WEBINAR VIDEO TRANSCRIPT

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Co-occurring Disorders:

Best Practices on Supporting At-Risk Populations

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INA RAMOS: Good afternoon, everyone. My name is Ina Ramos, and I'd like to welcome you to the Minority Fellowship Program webinar-- Co-occuring Disorders-- Best Practices on Supporting at Risk Populations. This webinar is brought to you by the SAMHSA Minority Fellowship Program Coordinating Center.

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I'd now like to introduce today's presenter. Dr. Brandy F. Henry is a Postdoctoral Fellow at Columbia University. Her background includes both clinical practice and research experience. As a clinician scientist, Dr. Henry uses her years of practice experience as a clinical social worker to inform her research, which aims to improve the house of criminalized populations with co-occurring disorders.

Her publications describe the epidemiology of co-occurring disorders as related to exposure to stress and trauma, and best practices for interventions to address these disorders. Recently, her research has pivoted to situate the COVID-19 pandemic as an adverse experience and is examining both the behavioral health effects of the pandemic and best practices for addressing behavioral health during the pandemic.

Dr. Henry, floor is yours.

BRANDY F. HENRY: Thank you so much, and I'm really excited to be here with you all today. As you all heard, today I'm going to be talking about co-occurring disorders in COVID-19. So COVID-19 has exacerbated co-occurring disorders for many people, due in part to the restrictions on service options, increased social isolation, increased stress, which can lead to relapse and development of co-occurring disorders, and increased risk of contracting COVID-19.

So having co-occurring disorders actually puts you at risk for COVID-19. And all of these factors have caused problems for those people who are most at need, which are at risk populations, as you heard earlier.

The objectives today for this webinar are three-fold. First, I want to cover the background and the foundational aspects of co-occurring disorders and their risk factors. Then I want to talk about best practices for working with people who have co-occurring disorders. And then finally, discuss current research on co-occurring disorders. And a lot of that discussion will focus on telehealth, which has been a really widespread increase in its use during COVID-19.

So first, we'll focus on the basics of co-occurring disorders. So what are co-occurring disorders? I'm sure you all have some sense of that, because you tuned in today. But so that we're all on the same page, I want to really just break it down. So according to SAMHSA, co-occurring disorders are the coexistence of both mental health and a substance use disorder. And both of those are behavioral health disorders, which you heard mentioned quite a few times in my biography.

And what both of those are are disorders that affect a person's brain and behavior to the extent that they experience impairment in major life activities-- so things like work or caregiving. But the key difference between these two types of disorders is that mental health disorders involve impairments in thinking, mood, and behaviors, while substance use disorders are primarily characterized by an inability to control drug use and/or psychological or physiological dependence.

And what dependence is is symptoms such as cravings, fixation on obtaining or using drugs, cognitive issues, like difficulty with concentration or judgment, and then physiological symptoms, like withdrawal or increased tolerance, which could actually require a medical intervention to address. Co-occurring disorders are very common. So people among people who have either a mental health or substance use disorder, about half of them actually have a disorder as well.

And the reason that this is so common is partially because these disorders share most major risk factors. And the major risk factors for both of these types of disorders include genetics, environment, and stress or trauma. And so genetic susceptibility involves things that we might say run in-- we might say the disorder runs in a family.

So you actually have a physiological predisposition because of your biology or your genetics that makes you more likely to develop a co-occurring disorder or-- a substance abuse or mental health disorder. But genetics aren't separate from a person's environment or a person's exposure to stress and trauma.

So what do you mean by that is that exposure to environmental risk factors-- stress and trauma-- can actually alter a person's physiology, to the extent that sometimes a person can actually genetically pass down environmental or traumatic exposure to risk. And this is an emerging area of research and not my specialty.

But there's a field of epigenetics which has recently started to document how, for instance, exposure to trauma actually physiologically alters a person's genetics, which can be passed on to their children. And so this distinction between genetics and environment is not so clear cut. There's a big overlap between the two.

And further, certain genetic predispositions can interact with these environmental risk factors, like stress, to collectively contribute to the development of co-occurring disorders. So there are certain-- there's actually certain genes that can be triggered by exposure to particular types of environmental risk factors. So again, there's a big overlap between the environment and the genetics.

In terms of genetic or environmental risk factors for co-occurring disorders, some common environmental risk factors include exposure to lead and other pollutants, traumatic brain injury, nutritional deficiencies, and exposure to infection or viruses. And oftentimes, the period in a person's life when they're exposed to those environmental risk factors can be really key.

So exposure in utero, or exposure in early childhood, often has much stronger effects over a person's life course than exposure to these things later in life. Now exposure to trauma or stress is probably the most

common risk factors for these disorders. And that includes things like experiencing child abuse, environmental disaster, neighborhood violence, personal injury, domestic violence, and discrimination.

And actually, something like the COVID-19 pandemic is certainly a stressor, and could be experienced as traumatic. And there's been a lot of research lately looking at, including some of the things I've been working on, how the COVID-19 pandemic itself could be a risk factor for increasing mental health and substance use disorders and co-occurring disorders. And I'll talk about some of that research later on, when we get to the end.

So all of these things can accumulate. So there's research that suggests that exposure to multiple forms of these risk factors, particularly multiple forms of trauma or stress, they compound, and the increased risk. So the impact of having a mental health and substance use disorder increases the more exposures you've had. And the impacts on your brain and being exposed to all of those different risk factors increases your susceptibility of developing the other type of disorder.

And then finally, recent research has been looking at age as a risk factor. And currently, young adults are at the highest risk of having co-occurring disorders, which I think is particularly problematic and concerning, given that we don't know what this population the, current population of young adults, will look like across the lifespan. And as they age, will they continue to be at high risk? Is this a new phenomenon that we'll continue to witness with new-- emerging young adult populations?

And how might we address that? And what are the causes of that? So that, I think, is a new area of research that is still being developed. So I talked about risk factors. And as you might have guessed, and hearing about what some of those are, not everyone is equally at risk of experiencing those risk factors. So there are certain populations who experience a disproportionate burden of these environmental risk factors, primarily stress.

And so those-- that disproportionate burden leads to an overrepresentation of these populations among people who have cooperating disorders. And then similarly, it leads to an underrepresentation in the people who receive treatment for co-occurring disorders. And there's a lot of overlap between those groups. But they're not exactly the same.

So research has found that populations which have higher rates of mental health and substance use disorders include people who identify as lesbian, gay, bisexual, or transgender, people with lower income, people who are justice involved-- so that means people who have been arrested, have been incarcerated, or have had other exposure to the criminal justice system, people who are homeless, and people with disabilities.

And as you may have guessed, it's true that there's a lot of overlap between those populations as well. So for example, being incarcerated, which is a focus of my research, is highly correlated with having low socioeconomic status, being homeless, and being disabled. And so you might imagine, there's a lot of people who fall into multiple of these different groups, which compounds their risk as well.

Now in terms of populations who are less likely to receive needed treatment for mental health and substance use disorders, there's been a lot of research that highlights Black and Latino people as being less likely to receive those needed services. And research has identified the reason for this as both because they're less likely to be able to have access to those services-- so they are more likely to have barriers like not having health insurance, or having difficulty in accessing transportation, or the physical clinic as far away from where they are.

But then there's also the added issue of discrimination within the health care system. So that might make people less likely to seek services, might make them more likely to leave services, or have worse quality services when they do actually receive care. Because the care is not tailored to their needs, and is also biased against them.

So the next topic that I want to transition into is best practices in providing services to people who haves co-occurring disorders. And best practices span all areas of care. So I'm going to focus on the three major areas, which include screening and assessment, treatment, and recovery.

So best practices for screening and assessment of co-occurring disorders include several factors. And the first is that clinicians should screen for both mental health and substance use disorders, as well as historical and current trauma or stress. And so we know trauma and stress are risk factors for developing co-occurring disorders. But they're also risk factors, in terms of exacerbating symptoms. Or they can be barriers to receiving care or having good outcomes with care.

And in terms of screening tools, there are many validated screening tools for mental health and substance use disorders, although many fewer which encompass both. So often, clinics or clinicians will use separate tools for both of those things. And the validated tools have been tested with many different populations. And one key aspect of them is they can often be used by non-clinical staff, which can be helpful in streamlining service delivery.

So you may be able to have patients do the screening questionnaire, for example, in the waiting room, or with a medical assistant prior to the visit with the clinician. However, screening instruments, they shouldn't replace a full clinical assessment. So they can give you additional information. And particularly, if you're using clinical time to gather that information, that can be really useful. But actually doing a full clinical assessment of best practice.

Now screening for trauma and stress is often done best done in the clinical assessment. There are some clinical instruments that have been validated for that purpose, although most of the tools that are used in clinical practice to assess or screen for trauma or stress were actually developed for research purposes. So they haven't been validated in a clinic for clinical needs assessment, which makes them less recommended for use.

During assessment, clinicians should also identify relevant psychosocial factors, such as patient cultural background, and barriers and facilitators to care, in addition to care preferences. Barriers and facilitators to care might include things like access the insurance, financial resources, transportation, child care, and family support.

And then finally, clinicians should work to establish trust and rapport. And this is particularly important since mistrust and shame are quite common in the population of people who have mental health and substance use disorders, and particularly co-occurring disorders. But there are forms of stigma that exist in our society against people who have mental health disorders and substance use disorders. So people with co-occurring disorders experience both of those forms of stigma.

And clinicians and clinical practices are not immune to perpetuating those forms of stigma. So that mistrust and shame can be exacerbated by those, experiences particularly within a clinical setting. And then it can be compounded if the person is also coming from a marginalized group, where they experience other forms of discrimination, like racial or ethnic discrimination.

And so clinicians can build rapport by engaging in non stigmatizing and culturally appropriate services, and generally meeting the patient where they are, in a nonjudgmental way.

So I wanted to try and apply some of the things that we've just learned to a case study. And so on the screen, you can see I have a case study described there for Clara. And I'll read it to all of you, so we can think about it together. So Clara is a 46-year-old White woman who comes to your primary care clinic for a physical after serving five years in prison. In the waiting room, she completes a written validated screening tool for substance use disorders and the patient depression questionnaire, which both indicate moderate risk.

During your visit, you ask about Clara's stress level lately and how things had been for her in prison. She says that she is struggling to find a job, because she has no driver's license, and everyone judges her based on her record. She tells you that in prison, at least she had a roof over her head, even if she had to put up with stuff from the guards. She says she'd rather not talk about that though, since it's between her and God now.

So I want you all to take a moment and think about this vignette, and ponder a couple of questions. So the first is, what relevant psychosocial factors says Clara already shared with us? And the second is, what can you do to establish trust and rapport with her? I'll give you a few moments to think about that. Maybe jot down some ideas. And then we'll come back in just a couple of seconds, and I'll give you my thoughts on this.

So you might have come up with different examples. But what I thought about when I was reading this was that Clara shared with us that transportation and finances are potential barriers to services for her. She said she was struggling to find a job, because she had no driver's license. And she also told us that she's experiencing stigma due to her past incarceration. So she said everybody's judging me based on my record. And also that she is religious and might have a trauma history.

So to establish rapport and trust, one thing you could do is reflect and validate the stressors that Clara has identified. So you might say, I hear that you're having a really hard time since you've gotten out of prison. Can you tell me more about that? Can you tell me about how it's been trying to find a job? And you might also ask her to tell you more about those screening questionnaires that you filled out in the waiting room.

And so the combination of those tools indicating to you that she's at moderate risk for both depression and substance use, and she has active stressors, likely trauma history, barriers to care-- all of that's indicating to you that she's likely got a co-occurring disorder, and that she is going to have some difficulty engaging in services. And so that sets you up to be able to think about what her diagnosis might be, and what her care plan might include.

So the second area of best practices that I want to talk about is treatment. And so best practices for treating co-occurring populations include several factors. So the first is providing integrated services, so treating the mental health and substance use disorders together. Their best practices include tailoring the treatment to the person's specific needs, like their symptoms, diagnoses, and psychosocial factors, applying trauma informed gender and culturally appropriate services, which helps establish safety and promotes trust.

If you're not familiar with trauma informed practices, what that means is starting from a place where you recognize that trauma is common, particularly among this population. And you work to proactively

promote recovery, rather than inadvertently re-traumatizing people. So for example, you might be mindful of organizing the exam room or the clinical therapy room so that the patient is closest to the door, so that they don't feel trapped in the room. That's just one example.

Finally, clinicians should work to use evidence based practices when available. And I say when available, because a lot of the existing evidence based practices have not been validated with diverse ethnic and racial groups. So oftentimes, you may be able to use an evidence based practice. But you should tailor it to your particular patient population with their cultural background in mind.

And then finally, evidence based care might mean that your patients require a combination of both behavioral and medication therapies. And in particular, there are very specific substance use disorders that have very effective medications-- so opioid, alcohol, and nicotine use disorders, in particular. Let's try another case study, focusing on treatment systems.

In this case study, we have Jose, who is a 19-year-old Latino man. He comes to see you at his college student health services for psychotherapy. You've been treating him with cognitive behavioral therapy for social anxiety, which he often copes with by binge drinking. Jose's family believes that mental illness is a moral failing, so he refers to his visits with you as a health class.

Today, you give him a homework assignment to keep a journal of when he feels the urge to drink. I'll give you a few moments to think about what best practices are you already using with Jose.

Some of the best practices that I identified in this vignette are that you're treating Jose's mental health and substance use disorders together. If you're providing integrated care. You're using an evidence based treatment. So cognitive behavioral therapy is evidence based for these disorders that Jose has. And you're also tailoring the services to Jose's cultural background.

So he is more comfortable with an intellectual approach to his behavioral health disorders. And so you're using cognitive behavioral therapy, which is very intellectually based. It's all about how you think. It's all about shifting your thinking.

It uses a lot of organizational skills-- so agenda setting. A lot of homework involved. So this really matches well to what he feels comfortable with. And he's seeing you in a student health services setting, which I think also matches his preferences for care.

So finally, we'll talk about the best practices in the recovery phase of care. Since co-occurring disorders are chronic and often relapsing conditions, recovery is typically the goal of treatment. And it's a long term process, where people with co-occurring disorders regain health and social function. And recovery might include continued engagement in services, including use of medication, but not necessarily.

And it's also important to note that recovery doesn't necessarily include abstinence, and that people may continue to have symptoms, including substance use. And finally, relapse is a very common and often normal part of recovery. And so because of that, one of the best practices in this phase of treatment is the development of a relapse prevention plan.

And so what that is is a document often developed with a clinician and the patient together, where the mental health and substance use symptoms can be identified and long term supports to address those symptoms are listed. And so in this document, the patient might list their symptoms, including triggers of symptoms, successful coping strategies that they've used, and supports to address relapse.

And so it could be quite detailed, in terms of when I feel the urge to drink, I should call my sponsor. And if I do drink, I should talk to my-- I should make an appointment with my clinician. And if I drink more than five days in a week, I should check myself into inpatient rehab, because those things have worked before for me.

And you might actually have phone numbers and there. It might be something that a person shares with their support system or the people they live with, so that others in their network know what to do when they see their family member or their friend having a problem.

And another best practice in recovery is connecting patients to peer recovery and mutual support programs, which can be very beneficial. So peer recovery groups include things like Alcoholics Anonymous, Narcotics Anonymous, smart recovery, and mental health clubhouses. Those are just some examples, but there are many others.

And one thing that I think is a great feature of-- silver lining of the COVID-19 pandemic, is there's been a real increase in the variety of these types of mutual support groups that meet virtually. And that's really increased access for people who either were homebound, or had transportation issues, or were unable to physically get to the meetings.

And so now there's a lot more of these online, or that meets virtually via apps and other services. So I have one more case study for the recovery phase of care. And this time we have Barbara, who is a 61-year-old black woman. And she comes to your adult day health center three times a week. Barbara has a history of injection heroin use and bipolar disorder, but has not had active symptoms in over 15 years.

At your program, she participates in a Narcotics Anonymous group and volunteers in the community kitchen. On your way to her-- on her way to your center, she always stops at her methadone clinic. So I'd like you to take a few minutes to think about, what are the best practices that Barbara is already engaging in? And what else might be helpful to Barbara?

OK, so the things that I thought of when I read this vignette are that Barbara's already connected to your adult day health center, which is likely a mutual support group for her. She's also attending peer support at the day health center, through the Narcotics Anonymous group.

And she's regularly participating in an opioid treatment program. So when she goes to get her methadone, there are other services there that she can engage in. And you know that she's regularly taking that medication, likely at a maintenance dose.

So other things that might be helpful to Barbara that we don't know about through this vignette are that Barbara-- we don't know if Barbara has a relapse prevention plan. So that might be one additional thing that she could benefit from is developing a relapse prevention plan if she doesn't already have one.

And another thing is, we don't know what sort of maintenance plan Barbara is engaging in for her bipolar disorder. So she might be seeing a primary care doctor through your adult day health center. She might be seeing a primary care doctor somewhere else. That's something that you might want to ask her about, to see if she's taking a maintenance medication for that, or if she has a plan or a connection with services, for if she has symptoms, and how she might manage them.

So the last topic that I want to talk about today in this webinar are research trends in co-occurring disorders, particularly related to COVID-19. So as I alluded to earlier, there's a recursive relationship

between having a co-occurring disorder and COVID-19. So having a co-occurring disorder, or even just a mental health or substance use disorder alone, puts someone at higher risk of developing COVID-19.

And having COVID-19 increases a person's risk of developing a mental health or substance use disorder if they didn't previously have one. And so there's this feedback loop between the two. And I think it's still not fully understood exactly what all the risk factors at play are.

But what we do know is that the increased risk of worse COVID health-- COVID-19 health outcomes among people with co-occurring disorders is likely related to associated vulnerabilities related to social determinants of health among people who have co-occurring disorders.

So what I mean by that is, people with co-occurring disorders, as I mentioned earlier, are more likely to have problems with housing. They're more likely to have a trauma history or active stressors. They're more likely to have a history of arrests or justice involvement. And so all of those things not only increase a person's risk of having disorders, but they also increase a person's health risk to other health problems, like COVID-19.

And so one likely factor in increasing people with recurring disorders risk to developing COVID-19 and having worse health outcomes is that they have these other underlying social determinants of health that are putting them at risk. Another issue at play is that people with co-occurring disorders have a high likelihood of other comorbid health conditions, which could put them at high risk for developing COVID-19-- so things like heart conditions or diabetes.

And then there are also documented changes in immune response among certain types of co-occurring disorders and reduced pulmonary, function particularly among people with certain types of substance use disorders. And so there's likely, again, this interplay between genetics, stress, and environmental risk factors.

So specific research on what the actual estimate of increased risk is has shown that about 6% of people who've had COVID-19 go on to develop a psychiatric disorder in the months after having a COVID-19 diagnosis. And that's relatively high.

And so the mechanisms, again, are not fully understood as to why people have that increased risk. But the increased susceptibility to developing a mental health or substance use disorder could be because of the increased stress of being sick. It could actually be altering a person's genetics.

So we know with other viruses that sometimes, viruses can actually increase a person's risk of developing a co-occurring disorder. And we may find, with research over time, that COVID-19 has some of those impacts as well. It's unclear at this moment.

The other issue that could be at play is exposure to specific environmental risk factors-- so particularly among people who have experienced ventilation due to a severe infection from COVID-19. Opioids are often used during ventilation for pain management and sedation, and prolonged use of opioids can cause physiological dependence, which is a major risk factor for developing an opioid use disorder.

And so it wouldn't be uncommon for a person, after ventilation, to have a methadone dose to manage that physiological dependence. And whether or not they go on to actually develop an opioid use disorder is a separate issue. But certainly, it increases their risk to have that exposure, particularly if they've already been exposed before or have other risk factors.

Now even in general, among people who have not contracted COVID-19 the pandemic is also intensifying other risk factors, and as I mentioned earlier, in and of itself, can be a traumatizing experience. And so the increased stress and trauma from being exposed to the death and economic fallout of the pandemic increases the entire populations risk for developing COVID-- or, sorry, developing co-occurring disorders.

And there's been some early research which is documented that this is true. There has been population wide increases in symptoms of anxiety and depression, and markedly higher increases in those symptoms for young adults, who we knew were already at high risk of these co-occurring disorders to start, with higher risk than other age groups-- and in particular, for people with less than a high school diploma-- so again, people with low socioeconomic status.

So this convergence of risk factors, really putting certain groups at high risk of developing co-occurring disorders. In particular, there was a marked increase in substance use among Hispanic adults in the United States. And this has been theoretically linked to increases in that group's psychosocial stress related to food and housing insecurity.

This, in particular, I think, is problematic, particularly problematic. Because this group is not-- there's sort of mixed research about the baseline risk of this group. Oftentimes, they're not at higher risk, even though they do experience higher socioeconomic problems as the population.

But what we're seeing is that those protective effects are not-- that sometimes play out with certain health conditions are not playing out during COVID. And so that's-- that, I think, is very problematic. And leads into what do we do about this? How can we scale up services for particular groups that are at risk? And what are the ways that we've already done that? What are best practices we have learned from in this pandemic/

So as I mentioned earlier, telehealth, I think, has really been the major way that we have addressed this during COVID-19. And what telehealth is is the use of telecommunications technology to deliver health care. And it includes a variety of different modalities.

So it could be audio only, using a telephone or the internet. Could be video conferencing-- so something like what people call FaceTime, where there's a video and audio component. Or it could be a written only communication. So texting has become very popular. Or something like email-- there often electronic patient portals where you can message your provider and get a delayed response.

So all of these modalities, they can occur synchronously. So that's live, like this webinar. We're here together, and we could talk, chat back and forth, or we could talk to each other if you all were on the screen as well. Or they can be asynchronous-- so I mentioned before, where there's a delay in the communication. So more like email, where you send the message, and your provider may get it an hour or two later, respond with this delay.

And telehealth can also include remote monitoring. So this might include something like the use of an electronic medication box, which is a box which can actually dispense medication at a predetermined time, and then remotely transmit the information to clinicians. And remote monitoring is also used frequently in place of in-person urinalysis, which is common in monitoring use of certain medications for co-occurring disorders.

So often, certain medications that-- like lithium, which might have a high risk, in terms of if you-- a patient has too much of it in their system, or medications for opioid use disorder, which again have a high risk of lethality, if a patient has too much. And also, it provides the clinician with the ability to monitor other substances which might be in the person's system, which could interact with those medications.

And so you can use telehealth to remotely do those sorts of monitorings as well. So prior to COVID-19, we had telehealth. And most telehealth at that time required, for reimbursement purposes, to be synchronous with video and audio. So it was somewhat cumbersome. And relatedly, most research focused pretty much exclusively on the synchronous audio visual mode of-- modality of delivery.

So most of what we know about telehealth and its effectiveness is that type of service. But because of social distancing recommendations due to the COVID-19 pandemic, many of the administrative barriers to using telehealth were eased. So for example, those billing reimbursement requirements to be using only synchronous video and audio and use of HIPAA compliant software platforms-- those were all eased.

And so that allowed for was a real explosion in the use of the variety of telehealth modalities-- so people starting to use texting, people starting to use telephone only, people using software platforms that they're already comfortable with, not having to download a new app on their phone, and figure out how to use it, and go through lots of permissions. They were able to just communicate with their provider the way that they communicate with anybody else, in the way that they were most comfortable.

And what that has done is, it's created this huge array of different ways that patients can connect with their providers in a much more patient driven patient centered way. Now what we don't know is, what is the effectiveness of all of those different modalities?

It's created a huge opportunity to be able to research in real time who's use these different modalities, how has it worked for them, and how might we leverage what we've learned from this going forward, to potentially increase access to care to patients who, for whatever reason were unable to access existing modalities of care, or didn't feel comfortable with those modalities?

And I think one group that might, in particular, benefit from this is those young adults, who we know are at much higher risk of co-occurring disorders, much heavily much more heavily impacted by COVID-19, effects on co-occurring disorders, and also are very, very tech savvy and tech driven.

So as I mentioned before telehealth has been around. And prior to COVID-19, we had evidence that telehealth was effective for many mental health and substance use disorders. It had been tested with a lot of manualized interventions. There were over 10,000 app based interventions just for mental health disorders, many of which went through rigorous randomized controlled trials to test the efficacy.

So we know telehealth works. We've been using it. But since COVID, as I mentioned, what's changed is the expansion into previously untested modalities-- so mostly that audio, only using the telephone, and also like texting, or a hybrid, where a patient is using a different mix of these modalities across various visits.

And so I think what we've learned from that, although the research is still coming out, is that telehealth potentially can be used to increase access and engagement and care for certain groups. And so some recent research, looking at telehealth for co-occurring disorder treatment of young adults, has

highlighted that for certain young adults, there's been increased engagement in services. And in particular, it's youth that live far from the clinic and youth who have competing time demands.

And so those are youth that perhaps have transportation challenges and/or don't have the time to physically come down to the clinic for a couple hours. And so it's been historically a different population-- a difficult population to engage in services, and I think intersects with this increased risk of that group. So it's a group that we haven't been meeting their needs well. And so potentially, there is an opportunity to leverage telehealth services to try and expand care for this group.

Another study found that there was a survey of patients. And 70% of patients said that in the future, they would actually prefer to use telehealth for the majority of their health visits. And I think what that says is, not only among these very specific populations with particular barriers to care, but in general, what patients found when they were forced to try telehealth is that a lot of them thought it was acceptable.

It was usable. And actually, in many cases, they preferred to at least do some of their visits that way. Now it's not all been perfect and rosy. There's other studies. And some of these other findings in these particular studies show also that as you might imagine, access to technology is a huge barrier to using telehealth. And that goes for clinicians and patients.

And so it could be a really difficult mix for these patients in remote areas, where perhaps they have transportation problems. But they may not all-- they may also not have good internet access. They may not have a cell phone signal. So telehealth might not be the answer for them either.

But I think what we have seen is that a lot of people, clinicians and patients, when they were forced to try telehealth, and often thought they didn't-- they wouldn't like it, that they found that it wasn't so bad. And sometimes, it was preferable. And so that's one thing that I think we need a lot more research on, is to identify, what are the subgroups where this is particularly effective?

What are the scenarios where you it might be best practice to have in-person visits, in particular for groups who the practice of going physically to the clinic is structure and stability? Those are people that you might-- it might be best practice for them to come into the clinic.

And so you might think back to our case example of Barbara, who's physically come into the adult day health center, physically going to her methadone clinic, and all of that those visits. There's a lot of touch points with different service providers, with peers. And all of that is part of her recovery plan. And so with telehealth, you lose a lot of that. But you gain convenience, and you gain access.

And so like any other best practice, telehealth needs to be tailored to the patient characteristics and what their specific barriers and facilitators of care are.

So looking to the future, what are the practical implications for future behavioral health providers like you all? Well, as I've alluded to several times, I think the future direction and treatment is going to include remotely delivered services. So telehealth is here to stay. And I think what we've also developed in the course of the COVID-19 pandemic is the infrastructure to deliver telehealth has really improved.

And so clinics have developed and have purchased the technology necessary to do this. Clinicians and patients have practiced using it. They've become somewhat comfortable in doing, using telehealth. They've learned about how it can be flexible. They learned how to tailor it.

And also, I think we're seeing these opportunities to engage diverse populations which had previously not been well served by this very rigid in person or very complicated previous use telehealth modalities, where you had a very particular app that was specific to your clinic. And you had to have video and phone at the same time.

So all the relaxation of all of that, I think, has shown us that when we can have different options, there are people who weren't-- they didn't-- they weren't well served by the previous options. And they may be well served by some of these new options. And so taking that risk benefit approach of being able to match patients to the type of care that meets their needs now, and is going to reduce their risk from symptoms.

And so I think a lot of that is going to come down to clinicians taking time to understand each patient's background, their needs, their preferences, and identifying what the best modality of care is, whether it's in person, telehealth, what modality of telehealth, and perhaps a mix of those things-- and thinking also about how they can, as a clinician, you can leverage other sorts of supports outside of the clinic.

So thinking about mutual aid groups and peer groups, which might be meeting virtually or in person, and in trying to help connect patients to all of the services to meet the variety of needs that they have across the different areas of their life to support the holistic health plan.

These are some key references that I used to develop this talk. I want to give you all access to those, so that you can check them out and have further reading, or look up some more of the statistics that I shared. And finally, I want to make space for questions from all of you all, or comments that you might want to share, best practices you all have learned during this time. I know that I'm going to have a little bit of help managing that.

So I welcome whatever you all hope to share, and hope to answer your questions. And thank you all so much for coming today and giving me your attention.

INA RAMOS: Thanks so much, Dr. Henry. And we have received several questions, the first of which-- would you consider individuals in abusive relationships at higher risk for co-occurring disorders?

BRANDY. F. HENRY: I would say that experiencing domestic violence or other forms of abusive relationships is definitely a risk factor for co-occurring disorders. Now it's one of many. And so considering what other risk factors that person might have is important. So it doesn't necessarily mean that alone would lead to it. But that, in combination with many other things, could lead to it.

And certainly, that alone could lead to it. And specifically in the instance of post-traumatic stress disorder, combined with using alcohol to cope or something like that, that's not uncommon. So definitely, I think that is a risk factor, and something certainly to screen for and to look out for in your patients.

INA RAMOS: Thank you. The next question is, shared some of the reasons that Black and Latino people are least likely to receive treatment for mental health and substance use disorders. Do you have any recommendations for overcoming some of these barriers?

BRANDY. F. HENRY: Yeah, I think that that's such an important question, and something that there could be a whole talk on. And I think you all may have some talks around culturally adapting services, which is a huge part of creating services that are, first of all, welcoming.

But there's a lot of different touch points to get a person into care. So at first, they need to be able to get to it. So are there, for example, services or clinics physically located in neighborhoods where there's a large proportion of those populations living? Often, there's not. So that's the first thing is, are there services available that they can get to? Are the services affordable?

So do they have sliding scale fees? Do they have assistance in helping people apply for different forms of insurance that they might be eligible for? This can particularly be helpful in scenarios where people may have also, on top of the racial and ethnic discrimination, a language barrier. So are these services provided in a way that the people can even communicate with the providers there?

Are they able to connect them to related services that they might need to access insurance? So things that might relate to like immigration-- there may be concerns around, for example, if I come to the clinic, will that expose me to liability from immigration services or something like that? So being able to communicate very clearly with people around that the clinic is a safe and welcoming place, where they can come to get helped, and that they won't be harmed by that.

And so that's all, I think, just getting people in the door. And then once they're in the door, are they receiving services that are respectful, that are appropriate to their cultural practices and understanding, that are not overtly discriminatory-- which even, in some instances, that's like the lowest bar, right?

But sometimes, practices engage in discrimination like the rest of society. And so being able to address all of those things, so that when people show up, they want to stay, and that the services meet their needs-- so that their clinicians are trained in providing services that are evidence based for those populations, that they have clinicians and staff who are representative of the population that they're serving.

They have, for example, they're employing staff of color, staff who speak the languages that are spoken by those communities. So I think it's so complicated. There's so many pieces. But also, we have-- the information is out there. We have the training available. There's this program that's providing services that anybody can engage with, watching the video to learn later. And so I think what we need is out there. So it can be done. But there's a lot of different pieces involved.

So I'm glad that the question got raised, and hopefully that helps answer it.

INA RAMOS: Thank you so much. The next question-- are there factors that you see in the field that clinicians overlook when screening and assessing for co-occurring disorders?

BRANDY. F. HENRY: Yeah, what I've heard a lot that people often overlook it intentionally. Because they're worried about, well what do I do if somebody says that they've been thinking about suicide? I don't know what to do about that. I'm afraid. I'm worried about the risk that the person is going to go hurt themselves, and that I was a bad clinician, and I didn't prevent it somehow. And so they don't ask the question.

And similarly, they don't screen for trauma. Because they're worried the person's going to start telling them some very sad story, and they don't have the tools to de-escalate the person, to provide support, to connect them with follow up care. And so there's a lot of, I think, intentional overlooking of these things, because they don't know what to do about it.

So I feel like clinicians, they need tools. They need tools to know how to screen. So sometimes, the use of these, as I mentioned before, paper and pencil validated screen you can give everybody in the waiting room, is an easy first step. So you can give it to the clinician. They have some information. They can think on it, decide what to do.

They can have resources available-- for example, a clinic with integrated services, where you maybe have a social worker, a case manager, where you can connect the patient to that person if they bring up, like yeah-- I'm living in this relationship where I don't feel safe to even go home-- that you can connect the person, with someone who can help them.

So giving the clinicians resources that they can share with the patients and skills on how they can manage what might come up for the co-occurring disorders, I think, is hugely important. And sometimes, our systems aren't set up to help clinicians in that way. Like, for example, historically, mental health and substance use funding streams have been separated.

So a clinician might actually need multiple types of endorsements or licenses to practice across mental health, and to provide actual integrated care for co-occurring disorders. And so that's a huge barrier to having the tools that you need. And I think that's shifting a lot. And there's lots of rethinking of funding, and trying to bring integrative care together. But that has historically been part of the problem.

And so I think there's reasons why people are worried about it. And helping give them the tools to be able to be successful in screening, and know what to do when it comes up, is, I think, a real key factor.

INA RAMOS: Thank you. The next question is, have you worked with mandated people? And if so, do you have recommended approaches for working with this group?

BRANDY. F. HENRY: Yeah, that's a great question. And as you may have guessed, given that I've, in my clinical work, mostly worked with people who were in the justice system, I worked with a lot of mandated patients, including people who are incarcerated or mandated I worked in inpatient settings, forensic inpatient settings.

For people who are not there on their own free will, or will literally locked in your clinic-- and as you may have experienced, or people may imagine, that's not a good feeling for the patient. They're usually upset about being forced to be there, having lost their rights. And I think it's upsetting also from a clinician's perspective. That's not really how you want to be providing care to people.

You want to be-- evidence based care is patient centered. It's patient driven. It's collaborative. And mandated care is none of that. But it exists. And so what are we going to do about it?

And I think really just starting where the patient is at, and working with them on whatever they bring to the room that day-- and so going slowly, developing rapport, identifying some sort of goal that you can help them with, and then building from there, has been what's worked for me, and I think is also borne out in research and best practices, too.

INA RAMOS: Thank you. The next question-- what services are available to justice involved people with co-occurring disorders?

BRANDY. F. HENRY: Yes, I think it really depends on the jurisdiction a person is in, and also what level of justice involvement they're experiencing. So the one continuum where there might be incarcerated,

systems of incarceration are legally required to provide health care. It's like the only population where that's the case.

But the level of care that may be available varies drastically by the system and how well it's funded, and how invested that particular political system is in providing care. And so I think, because of the lower level of priority of that population politically, there has historically been a lag in best practices being available within systems of incarceration.

So for example, there's historically been lower levels of access to medications for substance use disorders in prisons and jails, although that's changed a lot. There's been recently a lot more research, particularly-- there's been increased interest in uptake in the injectable forms of those medications. So that's starting to shift.

And I think the same thing goes within those systems, as I was talking about before, around historically funding being separated-- so mental health and substance use programs maybe being delivered by different entities, and not being integrated. And that's starting to shift.

In general, I think there's a lag from the best practices in the research. And then there's quicker uptake in the community. And then the settings of justice involvement are sort of lagging behind. Generally, there's some places that like to be on the forefront of these things. So there's certainly outliers.

But I think, in general, there's typically the same array of care available. But the availability of it is lower, and the rate at which new things are introduced lags quite a bit.

INA RAMOS: Thank you. The next one is a comment. This person said I was shocked by the COVID-19 impact on psychiatric diagnosis.

BRANDY. F. HENRY: Yeah, I think I was, too. I mean, it's not surprising in one sense, that like I'm stressed. Everybody's stressed. It's a very stressful thing. And so of course, that's related to psychiatric disorders. But to actually see figures around how high it is, and who it's impacting-- it is quite shocking, and I think does lead to, what do we do about that? And what are the long term effects, which we don't yet know?

INA RAMOS: Right. OK, the next question-- have there been any unintended outcomes or consequences with the uptake of telehealth and treating co-occurring disorders?

BRANDY. F. HENRY: I'm sure there have been. And I've read about some and learned about some in my own research. I think one of the things that's hard to know right now is, we know that there has been an increase in overdoses and fatal overdoses. And certainly, some of that is probably related to social isolation. So people are much more likely to die when they use it alone. There's no one there to rescue you.

But how much of that might be related to reduced service access? We do know that some people actually experience increased services. So really sussing out who did telehealth work for and who did it leave behind, I think, is unknown. And I'm certain that some people did-- were left behind. And there's also been impacts on the providers, too.

So some of the work I've been involved in looking at provider wellness, and in relation to COVID, and in relation to these changes in practice. And some providers have indicated that it's increased burnout.

Now it's also it's hard to suss and parse the difference between how much of that is the telehealth, and how much of that is the pandemic. It's both, I think, in some regards.

Some providers, though, like some patients, said that they preferred it, that telehealth let them stay at their house. They felt more comfortable there. They didn't have to address all the stressors of leaving their house during a pandemic. So in the same vein, I think that there's-- that the impacts have been different for different subgroups. And really understanding who was helped and who was harmed is so important.

And I think it's complicated that some people experience the opposite impact from some telehealth. Like some people, it was useful, and some it wasn't. And so I think it'll probably take us a long time to really understand that.

INA RAMOS: Thank you. OK, we have two more questions. So the next is, how effective is remote monitoring? For example, you talked about urinalysis. How does the provider ensure the sample is actually from the client?

BRANDY. F. HENRY: Yeah, so that's a good question. And it's something that's not been tested as much. My impression from doing qualitative work with providers is that prior to COVID, they didn't really use remote monitoring for this thing, because of all the complications. And patients also seem to not generally like it very much.

Like you basically-- most of the forms, you literally videotape yourself providing the sample, instead of having someone watch you. And so you might imagine that patient privacy would be concerned about there being a video of that. And where's that going to go? Where's it going to be stored? It'll just come in person.

So I think the effectiveness of it, in terms of are you actually collecting-- is it in real time? Is it is the sample that's being mailed to you actually the one that you saw? I think there's lots of-- it might be sort of thinking opportunities for that to be not accurate. Whereas in person, there's less of those opportunities.

My impression is that it's not used very frequently because of that. But it seems like it's, in sort of extreme circumstances, something that clinicians like to at least have the option to do it when the patient really should not be leaving their house, that they could use this. But again, there's a lot of concern about liability. If they feel like they can't trust the remote monitoring as much as the in-person.

So I think we'll find out over time that that's something that will actually have a lot of uptake. My impression is that it's not been as popular as the other forms of telehealth.

INA RAMOS: OK, great. And the last question-- can you talk more about your work with criminalized populations and co-occurring disorders?

BRANDY. F. HENRY: Sure, yeah, so most of my recent work has been research with this population. And so in the context of COVID being quite recent, I've been looking at what's the intersection of infection outbreaks within jails and prisons and service receipt?

And there's-- like there were changes with policies for-- that created this opportunity to use telehealth for behavioral health services, there's a whole host of policies that have also been changed due to

COVID-19, related to criminal justice. So there's been a lot of decarceration. There's been a lot of reduced prosecution. There's been a lot more compassionate release.

And so trying to look-- well, part of my research has been trying to look at how those things intersect. What have been the effects of those policies? Like for example, has there been increased risk to these patients that are being released with limited services available because all the clinics are shut? I also do some consulting with clients who are in these scenarios, so working to try and set up care plans and release plans for people who were, for example, being released under this compassionate release policies that were allowed.

And it's been very, very difficult to try and find service. It's typically not easy. But in this environment, where clinics are closed, and people are hesitant to do remote induction-- so start people and services remotely-- like they were more comfortable continuing services with their patients that they already were working with. But taking new people, they were more hesitant.

Funding was low. So sometimes, it was just a capacity issue. So that, I think, has been a real challenge, where there were some opportunities for people to stay in communities and stay more connected to care. But the care system weren't ready for-- weren't ready for anything. So you're trying to think about how we can, one, serve the people who have needs right now. But two, think about how we can use what we've learned from this to inform policies going forward is sort of the second thing that I try and work on.

So that's, again, an ongoing project. And hopefully, there'll be more to learn. But I think there's been a lot of silver linings that we've learned about. And we've tried a lot of new things, and even learning about the parts that didn't work can be useful.

INA RAMOS: Absolutely, absolutely. So we would like to thank you, Dr. Henry, and the participants, for a great question and answer period, and for joining us today on this webinar. We hope that you will be able to utilize the information presented today to strengthen your work.

In closing, we would like your feedback on this webinar. After you close the webinar window, a new window will pop up that includes a brief survey. You will also receive a follow-up email with the survey and with a link to download a certificate of participation.

So thank you, and this concludes our webinar.