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NAADAC WEBINAR
THE IMPACT OF DISASTER ON RECOVERY:
THE PERFECT STORM

FRIDAY, APRIL 3, 2020
11:00 A.M. - 1:00 P.M. CT

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>> SAMSON TEKLEMARIAM: Hello, everyone, and welcome to today's webinar on the impact of disaster on recovery, the perfect storm, presented by Dr. Timothy Legg. It's great that you can join us today. My name is Samson Teklemariam and I'm the director of training for NAADAC the association for addiction professionals. I'll be the organizer for this event. This webinar is sponsored by Recovery Path. Recovery Path helps addiction professionals to meet the urgent need to deliver quality virtual care. This app works hard between telehealth or in person sessions to keep patients motivated and on track while keeping you looped in on the challenges and victories they are experiencing. To learn more from our sponsor, the website is https//www.Recovery Path.com. We're going to send that hyperlink to you in the chat box. Please stay tuned towards the end of the webinar for instructions on how to get your CEs from this webinar and a demo from Recovery Path.

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And as you can see, we are using go to webinar for this slide

event. You will notice the go to webinar control panel that looks like the one you see on my slide here. Here's some important instructions. You've entered into what is called listen only mode. That means your mic is automatically muted to prevent any disruptive background noise. If you have trouble hearing the presenter for any reason, consider switching to a telephone line by clicking on the audio option which is right next to the orange arrow. You can use that orange arrow anytime to minimize or maximize the control panel and if you have any questions for the presenter, just type them into the questions box. We will gather questions and I will pose those questions to the presenter during our live Q and A. We are also super fortunate to have Recovery Path on line with us live during this webinar, who will address any questions you all may have about using mobile technology to support recovery.

Any questions we don't get to we will collect from both the presenter and our sponsor and post those questions on our website in just a couple of weeks. So with no further delay, let me introduce our presenter.

Dr. Timothy Legg is a licensed psychologist, as well as a licensed and board certified psychiatric, mental health nurse practitioners, a master addictions counselor, through the national certification commission for addiction professionals, and a certified addictions registered nurse, advanced practice, in private practice, in upstate New York area where he provides a combination of psychotherapy and medication management services to individuals who struggle with substance use and co-occurring disorders. In addition to his Doctor of Psychology, Tim holds a Doctor of Philosophy in the field of health sciences research and education. He is certified in public health by the national board of public health examiners. He is the coauthor of the book disaster nursing, a handbook for practice, which received the American journal of nursing's book of the year award. We are delighted to present this webinar to you by this accomplished trainer who also shifted his entire schedule to bump this up on our schedule to offer to you earlier this year.

So Tim, with no further delay, I'll turn this over to you.

>> TIMOTHY LEGG: Thank you very much, and I just wanted to begin by saying it's wonderful to be here. I understand that there are over 1500 people that have registered, but -- and that wasn't concerning me too much. But what did concern me, I found out that two members of my doctoral dissertation committee are going to be here, so that's always intimidating.

But at any rate, without any further ado, I'd like to jump into what we're going to talk about today and then at each of the sections that we go through, I will remind you of the learning objectives so that you'll have some context for the content that we're about to go through.

So first we're going to describe natural and human-made disasters that can and do happen, and how they can disrupt the lives of people in recovery.

The second thing that we're going to talk about is the psychological implications of disaster, and the potential negative consequences that disasters could have on persons in recovery and the recovery goals.

And the last thing we're going to talk about is a disaster recovery plan, because many times we talk about a disaster plan, we talk about a recovery plan, but unfortunately the two don't always get discussed simultaneously. And I think that that's an opportunity that we are missing.

So before we go too much further, I would just like an idea of who's here today. Licensed or certified addiction counselors, and I know that every state has their own shorthand. New York has the CASAC, some states have L ADC, so anybody who is licensed or certified in your state or nationally as an addiction counselor. Same thing with letter B, we have the licensed professional counselor, a licensed mental health counselor, social worker, many different terms in different states.

Psychologists or psychiatrists, registered nurses, or anybody else. So just give me an idea of who's here today, please.

>> SAMSON TEKLEMARIAM: Thank you so much, Tim, you will see the interactive poll on your screen. This is one of several chances to interact with the presenter. You will see five answer options. It looks like over half of you have answered. I will give you five more seconds to answer that poll.

Perfect, thank you so much everyone. We exceeded, so more than three-quarters of you answered. I will share the results and I'll turn it back over to Dr. Legg.

>> TIMOTHY LEGG: Fantastic, so we have a lot of addictions counselors. This is exciting. Professional counselors, social workers, psychologists or psychiatrists, nurses, that's great, and others. So I'm not sure if that may include individuals who are currently pursuing addiction credentials or not, but it's great to see a nice diverse audience.

So this actually, the request of course to do this earlier clearly came about from the current state of affairs in the world today. And last week, on Friday afternoon, when I did say yes, we could definitely bump the time frame on this, I think many people have seen this, the Johns Hopkins University's school of medicine's interactive coronavirus map. As of last Friday afternoon, we were hovering around 585,000 cases throughout the world. I was finally told yesterday, come on, you got to get your slides in, so I did have the opportunity to check, and we were at 941,000 plus cases throughout the world, and this morning we are over the 1 million mark. So it is clear that this is a source of concern for many people, and this has truly impacted so many things we do. I'm not

just talking only about our professional life but the way we live our personality lives and I wonder and am concerned about individuals who are themselves in recovery.

So that takes us to the formulation of my first objective and I wanted to talk about both natural and human made disasters that can and do happen, and how they can disrupt the lives of people in recovery. And this is something that I've been interested in for a very long time. My colleague, Dr. Eliman and I, when we had written the disaster nursing book several years ago, we were interested in topics of how disasters impact humans but over the years I've become much more fascinated and interested in how it impacted people who were themselves in recovery. And after doing many years of reading research articles and trying to see where we are, I have to tell you that the answer to the question depends on who the researcher was, the way the study was conducted, and so many different variables. And unfortunately, many of the research studies, sometimes they do support one another, more often than not they contradict one another, so we're basically stuck with a hodgepodge of research from which we're going to have to draw some of our own conclusions.

So just to give you a few examples, and again there are literally hundreds of these out there, I have included all of these in the reference sections of the slides which you can download from the webinar's landing page, but when we start with the 2008 study, this looked at the Southeast Asia tsunami, which had occurred, and the authors Vetter, Ross Egger, Rossler, Bisson and Endrass in 2008, looked at a study of people who were Swiss tourists concluded that the tsunami did indeed result in increased substance use. However, eight years later, another study done by Nordlokken, Paper and Heir, concluded that as a result of their longitudinal study focusing on Norwegian adults who were affected by the tsunami, the consumption or frequency of intoxication did not change significantly. 18.3 percent of the sample reported increased consumption whereas 21.1 percent reported decreased consumption. So what do you do with this?

Let's focus to the dreadful events of September 11, and Vlahov, et al., did a study focusing on increased substance use experienced on 9/11 and they found that there was an increased substance use among people who responded to their survey, specifically cigarette, marijuana and/or alcohol use was found to have increased among 29 percent of their respondents.

Fast forwards 11 years, however, north and collaborators completed a study of volunteers from New York City agencies who were impacted by September 11's event. And they concluded that there were increases in alcohol consumption, but they were small. And that they returned to baseline after three years following the disaster. And of course there were a few cases of new alcohol use disorder or relapse, but not enough apparently to achieve

statistical significance.

Boscarino, Adams and Galay in 2016 found that greater exposure to disaster was associated with greater amounts of alcohol consumption at both one and two years following the World Trade Center disaster. And I can spend probably a week here talking about the dozens of other studies that basically contradict one another and lend support to others, and, you know, meet other studies halfway, but the big question that I always get when I talk about these things is why? Does this mean that research is a waste of time or doesn't work? And of course the answer is absolutely not.

You have to remember that research can be trendy after a tragedy. Some studies are done almost immediately, but I challenge you, if you were in the middle of a natural disaster, how many questions would you feel like answering to a researcher? And then don't forget a few years later, follow-up studies, longitudinal studies, I really don't remember what I had for dinner last night, so I really can't tell you how many cocktails I may have had eight years ago, so of course that could be a problem.

And then many people --

>> SAMSON TEKLEMARIAM: Hey Tim.

>> TIMOTHY LEGG: I encourage you to just think back to graduate school, or undergraduate, where you had to take that -- yes, yes?

>> SAMSON TEKLEMARIAM: Yeah, sorry to interrupt, Tim.

>> TIMOTHY LEGG: Yeah.

>> SAMSON TEKLEMARIAM: The audio shifted and as we practiced earlier, is there a way that you could just go ahead and disconnect from the computer audio and connect to the phone call? You can click on the audio tab in your go to webinar control panel, and you'll see under audio, it'll say computer audio, phone call. If you click on phone call, try connecting with us using the instructions there. And everyone thank you so much for your patience. Some great questions coming in. We will pose your questions in the order in which they have been received. If you're wondering how to send questions to the presenter, you can click on the go to webinar control panel. It's that little orange arrow. Click on the questions box, it's underneath your audio tab. And any questions you send in there will go to our administrative assistant who is helping with the questions. We'll make sure those are added to the queue and we'll make sure to ask those questions to Tim in the live Q and A.

Hello?

>> TIMOTHY LEGG: Hello.

>> SAMSON TEKLEMARIAM: Hi, Tim, can you hear me?

>> TIMOTHY LEGG: Great. Can you hear me?

>> SAMSON TEKLEMARIAM: Yes. Tim, can you hear me?

>> TIMOTHY LEGG: Yes, I can.

>> SAMSON TEKLEMARIAM: Yes. You're coming in loud and clear.

We heard almost you said. It got a little staticky and so if you can go ahead and take over right where you left off and we'll continue the presentation this way.

>> TIMOTHY LEGG: Okay. Fantastic. Thank you.

Okay. So I'm sorry about that. I don't know what happened. You know, of course, whenever you want something to work, that's the time it's going to decide not to.

So just to continue, I want to challenge everybody, about back to where you were in graduate school or undergrad when you had to take that research class, and just remember there are things that threaten studies. Things like history, events that naturally happened since the time of the study that in some way impacts the response of participants.

Maturational process the. Some people with the passage of time do change. Again testing. Anytime you test with one instrument and testing with something else, there is potential for differences in response.

Problems with instrumentation. Remember that statistical regression thing you might have heard of it as regression to the mean. It's simply a mathematical phenomena that occurs when you get scores. They tend to move towards the average.

And also remember selection of subjects. One particular group of subjects who participate in research may not be the same or have the same response or same experiences as another group.

And there's of course mortality, which is your loss of subjects, and don't forget social desirability bias, and we see this in counseling all the time. Very few times are you going to get a patient who simply comes in and starts telling you all sorts of problems or issues or concerns they have. Initially they might be very tight lipped because they don't want you to think ill of them, so social desirability bias is another phenomenon that could definitely impact the results of what you're going to see in research. Again some people just do not want to share certain things.

Okay. There's other research out there, which I also thought was interesting that I wanted to share with you. Ager in 2008 considered the role of denial as it related to those who were living in New Orleans and the events that led up to Hurricane Katrina, and, you know, I wanted you also to think of the role of denial during disasters that you may have been seeing in your practices up to the point as the pandemic was unfolding.

When it occurs to people, sometimes that they are in over their heads or that this really is as bad as, you know, government officials may have said it was going to be or health care professionals said it was going to be, sometimes you're going to see an increase in maladaptive coping techniques, specifically perhaps substance use, it can increase. So there are many people that do live in perpetual denial. You've seen them. I've seen

them. You know what I'm talking about.

Gargano, Welsh and Stellman in 2017 found that children who witnessed the events of September 11 were twice as likely to report drinking and three times as likely to have used marijuana.

Prost, Lemieux and Ai considered social work students who reported post disaster alcohol use disorder, and this is going to become very important for those of you who do supervised studies during this particular time of disaster so be sure you're checking in with students that you're working with. Cerda, Vlahov, Tracy and Gala in 2008 found higher levels of use over time predicted by ongoing stressors, traumatic events and lower incomes and this actually does support what we know about the development of PTSD and we're going to talk about that a few slides down the road, but their work really did support our knowledge of the development of PTSD.

And finally in a 2015 study, Tofighi and colleagues demonstrated the adaptability of the buprenorphine program and how it can help maintain positive treatment outcomes. So things can happen but it also depends on our ability to be prepared.

And again I have mentioned earlier that in the references you will see all these studies, for anybody who wants to read them all in their entirety.

So now where does this leave us? As you can see, the research does not give us a good or a direct answer as to whether or not disasters truly do impact substance use patterns or disorders.

I on the other hand am going to believe what my own eyes are capable of telling me, and I did a great deal of research on this topic across many states, and it is quite apparent in many states that alcohol use, at least alcohol use which was being discussed on these various news channels and news sites, has increased, so I'm not really sure what longitudinal studies will say about this pandemic, but in the time now that we are living in, it's quite clear that alcohol use has increased. So I just think that's kind of important to see what is happening actually in front of us.

So we're going to turn a little bit now toward concepts of disaster. What exactly is a disaster? And this is another -- this is one of those terms that has been defined to death. I like the international federation of red cross and Red Crescent society's definition, because I think it really encompasses what we're experiencing. A sudden calamitous event that seriously disrupts the functioning of a community or a society, or what we're living through right now. It causes human, material, and economic or environmental losses that exceed the community or society's ability to cope using its own resources.

And from that definition, clearly we have a disaster on our hands.

Though often caused by nature, disasters can have human origins and as we're going to talk about in a few slides, sometimes it's

difficult to tell which is the man-made disaster and which is the natural disaster. More on that in a few slides.

Okay. So it does differ from emergency, which we define according to the World Health Organization as a state in which normal procedures are suspended, and extraordinary measures are taken in order to avert a disaster, and at this point, we're beyond the emergency phase, and we're in a disaster.

So we're going to talk about the relationship between the emergency, the disaster, et cetera, in our next slide.

Okay. So this is very busy. We start in the lower left-hand corner, because these are the things, these are the factors that impact or result in our collective vulnerability. And I want to talk about these in just a little bit of detail, because these are things that we seldom think about.

So underlying causes. We know that poverty, limited access to power structures, resources, et cetera, we know that people who find themselves in poverty and disenfranchised groups tend to have a greater likelihood or greater vulnerability of being impacted by negative events.

Ideology is of course, economic systems, age, sex, illness, disability. These are all factors that help play into groups of vulnerabilities.

Dynamic pressures, and by dynamic, we talk about things that change, so lack of local institutions or lack of education, training. Many of us work with disadvantaged groups that live in areas where individuals are in areas where they don't have appropriate job skills. They lack education. Many businesses don't invest in local economies. You might find that local markets are limited. There may also be limited services available to individuals in some of these areas.

Additionally, there are places in the world where even though things are bad and things are getting worse, there's not exactly freedom of the press. Larger forces like population expansion, urbanization, environmental degradation also come into play when we're talking about vulnerability.

And of course unsafe conditions. Fragile physical environments, dangerous locations, buildings, et cetera. And some local economies are actually quite fragile. Low levels of income, livelihoods that are precarious, and of course public actions. These all come together to establish or to inform our level of vulnerability.

Okay. On the lower right hand part of the picture here is the next part we talk about, a trigger event. Something happens. These are our man-made or natural disasters: Earthquakes, winds, floods, volcanos, droughts, war, technological accidents, or the introduction of a new virus or our pathogen, or pathogenic micro organism, that represents a hazard. Where vulnerability and hazard meet, we find disaster.

Now, I have another little element in here which I think is important to talk about and this is our capacity. And this is actually how the disaster differs from the emergency that we talked about in a previous slide.

Typically we can handle emergency, yes, we have to call on many of our resources, but typically it's something that could be handled. But once that capacity has been exceeded, we are dealing with a disaster.

So it's a very busy slide, I acknowledge that, but I think it helps to understand what it is we're talking about when we are discussing such concepts as vulnerability, hazard, disaster, what's an emergency, what's the difference between the two, et cetera.

Okay. So let's talk about some of the sources of disaster. We alluded to them on the previous slide, but natural and man-made are sometimes difficult to discern. So a natural disaster we think of avalanches, earthquakes, floods, blizzards, wildfires. Several of these things can also be man-made as well. An avalanche may occur because of deforestation. Earthquakes may occur because of a man-made natural environment. Floods can happen due to urbanization, removing areas of forests that once protected from floods, et cetera. Your heat and cold waves, tornadoes.

Man-made disasters are things like terrorism and unfortunately the world has become very familiar with this concept. Biological warfare, chemical spills, road accidents, and sometimes when I say infectious disease, people look at me and say how can that be man-made? Diseases happen because of the micro biological kingdom. Yes, they do, but also humans do a great deal to spread disease in terms of living conditions, crowded living conditions, cities, et cetera.

So even though the agents may be something that naturally occurs, humans do have a role in that being a man-made type disaster.

So does it disrupt -- do disasters disrupt things? Of course they do. Think about your normal routine. Many of us have been affected by the cancellation of work. We're closing down, all of our work is moving to telehealth. So think about your normal work routine. Think about family. We sometimes complain we don't see enough of our family and now you're probably seeing too much of them. What about friends? Recreational patterns, things that you enjoy doing, but, gosh, can't now.

What about appointments with providers for yourselves? Not just your clients. And what about support group meetings? I work with a lot of individuals that go to AA, NA, et cetera, and those -- many of those have been suspended. So what happens when they're deriving a sense of social support from those organizations.

How many people are experiencing so called cabin fever right now? And again you're stuck with family members. You're probably learning a lot more about your family members than you wanted to.

Many people are experiencing what I call excessive discretionary time or free time boredom. They have all this time, and what do I do with it? And of course the lack of diversional activities that come with being stuck in the home can also be a source of disruption.

Okay. So we are at our second polling question, and it's a nice time to check in and just find out how many of you are experiencing this with your own clients. So have any of your clients talked to you about an increased desire to use or share other concerns related to their ability to adhere to their recovery goal?

>> SAMSON TEKLEMARIAM: Thanks, Tim. Yes, everyone, you will see the polling question pop up on your screen. In just a moment -- Tim, it looked like we lost you for a minute. So everyone you'll see the polling question pop up on your screen. Wow. Over half of you have already voted. Excellent. This is your opportunity, one of many opportunities to interact with your presenter. We will also have a live Q and A towards the end of the webinar, with both the presenter and our webinar sponsor, Recovery Path. The question is have any of your clients talked to you about an increased desire to use or related concerns to COVID-19 impacting recovery?

Tim, I'm sorry to do this to you. If you could actually switch back to computer audio, although it was coming in loud, the disconnection was happening more.

Everyone who got a link to the stream text so you can follow along with the closed captioning, Tim, if you could go back to your control panel, click on audio and click back to computer audio, switching back to computer audio, then if you could switch off your phone. I have a feeling that's what's happening right now is connectivity related. So any devices you have currently connected to your Internet, Tim, if you can disconnect those devices from your Internet. I just set my phone to airplane mode, so hopefully that helped, but just so you guys know, we actually just got a report from CNN and ABC news, they're actually reporting a lot of outages of Internet connectivity and video conferences around the world. Right now several companies decided to do a virtual conference on the exact same day, and so we are all using go to webinar. Just a few hundred million people across the world. That's all. Since every profession is shifting in as a part of this disaster or national emergency, as Tim is referencing, we may have some technical issues, but no worries. You will get a recording of the webinar after the live event. You will also have a transcript from CaptionAccess, and you can access the live captions right now by going to the chat box and clicking on the live stream text. So I hope that tells. Tim, thank you so much for bearing with us and switching over. Everyone, thanks for participating in the poll.

>> TIMOTHY LEGG: That's fine. Can you hear me?

>> SAMSON TEKLEMARIAM: Yes. You're coming in loud and clear. Thank you so much.

>> TIMOTHY LEGG: Can you hear me now? Okay. Great.

>> SAMSON TEKLEMARIAM: And Tim, the results are on the screen now. If you could speak to those results.

>> TIMOTHY LEGG: Okay. Yes. Yes. This is great, thank you so much.

All right. So 66 percent of you are experiencing this, and, you know, quite frankly, I expected it, because quite frankly, around about the same number of people that I work with are having this experience, and, you know, what is both interesting and particularly concerning/frightening about the pandemic is that for most -- most of my clients, they have never experienced anything like this before. So obviously it's the unknown that is a source of concern for so many.

Okay. At this point we are going to turn our attention to the second objective, which is to discuss the psychological implications of disaster and potential negative consequences that disasters could have on personal recovery goals, and we start this out actually with a discussion of phases of disaster, and, you know, many different authors offer many different phases, and conceptualizations of phases. I like this one, because I think that it's going to help inform our discussion of PTSD.

So in the pre disaster or pre event, this is the time in which we should be engaging in those activities to develop preparedness, preparedness plans for the organization, disaster recovery plans for our clients.

Now, whereas all of these phases are important, as they definitely are going to inform our later discussion of PTSD, I'm going to argue that our second bullet point here is extremely important, because we are in the disaster right now, and in this phase, our goal is to mitigate the event and its consequences, and focus on the delivery of aid. Other professions of course are helping with shelter, medical care, et cetera. But I am going to argue that psychotherapy is essential to this phase. Let me say that again just in case the Internet tripped anything here and nobody heard it, but psychotherapy is essential to this phase. This is where we now have to focus our efforts, and when we talk about PTSD in a few slides, you'll appreciate why.

In the post disaster phase, there are efforts to rehabilitate, and to return the community to its pre disaster phase. But then a second disaster sometimes occurs in many cases, which represents or are represented by secondary losses, such as disruption in business activity, job loss, negative economic consequences, and for everybody who has been paying attention to the news, I'm sure you're very much aware of the current economic state of the United States right now.

So even though the research doesn't give us a direct answer,

what can we infer from the research that is out there? First and foremost, the responses psychologically to a disaster are varied. They range anywhere from I'm fine, why? Do acute stress disorders, up to and including PTSD.

Individuals try to make sense of the experience, and as you all know, previous experiences, culture, lifestyle, these are all going to help inform how they actually make sense of the experience that they're living through now.

Fortunately, these statistics do tell us that most people will return to their pre disaster state of mental health. Thank goodness for that. Some, however, are going to develop a variety of sequela secondly to the disaster. Some are going to experience exacerbations of preexisting conditions. That could be generalized anxiety disorder, panic disorder, PTSD, substance use disorders, et cetera. So we really don't know exactly who, but we do know that it can happen.

So even though the research didn't tell us very much in terms of a concrete answer, individuals in recovery and the impact of disasters should tell us that the type of disaster may or may not play a role. And, you know, obviously the events of 9/11, the 9/11 tragedy, were much different than the events of hurricanes Katrina, Rita, et cetera, and, those events were different than the wars in Vietnam, Iraq, and Afghanistan. So the type of disaster may or may not play a role. The research is still out there and still in some cases conflicting.

The type of substance use disorder, yeah, a very definite maybe. We really don't know.

Exposure to ACEs, probably. What about co-occurring disorders? Probably, but not everybody. So the little icon at the bottom is me with more hair simply saying we don't know. How do we know? The answer is going to come from your assessment and professional judgment and independent of what the research tells us, you're the one working with the client, you are the one that needs to assess them, and use your best professional judgment in working with that individual.

In the couple of days leading up to this, there were a lot of questions around who is going to develop PTSD, and I like to talk about and I'm borrowing from the DSM-V and their discussion of PTSD, because quite frankly, it's succinct, and I really think that it gives us some great information. And there are three overarching elements that are going to tell us about whether or not somebody is at risk for PTSD, and these deal with your pre traumatic factors, your peritraumatic factors and your posttraumatic factors. So let's talk about the pre traumatic. These can be broken down into your temperamental and environmental and genetic/physiological.

Your temperamental, of course childhood emotional problems prior to age six. Externalizing anxiety problems, prior mental health

disorders, specific panic depressive disorders and OCD.

Environmental, we talked about this. It's interesting how it impacts disasters and PTSD, low socioeconomic status, low education, exposure to prior trauma, especially during childhood. Childhood adversity, economic deprivation, family dysfunctions, parental separation, parental death, et cetera.

Cultural characteristics. You have some individuals who are in a fatalistic or grow up having self-blame coping strategies, lower intelligence, minority racial ethnic status, family psychiatric history, social support prior to the event we know is protective against the development of PTSD.

When we talk about your genetic and physiologic factors, female gender tends to be at increased risk. Younger age at the time of trauma exposure for adults tends to be a risk factor, and certain genotypes might be protective or increase the risk of PTSD and anybody who is into genetics, genomics, epigenetics, Dr. Steven doll from the neuroscience institute, has a webinar called worriers versus warriors and I've seen a couple of different versions. He talks about alterations (inaudible) variance and their risk for developing PTSD. So if anybody is interested in that, I highly encourage you to check that out.

Okay. We then turn our attention to the peritraumatic factors following our pre traumatic factors and peritraumatic deal with things at the time of the trauma, and this is pretty much related to environmental. Severity or dose of the trauma is going to be highly influential. Perceived life threat. Personal injury or interpersonal violence, in particular trauma that was perpetrated by a caregiver or involving or witnessing a threat to a caregiver and children. And we do know that with dissociation, there's a higher risk of PTSD.

Posttraumatic are important, and these are (inaudible) and environmental. Because how does a person see their role in it and what should they have done or shouldn't they have done. And inappropriate coping strategies and I'm talking of course among other things substance use disorder and individuals who go on to develop accuse stress disorders.

In terms of the environment, subsequent exposure to repeated unsettling reminders of the trauma, subsequent adverse life events, financial and other trauma related losses and I already mentioned this. Many people are experiencing considerable financial loss right now.

Social support, by the way, another protective factor, family stability for children, it could help moderate the outcomes after the trauma. So again making sure that you're trying to encourage clients to connect with existing social supports or helping them to identify social supports can go a bit of a way here in preventing the development of PTSD.

What does your area look like right now? What has been

disrupted? As we think about how these different factors influence the development of PTSD. What about business and industry? There are some areas of the country where it's been business as usual. What about individuals in the educational process? Some areas in the country have been very much significantly impacted. Others not so much.

Lifestyle, patterns of living, et cetera.

And what about coping patterns during this time? You know, individuals who do deal drugs may also be hit hard, and I don't know what your practice is like. I do know that I've work with many people who simply, quote, unquote, deal in order to use. If people are not making money right now, if money isn't coming in, am I able to afford it, to purchase substances? Am I looking at precipitous withdrawal?

There are, and I have worked with many sex workers who do it to help maintain their very use, and if I don't have money to purchase a sex worker right now, they're of course dealing with loss of income, and could they be experiencing withdrawal.

I am actually working with a student right now who is doing a very interesting study on service industry employees, specifically waiters, waitresses, cooks, et cetera, in service industry and the numbers of individuals in these -- in this industry who are -- have some form of substance use disorder. Well, right now so many restaurants and restaurant chains and private restaurants, et cetera, across the country have been closed, and are they experiencing -- they're of course experiencing decreased income and are they experiencing withdrawal?

And, you know, couple all this, by the way, with the fact that many hospitals and health care establishments out there are converting beds typically reserved for psychiatry or withdrawal to medical beds to meet the demands of the influx of patients. We have a disaster here is what we've got, and what about people in essential occupations, specifically doctors, nurses, social workers, psychologists, drug and alcohol counselors, et cetera. I'm going to talk about our coping in a little bit, but there's still another group that I didn't talk about, and I think now would be a good time to mention this. What about the clients that you work with who are living in a horrible family situation? What about those individuals that are the victims of domestic violence who typically their spouse or a significant other had left for the day to go to work. Now they're stuck with them. So what is that looking like? So as you can see there are many factors that go into the development of PTSD.

What about health care professionals? How is this impacting health care professionals? This is a very recent study done by Lai in 2020, actually two things ago I think it came out, and this was a cross-sectional study of health care workers in China, approximately 1,257 people participated over several days, and the

study, by the way, involved doctors and nurses. Reporting depressive symptoms, 50.4 percent of the sample, anxiety symptoms, 44.6, insomnia, 34 percent and generalized distress, 71.5. These are not small numbers by any means.

As we move into our last objective, the elements of a disaster recovery plan, and, you know, over the last couple of days, I talked to several colleagues, and I was met with some cynicism actually. One actually said, well, Tim, don't you think that a webinar on this is closing the barn door after the horse has already taken off? And a friend of mine who wasn't in the mental health professions said Tim, that ship already sailed. How many people do you think are going to be interested in that? And again, sure, we might not be able to get our disaster plan together now, but there are definitely things we can do. And I include, and all these things I got them to work from my PDF copy, they should be able to work from your PDF, SAMHSA has a publication on disaster planning for behavioral health treatment programs. I definitely encourage you to download that, because when this is over, I'm positive another type of disaster will be out there somewhere. And even though we can't prevent it, we certainly can be prepared.

So what is a disaster plan and should you develop one? The short answer to that is yeah and we'll discuss this in the next slide. How do you integrate this into a recovery plan, and everybody, we all have recovery plans, I develop them with my clients when we first start working together, what are your goals for recovery, what do you want to do. But somewhere, somehow, some way your disaster plan in your organization has to meet your client's recovery plan.

I hear somebody talking. Hello? I hear someone talking.

Okay. So at some point you have to blend the two.

So in short, the question becomes what does it that you're going to do in the event of a disaster where the normal activities of your organization are interfered with? And how do you do that? Well, it starts by asking yourself what risks exist if your geographic area. You should know that epidemics can be experienced a risk anywhere at any time. But also ask yourself the question of how far do you go with this? Because you can technically what if yourself into a state of paranoia, but I do encourage you to start looking around you, where do you live, what type of disasters have happened in the past. History is a good way of telling you if it happened in the past, it theoretically could happen in the future. Have you had floods wherever you live, work or practice? Do you live near any nuclear power plants or any type of chemical plants? Have typhoons or tornadoes, et cetera, have they occurred? These are all questions that you could begin with. And then of course it will help inform you as to the types of disaster that might -- your area may be at risk for developing.

Okay. So in a disaster plan, and when you actually do plan, and

do develop your disaster plan, many things come into play. First and foremost, what type of a -- oh, excuse me, what type of an organization are you? Are you a multiple event -- or a multiple provider group? Are you part of a state or a local group? Do you work for a state office of substance use, et cetera? Are you in private practice? I could tell you being in private practice, the -- my disaster planning is much different than if I worked for a large health care organization. And what you do is you develop policy and procedures that address the who, what, when, where, how and why of a disaster and you have to ask very important questions, like who is going to be the commander when stuff gets real, who takes charge? Who is going to be the one who steps up and directs the remainder of the plan? What is the chain of command going to look like in your organization? What type of contingencies do you to plan for? And in this question, you're charged with considering the essential processes and practices that happen in your organization. Do you take care of special populations, such as people with neurocognitive disorders or neurodevelopmental disorders? What about cultural considerations in the places where you work? And incidentally some cultures do have -- we talked about this a little bit earlier, we sort of brushed past it, but some cultures do have a fatalistic orientation and believe there is very little that man can do to alter the plans of the divine, and what do you do in that case? Some people simply don't believe in disasters, period, and literally just this past week, somebody actually told me they believed this is all a government conspiracy. So how do you deal with that?

What about communications? What happens if, you know, and right now we're already seeing some communication difficulties. I jumped from my wireless headset to the phone, back to the headset. What happens when communications are disrupted?

And in terms of law and ethics, I encourage everybody, hopefully everybody does know the laws that impact you in your respective state of practice. You do know your own ethical codes, but this is also a very important time for you to build into your disaster plan the importance of visiting the web pages of your state licensure site or your professional organization that certifies your site, because they are -- they do offer updates and they do tell you important things about areas that are going to influence or impact the way in which you're going to respond to the disaster. For instance, some states have relaxed telesite visits, that you can be living in one state and you can see clients in another state. Some states have said absolutely no, you cannot do that, so you need to know what's going on in your state and of course any other state that you might want to try to render aid to.

What about HAZMAT disasters? And do you have HAZMAT response teams in your area?

And who could render acute medical care in your particular

organization? Now, fortunately I'm also a registered nurse, so, you know, anything happens, I could deal with some limited first aid, CPR, et cetera, but you don't have to be an RN. You could, you know, of course become certified in CPR or first aid, the stop the bleed trainings are available. So ask yourself if you don't have access to a licensed nurse, who can pick up these skills so that immediate aid could be rendered in the event of a disaster at your organization.

And also what resources are available in your community? For instance, EMTs, how far is it to the nearest hospital, et cetera? These are the types of questions that you're really going to want to ask yourself, because they're going to be able to inform your organization's disaster plan.

Now, one way that you could do this is to -- oh, I'm sorry, I slipped there.

Your disaster recovery plan. Okay, so again who needs them? I argue everybody. And this involves integrating the existing recovery plan with the disaster plan. So what is this going to look like? The answer to that is going to depend on what your client's substance use disorder looks like. What have been the histories of use? What about their past relapses? And of course everybody is very well aware of the stages of change model, so when they have returned in the past or experienced a resumption of substance use, what were the factors that resulted in that? Because that's going to be key in the development of an individualized recovery plan. If you know that the last time there was a flood, that they returned to drinking, and you know that there's some evidence that a flood might be in danger of occurring, let's start talking about how much more critically are we going to check in? What about existing supports? Can you help them identify additional supports and even though AA and NA, et cetera, and face-to-face meetings aren't happening right now there are online AA and NA meetings and sometimes providing information on that to help your clients could be useful as well.

The moral of my story with this is what are the unique risk factors that your clients have, and how can you help link those unique risk factors to potential solutions.

In terms of developing general disaster plans, some people asked me, how do we do this? This sounds so academic. A patient shows up at your organization or office on a usual day and go. Who was involved? Who sees the patient? How are they checked in? What about insurances, what about -- do you have somebody who sees them first? Do they immediately come to your office? In private practice, you have no other individuals. So think about your entire client handling process, and what that looks like.

If you have to be sick for the day and you have to cancel client appointments, who handles that, et cetera, and how is that going to change in the event of a disaster.

What about your collaboration with other providers? What does that look like? How will you continue to work with them? And a wonderful example I'm going to give right now is drug court. In the cases where you have individuals who are justice involved, how are you maintaining those communications with the individual and drug court, especially if the person has been court mandated into treatment?

What about your records? Some people still do paper. Some have EMR. There are wonderful EMRs now that exist in the cloud, which I think can be fantastic, because if all of your work is stuck on your work computer, how do you get there? How do you access it? Can you access it? Does your IT department have the ability to give you remote access to your computer's desktop, et cetera?

And for those of you that work with -- in collaboration with prescribers, what about your opioid treatment programs where people are receiving methadone or buprenorphine. Even if you're open for business and able to get their doses, what about buses and taxis or subways or other types of public transportation, et cetera? What happens if -- even if they own their own car, they haven't worked in the last two weeks, and they don't have money for gas? What's that going to look like?

What about, does anybody here work with homeless or marginally housed individuals? What is that going to look like?

You know, interesting, we do know that some clients are remarkably resilient also. When a disaster occurs, in some people, using maybe the absolute last thing that they think about doing. They might find themselves in volunteer situations, perhaps potentially trying to help others in shelters or trying to help others, you know, by giving them rides, et cetera, to get their doses of methadone or buprenorphine. For many people, when a disaster occurs, using is not even on the table for them. They're not even thinking about that, and, you know, sometimes this does give a renewed source of purpose. You know, who was it that once said, you will never know how much light you have within until you try to shine it for others, and we do see that in many patients.

Okay. Continuing with the concept of your general plans, what about staff training, treating stress induced conditions, does anybody know how to do that? Does anybody know how to provide psychological first aid or critical incidence debriefing and the studies of these are mixed. Some say they have, some say they don't know. I think Faulkner once said between grief and nothing I'll take grief. Between leaving people with nothing or giving them psychological first aid or critical incident debriefing, I think I'll take those.

Okay. What about telemental health? We're going to talk about this in our next slide. But is that an option in your practice? What about the frequency of visits? What about the length of the visits? Are you going to cut back on the length of visits so you

can increase your ability to visit people within the confines of a typical workday?

How are you going to follow up? And again I asked you before, does anybody here have a student? Because right now they're experiencing stress as well. Am I ever going to graduate? Am I ever going to finish this license certification, et cetera? What am I going to do?

So if you have been working with students, I do encourage you, please do check in with them now.

Okay. In terms of telemental health, of course having a really good informed concept is essential. So in my own disaster plan, knowing that one day something like this could potentially happen, I did mention telehealth and received -- I have obtained informed consent from my patients to participate in telehealth sessions. You're going to see a lot of options out there. I was debating about whether to mention Doxi and Mabus which is what I used. That's me in a session. The patient mentioned I looked kind of informal in it. People are used to seeing me in a shirt and tie. But things change during disasters.

What about your phone service? Because if you're no longer working at your usual office, how are you going to use your phone? And there are different technologies like grasshopper and mighty call and, you know, various other -- Dox meeting also has a phone service as well, so again it's a matter of asking yourself multiple questions. If you work for a multi provider group, if you work for a company, state, local, or if you're a solo practitioner, what does my budget afford me? What is going to work and, you know, what makes the most sense to me?

So part of this in terms of disaster planning also calls on us to give practical advice to patients who need it, and of course this is me on the Hoodoo doll, because some of my peers are appalled how far into the harm reduction mentality that I am, but I do have some people who have not been able to stop use, and in these cases, I do the best I can to prevent them from grave harm. So some of the advice I give, no sharing e-cigs, pipes, bongs, joints, anything for nasal use, and if you can't avoid sharing, clean them with bleach.

No contact. I mentioned some of my clients are sex workers. Reframe conversations. Tell them to try to avoid kissing or direct contact or at least use condoms. If they are preparing drugs, do it yourself. Washing your hands thoroughly. Soapy water, 20 seconds, et cetera. Washing the surfaces on which you prep, and if you don't prep your own, get the person who does to do this for you. And preparation for overdoses is essential. At this time the EMS is essential. Make sure that Naloxone is available. And I tell them if you're going to use, please, whatever you do, do not use alone.

Here we are with another polling question, and I want to know,

do you typically use harm reduction strategies in your practice or do you insist on abstinence only as a goal.

>> SAMSON TEKLEMARIAM: Thank you very much. You'll see that polling question pop up on your screen with three answer options. It looks like almost half of you have voted. I'll give you five more seconds as Dr. Legg starts to wrap this up. Please keep sending in your questions in the questions box. We've got some great ones and we will use them during the live Q and A. Any questions we don't get to, we will of course have those questions in a Q and A document. We'll send them to the presenter, and we will have them posted on the same web page that you used to register for this webinar.

I'm going to go ahead and close the poll in three seconds. So we're trying to get to three-quarters, 75 percent. Hold on one second. Perfect. Almost 75 percent. I'm going to go ahead and close the poll. I'll share the results and turn this back over.

>> TIMOTHY LEGG: All right. Fantastic. Well, hey, this is exciting. 72 percent of you do use harm reduction strategies. 19 abstinence only, so I don't have to worry about the feelings of being poked from the Hoodoo doll. No. I'm just kidding. We all have philosophies of care and being in touch of those of course are definitely important.

So I also want to encourage you, this is a time where you should be reaching out and knowing your resources. This is of course very important. And I want to find out if you haven't been on the home page of SAMHSA, do take time to examine and explore some of their resources, because they do have a disaster kit. They do have tips for talking with children, parents, et cetera, during infectious disease outbreaks and they have a cornucopia of resources so please take your time -- take some time to go there.

Okay. Before we actually get into the formal question and answer, which is going to happen in a minute or so, I wanted to point out that I was given a lot of questions, and I do have -- I'm not going to go through all of them of course. I got a lot of political questions, which I definitely will not answer. That's something very personal among you that you have to answer for yourself. How do we deal with conflicting information from professionals and politicians? I'll be honest with you, I went for a master's of public administration, and I still can't figure out politics. Suffice it to say that I tend to take the word of individuals who are college educated, who have a license or code of ethics. I tend to take some of their word quite a bit.

People have also asked me about how do we cope when dealing with stress of the unknown, how do we assist clients when our own life is being negatively impacted and how do we as professionals remain calm and you're going to roll your eyes but this takes into account self-care. And this takes me into the next polling question, what kind of self-care activities have you been engaged in since the

outbreak of COVID-19.

>> SAMSON TEKLEMARIAM: Thank you, Tim. It just activated on your screen. You'll see on your screen what the type of self-care activities have you been engaged in since the COVID-19 outbreak? We'll give you five more seconds here.

Thank you so much, everyone. I'm going to go ahead and close the poll and share the results and just as a heads-up, just because we had a little bit of technical difficulties earlier, we're probably going to extend this webinar about ten minutes, so no rush to jump off at 1:30 eastern. We'll try to go until 1:40 eastern to answer more questions and to give a little bit more time to make up for some of the technical issues we experienced earlier.

I'm going to close the poll and I will share the results and turn this --

>> TIMOTHY LEGG: Okay. This is exciting. So 41 percent of you have been exercising. Medication -- that should have been meditation, but hey, if you're using medication, that's okay too. 14 percent. Reading or catching up on research or self-improvement, 28. I'm proud to say my own CEUs are done for the year, hey. And it's fine if you haven't had any up to this point. Commit yourself to maybe a half-hour, 20 minutes, of just doing something for you, because, you know, on my desk in my office, I don't know where I was flying to at the time, I ripped it off from the seat in front -- I shouldn't be acknowledging that I stole something from an airline, who cares, I didn't say which airline. But it's the information card that shows you what to do in an emergency and I have that on the corner of my desk and patients new to my practice say what's the deal with that and I'll open it and I'll show them where it tells them how to deal with cabin depressurization, when oxygen masks fall from the ceiling, and the airline industry had it before any of us, be sure to put on your own masks before helping others, and there are people who don't fully understand or commit to that level of self-care. Truly you have to take care of yourself before you can take care of anybody else, and quite frankly if you allow your own mental health to deteriorate, you will quickly find yourself in a position where you're really not able to fully help your clients.

I did have some other really good questions about how you engage adolescents in treatment, and I have one adolescent in particular, his mother was appalled, I felt bad for the woman. I thought she was going to need a session after this, but he came out by calling me old man Legg, and it was kind of funny actually. No respect whatsoever, but he perceived that I was just so far removed from him and his generation that I couldn't possibly help. And during the last telesite session, my name changed from old man Legg to Tim. And, you know, you're dealing with a group of young people today, they take to technology like ducks to water, and when I showed him, look, I can do a FaceTime thing too, I earned

credibility in his eyes.

I include here some remote telesite guidelines, guidelines from the CDC, a lot of existential questions have been asked and one question in particular, I don't know who you are or if you are on the call today, but they asked a really existential question, where does hope lie? And I found myself reflecting on this, and the only answer I can give you, quite frankly, you know, came from when I was in college, and when all of us went to school, we found ourselves questioning why did we have to take those horrible art classes and philosophy classes and music classes? And I think I finally know why. Because sometimes science does fail us. Sometimes we don't have enough of a respect for the natural world that things happen, like we're dealing with right now, and when science can't come to our aid, the aesthetics can perhaps help us and to that end, I offer you a poem by Kitty O'Meara. Kitty O'Meara is a -- this is the link to her site, and some of you may have seen this. I don't know, I don't do social media, like Facebook, but her poem is haunting, and I thought it was interesting, and even though people might say, the earth began to heal. Well, what do they mean by that? I hasten to point out that I was reading an article which suggested that seismic activity on the planet has decreased since there hasn't been as much industry activity, et cetera. So I found her poem not only haunting but also dead on.

And I also encourage you, you know, in response to these existential questions, you know, what do we do, and, you know, how do we help? And I just seem like I'm one person. What could I do? There seems like there's so much to be done out there. I do want to remind you of sentiments that you can find in the Talmud. He who saves one life saves the world.

So that's basically all I've got for you with that.

I did try to come up with a lot of resources for everybody based on the questions that were being given to me. CMS has some great information. The national consortium of telehealth resources center. New England Journal of Medicine also has some interesting sources.

The little known therapeutic stories for kids, there's a nice link to that. The my pandemic story, a guided activity workbook for children, families, teachers and caregivers, the very last one here, was also kind of neat and interesting.

And I also included on this last resource slide, the emergency conversion to telehealth, making it work. This was a great webinar. It's on YouTube. I encourage anybody who has been thrust suddenly into the world of telehealth, teletreatment, take some time to watch this, because I think it's a really great primer that's going to help tremendously.

Okay. And I am now going to just move into -- I pointed out or I mentioned before that I had a couple of slides of references for

everybody, and all of the studies that I talked about throughout the presentation are included here in the reference section. So of course by all means -- some of them are PDFs. Others you can find with a pretty quick Google search. Others require you to access pro quest or other databases.

And thank you very much. I do know that we went over a little bit. Thank you for the extension. But --

>> SAMSON TEKLEMARIAM: Tim, I think I lost you there for just a second. I wasn't sure if --

>> TIMOTHY LEGG: We're done. I'm finished.

>> SAMSON TEKLEMARIAM: Oh, great. Okay. Great.

So the yes. So everyone, we are going to do a live Q and A with Dr. Legg in just a moment. Just for a quick heads-up, the last YouTube clip that he mentioned on teletreatment, we went ahead and sent that to you in the chat box. We're also going to accepted some of the PDFs that was referenced in the recommendations slide. On the same page that you used to register for this webinar, you'll see additional resources. Go ahead and book that web page as a home page or as a saved page that you can access to get additional resources.

Thank you so much Dr. Legg. Before we launch our Q and A, we want to make sure that every addiction professional is equipped with the digital tools to help people in recovery. Whether you're familiar with mobile treatment tools or if leveraging a type of technology is a foreign concept to you, either way Recovery Path helps addition professionals to meet the urgent needs of quality virtual care. This app works hard between telehealth or in person sessions to keep patients motivated and on track while keeping you looped in on the challenges and victories they're experiencing. Before I turn this over to Elissa, just as a reminder, for those of you seeking information on how to get continuing education on this webinar, we will provide that to you after this demo and after the live Q and A.

So I'm going to turn this over to Elissa from Recovery Path. Elissa, the floor is yours.

>> ELISSA: Thank you so much, Samson, and thank you, Dr. Legg, for that wonderful presentation. My name is Elissa. I'm the clinical implementation manager for Recovery Path. I'm excited to share with you a set of apps that can help you meet the urgent needs you're facing right now to deliver high quality care to your clients. I'm going to jump right in and show you how it works. So as you can see on my screen, I have a patient and clinician app installed, opening the patient app now, so this patient is connected to their therapist who has sent them a meditation, which is particularly helpful for clients experiencing heightened anxiety during this time. The client is also taking a medication which they are reminded before and can track right here. An important part of relapse prevention is planning enjoyable activities, and as

you can see the app also has suggestions for self-care activities, you might have noticed that this person has an upcoming risky event of an online happy hour. You may have seen this trend with your own clients. This person participated but are feeling triggered so right here in the moment they can engage if a trigger log so I've entered information about it. So Mark from work triggered this client. They can say what contributed to the trigger, who they were with, and provide more details for the trigger.

Now the clinician will get this information right after the client enters the information on their respective app. So right here they're saying what was going on, so Mark called this client out for drinking water during the online happy hour and called them uptight. Not very nice.

They can slow this down.

After they have done the log, Recovery Path then presents them with two coping strategies to try right then and there. The app also has over a hundred relevant skills that the client can pick from, and after logging the clients also get an affirmation and a cute baby hedge hog helping them stay in the moment. (Inaudible) here clients can select from different text messages that you're seeing on the screen, and they can send them directly to supportive others through the app, so now they're sending a message to Lauren that they need help.

Help is also available with the most comprehensive meeting finder that exists. This now includes virtual meeting options and there's also an in person option for when clients are able to get back to their in person meetings. And as a provider, what you can do is see the in person meetings as the clients can check in and note how helpful the in person meetings were.

Another very popular feature for clients work toward abstinence is a sobriety tracker. It can update you if they have something they can note it in there.

Now I'm switching over to the clinician app. Here you're seeing the clients that this clinician is dealing with. (Inaudible) you're not expected to be available 24/7. Clinicians also find it invaluable to review their patients' logs right before session. So here we can see the trigger log that Liz just entered and one of the most things you can do as clinicians in the app is provide support and reinforce what the client is already doing, keeping up with the work between sessions and one way to do that is to enter a comment directly on the logs that the client wrote and here you see what this clinician is saying.

Now what I'm going to do is to set up a goal for this client. Because I know they're working on managing triggers, what I can do is go directly into the manage goals feature and you can see there's a triggering management section, and so I'm going to into this category and pick a goal directly from there.

Another excellent way to create (inaudible) so going in here and

sending them this image to work on. You are worth with. So we have limited time. That concludes my demo today. Just so you know Recovery Path is available for download on iPhone and Android, all you have to do is search for Recovery Path in the app store. There's also a doc on Recovery Path.com. I want to thank you all for the work you're doing for your questions.

My colleague and co-founder Jenna will be joining me for the Q and A.

>> SAMSON TEKLEMARIAM: That's perfect, thank you so much, Elissa, thank you so much for viewing that demo. If for some reason, no worries. You will have a recorded version of this demo. You will be able to see, just one second here. You will be able to seat recorded version of this demo in two different ways. One is about an hour after this webinar, on the same web page you used to register for this webinar will be a link to view the recording of the also those of you who were here live, within one hour, you will see a thank you for attending or sorry you missed automated email from go to webinar. Please, please, please, do not interpret that as some sort of measurement as to whether or not you were here. Do not reply to that email because it will not go to anyone, you will not get a response. But at the bottom of that email, you will get a watch recording link. You will get to watch the recording of Dr. Legg's webinar and you will get to watch a webinar of the demo.

So we are going to shift to the live Q and A, I have great questions for Recovery Path and Dr. Legg. Please continue to send in your questions for Recovery Path. If you have questions about mobile treatment tools in general or specific about Recovery Path, feel free to send them in.

Tim, Dr. Legg, I have a question for you.

>> TIMOTHY LEGG: All right.

>> SAMSON TEKLEMARIAM: Kim asks -- so Kim asks, I see the correlation between increased alcohol use and she asks has there been an increase in other drugs that you've seen as well? Such as methamphetamines or opiates.

>> TIMOTHY LEGG: So from a research perspective, and that's a great question, the further you dig into the research, the more you find many of those challenges. One group of authors will say yes, another will say no. Some will say, yes, but transient. Others will say yes, but prolonged. So it really does -- it depends. I will be honest with you, I have seen in my own practice an increase in a few people who have been using. Now, alcohol has been the number one. I do have one person that did have an issue with methamphetamine, but so far none of the people I've been working with with opioids have told me of an experience yet.

Now, of course with -- how I've been doing things, I've changed things up a little. When I was mentioning before about, you know, asking yourself in times of disaster, do you decrease the length of your sessions and increase the frequency, that's actually what I've

done. So I'm connecting with my patients a couple times a week in an effort to prevent that from happening. So unfortunately in real time, I have seen some increase. It'll take a few years from now to know what the research says on it, and I'm sure just like any other disaster that I've researched, I'm sure the results will be conflicting.

>> SAMSON TEKLEMARIAM: Thank you so much, Tim.

And this next question is for Recovery Path. The question comes from Wendy. She asks what if the peer doesn't have an iPhone? You guys may have addressed this, but I'm not sure. I'll let you guys readdress that. The question again from Wendy, what if the peer doesn't have an iPhone?

>> ELISSA: The great news is they can have the app on an Android phone as well.

>> SAMSON TEKLEMARIAM: That is great. And then you also mentioned a web page, right?

>> ELISSA: Yes. So for providers they can log in on the web. So if you prefer to use it on your computer, you can log in via web and it's very similar in the way that it's set up as the app.

>> SAMSON TEKLEMARIAM: Perfect. Thank you so much.

And the next question is for Dr. Legg. This question is from Samantha in New Jersey. She asks in regards to programs that do use abstinence only, how do you suggest using telehealth or the trying to change our approach during disasters, especially during the pandemic we're in now?

>> TIMOTHY LEGG: That's a great question, Samantha, and the good news is regardless of what your orientation is, I always think back to Harry stack Sullivan. He said all of us are more human than otherwise. Regardless of the approach you use, the one thing -- the one consistent thread throughout it all is I think essential, that connecting with that client. So what can you decrease the length of sessions, but increase the frequency? Letting your clients know, look, I realize that we can't be present in the same physical place, but that doesn't mean we can't be present. So leveraging technology, and yes, you're going to have the dropped call. You're going to have the delay in the voice to answer of the connection through, you know, whatever telemental health platform you use. Fine, acknowledge it. But still reaching out and letting your clients know, I'm still here for you. You're just not driving someplace or you're not riding the bus to come and see me. I think that's going to go a long way in helping people. Especially during these times where people are -- and what do you do with a person, you know, I mentioned before about people who might be stuck at home with people who they're climbing the walls. What about the people that are stuck home with nobody? So this is a time when that increased frequency can really help decrease some of that stress.

>> SAMSON TEKLEMARIAM: Thank you so much, Dr. Legg.

And so what we're going to do is have one more question for Recovery Path. I'll explain how to access your CE quiz and a little bit more information about NAADAC, and then if Dr. Legg is okay, and Recovery Path is okay, we'll stay on line for ten more minutes to do an extended Q and A, which I almost never do because you guys know I'm obsessive about our time, but we will respond in an uncertain time and maybe do something a little bit out of the norm, and do an extended Q and A at the end of this webinar if that's okay with our presenters.

For now let me go ahead and ask one more question for Recovery Path and then I'll explain some information about the CEs.

So for Recovery Path, this question comes from Sonia, she asks how much does the app cost? And then a related question from Elise, are there any updates or information about being HIPAA compliant?

>> ELISSA: Yeah, Jenna, I was going to toss it over to you, you can have a chat.

>> JENNA: What a fantastic webinar. Please know this platform is fully HIPAA compliant. (Inaudible) all the information your client enters is encrypted (bad audio).

You can feel confidence in that. (Inaudible) or a friend might open their own app on their phone, so the client and your app are (inaudible) protected for that very reason and then extra security measure.

So I hope that addresses that question. We don't sell patient data. (Inaudible) security and privacy and doing everything we can to protect this incredibly important relationship that you have with your client.

So with regard to cost, we're a mission driven company and we're grant funded (inaudible) the app to your patients is free and available to download right now, (audio breaking up).

It's available on Android and iPhone which covers most people in the country at this point. (Inaudible) desktop you should be seeing also. And as Elissa mentioned (inaudible) you can get going and have a go with it. See how you feel. (Inaudible) instead of old man or old woman so and so. That's a reference to Dr. Legg, and after that you're looking at about $20 a month, which essentially covers costs for us. We're seeking to try and break even (inaudible) behind the scenes in developing HIPAA compliant technology (inaudible) so I think this is the most cost effective technology out there and it's actually HIPAA compliant. So hopefully you'll consider investing that for your practice. (Inaudible) eat your own dog food which is a weird expression and as providers I think we should also try it before you give it to a client. So install the patient app, try and link to yourself as a provider, get comfortable with it before you think about bringing this into your treatment approach. So we hope you find it valuable.

>> SAMSON TEKLEMARIAM: Thank you so much, Jenna. Thank you, Elissa. We will be back with you in just a moment.

So everyone, thank you so much for staying on line here. Wondering about your CE quiz for this webinar or how to access the recording after the live event, as another reminder, every NAADAC webinar has its own web page that houses everything you need to know about that particular webinar. Immediately following the live event you will find the online CE quiz on the exact same page that you used to register. So everything you need to know will be permanently hosted at www NAADAC.org. Look at the slide you see here, you'll also notice a little yellow arrow pointing to where the quiz will be. It says CE credit, online CE quiz active soon. You'll be able to click there and get to your continuing education quiz.

You also notice in the handouts tab right underneath the questions box, you can click there to download the Power Point slides interest today's presentation and a quick reference guide on how to get your CE certificate for this webinar.

Here is a brief schedule of our upcoming webinars. Please tune in because there are interesting topics with great presenters and we're off to a great start with our peer recovery support series in connection with Great Lakes ATTC. These webinars will be presented by Chris Kelly, Phil valentine and more, you can learn more about our free peer recovery support series at the links.

NAADAC is also offering two specialty online training series. Visit the website below. For more information on this exclusive content. It's a little bit different. Each webinar has its own price point to access the content. But that price, which I think is $25 per webinar also includes a certificate of achievement in the entire series.

Even the most experienced clinical supervisors in our field admit that clinical supervision in the addiction profession is much more complex than general supervision and there's a wide array of variables to consider and this series provides the most up-to-date research as a complement to our newest workbook that is available in our bookstore. The training series and workbook is led by Dr. Thomas Durham, protégé and close friend of the late Dr. David Powell.

The next is addiction treatment in military and veteran culture. Right now some of our most respected are also our most vulnerable. As the nation tries to stay in balance during a national crisis, those with trauma related symptoms and a history of substance use disorder are reexperiencing some of their worst fears right now and trying to manage triggers in an ever changing environment. This series is presented by Dwayne France, a licensed counselor, addiction treatment specialist and a retired combat vet. To learn more about this exclusive content, visit the web page you see at the bottom of this slide, www.NAADAC.org/military - vet - online -

training - series. As a NAADAC member, there are tremendous benefits of being a member, of course access to CEs, free CEs from magazines.

I'm going to try to add a few more minutes for Q and A. For everyone else, please note that there is a short survey that will pop up at the end. Please take time to give us feedback. There are -- and any additional notes for our presenter and tell us how we can improve. Your feedback is very important to us as we continue to improve your learning experience, in fact this webinar occurred because of someone's feedback. So thank you again for participating in this webinar. I'm going to encourage you all to take some time to browse our website, learn how NAADAC can help others. You can stay connected with us on LinkedIn, Facebook and Twitter. I'm going to go right into our Q and A, and I have two questions for Tim. One question for Recovery Path.

Tim, the first question for you comes from Jeffrey in Texas. He asks does resilience and the ability to make meaning from a disaster impact a person more or less that supports in another person's life in a disaster. What do you see as powerful factors of resilience.

>> TIMOTHY LEGG: Can you give me the question again?

>> SAMSON TEKLEMARIAM: Yeah. Jeffrey from Texas. It's a loaded question there, right? So does resilience and the ability to quote, unquote, make meaning there a disaster impact a person more or less in how they're supporting someone during a disaster? And then he asks what do you see as powerful factors of resilience?

>> TIMOTHY LEGG: That is a wonderful question. So actually coming into an area of philosophy that I always loved, existentialism.

So I think one of the earliest works on this topic was done by Victor Frankel, who wrote his experiences in -- of his experiences in a concentration camp and he spoke of those factors that eventually would inform his resilience, and he saw that when people gave up and when people surrendered to the circumstances around them, it was only a matter of time before they died, and quite frankly, the ability to make meaning, the ability to find that existential answer for yourself, those questions of why are we here, what are we meant to do, you know, remembering that we are -- I quoted Harry stack Sullivan before, we're more human than otherwise. Remembering that we're all in this together. If you are able to make meaning of that, it does have a protective element against the development of trauma and it can potentially help prevent individuals from experiencing relapse. You know, again, I mentioned that there are some people that during times like this, they couldn't even imagine using. There are too many other things that -- they want to reach out and help others. So, you know, again the ability to derive meaning and the ability to find that existential answer in any situation could be quite empowering.

On the flip side, some people who cannot find meaning, who don't have that orientation, they tend to find themselves a bit more distressed, I think.

Great question.

>> SAMSON TEKLEMARIAM: Thank you so much Jeffrey from Texas for that question and Dr. Legg thank you for that answer.

A final question for Recovery Path. I know you guys are busy. We'll let you off after this. So a final question for Recovery Path. The question is it's kind of twofold. One is does the app have the ability to set reminders for our patients who are struggling to remember their virtual appointments, and then also is there a way to share our access to a client with other medical providers, if they're seeing a counselor, and they're also seeing a social worker or case manager and a doctor or does that person connect -- you know, have to share that connection themselves?

>> ELISSA: Jenna, I'll let you answer that if you'd like. Are you there?

I can answer the question. So yes, you know, clients just like us are mere mortals. There's lots of ways they can set reminders in the app, which if they tap on more and look, there's a notification pop up and reminder section, and I love that you asked the question about collaboration. We're all about that. So if there's multiple providers that are linked with a client, they all see all of the logs and comments that everyone is making. So for example you know how I commented on the trigger, if there was say a case manager, a psychiatrist that was also seeing the client, they would also see that comment and could write back. So the app really does support a collaborative process.

>> SAMSON TEKLEMARIAM: Thank you so much, Elissa.

And right when you started to say that, we got a question for you, they're asking how can I test it now. As people are realizing it's coming to an end, they're pretty excited about the app and we're getting some great questions and I think the answer for can you test it now, is to go to the web page. And then Recovery Path, Elissa and Jenna, you're free to leave and then I'll do a couple more questions with Tim.

>> ELISSA: We're excited that we were able to share this with you also. So if you go to the app store and just type in Recovery Path, you can download the app for clients, and there's also, if you see there's one for clinicians as well. So you -- I would encourage you to download both and test it out. You can have your clients download and start using it right away. If you have any questions or want further information or more thorough demonstration, feel free to email me at Elissa at Recovery Path.com and I'd be more than happy to go through another demonstration for you.

>> SAMSON TEKLEMARIAM: Perfect. Thank you so much, Elissa, and as a remainder, Elissa's email is on the handouts.

Tim, there's a ton of questions. Everyone, we will not get to all of them right now. We're only going to do two more and then we'll close out but every single question you ask, we will send them to Tim and hopefully there's a way to address most of them and we'll post them on our web page in a week or so.

So Tim, last two questions, this comes from Laura. Laura was a long term patient of mine who was on MAT, relapsed in their first week of quarantine. With fears of exposure to COVID-19, they are fearful of inpatient treatment. What are your recommendations for therapists working with clients who have relapsed during COVID-19 and are now using teletherapy?

>> TIMOTHY LEGG: My very first question is -- goes back to assessment. So was this a one time, once or was it one and then another and then another and then another. So I guess my -- I would need to know a little bit more about the situation. And what is your relationship with the prescriber? This would definitely be a time that I would be reaching out to that prescriber to discuss, okay, where do we go from this point, because yes, some people may need that. Others might not. So, you know, again a lot of moving fasters -- or a lot of moving parts are involved in this. Does that prescriber feel comfortable continuing with treatment after the person has had a one time use? If it's been more than one time, if this is going on now for a couple of days, a week, et cetera, then obviously that's a little bit more complicated answer. But that is definitely a time to reach out to whoever the prescriber is and have this conversation, and, you know, we do have to advocate, you know, for the patient in that -- and I've heard some people, well, the patient has to do it themselves. Part of being a helping profession is doing for others what they have to do in the moment. So definitely we do want to see that person be able to take over their own self-care, but in times of stress, people do sometimes -- you know, you hear it. They regress. So those times that they may need us. In that case, if I weren't the prescriber of the medication assisted treatment, I would be reaching out to the prescriber. What do you feel comfortable, what do you feel would be the best way to go here? And then of course, you know, sharing and advocating as appropriate. Quite clearly if the patient has been off of medication assisted treatment for, you know, a week, two weeks, you know, and has been experiencing increasing use over that period of time, inpatient treatment might be the most appropriate, and then having that conversation with the patient. However, as I mentioned earlier in the webinar, I have heard of several inpatient beds in hospitals being surrendered to the medical side of things. So where you are geographically an inpatient a stay in detox may not be appropriate. It may not even be on the table. So in that case, you and the prescriber are going to have to have serious conversations about what is the best course of action to help this person, because, you know, at the end of the

day, in times of disaster, sometimes we really can't do, you know, the textbook perfect, you know, course of treatment that we would like to do, and sometimes we're really stuck with, you know, what we've got. Again I go back to Faulkner, between grief and nothing, I'll take grief. Well, between the best plan and one that's, well, this one is a bit iffy, we might have to go with the one that's a bit iffy. But again I will argue that that's going to start with your assessment and really having -- there's very important serious conversations with the patients, and I work very closely with many of my patients, and I just tell them cut the BS and tell me. How much have you done. I don't yell. Just tell me. I need to know exactly where we're at so we can come up with the best plan for you. And having those conversations and do that assessment I think is the most important starting point.

>> SAMSON TEKLEMARIAM: Thank you so much, Dr. Legg, and Laura, thank you for that. Feel free to send a follow-up question if you have one in the questions box. We'll get them in the document.

Final, final question from Tracy. So with the numerous what if's that exist, how do we know we are covered in our disaster plan? Are there steps that you consider universal as we wrap up, regardless of the type of disaster?

>> TIMOTHY LEGG: Yes, most definitely. So think about those elements that the patient needs and think about where you are geographically. As we're seeing right now, epidemic is always a potential problem. So what is it that you do with the patient? Is it therapy? What are you going to do if you can't meet that person face-to-face? What kind of technology can you leverage? And then of course looking outside at the other types of disasters. If you live in a town or a city that has had problems with flooding, if it's happened in the past, it's probably going to happen in the future, so what contingencies are you going to need to prepare for that? If you live in a town that has a rather large chemical manufacturing plant, is there ever a potential for chemical spillage? You know, and reduced air quality, et cetera. What do you do in that case? What would be your contingencies there? And back in, I think it was the second objective, I gave the link, the hyperlink to the SAMHSA's disaster preparedness guide. I would definitely encourage everybody to take some time, pull up the slides. As I said, I believe the hyperlink -- I know the hyperlink worked from my PDF version but take a look at SAMHSA's disaster preparedness planning. It doesn't matter how big or small you are. The worksheets contained in that resource, it will stimulate thinking, because, you know, again you can get into 10 billion -- what happens if an asteroid hits the earth and spins us off our access and we go all hurling into the sun? Some people can get so, you know, bogged down in, you know, these really out of their hypothetical what have yous, but really -- and there are always going to be things that nobody predicts. You know, and that's

another element of being human. The fact that sometimes things do occur, and do hit us out of nowhere. But the idea is, at least from my perspective, to constantly be improving on what you do, and even if something does happen -- let's assume that your organization had the best disaster plan out there, including what would happen if the building were ever hit by an airplane or, you know, what would happen if there was fire. You have the best disaster plan going. How many people really saw this coming? So the risk is always out there. Of course we move forward with now even greater knowledge than we have in the past, but, you know, really challenging yourself, what could happen in your organization, and just working at those major systems. How are we going to deal with patients that can't come to us physically. If you do have a medication assisted treatment program, what are you going to do if buses stop or taxis or the person runs out of money that they can't purchase gasoline for their car to get there, then what are you going to do? So really it's all about assessing where you're at, where you are located geographically, the nature of your patient population, and then really, you know, getting in there with some of those what if's and looking at the major systems that have the potential to be impacted and what contingencies you can develop.

>> SAMSON TEKLEMARIAM: Thank you, Dr. Timothy Legg. Thank you, audience. Thank you Recovery Path. You all have a wonderful rest of the week and weekend. Thank you for staying with us for this extended Q and A. Be well.

>> TIMOTHY LEGG: Thank you.

(End of webinar.)

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