Dialogue4Health Web Forum

Pain in the Nation: The Drug, Alcohol and Suicide Epidemics and the Need for a National Resilience Strategy
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>> Laura Burr: Welcome to today's dialing web forum Pain in the Nation: The Drug, Alcohol and Suicide Epidemics and the Need for a National Resilience Strategy, brought to you by our partner Trust for America's Health. We also thank Well Being Trust for funding today's event. My name is Laura Burr and I will be hosting today's web forum along with my colleague, Christina Lane.
Now it is my great pleasure to introduce our moderator for today, Dr. Nadine Gracia, Executive Vice-president and Chief Operating Officer at Trust for America's Health, TFAH, where she is a senior policy advisor to the President and manages core business functions and internal operations. She has more than 20 years of leadership and management experience in federal government, advocacy organizations, academia and clinical practice.
Prior to joining TFAH, Dr. Gracia served in the Obama Administration as the Deputy Assistant Secretary for Minority Health at the U.S. Department of Health and Human Services.
So welcome back to Dialogue4Health, Dr. Gracia. We're happy to have you on.
>> Dr. Nadine Gracia: Thank you very much, Laura. Thank you to everyone in our audience for joining us today for our web forum.
Trust for America's Health is dedicated to saving livings by protecting the health of every community and working to make disease prevention a national priority. We have been privileged to partner with the Well Being Trust and the Robert Wood Johnson Foundation on this important report, Pain in the Nation that focuses on emerging set of new epidemics facing the nation. For the first time in many years, we have seen overall death rates actually increase in the United States. In large part driven by the opioid crisis and the related broader context of what some have called the depths of despair through the Pain in the Nation report we examined the full scope of what we are facing and what we need to do as a country to address these crises. Today's web forum will highlight the report and a need for a National Resilience Strategy. The panelists will also discuss public health efforts underway. Following the presentations there will be a question and answer period to follow.
It is now my pleasure to introduce our panelists.
We are excited to have such a distinguished panel of experts for the discussion today. I thank them for their time and for joining us. First I would like to introduce Dr. Ben Miller, Chief Strategy Officer at Well Being Trust. He was an important part of Trust for America's Health on this project. Well Being Trust is dedicated to realizing the vision of a nation where everyone is

well in mental, social and spiritual health.
Next we have Michael Botticelli, the Executive Director of the Grayken Center for Addiction at the Boston Medical Center and Distinguished Policy Scholar at the Johns Hopkins Bloomberg School of Public Health.
Prior to this role he was Director of Public Health Policy at the White House in the Obama Administration. He has more than two decades of experience supporting individuals affected by substance use disorders.
The next is Dayna Bowen Matthew is a Distinguished Professor of Law and leader of Civil Rights. Professor Matthew is a leader in public health who focuses on racial disparities in health care. She joined the Virginia faculty in 2017.
She is the author of the book "Just Medicine: A Cure for Racial Inequality in American Health Care."
And finally on our panel today is Kat Allen. Kat is the Coalition Coordinator for the Communities That Care Coalition of Franklin County and the North Quabbin, which works to promote health and wellbeing of young people in 30 towns in rural western Massachusetts.
Under Kat's nearly 14 years of leadership, the Communities That Care Coalition worked successfully with local school districts and partners to sustainably promote evidence-based programs and seen the substance use rates in youth cut in half.
As you can see we have a great group of speakers for today's discussion.
Before I hand it over to Ben, I would like to bring up on your screens a second poll question.
So the poll question is: What sector/industry best represents your sector? Please check all that apply.
The choices are A, advocacy. B, government. C, community-based.
D, early childhood. E, education. F, faith-based.
G, health. H, nonprofit. I, public health. And J, other.
Please be sure that after you make your selection you click "submit" so your response can be entered.
(Pause.)
>> Dr. Nadine Gracia: Laura, you may close the poll. As a note to our audience, as we prepare for the presentations, all of the audio and slides of this web forum will be available to download on the Dialogue4Health website following the web forum.
So as you can see with regard to the sectors and industries that are represented on this call, you will see we have a few sectors represented including leading government and public health, followed by nonprofit sector, health sector, and community-based organizations.
So with that, it's now my pleasure to hand the presentation over to Dr. Ben Miller of wellbeing trust. Ben, I'll turn it over to you.
>> Benjamin Miller: Thank you, Dr. Gracia. Welcome, everybody. Good afternoon, good morning, wherever you might be.
It is my distinct pleasure to be able to describe to you reports that we did called pain in the nation in partnership with Trust for America's Health. Those of you wanting a little bit more information on the report can go to the website, Pain in the Nation, which I will be describing today in the webinar. We focused on emerging sets of epidemics facing the country. As many of you have seen maybe firsthand we have a crisis. This crisis is substantial. It is abroad context that exists out there in our country around what we are calling diseases of despair. In this report, we really wanted to examine the full scope of what we are facing and what we need to do as a country to deal with these crises.

In the past decade, more than 1 million Americans have died from drug overdose, alcohol, and suicide.
What we found in this report is that if these trends hold we can see an increase of 60 to 100 percent in the next decade. I'll get more to that in just a second.
With the rise in death from alcohol induced causes and drug overdoses and suicide, it is not a surprise that life expectancy has decreased for the first time in two decades. Now, we have a problem. Drug deaths have owe suicide rates have grown 28 percent in 15 years.
There have been particularly large increases among mid em aged whites, those living in rural areas as well as disproportionate impact on the nation's veterans. As you'll hear on the webinar today these issues are not just those found in healthcare. These are social issues, systems issues. They all drive us back to the place of recognizing that our fracturing of health into pieces has not served our community.
One of the most egregious examples of this fragmentation and fracturing is how we address mental health in this country.
More than 43 million Americans experienced a mental health issue and more than 20 million experienced substance use disorder with 8 million of those experiencing both as of 2015. 100 million Americans experienced chronic pain and millions more experienced acute pain each year. Around two-thirds of Americans experience adverse event as a child and 40 percent of the nation's children experience prolong understand and persistent stress.
Time for paradigm shift where we react to pain, despair and distress rather than responding crisis by crisis. We need a comprehensive approach to address issues around substance use and mental health in this country.
In recent data that we looked at as of 2015 to 2016, we saw an 11 percent increase in those deaths that I just described. This is one death every four minutes. These are our friends, these are our family, these are our colleagues, these are our neighbors, people you see every day.
As a country we must come together and figure out what are the strategies that we can put in place to create more of a national resilience approach to addressing drug, alcohol, and suicide.
As you'll see in the report, we found that certain states of disproportionately impacted. As a matter of fact, you can go to the website and download slides like this for each state in the country to see what the projections are.
If you take a look back to 2005 fewer than half the states in the country, 21 states and Washington, D.C. had death rates from drug, alcohol and suicide a before 30 per 100,000. Six states had death rates above 40 per 100,000.
In the recent data 48 states including Washington, D.C. had rates above 30 per 100,000, including 30 above 40 per 100,000. This is unprecedented that we see states that have death rates at this level.
As many of you have seen in the news and read recently, we are watching deaths due to fentanyl, carfentanil and other opioids rising substantially. If you look at disproportionate populations affected we are watching deaths among blacks and Latinos up disproportionately.
The problems are clear. What are the solutions? We need to effectively expand mental health and substance use drug treatment services. To do this effectively he we must move our health to supporting the health of whole individuals. These are intertwined but the systems don't support that. We must integrate healthcare into our systems, into our community as opposed to it being called out as a separate category of care. We need to improve systems to be able to identify problems and risks earlier and to connect individuals to supports and services as a

routine practice, not simply in response to an acute problem or once something is escalated. We need to go places like primary care and ensure those practices have a member of the team who are a mental health clinician. Many of the approaches to how we treat mental health and substance use disorders are out of date and simply do not match modern research to what is most effective. Treatments shouldn't include patient limits or limits to the most effective evidence-based treatments for different individuals experiencing different conditions.

Finally the provider and payment systems must be changed to do what works and to reinforce the concept of a team.

We also have to pay attention to how we can break the cycle, how we can go upstream and focus on prevention. By that I mean reducing the Rick factors that contribute to problems in supporting influences such as stable secure families, homes, and communities.

Research from NIH and others show how these programs have a profound, positive effect. Investing in early child and adolescent and supporting parents has a big payoff and helps children avoid a cascade of problems. Children who have parents who have a substance use problem are at risk for abuse or being neglected and in the future of substance use problems themselves.

Consider the role of the education system. How can we go into the schools and reinforce this new concept or construct of health? There is strong evidence based problems such as nurse family home visits, which show strong results. We are a generation behind these mental health supports in our school. Stop school substance use programs show returns of up to $34 per dollar invested but they are not widely implemented.

We also need to improve how we as a nation treat and address pain, helping people with physical emotional or mental forms of pain, not seeing pain as tissue and nerves but really thinking more holistically about how people hurt. There are underlying causes driving pain. As a nation we have not done a great job about identifying types of pain as well as how to manage it through team based approaches. Approaches must acknowledge there are different types of pain and experts for mental health, medical and other disciplines must develop team-based solutions that focus on proactively addressing pain before it gets worse.

We also need to be able to consider how we are going to stem our current crisis. Simply decreasing the supply of opioids without decreasing the demand leads people to other ways to address their pain. Sadly, within the opioid epidemic we have an addiction crisis of individuals who in the he effort to heal may have become addictions to opioids adding a problem on top of a problem. We need a full scale approach with better guidelines and training for providers and best practice use of tools like prescription drug monitoring problems. Public education and safe storage and disposal of medications.

We need to stop the flow of illicit drugs and be able to respond when heroin or other drug use emerges within our communities. We need to take this to our local neighborhoods, our blogs and expand the availability and use of rescue drugs and other harm reduction approaches including drug courts.

We need to address the fact that this impacts families. This is a multigenerational impact of this epidemic and we need to look at how we can provide substance use counseling and assure that children receive supports that they need in a timely manner, with a focus on helping grandparents and other relatives receive the support they need when they are called upon to provide care for their children and grandchildren.

For alcohol, there are evidence-based practices and policies that allow us to reduce excessive alcohol use. This includes pricing, limiting the hours and density of sales and enforcing

underaged drinking laws and liability for selling to minors. It is worth noting alcohol is involved in around 20 percent of suicides and 40 percent of suicide attempts. And around 16 percent of suicides are from poisoning which includes drugs.
For suicide, there are also strong evidence-based policies and programs. CDC put out a comprehensive guide this past year to address suicide. This ranged from crisis intervention services that helped people cope during times of stress and despair to teaching life skills in schools to improving the training of youth and support professionals to identify and prevent depression. We need to go into primary care where most people identify some type of depression or suicidal ideation and address the needs there.
And these programs and practices work. They not only work in terms of outcomes but they work in how much dollars we can save by investing upstream and practicing prevention.
Our report highlights more than 60 of these evidence-based practices and policies. You can see the link to the website there. We know what works. The challenge that we face as a nation is how to do this in a systematic and comprehensive way. Not to incrementally approach a new program and think that's going to be the answer, but really and fully think through how the various pieces and parts fit together to address the underlying needs of our community. We can prevent these avoidable deaths. Let's see the issues for what they are and comprehensively approach them.
Thank you so much.
>> Dr. Nadine Gracia: Thank you, Ben, for that wonderful presentation. I now would like to bring up our third poll question. I encourage you all to respond. The question is: Is your organization doing work around drug, alcohol, and suicide prevention? And please do check all that apply. The choices are: A, specifically drugs. B, alcohol. Or C, suicide prevention. And please remember after you make your selection to choose "submit" so that your response can be recorded.
Laura, you may close the poll.
As a reminder to the audience, in case you just joined the web forum, all of the slides and audio of this web forum will be available to download on the Dialogue4Health website following the web forum. We'll have more instructions at the end of the web forum.
So as you can see here with the results, we see that many of you are working on each of these issues. 89 percent were specifically on drugs. 72 percent addressing alcohol misuse and 68 percent suicide prevention.
So we'll now hear from our next speaker, who is Michael Botticelli from the Boston medical center. Michael, I turn it over to you.
>> Michael Botticelli: Great. Thank you for that introduction and thank you for the sponsors for today's webinar. It is really an honor to be on the webinar today.
As Ben has discussed, these are intertwined epidemics. It is important for us to understand that these epidemics share many of the same risk and protective factors that we see as it relates to significant health outcomes for both mental health and substance use disorder issues.
And those risk factors generally fall into kind of two categories. One, we know there's a significant genetic predisposition for both substance use and mental health issues. There are a host of environmental risk factors that may contribute to someone developing a problem later in life.
So in addition to genetic predisposition some of the Rick factors fall at both the individual, the family, and the community level. And this list is certainly by no means exhaustive, but I have

highlighted here some of the major issues that contribute to both substance use disorders and mental health issues.

Clearly we know negative self-image and, as Ben discussed, significant impact of adverse childhood events have a whole host of poor outcomes. Particularly for substance use disorders, early use is a significant predictor that people will develop these problems later in life. Generally the early use of alcohol, toe tobacco and or marijuana has an effect on developing a substance use disorder later in life. Not having access to affordable healthcare is a significant risk factor for many people. At the family level we talked about the role of parental substance use not only in genetic contribution us but in the anxiety and trauma it can set off for children.

Clearly, the lack of parental supervision and for that matter, the lack of a loving, caring adult in the child's life has a significant risk factor for people developing more significant problems.

I think it's also important to note that many community level policies and practices contribute to both mental health and substance use disorders. We have talked about student and school policies and norms play a very large role. Clearly, availability and price play a significant risk factor as it relates to particular substance use disorders. We have seen with our successful work around tobacco control how diminishing availability and increasing the price of tobacco products has contributed to significant reductions in tobacco use rates all across the country. As well as our work on advertising, we know that particularly youth-directed advertising increases the probability that youth will begin to use alcohol and tobacco and other products. But we also have come to understand that social determinants are a significant driver of these diseases of despair. And clearly poverty, lack of educational and economic opportunities play a huge role in many of our communities. The lack of social cohesion. We need to ensure that all of our citizens have fair and equal opportunities for participation and for advancement.

We also know that housing instability and food instability for that matter its have contributing factors, as well as the insufficient treatment structure all across the country. A fairly recent study done by Emery University School of Public Health showed that 40 percent of countries in the United States did not have an outpatient substance use provider who took Medicaid. So we know that some of the rural impact is due to lack of infrastructure that we have.

But I think on the good news side I will echo what Ben said, that this is not a function where we don't have effective policies and programs. We know what works here. We have the tools and the evidence to really change this trajectory. Clearly we need the will power and the resources to be able to implement these programs to scale and change the trajectory of these intertwined epidemics. Again the list is not exhaustive. There are certainly a whole host of these programs issued in the report that I would call attention to.

But as we have seen kind of those risk factors that the individual family and the community level we also know that we have prevention, early intervention and treatment approaches that can really support the work that we are doing and reduce those risk factors.

Clearly programs like life skills training and giving our youth the ability to make healthy and positive choices is very important. But we also need to make sure that we are doing a good job at identifying people with emerging mental health and substance use disorders for both of those conditions we often wait until those conditions reach their acute phases before we provide intervention and treatment.

So tools like screening and brief intervention in mental health as first aid become important for us to identify diseases at the first sign of symptoms.

We know at the family level we have programs like guiding good choices and strengthening

family programs that can play a supportive role in helping parents an helping families to make good choices and also provide good parenting skills.
We've also discussed community level interventions. You'll hear from one in subsequent speakers, Communities That Care Coalition is an evidence-based program that had dramatic results not only in western Massachusetts but across the country.
We also need to make a concerted effort to reduce alcohol outlet density in many of our programs. We know that the density of alcohol outlets contributes to higher alcohol use rates and that the preponderance of alcohol outlets are more dense in communities of color and poor communities.
Clearly increasing the price of substances has a dramatic impact and is probably one of our best., but unfortunately under-utilized public health tools. Increasing the price of alcohol will have a direct impact not only on reducing underage use but reducing heavy use for many of our communities.
We talked about the role that reducing over prescribing and prescription pain medications has. We need to assure that we are promoting good pain management therapies through the use of non-opioid medications and non-pharmacologic approaches like acupuncture, behavioral therapy, yoga. We need to promote safe storage and disposal programs for communities for diversion. We continue to invest in early childhood programs that have significant payoff and return on investments. We also need to continue to build our mental health and substance use infrastructure to make sure that people have access, appropriate access in their communities. We know that time and distance to treatment has a direct impact on whether or not people enter treatment or stay in treatment. We need to continue to build our infrastructure and our workforce to support ease of access for services. We also need to make sure that we are integrating those services with medical care. For far too long we have had a bifurcated mental health and substance use system apart from medical care. We need to make sure we are dealing with the host of concerns that people bring to us.
We need to engage multi-sectoral community coalitions. We have seen time and time again the role that every sector of our community brings to bear on implementing good evidence-based programs. You'll hear about one from subsequent speakers.
So thank you for your attention today and really appreciate our sponsors calling attention to the magnitude of these epidemics. Thank you.
>> Dr. Nadine Gracia: Thank you, Michael, for that great overview. As a reminder to our audience members, if you have examples of programs or policies that you are working on in user communities or areas that perhaps need improvement, challenges that you have had as well as successes, please do use the Q&A feature on the Webex platform, which is on the right-hand side of your screen. You can send in your examples as well as questions for the panel as you are listening to the discussion today.
Our next speaker is professor Dayna Bowen Matthew with the University of Virginia School of Law. Dayna, I'll turn it over to you.
>> Dayna Bowen Matthew: Thank you very much, Laura. And thank you very much for the privilege of being on this panel and thank you to our sponsors for calling attention to this important topic.
Of course, as a professor I'm going to ask you to go a little bit academic with me for a moment. I would like to speak historically about the opioid crisis in the United States. My purpose for doing this will ultimately be in suggesting that history has some lessons to teach us about how best to structure policies that are preventive, that are systemic and address the public health

root causes of our opioid epidemic.
Beginning with my first slide that titles America's first opioid epidemic I want to call attention to the fact that there have been three opioid epidemics recorded in our public health history in this country.
The first lasted from approximately 1860 to 1930. And for those of you that are familiar with this epidemic, you know that these graphs are an estimate of what we believe the prevalence might have been of the use and addiction between the periods shown on these graphs. We didn't have the kind of record keeping that we have today in order to be sure, but in a wonderful book called "Dark Paradise" David Courtwright uses the statistics available from the bureau of narcotics to estimate that we had approximately an 80,000 to -- excuse me, 80,000 to 90,000 people addicted to opioids somewhere near 1920-1921.
That opioid crisis had some important demographic characteristics in order to summarize those you see on this slide that during this period most of the people who were afflicted with the abuse disorder during this first crisis were white. They were American or native born. They were largely wealthier, middle-aged women and particularly housewives and their physicians. Why was this? Primarily because we did not have a very good understanding at the time that opioids did not cure whooping cough. Opioids did not cure back pain. Opioids were not the solution to men of the maladies that unfortunately they were over prescribed for during this period.
As a result, those who had access to excellent healthcare and had the leisure time to engage in recreational use of pain killers ended up being the population most affected. So again, white, middle class, and upper class women and their physicians were largely the victims of this first crisis.
The way this crisis was quelled was by controlling supply, shift in medical practices, in addition to two very important legislative interventions. One aimed at criminalizing over prescription, The Heroin Narcotics Tax Act shown on the slide but the other aimed at addressing the use of smoked opioids by a Chinese laboring population, the other population that was affected.
So then America's second epidemic as shown here between the 1960s and 1980s had a very, very different demographic population affected. During this second epidemic, the populations that were burdened were largely urban, black, Hispanic, poor and in the inner city.
What we see here is a very different pattern of addiction, a very different pattern of burden in the population that was affected during this period.
Heroin and methadone were used in large ski cities, New York being one of the very prominent examples. So at the height of this epidemic, somewhere in the 1975-76-78 range it was recorded that approximately 500,000 people were addicted to heroin and heroin derivatives in the United States. They were largely in New York City, over 250,000 of them were in New York City. That is not to say there weren't some other populations, Vietnam veterans, for example, were largely affected. As you can see on the slide it was largely an inner city phenomenon.
That second opioid epidemic, if you'll advance to the next slide, had some unique characteristics in terms of the demographics, as I said, but also in terms of the government response. Government policies focused on criminal law enforcement. In other words, the second epidemic was treated largely as a criminal justice advertise not as a public health problem. The public awareness and outrage that accompanied this epidemic caused our politicians and our policymakers to work this not from the treatment perspective but the interventions again were the beginning of what we now call mass incarceration. Many people

being incarcerated.
The next slide shows that the opioid overdoses in this third epidemic are again very different in terms of demographic characteristics than the first and the second opioid epidemic. Here on this slide we can see that the number of people who have sadly overdosed and died is climbing. And it is predominantly concentrated among white, non-Hispanic populations. That population is largely male, largely young to middle-aged, and is geographically concentrated in Appalachia, New England and other states and we heard from other speakers that the prevalence of death has been high.
My reason for asking you to review this history, however, is because it is important to understand from a policy perspective, I believe, what mistake we might be making in our interventions in this third and present tragic crisis. We concentrated on intervening on the supply side. Certainly these are important interventions. However, I would like to suggest that much more important would be interventions that address the social determinants of mental health disease, of substance use and abuse in the United States of the opioid epidemic.
I have a slide up showing the 2005 alcohol, drug, and suicide deaths per 100,000 from the very fine Pain in the Nation report. I would like to review for you a few statistics that suggest that rather than interventions that we are looking at that are the supply side interventions, we should be looking rather at the social contexts that drive or the social drivers that influence people to use and abuse substances, as we should have been looking in the second opioid epidemic.
In other words, the message here I would like to suggest is that this third crisis is much more like the second opioid epidemic of the '70s and '80s than it is of the first opioid epidemic of the 1860 to 1930 period. For that reason, because of the similarities, we should be looking more at social interventions, interventions that are preventive, interventions that have to do with the social determinants that influence the opioid use and abuse among the populations affected.
Let's look at the map briefly. In the report you read that two states are experiencing such a high rate of increase deaths per 100,000 due to overdose, due to alcohol and drug deaths, those two states are New Mexico and Arizona. Those two states are also two of the highest unemployment rate states in the nation. Those two states also share the similarity of being states where the spending on the social safety net is smaller as a proportion of public benefit dollars spent than in most states.
Recently a very fine study done by Elizabeth Bradley was reported in the Health Affairs magazine. And that study talked about the variation in health outcomes based on the spending on social services that states engaged in. It turns out from that study that we can see that mental health outcomes follow largely the proportion of dollars, public dollars that states spend on the safety net, public benefits as compared to spend on healthcare alone.
So, for example, we see that in the State of West Virginia one of the states hardest hit by the opioid epidemic, that state has one of the lowest proportion of dollars spent on social services. So supportive housing, food interventions, employment training, as compared to the amount of dollars better GDP spent in that state for medical care.
This map is intended to suggest that if we look at unemployment rates, if we look at social spending, if we look at the social supports for housing, education, these kinds of social determinants are very closely correlated in the current crisis as they were in the second crisis. People were again unemployed largely, had few social supports, and these were some of the most important reasons and, therefore, the important interventions that we could undertake if we wanted to really address the opioid epidemic as a public health crisis.

This slide is intended to suggest that the criminal justice framework has continued to be a poor one for addressing the opioid epidemic. The message to take home here is that we should question the recent suggestion that increases in mandatory sentencing, increases in the death penalty for certain drug dealers, these types of interventions are much less likely to be effective than a social intervention such as has been suggested by various previous speakers and the next speaker as well.

What should we be trying? We should be looking, I would argue, at public health responses. Some of the most important are shown in summary on this slide. Let me review two for your consideration. First, Medicaid reimbursement is probably the most important action step needed to improve population health outcomes generally and specifically with respect to the opioid dependency. These reforms, if directed at allowing states to spend on the social determinants of health, the social determinants specifically of dependency on opioids, would in fact be a very important reform.

Secondly, supportive housing and making sure that we rebuild our workforce are two other important social interventions. Examples might include eliminating the requirement that immediately upon finding a person in treatment who is dependent, they are excluded from public housing, thus making them a member of the homeless population rather than providing supportive housing. This would be an important intervention.

Let me lastly mention the importance of the public health frame both prospectively and retrospectively. It would be important for us if we were to address the opioid epidemic as a public health problem uniformly, for us to look retrospectively at those people who were caught in the web of the criminal justice approach to the opioid epidemic during the '70s and '80s.

It would be an important and equitable way to approach this crisis to broaden the public health approach to all drug users. That is, retrospectively to review, revise, and reverse the extreme sentences for nonviolent individuals who were, unfortunately, incarcerated rather than treated for their addiction. You'll see on the last slide several other public health responses and interventions. I know that the remaining speakers are going to give practical examples of the way that we could take a public health approach much more importantly learn from the historic errors of our past and go forward with a more resiliency oriented approach to the crisis. Thank you very much.

>> Dr. Nadine Gracia: Thank you, Dayna, for that terrific historical and present day perspective on these crises.

To our audience we'll have a question and answer period. Please do continue to submit your questions. Now we are going to hear about a local example from Kat Allen from Communities That Care Coalition. I'll turn it over to you, Kat.

>> Kat Allen: Hi, thank you. Thanks so much, Nadine and thanks to the speakers who have spoken already. I'm Kat Allen, Coalition Coordinator for the Communities That Care Coalition. I work out of the Franklin Regional Council of Governments in western Massachusetts. I'm really excited and honored to be part of this webinar today. So thank you.

Our coalition, the Communities That Care Coalition, was started in 2002 as an initiative to reduce use, substance use in our region. Let me tell you a little bit about our region first. This is an image of our valley, part of the Franklin County region, North Quabbin region. It's a very rural area. We have, obviously it's a very beautiful area. We have less than 100,000 people in the area that we serve, over 1500 square miles. I have heard that there are more cows than people in the region but I've never seen that data. I don't know if there's a cow census or where that information comes from.

In any case, it is a very rural area. It is also a very economically depressed region. The economic base was the mills. This economic base was hollowed out when the mills all closed. Our area, I think it is important that you know our coalition doesn't have any access to any special resources. We sort of pull it together on what grants we can get. It's a pretty scrappy and small organization. I say this so you know that everything that I'm sharing with you is totally replicable -- not only totally replicable, it is totally replicated. We didn't come up with anything new here. We are implementing the communities that care program developed by researchers in Seattle by the Social Development Research Group. We are also just using evidence-based programs that come out of the national literature.

So bringing you back to 2002, our community leaders were very aware that we seemed to have elevated substance use rates, but we had no local data. We didn't actually know what the numbers looked like. So a group of community leaders brought together leaders from all of the community sectors, every community sector was recruited to the effort and formed a coalition together. This was in 2002-2003. That's how the Communities That Care Coalition was formed. We were trained in the CTC model and we, one of the first things we did, we pulled together representatives from each of the public school districts in our region. We serve nine public school districts. And we formed a regional school task force. Their first job was to conduct a teen health survey. We used the communities of care survey, now called the Communities Needs Survey. That showed us our substance use rates are far higher than the national rates. You can see the green bars are higher than the blue rates showing that we were elevated over the national rates.

We set measurable goals for reductions in substance use. We also from our data got really rich data on our local risk an protective factors in our region from our young people. We had more than 2,000 young people participating in the survey each year. We've gotten really, really good data. From this we have been able to set priority risk factors based on what risk factors were particularly elevated here and what the community felt like, where we could make a real impact.

So from these priority risk factors that we wanted to address, we formed a series, a number of work groups. So we have a policy and practice change work group that has members of law enforcement, members of the recovery community, youth members, so on, that works to address policy and practice change.

We have this regional school health task force that links everything that we do to all of the school districts. We have a youth leadership initiative that links everything we do to a number of youth groups an helps develop young leaders. Then we have a parent education work group that consists of many different community organizations all working together to address risk factors in the family domain.

And together these work groups have created a community action plan that we update regularly and we keep as a living document and we really refer back to regularly. It has sort of something for every community organization and institution, a piece for everyone.

And I'm not going to go into this in detail, but this is our logic model from our action plan. It is sort of the heart of our action plan. You can look at the captions. It outlines the strategies, the evidence-based strategies that will reduce the risk factors that our data shows are elevated which will improve the behaviors. These strategies are organized by work group.

A couple examples of some of the strategies just to show you the variety of strategies that we've implemented. We've implemented or are working with the schools to implement the life skills program in all of the middle schools. It's a curriculum. Michael Botticelli talked about the

Screening, Brief Intervention, and Referral to Treatment, we are working with the schools to do that with the schools. Above the influence campaigns, social norms marketing campaigns, raising the legal age for tobacco sales to 21 and doing flavored tobacco bans, compliance checks for alcohol, server training for servers of alcohol. This is a sticker shock campaign, prescription drug take-back days, helping promote those. A safe homes parent network. Let's see, what else? Provider education for prescribers. Parent education, evidence-based parent education like the providing good choices program, this is a social norms marketing campaign we did and some advocacy, as well as youth leadership and youth advocacy empowering young people to get involved.

So those are just a sampling of some of the strategies that we've done. This next slide shows some of the outcomes, shows our outcomes that we've gotten to from 2003 to 2017, you can see that this whole range of strategies that were done by many, many different organizations. We've seen dramatic decreases in alcohol use, binge drinking, marijuana use and cigarette use. This is for eighth, ninth and tenth graders across the region. We have been able to accomplish this with a very modest budget and modest staff, because it is a collaboration with all of the different community organizations involved.

Because I know many of you are quite savvy. You know that substance use rates have gone down across the country. This next slide shows you, the blue is our local data. The red is national data, to show that while substance use rates have gone down across the country, we have seen even more dramatic declines locally over the course of our coalition's work. We also have looked at demographic and economic changes in our region and there have been no demographic or economic changes that would explain any of these differences.

So the question that then arises is: Were we then spared the devastating effects of the opioid epidemic? Unfortunately, the answer is no. We are located on interstate 91, which has been dubbed heroin highway by Anthony Bourdain. We have more than our share of opioid epidemic here. This data shows when we started measuring in 2014-2015 it shows that our local rates were elevated above the U.S. rates.

One thing we can say is this next slide shows that while our rates were elevated, when it did rise to the attention of community leaders that we were in the midst of an opioid epidemic, we had the infrastructure in place in the community. We had community leaders who were on board. We had many different community institutions that already had relationships with each other that were accustomed to collaborating in this matter that already were collecting data. We had a lot of the organizational capacity and community capacity to embrace evidence-based strategies and help get the youth substance -- these are youth rates from our teen health survey, but we have been able to make a difference in some of these youth rates in items more quickly than across the country.

So I also wanted to share that these priority risk factors that we identified, and the three priority risk factors that we have had since 2003 are family management problems, laws and norms favorable to drug and alcohol use and parental attitudes favorable to drug and alcohol use. All these of these risk factors, as you can see, have declined.

The next slide takes a second to absorb. This is the number of overall, the overall number of risk factors per student in our sample in our population. So we really would like to see the bulk of these kids here, we would like to see the bulge over on the left in the fewest number of risk factors as possible.

In 2003 this is where we stood with the dot the line being the median. In 2006 you can see the bull building is starting to move to the left. In 2009, 2012, and 2015. So what does this mean?

This means that we have been able to achieve with pretty modest resources a community where young people have fewer risk factors, are making healthier decision also and a community that is better prepared for not only the current crisis but for whatever the next crisis will be.
I also have to point out, though, that our coalition is very much always struggling to find resources to stay in business. We are facing a major fiscal crisis right now because our grants are running out. We have a situation where we know what works, we know this is working. Yet we don't have the national and statewide infrastructure to be able to support these programs. I think that is what this report, this Pain in the Nation is about and that's what this call is about. So I'm excited to share. Thank you.
>> Dr. Nadine Gracia: Thank you very much, Kat, for that terrific example of what is happening in a local community. As you can all see, this has been a wonderful set of presentations from our speakers. We do have now time for Q&A. I would like to thank the audience members who have been sending in comments or questions using the Q&A panel. We ask that you continue to submit your comments and questions.
Before we go to Q&A, I would like to bring up our final poll question. It is on your screens right now. So please, look on the right-hand side of your screen. You can click on the response to the following question: As you think about drug, alcohol, and suicide prevention and your community, what additional resources or support do you need to increase your work in this area?
And you can check all that apply. A being increased understanding among leadership of the importance of drug, alcohol, and suicide prevention and the need to partner.
B, best practices, models, examples of drug, alcohol, and suicide prevention that are replicable.
C, ways to engage with other leaders and partners and elected officials around the country, and D, a National Resilience Strategy.
Please do take a moment to make your selection. Once you have made your selection, choose "submit" so that your response can be entered. We would like to hear from all of you on this question.
All right. Laura, you can close the poll now.
As we prepare to see the poll results I'll give as a reminder, we will share the audio and slides for this web forum. That will be available to download on the Dialogue4Health website following the forum. We'll have more instructions with regard to accessing those slides.
So thank you all so much for your responses. As you can see, we have across the board responses in those four areas with regard to an increased understanding among leadership, best practices, models and examples, ways to engage with other leaders and partners, and a National Resilience Strategy.
Thank you very much for your responses.
We will now begin our Q&A portion of today's web forum. And please do submit your questions. We'll do our best to respond to as many of the questions with the time that is remaining in the web forum. We will start with this question from one of our audience members, as many of our panelists have been talking about youth and schools, with a question about what you recommend -- one second here.
What do you recommend when working within schools? A challenge actually that one of our audience members highlighted, their health system tried to address the impact of trauma for third graders in southwest Michigan through theater and performance. However, teachers

trained in mental health first aid were not supportive. Any of our panelist speakers like to respond to strategies and ways to work within schools, especially if encountering challenges in the schools?
>> Benjamin Miller: I'll take a stab at this one. First of all, thank you for raising this issue. It is critical that we figure out ways to go into the educational systems and support not only the schoolteachers but also provide some type of consistent connection from the folks an kids that we identify as having needs back into the health system. We released and educational brief with TFAH specifically highlighting some of the policies and practices we discussed today and their application to the educational system. I don't think it's lost on anybody the importance of making sure that our schools, especially those front line teachers have the support and the resources, but we must be careful to simply not ask them to do more without putting a really comprehensive and complete system of care in place so that we identify kids that have needs, but we have nowhere to send them. We identify the needs and the kids now know there's a problem but there is nothing for them to do. We need to be cautious of that. I encourage people to go to the Pain in the Nation website and look at the educational brief which has a great deal of information to answer your question.
>> Dr. Nadine Gracia: Thanks for that, Ben. Kat, you wanted to reply to that question?
>> Kat Allen: Sure, I wanted to share a quote that I heard years ago from John Auerbach, the President now of TFAH who was the Commissioner of Public Health here in Massachusetts. He used to say that the challenge for public health today is to learn toe lead where we have no authority. And I find that to be so incredibly true, especially in our work with the schools. Our coalition has zero authority in the schools. Yet we have been able to get all of our school districts doing evidence-based substance use prevention and all of the school districts doing SBIRT and other programs. I think for us it has been a matter of finding your allies and finding your sort of sources of power. We have great allies in the District Attorney's office, the sheriff, and really sort of using those points of leverage as sort of kindly and gently and collaboratively as possible.
I think it's a really important question. That is the challenge for public health of our time is learning to lead where we have no authority.
>> Dr. Nadine Gracia: Great. Thank you, Kat.
We have another question that is on the topic of bullying, in which our audience member states that bullying doesn't seem to be addressed but certainly seems to be a huge factor as it relates to suicide rates or exacerbating mental health challenges and feeling that kids and youth are feeling that adults are not listening or doing anything when bullying is being reported.
Any strategies and thoughts that our panelists have with regard to how to really raise attention to this issue and also to garner more attention and action on the part of adults who are poised to be able to take action?
>> Benjamin Miller: This is Ben again. I'll say one thing. Referencing the report again, I think the audience member is very astute in pointing this out because of how substantial it is as a problem. In 2015 the data suggest that 20 percent of high school students reported being bullied. This is a substantial number of our kids.
If you look at the impact of bullying on long-term health especially things around suicide ideation and suicide, there is a direct relationship.
Back to the brief that we put out there, there are a tremendous amount of evidence-based anti-bullying programs that schools can adopt. I'm cognizant of bringing new ideas and programs here because of what Kat mentioned eloquently. We have to figure out a way to invest in

these programs that aren't necessarily going to have an immediate impact tomorrow. These are prevention programs, things that could ultimately stem the tide of some of the crises we are facing. We don't necessarily always have the adequate payment structures or mechanisms to reinforce the evidence-based approaches. I encourage us to think more about how we are going to think on the payment issue especially as it relates to critical issues like bullying.

>> Dr. Nadine Gracia: Thank you, Ben.

So we have a question that perhaps helps us to take a step back as well and in particular on some of the data that has been presented and looking at substance use rates. A question from the audience is: With substance use rates going down and described in specific communities, why do you think deaths from substance use and suicide are rising?

>> Michael Botticelli: I'll take a stab at that. One of the areas that is somewhat concerning is that while we see significant reductions in many of the markers, not just here in Massachusetts but nationally in adolescent substance use issues which is good in and of itself, I think if you start to look at particularly substance use rates in the 18 to 25-year-old range, once people get out of adolescence, that it is particularly disturbing in terms of looking at markers for substance use. We are not seeing a tremendous amount of success. It is actually moving in the wrong direction when you look at 18 to 25-year-olds.

I think some of the issues around those issues also factor in to some of the issues that we see around not just substance use but mental health and suicide issues. That developmentally young adults, we are coming to understand they have different developmental issues and developmental needs than even adolescents and adults, often marked by feeling dislocated and isolated, not being connected to some of the historic institutions, whether it is parents or schools or other institutions that they have been he connected to.

Often they have a significant level of financial security issues that we see.

So I think while we need to get focus on driving down use rates for youth because we know that again that has a dramatic impact, I think we need to pay more attention to what is happening with young adults in our society and in our communities because when you look at some of the markers and some of the developmental issues, the picture is not so rosy.

>> Dr. Nadine Gracia: Thank you, Michael. Great response there.

We have a question about what are your recommendations public health organizations and suicide prevention organizations can work together nationally.

>> Michael Botticelli: I'll take a stab at this and I'm sure other folks can as well. When we talk about the importance of data, you know, one of the areas where I think we need to spend significant time in looking at both the local, state, and national picture is how we get better data looking at both of these issues. I will tell you that I think there is, there has been some studies that looked at this. There is a much more significant nexus between opioid overdoses and suicide than we are aware of. Many states have abysmal reporting on just overdoses in general, but particularly I think distinguishing between unintentional and intentional overdoses. We need to make sure that we are working off good data both nationally and locally to make sure we are focusing on those issues.

Again I think there's lots of opportunities for the implementation of evidence-based prevention programs that deal with all of those risk factors, as well as making sure that we are screening for the early issues and identifying people who may be having both mental health and substance use issues.

I think to a large extent the mental health and substance use system have much, a

tremendous amount to improve on in terms of looking at doing treatment for what are often co-morbid conditions but often treated separately.
>> Dr. Nadine Gracia: Thank you, Michael.
We have a question that I would say Dayna, I refer to you. What recommendations do you have to transition attention from criminal justice to the social determinants? Dayna?
Dayna, if you're starting to speak --
>> Dayna Bowen Matthew: I can't unmute myself. I hope someone can unmute me. Am I on? Great.
My family would like to have this button.
(Laughter.)
>> Dayna Bowen Matthew: I'm grateful for the question because the paradigm shift actually is going to have to come from the mental health community. It is going to have to come from the primary care physician community. And I think the leadership from the public health community is going to change the focus. The focus to a public health frame does not happen because it is politically popular. This is going to happen because people begin to understand that as a disease, we have left a group of people untreated and in fact a very heavy and expensive burden on society. The cost of keeping someone housed, fed, and clothed in prison and drug dependent, the cost of recycling those populations in and out of prisons as what we call high end utilizers, the cost to lost productivity and the lack of a full capacity labor force, all of these are costs that will be communicated and really understood as our public health and healthcare communities make clear. Not only that the description of the epidemic should be as a public health crisis but the impacts are as broad as any epidemic might be across the country.
So I love the question also about how we can get mental health and public health to work together. And the solutions when we do change these frames will look more like Mercy Maricopa Integrated Care, which is located in Phoenix, Arizona, it is supportive housing that has not only mental health and substance use treatment, but partnering, it has job training provides, Medicaid services, financial management and budgeting services and drug counseling. That should be available to recently released people from incarceration. As well as people in the community struggling to overcome use disorders generally.
The framework has to be one that we lead from a health perspective to our policymakers. And I think that will improve our perspective.
>> Dr. Nadine Gracia: Thank you, Dayna. Staying on that theme of social determinants, and this is a question for certainly any of our speakers. One of our audience members is asking: Is it fair to flip protective into risk factors, employment being a protective fact if unemployment is a risk factors? They would in general like to hear more about protective factors and how that factors into addressing these crises.
>> Dayna Bowen Matthew: If I'm not on mute I would be happy to get started.
>> Dr. Nadine Gracia: Certainly.
>> Dayna Bowen Matthew: I think that is exactly the right frame, to flip into protective factors is exactly the way to begin to think positive interventions as opposed to just negative descriptors.
Rather than just describing the problem, normatively, we should see the risk factors as an opportunity for targeted intervention. Earlier I spoke of making Medicaid reimbursement reforms available to states and localities that are interested.
When we tell them to make that reform, we should also be able to say here is where the data

tells us the money will be best spent on protective factors like employment. I pick unemployment and under employment because the continuity or similarity between unemployment rates in the hardest hilt areas of the country on this crisis and during the second crisis are so similar. We should be able to say that job readiness and employment is a protective factor. We should be able to talk about keeping kids in school so early interventions like Kat was speaking of is a protective factor.
That will tell people where to spend the social dollars that we are hoping they will focus on this crisis.
>> Michael Botticelli: Let me chyme in a bit here. Boston Medical Center is the largest safety net institution in New England. To that point that we actually try to look at the risk factors of our patients and turn those into protective factors. So we actually ask in all of our primary healthcare screenings questions around social determinants. Looking at food insecurity, housing stability, looking at economic insecurity and the history of violence, and try to support our patients with a number of interventions to be able to address those issues.
We are fortunate enough to use some of our state-mandated capital expenditure money to support housing development in some of the neighbors in Boston. So I think many hospital systems are also understanding that we have to get further upstream and deal with some of the social determinants in trying to come up with novel payment mechanisms as well as screening tools in our primary care settings to make sure that we are not only addressing those individual level issues but how do we spend some of our resources and redeploy some of our resources away from just acute care settings and look at some of the community and social factors that often drive poor health outcomes of our patients.
>> Dr. Nadine Gracia: Great. Thank you, Michael. Any of our other panelists who would like to weigh in on this question?
>> Benjamin Miller: Briefly, I think it is important to recognize that the fragmentation that we described so egregiously that exists in healthcare is also seen in our attempts to try to connect some of the issues that my panelists are describing. It is not just about how we can connect social to healthcare. It is how we can think about connecting treatment to prevention and looking at these protective factors as Michael just so eloquently outlined.
The more we recognize it will take us creating a culture of shared benefit where we align the pieces into much more of a systematic approach, the more likely we are to actually achieve the outcomes that we are setting ourselves for this epidemic.
As Dayna pointed out the last thing that anybody on this call wants to do is jump from crisis to crisis. If we don't thoughtfully think about solutions that can bring together the pieces we described on the webinar today, unfortunately I'm afraid we will have webinars like this for the foreseeable future, which I don't think any of us want.
>> Dr. Nadine Gracia: Thank you, Ben. We now have a question a dressing stigma. There is still a stigma around mental health that may prevent someone from receiving necessary care an leading to suicide. How have we, if we have, addressed this issue? What can we continue to do to rid us of this stigma?
>> Dayna Bowen Matthew: I'll get started and just suggest that here the power of the public health messaging and promotion is going to be key. I am never, I never cease to be amazed at how influential medical professionals, clinicians of all areas and ranges, whether they are nurse practitioners or public health specialists or substance use social workers, but people who have real, live patient contact who have narratives to tell about the people who are affected on the ground, who can explain to policymakers who are once removed, twice

removed from the impacts that people have experienced in their communities and on their lives, those narratives from professionals with medical and public health backgrounds makes all the difference in the world.
So this messaging indeed I would say even advocacy makes a huge difference in terms of paradigm shifting and understanding better what works and does not work. Stigma does not work. I think people understand that when those who are on the ground with communities are able to communicate that effectively.
>> Michael Botticelli: Let me just -- Dayna, I think that was really telling and moving. And I also think it is important that when we look at the treatment rates for both mental health and substance use disorders they are dramatically lower than any other chronic condition that we see here. And I often have said unfortunately that issues of mental health and substance use disorders are kind of discarded stepchildren of our healthcare delivery system. And one of the reasons when you ask people, even though they need treatment, why they didn't get treatment, stigma often comes up as one of the top responses. Fear of what family will think or employers will think, fear of what families and friends.
We can have the most robust treatment system possible but without diminishing some of the stigma that is often associated with this, I think we are not going to make progress. We also know that stigma leads to bad public policy. The study out of Johns Hopkins showed that even when compared to issues of mental health, it is not good for both conditions, but that many people felt like people with substance use disorders were not deserving of a treatment benefit, not deserving of housing and employment opportunities.
So I think there are a couple things that we can do. One, I don't think we can -- we have to make sure that our laws and policies don't perpetuate issues of stigma and discrimination especially in terms of the treatment of those disorders through rigorous enforcements of our federal parity laws.
We have to promote the people in recovery, personal narrative an stories have been shown to eel list I it more positive responses than punitive responses to this.
Particularly in the substance use field we have to move away from language from discriminatory and stigmatizing language that we see in media reporting and even among ourselves that have been shown to perpetuate issues of stigma. Calling people addicts, junkies, substance abusers are all language that we need to change to eliminate stigma.
>> Dr. Nadine Gracia: Excellent points. Anyone else?
>> Benjamin Miller: Just to close this one out, you obviously hit on a hot topic. Whoever asked the question, thank you. This is important. Building off what my colleagues suggested I want to reinforce the notion that he language changes culture. We need to be considerate of the culture we are trying to create around whole health or health in general and make sure it is not artificially dichotomizing, medical from social and think about the broader construct. We need to think about the policies that reinforce stigma, inadvertently or not. Sometimes when we are trying to have people, encourage people to come forward as Michael was suggesting, to express some need or some concern they have around their mental health or substance use, we can not penalize them for that. We have to think a lot more thoughtfully and carefully about ways that we can provide treatment without having people fearful that they are going to lose their job, we ostracized by their colleagues or worst case scenario isolate themselves an not talk to anybody else until the issue becomes much greater.
Thank you for the question.
>> Dr. Nadine Gracia: Thank you, Ben. We are approaching the end of our web forum. I

would like to again thank our terrific speakers, Dr. Ben Miller with Well Being Trust, Michael Botticelli with the Boston Medical Center, Dr. Dayna Bowen Matthew from the University of Virginia, and Kat Allen with Communities That Care Coalition. I would like to thank Trust for America's Health funders and the Well Being Trust, and many thanks to our colleagues at Dialogue4Health, the staff, Laura Burr, for their work behind the scenes in helping to organize and host this web forum.

Finally, I would like to thank all of you for attending and participating in today's web forum. This has been a web forum on Pain in the Nation: The Drug, Alcohol and Suicide Epidemics and the Need for a National Resilience Strategy.

You can download a recording of today's web forum and materials online at Dialogue4Health.org. And I'll now turn it over to Laura from Dialogue4Health for final instructions before we end today's web forum.

>> Laura Burr: Thank you so much, Dr. Gracia. Thank you, Ben, Dayna, Michael and Kat for your presentations today and the really great discussion.

Thanks also to TFAH and Well Being Trust for today's event.

Thank you to you, our audience. A recording of today's presentation and the slides will be available to you later this week at Dialogue4Health.org. You will receive an email from us with a link to a brief survey that we hope you'll take. We would really like to hear from you. The survey includes instructions forgetting a certificate of completion for this event, which you may use to submit request for CEUs to other organizations.

Thank you so much for being with us and that concludes today's web forum. Have a great day.

(The event concluded at 2:30 p.m. EDT.)

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