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PHI- Colliding Crises: Tackling Behavioral Health in a Pandemic

Public Health Institute (PHI)

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>> Welcome to colliding crises, tackling behavioral health in a pandemic. My name is Murlean Tucker and I will be running this dialogue for health web forum rum with my colleague Jeff. Thank you to our partners the national overdose prevention network. Moderating today I would like to introduce Dr. Carmen Rita Nevarez. Dr. Nevarez is Director of the California opioid safety network. And the national overdose prevention network. She is public health institute Vice President of external relations and preventive medicine. Director of the Center for Health Leadership and Practice and Director of Dialogue4Health. Welcome, Carmen.
>> Thank you so much, Murlean. Welcome to everybody. We appreciate you being here. And joining us for this really important conversation. While working against the huge challenges that families communities and individuals who are impacted by substance use, but at this moment with the pandemic impacting every single phase of our lives how do

we pivot in order to make sure that we work to make -- to assure that no one is left behind? Hopefully today's conversation will help set up our thinking for this reality with are in and we are certainly thinking of this as a conversation. We want all of you to be involved and ask the questions that you -- that are on your mind that have been -- that's cooking around in our consciousness, whatever comes to your consciousness, please, please let us know in the Q&A session and we'll make time to hear what your thoughts are and to try to answer your questions. I wanted to give you a little bit of an idea of what the national opioid network -- national overdose prevention network is about. And what we are trying to accomplish. First this is a national group of learners, we are community of folks who are trying to share our best practices, help save lives with partnerships strategies and resources for overdose prevention. Next slide please. We know that you get this kind of really heavy work done only by having lots of partners. And hopefully in our conversation today we will be modeling that. But here are some of the partners

we know to work with and connect with and we know that you know and are thinking about many more. Hopefully after today you will be thinking about how to connect with them and even stronger more ways to get your work done. Next slide. The national overdose prevention network is a model of interconnecting for preventing overdose deaths. We look very strongly at coalition building, building partnerships that make the work happen but we base that firmly grounded in overdose strategies that are evidence based. Next slide. Strategies that we emphasize preventing new addictions, managing pain safely, treating addiction and stopping overdose deaths. You are going to see often we come back to this, our work is evidence based and we are trying to make sure that we are always bringing uplifting up those practices that have been affected. Next slide. So how can we benefit you? We want you to sign up for a digest, stay tuned for our webinars, check out the web sites and programs that can help you with your work. We are focusing on the strategies practices partners, policies is and sustainabilities that keep coming back

to those themes over and over again in this webinar series. But again, it only happens when we hear from you and know what it is that you need. Next slide. So at this point, what I would like to do is go ahead and start with our first presenter and let you know about Brooke Briggance, comes from a multi-sector background in health, direct impact programming for children youth and families and public education non-profit work. She began her career in healthcare in the department of neurology in stony Brooke NU and has experienced administrative leadership, public education advocacy and reform. She's also served as the executive Director of the ALAMEDA education foundation and worked as consultant in assisting in projects from school districts, redesign community engagement and best practices for non-profits. Currently she's working as the deputy Director for FACES, a future coalition and as program direct for for site for resilience project both at public health institutes. We are proud to be working with her and I want to transfer the mic over to Brooke.
>> Good morning, everyone. Thank you Carmen, for that lovely intro. I always

love it when you say we are proud to work with me. That makes me feel good. Thank you. Good morning, everybody. So I'm Brooke Briggance, as Carmen said. Think through how we can as Carmen said pivot our thinking maybe break down some silos that have existed and think about what tools we already have in place particularly when we think about community based solutions. What can the community bring to our work and addressing both behavioral health concerns we have as well as substance use disorder and overdose. So I want to start out, I am a trainer in mental health for state certification in trauma informed systems, I'm also a grief recovery specialist. And so I'm doing these trainings on a regular basis and I always want to start first with acknowledging what's in the room. I see when I look up that I have got panelists but I also have now 230 participants who have joined us today and it's not just that you are joining us on a regular old day, right? You are joining us to talk about hard things in the middle of 2020. I feel like 2020 is the year that's trying to kick my butt. I don't know about how you guys feel. But this is

such an incredible moment for us because in the room we are standing together. We are all experiencing a collective trauma. We are all experiencing the ramifications of toxic stress. I don't know about you guys but my long term exposure to court sol right now has meant that I've gone up a size in my yoga pants and I'm not happyn't about that. Some of us are having sleep disruptions, some are grieving, some are managing things at home while we are trying to have a discussion. About how we still want to help our community and we still want to help each other and systems. So I just really applaud the bravery that is here and the internal resilience that's present today that allows us to continue our dialogue. So Carmen said that I am Program Director with sight for resilience project. The idea behind Cypress actually started in my other job with faces for the future. I'm deputy Director of faces to have future, a healthcare pipeline program working with under-represented youth and I -- one of the things that was a concern to me is when you work with young people really closely, you see that they are interacting with a lot of

systems that are not necessarily well trained or prepared to manage the trauma they experience. So things like schools, health systems, I think of like foster systems, et cetera, and we wanted to get trained on how to better address some of those impacts on young people and their families. And as we did that, it just became more and more important to embed ourselves in this community based approach. So Cypress is actively training right now in mental health for state certification -- first aid certification. If you don't know what that is, it's a three year professional certification that's evidence based and confirmed by the,nanal counsel of behavioral health. Oftentimes when we think of things like these training professional development for our teens in the system or even for ourselves, we often think of like something like that would be a best practice but I'm here to sort of get the word out, this is going to be a first practice for us. We are starting to see, mental health first aid legislation, we are seeing it ooze a metric for funders who are interested in ensuring that we have trauma informed systems and that people know how to

respond to a crisis. Really mental health first aid is about sort of your approach to -- start a conversation with someone that is close to you or maybe work with or your neighbor that you think maybe experiencing a mental health challenge. All the way to managing crisis. What do I do if someone tells me they are going to end their life? What do I do if someone near me is experiencing an overdose? And you will see that there's adult youth and teen, the teen is brand new, and we are super excited about that. That is for adolescent supporting one another. And we are really one of the criteria is that if you do that at a school, you are going to be doing a whole grade at a time. So it's an opportunity for us to change the dialogue and culture at schools holistically which is really exciting. We also know that people are grievers and that a lot of the secondary behaviors that come from grief can lead to mental health challenges including substance use. So identifying grief, when we do grief recovery we talk about grief outside of the bereavement only lane. This is not just a discussion about losing someone to a death.

Sometimes we experience loss maybe we have a divorce or we lost our job or we are having to move. It can be complicated for us. So a lot of times there are these short-term behaviors that come when there's a griever and that can led lead to some substance use as well so we want to break down that silo. Then of course trauma informed practice. Trauma is directly related to the six leading causes of health in our country. Things like hypertension, autoimmune disease, diabetes, it was a public health crisis before COVID hit and now we are seeing really significant concerns. So we want to ensure that individuals have trauma informed practice in their interpersonal communication. They know how to deescalate a situation with someone who has been activated in their trauma. But we also want to think about systems approach. How are our policies and procedures within a system letting people know they are other. So for me trauma informed practice is at very heart of all of our diversity equity and inclusion work. Because inclusivity really accepting people where they are, how they are, in all of their beauty in

our systems is really about trauma informed practice. And we have to talk about things like institutional racism, historical trauma, intergenerational trauma. Not just adverse childhood experiences. Adverse childhood experiences are really important but they must be married in our conversation with adverse community experiences. So we know through our work that two things help the brain heal from trauma. The first is protected space, the second is protected relationships. So we can be doing individual work that is trauma-informed but unless and until we have dialogue with systems we are not creating protected space. That's going to be absolutely critical to people's healing. We know of course that we have some problems that we are facing. Holy mowly. We just have one after the other. Some of these have been keeping me up at night. People sometimes criticize me because I start throwing data at people and it can be a little depressing. So I only gave you one data point here which is the CDC report. But I have more if you want them. The reality is, it's dire. Right? We know the secondary impacts on people's mental health

substance use, suicidal ideation, all these things are going up and going up significantly. I was on the phone the other day with the county and they were expecting a 950% in overdose rates from last year. San Francisco near where I live had 468 overdose deaths in the first eight months of 2020 which surpassed their death by COVID rate. So what I'm hoping to see is a response that is similar in kind to COVID in the sense that it is all hands on deck, it is considered a public health issue. And we are going to think about systems reform to address it. Carmen, that speaks directly to your concern about our pivot. Right? That idea that we can't think about this -- often times we think we stigmatize folks with mental health challenges and substance use and who have trauma backgrounds, and we treat it as just an individual thing. And it's not really systems dialogue. But when we look at that circle of cross sector partners that Carmen showed us earlier, we know that it is going to be and all hands on deck approach. We knew social isolation is horrible for the brain, it's not good for young brains, we know that young people need caring

adults in their lives in order for their brains to heal -- to heal from trauma and just to develop naturally and normally. We know that buffering and protective factors are critical when young people are experiencing adversity. So we knew it was very dangerous for the elderly. I just did mental health for first aid certification for pharmacists and they were deeply concerned because they have got a lot of their elderly patients coming in and they are are walking out with multiple prescriptions and they just were hanging around the counters because they are lonely. So they were like what do we do, what do we say, we are so scared about sending these folks out back home knowing there's no one there to monitor them and no one can check on them. The elderly are two of our top three categories for -- so we are -- there's a lot of vulnerability in these two populations. We have got to think concretely about that. We know also that the fact is growing demographic in our country death by suicide is elementary school. So national council of (inaudible) piloting a mental health first aid curriculum for adults supporting children which we are

really excited about. And I wear this other hat. Right? I have a health career pipeline program that I run and oversee. In several states so I do a lot of research on health work force and I hate to break it to us but we had significant short falls in mental and behavioral work force numbers across the country and on top of it we don't have enough multi-lingual multi-cultural providers of care. It is not just prescribers, it's also things like peer specialists, social workers, et cetera, I'm talking to some counties sometimes or the entire county has one LCSW. I'm sitting there thinking gee, we should wrap them in bubble wrap and they can make it to 2022. Because we know that there are really significant barriers to accessing care and so to me one of the systems dialogues we have to have is going to be around work force. How are we going to make sure that we can do that. Well, for me one of the things that's important to remember is that if you are an individual people with knowledge -- arm individual people with knowledge how their own brains work, you get more people on your team. Right? And we know that in order to really hone in on

overdose and drug use in and of itself, we need to think about the origin stories of people. We need to think about prevention. We need to think about how did we get to this place? I just read such an interesting article. It's actually now doing research on death by suicide that aren't related to mental health. They are just suicide we are seeing upticking in suicide now just related to a sense of desperation, where the person does not have a history of mental illness. And so what we need to do is help people individual people understand how we all work neurologically and how someone they are encountering is working neurologically. And how they can deescalate that situation by managing their own interpersonal communication. Verbal and non-verbal. So this is one aspect. It's an individual intervention at the community level. To me, everybody needs to be trained in mental health first aid, everybody needs trauma informed practice. If you haven't gotten trained do it now because we need you more than ever. And this is also a community conversation. One of the things that I think is easy for us to forget is that

communities have inherent resilience, they have the ability, they have been strong, they have been navigating systems. And they need our systems now to recognize the ways in which they have been excluded. And I take this piece of art, I don't know if any of you know but VIC MUNEZ is a Brazilian artist. He does ODES to western portraits so if you imagine this image at the L,OVE or something but he -- LOUVE or something, but he goes down to the land fill in San PABLO and works with the people living in that land fill and he creates these portraits of them using the things from the land fill. It is this beautiful expression of intense humanity and its advocacy. So when you look at communities and we have got to stop having this sort of idea that somehow there haven't been these expressions of beauty, there haven't been resiliency strategies, it's been passed on by generation and generation, just the way trauma has. So what we need to do is acknowledge white supremacy exists and that we have to tackle it in our systems and in trauma informed practice and we need to begin to change systems in our own dialogue with ourselves about the

biases we bring. The reason I mention that is because in mental health first aid we talk a lot about signs and symptoms. Signs are the things you can see, symptoms are the experience for the person. If I am only -- if I'm not in dialogue with another human being and I haven't given them a sense of safety, so that they feel they can speak to me about what's going on with them, I only have signs. I'm going to read those through lens of my own bias. That's trouble. If you do that you have to concede ideas of folks you are going to miss an opportunity to get them to talk to you about where they really are. The great thing that I think is -- we have really the data about post traumatic growth. So 65% of people talk about experiencing post traumatic growth and that is when I have gone through something, I felt broken, it really impacted my life, and I built myself back up. I came out of it stronger. A different sense of values. Maybe I redirected my life and made some decisions differently. So I agreed to capitalize on that, a lot of people have that experience. We are going to catalyze on the inherent resilience and

communities and we are going to educate ourselves about what's really happening with our brains so we can intervene earlier in the life of people and perhaps then move away from seeing some of these escalation rates we are seeing right now. I just want to end with the fact that some people talk to me and they come to my trainings first with a professional hat on. I'm here as teacher and here is a social worker, I'm here as law enforcement, and we end up talking about their brother or we end up talking about their child or we end up talking about a colleague or a friend. And I just want to acknowledge that it's kind of silly for us to continue to silo the work, right, how trauma people over here, substance use people over there, but I think the other thing is it's kind of silly for us to silo ourselves and the parts of ourselves. We come to the work as real people. And CPR for example unless you are an ED provider or first responder, 80% of CPR is done on someone you know. Because that's who you are around. So one of the things that I want to bring to you is a sense of urgency about your own practice. How are you going to discipline yourself around

these skills? Are you prepared to talk to your loved ones about these issues? And so let's make sure that one of the priorities we have coming out of COVID, whatever that's going to mean and what life, I don't know yet but let's make sure that one of our conscious and thoughtful decisions and intentions is that I have decided now to be present for my fellow man kind and that I'm going to build my own skill set moving forward so I know what to do.
thank you, Carmen.
>> Thank you, Brooke. very moving and we'll come back to some of the things you listed up in the Q&A part. So it is my complete pleasure to bring Dr. Vanessa Jacobsohn to the mic. Originally from Massachusetts attended the University of Massachusetts medical school. She completed her family medicine residency University New Mexico in 2008, dual board certified in family medicine and addiction medicine. Currently she serves as Medical Director of Primary Care at UNM Addiction and Substance Abuse Program as assistant Program Director for UNM's addiction medicine fellowship. Her primary professional interests include teaching

students, residents and fellows, working with -- fellows, working with underserved patient populations an increasing access to treatment for substance use disorders and hepatitis C. So thank you so much for being with us and welcome, Vanessa. It's your mic.
>> Thank you so much, Carmen. It's an honor to be here. And thank you, Brooke as well, I loved hearing your words. Thank you, everyone. I'm going to talk today about the treatment of substance use disorders during COVID-19. And look forward to a conversation that we'll have. So much the main take away is from my private -- integrated care approach that addresses social inequities. Health outcomes both before and during COVID-19. Also flexible approach during COVID-19 allows for supportive high quality care while decreasing risk of exposure. And continuing medication therapy and harm reduction are key to survival. We need to make these services more available. So what are we seeing in terms of behavioral health outcomes during the pandemic? Let's discuss this as well. This is a slide from similar I think survey from CDC that represents data collected from April to June with

published in the morbidity mortality Cleveland report from August and shows significant worsening of behavioral health compare with the same period in 2019. You can see 31% respondents reporting anxiety and depression. That represents three times higher rate for anxiety, four times higher rate for depression in the prior year. Also that you can also see 13% reported starting or increasing substance use and seeing increase in drug related death by at least 30%. 11% in this report reported serious suicidal ideation and found a disproportionate affect on specific populations. Racial minorities, youth, unpaid caregivers and essential workers. Specifically surveyed here we know that social isolation absence of school, increase unemployment and poverty intimate partner violence all affect stress which in turn has behavioral health consequences. And the report also indicates potential for increase use of telehealth which I will talk later to help people access care they need but we have to ensure the country people value the ability to use telehealth and that everyone has access, continued access and expanded access to healthcare. Like

to take a moment to address the higher rates of behavioral health stress negative outcomes experienced by racial minorities. Also going along with what Brooke discussed. So we know this compounds and creates behavioral health disparities across the board discrimination in every form from microaggressions to overt prejudice has been shown by directly and indirectly to worsen health outcomes. Also historical mistrust of the healthcare system rising up from centuries of discriminatory practices, that's led to decrease access to care. A failure of our government to protect the most vulnerable groups accentuated these disparities. In New Mexico where I am 10% approximately 10% population identify as Native American and during first wave of COVID, 50% of cases were among native people. We also see increase rates of incarceration minority communities which perpetuates poor health outcomes. So what can we do? And my talk certainly postures answering this question but I will say that a health justice approach has to guide our steps in addressing COVID-19 and behavioral health.Ment and that includes increasing economic support in minority

communities, providing culturally linguistic outreach expanding the anti-racism education and increasing medical health from providers both from and within minority communities. So we can see briefly on this slide you can see the disparity played out in COVID, this is also CDC and you can see see increase rates of cases, hospitalizations and deaths among Native American, African American an Latino populations when compared to whites, non-Hispanic population. Death rates, I'm sure everybody has heard they much higher due to COVID-19, at least two times higher. Among African American individuals. Here you can see this is also from the CDC, the slide showing our three layered wave of the opioid epidemic in this country. So we have seen over the past few decades the shift from overdose death rising due to prescription opioid in '90s to heroin, struggled with that over many more decades and then synthetic opioid, namely fentanyl starting in 2013. Prior slide depicting racial disparities from COVID, we found sadly data from 2015 to 2017 shows the highest rate of opioid overdoses was in African American males living in large

metropolitan areas. The CDC estimates are not promising. They expect that overdose death in 2020 will continue to rise. They have already exceeded those of 2019 by over 10, 13%. And this is likely due to the psychological and difficult affects of COVID increase isolation, causing people to use alone which is something that we recommend against. And decrease access to needle exchange, we know some are closed here and sufficient resources and PPE contributing to that. We are seeing chronic -- worsening of chronic disease an multiple othersome determinants of health. -- other social determinants of health. This is our reality. So on a more positive note I would love to introduce you to our model care, talking about the work we do. And how we have adapted our services during COVID-19. ASAP is outpatient substance use treatment center, we provide integrated medical and psychiatric care to individuals of all types of substance use disorders. And we currently have last I checked 848 patients so that number changes daily. And hopefully usually it's growing and about half receive methadone at our dispensary.

Many patients with opioid use disorders also receive instead of methadone receive buprenorphine prescription through our walk in clinic and prescribe medication for treatment of alcohol use disorder and other psychiatric conditions such as major depression and anxiety. In many addition you can see here, one picture shows the outside you can see the dispensing window. And you can see some our team there. So in addition to the medical providers and wonderful staff, we have many counselors and sigh alcohol gists who also -- psychologists who also form the backbone of our program. They provide evidence based individual and group therapies, ranging a few, cognitive behavioral therapy, seeking safety, parenting groups, groups for family members, relapse prevention, skill building, many things. And always amazed by how much they offer. Many of our patients again connecting to what Brooke said, vast majority I would say have experienced trauma often from a very young age. We work from trauma informed approach so from the front lobby setup there's been a lot of thought going into the whole process, the lobby to screening and

assessment to trauma specific treatment, to tools for staff wellness because we also need to support one another in this work. We meet weekly as a clinic to discuss challenging cases and put our minds together to help patients, case management to help with resource needs. We have a dual diagnosis clinic where psychiatry residents provide continuity of care with patients with more complex psychiatric conditions. And in addition to my work in the walk in clinic for substance use I work with, nurse practitioner to provide Primary Care to patients whose don't have it in the community or prefer to have everything at one site someone else patient centered medical home. We offer probably the thing I love to talk about the most but I won't here is we are treatment to all patients regardless whether or not they get Primary Care with us and regardless of ongoing substance use. We also have an adolescent and transitional age programs for ages 14 to 22. Many learners who work at our clinic so that is who we are in nutshell. So what are we doing now? We continue to build upon our services to meet changing needs of our patients during COVID. So for opioid

use disorder the centerpiece of treatment our treatment is medication. Namely method done and buprenorphine because we know from years of research that medication staying on medication keeps people alive. Nationally less than 20% of people with opioid use disorder receive medication. So why is this? There's many reasons. We definitely need more prescribers. And there is a huge amount of stigma that's contributed to this and lack of healthcare access in general. So stigma going back to that existing both within patients but also family members, medical systems as a whole, medical providers, and community toward people with substance use disorder. So often people hear it's their fault for having a use disorder. Or that taking medication can't tell you how many times I her this from patient and from providers that medication for opioid use disorder is just like being on drugs. It's just like having another chronic medical disease where people need medication in fact so they encourage people to stay on their meds. And every visit we ensure patients have Naloxone and are integrated team based care helps to increase access for

patients. Our staff work together to reach tout patients the address lack of resources including food, clothing transportation and housing, all which have worsened during the pandemic. And in terms of increase stress experienced with COVID the next slide I'll just review some ways that our approach to care has changed to help support our patients. So the three main take aways, the first two have been most of the changes and I will start by saying truly grateful to our compassionate team for the work they have done, they really responded very quickly and we are very flexible to respond to patient needs during the pandemic. So what we have done is across all visits we largely transition to telehealth via phone and zoom, SAMSHA which oversees treatment of opioid use disorder more flexible in order to decrease risk of exposure and so in line with this we switched completely in person the telehealth for mutation an follow-up visits for buprenorphine and patients struggle with technology might not have a phone, we can -- they can come to clinic and call counselor or provide freer a room falling it our phone booth. But overall

patient response to telehealth is positive. More patients actually prevent virtually to appointments without prior barriers such as lack of transportation, child care, work schedules. So although new patient visits are requiredded in person we are able to dispense more days of methadone at a time, that's another change rather than pre-COVID requirements that patient being in treatment for certain amount of time before receiving take home doses. I will say we were nervous at first until about how patients would do if that jumped from many time one day of take home to them leaving clinic with two weeks or more but we have found in general most have done really well and in fact have been able to main stain stability or decrease use -- maintain stability or decrease use. We see some cases of diversion and we needed to decrease take homes again but there's not been increase in the reported frequency of overdose, no overdose deaths have occurred in this case thankfully so the staff is proactive about dispensing Naloxone, providing lock boxes, and calendars, help remind people increasing calls and also

socially distance, we have been for a while few months, and dispensing operation to the parking lot. So patients really rarely had to leave their vehicles. And quickly through the last bit here. Coming close to my 15 minutes. So I'll come back to the second point about echo in a minute because it has to do more with education but regarding the overall decrease frequency of urine toxicology testing that's another big change, this is also in line with decreasing exposure risk for our patients on buprenorphine unless specific concern arise we have delayed our tox screens for patients on methadone we significantly decrease in testing frequency to the minimum Federal requirement of 8 per year. And one of our outstanding nurses conducted a review and found zero correlation between the frequency of testing and opioid use. So I think this will inform our approach in the future. And lastly, going back to point on about education. We strive always to teach our learners about the need to treat substance use disorders as chronic diseases they are, I hope that we continue to increase the -- to counter stigma. I want to tell you

briefly about the excellent work of project echo before concluding. Echo which stands for extension of community healthcare outcomes started years ago by a hepatologist, Dr. -- to address the need for rural Mexicans access to treatment and remodel of didactics and case presentations specialist on hub team and network in the immunity participate in the growth of knowledge and expertise so patients increase access to care. And in addition to receiving years from the HEP C team I participated on hub teams that focus on treatment of substance use disorder and behavioral health and we offer experts to get more providers on prescribing buprenorphine and echo increased globally involving over 40 countries 900 program and they responded to COVID with lots of programs there as well like emergency responders, resilience and nursing home care. So there are monthly trainings for people who want to participate, everything is found on web sites listed there. There's a lot of information there about how to become involved. So I know I'm running out of time. I was asked to share a story so I will just say that this young man who

prior to COVID only got about one take home of methadone at a time, because he wasn't able to keep employment, was often unfortunately positive for lots of substances, when he got lots of take home and do telehealth visits he was able to keep a job, buy home, help take care of his mother and things are going much better so this is a story of hope and I think we see this in many individuals. So I'll conclude by saying that we are only as strong as our willingness to help one another. And we can each work to reduce stigma that interferes with treatment. We can address our own biases and counter systemic racism and we have to support and advocate for members of our community our best. Sorry for taking over my time here. Thank you.
>> I'm really glad you took that time because I think you brought a really good story to us. I'm going to park that in my head. I was actual will I going to ask both of you -- actually going to have you both to come back and help us with the story because one thing stories do is really help, cement concepts into our thinking in a much better way and I think that you did a nice job by

bringing in that story. So thank you, to that. Couple of questions that come from our audience that I want to lift up. So first one is actually what practices have you found to be effective to support homeless folks with minimal cell access? They don't have enough meds. And how do you see engaging in conversations in the telehealth environment or for addiction treatment?
>> This is Vanessa, happy to take a stab at that one. We do have several homeless members of our community who come to ASAP. We have in general been able to still help them socially distance and talk with them over the phone but we have invited them into the building, if they don't have an app, we provide them with one an they can talk with a counselor over the phone and provider regarding hair medication, we are still trying to help them with access for transportation, things like that, to get pharmacy and in some cases we have had -- we have had family members or friends be able to also help out by connecting them with their cell phone. So it's been challenging but I would say it's been very doable.
>> Great. Then I want to ask, let's

start with Brooke this time. Would you speak to your observation related to trauma and resilience during COVID as well as how organizations may need to incorporate specific actions into their trauma informed approaches due to COVID?
>> Yeah. So again, I think -- so there's sort of ubiquitous of the traumatization from COVID offers us an opportunity. For instance to tackle stigma around trauma informed practice, in certain communities. So Vanessa spoke so eloquently about stigma in the individual realm, in the family realm but also in immunities and systems, right? And -- communities and systems, right? One of the back doors that I use for that is our own vicarious trauma in professions, right? The sense that providers, law enforcement, teachers, et cetera, when we serve populations we are experiencing that ourselves and we are experiencing increased rates of secondary vicarious trauma. So that oats if someone in the past may have had a sense of like that's not really for me or we don't really need this right now, what I'm hearing now is I want to talk about my trauma too. Right? I need to tell you what it's been for me to be a

front line worker. I need to tell you what it's been like to work at an urban high school as teacher and not have resources I need during shelter in place. So when we come to an understanding of our own traumas, we have more empathy and compassion for people who are experiencing their version. Carmen, I think when you said story telling, that is such a core element in many professions and helping professions we draw a line at story telling. We say that that's not appropriate. I would ask us maybe to challenge that or to find ways where story can find its place again. I was working with elders in a tribe lieu the opioid networks in California and one of the judges there in their wellness court they receive referrals from the county. These are people who are offenders, who have multiple diagnoses, who have extensive histories of trauma. And one of the things that's judge in the wellness court does in restorative justice practice, they actually require that person to go and hear the story of the elders in their family. So that they can better understand how did I get here? How do I understand my own

behavior? How do I understand the behaviors of my parents, of my siblings, of my community? So I do think story telling is going to have a pivotal role as a community based buffer. We think of trauma informed practice as removing toxins, harm reduction strategy for the things that cause our brain toxic stress and then adding in protective factors an buffering factors. So hearing stories and understanding ourselves better will be some of those community based buffering factors. And how can systems help with that? Others -- that we can do, the first -- Vanessa, I loved it when you said we also have to talk about how are we treating our own teams? What are our internal -- so often there's great work that is outward facing. How am I supporting clients and patients and students and my community and we forget that we are dealing with these levels of burn out and vicarious trauma within our systems themselves. So a great place to start is to look within. Both as an individual and within my own system of whatever service I provide. And then begin to teach outward facing practice.
>> Those are some really good examples. Vanessa, anything to add to that?

>> Thank you, yeah. I completely agree. I think that we too often neglect to check in with one another and with ourselves and so I think that that is a key part of being able to carry out work and do it well. I don't think I have anything further to add. Thank you.
>> Vanessa, couple of questions for you, then I'm going to weave them together a little bit. What -- how well do people stay in your program? Can you give us a little bit about your relapse rates and what you do to reduce relapse? And then kind of along with that, what do you see about the percentage of people that start your program and stay with your program?
>> So I don't think that percentages but I will say that we have the vast majority of people who start do stay. . We have people who come to our program and sometimes will drop out a few times at first. That's part of the process I think of readiness and both self and community support for being in treatment. We have opened doors for folks to come back so sometimes we'll have it, we call intake for new patients and that person may not -- sometimes I don't even stay through the intake data,

they are not quite ready, sometimes they stay a few weeks then we don't see them and our outreach team tries to get hold of them multiple times but we are always happy when they do eventually come back. I think that as far as staying on methadone, like I was talking before we want people to stay on medication because unfortunately when people stop taking methadone or buprenorphine, the relapse rates are I believe upwards of 80, 85% and risk of death high due to decreased tolerance when they use. So we always encourage people to stay on medication, not everyone wants to and if they do want to taper off, we work with them at their pace but also let them know the door is open to continue. So relapse rates here I would say, substance use of any kind is like diabetes, relapsing disease so I can't say for sure what the rates are. When I say that we expect that relapse occurs, it's not discourage people or discourage what we are trying to do with treatment but it's part of the process. So we try to work with people to identify ways wherever we can to keep them moving forward and reach their goals. So as far as time and treatment, I think we have

last time I checked, the average time someone is on methadone at our center is way over five years but not sure the exact amount. That would be similar for buprenorphine.
>> Very interesting. So one more question related to methadone, if you don't mind. Do you have any concerns about providing additional doses of methadone at visit will cause increase in methadone related overdoses?
>> Definitely have a concern about that, every time. There are many things that keep me up at night and that is one of them. I find it reassuring the data we are seeing coming in from what our nurse reviewed and what I am hearing from patients and other providers that rates of overdose have not increased and I think that that's in part due to being careful with the process, so even though we started in March by increasing take home say from one who was getting just one take home and were closed on Sundays to having a lock box and calendar and two weeks of take homes. That was I think startling for patient and for us. We checked in with them frequently, our engagement team here checking in with some people at least weekly. And if

there was any concern like someone showing up earlier than when we thought they should pick up and not sure where doseses were, any concern at all we go down in terms of take homes so that it's flexible to have that approach and everyone has Naloxone and training for them and families.
>> Do you also train families with Naloxone?
>> We offer it. It's for patients who have family ha can come with them but we certainly do.
>> thank you. These are really good answers. Really good thoughts and the audience has certainly had some great questions. I'm going to sort of skip over to a much more global question. And ask both of you and maybe Brooke you can go first, how do we center solutions on the needs on black indigenous people of color, LGBTQ plus disabled and undocumented patients?
>> Thank you, Carmen, I appreciate that. I want to start by answering that question with, I come to this answer as a SIS gender Caucasian woman from Michigan originally who drives a Subaru. So I get that I am super white and about to answer this question. Let's

acknowledge what I can't know first. The -- I think trauma for me is the bell that once I heard it I can't unring it. Once I see it I can't unsee it. It is directly related to the public health issues that have left people vulnerable to COVID. We know that African American gentlemen for instance are dying of COVID at higher rates and part is because of pre-existing conditions, things that I told you are directly related to trauma. So did we set ourselves up for vulnerability in many communities because we didn't address in other underlying factor in addition to other social determinants of health that lead to different more negative health outcomes for people of color. So I think trauma to me is again, I would advocate trauma informed practice within systems is the ultimate expression of diversity equity and inclusion because it's acknowledging the impact that toxic stress has on the body over time. It's saying it's a health problem. It's not something that I'm doing because I have white guilt or because I want to be a nicer person and people should be valued equally. This is a health issue. So when we start to think about systems, do

we have a right to have different health outcomes for certain children in classrooms versus others? And in thinking about that right now, if I have protected space in my home but I go out and I can't get the same type of care in an encounter because maybe I'm non-binary identifying -- (lost audio)
>> I think we put all of our work and energy and hearts into correcting where history has gone wrong. We need to support these communities, we need to have open doors, we need to teach we need to have anti-racism education, we need to teach LGBTQ rights, we need to be open about it. And we need to infuse these communities with the resources that they need. So I think we have ignored for large part especially in medicine, too long these communities. So we really need to turn the tide on that. Thank you.
>> I want to thank both speakers Dr. Vanessa Jacobsohn and Briggance for joining us today. Great conversation. A lot more to uncover. We will keep this series going. And based on input from all of you out there in our listening audience, we want to make sure we are bringing the kinds of issues and

questions you have related to overdose prevention. Is there a last slide? Yes. Thank you. So please do contact us, let us know how we can support you and your efforts to prevent overdose deaths. Here is our email address is here and you can sign up NOPN.org. Thank you so much for joining us today, it's been a real pleasure with this conversation. Thank you, Brooke, thank you, Vanessa and thank you to the staff. Goodbye.