Family-Focused Strategies for Addressing Opioid Addiction and Recovery Webinar

March 19, 2019

Presenters:

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Robyn Cenizal, CFLE, Project Director, ICF, National Resource Center for Healthy Marriage and Families
Christina Zurla, Partner, ICF and Public Health Communications Expert
Theresa Lemus, Director, Family Treatment Court Training and Technical Assistance Program, Children and Family Futures
Anne De Santis Lopez, Director of Family Programs, Shatterproof

Operator:

Welcome to the National Resource Center for Health Marriage and Families Family-Focused Strategies for Addressing Opioid Addiction and Recovery Webinar. Today's conference is being recorded. At this time I would like to turn the conference over to Jackie Rhodes. Please go ahead.

Jackie Rhodes:

Thank you and welcome, everyone. Thanks for joining us today for the National Resource Center for Healthy Marriage and Families Webinar, Family-Focused Strategies for Addressing Opioid Addiction and Recovery. My name is Jackie Rhodes and I will be helping with the logistics for the webinar today, along with my colleague Kate Dumanian and the Resource Center Director, Robyn Cenizal, who will be moderating.

Before we get to the content for today's webinar, we are going to go through a few logistical items. The webinar today will be an hour and a half ending at 3:30 p.m. Eastern Time. The webinar will be recorded and the slides, transcript and recording will be posted on our website in the coming weeks. Audio for the webinar will be broadcast through your computer. Please make sure your speakers and volume are turned on and up. If you have any technical issues, problem seeing something or hearing something, you can send us a message in the Q and A box on your screen or call us at 1-866-916-4672 and we'll be sure to assist you.

After the presentations today, we will have an online Q and A session. We encourage you to type in the questions you think of at any time while presenters are presenting by typing them in the Q and A pod located at the bottom right corner of your screen and clicking "enter." We will collect submitted questions and then address those during the Q and A session at the end as time permits. If your question is for a specific presenter, please reference that when typing it in, if possible.

Throughout the webinar, presenters may reference materials or links relevant to their presentations. You can browse web links by clicking on any of the links in the web links pod at the top right hand corner of your screen. And you can download material by selecting the downloadable resources pod on the right, the middle right side of your screen.

We are excited about the agenda for today's webinar. We're going to start with some introductions of our speakers. Next, I'm going to turn over the webinar to our Project Director who will provide a welcome and overview of the Resource Center. Then, we will talk a little bit about the opioid epidemic in general by setting the stage on the scope of the problem and then strategies for communicating to stakeholders.

After that, we'll hear more about a family-centered approach to substance use treatment and then we will have a program example, the Shatterproof Family Program, and we'll have someone from that program present for you and share more about their model, and we will end the day with discussion and Q and A.

Following the presentations, as I mentioned, we'll have an online Q and A session. When we close, a brief feedback survey will pop up on your screen. We encourage you to complete the survey to provide us with valuable feedback for improving future webinars. Once you complete the survey, you'll be able to download a certificate of completion for attending today's webinar.

So before we begin, I just want to briefly introduce our speakers for today's webinar. Robyn Cenizal is the Director of Family Strengthening with ICF and the Project Director for the Resource Center. Robyn will be sharing more with you about the Resource Center and will moderate the session today.

Christina Zurla is a partner at ICF and a Public Health Communications Expert. She has nearly 20 years of experience leading large complex public health communications campaigns that help federal agencies, non-profit organizations and private sector entities address some of our nation's most critical public health issues. She currently manages ICF's Opioid Communication Portfolio with clients including the US Department of Health and Human Services, the Substance Abuse and Mental Health Services Administration and the Centers for Disease Control and Prevention.

Theresa Lemus is the Director of Family Treatment Court Training and Technical Assistance Program at Children and Family Futures. Ms. Lemus is responsible for overseeing the Family Treatment Court portfolio that includes the US Office of Juvenile Justice and Delinquency Prevention, National Family Drug Court Training and Technical Assistance Program and the Prevention and Family Recovery Initiative. She's a nationally recognized expert in collaborative practice to improve outcomes for children and families affected by substance use disorders, family treatment court models and clinical treatment. She's also a registered nurse, licensed alcohol and drug counselor and a certified clinical supervisor.

And then last, but not least, is Anne De Santis Lopez. She is the Director of Family Programs at Shatterproof. Her personal and professional mission is to empower families and individuals living with addiction and a mental health diagnosis through education and support while connecting them to essential resources and skills that aid in recovery and healing. Before coming to Shatterproof, Miss Lopez was a key leader in developing and launching a statewide program of psychosocial educational family workshop in New Jersey. The program was built on evidence-based framework to educate loved ones of someone living with a substance use disorder.

To learn more about our presenters, I encourage you to download the speaker information document in the downloadable resources pod on the right hand corner of your screen. This document includes more detailed biographies, as well as links to each speaker's website.

And now that we know a little bit more about our speakers, we wanted to do a quick poll to learn more about you all in the audience and get a better perspective of who is listening today. So if you could just take a minute to check off which stakeholder groups you're affiliated with related to the opioid epidemic, that would be wonderful.

Excellent. So it looks like we have a big mix and the largest stakeholder group is child welfare followed by education and then we've got a lot from public health and substance use treatment or prevention as well, and the general community. Excellent. Well, thank you everyone for participating. And now Robyn, I'll turn it over to you to get us started with opening remarks.

Robyn Cenizal:

Awesome, thanks Jackie, thank you very much. And welcome everyone, we appreciate you taking time out to join us today to talk about this very important topic. And I do hope that our focus on families as it relates to this topic is kind of a new perspective. We've heard a lot about the opioid epidemic, but we think it's also important to be focused on the families that are affected. As I noticed in the poll, a number of you are also personally affected, so thanks for joining us.

Just a brief overview of the National Resource Center for Healthy Marriage and Families, for those who are not familiar. Our focus is on integration of healthy marriage and relationship education skills as part of a holistic approach to strengthening families.

And so when we say healthy marriage and relationship education skills, I want to focus on four core skill areas: interpersonal skills, such as communication and conflict resolution, along with critical skills like parenting and financial education. Parenting and finances are the top two stressors that impact all families, but they can be even more stressful for low resource families. And these skills can be integrated into existing programs. So I hope that you are thinking along those lines as you look into some of the rest of today's presentation.

As Jackie mentioned, you can visit the web links that are in the box in the center of your screen. But also, just to give you a little heads up in terms of the Resource Center, what you'll find if you visit our website. We have a media gallery with videos, we have webinars, all of our webinars, including this one, are archived there, along with our newsletters.

We have a calendar of events that highlight events that are happening around the country that are focused on healthy relationship education and family. If you have an event that should be included in our library, please let us -- I mean, in our calendar -- please let us know. As well as our library -- our resource library is very robust, over 3,000 research based resources. But if you look for something in there, you may be aware of a resource we need to add. And in that case, let us know -- we'd love to add it.

We also have a virtual training center with seven different courses that can be completed for free. And if you complete the course and pass the quiz with an 80 percent rating, you can get a certificate which can also be used for CEUs. So I hope you'll take advantage of that. We have a monthly newsletter. If you're not already on our listserv, be sure to get on. And we're also on LinkedIn, so please connect with us on LinkedIn and Twitter. If you are a tweeter, please connect with us on Twitter as well.

We develop a lot of resources. We've produced over 90 plus resources to address what we believe were some gaps, particularly as it relates to being stakeholder-specific and culturally responsive. So we have toolkits, as you see here, reference to our American Indian and Alaska Native, our Latino and our African-American toolkit. Our latest toolkit focuses on Asian-American families, but we also have resources for working with Muslim families, Orthodox Jewish families, same sex families and the list goes on.

We have fact sheets which are simple fact sheets that are easy to read, easy to digest, research to practice briefs, tip sheets and guides. So again, I hope you'll take advantage of these resources. And a few of these resources are highlighted in your downloadable section. But I hope you'll visit our website and take advantage.

One of the things that we did this past year is we highlighted healthy dating leads to healthy marriage based on a bunch of research that indicates that this millennial generation doesn't date. That there's a lot of hooking up versus dating. And so we developed this special collection that focused on that. If you visit the website, you'll see it's all organized, including issues like dating violence in teens and so forth.

But we also partnered with Family Bridges to create a video series which was pushed out through Instagram, "Dating IRL." So if you're young enough to know what IRL is, In Real Life, I hope you will check out that information on Instagram.

And so before I turn you over to Christina, Theresa and Anne, I just wanted to mention, I will be coming back to you after their presentations to help facilitate questions. So as we go through the presentations, so you don't forget your questions, please type them in the Q and A box and then we'll come back and revisit them. Again, thank you all for joining us and I know you're going to enjoy this presentation. So with that, I'm going to turn it over to my colleague Christina.

Christina Zurla:

Hello everyone, good afternoon, good morning for some folks if you're all the way on the west coast or not here in the afternoon where we are in the D. C. area. Thank you so much for that introduction. I'm really excited to be here today. I've got about 15 minutes and in my time I want us to sort of talk about a couple key things.

As Robyn said, feel free to type in questions within that Q and A box throughout this piece. I'll try to keep my eye down there in case there's something that's just kind of not -- not really coming through that I'm saying that requires a bit of clarification. But in the time that I have, I really want to talk a little bit about the state of the opioid epidemic, kind of where we've been, where we are now, how we got here.

But really, more importantly, how the words that we use and the way that we communicate, not just about this epidemic, but in general, really makes a difference in people's ability to kind of click in and connect with us. My background is in public health communications and in behavior change and social marketing. I could do 90 minutes myself on sort of the ins and outs of strategic communications.

For the sake of time, I want to hit on a couple of key things and some key tenets that I think can help guide this sort of, the collective work that we do moving forward in the context of the opioid epidemic, but also sort of more broadly as we think about how we communicate with individuals.

So first and foremost, there is no shortage of news stories and articles and information out there about opioids. You know, I think sometimes it's just kind of overload, right? And if you don't live and breathe this stuff every day, like many of us at ICF do, it can either be confusing or then the information can be kind of caustic.

So, I want to take just a minute and really just get very, very basic, right? Like what do we mean when we say 'opioids'? And there are different types of opioids. This specific, this information, has come from the Centers for Disease Control and Prevention. And I'm not going to get into kind of the nitty-gritty, but I want to share these terms just as we think about kind of how people are reporting about and talking about opioids, kind of in the general public to sort of get us all on the same page and create a foundation.

So, prescription opioids. These are medications that are prescribed by healthcare providers and they are used to treat mild or moderate to severe pain. Heroin, on the other hand, is an illicit, which is an illegal substance that is synthesized from morphine, that essentially is kind of what we consider like the street drug, right?

Synthetic opioids can mean lots of different things. In many respects, prescription opioids can be synthetic or semi-synthetic. But in the context of kind of the news coverage and the information out there about synthetic opioids, really when people talk about synthetic opioids they're talking about Fentanyl. And Fentanyl again is a synthetic, which means it's kind of created in the lab and it is 100 times stronger than heroin. It is not illegal, because it is oftentimes used in palliative and end-of-life care, or for severe, severe pain management.

But what we're encountering in the kind of out there in the world, is what we call illicitly-manufactured Fentanyl which is basically not the stuff that's on the up-and-up that's administered by doctors, that's prescribed by healthcare professionals, that's given to people in hospitals. But rather the drugs and the substances that are within our current drug supply, and that are coming from abroad and tainting many of the street drugs around opioids that we're encountering. And finally, Methadone is also a synthetic opioid, but Methadone is used to refer to a medication, is the name of a medication that helps people reduce or quit their use of heroin or other opiates or opioids.

So how did we get here? This has not - a crisis doesn't happen overnight, right? So let's look at the rise in opioid overdose deaths in America. In the '90s we really experienced a boom and a surge in the number of prescriptions -- prescription opioids that were being both written, and that were kind of out in the world. What resulted, ten, twenty years later, is really this uptick in the rise of heroin overdose deaths. And what followed that, which is where we sort of are today, is a rise in synthetic opioid deaths from Fentanyl.

So what does this kind of look like when we chart it over time? So this chart is overdose death rates involving opioids by type from 2000 to 2017. So about a 17 year timeframe. And you can see this green line at the top. Any opioid, death rates are rising. If we look at the purple and yellow lines of prescription opioids and heroin, over the past couple of years with the relief of CDC's prescribing guidelines, with more funding and support and resources on this issue, with boots on the ground to really stem the tide of the opioid epidemic, we are starting to see rates of opioid overdose deaths involving prescriptions and heroin, really leveling off. But what is still really skyrocketing, and what I believe and what many

believe is really the crux of the issue today, is the deaths resulting from overdoses of synthetic opioids like Fentanyl.

So how is this happening, right? We started in the '90's, we had a lot of prescription opioids out on the street. Providers got smart. Public health caught up. Communications campaigns got out there. We were able to reduce the number of prescriptions. But in that time we saw people who became, who developed opioid use disorders, prescription opioid use disorders, from their prescriptions, from their legit medications that they received from their doctors.

And as their ability to obtain prescriptions, prescription opioids, decreased, many transitioned to heroin either because it was easier to get, or because they preferred it, or because it was more readily accessible. And now what we're seeing with synthetic opioids is the typical street drugs that you're getting now related to opioids, whether it's in a prescription that you think is legit that you're buying from someone, like buying a pill of Percocet or buying a bag of heroin. They are tainted with Fentanyl, illicitly-manufactured Fentanyl.

And because Fentanyl is 100 times stronger than heroin, individuals who think they're taking one pill of Percocet or whatever their regular dose is of heroin, don't realize that their supply is tainted, and so they're overdosing because they're taking, in reality much, much more.

So let's look at the numbers. Let's sort of dissect this epidemic by the numbers a little bit more and look at the demographics associated with this. So, we know that, you know, while prescription opioids is getting better, right? There's more awareness, there are fewer prescriptions, generally speaking, out there on the street. Providers in most all fields at least have a better sense and understanding that sort of this is an issue. There's more education happening. But they're still involved -- prescription opioids are still involved in about a third of all opioid overdose deaths.

At the same time, half a million people in 2017 reported using heroin in the past year. And what's really interesting about the opioid epidemic, and I think what is sort of helping to cement it as a real crisis, is that it is beginning to impact demographics all across the board. With heroin as one example, we are seeing heroin use increase among demographics that have historically low rates of misuse and use, like women, those that are privately insured, and individuals with higher incomes.

When prescription opioids first kind of came out on the scene, the issue remains with middle-aged white guys. But over time, as the epidemic has evolved, as individuals have transitioned, as the response has sort of come and really been addressed at the community and state level, we're really seeing everybody across many different demographics impacted by this.

And it's important to note that past misuse of prescription opioids is really the highest risk factor in current heroin use. So, there are individuals that certainly started with heroin and they didn't transition from prescription opioids to heroin, to illicit opioids. But the data really point to this sort of path to opioid use that begins with prescription opioids. Synthetics, as we saw in the prior slide, really have been involved in more deaths than for any other type of opioid. So that really remains a big issue that I know perhaps many on this call, many federal health agencies that we work with, many communities are really working hard to address.

So I am a communications person by trade. I am not a numbers person. This is the last graph that I will - the last chart, and the last math and data that I will show you. But I do think this is a really important

point, and one I want to mention, especially because the topic of this webinar is about opioids. That being said, I do not want to discount that there are other substances out there that are impacting certain communities at far greater and higher rates.

So we've got 18 million people aged 18 or older that have a substance use disorder, whether it's heroin or another opioid or something else entirely, or alcohol, or polysubstance use, right? We have 18 million individuals that have a mental illness and about 8.5 million people across the country that have both a substance use disorder and a mental illness, or co-occurring mental illnesses.

So, I want to recognize the crisis that is at hand with opioids, but I do not want to discount broader substance use prevention, treatment and recovery. And how very, very important it is in our work, sort of collectively, to look at opioids, yes -- but really take this broader area of substance use, prevention, treatment and recovery, addressing individual's mental health, and mental illnesses. And really getting, sort of really recognizing the important role that the work many of us on this call do outside of the opioid epidemic.

And that's why I think, you know, when we think about communicating about this topic, that's why the words that we say and the way that we talk to people about this is so important. The stakes are pretty high and the work that you do is critical, whether you're dealing with individuals, with families, with young people, with young people, regardless of demographics, this topic is really important.

And in many respects, our job collectively is to inform people about available services programs issues and to persuade them to take some kind of action. And that's really the definition of communication. As a communication professional, what I study, what I do every day, what people pay me to do for a living -- that is, in essence, the definition of communication. It's to inform people about something or persuade them to do something different than they're already doing or to continue doing something that, a habit or a behavior that they're already doing.

And so much of our work really can hinge around how we communicate to the world, not only the services and the programs and the opportunities that are available to individuals in our community by sort of working with us or coming to us for something, but really in telling the world your story as an entity, as an organization, and reinforcing this idea that the work that you do really, really matters.

And beyond that, as we had seen a moment ago, if we consider the importance of substance use prevention and treatment and recovery and how many individuals are suffering in our community, we really can take the way that we communicate and help normalize substance use disorders. We can position them as a disease versus a moral failing. And in the language that we use, in the way that we speak, we can help reduce stigma. And it really does start with our words.

What I'd like to do now is talk a little bit about kind of how, what are some kind of tips and dos and don'ts when it comes to talking about this issue. For individuals who live and breathe this stuff every day, this might be a good refresher. For those who may not be as entrenched in sort of the public health field, this could be a good sort of intro and overview to the way that the field really considers, what the field considers best practice in terms of how we message to individuals and the words and the phrases that we use.

So not too long ago the Office of National Drug Control Policy released a paper called "Changing the Language of Addiction." And what, essentially the key message here, is that in order to help reduce

stigma and make that transition so that individuals can begin to see this truly as a disease and not something that's just wrong with an individual, right, we should use something called People First Language which puts the individual and his or her situation above the issue that he or she is facing.

So as we think about how to sort of characterize and talk about some of our work, instead of saying things like addicts or drug abuser, which puts the blame on the individual. The ONDCP and federal health agencies really recommend that we say 'substance use disorder' or 'opioid use disorder'. Same deal with thinking about, is someone clean, are they dirty, are they on the wagon, are they off the wagon, right? Characterizing somebody in that situation as a person in recovery, or a person in treatment, or saying they have a positive or negative toxicology screen, really humanizes the issues, humanizes the topic, and helps -- can help fight stigma.

And finally, another example that ONDCP gives that I think is valuable for the work that many of us do on this call and on this webinar, is using the phrasing 'medically assisted treatment' instead of 'drug replacement' or 'substance substitution', right?

The idea here is that we are not replacing one bad habit with another, we are not replacing one issue with something else, but rather we are using medication to assist in the addressing and the treatment of something that is a legitimate disease, much in the way we would if had -- if we were treating high blood pressure or heart disease or diabetes.

So, moving on, I pulled together just a bit of a cheat sheet and I know these flags are going to be available after the fact. But I found this to be a helpful resource, even in the work that I do, as we sort of write and think about how to communicate with individuals. I've shared on the left here some words to avoid and on the right, some suggestions for other phrasing and terminology to use.

Again, so that we're putting people first, we're helping to reduce stigma, we're sort of staying up to date and abreast of where the field is going in terms of how they're characterizing many of these issues and the words and the phrases that they're using.

So typically when we talk about opioids, we don't like to refer to them as pain-killers. We instead would like individuals to say prescription opioids or prescription opioid pain medications. And that's really because the term 'pain-killer' is not only charged, but it may not be all that accurate. I think there is debate about the efficacy of prescription opioids in the management of long-term chronic pain. And so it's a bit of a misnomer, it's a bit inaccurate to say that it is, in fact, a pain-killer.

Going down, drug addiction, drug habit - here too we want to refer to the individual. So it's an individual with a substance use disorder or an opioid use disorder; not somebody that has a drug addiction or a drug habit. I think 'abuse' is another term that I have seen in my twenty years working across federal health agencies and with states and grantees that has really sort of dissipated. We don't talk so much about abuse any more, again, because it indicates sort of an elected choice by an individual to do something negative. Rather, we say that there is a person with a substance use disorder or people who use drugs instead of addicts or junkies or perpetrators or criminals. Again, where we want to put the individual sort of before the issue that he or she is dealing with.

And then finally this is a bit of a nuance that may or may not touch the work that you do, but I wanted to mention it because the field is moving away from the phrasing 'recreational use,' and instead we are going towards the phrase, 'non-medical use'.

And the idea here is that sort of recreational sort of implies certain things, and non-medical is simply a bit more accurate, especially when it comes to prescription opioids because prescription opioids do have a medical value. When they are misused, not taken as they're prescribed, why they're taken too often, or taking too many, not following how they're prescribed, they're being used non-medically.

So, a couple of other things I want to mention before I close with a bit of an activity and kind of download a bit of COMS 101. So, there is an opportunity, as I mentioned before, for the work that we do to help reduce stigma. When we think about communicating to individuals, officially or unofficially, we know that scare tactics don't work.

We have about a decade of research now from not only public health communications campaigns, but other efforts, that trying to scare someone straight doesn't actually do anything in the end. Instead, and I've been doing research with individuals across myriad demographics for two decades, and regardless of age, this is true.

And that is, that individuals really want to see the human side of a topic or issue where we show the people and what they're struggling with, and not necessarily the problem itself first and foremost. When we think about how to communicate the phrasing, the pictures we use, the images that we put online and on social media, research has shown that we should really avoid imagery of paraphernalia because not only can it be triggering, but it also, back to the second bullet here, it doesn't really humanize the issues.

If seeing somebody lying on the ground with a bottle of pills spilled, or a spoon, or a needle only further reinforces the misconception that this is a moral failing or that there's something wrong with this individual. And for those who are in active recovery or in recovery or even in treatment, that imagery could be triggering, whether it reminds them of an earlier time, or it makes them feel sort of negative about themselves.

Rather, our tone should really be empathetic and supportive and informative. In a lot of the focus group research that we've done, we've heard individuals tell us things like - we know this is an issue, right, we want to understand that this is an issue, but we also want to feel somewhat hopeful about this. And I imagine many of this call in the work that you do day to day with individuals for talking about substance use issues, this sort of rings true to you as well, right?

And something else that we found in terms of communications best practices is thinking about a call to action or resources. Where can people go for more information, whether it's -- and I'd say this is mostly for when you communicate sort of verbally or visually on social media, online if you're printing out fliers or brochures. Make sure that there's a call to action for individuals where they can go and get more information.

I think oftentimes in communications campaigns we raise a level of awareness, but sometimes we fail to sort of tell the individual, tell the audience, what it is that we want them to do. Go to this website, get more information, get resources. Check this site out, learn more here.

So if it was just as easy as figuring out kind of the right words to say and then getting those words out into the world, then how come people are not banging our doors down and throwing money at us, right, and all of that we do? Why aren't they saying - your work is fantastic -- here, here's a billion dollars, right?

And I would say that from where I sit, that issue is a communications issue. And that is because oftentimes there is something called the curse of knowledge. Because everybody on this call, myself included, is an expert at something. And many times when we communicate to individuals, we use something called the expert approach which is that we say to ourselves we know what's best, we're going to talk to you, we're going to give you all the information, the stuff that we think you need to know and we expect you to do something with that that we approve of.

I'd like to take just a minute to do a brief example and a brief activity to sort of communicate this fact. So I'm going to do something with my hands. I hope you can all hear it, and then I'll come back. And when I'm finished, I'd like folks to type in the Q and A box what you think I did. So get ready to listen. If you're multi-tasking, close that other window and listen up. All right, here we go.

[Clapping] Does anyone have an idea about what I just did? Type, type, type away. Did I do some Morse code, did I do SOS, did I clap something in particular? No one knows, right? You guys didn't realize, you didn't hear what I just did? You didn't hear the sound and the song of "Take me Out to the Ball Game" when I was clapping like that? Take me out to the ball game - I'm a big baseball fan and opening day starts pretty soon -- baseball seasons starts up again.

You didn't hear it, you couldn't smell the popcorn and hear the team out on the field and listen to the song and hear the band and the music and the people laughing and the people singing? No, of course you couldn't do that. Of course you couldn't understand any of that.

And why? It's because me as the expert, I just basically clapped at you for 15 seconds something that to you was absolute nonsense. To me it made sense. I was the expert of that song. You were not the expert; you were the audience. And when we think about who we're trying to reach, oftentimes we need to say to ourselves, and oftentimes we make the mistake of communicating to people using words or phrases or language or approaches or methods that they can't even understand.

You're on a webinar -- that's a terrible way for me to communicate a song to you. I didn't even tell you what that song was about. I don't even know if you all like baseball. But oftentimes we make assumptions about the people that we're trying to reach and we don't put ourselves in their shoes.

So I want to leave you with this sort of key tenet of effective communication given all that we've talked about -- the opioid epidemic, using people first language, how to manage stigma. And that is that instead of thinking about things in the context of how we as experts expect individuals to respond to the things that we say, I would propose that we think of an audience-centric approach.

Where, instead of blaming our audience for not understanding what we're trying to accomplish and not doing the things that we want them to do, we instead look internally, both within ourselves and within our organizations, to consider what is wrong with our offering. What's wrong with the way that we're delivering our message? Can our audience even hear us? You could hear my clapping, but did you really, really hear it? You probably didn't. You were really confused. Maybe I gave you a headache.

And then more importantly, is this really the best way to reach those individuals? And so as we think about sort of how to communicate to individuals out in the world, these are some of the key tenets that, as the COMS expert, we sort of apply and I apply every day.

As I mentioned before, there's a whole field here. If there are more specific questions, I'd be happy to answer them. But in the time allotted, I wanted to give folks a little bit of a sense of sort of what it takes to communicate and some tips about some of the language that we use and how that can impact the way that individuals receive our messages. So with that, I am going to pass it to Theresa.

Theresa Lemus:

All right. Well, good afternoon, everyone. My name is Theresa Lemus and I am with Children and Family Futures. We operate the National Center on Substance Abuse and Child Welfare, so that should sort of tell you a little about what I'm going to talk about today. I'm going to talk about a family focus strategy for addressing not just the opioid epidemic, but also just substance use disorder in general. When it impacts parents, when it impacts individuals who are responsible for children, particularly young children, family treatment court are a very effective strategy for improving the overall health and well-being for families. So I'm going to talk a little bit about that today.

The mission at Children and Family Futures, you can see it here, is to improve safety, permanency and well-being and recovery outcomes for parents and families that are impacted by trauma, substance use and mental health disorders. And we certainly know that with substance use disorder, including the opioid use disorder, many, many times when we are working with these families there is a lot of trauma that exists and maybe have been passed down for generations, may -- just continues to recur over generations, and then we do mental health disorder as well.

So as Christina referred to earlier, the problem is much bigger than the opioid epidemic, but this gives us an opportunity to really talk to folks about ways to address substance use disorder in general. I want to just highlight some data as it relates to children who are taken out of their homes because of parental substance use disorder.

So this first graph really shows you, and I'm going to sort of point to the yellow line here, in 2012 we were really at our lowest census for the number of children in the United States that were, that had to be removed from home because it was no longer safe to be there. So for those of you who aren't familiar with the child welfare system, usually what will happen is a call will come into a hotline in that state or that county. Child welfare has to go out, usually it's the child protective worker, they go out to see if there is, in fact, a problem.

And, unfortunately, when there is substance use disorder, many, many times there is also other safety factors, and so children have to be removed -- not all the time, but a lot of times. And what you see here is that that trend line is starting to go up again. And in the next slide that I'll show you, it's a little bit more dramatic and a little bit more of a concern. Because when we look at the data and a lot of it does correlate to the opioid problem, but again, other substances are definitely a factor.

You see that for all the children who were removed from their home, the biggest increase is in children under the age of 1. So that number for children under the age of 1 is going up. And that is a big concern because you know, if you're a parent, that the time in that first three years in particular, bonding and attachment are critical. There are so many things that are critical in that first year that if a child has to be removed from their parent, it is definitely going to cause trauma and also other things that are going to show up over the lifetimes of that child. So it's a big concern that we're seeing that.

Many states -- well, all states report on the number of removals, child removals that happen because of substance use disorder. It's not counted very well, but what I can tell you is that that number, too, is going up. So basically what we're seeing is that when child welfare goes out to investigate a concern, we're seeing the numbers go up in terms of substance use being the primary factor for that child having to be removed from the home.

And I want to point out, it's very important, that substance use in and of itself doesn't cause a removal. What happens a lot of times is that because of the substance use, because that person who had been using substances is now paying all of their attention to obtaining the substance, they're under the influence and their brain is dependent.

They're no longer doing the things that we would see as being so quote/unquote "normal" like taking care of their child, buying food, things like that. So a lot of times the safety issue is really around other things and not directly the drug itself. So I think that's really important.

What we know about children who come into the child welfare system, particularly because of substance use disorder, they have a lower likelihood of successful reunification than other families. So if a child is removed for other reasons, substance use is not a factor, that child, those children are more likely to go home than ones where substance use disorder is a factor.

And a lot of that is because we just don't have -- we haven't found the best resources for the number of people in this situation and so that's a big issue. And I think also we've had a misunderstanding about substance use disorder for a very long time, again, going back to Christina's point about stigma.

We also know that children who are in homes where substance use disorder is a factor, is that they have things - they have difficulty in school, they have school delays, maybe they're truant in school, they're not going to school, they don't have immunizations, and they tend to stay in foster care longer than other children.

Substance use disorder impacts the entire family. It impacts the immediate family, the extended family, it might even impact the neighbors. I mean, it impacts everyone. But what we know is that the impact on child development is particularly concerning, so some of the reasons I just talked about. We also know that it's very, very often combined with added trauma. And certainly, any time a child has to be removed from his or her parents, regardless of the situation and what the situation was in that home, it's extremely traumatizing.

So we also know, and we're getting better and better at this, that substance use treatment has to be done in a family-centered way for it to be effective and when it's not, you can have very severe disruptions for that family. If the family is disrupted because of substance use disorder, then treating it needs to also be family-focused.

So, you know, I said I was going to talk about family treatment courts. Family treatment courts are one of the best ways that we have found to work with these families that have a moderate to severe substance use disorder meaning that their brain is dependent, addicted to that substance. And when that happens, again, that parent, that part of the brain is going to dictate what that parent pays attention to, what that parent does. And unless that's disrupted, that child is going to fall second to the force that's driving that brain.

So, family treatment courts understand that. We know that when the brain is dependent on the substance, that it's very serious and there needs to be a collaborative approach to serving this family. First of all there needs to be an awareness of how serious the substance use disorder is, what kind of safety and other challenges are impacting that family. It could be poverty, it could be homelessness. Usually it's all of the above. It could be mental health. But to understand that and then to work together so that we can have better outcomes for these families.

So, I'm not going to read this whole slide -- you guys have access to this. But this is just some of the research that talks about, again, the likelihood that these families don't do as well, they don't reunify as often, if we don't have a collaborative way to address the needs of these families.

So, family treatment court takes really three main partners, although it's not just three partners -- it's really the court. So it's usually the family or the juvenile court. Adding that to the child welfare services and the child welfare agency in that jurisdiction, in that town/city, and also treatment. And treatment is not just substance use disorder treatment, but it's parent/child therapy, it's developmental services for children. But taking those systems and coming together for the purpose of serving this family who is in trouble, and the child may have had to be removed from the home.

We know that when these systems work together, one of the things they do is the child welfare agency, the court, the treatment folks, come together, and they say our goal is to do whatever it takes to help this family reunify if at all possible. Second to that is that this child needs permanency, and I'll talk about that in just a minute. But we know that when these systems work together with that as the goal, you have increased recovery for parents.

Many, many times these children can remain at home, even though there may be substance use that is still happening or is decreasing because of treatment. That kids can stay home because there's other supports at home. If they have to be, if children have to be removed from home, we know that family treatment court families reunify at a much faster rate. And when they reunify it sticks meaning that they don't come back into the system as often as families who don't go through a family treatment court. So, again, family treatment court focuses on the entire family.

Because of the role that family treatment courts have played in serving families, you see that we've just had a steady increase, and actually even today this 495 is a count that's about three years old and we think it's much closer to around 600-plus family treatment courts across the country. So the likelihood of any of you on this webinar today having heard of family treatment court, maybe have worked with a family treatment court, is pretty likely. And so we're very busy right now trying to help family treatment courts sort of get started and understand how to do this work. Because it is very effective for these families.

I'm not going to read this slide, but I wanted you to have it for reference. It's just basically a definition of family treatment court. But what I do want to pay attention to is what a family treatment court approach looks like, and why this is important. There's been a lot of research done with family treatment courts and this collaborative model.

And there's really seven key ingredients that you should see if you're working within, or you're working with a family treatment court. And one is that we have a way to identify families where substance use disorder is an issue. The faster you identify substance use disorder in a parent or in that family, the more

likely you are to be able to keep that child home, and/or to have that family reunify as opposed to having the child languish in the foster care system.

Another common ingredient of family treatment court is that access to treatment and other services is fast -- lightning fast. Sometimes you'll hear that there's a waiting list for treatment. And if you think about it in this context, if a child has to be removed from his or her parents and can't be with his or her parents because we can't figure out how to get that parent into treatment, that's a huge concern.

So family treatment courts ensure that that happens. We make sure that there's a host of services wrapped around this family, to help that parent in their recovery. And then there's also services that are attached to the family treatment court that help to heal some of those wounds that occur because of what happened in that family due to the substance use disorder.

Judges are extremely important in the context of family treatment court and it looks very different than maybe in a regular court, for those of you who have been in court before. Because in family treatment court, the judge is a part of the therapeutic treatment team. They're still a judge and they still have their job to do, but the judicial oversight looks very different.

So, probably the most important one that I want to hit on is that a family treatment court uses a collaborative approach, that no one agency can solve the issues, challenges for these families and time is of the essence. So I won't spend a lot of time on this, but it's important to know that whenever you have a family that has come to the attention of child welfare and substance use disorder is a factor in that case, there is a clock that's ticking. It's called the Adoption Safe Families Act and it's something you can look up if you're not aware of what it is.

But it's very important because it basically means that the parent, that family is on a clock. And it definitely means that the agencies involved, the child welfare system, the treatment system, the court system, are on a clock as well. What matters here that I think a lot of times practitioners and others don't realize is how those clocks don't match up.

In the court system, because of ASPA, and in the child welfare agencies, are mandated to ensure that children have permanency. So we basically, if a child is removed because of parental substance use, we have twelve months -- twelve months to help intervene, identify, get them into treatment, work through all of these different issues.

Twelve months is not a long time when you consider going over to the right hand side, that treatment and recovery for substance use disorder is, first of all, it's one day at a time. It takes a lot of time for any individual to withdraw, to stop using, reduce using, and then to address all of the behavior issues, and the psychosocial, mental health, other issues that have occurred because of the substance use disorder. So that's not a twelve month timetable; that's a forever timetable. Anybody who's in recovery would tell you that it takes a little bit every single day. And certainly when somebody is in early recovery, it's in a very intensive process.

And then you think about the fact that I told you earlier, that the majority of kids that are being removed are under the age of 1. I want you to think, if you're a parent or you've ever been around a baby, what changes in a week, what changes in a month? So, if a child is in out of home care and they aren't able to be nurtured and bond with his or her parents, you're losing a lot of time and so you've got that child development clock.

So, family treatment courts take all these clocks into consideration, and we buck down every barrier that we can find to ensure that this family is being served and that those children can go home to a safer healthier home with parents who are in recovery and working on their recovery. That's what family treatment courts do.

I already talked about the fact that no single agency can do this alone. It takes a lot of collaboration in a family treatment court model to help these families and it's extremely rewarding. And the data around the effectiveness of the family treatment court model, when it's being carried out with those seven ingredients, we have much better outcomes with these families than if they don't go into a family treatment court.

So here's just a little bit of data around family-centered, the family-centered approach. And I'm just going to pick one to highlight, and that is that retention and completion of substance use treatment in recovery is the strongest and it's one of the strongest predictors of reunification for parents with substance use disorder.

And so I think that's very important and I think you can read these. It's pretty compelling and there's a lot of research that's been done around family treatment courts and the benefit. The one I want to pay attention, the other thought I want to pay attention to is this one. That when we focus only on the parent and not on the parent in the context of his or her relationships, including the relationship with their children, we miss a huge piece of who that person is. And so family treatment courts really focus on the relational aspect of substance use disorder and healing needs to occur within that same context for children and for parents.

This piece here about guilt is the third bullet, fourth bullet down, is a big one that when you have a parent where children have had to be removed because of their substance use disorder, if we don't help them through therapy and other types of resources with that grief and that guilt, it can continue to fuel their substance use long-term.

So here's some costs of focusing on parent recovery only and not paying attention to what's happening with the children who have gone through this ordeal. We know that these are generally our future clients. Because if we're not addressing parent/child dyad, if we're not ensuring within our collaboratives that children are getting the services they need in context of what's happened in their lives, they will be our next customer, so to speak. So we really pay attention to that.

Lastly, I just want to talk about the fact that treatment needs to support the whole family. And when it does, it increases the recovery for parents who have substance use disorder. It can decrease the likelihood of substance use disorder in older children in the family. We know that family treatment courts pay a lot of attention to helping parents either obtain or improve their parenting skills. And so doing that enhances child well-being and overall that whole family's well-being.

I would encourage you all, if you have a family treatment court in your community to seek it out, to find out a little bit about it and maybe ask some questions or be involved with it if you are in the position to refer families or be involved with families who might be in family treatment court. So that concludes my discussion. I am going to turn it over to Anne Lopez with Shatterproof.

Anne De Santis Lopez:

Thank you, Theresa, and good day, everyone. At Shatterproof our mission really is to help end the devastation the disease of addiction causes families and we are doing that through advocacy and education. So our family program, which is under the umbrella of our entire organization, has a mission to educate, equip and empower those families.

We do know that one in three families are impacted by addiction and chances are you know at least one of those people that have someone in their family struggling with the disease of addiction. We have come to learn that these families most likely have gaps, many of them do, and there's others that we don't know about. They have gaps in the information in all the areas of dealing with addiction.

Because we know that this disease has many components to it and they don't always understand all the facets of the disease of addiction, how it affects the brain. Sometimes they don't necessarily know how to navigate the treatment and the options. So we really want to inform them of all the options that are available to them. And finally, they don't fully understand what recovery looks like. Sometimes people believe that treatment is recovery and they are really two separate components.

So we've built this program on three pillars. It is a psychosocial educational program and I'm going to leave that slide up so you can take a look at it, but our other two speakers spoke about these are on the slides. So the education program is for loved ones of someone with a substance use disorder. Our curriculum contains many relevant topics, and you'll see them in just a minute. These topics and issues have been suggested by families that we met with across the country and they have been reviewed by our scientific advisory board.

These are the program topic sessions and there's a couple in there that you'll see our previous speaker kind of touched on and one of them is the communication, overcoming stigma. So this, the content of this program is evidence informed. It's been compiled by various evidence-based models, research and resources. And like I said before, it is reviewed by our scientific advisory board.

The whole purpose is that this equips loved ones with the skills, tools and information strategies that aid in understanding and navigating the disease of addiction. And like I said, there are treatment options. But also what we added to it is understanding self-care, not only for their loved ones, but themselves. And we really focus on multiple pathways of recovery.

And we understand and really nail down and hammer home for them that there's not only one way to do it. And our goal is to introduce them to all the different ways that they can introduce themselves, they can introduce someone else to all of those options they have available to them, meaning that it doesn't always have to be just an abstinence-based approach to recovery. It could be harm reduction, it could be another alternative to it.

We really focus on a lot of the components of changing language, and Christina did share about that. One of the big pieces that we like about the program is not only that one builds on the other, but there is, you know, there is this final piece of the ongoing support, talking about the resources. And we build up to that by introducing all these different areas to focus on. And one of them, and this is what a lot of people really do prefer, is that we go through the program with them and we build an action plan that is non-crisis focused or crisis-focused.

Meaning that if someone is in active use and all of a sudden they decide, like you know what? This isn't working for me anymore; I want to go to treatment. The family members build that action plan and

that's in the session eight topic. They build that action plan with their loved ones that help them explore what they options could be so they're not making a decision when they're in crisis or they're not making a decision while they're vulnerable because we know that sometimes you're not thinking straight when that pressure is on.

So they can look at it, one on wellness, and it's applicable for, if they just want to go to treatment, if they need to go to detox. The crisis part of it is if they've overdosed. If they are in crisis, they end up in the emergency room and family members know exactly who they're going to call. If they do nothing else in the action plan, like knowing what things cost in pocket, out of pocket, the insurance benefits, all of that stuff, at least they know who their first call is. And nine times out of ten, that first call may be that trusted person or they know the detox they want to send the person to.

So we really help families understand the research, help do the research, help them find out to advocate for themselves and others so that they can make the decisions that are the most appropriate for their family members. We do touch on the co-occurring piece because we know that the co-occurring piece is recognized more widely than it has been in the past and we know that there's a very high percentage of those that have a mental health diagnosis.

We help them explore. We talked about the language. We talked about them gaining the knowledge and skills. Because here, if we go back to we want to educate, we want to equip, and we want to empower. We know that when family members are equipped with new language tools, questions to ask, they feel more empowered to advocate for their loved ones.

We do this through delivery. In our program this is community-based or organization-based delivery and our facilitators and our participants do have access to all materials. And the facilitators, they are trained and certified co-facilitators. And the recommendation is that one facilitator is a peer, meaning someone with lived experience. It could be a family member or it could be a certified peer, a recovery coach, and a clinician.

They all, and including participants, all have access to this portal. This portal connects the facilitators with the videos, the handouts that they need. They can look at evaluations by their participants. For the participants, they have their own login and they can provide the feedback to the program while accessing all the handouts, the materials that they see in the videos, that they see in the groups.

They also can have a participant journal. Now this is for the participants that are attending the program. This is a hard -- kind of a magazine type of material and it has everything that they do in the program in person. But what we've added to this, and the difference is what's online than this, is we actually have a place where the family members can begin self-care of setting intentions for the week, reflecting on how their week was, and journaling.

Because we do know that the journaling really taps into that subconscious that allows sometimes the feelings and emotions, what they do, what's working, what's not - it comes to light as that pen is going to paper. So there's such a value in journaling. And we actually have a page in there that talks about the value of journaling for an individual. And they can look at their own growth and reflect on what they've learned, and how they've changed as an individual.

If you want to bring that program to your area on our website, which I'll show you in just a minute, it tells you what the content is. If you want to partner with an organization or if you're looking for funding

to help you bring the program to your community, all the details are here. And you can share it with other co-facilitators or potential co-facilitators, an organization if you want to bring it to a recovery center. So everything is there for you. And going back into the portal, these templates are in that portal. So you have a lot of materials that are at your disposal here. But most times a lot of people just share the link with people that's maybe interested, so you can refer them right to that link.

We have launched our program in a lot of different communities throughout the state, so we just direct them to this often. We've been running facilitator trainings as well and I'm going to just show you the content for it before I show you the website and then our dates. So, our facilitator training manual. Our facilitators have access to this online and really what it does is it provides whoever wants to deliver this program with everything that they need to deliver the program. Including how to talk, how to guide them through each session that they're delivering.

We do have each session scripted, should they want language to use; or we give them prompts and objectives and key points for that session. And let me just hit on this, introduce it, and then I will use my own words, but everything is built for a facilitator and what they need to deliver the program as I said, including the videos, the handouts, how to start it, how to end it. We also do our training in three parts. And it includes a first part of the training which introduces any facilitator, whether it be peer or clinician, with group dynamic skills.

If I want to send this out to someone, we give you an email template. How do I promote it? You will get a template that has all marketing materials. So you have everything at your disposal. This is a boxed curriculum. So when someone is trained, and when they pay for the program, they get all those materials. You do have a two-year certification. You have access to all the videos.

So, what this does, it really simplifies for people that want to bring it to the community. They know their families need it, but they don't know where to begin. And also the big part of all of this is that we want to encourage consistency in delivery of material. So it doesn't matter where you are in our country. That you get this scientifically-backed information. You get consistency that doesn't include a personal objective or opinions. You're getting this very objective information delivered to you in a way that includes how do I deliver it.

That process in delivery is just as important as the content because we know that many of these family members that walk into our programs, they have a lot going on. There's a lot of stress, there's trauma behind what they've experienced. So we need to give them some process that introduces them to their own wellness. Because many times we do know that family members, they put themselves second. They put themselves aside. They focus on their loved ones that is dealing with substance use disorder.

So for just that hour or hour and a half of time, whatever it is, that a facilitator chooses to deliver it in, we want to give them the opportunity to just sit, be supported, and focus on themselves. And if they are told to do it on themselves, and a lot of times they don't. So we actually take them through the process, and we actually model what they're seeing or how to do it. Our biggest piece of our training, and really what I focus on with my facilitators, is really how to learn how to listen, and then speak directly from the heart. And when they do that, a lot of times it comes out very differently, and they support their loved one very differently as well.

Our website is: shatterproof.org and then our family program website is here. So our page has everything that you need to look for the materials and a lot of the pieces that I spoke about. Let me just mention our -- here, let me show you the bottom part. And this is just the bottom part of our front page of our family program. It's if you want to host a program, it's here. If you are an organization and training facility, that you want quite a few of your staff trained, you can actually host a training. So you would just click on the green button.

If you want to bring a program to your community, if you're a peer, that a family member or somebody else with lived experience, or some community member, and you want to bring it to your community, you would click here and it would take you to the application page. Or, if you're just looking to find a program, family members, or just see if there's a program already running in your area, you would click here.

We are still in our pilot phase of delivering the program or launching the program, so we don't have a lot of locations listed here just yet. But as we continue to add more locations, you can find them here. Now we do have a few locations that are launching. We have launched in two locations in New Jersey. One of them is not quite listed yet. We will be in Massachusetts, and we will be in a virtual delivery. That's a closed one just yet because we're running our test on that one.

So our upcoming training locations, I didn't list them though, we have seven coming up from May until November. And they are listed once you go through the -- bring it to your community, you will see the trainings listed there. And really that's all I have for you. So I'm going to turn it back over, because I'm done with my presentation. So thank you so much. I think Robyn is going to take it back now.

Jackie Rhodes:

Thank you so much, Anne. Sorry, just real quick as a reminder, you can ask a question by typing it in the Q&A pod, located at the bottom right hand corner of your screen and we will get started in a few minutes with the Q&A session. Robyn?

Robyn Cenizal:

Sure. Thank you, thank you all for that wonderful information and I hope that our participants today enjoyed it as much as I did. I do have some questions in the queue, and so we're going to start with you, Christina. Thank you for, first of all, thank you for helping us to think more strategically about communication. The question is, can you share some strategies or some resources for talking to kids about opioid addiction and substance abuse disorder? And also, what age is appropriate to start those conversations?

Christina Zurla:

Yeah, that's a great question. Hello, to everyone. So let's do this the age thing first. I mean, I think we know from this field that, and from sort of substance use prevention, that it's almost never too early to start talking with kids about the dangers of underage drinking, of substance use and misuse, as sort of part of kind of overall education and creating open lines of communication. I imagine Theresa can even share more specifics than I can about that. That's not necessarily my area of expertise.

But what I will share is what we know from the data. And we know that really before the age of 18, at least from the latest crop of data that came out around SAMHSA from the National Survey On Drug Use

and Health, as well as other surveillance reports from the CDC, we know that before 18, prescription opioids isn't really that big of an issue. Even 18, 19, 20 - that's still not - I mean there are other substances: alcohol, marijuana, Adderall, right? Those substances are more pervasive and used and misused at far greater rates than prescription opioids. As we start to get into the kind of mid-20s, the 22, 23, 24, 25 , that's when we're really seeing rates uptick.

Now the counter to that though is that we are seeing the highest rates, the highest increases in the rates of opioid overdose deaths, among that 18 to 25 year old range. So while not many individuals are encountering prescription opioids, because they are the age that they are and have the brains that they do, they're overdosing at higher rates and in greater numbers than others. So, I just kind of want to share that as context.

And in terms of reaching those individuals, I think something that's critical in any work that anyone does to try and reach young people is to literally ask young people, and to ask representatives from your target audience, what motivates them, what they think, feel, desire from a particular issue, how they like to receive information.

This can sound daunting and cumbersome. It can be a multi-million dollar research effort; it could be a very, very small and limited conversation that we have with people who represent our end-users. And I think that's really the best way to sort of figure out what it is that's going to make any particular audience segment tick and click in with a particular message.

That being said, NIDA has drug facts week, which is in January. So NIDA is a good resource for, I believe they have information for youth and young people. I'd also encourage folks to look at the Substance Abuse and Mental Health Services Administration's site. They have underage drinking prevention and substance use prevention resources in their SAMHSA store.

But what I've learned in their research is that it really varies based on kind of where the young person is, what situation they're in, what demographic, what particular age range, what ethnicity, in terms of what it's going to take to move the needle for them.

Robyn Cenizal:

Thanks. I think that it's also important to keep in mind as with any sensitive conversation that a lot of times we can find teachable moments when there is something that comes on the radio or on the television and it opens up an opportunity for us to have a conversation that might be age-appropriate. And Theresa, I wanted to see if you wanted to add anything to that, given? One of the comments that I've heard is that that's Mommy's juice - referring to wine. Is that the kind of conversation we should be having, what do you think?

Theresa Lemus:

Oh, no. Making those - that those are the things, you know, from the mouths of babes, when you're around children and that's the norm for them. I mean, that's - that we have to deconstruct that. And it takes a long time. And really I would go back to, for folks on the webinar, the National Institute on Drug Abuse, NIDA, has teaching packets for teachers, for counselors, for different levels of - even for parents, about how to talk to your child at a certain age. So it's developmental in nature.

I think that it's scary for kids to hear that your mommy is sick. It's horrible to hear it from another grownup or somebody else that your mom loves her drugs more than she loves you. That causes irreparable damage. And if you talk to foster children who have grown up in the system or been in the system, it's almost hands down the number one thing they would tell you.

If you could grant their wish to them, other than going home, that they wish they could have gone home, was, I wish that people would have helped my Mom. I wish that people would have helped my Dad. And I wish that people wouldn't have said bad things about them.

And so, the, I think, atmosphere around substance use disorder is changing, thank goodness, and even to the degree that foster parents and resource parents in more forward moving jurisdictions get a lot of training on how do you talk about these parents that you're very mad at. You're mad at them because they've done some things, they've neglected some things, including their children. It's hurt the kids.

But then to have these resource parents, foster parents, other professionals like stop the hurt and start the healing and some of that is in our language about how we talk to kids. So those teaching packets really help any of us, depending on who we are and what our level of expertise is to talk to children at different ages about what's going on. And I would suggest that people look for that if that is something that you would like to understand a little bit more about.

Robyn Cenizal:

Sure. Another question that's come up, a couple of question have come up around homelessness and opioid use and homelessness in high school students. Can either of you speak to that?

Theresa Lemus:

What was the question exactly?

Robyn Cenizal:

So what's a good approach for dealing with the intersection of homelessness and opioid use?

Theresa Lemus:

Now I work with a few jurisdictions that are in the, they're in the worst part of the country as it relates to the opioid use, the opioid epidemic, in upstate New York. Basically they say, you know, you keep them alive first. But there -- and so that's imperative. Obviously finding any way to prevent accidental overdose, which is no easy task given what we don't know about what's out on the street.

But certainly if you think about Maslow's hierarchy of needs, for those of you who took this in school and you have -- people need to have a safe place to go. They need to have food, they need to have a relationship, right? And those are at the height of the hierarchy.

And so to think that someone, anyone, can find recovery when they don't know where they're going to get their next meal and they don't have anywhere to lay their head at night is not very -- I mean, we're not being honest with ourselves. And so you really have to have a concurrent, you have to have a concurrent plan.

And this is probably one of the issues that we don't have all -- a lot of answers to because of the housing epidemic in and of itself is really a challenge. But you know, I would say for those, again, that are listening, if you're working with these youths, I mean, it has to be concurrent planning around -- it takes a whole other meaning for that word, to be around how do we find safety and help this individual with their basic needs while we're supporting them in their effort to reduce -- well, to stay alive, but then to reduce their illicit drug use and find alternatives. So I think it just, it has to be concurrent. It has to be happening at the same time.

Robyn Cenizal:

Sure, thanks. And so Anne, I have a question for you. There's a question about the curriculum. Has there been a study of the curriculum using a quasi-experimental or an experimental approach?

Anne De Santis Lopez:

We just launched a program in September meaning a first location delivery. So we're not there quite yet, but we are bringing onboard an academic that can do that for us. So we're not there yet, but that's why we pulled from evidence-based information so that it's not -- we will be evidence-informed once we do collect that information.

Robyn Cenizal:

Awesome, okay. So another question, how do you determine if an adult is overusing their prescribed meds? Any tips?

Theresa Lemus:

Oh boy, gosh. I mean, there are a lot of ways and hindsight is always 20/20. But I mean, first and foremost you're looking for, you're looking for things that you, there are things that are just not normal about the way that that individual might behave or act. And there are so many examples.

If that individual is dependent on that medication and they're taking too much, then they're going to run out of their prescription. They're going to be looking for ways and they'll find ways to get their prescription filled earlier, to borrow, to steal, to do whatever they need to do to get that medication because they sure can't run out.

So they're going to spend an inordinate amount of time maybe alone off doing things that they're not able to tell you what they're doing because they're seeking the drug. And they're doing that because their brain has got to have it.

So it's important to recognize when it feels like some things just aren't, they're just not making sense or maybe that individual's behavior is somewhat erratic. And that's not always going to be something that you're going to pick up on. But when they're starting to run out of their medication, they're going to have some sort of panic, whether it be very irritable.

Again, it's one of those things in hindsight you look at it and you say wow, I should have noticed because that wasn't normal. But those are the things, I think, that I would look at first. And certainly trying to just engage with them in discussion about what's going on with, what's the reason they're taking the medication. How is it doing?

You know, if they had a surgery, how is it doing? If they had a surgery, how's the pain, what's the doctor been saying? If you're trying to engage in that conversation with somebody and they're just not willing to engage back and they're really short with you and even irritable, you probably have -- you may have some cause for concern. And I think it warrants, just further question asking.

If you ask an adolescent where they get the majority of their prescription pills, it's in our bathrooms. It's a kid comes over to hang out with your kid and they ask to use the restroom. You have kids telling you, I go through all the cabinets. I go through everything. And that's how they do it. Adults do the same thing, by the way. So I think those are some of the things to look for, and I'm sure there's many, many more that others could think of.

Robyn Cenizal:

So it sounds like we need to be proactive in thinking, if we know that a family member is on a particular medication, we need to proactive instead of wait until we start to see warning signs.

Theresa Lemus:

Absolutely.

Robyn Cenizal:

So here's another question and I'm going to spell this out, because I don't know exactly what it stands for. It's an acronym which is something I don't do well. But it is for Theresa. Are COAMFTE accredited doctoral program eligible to apply?

Theresa Lemus:

I'm not sure I know what is either. I don't apply for -- I'm not sure what it references in terms of applying. Sorry, I might need more information on that one.

Robyn Cenizal:

No worries. And whoever submitted that question, if they would like to provide some additional information, we can respond to them offline. We are at our time and so to be respectful of everyone -- we do have a few questions left and we'll share them with our presenters and provide responses. With that, I will turn it back over to Jackie for some housekeeping. And thank you all very, very much for participating and for all of the wonderful questions.

Jackie Rhodes:

Great, thank you so much Robyn and thanks to our speakers for your expertise and willingness to share with us today and for the audience for joining and for your questions. As the webinar concludes, there will be a brief survey that pops up on your screen. Please remember to provide your feedback using the survey as it helps us with future planning. Once you complete the survey, you'll be able to access your certificate of completion for attending the webinar today. The survey link will also be sent out via email following the webinar. If you have any additional questions, you can send them to info@healthymarriageandfamilies.org. And check out more of our resources and information at our website, which is www.healthymarriageandfamilies.org. Thank you all for joining us today.