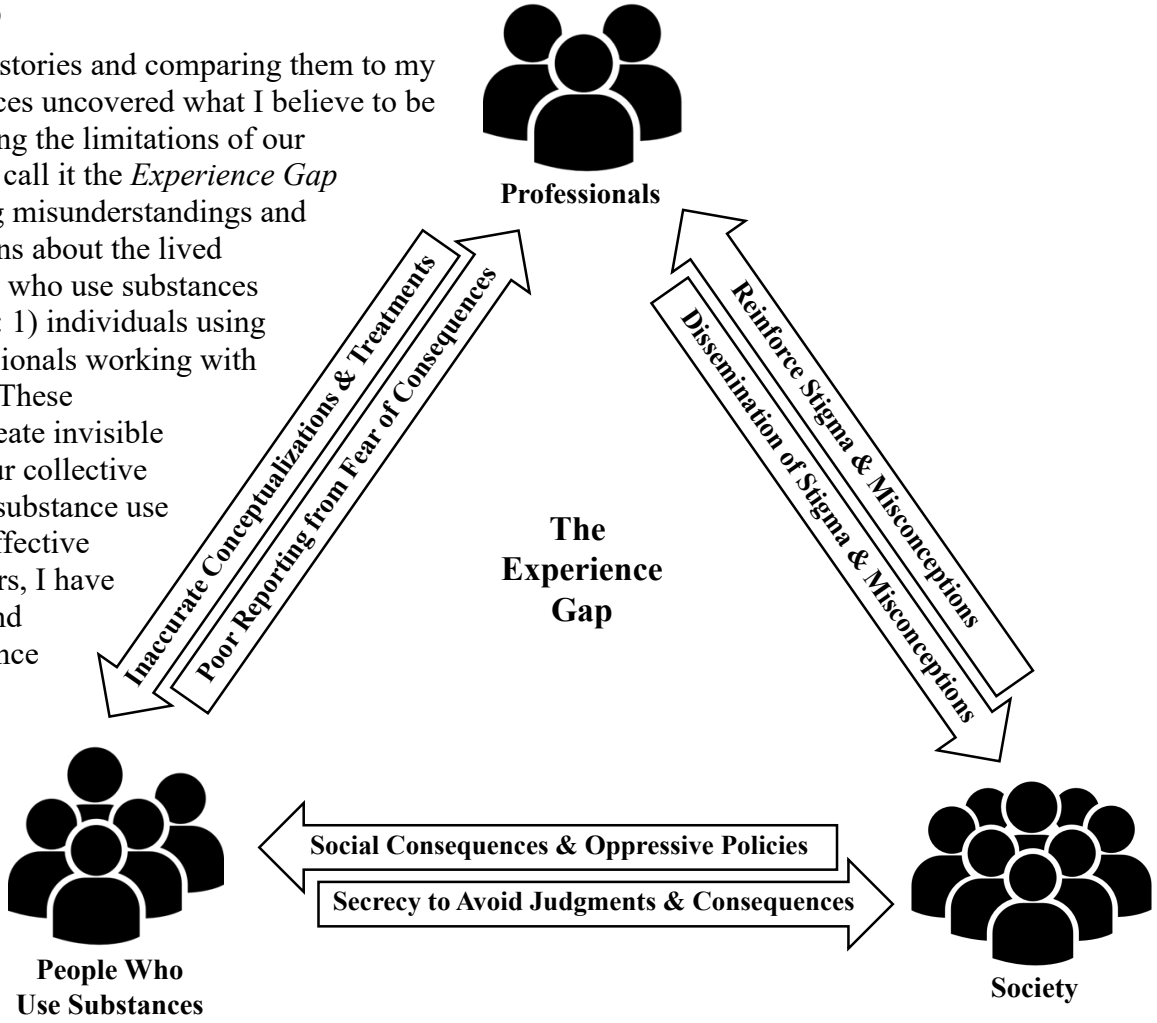
My Research Program

There are over 1,000 substance-related fatalities every day worldwide.[1] However, it is not just to substances but to deep misunderstandings that perpetuate ineffective approaches to managing substance use and co-occurring disorders. Our larger systems hinder everyone – those using substances, medical providers, researchers, families, and policymakers – from rethinking our understanding of people who use substances. Challenging our knowledge and approaches to substance use is critical; if we do not, we will remain stuck, perpetuating the same unchallenged assumptions and rigid attitudes that caused our stagnation in the first place. I have spent the last eight years working with individuals using substances who have severe or co-occurring conditions, using evidence-based conceptualizations and treatments. Through these experiences, it is clear that we, as people, professionals, and society - know far less than we think about why people use substances and how to treat them.

The Experience Gap

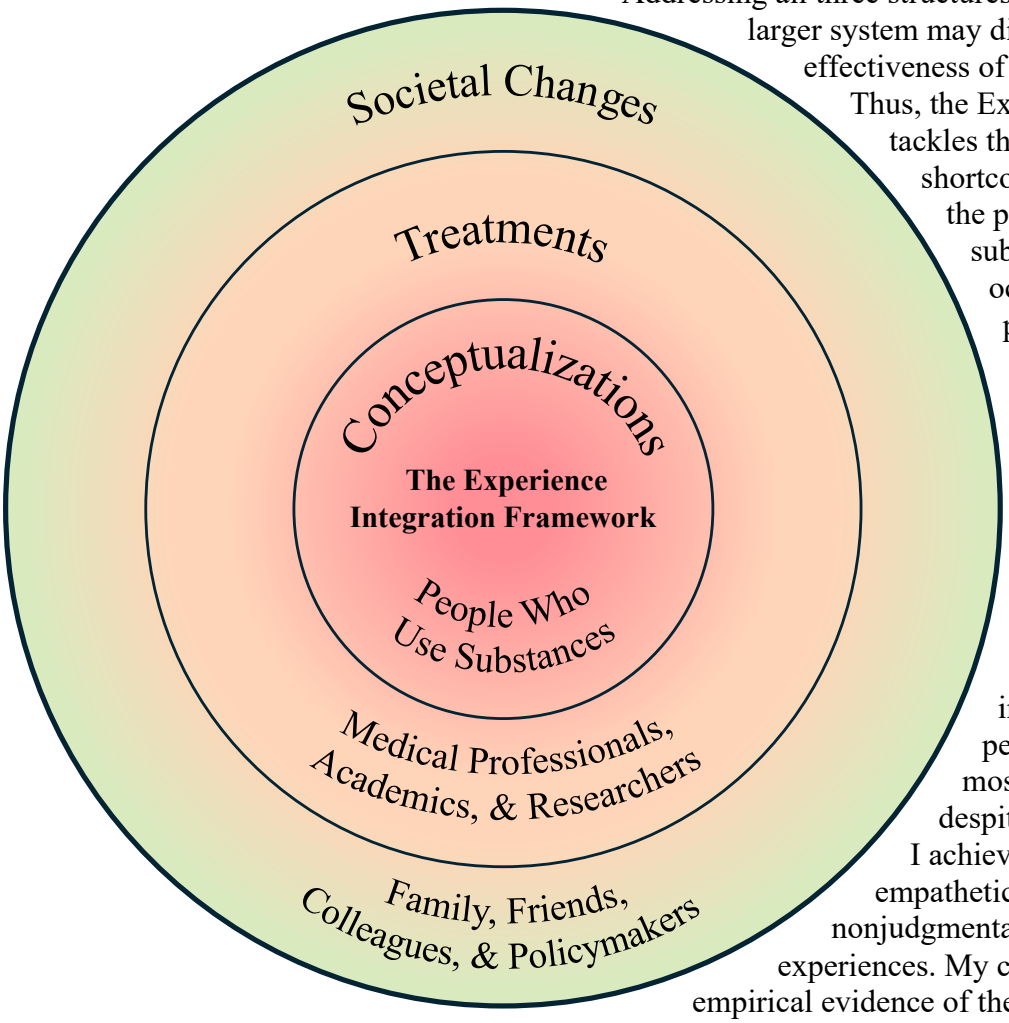
Listening to peoples' stories and comparing them to my training and experiences uncovered what I believe to be the central issue driving the limitations of our professional efforts. I call it the *Experience Gap* – a disconnect driving misunderstandings and unchecked assumptions about the lived experiences of people who use substances between three groups: 1) individuals using substances, 2) professionals working with them, and 3) society. These misunderstandings create invisible barriers that hinder our collective efforts to understand substance use problems and enact effective solutions. For the years, I have attempted to define and articulate the Experience Gap, raise awareness of its effects, and generate solutions. I realized that, as professionals, we cannot shy away from the harsh reality of substance use and how the limitations of our knowledge and strategies perpetuate it. Instead, we must listen to the perspectives of individuals using substances and strengthen our foundation from the ground up – like constructing a building; if there are cracks in our foundation, it is unwise to continue adding floors.



The Experience Integration Framework

Acknowledging the Experience Gap comes first, but closing it requires a framework addressing misconceptions and communication gaps across people while bridging lived experiences and scientific knowledge into practical,

applied strategies. I have developed the *Experience Integration Framework* – a systematic model with three interconnected phases: **Phase I) Conceptualization**, **Phase II) Treatments**, and **Phase III) Societal Changes**. This design accounts for the hierarchical structures reinforcing the Experience Gap: lived experiences of individuals who use substances, professionals using conceptualizations and treatments, and societal structures. Addressing all three structures is crucial, as failing to tackle the larger system may diminish the long-term effectiveness of our efforts in the nested systems. Thus, the Experience Integration Framework tackles the root causes of our shortcomings by defining a plan to align the perspectives of people using substances (including those with co-occurring disorders), professionals, and society. Still, achieving these goals follows an inverse strategy, working from the bottom up. Here are the phases with their progression and my ten-year proposed plan with my methods and funding:



Phase I – Conceptualizations: I will first focus on refining our substance use conceptualizations, including the qualities of the people who use substances and, most importantly, *why* they use despite known risks and consequences. I achieve this aim through honest, empathetic, collaborative, and nonjudgmental examinations of their lived experiences. My current contributions involve **A)** empirical evidence of the adaptive, emotional, and functional purpose of use and why it makes stopping or reducing challenging, especially in co-occurring disorders,[2] **B)** the accuracy of self-monitoring one's risk of developing substance use problems,[3] **C)** the enthusiasm and perceived benefits of use rarely captured in treatments and literature,[4] and **D)** a positive psychological framework explaining substance use with the PERMA model.[5,6] This phase closes the Experience Gap between professionals (with an improved conceptualization) and people who use substances.

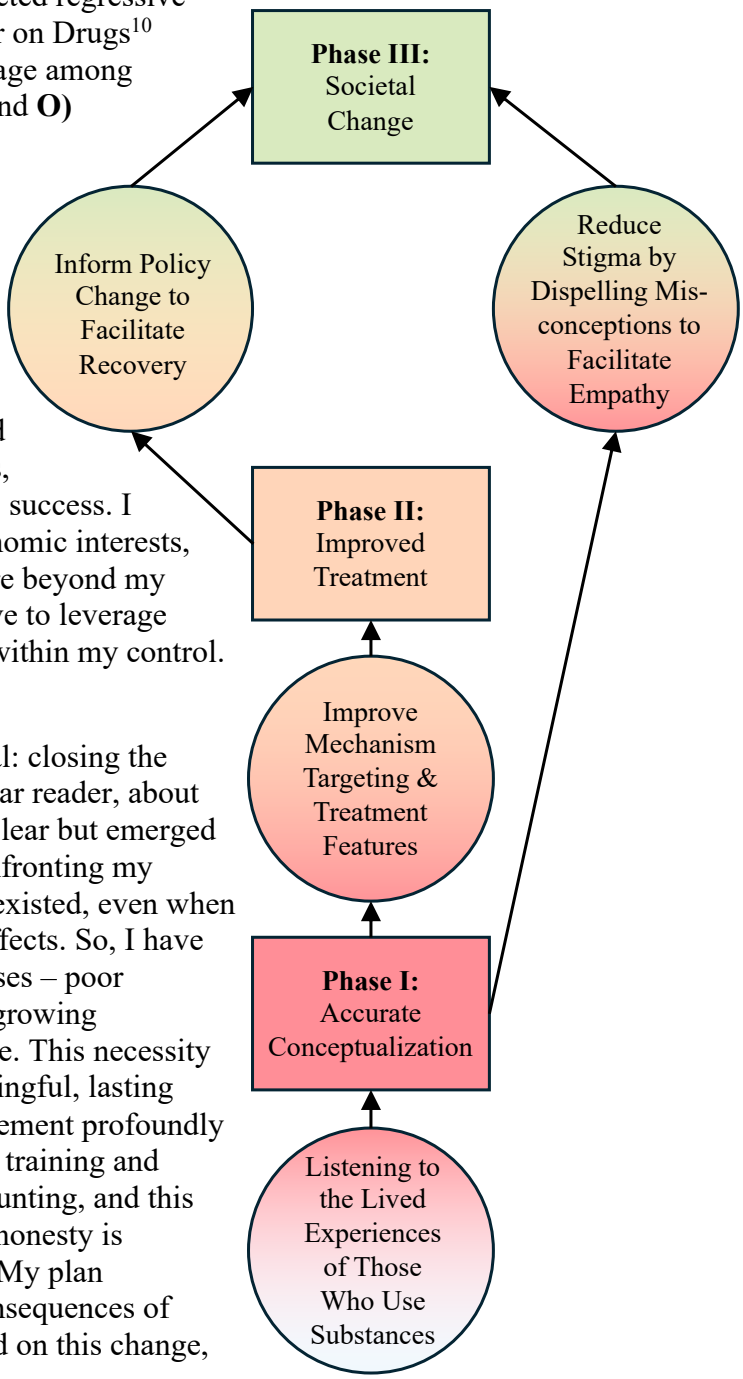
The Experience Integration Framework 10 Year Proposed Plan

Phases	Content Focus	Methods	Funding
Phase I	Motivations & Functional Explanations	Community-Based Research	F & NP
Conceptualization	Maintenance Factors	Interviews & Focus Groups	P20
Years 1-3	Antecedent-Behavior-Consequence	Observational Studies	R21
Microsystem	Individualized Conceptualizations	Mixed-Methods Approaches	R34
Phase II	Functional Analysis & Replacement	Intervention Pilot Studies	R21
Treatment	Positive Psychology Integration	Ecological Momentary Assessments	R03
Years 2-6	Improving Accessibility	Randomized Controlled Trials	R01
Mesosystem	AI Study & Mobile Health	Protocol Analyses	U01
Phase III	Stigma Reduction	Implementation Studies	R24
Societal Change	Public Health Educational Campaigns	Policy Analysis	R25
Years 5-10	Policy Changes	Meta Analyses	P50
Macrosystem	Challenging Professional Norms	Metascience	F & NP

Note. F & NP = Foundations and Non-Profit Organizations.

Phase II – Treatments: Using the refined conceptualizations from Phase I, I will revise treatments in two key aspects: 1) align treatment targets to crucial yet neglected mechanisms to improve efficacy and reduce relapse rates, and 2) mitigate treatment deterrents (e.g., shame or inflexibility) to enhance motivation and effectiveness. I will align treatments with patient preferences,[7] irrespective of existing strategies. I have articulated these arguments in papers demonstrating **E)** positive outcomes from harm reduction over mandatory abstinence,[8] **F)** the viability of unconventional mechanisms (e.g., craving reductions),[9] **G),** and the benefits of prioritizing well-being and life satisfaction in treatments.[10,11] I have implemented these changes in **H)** a treatment protocol,[12] **I)** its associated workbook,[13] and **J)** an implementation study of my strengths-based curriculum[14] in Cleveland schools. This phase closes the Experience Gap between professionals (with a better understanding of substance use and improved solutions) and society. Still, sustainable change requires addressing structural barriers.

Phase III – Societal Change: With this new knowledge, I can work to address societal structures, including two components, using 1) Phase I knowledge to dispel stigma and cultivate compassion and respect, rather than viewing people as degenerates or criminals and 2) Phase II knowledge to reform policy to facilitate recovery over recidivism and relapse. In my research, I have targeted regressive behaviors and oppressive policies, including the **K)** War on Drugs[10] and **L)** its effects on academia,[15] **M)** stigmatizing language among professionals,[16] **N)** especially medical professionals,[17] and **O)** cannabis-related legislative resistance.[18] In this phase, professionals close the Experience Gap between people who use substances and society by aligning everyone to the same knowledge, creating an environment that sustains progress and encourages unity.



Limitations

Although the Experience Integration Framework is comprehensive and expansive, I continually critique and refine its features to address its limitations. Many forces, including its ambitious scope and timeline, challenge its success. I often reflect on the unavoidable obstacles – hatred, economic interests, privatized prisons, dehumanization, and racism – that are beyond my control. Yet, these limitations only strengthen my resolve to leverage collaborations within our department to drive progress within my control.

Why Me?

My plan may seem broad, but my focus is on a vital goal: closing the Experience Gap. Though, I must be candid with you, dear reader, about my journey and convictions. This plan was not always clear but emerged through years of listening, learning, unlearning, and confronting my conformity. Looking back, the Experience Gap always existed, even when I lacked the words to identify it or grasp its pervasive effects. So, I have come to realize that to address our substance-related crises – poor treatment outcomes, unintentional fatal overdoses, and growing prevalences – closing the Experience Gap is unavoidable. This necessity is not regressive but the essential underpinning of meaningful, lasting progress. Despite this conviction, I find writing this statement profoundly challenging, as I am pushing against the very norms my training and cultural experiences taught me to uphold. My plan is daunting, and this vulnerability is deeply uncomfortable. Yet, I know this honesty is necessary for real change, and I believe in its potential. My plan transcends my reputation, fears, shame, rejection, or consequences of challenging expertise. The stakes are high; many depend on this change, and I am prepared to lead it.

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