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Considering Children: How the opioid epidemic affects child survivors of domestic violence

Closed Captions Transcript

>> Hello, everyone. It is 2:30 p.m. eastern here in Boston, and we are going to start with our webinar today. Considering children, how the opioid epidemic affects child survivors of domestic violence. We appreciate everybody taking the time to be on our webinar today, we have some great presentations. And some outstanding experts with us today. The current opioid epidemic is affecting every part of our society, and we know that children are especially at risk to the negative impacts of opioid use and addiction so it's critical for us to understand how this epidemic affects kids so that we can better support adult and child survivors of domestic violence. What you're going to hear today are -- you're going to hear some information about how this epidemic affects and intersects with those affected by domestic violence, particularly children, with a focus on concrete harm reduction strategies to use with adult and child survivors of domestic violence. Before we get to the introductions of our amazing presenters, I would like to turn it over to my colleague who is going to walk us through a little bit of technology.

>> Thanks, hi, everyone. Welcome to the webinar. I'm going to quickly go over the technology, not take up too much time. But for those of you who are already on, you may know that you can listen to the audio of the -- for the webinar through your computer speakers or through your phone, and if you choose to join us through your phone, please dial 1-800-832-0736 and enter the conference room number 7404927, and I forgot to put the pound on there but if you put pound that'll complete the code. Your line will automatically be muted to minimize background noise, that's it for the audio. All of this information I'll be putting into the chat box later for folks to have access to if needed.

For a couple other features is the chat box locate order the top -- located on the top right side of your screen, we'll be using this to communicate with you and hear from you. We'll be posing questions there and hearing -- and your answers as well. So if you could type any questions or comments that come up for you throughout the webinar we'll be keeping a queue of questions we'll answer in the Q & A section dedicated at the end. We hope to answer everyone's questions. We also have closed captioning today on the webinar, and that pod should be right underneath the chat box on the right-hand side of your screen as well. The captioning box has an auto scroll that you can disable to look at what was typed previously by scrolling up and down the box. To reenable the auto scroll, just click on the check box on the right top side of the pod. If you have any technical difficulties throughout the presentations you can send me a private chat. The way you'll do that is by clicking on the drop-down menu on the top of the chat box, and there should be a start chat with host option. If you click on that you can send me a private message there. With problems with the system itself, please call adobe tech support, their phone number is on the screen as well, 1-800-422-3623, and again I'll put all of this into the chat box as well. Like I said, there will be a short Q & A section at the underof the webinar. Please feel free to type in questions into the chat box before then. I'll prompt you to take a very short survey, your feedback is

very important to us, we try to integrate it into our upcoming webinars so we encourage everyone to fill that out as well. Thanks, everyone.

>> Thank you. Just to give a little background, this webinar is part of our promising futures program in partnership with the family and youth services bureau. It's the center to expand services for children, youth and parents impacted by domestic violence. As you see on this slide we have a series of resources. Upcoming and past webinars, the promising futures website, the DVRN website. I would highly recommend folks taking a look at these websites. There's an enormous amount of resources on there, and pretty well organized as well. So you can go deeper on any of the topics that we talk about today or that we talk about on our other webinars, throughout our programming so please check out these resources. Before we get started with our first presenter, I want to introduce our presenters to you. We're very excited to have first Dr. Margie Skeer who is an associate and the interim director at the Tufts University School of Medicine, the department of public health. She's been in the field of substance use and addiction for everyone 20 years, and her current research focuses on add less thannens public stands misuse from epidemiology and development perspectives. She is working on family engagement and novel interactions. Dr. Skeer also teaching with medical students. I would like to introduce Tanagra Melgarejo who works with underserved communities, particularly of color. She has knowledge and experience in capacity building. Her commitment and passion for harm reduction started out in holy oak Massachusetts in the 1990s while she worked as education coordinator for local HIV prevention program. Before moving to Oakland she was working in Puerto Rico with woman survivors of gender-based violence focusing her work in activism around economic rights of women and BGBT persons, she has a degree in social work and was a lecturer in Puerto Rico. She comes to us from the Harm Reduction Coalition. So thank you, Margie and Tanagra, for being on our webinar today. I will now turn it over to our first presenter, Dr. Margie Skeer.

>> Thank you so much. I'm really happy to be here, thank you very much for having me. So I'm happy to be able to talk with you today about how the opioid epidemic affects child survivors of domestic violence because the work they do really is thinking about the intersection of substance use and a lot of traumatic events that come along with substance use. The opioid epidemic is not a few phenomenon, it has been around for a long time. What's making it so -- stand out so much right now is the speed with which we're seeing people dying. So the effects of this epidemic are very far-reaching in so many ways in addition to all of the things that accompany addiction but also the rise in deaths associated with opioid use and addiction. And I think before we get started with talking about this, I want to just tell but my path and how I got to where I am today with the work that I do.

I started out when I was in college interning at a drug rehabilitation center, and I was working kind of as a case manager in a way meeting with young people who are addicted to drugs. My primary population at that point was working with 18 to 20-year-olds, and I was working with these young people, and I was young at the time as well but they were addicted to heroin primarily. Seeing the way their lives were ravaged by addiction. And I continued volunteering at the rehabilitation center, and then even after that with higher -- doing case management of an employee, and really felt like this work was so important. I decided to pursue a degree in social work, and was working with people who were addicted to drugs and trying to get them -- help them work in recovery around addiction.

And it was incredible, it was incredibly challenging in many ways, the work that you all do on a daily basis. What I recognized after meeting with particularly people who are in their 40s and 50s, after having worked with younger people, was that the stories around childhood adversity, traumatic events in childhood, adverse experiences in the family environment, that message was pervasive with everybody that I met with, and I decided at that time that I would actually like to work on the prevention side so pursued a degree in public health and worked to design interventions to prevent substance abuse from beginning in the first place. Now the majority of my work is around prevention but I also work with people who are addicted. But it was that experience with working with people and hearing the adversity and childhood over and over and over that led me to focus my work on the prevention side, and a lot of it related to family engagement.

So I wanted to start talking about the opioid epidemic, and many of you may know a lot of this topic and some may not so I wanted to give you an overview before we delved into how it affects children. What are opioids? We hear this term almost daily in the news the opioid epidemic but it's elusive if you don't know what we're talking about. Just to get us all on the same page, opioids are a larger class of substances, it includes both natural and synthetic opioids, there's opiates and opioids. Heroin as many of us know is a schedule I drug which means that it is illegal in the United States, and it has no considered medicinal value. It's highly addictive and is not used in the medical practice.

Then we have prescription opioids which includes things like codeine, hydrocodone, oxycodone, Oxycontin, these are schedule II drugs meaning they have high abuse potential but they do have a place in the medical world for pain. And then we have something called fentanyl which many may have heard about. It is a prescription, it is used in pain relief, but it's being manufactured and sold illegally, and it's incredibly potent. So we've seen a big rise in deaths related to fentanyl which is a synthetic opioid. When we're talking about overdose it could be any of these. People sometimes think that the overdose deaths are related to heroin and injection drug use, particularly heroin. However, more overdose deaths are occurring with prescription pills so it's important to know if we're thinking about trying to identify signs and symptoms, if we're looking for needles, for example, it's not always going to be that way. People are prescribed drugs, people buy prescription drugs on the black market. So that's what we're talking about when we're saying opioids.

So I want to show a brief video just to talk about opioids and fentanyl, again to put us all on the same page but also there's some nice descriptions about what's going on in the brain because I want to talk a little bit about what is going on, why people are using opioids and what happens in the context >> Fentanyl is not a new drug but has seen a dramatic increase in the past three years. It's become a crisis in North America. Simply touching it may cause you to overdose. What affect does it do to your brain and body? It can inhibit pain signals in multiple pathways along the brain and spinal cord. It also causes your brain to make extra dopamine creating euphoria and sensation. It binds to your opioid receptors in the same way your endorphins do at a significantly stronger level. This might sound fun but it can suppress your brain's ability to detect CO2 levels in the body potentially causing a person to stop breathing. Dizziness, chills, vomiting, fainting, extreme constipation and more. Fentanyl is stronger than other opioids, 100 sometimes stronger than morphine and 50 times stronger than heroin. They need to pass the blood-brain barrier. Water-loving Martin Luther King, Jr. are inhibited. Morphine and

heroin are lipid soluble but have water-loving groups that helps them pass the barrier slowly. Fentanyl enters the brain within seconds. This means you only need tiny amounts to get high. That's where in part the danger lies. A lethal dose can be around 2 milligrams, looking like two grains of salt. Since a high level of precision is needed it's very easy to overdose. There are some reported incidence of first responders ODing from touching fentanyl powder or inhaling its dust. Some toxicologists doubt the accuracy of these cases. An injection can be given to a person which works to stop an overdose if given in time but the science cannot keep up with the rate of opioid analogs being produced like one that's 10,000 times more powerful than morphine. Today drug overdose deaths in America are rising faster than ever with 65,000 deaths in 2016 compared to 59,000 in 2015 and opioid use is the crux of the problem. For context this is higher than the peak gun deaths, peak HIV deaths and peak car crash deaths. All points towards the problem worsening by the end of 2017. The reason, research points to widespread prescription of opioids for pain which leads to addiction, an easy of access for non-prescribers causing millions of tablets to fall into the wrong hands. Doctors decreased prescriptions but this didn't decrease the fact that thousands were addicted causing them to seek out illegal markets. With an increase in demand there were cheaper production solutions. Unlike heroin, fentanyl can be made anywhere for cheap. China has become a heavy weight in manufacturing it, and north Americans are looking to seize supply. People should be persuaded to not use opiates. Several experts are asking for government support minimizing risk of overdose and being supported with counseling and anti-withdrawal drugs that can help people stop using. Can some drugs be good for you? Check out our second video where we look at the surprising evidence.

>> Thank you. That gives us a background around what's going on with the opioids epidemic and fentanyl in particular but a lot of what's going on with the brain is very similar with the exception of the fact that fentanyl can enter -- can get people intoxicated very, very quickly.

But I wanted to show that because I want to talk a little bit about what's going on in the brain. Because I think it's important as we understand addiction a little bit more, which will help us understand how to work with people who are addicted or who have been affected by those who are addicted. So as the video said, one of the pieces that is really involved in addiction and getting high with opioids and most drugs is dopamine, a neurotransmitter responsible for pleasure and reward in our bodies. Almost all substances that people use and misuse, become addicted to, involve dopamine. It's critical to survival, too, so when we do things in our normal lives that give us pleasure, eat really good food, have sex, things that we just, you know, feel really excited about, a lot of joy, dopamine, normal, healthy levels of dopamine get released into our bodies. What happens with drugs is that usually much, much larger amounts of dopamine get released. So if you look at this image, opioids are -- bind to the opioid receptor. So we have opioid receptors in our brain and opioids binds to these receptors and they suppress GABA. GABA inhibits the release of dopamine. So if you put opioids into the brain it inhibits GABA, allowing more dopamine to come out. If you look on the left side of this picture you'll see the little gray T's in the synaptic crept on the bottom left side of the image. This is what a normal amount of dopamine looks like. GABA is inhibiting large amounts of dopamine from coming. Then in the right picture you see when heroin binds to the opioid receptor it actually allows a lot more dopamine to flood the synaptic cleft so you're getting extensive amounts of dopamine, and again it's flooding the brain. So

that's where you see this euphoria that's coming along. And what happens over time, when people start to use drugs and drugs that really are flooding the brain with dopamine with something like opioids, the brain actually starts expecting that large amount of dopamine, and over time your normal amounts of dopamine levels don't -- it starts to go away, so you still need the drug to be able to get that pleasure. And so we see brain images of people who have used drugs for a long time, and we see these reductions in dopamine so in order to feel any kind of pleasure when people are already addicted they need that drug to feel any sort of pleasure or reward. So that's why we see when people come off of drugs and start to go into treatment or into recovery, there's a lot of depression that's associated with it because the normal amounts of dopamine that aren't being given through the drug aren't there, and our brain has an amazing, tremendous capacity to recover and bring back the normal levels of dopamine but it takes some time. So when we think about addiction, we're talking about something that -- it's controversial to be called a brain disease but it really is something that affects the brain. There are lots and lots of reasons that people use drugs, and it could be, you know, people start off experimenting, but a lot of times it's in response to coping with stress, there's coping with stress related to trauma, there's self-medication.

We know that if you're using substances as an adolescent you're more likely to actually use as adults and become -- develop substance use disorders. We know that people are prescribed opioids and take them as directed. And a lot of times we'll hear people say, oh, they were prescribed an opioid and through no fault of their own they became addicted and they turned to heroin because it's cheaper. That happens a lot. We don't know who we're prescribing to so if we prescribe to people with lower levels of depression or anxiety, anecdotally people will say when I took the opioid I felt normal. If you go through your life maybe not feeling quote unquote normal and take a substance that makes you feel normal you want to keep doing that. You feel normal, and also your brain is being flooded by this pleasure reward constantly. So it makes sense why your brain starts to become really used to that. And then what happens with drugs when we're thinking about addiction, the drugs essentially hijack the brain. So we hear a lot of why are people using drugs or choosing to use drugs over taking care of their responsibilities, going to work, going to school, taking care of their kids, paying their bills? It's not that they want to be addicted, it's not that they want to shirk all of their responsibilities, it's essentially that their brain is driving the train here, and it's saying go get the drug, go get the drug, go get the drug because it's really -- the drugs take over the brain. Again, we have a tremendous capacity for recovery, but just saying that it's a moral, you know, some people are choosing this, it's something they want to do is not fair because when the brain becomes dependent and people become addicted it really is something that's happening a lot. So their brain's telling them to do this.

And we also know that, you know, with domestic violence, that another reason people use is sometimes they're coerced into using. So they may not want to but their partners are coercing them to. And so generally people don't want to be addicted to drugs. It's not something they want to do. They almost always are saying I hate this, I want out of this life. But you get caught into a cycle so it's very, very hard to get out. And this slide, I wanted to put this up because the director of the national institute on drug abuse, Dr. Nora Volkow said in all my years as a physician I have never, ever met an addicted person who wanted to be an addict. People don't want this. It's something that happens, it can spiral out of

control, and then people find themselves in a situation where they don't know what to do. And if they don't have the resources to get help it's very hard. Even when they do have the resources it's still very hard.

The other thing about this slide that I wanted to point out is the term -- and it was in the video as well, we use the term addict. And I think in many fields we're thinking a lot more about how do we talk about people where we put the behavior first and not the person. So the term addict is a term that I as somebody who's not addicted or not in recovery do not use. If people choose to use it about themselves, that's okay, but I talk about I think language is incredibly important so if we're thinking about addiction we want to talk about somebody who is addicted or who is struggling with addiction.

So just -- that's to give you a little background about addiction, what's going on in the brain, what's going on sort of in the lives of people who are addicted. And I just want to give you a little bit of background about how prevalent this is in the United States. So we know that 11 1/2 million people have misused a pain reliever, this was in 2016, people 12 and older. Misuse means they were using somebody else's prescription pain relievers, they were using their own but at a higher dose than they were recommended or they were buying on the black market. But we see that, you know, this is a very large number of people. And -- who are misusing pain reliever, primarily opioids. And we see there are a lot of people, too, who both are misusing pain relievers and heroin. So just so show you that almost 12 million people are misusing opioids, were last year.

And again, we've heard a lot about the opioid overdose deaths, and we see that even just from in the last 15 years how this has skyrocketed, and it's -- we see it with synthetic opioids, fentanyl, heroin. And you notice that prescribed opioids as I said earlier, it's higher. The opioid overdose death is higher with pills than heroin. We're seeing a difference now with fentanyl. Fentanyl is outranking that. But so here you see now, even in 2016 what a sharp spike the synthetic opioids have. But this is just to give you a picture of what's going on in the country with respect to overdose deaths.

We also need to think about how this is affecting different communities. We see that -- so this is a few years ago. We see heroin and opioids largely affecting white communities. It's still very much a problem in other communities. Native American in particular for opioids in general. And it's interesting, just to say we need to understand where disparities exist is well just in Massachusetts we have an incredibly high overdose rate in Massachusetts where I live, and the -- what I heard on the news last week, that the rate of overdose death is actually going down compared to 2016, it's lower right now in 2017 than we were in the same time last year. However they were noticing that -- that's just in the general population. However in Latino communities they're seeing there's almost a doubling of overdose deaths. So we need to think about where our community's being hit the hardest and where are the disparities with respect to who's being affected.

Again, just to show what the drastic increase. We see in non-Hispanic white populations the increase from 15 years ago has just -- it's gone sky high. So we're seeing it a lot in white populations.

And this is also by age. We see that for heroin we have highest in the 25 to 34-year-olds, but it's still, you know, getting sort of mid-older. And the opioids are affecting older populations as well. So the highest prevalence is 45 and older.

We also know that there is a huge correlation with drug use and opioid use and domestic violence. So we know that women in particular if we're talking about women with opioid use disorders, which means that they have met criteria for an opioid use disorder which used to be called drug dependence or drug abuse, it's now called drug use disorder from the diagnostic and statistical manual 5. Women with a disorder have an increased risk of victimization. It could be that this increases the risk for victimization or the victimization may lead to opioid use disorders. It could be bidirectional, and it's also cyclical. If you have an opioid use disorder you're victimized or and then you want to use to deal with the pain associated with that. So it really starts cycling.

And we also know that this is data from the substance use coercion survey from the national center on domestic violence, trauma, mental health and the domestic violence hotline. About a quarter of participants were using substances to reduce the abuse pain they suffered. Over a quarter were pressured, forced to use substances by a partner or ex partner, and 15% tried to get help but of these, 60% had a partner trying to prevent them from getting help. So we see how substance use affects domestic violence and how domestic violence affects substance use.

So what does this all mean for children? Many of you may be familiar with the social ecological model. Just to say that we are all individuals nested within our larger social contexts. Kids are nested within their families, they're nested within their peers, within their social networks, within their social media networks, their organizations, their schools, their community, the policies that we enact affect all of us. But we need to think about how kids and young people in general are affected by these larger systems that they live within. And the younger you are, the more that the family environment in particular affects their behavior, their health, and their outcome.

So we know that children who live with at least one parent in the past year, with a past year illicit drug use disorder are -- I'm sorry, we see that we have a large number of people who are living with a parent with a drug use disorder. And we know from other research from Morton and Wells that recently came out that living with a parent with opioid use disorder increases a lot of negative outcomes. So there are an increased risk of externalizing behaviors which is meeting diagnostic criteria for a disruptive disorder or delinquent went behavior. We know that living with a parent with an opioid use disorder has an increased risk, these children, of internalizing disorders which is mood disorders, anxiety, depression. So this is about a quarter to a third were characterized as having internalizing disorder. Living with a parent with an opioid use disorder has -- is associated with a reduced chance of being functionally resilient so only one quarter of youth met the criteria for this functional resilience, employed or enrolled in an educational program, no lifetime substance abuse or dependence, no adult criminal charges in the last five years. So it has such an impact and strong correlation of increased risk of illicit drug use themselves. 50 to over 50% of youths in this study had a substance related problem. And we know that living -- that having a parent who has a substance use disorder, that is a big risk factor for young people also developing substance use disorders.

So when we think more broadly about risks for substance use among youth because when we see it in parents, the risk is so much higher for children for a few reasons. One if it's a biological parent there's a genetic component absolutely where the risk is higher if you are genetically linked. It's also modeling behavior. So children see parents using substances. And whether they think it's wrong or not, a lot of times they will go down that path even if they think I'm never gonna do that.

Then there's also living with a parent with a substance use disorder may be related with trauma, abuse, neglect, embarrassment, there's a lot that goes along with living with a parent with a substance use disorder so because of the underlying risk factors as women. This isn't to demonize a parent. With addiction there's a brain component. It's something that's happening. But addiction does go along with a lot of other traumatic experiences as well. So the risk for substance use among youth, we know that substance use in adolescence interferes with the brain development process so it's really important that we're mindful about when youth are exposed to trauma that if they're turning to substance use, the earlier they start the worse their outcomes are with respect to becoming dependent or addicted to substances themselves.

We know that living in adverse family conditions is associated with substance use. We also know that peer networks of peers who are also using substances is a big determinant of whether young people will use substances. If there are problems in the home environment and they turn to peers who are using substances, that also increases the risk. Also, we know that individual social factors are important determinants, socioeconomic status, social support, other important people, adults in their lives whether they are or are not using is a risk factor or protective factor. Nine out of ten people with substance related problems started using by the age of 18 so that's 90%. So if we were able to sort of push the number of people or delay the initiation of use, we'd actually see a lot fewer substance use disorders but this really has to do with the way the brain is developing. So around puberty the brain starts going through a massive restructuring where the parts of the brain that young people are using really start to get hard wired into the brain, and the parts that they're not using, they get it's called neural pruning, the connections aren't made or are weakened, and they go away. So if young people are engaged in academics, playing a musical instrument, sports, and those are the connections that are getting hard wired. If they're -- and they're not engaged in substances during the time that the brain is really going through this restructuring which happens from puberty till the mid-20s, it's protective so they're not going to start developing these connections as much. If you start seeing young people using substances at a young age and less engaged in the other activities of their live, academics, less engaged in communal events like sports but using substances, those are the connections that start getting hard-wired. So it's not impossible to achieve recovery later in life but your brain becomes more hard-wired to want to do those things. So what we see is that -- oh, I'm sorry, there was supposed to be a slide here. So what the image that you can't see which I apologize about is that there is a dose-response relationship between starting drinking even alcohol before the age 14 and the risk of using illegal drugs or becoming dependent on illegal drugs when you're older. So compared -- so about half of those who start using alcohol before the age of 14 are using illicit drugs as they get older, and 17% are -- meet criteria for a substance use disorder with illicit drugs compared to 1% of those who start after they're 21. And a lot of that has to do with brain development.

So with respect to exposures, and what increases the risks for children, many of you I'm sure are familiar with the adverse childhood experiences study and just adverse childhood experiences in general where the original study which was conducted in 1998 with 17,000 members of Kaiser health plan in San Diego where they -- all these people filled out a survey measuring the number of adverse childhood experiences on these traumas seen here. Then the number of categories they were exposed to. It wasn't the frequency or the severity within one category but it was the accumulation. And so then they connected the number of ACEs, adverse childhood experiences, with later health issues. So we know that if a child is coming in with -- is a child survivor of domestic violence but also had been living with a parent with an opioid use disorder whether it's the parent who comes in with the child or if it's the offending partner, doesn't matter if they're exposed to that, you can see on the right, that's already two ACEs. If there's substance use disorder, and there's also violence, you can assume that there are probably other ACEs that are going on as well. These were all asked before the age of 18. So we see here that there's a dose response relationship with ACE score and drug use and substance use. So I'll show you some slides as they relate to ACEs. So for this, teens exposed to ACEs are more likely to start drinking before 14, drank to cope during their first year. This is for each additional ACE we see an increase in the percentage of people who had started at a young age.

We also see that ACE score, again, that those response relationship with ever having a drug problem, ever addicted to drugs, ever injecting drugs. So the more ACEs somebody has, the higher their risk of having these problems. And again we see here with injection drug use. So 4 or more ACEs has a higher percentage of people had injected drugs.

So what does this all mean? How do we help the next generation? So we know that children of parents who are addicted have a much greater chance of addiction and children of parents who are incarcerated have a higher chance of incarceration. There's modeling going on. We know that when there's trauma there are coping strategies. So what can we do to help bring kids on a path of resilience rather than straight risk given the fact that they are faced with a lot of risk factors?

This next slide is a slide about treatment and treatment services but that's not why I wanted to show you this slide. On the inside of the slide it's all about treatment and how substance use treatment would be considered. But the reason I put this slide up was more about the external ovals. Those ovals are representative of even when somebody is in treatment for a substance use disorder there are all these other factors that really need to be considered when thinking about it.

So they -- we need to be thinking about what are the child care services, vocational services, legal services. There's often legal trouble. All of these things say that these are the contexts that people who are trying to get into treatment or who are addicted have to contend with. And these all affect children. So we need to be aware of what goes into substance use disorders and addiction as well as treatment for parents. And there are some strategies that we can think about when we're working with youth. So just to leave you with some ideas of first of all, before even thinking about working with youth, we have to be aware of our own personal biases around addiction. Addiction is one of the most highly stigmatized diseases. It comes with a lot of pain, trauma and a lot of stigma. I recently was working with people who injected drugs and talked to them about their hepatitis C testing experiences,

and across the board they talked about the stigma they felt from health care providers specifically there to help them so we have to know our own biases around addiction. It's everywhere, so if we are able to think about it and check ourselves, it's really important. We also need to recognize that youth may be using substances themselves as a way to cope with the trauma that goes along with addiction and also domestic violence. So that's -- you know, if we just go in not thinking about that, not asking the right questions, we might be missing something. We also need to think about for intake questions, what are we asking? Are we asking the right questions and how are we asking them which comes around to our own personal biases.

We need to make sure that youth are connected with services and care, and we need to think about it not just in the short-term. If we're thinking about somebody is working in shelters and working with people who come to shelters and they bring their children, we may want to consider groups for youth in shelters because the youth will definitely be very strongly impacted by everything that's going on. But we need to be thinking about helping youth acutely but also in the long-term. So what does that mean in terms of prevention strategies? What does it mean in terms of working with youth around resilience, recognizing that trauma is there and trauma has so many negative outcomes both with respect to substance abuse and other behavioral health outcomes as well as other physical health outcomes. So the more that we can be thoughtful and inclusive around youth, and recognizing that they feel this in so many ways, it's really important moving forward.

So with that I will turn this over, and I appreciate your thoughts, and I'll be able to answer questions at the end.

>> Great. Thank you so much. And that is our background on the issue of opioids and how it affects kids and how it affects the brain. I'm now going to turn it over to our next presenter, Tanagra Melgarejo who is going on tell us about her work at the Harm Reduction Coalition and really give us some concrete strategies on doing harm reduction with kids and survivors who may be experiencing opioid addiction. Tanagra, I will now turn it over to you.

>> Thank you so much, thank you, doctor, for your amazing presentation, I learned so much from listening to you. And I am humbled and honored to be part of this webinar. I work for the Harm Reduction Coalition, an organization that is national with an international impact. We were funded in 1993, and it was funded by drug users for drug users. And we are committed to challenging stigma, the persistent stigma that people that use drugs face as well as providing advocacy around policy and public health reform. We also have a capacity building team that is committed to bringing harm reduction to communities that want to start implementing it. And so for me, I feel really passionate about harm reduction because in many ways harm reduction saved my life. And I feel that I was extremely lucky when it found me, and I have been a passionate advocate ever since. In the work that I did in Puerto Rico which is where I am originally from and where I lived for the past 13 years before moving back to the United States I worked with survivors of gender-based violence, and I found that even though our program was not a harm reduction focused program that I was excellenting and using a lot of the -- implementing and using those principles, and I learned a lot. I hope that I can share a little bit of that experience with you all. Hopefully this will be a taste. If you're not familiar with harm reduction it will

make you look for more information with how you can continue to implement that in the work that you do. Harm reduction is a really practical, concrete set of strategies that help us reduce the negative consequences associated either with drug use or sex work. One thing that harm reduction does is that it really recognizes that folks have the power to make changes, and that the reason that sometimes they have a difficulty enacting or carrying out those changes is because there's structural barriers present in their lives that won't allow them to do that, that don't allow them to be as healthy as they can be, don't allow them to be treated as human beings with the respect and dignity that they do. As we look at drug use, harm reduction poses or presents us with this idea that we can look at a different spectrum of strategies in terms of drug use. Every individual we meet is different and their drug use will be different. In the media we see folks that have representations or in the media we see that drug use is extremely chaotic. That's a reality for a subset of people. For the majority of people they are within a spectrum of drug use, right? We can also look at drug use in terms of some folks for what harm reduction may mean in their lives, in their relationship with drug use that they can engage in safer use. It may mean for someone that injects drugs that they the not share needles, that they will every time use a different needle to inject. For someone else safer use may be they will try their drugs before they use them, they will do a test shot to make sure that the drug, it's not going to lead them to an overdose. Managed use means for someone instead of using ten bags of heroin maybe they will start considering using five or that for someone who has a problematic relationship with alcohol, that instead of starting their day by drinking, they will consider drinking after 1 o'clock in the afternoon. And we have abstinence which means when a person chooses not to engage with a particular substance that they are having a problematic relationship with ever again, not touching the substance again. Some define abstinence different. Some had problematic relationships with heroin or opioids and found that using cannabis or marijuana has helped them in their problematic relationship with heroin. For some folks if they hear that they think that's not abstinence because you're not abstaining from every drug. They will say my problematic relationship was with opioids, not with cannabis, it has helped me with my problematic relationship with heroin, and I feel healthier, that I can engage with my world and life differently.

The other thing about harm reduction is it helps us meet people where they're at. That means that we're going for connect to that person and listen to that person, and that person is going to help us support them in their process, they're going to be leading us along the way, telling us what they think works for them, what they think they want and they need but we don't lead them there. Our goal is to accompany them without judgment, without stigma through their process that they define to be the best self that they can be. My coworker Emma Robert says that harm reduction is about making sure people are in tip top shape. And they get to define what that tip top shape is. Harm reduction is also risk reduction because we are having conversations about the dangers of drug use and finding ways in which we can lessen or lower those dangers, and those risk-taking behaviors that sometimes come along with the drug use. In order for us to do that we need to be holistic. And that means as Dr. Skeer was saying when she presented that last slide in terms of substance use, that have the circles, right, that we need to look at the whole person, understand the context where that person is coming from, who is that human being, what are their dreams, goals, aspirations, challenges, their struggles. What is their immigration status, economic status, gender status, are they employed, have they been in prison, survivors of trauma or violence, how it impacts their lives or drug use. And it calls for us to look at drugs

and drug use through a lens that includes the drug and the setting so I need to be able to hear from that person and know what drug are they using. Heroin? Methamphetamines? Synthetic opioids? Is it pills? Is it cocaine or crack cocaine? How are they injecting that -- using that drug? Are they injecting the drug? Are they smoking the drug? Are they inhaling the drug? Are they taking pills, for example, orally? What is the set? And the set is the person, who is that human being, what is the reality of that person. Do they have mental health conditions, physical health conditions? If they're young adults or young children do they come from a background where they have extensive drama and violence? Are their parents immigrants? Employed? What is the reality of the person and the setting. Is the person housed? Precariously housed? Is the person houseless, are they in a shelter? Did they have to move from the place that they used to live to a new place so they have been uprooted, and they have had to leave behind their friends, their family, the things that they care about? Those three things, if we look at the person through that lens and engage them in a conversation, if we can get responses for those things it can help us support that person. We need harm reduction as Dr. Skeer said because we need to have an efficacious response to the disproportionate disease that comes from drug use. If we don't do that, the reality is we're going to continue at this cycle, right? We've tried things and realized they don't work so harm reduction says to us we can do things differently. And we have evidence based documentation that shows that harm reduction works. Harm reduction allows us to reach folks that are really vulnerable. Harm reduction to me is a strategy that I use to reach people that are really, really hard to reach, and sometimes we forget that they exist because of their invisible lives. Drug use is highly stigmatized and dears and carries a lot of shame from people. I know from myself the shame and embarrassing that I felt and how it was an obstacle for me to seek support, to seek services, to seek services. Harm reduction because it's nonjudgmental, because it's rooted in the person, allows us to connect with them in a space of love and transparency so people can tell us what they need and what they're struggling with and we can listen. Since harm reduction doesn't judge it allows us to engage when folks relapse and haven't he chosen abstinence. For many folks relapse means they will lose services, that they will lose connection to their kids or to their families. That is really painful and scary. That's why sometimes or many times folks that relapse or lapse choose not to speak about it because they know the consequences, and they know that those consequences are going to be really painful for them. And damage fog them. And so -- damaging for them. So I think in part one thing that I would encourage folks to think about is how to open the door for a conversation where people can look at relapse and lapse, the consequences of those things and think about tools and skills-building that they may need so that if they feel they're going to encounter themselves facing relapse or lapsing that they can have those tools to use so that they don't engage in a behavior that could potentially lead them to consequences they don't want. The benefits of harm reduction, it helps us challenge stigma and engage in a conversation about how that stigma looks and feels for people that use drugs, particularly around a language. And the way that people that use drugs are perceived and represented in society. It also is a benefit because it helps us increase trust with our clients and foster engagement. Harm reduction causes us to be transparent and honest about consequences and accountability and responsibility. If we start from that point that participant will know what they can expect from me as a provider and hear from me what I can do and not do for them and what are the expectations and rules and regulations of the program so that if they find themselves struggling with those we can have a conversation about what it would mean to break them but also how I can support you not to break them. And finally, you

know, harm reduction helps us improve public health not only at the individual level but also community-wide level, and it opens the door for a more honest and honest parent conversation. I'm not going to go too much into this but harm reduction is also a really practical tool to use when talking about safer sex and the risks associated with different sexual behaviors. One of the things that I find is that for folks that have a difficulty addressing this issue, using harm reduction framework really helps to open the door for a conversation and for people to reflect about what those behaviors may be and how they can make themselves behave healthier.

Some things health reduction is not. One of the things we have struggled as harm reductionists or being in this movement, there are a lot of misconceptions about what harm reduction is so I I can clarify. It doesn't mean anything goes, it's not permissive. Harm reduction is based and centered in personal accountability and responsibility. I am responsible for my own personal change. I am responsible for my journey, for my process, I am the one guiding it so therefore I need to make sure that I really look at myself and find the things that I need to do and then how I can do those and seek the support that I need and want in order to transform that.

Harm reduction go does not enable drug use or high-risk behaviors. In fact we are constantly talking with participants about the dangers of drug use and risky behaviors and how we can minimize those, how can we create protective spaces for people so that they don't have to engage or do the things that are hurting them. So we don't condone or endorse drug use or sex work, and we don't exclude or dismiss abstinence based substance treatment as a viable option. In fact it's one of the things that, you know, we believe works, it just means it doesn't work for everybody. Harm reduction is not a one size fits all. Harm reduction is a space where we look at individuals and their own live, struggles and strengths. So abstinence works for a lot of folks. For some other folks it may never work. For others it will work but the journey, the path, the walking along to get there will take longer, and it's going to be different for everybody. There are contributing factors and harms that we encourage folks providing services to really have conversation with the participants about these things. I'm sure some of you have probably thought about this as well. When we look at a participant and that set we need to ask ourselves, what are some of the contributing factors or harms they may be facing in terms of their physical health. Have they experienced violence? Have they experienced an overdose? Do they have poor health outcomes or health conditions impacting them? What is the psychological impact of the reality that that person is facing in their lives? Are they experiencing depression? Are they isolated? Do they struggle with stigma? What are the social relationships? Sms connected to the psychological aspect. For some who use drugs they have a lot of community or isolate from their community because of that shame and that stigma that they carry. Are folks struggling with economic issues? How do they find the money to acquire the drugs? This may be useful to open up a conversation about risk behaviors. Some who acquire money to use drugs may engage in behaviors that are not as healthy and safe as they would want to be. Are folks unstably housed or not housed? Did they lose their house because of their drug use? Is their drug use preventing them from finding work or engaging in employment? Finally, legal aspects that are so important, and sometimes one of the biggest barriers for people to feel that they can transform their lives. In legal aspects I want to mention immigration status as a barrier that folks face and encounter when trying to engage in services. So if I am someone whose

immigration status is not clear in this country and is engaging in drug use I may feel really scared about reaching out and accessing services because one of the consequences could be that I may be deported, we've seen that in the field of domestic violence, folks that are experiencing domestic violence may not necessarily seek the remedies that they could potentially have access to to make themselves be safer because they know that those could potentially also put them at risk of being deported. There was a case in Texas of a woman who went in to seek a protection order from the court. Her ex-partner who abused her knew she was doing that so he called I.C.E., told them she was in the courthouse seeking a protection order and she was someone whose immigration status was not clear. She did get the protection order but she was also then arrested by I.C.E. and was then put in a detention center to be deported so it's real, the fear that these people have. There are six principles of harm reduction. The first is that we should focus on the health and dignity of people. That should be the first thing. Harm reduction asks us to look at human beings and recognize their humanity and to treat them with the dignity and respect that they deserve. It also establishes that everybody deserves to be healthy and to be treated with love, appreciation and to be heard. I think that's the first step in terms of opening a dialogue with someone. For our participants, many of them who have struggled with substance abuse, experienced sexism, classism, homophobia, this may be the first time they're seen as human beings, experiencing a connection with someone there to listen to them and support them. That can be a really powerful space to develop rapport and connection with someone. The second principle is asking us to really consider developing participant-centered services that are nonjudgmental, noncoercive. Services should be participant-centered because we want them to be relevant to the people that we are working with. When I'm thinking about services around domestic violence or gender-based violence, one of the things that I want to know is what are the things that we are doing that work well, and what are we not doing that we should be doing. Are services representative of the population that we're working with? Are they in the language folks feel most comfortable speaking? Are we representing through our materials and other documents that we have the gender diversity, gender identity diversity or sexual orientation, the diversity of those in those documents, in the pictures that we have on the walls, in the way that we speak to people, so that they feel that they are seen again and that they're being heard.

We also, in order for us to do that, to have participant-centered services, makes sense for us to involve participants in the creation of programs as well as policies, right, that are designed to serve them. And so this may prove challenging, you know, for some of us that are working in programs that have been in existence for a really long time, and participants may not necessarily have been there in the process of creating, developing the programs and services but there are other ways in which we can engage people, our participants, to hear from them, what they would like to see if we're not doing some of those things. One of the things that we did at the program I worked in in Puerto Rico was we had several times a year informal focus groups or conversations with program participants designed to help us evaluate the program and to hear from participants the things that they thought were working well and those that they thought were not necessarily the best that we were doing. So we ensured for that to happen that, A, we had child care, B, that we did it in a time of the day that participants could come that wouldn't interfere with other things that they were doing. We ensured that we had food and as well as some types of stipend to provide them for their time. So, you know, when they came in, you know, we asked them questions, and we heard from them, and then we committed ourselves to

implementing some of their recommendations that, you know, were realistic for us to implement. The ones that weren't realistic we spoke about maybe what at that time they were not something that we could do but work on, and also maybe think about how we can make those things happen. For example they wanted us to have a traveling van that could go around the cities, 74 counties in Puerto Rico. That was not something realistic at the time that we did that evaluation. So one of the things was we need to think about how we can make this happen, seeking additional resources, asking for grants. So this is not something immediate but something we're going to think about for the long-term, for the next five years.

Participant autonomy. People that use drugs are the primary agents of change. The person who's sitting in front of us is the person that knows what they can and cannot do, and they should be the ones guiding the process when it comes to us providing services. Sometimes what happens is we care about people, and we want people to do things in a certain way because we think that's the way it works but what works for me, Tanagra, doesn't necessarily mean it's going to work for someone else. In order for the space to be productive and for that person to be successful we need to make sure that the person has the capacity to determine what's best for them. And so in harm reduction, the person who is receiving the services is the person that is driving the process.

Sociocultural factors, we need to look at race, gender, sexual orientation, gender identity, class, how those interact in that person's life, immigration status, how are they creating barriers to access services or seek support as well. And finally pragmatic and realistic. There are real and tragic harmful consequences associated with drug use. We are constantly talking about those, and we don't promise something we can't provide. We're realistic about the things we can and cannot do and are transparent with program participants making sure they know and are aware of the scope of the work and our capability in terms of how we can engage with them. And if I can do something because it's not in the scope or capacity of the program I always make sure that I was able to link that participants to someone that could. That meant to me I had to do the research and know who in the community also provided services from a harm reduction lens in terms of healthcare, in terms of legal support, in terms of housing so that I could connect that person to those services.

Now we're going to look at harm reduction we can apply it when working with folks that are survivors of domestic violence and with their children, right, if they're parents and they have kids who may or may not have used substances.

So one of the things that we need to ask ourselves as providers in the context of providing services for folks who have experienced gender-based violence, before they enter, look at our intake process and the questions that we're asking and make sure we're asking the right questions and questions that help us hear from our potential participants if they're using or not using substances than add why is that. Because if I'm having someone come in the shelter who has had a history of trauma and domestic violence and it may mean that that person has dealt or has used drugs to self-medical indicate and to -- self-medicate. If I don't ask I may be avoiding factors that may be, if I don't have that information, it can prevent me from providing the best services that I can. If that person is currently using drugs, I want to know. What drugs are they using and how are they using them. A, I want to support them in preventing

overdose, and B I want to know as a provider if I have the skillset and tools to support that person. If I don't I can connect them to the services that can support and help them to be safe and healthy. Also our first impression. When those folks walk through the door are we demonstrating that we're willing to talk about and support folks that use drugs? That may mean through our materials, language and through our narrative. One of the things I realized in Puerto Rico that we were not doing that. We used stigmatizing language when addressing drug use, that we did not have anything in our forms, intake that spoke about overdose prevention and education, that we did not really engage folks to ask the questions if they were using drugs or not. The reality was we had participants that were using drugs. We were not serving them as best as we could because we had ignored asking those questions. We had to rethink that as a program and completely redefine our intake forms to allow folks to have conversations with us instead of it being a one-sided interview process. For them to feel comfortable in sharing information knowing that we did not stigmatize them, judgment or prevent them from accessing services. And if we couldn't provide the services there that we could connect them to someone that could that worked from a harm reduction perspective as well so when they came back to us, if they did, that we could then work with them.

While they're at shelter, these are things we can do. I would encourage folks to use a tool that has harm reduction persons we use which is motivational interviewing. It asks us to look at the person and ask ourselves, you know, where is that person at and what are the questions that I can ask to elicit from them the information that I need to support them. Motivational interviewing looks at the participant as the expert. You ask questions, and most of the talking is done by the participant, not the provider. It's also an excellent tool to help us bridge dissonance. They want to stop using substances but they continue to use them chaotically for example. So I hear you saying that you want to stop using X, Y or Z substance but I see that you actually used this morning so let's talk a little bit about that. What's happening? Then that person can hear what they've said to you and say oh my God, yes, I want to stop using but I'm having horrible flashbacks to an experience with trauma that I had. Substance use has kept me alive. Otherwise I would have killed myself because of those memories. Motivational interviewing is a good rule and is rooted with the stages of change which is also an excellent tool that folks can use. While they're at shelter we should look at our services and our programming and really consider if we're not doing this to provide them through a trauma informed care lens. It's powerful when we engage with folks and we recognize the pain and the suffering that people carry because of their experiences with trauma, and that trauma for many of us is ongoing, it's not something that I can switch off and on, it's there, it's latent, and I will react in a certain way if I am having a recurrence of my experience with trauma, right? So understanding that, normalizing that, giving language to the person so they can speak from a place where they know we're recognizing the impact of that trauma and providing tools for them or navigating those tools with them can be really useful and productive in moving people -- or helping people move to the places they want to get in behavior change. Finally, overdose prevention education. We're seeing a lot of people that are experiencing overdoses in shelters, and folks at shelter don't have the tools to support them, and so part of it is assessing ourselves as if we're in shelter or providing those services to say, A, do I know what an overdose is, B do I have the resources to address it if it happens, can I have this conversation with my participants so they don't feel fearful or afraid to say they need support with this. I'm going to talk about overdose prevention and

harm reduction. There's a medication, N arbitrationloxone super effective in countering the affects of overdose. It can use for heroin as well as fentanyl and other substances opioid-based. Naloxone is the opioid bully, right? It gets in there and gets you 20 to 90 minutes to make sure that you can help that person become stabilized and get the services that they need. So one of the things that I would recommend to people if they, you know, haven't done so is to explore the possibility of becoming trained in administering Naloxone. It's super simple to do, it's something that anyone that goes through an hour training can do. We here in the Harm Reduction Coalition train people in San Francisco and the bay area to administer it to people if they are in the face of an overdose. If you administer it to someone and they're not overdosing, they don't have opioids in the system, they won't be hurt, it won't do anything to them but in fact if they're in the throes of an overdose you will save their lives. And it has no potential for abuse, wears off between 20 and 90 minutes. So our recommendation is you're administering it to someone, is to administer it, call emergency response services to make sure that then the person can be taken to hospital if necessary to be stabilized. Also it's important to make sure that that person doesn't use within the 20 to 90 minutes when they come back because they still have opioids in their system, it's just that we have stopped momentarily the impact of those in their brain.

One thing is I know folks are listening to us from many different parts of the country. Each state has different regulations and laws when it comes to prescribing and/or administering Naloxone so if you're interested in becoming trained or having it at your shelter and providing it to people, as well as exploring the regulations to how they would look in your particular state, Eliza Wheeler, her work is just to do that, she's brilliant, has been doing this work for about 20 years, she has a wealth of knowledge so I encourage you to email her, wheeler@harmreduction.org, she would guide you through this process if you wanted.

Another recommendation, before folks leave, what tools we want them to have in their tool kit so we know they're ready and prepared when they're leaving us to continue moving in their process. That would be maybe, you know, information around other harm reduction services. It may mean information about safer use or managed use. It may mean a connection to a harm reduction program. It may mean information or a connection around how to best address mental health conditions and issues that are occurring as well as substance use. It would be good for us before folks leave to review an overdose prevention and information materials. So that we know that they're prepared so if they use before they came to us and they pick up again that they have that information with them that can potentially save their lives. And I think one of the most important things is that we make sure folks are actively linked to support at harm reduction services. You can find them in all the areas, you know, like housing services are supportive that are harm-reduction based. Youth services that are harm-reduction based. When we're looking at working with youth particularly, you know, we need to know that we need to use different strategies to engage with them, and that what works for adults may not necessarily work for young people, not for adolescents, teenagers or young people. We need to know the population we're working with, where to connect them. To make sure we're connecting them to providers that really know the work that they're doing and that can continue to build upon the amazing strategies that you develop with your participants.

So this is my piece. I really thank you for listening, and I'll be happy to answer questions.

>> Great. Thank you so much, Tanagra. From both your presentation, from Margie's, it's so clear that this -- the need for linkages between services to better support survivors and their kids, and in approaching it from a nonjudgmental way and using a variety of strategies and by supporting the survivors of domestic violence, we are also supporting the kids.

So we had a couple questions. One was around the effects of the legalization of marijuana. And does that lead to an increase in opioid use and abuse. And I would say that Margie answered that a bit in the chat but if you want to give a quick answer to that so everybody can hear, that would be great.

>> I, you know, I know that there are studies that have been done. We're not sure that there's -- that marijuana could be a gateway drug, right? I think we need to look at social factors and the structural factors that lead folks to use substances, right? And that probably, for example, for in my experience, you know, I -- marijuana was never an issue for me, you know? I, you know, my issue was with alcohol use, for example, and that came from a particular compulsive relationship at my house, my childhood, my family, right? It's thinking about what does that child's family look like, what are the access to services that they have, how does racism, classism play into that person's life, right? I think that there are studies, I'm happy to provide links that are sort of challenging that idea that legalizing marijuana can lead people to then use other substances. And I can send them to you if you want, and you can provide them to folks if they want to read them. I do know that marijuana has been helpful in addressing folks' opioid use so -- it's a harm reduction tool for many people, so it's the reverse in our experience with folks that have had opioid use and found that cannabis has helped them to be healthier and actually not use opioids anymore.

>> Great, thank you. And Margie, I don't know if you want to chime in on this one as well?

>> Yeah, I mean, I answered it in the chat. The question was also, you know, sort of from a population perspective, will it be helpful in terms of helping to reduce the overdose death rate by opioids. And I think the jury's out at this point. I think as Tanagra said, for many people it might be an important tool for them to actually get off of opioids or, as I said in the chat, some people who are on medication-assisted therapy like methadone will continue to use marijuana because it helps assuage the anxiety they have from opioid dependence. That's a harm reduction perspective, and some clinicians will be okay with that, some aren't. I think you need to work with people sort of where they are. From a population perspective I think really the jury's out. We don't know if it's going to be the answer to the opioid epidemic. I think a lot of people are hopeful, but there is some evidence that -- from the study that just came out, the data were older but showing that actually marijuana use is associated with increased use of opioids, and also the stuff coming out of Colorado, I feel like people think it's too early to tell if it's actually causality. It may be related to other interventions happening at the state level with respect to opioids rather than the fact that marijuana is legalized but I think it's important for us to have an open mind about it. We'll see what happens. And I answered a couple of other questions but one question that we talked about yesterday in our smaller group was about offering guidance about how a child welfare worker can assess the best interests of a child living with a parent using drugs.

>> Actually, you know, I feel like we were talking yesterday about how our work sometimes is siloed, and I think they have been siloed in our harm reduction bubble. And we sometimes connect to people because they are either working in drug treatment centers or they're engaged in mental health treatment. But we're not really sometimes reaching out to folks that are indirectly engaged with participants or with the children that are participants so I think harm reduction is a tool that we can use. I think that the challenge is that when we're thinking about Child Protective Services as someone who's a social worker, in Puerto Rico we have a mandate to report. If we perceive that the child is in danger, right? So one of the things that I, you know, did was ask myself let me look at the situation, and look at the situation from a lens where I lift out the drug use. So I will look at the situation as if this parent -- I was looking at the same situation but with a parent that wasn't using drugs, and I was honest about whether or not I would react and address the situation in a similar or different way. And my reality was that sometimes our prejudice and our judgment comes in, and that I would probably react in a harsher way when it was a parent actively using versus a parent that wasn't. So that's one thing for me that was helpful for me to do, to look at the situation from a different lens to see how I would address it.

Then the second piece was to engage with that parent that was actively using, and to -- a lot of parents that I worked with that were actively using were extremely amazing parents, and their kids were loved and cared for and did not experience insecurity in any way. And this may be -- people may think that it's not true, but it is, you know? And they would never -- they had food, they have housing, they were loved, they went to school, they didn't -- you know, their parents were present. They happened to also use drugs. There were kids whose parents didn't use drugs who experienced tons of violence and drama. If we're engaging with someone using drugs, see how is that drug use impacting the lives of their kids and being transparent about what you as a worker can or cannot do and what you're mandated to do. I am a mandated reporter so if you bring something up to me, and I see there's a danger I will have to address it. And I need to be honest about that but I'm also here to support you in your process. If you want to address the issue before it becomes dangerous I can also do that as well. That meant that I left that door open for that person to come in and tell me I am really struggling with sobriety right now because I am having horrible flashbacks, and I feel like I want to pick up by I haven't done so because I don't want to losing my kids, and I need help. That made a difference because they came before they did something that could be potentially dangerous to their process for support, and I provided for them. If they picked up they knew what I had to do. But that didn't prevent them from coming to seek support because they knew they would find someone who wasn't judging them and that was really also honest about the scope and the limitations what you could do. I don't know if that answers the question, but I think if we come from a place of nonjudgment and honesty and transparency we can engage people in a much more effective way than if we immediately lift up a wall.

>> Great. Thank you. And we are officially out of time, and I want to give our deep appreciation to our two expert presenters, thank you for sharing your time and your expertise and your knowledge. On this important issue. So --

>> Thank you for having us.

>> Thank you.

>> And thank you for everybody that has attended the webinar as well. My colleague Mie has one very quick announcement before we officially end.

>> Thanks, everyone. So sorry to run over just by a little bit. As I promised at the beginning I wanted to prompt you to answer a quick survey. The link is on the screen, and when you exit out of the webinar you should be automatically taken to the website to fill out the survey. Your feedback is very important to us. We definitely use it to inform what we do in our future webinars so please take the time. We would really appreciate it. And all of the slides and the recording will be posted on the website after the webinar. So in a couple of hours. Thank you so much, everyone.

>> Thanks, everybody.

>> Thank you. Bye.

>> Bye.