

NAADAC

Substance Use Disorder in the African-American Community

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>> Hello everyone and welcome to today's webinar on Substance Use Disorders In the African-American Community presented by Dr. Sherra Watkins. Our virtual town hall event begins immediately after this one hour of continuing education webinar presentation.

It is great you can join us today in my name is Samson Tecklemariam and the director of training and professional development for NAADAC the association prediction principles. I will be the organizer for this training experience. The permanent homepage for NAADAC webinars is listed on the slide.

Make sure to bookmark this webpage so you can stay up-to-date on the latest in addiction education. Also closed captioning is provided by CaptionAccess. Please check your most recent confirmation email or our Q&A and chat box with a link to use closed captioning.

We are using GoToWebinar for today's live event risk you will notice the GoToWebinar control panel that looks like the one on my slide here. You can use that orange arrow anytime to minimize or maximize the control panel. If you have questions for the presenters type them into the question box and will go the questions and give them to the presenter during our live Q&A.

Any questions we do not get to we will collect from the presenter and post the questions and answers on our website.

Under the questions tab you will see a tab that says handouts. You can download the PowerPoint slides from that handout tab and a user and friendly instructor got have access our online CE quiz and immediately earn your CE certificate after the webinar.

Please use those instructions in our handouts tab when you're ready to take the quiz. I will explain more detailed instructions towards the end of this presentation. Let me introduce you to today's presenter. Dr. Sherra Watkins if the director of wellness and counseling and American University of the Caribbean School of Medicine in St. Maarten.

She earned her degree from East Carolina University including a doctor of philosophy degree in Rehabilitation Counseling & Administration, a Master of science degree in clinical counseling and substance abuse counseling, a Master of Arts in education degree in health education and a bachelor of science degree in school health education.

Her research focuses on decreasing the stigma of mental health, chronic pain and chronic disease among African-Americans. Dr. Watkins is the co-owner of Sister WELLS, Coaching, Counseling & Consulting, PLLC. With Charla Blumell and Shawnte Elbert all who are proud members of the Zeta Phi Beta Sorority, Incorporated. Please stay tuned for the end of this webinar to participate in our virtual town hall event with additional panel members. NAADAC is delighted for this webinar presented by this wonderful expert and Dr. Watkins, if you are ready I will hand it over to you.

>> Thank you, Samson. Good afternoon everyone. It is so good to be here to have this discussion. When it comes to African-Americans and substance abuse disorders in this community. Our objectives we are going to cover the date will be examined substance abuse disorders in African American as a whole and examine societal constructs that play a role and.

[Reading from slide]

It's important to stress today my goal is not to make you feel bad or blaming or attack you but say may be triggered after the workshop. My premise is to create an environment to provide knowledge, tools and a safe place to discuss this topic as were in the middle of racial unrest.

Feel free as we continue to popular questions into the chat box as we move forward into this presentation.

As we get started, when the most important things I want to always suggest and we start with the foundation is what are foundational definitions of what understanding addiction. We want to talk about defining each one so we will be on the same page. Addiction is characterized by.

[Reading from slide]

As we look at the addiction cycle we have to keep in mind as talk about how this is affecting African-Americans, we are looking at what are some emotional triggers that may be contributing to this population? Cravings and ritualistic may be relevant to this population. Like any other disease, addiction often cycles in relapse and remission and make sure we constantly need -- sometimes people the field, addiction is a chronic disease and lead to premature deaths and other types of negative activities and health.

In understanding addiction, we have to focus on understanding the basis of tolerant dependence and substance misuse. This is big because I have discussed this with my colleagues and working in my former positions in the medical field. Tolerance is related to addiction says...

[Reading from slide]

Anyone of us can develop a tolerance to both illicit and prescription medication. It is the physical effect of repeated of drug use and not necessarily a sign of addiction. Sometimes that is a big major issue for medical professionals who are not cognizant of what substance abuse behavior health and mental health is because they think one someone develops tolerance they automatically have an addiction and that is not true. That is one component of it.

The second component is dependence.

[Reading from slide]

Withdrawal syndrome of a person's drug of choice will vary person a person. And edition is described as.

[Reading from slide]

It is similar to the DSM on the first slide. It is not consistent with legal or medical guidelines as described in a common example of substance issues may be the doctor prescribes oxycodone for pain management and take two pills a day. Every eight hours but they may take it multiple times a day like every two or three hours. We establish guidelines of making sure we understand what is addiction? What are the components of addiction as far cycle?

We went over the major characteristics and components within addiction which is dependence, tolerance and substance misuse. Let's move to switching over and tie it all together. Let's talk about history of African American and how do we get here? Things when we look at the term trauma of what has led African Americans have an advocate health behaviors and hope? Everything ranging from unhealthy eating, drug use and other types of issues. We take into consideration the context. We have historical trauma.

[Reading from slide]

We can see through past history they, typically, have higher establishment of alcohol in stores in their neighborhoods. When we are looking at the historical context of African-American communities, we take all of this into consideration. What are the most questions many attendees ask is how do I commonly treat my African-American patient? You have to understand where we come from. In looking at historical trauma,

[Reading from slide]

Historical trauma is not just African-Americans but you see it with Hispanics, Native Americans and Jews and the list goes on. Is related to family members and cultures of people that experienced trauma and past generation however the family members of today even though they were not directly imposed with this particular trauma, they experience it generations later.

One of the sub context is looking at historical unresolved grief which accompanies historical trauma. Post traumatic slave syndrome.

[Reading from slide]

What is chattel slavery? Is the term slavery but the more appropriate term is chattel slavery. The personal property of people that are sold as commodities similar to tobacco and cattle and those

types of things. We know after 1808, importing of Africans as slaves was banned but the selling of slaves and cattle of people of African Americans in the country still continues.

It is important understand during this time of 1619 the typical slave family was headed by matriarchal system. What does our society say about family systems is patriarchal. It was led by matriarchal because at times the father's once a year could be shipped off and they were not around and often times their names were omitted from birth records.

We often have continuation of this type of trauma and some African-American homes of today and know that African-American homes have slight higher rates of single-family homes compared to other races. We taking context where did it start from? Was this by choice? How do we stop this or prevent this from continuing to the next generation?

Jim Crowism, we had Jim Crow laws there was separate and equal. It was not equal and there were differences in the school system and differences where we could eat and go into different activities. That was that era.

In 1865 the 13th Amendment abolished chattel slavery and we did say switching history from chattel slavery to servitude. That was linked to what we called convict leasing sharecropping. It was disguised as I will give you this property and you will pay me to use it but when we look at the possibility of a family being able to pay off and buying the land and never having it. 1866 with the formation of the Ku Klux Klan and still running active as of today. You saw a high number of lynchings which is a so did with Ku Klux Klan which often times can include castration.

When we look during the era, they said, approximately, over 4700 lynchings in southern states in a little over 200 in the northern states. This is very rapid. And looking at historical context is the use of ghettos and welfare which was introduced in 1968-1975. How was this important compared to other historical contexts I mentioned above? Let's go back and look at what we call American chattel slavery and look at the last bullet.

The family during that time was matriarchal. During the ghetto and welfare era, which was initiated, we know that men could not live in the same houses as the women and children if you were to receive welfare and being able to stay in ghetto housing. This type of mentality was reciprocated years later to lean and yield towards many African-American families being left

without the father in the home with no choice if they wanted to receive benefits than if the father remained there.

When we think of it in that context, we had single-family homes in which the mother would sometimes work and created the latchkey kids of the 80s and 90s. We had absent fathers. What was the cognitive and emotional impact that had on children?

We had to look at the historical context these are many different elements that have contributed to the use of substance use among African American community. This is a summary of everything we talked about. One that is not on the previous slide that I wanted to mention is that drug use of African-American role model seemed unafraid of white rules are oppression and use of violence to maintain our fearful respect of others. There is association of drug use when it comes to culture or to looking at how society looks at the high rank use of drugs and when it comes to music and television and those types of things.

We have to have those conversations because they are relevant to young adult and adolescent population. We want to address that aspect as we continue.

As we move further along, I want to mention I will provide you with specific data. As a presenter and educator for over 10 years, I provide more data than I will cover it because I do that because many of you questions I may not get to cover. I want to provide you data to go back and look at.

As we get further along, we will see data but I want to mention that. What are some long-term effects of historical trauma response we see in today's society? Survivor guilt.

[Reading from slide]

There are many of us as clinicians and have asked I have this belief of possible wonderment is my client's perception of being willing able to change a possibility because this is our normal? Coming out of normal stress and drama seems indifferent to them and is it hard for them to see? Sometimes there can be fixation because they use the term [indiscernible]. Somatic or physical symptoms, low self-esteem, victim identity, anger and depression, and suicidal ideation, hypervigilance.

That is a biggie. We send data looking at hypervigilant behavior in children and adolescents and sometimes misdiagnosis when it comes to those characteristics. That is something to consider. Disassociation and poor affect and tolerance. Not being able to reconcile these emotions and internalization of ancestral trauma.

As we talk about historical trauma and intergenerational trauma and long and short term effects of it, I have the premise of toxic stress syndrome. It is easy to remember and relate because when we talk about toxic stress syndrome where related to basics. Listed on the screen shows when we have a positive stress response it is normal and essential part of healthy brain development and health development. Brief increases in heart rate and mild elevations in hormone level.

The next stage is tolerable.

[Reading from slide]

They can revert back to some sense of normally and go back and forth between positive or tolerable levels. Toxic stress response is strong, frequent and/or prolonged adversity. This type of response can lead to possible disruption of typical development. Everything from social development to cognitive development to emotional development.

When we look at intergenerational trauma if we have grandparents and great-grandparents who came from the era of chattel slavery working for the area of Jim Crow, they brought those dysfunctional emotions and unhealthy behaviors and disruptive developments from their childhood and brought it to the next generation. We have to ask ourselves how do we begin to address some of these long-term health issues and mental health conditions and substance abuse disorder conditions?

Sometimes looking at the bigger picture of when looking at the holistic part of the client fitting into the environment micro and macro. And what happens when you go back to your environment? That is a big thing we have to focus on because many returned back to homes that are very toxic. How do we teach them to endure? How do we provide resources for them once they exit?

That has been a larger number of research over the years that has taken into consideration epigenetics. It says how the experiences of previous generations can affect who we are also. It is leading back to historical trauma into intergenerational trauma to say it is genetic makeup that predisposed African Americans at higher levels than other races when it comes to being late to mental health disorders and substance use disorders.

There have been numerous studies connect the two. I am not a sound believer that epigenetics is the cause of all substance use disorders in African Americans. You have to take into consideration it may be a contributing factor. When we look at epigenetics it tells us that in many ways it is the ultimate intersection between lifestyle and health and even the health of your children.

It tells us once again how lifestyle factors like diet and stress and exercise can change the way our genes are expressed. These changes appear to add up to affect things like health, risk for disease and general well-being. We take the concept and even though we have historical trauma and racism and discrimination and there may be genetic coding for that person, had we create holistic encumbrance of treatment plans to tackle some of these past generation characteristics and effects?

We create treatment plans that have died in stress management and physical activity programming. And link back to PCP that many of not seeing the primary care doctor ever. Getting current disease that may have underlying conditions treated so we teach the whole person.

Looking at epigenetics we need to understand it is a component but does not encapsulate all when it comes to substance use disorders in African Americans but posttraumatic slave syndrome which is a term used when talk about historical context of mental health addiction among African Americans.

I want to pose this question to you as we begin to turn the presentation and looking at data. Let's answer questions you have when it comes to the use of African-Americans compared to their counterparts.

[Reading from slide]

>> Thank you so much, Dr. Watkins. Everyone see the polling question launch on your screen in a minute and this will be one of several opportunities to interact with your presenter.

[Reading from slide]

As you are answering the polling question on your screen, as a reminder, you can continue to send the questions for our presenter and that GoToWebinar control panel in the questions box. We will have live Q&A towards the end and ask questions in the order they are received and least 18 for the end of this webinar to participate in our virtual town Hall event. With additional panel of experts.

It looks like a little over half have participated in our poll. I will give you five more seconds.

I will close the poll and show the results and turn it back over to your presenter.

>> Thank you, Samson. Let's look at the results. 22% believe the statement is true that African-Americans are more likely than white Americans to have used most kinds of illegal drugs. 78% said it is not true. The correct answer is false. It is not true and let's talk about this question and why I put this as a beginning question as we look at some data.

When we look at demographic data, the U.S. Census says 44 million African-Americans here in the United States and we have to look at the makeup of African-Americans. When we look at that, the rates of substance use among African-Americans compared to the population there are slight differences.

It is coming from the 2018 National Survey On Drug Use and Health. Let's look at what the data says in regards to that. We know from this slide that usage of African-American is similar to general population and it is going to make the poll question falls. There is not high significance of African-American use using illicit drug compared of the rates and it really is about the same.

When we look at mental illness and substance use disorders among African-Americans adults greater than 18, 6 in 13 struggle with illicit drug use is. 2 in 3 struggle with alcohol use and 11 in 7 struggle with illicit drugs and alcoholism. People age 18 and older from this study had substance use disorder and equate it to 7%. Those who had both is about 3.6% and those who only had mental health illness is about 16%. When we are looking at it is 44 million plus African-Americans in the United States and only 7% do have a substance use disorder.

This slide will give you more information and African-Americans to Caucasians and Hispanics. When we look at what are the common questions I saw is what is African-American use when it comes to alcoholism and cocaine compared to white Americans? 6.9% compared to 7.4% of the total population.

[Reading from slide]

It was very similar and very minute. We are not more predisposed to use alcohol and drugs. However, when we dig deeper those who do use, marijuana use is higher in African-Americans compared to white Caucasians or white Americans. Alcohol use disorders are less common in African-Americans compared to total population. You can go back and dig deeper into data statistics to see comparisons between race but I will not go that far into it.

When we look at the war and drugs in the 1970s and 80s the premise was not treatment. It was not prevention but criminalization. We look at it when we look at some mandates and laws that came from that era. We start with the heroin epidemic and the soldiers came back and African-Americans were addicted to heroin.

What was the treatment looking like back then? Very small to none. But there was some out there but how was it affecting those in African-American communities? There was an increase in single-parent homes at that time. And not soon after that epidemic began we have the crack epidemic that really affected the African-American communities in two different ways. From higher legal placement for African-Americans was position and selling it and dispersing it.

Having crack compared to cocaine, those who had crack in possession or selling it got higher sentences compared to counterparts and many are still incarcerated to this day. What was the treatment for crack cocaine? They would have a wide, sweeping aid to providing treatments and making sure it is accessible to African-Americans in the community and the answer was no.

When we look at this and focus on the current opioid crisis in America, it was declared a national emergency.

As clinicians we have to often times understand why there's anger among African-American patients and clients who have substance use disorders. I have been trying to get help for years. There are many users in their 50s and 60s who are still using and they started years ago. And

looking at access to it. It is not sometimes treatment is right around the corner. We know there has been a curve when it comes to application of money making sure is accessible for all people.

With the opioid crisis does not look at is government overdoses among African-Americans, Latinos in a different Americans has tripled since the opioid epidemic began. When we look at what is the media focusing on is white suburbia.

Let's look at data. Illicit drug use among African-Americans and the most prominent question is what the most common drug among African-Americans. We look at for those who do use one of the most common ones across all age ranges is marijuana. Almost close to 18% of who use among African-Americans the most common one is marijuana. And then psychotherapeutic drugs, cocaine, hallucinogenics, inhalants, heroin and methamphetamines. When comparing to the regular population, that is something to consider.

When looking at alcohol use disorders among African-Americans and this graph shows age ranges between 12-17, 18 happened 25, 26 and older, this is age categories for the remaining of the slides we look at as far as data.

We can look at that from starting from 2015 until 2000 a team when the study was done and alcohol use disorders compared to those of the overall US population and 6% is where it falls that when it comes to alcohol use disorders among African-Americans. Looking at the statistics and not a big gap in between.

We move from looking with alcohol data as stated in the summary says no significant change in alcohol use initiation rate among youth since 2015 and declines in alcohol use disorder among African-American youth and young adults during 2018 and so a decline of usage compared to previous years.

This is the second poll question.

[Reading from slide]

>> Thank you so much, Dr. Watkins. This is a second poll and you can interact with your presenter by answering this polling question. You will see three answer options. As a reminder, thank you for all who have been sending in questions. You can continue to send in questions for our presenter in the questions box of the GoToWebinar control panel. We will have live Q&A

towards the end of the webinar and ask your questions in the order in which they received. Please stay tuned for the end of this webinar to participate in our virtual town hall event.

I will give you five more seconds to answer the polling question. It looks like a little over 70% are you able to participate in the poll. I will show the results. I will turn this back over to you, Dr. Watkins.

>> Thank you, Samson put the answer is false and as we have seen, they are part of the opioid epidemic, however, when you look at the media and what their talk about the news and in print, this is not addressing African-Americans and Hispanics and Native Americans because we do know the numbers of overdoses among those three different populations has tripled since 2015. We have to remember as clinicians that the opioid epidemic still faces all different types of populations and not just white suburbia. The numbers when you look at the data is really consistent across the board. Overdose has increased and tripled among all three even though there's a slightly higher percentage when it comes to Caucasians.

We have to make sure we provide conference of treatment to all populations when it comes to the opioid academic and advocate for African-American clients to make sure they receive adequate treatment. What we know it comes to prescription pain reliever issues among African-Americans is only 1.2 million African-Americans with opiate misuse fall into this category.

We look at the breakdown between heroin, prescription pain relievers and misuse and heroin abuse combined and see more prescription pain misuse from African-Americans comes from prescription pain pills. That is something to consider. Access to the pain medication and we make a quick parallel between looking at some higher health disparities among African-Americans and the use of chronic pain in the use of medications to treat that pain and have access to those drugs among African-American communities.

It is being provided sometimes through the grandparents. When we look at the breakdown here, you see a breakdown when it comes to 2015-2018 when it comes to heroin use and pain reliever use disorders and initiation to disorders to misuse. At your time, feel free to look at some of the statistics.

The one thing you want to go over when it comes to opioids and pain prescription misuse in African-Americans is where do they get it from? This is where they primarily get it from. A

friend or relative or free. You heard me mention where is it coming from? The second largest is prescriptions from one doctor. And the remaining top will be other way and bought from a drug deal or a stranger.

It is important to reconcile they may misuse and get it from a doctor, African-Americans are at significantly lower chance and lower ability to receive pain medicine compared to other races. We know there are many African-Americans who are turned away are given less amounts or dosage amounts when it comes to chronic pain usage.

Some other types of data when it comes to it, let's look at when it comes to heroin use among African-Americans broken down. I will skip ahead. Looking at medication assisted therapies when it comes to patients in African-Americans getting treatment. The majority of patients received norepinephrine and a few receive methadone. Those numbers have increased since 2016 and that is a good thing. There are more African-Americans receiving treatments with the use of MAT compared to the past. That is something to consider when talking about modalities.

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We take into consideration as far as misuse and abuse. Overdose is something totally different. That number has tripled. As we look at other illicit drugs let's talk about marijuana use and that is one the most frequent ones used according to the chart. Typically, the highest uses among those between 18-25 and overall use population is 22.1% usage and it's a little higher for the older population. That is something to consider.

When we look at marijuana, look at the disorders when it comes to age groupings. We can look at the increase and decreases and the one particular group that is increasing is 18-25. We take into consideration legalization and the age group as far as other types of events going on at that time. Cocaine usage among African-Americans in the highest group would be ages 26 and older. About 1.7% of African-Americans still use cocaine.

Methamphetamine usage highest age group is 18-25. The highest one being during the timeframe about .3% of the population we use methamphetamine and is not as high. When we look at it among states that California and Texas are the highest states of usage when it comes to using methamphetamines. You can see what other states come in and second or tertiary. It is not prevalent across the United States as a whole but there is hotspots in hot states.

We talked about prescription uses before but this is prescription stimulants among African-Americans in the age group of 18-25. 2.8% compared to 3%. And African-Americans use hallucinogens and, particularly, LSD. There's something about ages between 18-25 when talking about targeting and advocating for change and things like that for substance abuse disorders we want to focus on this age group.

The increase in marijuana usage and no significant change.

[Reading from slide]

I did want to show one slide that talked about co-occurring disorders and substance use disorders in African-Americans. When we look at totality combining those two, cigarettes can be a contributing factor for co-occurring issues with substance abuse. Tobacco use is also another substance abuse disorder addictions that has to be targeted and sometimes we have to get them to choose which one to stop first because sometimes they come motivated to change and want to do both.

You want to break it down and give them a choice and make them choose between what they like to focus on. When looking at substance abuse disorders frequency among African-Americans 18 and older, the highest ones is illicit drugs. And marijuana comes next and opioid use disorder comes after that. We have to be mindful that there is a thing as having a correlating issue between substance abuse and mental illness. I want to skip to the slide that talks about substance abuse when it comes to suicidal ideation.

We can look at how does this look when it comes to data? When we look at co-occurring substance abuse disorder and suicidal thoughts and plans and attempts among African-American adults, we look at those who had no substance use disorders and those who did and there is a significant difference between the two. 18 compared to 3%.

[Reading from slide]

We do know that the use of substances is a big contributor to those suicidal thoughts and plans our past attempts when it comes to African-American adults and something that needs to be addressed when creating these comprehensive treatment plans.

One of the most important factors despite consequences and disease burden, there are significant treatment gaps among African-Americans when it comes to entering treatment for substance use disorders and mental health disorders. The overall US population of 18 older is 56.7% with no treatment compared to 69.4% of no treatment among African Americans. There are big gaps. How do we address that and create programs that are accessible and lead to transformation and accessible to insurance/no insurance to this population that needs it?

As we move and talk about treatment, we talked about where the gaps are in talking about making sure we understand there is high significance of co-occurring disorders compared to substance abuse disorders alone and take into consideration. The overall premise of the study stated a couple of things.

[Reading from slide]

What are long-term consequences? From prison to incarceration to mental health problems such as depression and anxiety and infectious diseases and HIV and other health problems. There are short and long-term effects of substance abuse disorders. When we take along with access to medical treatment and when it comes to substance abuse treatment, we have to understand by the time our clients reach us, they are not sick from substance abuse disorders but also sick from other underlying conditions.

We have culturally competent treatment. Culturally competent treatment has to take into account the African-American backgrounds and struggles and have an awareness and understanding of how culture affects a person's drug use and I call abuses. A question I was asked when I provide consultation is what do you and your staff look like? What is your building like? Is it clean and in good shape? Sometimes clients go into accessible treatment because of no funding and they cannot keep it up. Do the people you serve match the people that provide the service?

The DSM 5 says there's cultural formulations you can apply to the substance use disorder and make sure you understand the ethnic and cultural reference groups when it comes to alcohol and other drugs versus what is degree of involvement with culture and origin and host culture?

[Reading from slide]

You have to understand and make them dig deeper than to say localism's which may be associated with African-Americans. Look at the psychosocial environment. Who are the supports or who may be using in the house? Do they have housing and running water? What is there access to food when it comes to this person? We have to understand when doing diagnosis and we treatment planning, are you looking at from culturally competent lens? Are you asking deeper questions then how frequent and how often do you use and what is your source of income?

There is co-occurrence of 50% or more of cases of African-Americans with substance use disorder who have underlying issue of mental health illness. One of the major ones is PTSD or other trauma symptoms. How do we address that? There are many ways to be culturally sensitive when it comes to the DSM formulation and ask ourselves the tough question. Which came first? The addiction or mental health illness first and which do we treat first? We have best practices that say we should treat the addiction first and then treat underlying conditions of mental illness and health disparities.

We call anything a thing and less than 2% of the APA members are black and African-Americans. What is a predominant race for those who are substance use providers? Typically, white females. How do we address the disparity when it comes to providers of color? How do we have an address unconscious bias or bias you may not be clinicians of color when providing treatments to African-Americans? Even though we've seeing an increase of having access to care, it is not where it needs to be. How do we address your own bias in providing care to African-Americans?

How do you engage? What should I do to make sure I engage and build rapport with my client?  
Greeting matters.

[Reading from slide]

Are you making eye contact. What does your body say? Start with the basics and make sure you address someone you want to be addressed. When it comes to building rapport, making sure you establish an egalitarian relationship.

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Looking and integrating family support, employment assistance, medical treatment and housing assistance and religion and spirituality. We know through the research there are three times more likely to be successful in recovery if and when you integrate religion. We all know the different types of treatment options out there. Make sure you know what is available in your area. For those with no service and no insurance and using regular insurance that may be commercial. Make sure you know what is out there.

On this slide as we begin to wrap up is making sure providing holistic care to treat the holistic person. Are we using trauma focused therapies? We know we are starting from historical intergenerational trauma just sometimes current trauma and they face according the premise of their use. There has to be better research because when we look at the research of treatment among African-Americans, there is not enough.

A lot of studies are looking at epigenetics and only a small portion of how we look at addiction among African-Americans and what is out there, 44 grants were awarded to research and the connection between health, racism associate economics from the NIH. We have to advocate for change. Addiction is multifactorial and the most important thing is we don't use a cookie-cutter approach. How do we progress in our field?

In moving forward, entreating African-American person, we do it from a culturally competent lens but address it from a place of comfort. Address your own bias and making sure you're not a comfortable making eye contact and have a relationship with your client. Making sure you're aware of your body language and be aware sometimes clients may co-switch.

They make co-switch which means the premise of I'm not going to tell my business and we don't tell anything that goes on in the house to outside people. Those are some things you have to take into consideration as therapists and we want to establish trust, honesty and self-disclosure that is appropriate and applicable.

>> Thank you so much, Dr. Sherra Watkins for valuable expertise on such an important and vital topic right now with everything that is going on. We have so many questions that came in. Thank you for sending in the questions. We do not have time right now to do a live Q&A directly with Dr. Watkins but I will final your questions into the virtual town hall event that will launch in five minutes.

For a moment, I want you to see Dr. Watkins contact information she shared on the screen and you can email [ce@naadac.org](mailto:ce@naadac.org) if you want to connect with our presenters. We have great questions and we will answer all those questions during the virtual town hall event. If you did send in questions and not able to stay on for the virtual town hall event, you will see a Q&A document that will be posted on our website. The same one you use to register for this webinar.

If you are wondering about your CE quiz for this webinar and access the recording after the live event, every NAADAC webinar has its own webpage that houses everything you need to know about that particular webinar. Immediately following this live event, you will find two online CE quiz a links for this webinar at [www.naadac.org.sud-African-American-communities-webinar](http://www.naadac.org.sud-African-American-communities-webinar). Please pay close attention to the instructions on this like to earn your continuing education hours.

You need to watch and listen to this entire webinar. NAADAC uses time tracking tool to verify your full attendance to earn the appropriate number of CE ours. You will pass the online CE quiz for this particular webinar. Please remember one CE continuing education hours approved through the NASW for webinar presentation you just viewed. If you're looking for CEs that are not seeking that approval, this webinar and virtual town hall event or proof or two continuing education hours.

When you click the link you will be directed to either log in if you've not done so or if you are logged in you'll be directed to a webinar survey evaluation questions to access the quiz.

NAADAC is excited to announce that you will now receive your earned CE certificate immediately after passing the quiz. To learn more about the new system and how to access the online CE quiz in your earned CE certificate click the hyperlink as you see here on the slide at the bottom. It has a yellow arrow that says click here for the detailed step-by-step instructions and we have our instructional guide in the handouts tab in GoToWebinar control panel.

Click the GoToWebinar control panel with the orange are at the top and under the questions box you will see the hand out box and please download and save a copy of the user-friendly instructional guide so you see how to access the online CE quiz and immediately access your CE certificate.

Here is the schedule for upcoming webinars. Tune in as you can as there are interesting topics with great presenters like today. You can visit our COVID-19 resources page and the website is on the slide. NAADAC provided to you six excellent free webinars covering top concerns in the addiction profession and presented by leading experts in the field. There are a lot of other resources.

NAADAC is offering two specialty online training series. You will see them on the slide in front of you and on the printout version of the slide. One is on clinical supervision and the other is addiction treatment in military veteran culture in the addiction treatment profession. Please visit our webpage to learn more. As a NAADAC member, here's a quick review of the benefits. If you join NAADAC have access to over 145 CEs through our free educational webinars and receive our quarterly advances in addiction recovery magazine where each article is eligible for CE's as well.

NAADAC offers in person seminars throughout the US and internationally and included in NAADAC membership or independent study courses, regional and annual conferences, certificate programs for addiction and specialty topics and much more. You can visit the email listed on the slide.

If you are leaving not being a part of our virtual town hall event, that is totally okay. If you're only seeking one NASW CE hour but you'll get a short survey at the bottom and for those who stay on as the survey will pop up at the end and take time to share your feedback and share any note you have for our presenter and how we can improve. Thank you for participating in this webinar and thank you Dr. Sherra Watkins, for your valuable expertise and agreed to stay on with us for our virtual town hall event.

We are going to shift now to our virtual town hall event. For those who are just now joining us or clicking the link to join us, welcome and thank you for joining our virtual town hall event on substance use disorders in the African-American community and the purpose is to allow an open forum discussion on a topic that really requires equal parts. Open dialogue and action.

For those who are just now joining us, you will notice the GoToWebinar control panel that looks like the one on my slide. Can use the orange arrow any time to minimize or maximize the control panel. We will gather the questions from the question box you sent and click the

questions you're going to send during the virtual live town hall. We will pose them to our panel and under the questions tab you will see handouts.

You can download the PowerPoint slides from that handout tab and user-friendly instructional guide on how to access our online CE quiz and immediately earn your CE certificate. Please make sure to use the instructions in our handout tab when you're ready to take the quiz.

In the questions box, throughout this virtual town hall event, we want to hear from you. The share any ideas, resources or innovations you have found successful on the topics we discussed during this event. We would love you to leverage something positive that has come from this new and constantly changing year and environment we are working in and just into the world resources in all caps and name and location and show your experience and ideas.

Our panel is here to answer your questions but we would love to hear from you and share your ideas with our audience. Towards the end of the webinar we will list out resources shared from the audience. Now a brief introduction to our panel. First Dr. Sherra Watkins in the new you were here and heard from her is the director of wellness counseling in American University of the Caribbean School of Medicine in St. Maarten. She earned her degrees from East Carolina University including a doctorate of philosophy degree in Rehabilitation Counseling & Administration.

A Master of science degree in clinical counseling and substance abuse counseling. A Master of Arts in education degree in health education and bachelor of science degree in school health education. Her research focuses on decreasing the stigma of mental health and chronic pain and chronic diseases among African-American and she is a co-owner of Sister WELLS, Coaching, Counseling & Consulting.

With Charla Blumell and Shawnte Elbert and all are proud members of Zeta Phi Beta Sorority, Incorporated. You can find out more about her background by clicking on the handouts tab and downloading her speaker sheet that has her contact information.

We are fortunate to have on our panel today Dr. Anthony Andrews. The owners of Andrews Counseling & Consulting. Dr. Andrew specializes in providing therapeutic services for individuals and families to address a wide array of challenges. As a licensed clinical mental health counselor in licensed clinical specialty work with young adults, older individuals and

couples. He works with children and adolescents with a variety of emotional, behavioral or psychological concerns.

Born in the small town of East Arcadia, North Carolina, he learned the importance of community. Dr. Andrews earned his bachelor's degree from Shaw University and traveled to Greensboro to earn both a Masters and doctorate degree in Rehabilitation Counseling from North Carolina Agricultural & Technical State University.

I am honored to introduce Cynthia Moreno Touhy the executive director of NAADAC. She previously served as executive director of Danya Institute and the Central East Addiction Technology Transfer Center part and prior to that she was the program director for volunteers of America Western Washington serving in the administrator of alcohol and drug centers providing a broad range of services and a trainer in domestic violence anger management and conflict resolution.

Cynthia has written on a variety of professional issues including addiction evaluation, counseling methods, Co-occurring disorders, treatment and recovery. She served as president of NAADAC Certification Board Commissioner, International Chair, Treasurer and Legislative Chair. You have seen and heard from Cynthia in our advocacy webinar series as a champion for the advocacy movement in the addiction treatment profession.

I will also join this panel and activate my WebCam in a moment. My name is Samson Tecklemariam and the director of training and professional development for NAADAC. With no further delay those who have not yet you can activate your WebCam as we shift to a virtual town hall event.

We are here. Thank you for joining us. Everyone, please continue to send in your questions. We have great questions that came in from the registration when you registered for the webinar. We have questions that are lingering over from the webinar presentation we just did.

As we start off, I'd like to open the floor first to our presenter Dr. Sherra Watkins. Since you lead us through so much incredible information and resources during our webinar. If you could begin with your opening statement. We will have opening statement from each panel member for about 2-3 minutes.

>> Good afternoon and thank you all for staying over and thank you for the webinar. Why am I here is one of the biggest questions I wanted to share. I am a child of the crack epidemic. My father is currently in and out of addiction using crack cocaine. I am a survivor myself of sexual assault that led to my own alcoholism.

My passion in being a therapist provider comes from a place of knowing that is. I lived this in many different ways as a child. And as a person in recovery for myself. I am passionate about being a therapist and psychotherapist about giving back to my communities of color and giving back and educating as a whole on how to look at some cultural lenses that we need to take into consideration in providing adequate and holistic treatment to our patients.

I am here to share my knowledge and share my strength for those of us in recovery to continue to fight one day at a time and I welcome any questions you have.

>> Thank you, Sherra. I will let Anthony Andrews, if you could start with your opening statement.

>> Hello everyone. I'm glad to be here. I think this topic is so important and vital to community and to communities alike. It is important to spread awareness of substance abuse in African-American community and I believe being here today will help individuals who are struggling or challenged with substance abuse get through as well as helping clinicians on-call to better serve the communities that are affected by substance abuse in African American community.

I'm glad to provide knowledge and Sherra did an excellent job. And I gained more by listening to you and ready to dive into a discussion and help.

>> Thank you, Anthony. Cynthia, if you start with your opening statement?

>> [inaudible]

>> Cynthia, you are muted.

>> Thank you, Samson. Thank you for being on this webinar. It is vitally important and we're happy to have you here. I want to start with NAADAC's position on Black Lives Matter and social injustice book some of you may have seen today a release on this. And [inaudible] And advocacy and knowledge and standards of practice and professional development and research.

We achieve that by universal knowledge and acknowledgment Black Lives Matter. I will leave it at that. Thank you.

>> Thank you so much, Cynthia. As both facilitator and semi-joining the panel, my passion is in workforce development and training. I was fortunate to almost accidentally fall into training as a counselor. As a counselor in addiction treatment, I realize more and more we are not always prepared to work with the people coming to our offices. We are not always prepared to work with everyone sitting in our group.

Now in the world of Telehealth, we are not always prepared to work with that person on the other side. Know how to much clinical supervision we get or years of experience, we still get shocked and surprised and have someone who sits in the other chair that says something we are blown away by.

I am very passionate about making sure our field is prepared. I asked myself during this challenging time how is it possible in our field we have a requirement for hours of ethics and continuing education and no requirement for cultural competence in continuing education? Something I asked myself and challenge myself of with as a licensed professional counselor and I love to be discussing during this town hall. Thank you everyone for being on this town hall and joining us. Sherra, I will start with you.

Our first question comes from Dena from Ohio. She asks, "what is the most common drug used by African-Americans?"

>> As I stated in the webinar, all drugs or all illicit drugs are very common and the numbers are very similar across the board from African Americans to the general population which includes Caucasians. As we dig deeper into the numbers, you see those who use illicit drugs the most common one is marijuana. We compare that to the overall drug issue among those in that population.

That is the most common one. It is also important to note that society by stereotypes and media has predisposition and when it comes to most common are most often used drugs to align crack cocaine with African-Americans only. And heroin use for needles with African-Americans and pills for Caucasians. We have to address some of the biases because they are used interchangeably. They are used differently from state to state and town to town.

When talking about the discussion of Substance Use Disorder in the African-American Community, we have to address the advices we see because what you may see in your own town and shared office may be different than what has been sensationalized from the media. Know your numbers for the areas and know the basics also.

>> [inaudible] Anthony, your first and does not first question comes from Scott from Tennessee asked, "how do I discuss race issues with black patients as a white therapist?"

>> Excellent question. Hello, Scott. I think it starts with looking at cultural competency and how we practice in the beginning is focusing on our clinical assessment and intake. Are we even putting cultural questions on our intake? We so we can figure out are there issues that people have when they start the therapy process? Then after that to become comfortable with having the conversation and focus on discomfort and what may be there.

And figure out why are those reasons and what is making it difficult for me to have that conversation? Allow the client you see to be vocal so your job will simply be to listen. To listen and provide empathy and focus on the raw emotion and focus on why that problem exists. A lot of people may not be aware and I reflect to a story or conversation I was having with my sister-in-law.

She said, "Anthony, have you ever noticed the white vans [indiscernible]?" I have not noticed that in my sister-in-law is Hispanic. She informed me that with my family we are fearful of seeing the white vans because it is ICE to detain my family and other community every day right there in the parking lot. I pause for a minute and realized I was not aware of these issues because they do not affect me.

Once I became aware of these issues, it was my job to advocate and acknowledge issues that are going on so I could be effective ally. I would suggest to you discuss the issues and have a conversation to make people feel you are hearing them and listening and make sure people are being heard.

I believe you can have a conversation and town halls like these are the gateway to opening up those conversations.

>> Thank you so much, Anthony. Thank you, Scott, for the honest question. Cynthia, your first question comes from Danielle from Oregon. She asks, "how can we advocate for culturally specific services for clients we work with and to whom do we advocate to?"

>> Great question, Danielle. I see an important piece of our lives as counselors and the reason is because part of our Code of Ethics that we promote the welfare of our clients and advocacy around this issue is vitally important. And the way we do that at the state and local level is you have a single state authority director and the single state authority director helps make decisions about how many is spent in your state and for what type of services. If we're not getting those types of services for African-Americans for other people of color, that is a big issue.

I live in Washington, DC and I am from the state of Washington which is a big state with a lot of African-Americans, Native Americans and Hispanics. All are minorities and Asians and all minorities need to have services but sometimes [indiscernible] is not as involved with the people on the ground. Think about what services we need to be having.

[indiscernible]. NAADAC is very involved at the state level and national level. We work on issues like minority Fellowship program to bring funding for education for people to become counselors. Counselors that are either from minority populations or who desire to work with minority populations. We have to continue to advocate for that.

I will say one thing about efficacy. It is a lifelong commitment. You not to seven advocate for a year and the be all done. Advocacy is a lifelong commitment and it may take years and years to get something through it took us eight years to get the minority Fellowship through.

It's important having that energy to keep it going. There is so much more so please look at the efficacy webpages on our NAADAC website. There is a lot of information there.

>> Thank you so much, Cynthia. I will ask myself a question that popped up. I should text it to Sherra and have her ask me. Tina asks -- regarding my opening statement -- "do I feel that helping professionals are more effective if they have traveled a similar road?" I will interpret it in two different ways and I don't what it means when you say traveled a similar road. Do you mean a black client working with a black counselor or do you mean a client who is in addiction recovery working with the counselor who is in addiction recovery? I will answer them both pretty much the same way.

No. I do not feel there is a difference and I do not feel one is more effective than the other. I have worked with horrible counselors who are black providing treatment to black clients. I work with horrible counselors who are white to providing treatment to black clients and white clients. I have worked with people in recovery for counselors and not good at what they do and they need more supervision and training. I have also worked with excellent counselors who were also people in recovery.

What it boils down to is someone who is willing to authentically on who they are themselves and build their self-awareness is one of the most critical skills of a professional helper is building your self-awareness. It is a lifelong journey. The second part is being available or accessible or listening to those clients and listening skills. Everything else in between like mastering DBT or ACT or whatever the letters are, all of that is techniques and signs in skills and strategies. What makes a counselor effective is their devotion to lifelong learning of helping people and learning how they can help themselves.

I hope that answers the question. I will ask a question to the whole panel that is something we can all speak to. The question is with the microscope on systemic racism and injustice in our communities, what can we as professional helpers and counselors do? This person is asking one thing. If each of us had one thing, what is one thing they can do right now? We can start with Anthony and then go to Sherra and Cynthia.

>> This question was for what professionals do?

>> Yes. Asking if one thing they can do right now in this current climate, what would that be?

>> I think we have a platform helping professionals. Whether it's a large platform or smaller platform we have a platform. If we spread awareness of what is happening in today's society out and that's one more person who becomes knowledgeable. Continue to use your voice and speak out. If I was a client, I have my own personal therapist and did not see them advocate or be vocal about what is happening right now, I may feel bad about that situation. I want to see my therapist or health professional noticing there is an issue out here.

If you do not notice that, seek why it is happening. If you see something happening, you have to have courtesy to acknowledge the situation and hear back from people. This is not just a national

thing. Local people are using their voice locally. You have to become aware and make sure you use your voice and be a part of that number.

>> That is a great response, Anthony. Stealing my thunder. I will try the second best answer. If I had to give one particular piece of advice as a therapist, one of the biggest things we do is challenge unhealthy thoughts, challenge resistance and challenge the lack of reality and perception to certain things.

This is not the time to do that. This is not the time to challenge someone's belief system and perception and experiences what they've endured when it comes to racism or bias or being stereotyped. This is not the time that type of intervention or therapeutic discourse is appropriate. There is one discourse we have been trained to do which is have interpersonal communication skills. It is great to just listen. It is not our job to save or heal or to feel you have to challenge sometimes those thoughts.

That is the best piece of advice I can give.

>> I think you both stole thunder and I will try to get some lightning. I think invalidation and validate those experiences and let them know I may not understand everything about it but I'm with you and my heart is with you. Participate and validate. The way you participate is by getting education and get education and awareness. The way you participate is by talking to other people.

The way you participate is advocacy and going on the streets and saying this is not correct and do that. Whatever it is that is in your heart to do, do that and it is so vital right now. I am a kid of the 70s. We thought we did something bad thing but we did not finish. It is time to do more. That is NAADAC's big statement, it is time for us to do more and together we can make a big difference.

>> That is really great and thank you so much, Cynthia. All of your answers makes me have a combined answer of what you said. I am a one do not and one do and I will cheat a little bit. The one do not is remember the first adolescent or teenage client that was referred to you with some sort of substance related issue in the got to a debate with you about marijuana or cannabis? It should be illegal. It should not be illegal? Most of your supervision and training go to is not a

vital debate to enter into. There is no way to win it or be a part of the argument and be there therapist.

You have strategies like deflection or cognitive dissidents that create space between you and that argument. If you take on a hat or role of being the enemy in that cannabis or marijuana argument with a teenager whether or not it should or should not be illegal and now you on the other side it's hard to build rapport from there. Dug a little bit of a ditch.

In the same respects right now, you may have a completely different opinion or political affiliation and that is totally okay in your personal circle and personal life. If you are part of someone's therapeutic or helping our treatment experience, it is not helpful in that environment. Your opinion, political affiliation has as much valid reason to exist but when you're working with someone, it just does not help and your role is to be help.

A lot of times we submit and surrender our opinion on things that are emotionally charged to focus on what that person needs in the moment and like Cynthia said, what they need is validation. Like Sherra said they need that listening ear and like Anthony mentioned his they need you to be there with them to make sure they know it is not in that moment about them being black or white or whatever the issue is. They need help and they're offering some language to you and be vulnerable about it especially if they paying. They need you to validate and that is my do and do not.

We have some questions for you. We are right on time. We have polling questions. For the panel, I will let you turn your WebCam off if you want and the polling question will pop up over the WebCam. They will not see you. Feel free to turn your web come off for a minute or so we have pulled questions that we would love to learn more from you all from the audience.

The first polling question is.

[Reading from slide]

Imagine the conversation where talk about with your peers and colleagues. We will ask the same question of how uncomfortable it is with your clients. We would love to hear your thoughts on this. I will give you a few more seconds to answer this polling question. Thank you everyone

and we will close this and show the results. I will ask the panel if you see something like to speak to, we have 49% who said it is not at all uncomfortable.

[Reading from slide]

Panel, what do you think of these results?

>> I think the results is very satisfying to see that we have a good majority of clinicians of all types that are comfortable and have conversations regarding race and what are the current issues facing us regarding African-Americans. And the second part I think about is how do we have that trickle-down effect? How do we have those who are not comfortable and mildly uncomfortable to teach and impact those who are of the lower two and trickle-down that affect to make sure we share our knowledge and expertise to our colleagues?

>> I agree, Sherra. You speak of trickling down to very uncomfortable audience. I would like to know what factors and what way makes the people not uncomfortable at all, what are they doing or what conversations are they having or taking the leap out to have those conversations? I think the more they continue to do that, it make or encourage the ones that feel very uncomfortable to have the conversations.

>> I would agree as well. What is it that NAADAC can do to help a person become more comfortable and people who are comfortable already, what else can we do? Conversations are important.

>> Thank you all so much. We will launch one more poll. It is for your clients.

[Reading from slide]

I will leave this on the screen 10 more seconds. I will close the poll and show the results. Thank you for your participation and we will continue with the open forum discussion in the Q&A and just a moment. For our panel I love to hear your thoughts. This is almost exactly the same. Maybe the dial has made a little in terms of very uncomfortable. We have 49%.

[Reading from slide]

Panel, do you have any thoughts to share?

>> I think is easier or maybe not easier but more comfortable to have the conversation with your clients because I can imagine in my experience that my clients may bring it up. If that makes sense? With the client leaving that conversation, it seems it would be more comfortable to have that conversation. With peers and colleagues, the conversation may never come up and that's when it takes the person to advocate or bring the issue to the light to start those conversations in those cases. This is interesting to see. I like the results.

>> I think Anthony to what you said earlier about what it is of certain questions on the intake. It drives the conversation and makes it more comfortable and gives that awareness for both the client and counselor. I think making sure your intake has cultural humility and cultural specificity to it is important.

>> Thank you so much. I will have results and shift back to the virtual town hall.

>> We will use some of the information as we continue discussed. Anthony and Sherra and Cynthia thank you so much. This next question is a bit of a loaded question. Comes from Mary and who would like to respond can go ahead. I sent it to you in our group text since it is a lot of words. She asked, "how to have a conversation with your staff to help them become aware of their cultural encapsulation? How do we as clinicians take the first step in becoming culturally sensitive on purpose to meet the client where they are?"

>> Anybody want to take it first? I will jump in. It is important, the training is important. As a person that is running an agency or trainings that, if you do not have all the answers, you can show your awareness. Maybe you should bring someone in to train staff because they will train you. We have to invest into ourselves and agencies in a place we were can to ensure were getting the help to get us to become more culturally relevant so we can avoid dismissing someone's culture or being ignorant to their culture. And bring someone into a with that is not a bad thing at all to do.

I may not have all the answers and I may not be the best at articulating these answers your questions or conversations to my staff and making sure we are getting the people in place so we can assure cultural competency.

>> I will add to that. Starting conversation with your staff is starting a conversation. I would like to talk about this topic. I would like us to have an honest open conversation. If you want to

use NAADAC position statement, if there is a tool you can use that will help you dissect that down a little bit and give you some meat to direct. I would suggest that.

When it comes to how do you learn or grow your own, NAADAC has a series of different cultural humility sensitivity webinars and it is good to listen to those to learn. There are podcasts on cultural humility which is important and I will go back to some reading that was done years ago. Some writings that were done years ago that got lost between the mid-70s and to thousands where we do not spend as much time reading about these issues and about cultural issues, racial issues, property and how those intersect.

I think reading is important.

>> My two responses would be piggyback off Anthony. Please do not use your African-American coworker to be the trainer. We are tired. We are enduring ourselves. We are trying to still be helpers while helping ourselves. And we are not ready to be at the table. You can use this as a resource is needed but there are many other experts outside in the field who do this for a living and this is within their wheelhouse and invest in the appropriate and accurate training for your team.

You may need to do a needs assessment. Specifics within culture competency do we need to address and can we make a plan of action? No one training is enough to cover cultural competency as a whole. How do we break it down into actionable steps and programming?

Two, in related to this question I think back to my program when I became a master level health educator. One of the final pieces in our senior year in order to graduate was we had to immerse ourselves inside of the cultures of our clients. I remember it was required and was a long listing of different things we had to do for the end of the semester. I went to a mosque and a form and went to Mexican or Hispanic faith healer. I talked to a rabbi. I went to a Catholic church and a black church in I could not speak from a place of experience until I immerse myself into it. I did it is I did it scare. I did not know what I was walking into.

Sometimes I had someone go with me and sometimes I cannot. I did it scared and when I went there if I had questions if I could pull someone beside her asked them afterwards or if I had a colleague or friend who could go, what type of culture, how do I need to dress? I researched and prepared to enter into the spaces so I would not going cause harm. We have to do the work

ourselves. Somehow it is interesting many of our programs in the helping field have this in course work but it stops there. How do we continue that entire professional career on an ongoing basis? Those were best experiences I have had.

I'm about to be 38 and my biggest experience was talking to the [indiscernible] and listening and have holistic treatment and American population and go into the areas and talking about it is beautiful because I see the intersection with my own faith and intersection within my own culture of African-American or black. I learned specifically they have worship different in different entity and be as, we have this belief in a higher power that orchestrated something that was bigger than us and when we do not understand something up there was doing it on our behalf and for us and for our good. That was some the best experiences I had.

>> I tried to promise myself I would not talk too much during this but it is so hard. Mary asked a great question about how to deal with this amongst staff whether you are a supervisor or colleague. I love what each of us said. One pain that me and Cynthia are both feeling this year is a truth is we wish we could do this town hall involved in every one of your states in every one of your programs because this is needed and you can do that.

You can get your colleagues or employees and you may not have training curriculum are done the amount of research you should be doing but what you do have is each other and open forum discussion. We are leveraging technology to connect but you can connect locally whatever is allowed in your state in terms of CDC guidelines. If COVID-19 wasn't going on, I'm sure we would all of the better programs and connect and help facilitate a discussion just like this that we could share ideas.

I try to avoid the should word from Albert Ellis Institute fans. The reason I said should research is because it is what Sherra said. We are tired. We are not your props. Sherra, Anthony and myself may have to have experience in research background may feel like pulling us alongside and use as training for your program, we are traumatized right now whether we like it or not. We are constantly overwhelmed with images of people who look like us being murdered or killed because of something they had no control over. And whether it is right or wrong or your perspective of the topic, it is hard to see that constantly over and over again and turn it off and help your employees or colleagues understand what that feels like.

The research is there. Cynthia started off saying this is past time or past due. That is so true. Because it is past due it means you have decades information on Google you can look up how to have a conversation about and talk about and do this or that. Look it up and research it first and do your work. If you want to be part of the solution, that is where it starts.

Hopefully, that's the last answer a question because we have a question coming up that is good. I know Anthony has a lot of background on this topic and trauma focus in trauma research. The next question comes from Lori. She asked, "what are some ways you can address the intergenerational trauma and ongoing racism that has led to the current public demonstrations in the death or murder of George Floyd?"

>> I think a lot of people are able to help during the situation or address the situation by simply acknowledging the issue is there. Historical trauma is deadly present and is a factor today. We look at the death of George Floyd, we are viewing this every single day. It is on Facebook, IG, Instagram, the news and it is coming over and over. People are viewing this and our kids are viewing this. Our parents are viewing this and professionals and teachers.

It takes me back and what it must have felt like to the people that have come before us who had to witness lynchings and see bodies hanging from trees over and over. We repeatedly see this every month, another black body is dying. Another blackbody is being out on display for people to see. How traumatic is it to witness that over and over again? If we cannot acknowledge that and do the research on our own to see where people are coming from and why this is so traumatic to us, that is when you see protests. People are simply tired.

When a client comes into your office or the session, they are so drained and tired because this is not the first time this has happened. We are talking things that have been that do not make the media and get reported. People are coming from a place of trauma and pain. To help that is simply listen to them and there is an issue here. We do not want to cover it up as if it is a one-time incident. It is not.

A lot of people like to dismiss the issue or dismiss the feelings behind it. I am here to say don't ever dismiss anyone's feelings behind it because people like to be heard. When you mute people and make them feel voiceless is when the rage comes.

We have to really listen and focus in on the feelings people are having and tune in and ask yourself what can I do?

>> Thank you, Anthony. Cynthia, you may want to respond to this. This is from a friend colleague of mine. It is someone from the mid-Atlantic region in Virginia and the question is "I was the beneficiary of NAADAC's Fellowship program in 2016 and I'm the better for it. I'm an African-American in recovery and I worked in several treatment centers and seeing low numbers of African-American seeking treatment. Most are externally referred. How do we address the issue of preventative outreach in these communities?"

>> Thank you for being involved in the fellowship program. That warms my heart. When I look at doing outreach and outreach in the African-American community, I think [inaudible] And going to the churches and meeting with pastors and ministers. Letting them know about what you have and what programs you want to make yourself available. If they have questions or there's a way to get information out to the church, I think that is important.

It is important to go to the community health centers because sometimes they do not make referrals to specific treatment programs or they do not know about them. Not every community health center does.

And also the welfare department. Not to be invisible in your community. You have to be visible and we are here and we are here to help. And find different ways to connect. Outreach is a skill. Outreach is important and is like advocacy to me. You go with what you know that your treatment center and how important it is to serve people and give them that information and make yourself available for questions and referrals. Sherra or Anthony?

>> For about five years, I worked in HIV and infectious disease realm. As Cynthia stated, how do we get to the place of getting the numbers down insert specific demographics within HIV and AIDS community? We went to touring parties and sex parties about houses and places they were. With a safety in mind, there places we could go from churches to barbershops, nail salons. Are we going to the schools? And everything else you can think of.

We have to ask how do we get past -- two things. With churches, had we get past God heals and saves everything which is a biggie in the African-American community. How do we get past what goes in this house stays in this house? Had we get past those two things? You have to

think outside of the box. If I'm a child who is a mother or father is an alcoholic or addict and I'm in the home, if I'm in the school a range -- were looking at school psychologists and nurses.

It is teaching the same skills we trained in all other types of domestic violence or domestic abuse and make a paradigm shift of prevention is prevention. Skill teaching and going to the places we are is going to be the most important.

It has worked so use what's out there and revise it and reframe it to fit within substance use disorder, for example.

>> Go ahead, Anthony.

>> I was going to agree. I think Sherra and Cynthia mentioned preventative care and facing the stigma that comes along with counseling or preventative treatment in the black community. And building trust that we can go to a professional to get help or treatment. And that takes trust because historically there is trauma behind getting treatment in the black community and trusting providers to do so. And defacing the negative stigma and knowing there is nothing wrong with saying I need help or I need assistance.

Once we do that and Sherra was referring to boots on the ground and going to these places and knocking on the doors and passing out flyers. Making sure we spread awareness and being transparent how we have personally been helped by a counselor or treatment facility or we know people that are being healed. Being transparent and putting boots on the ground.

>> Thank you so much. We're getting close to the end and I know you have a lot of questions from the audience. Thank you audience so much. We will put those in a Q&A document and work to complete that document so it is an additional resource on our webpage. We will type out the answers so you have it as a resource.

Now we have about a minute or two from each panel member to do closing statement. I have a closing statement I will say quickly. NAADAC has done a lot for me and many of us in our field. I am excited. You may have heard it or read it on our website or hurt Cynthia mentioned it but if you're wondering what now, we are forming a new NAADAC committee focused on critical issues in the black community and donating all proceeds that is generated from our

upcoming webinar series on cultural sensitivity to the Third Good Marshall College Fund support black students who are seeking addiction focused career.

I think Sherra mentioned everyone who's a counselor or professional help or sponsor wants to change the world and heal everyone but we can't. We can only do something to move the needle and move the dial to make a statement or stance and get boots on the ground like Anthony said.

This is one of many things that NAADAC will do this year. If you're interested in this NAADAC committee that will focus on critical issues in the black community, please email us. You can email me and reach me through my email if you want to learn more and work together to continue this discussion. Closing statements from Sherra and Anthony and Cynthia and we will show the resources for our audience.

>> Thank you all for having me for the webinar and the town hall. My closing statements would be two things. For my colleagues out there who are not people of color, I know it is difficult right now in watching and seeing everything that has been going on and continuing to go on. It is okay to reconcile with yourself that they may not have been the initiator of the cause of a lot of historical trauma that you don't have too always say it. We get it. We know it was not you. We know it may not been your parents or grandparents. It is historical context to it.

However, there is expectation within our Code of Ethics for you to be present and provide safe places of therapeutic realm for people coming in and seeking our services. My challenge to each one of you is ask yourself the question what is one thing I can do after I leave this webinar?

The biggest thing I share with medical students on Monday night is not all of us are marchers or protesters or have great writing skills and want to write great posts on line. But do what you do best. If you want to donate \$5 to that food bank or whatever but get involved in the best way you know how would be my suggestion. Choose your one way.

>> Piggybacking off Sherra, thank you for the town hall. When talking about substance abuse we cannot forget the trauma or traumatic piece that goes there. That is why hear the theme of historical trauma when you ask about intergenerational trauma and that is often a lot of cause for the substance abuse going on in the community now.

I encourage you as Sherra said to make sure you're using your platforms for big or small. Be an advocate because that is what is in our policy. We continue to make sure we are being advocates and policy change. We have systemic oppression that we do not get to because of time. These things because this cycle of oppression and trauma and substance abuse.

We have to use our voices and we cannot afford as a community and as professionals to be silent. Now is not the time and I challenge you to everyone do your part and you do not the protest do things we see in the media all the time.

Make sure you do your part to sit down and figure out how can I be a part of this?

>> Andrew and Sherra, you wrap up nicely. The only thing I would say is that I can add to that is we know that all lives matter. [inaudible] That is not helpful either. [indiscernible] I keep in mind this little quote. If not now, when? If not me, who. For yourself, think about that. Where do you fit in that answer?

>> Thank you so much, Cynthia. You will see a last poll.

[Reading from slide]

You all sent some great ideas and great resources. I know there's a lot more and a lot of links, bookstores and go here and click there and go to this agency. Great information. I only typed up what I can fit on the slide. The next slide after we see the results of the poll will show ideas you sent in. Resources, innovations and ideas you think can help your peers or colleagues in everyone here.

I will show the resources in a moment after we close the poll. 79% says yes. We have work to do. 79% says yes, they want more virtual town hall events like this. 21% said depending on the topic and maybe we will have different topics.

Thank you so much for sharing that information. There is the results. Dr. Andrews and Dr. Sherra Watkins and Cynthia and myself have seen and heard these results. I will hide the results and show the list you shared. Resources and innovations came from the audience.

[Reading from slide]

Stay tuned, you will learn more. Thank you all so much for being here and thank you for joining the open forum discussion. We would love it if you join NAADAC. You can do this by visiting the email on the slide. A short survey will pop up on your screen when we close out this webinar. You will get in automated email from GoToWebinar. It will be at the bottom of the email. The watch recording link will be in that email also. Thank you for attending. Please give us your most honest feedback. We use that to sharpen these experiences for you.

Thank you Dr. Anthony Andrews for joining us and Dr. Sherra Watkins and Cynthia director for NAADAC and thank you for your valuable expertise for sharing with us. I encourage you to take time to browse our website and learn how NAADAC helps others and stay connected with us on LinkedIn, Facebook or Twitter. Have a great day.

[End]