Connecting the Dots: Unifying Service Silos to Promote a More Equitable System of Care

October 24, 2024, at 3:00 pm – 4:30 pm EDT

Daniel Fishbein:

Good afternoon, everyone, and welcome to Connecting the Dots Unifying Service to Promote a More Equitable System of care webinar. My name is Dan Fishbein. I use he him pronouns, and I am a public health advisor in the Office of Behavioral Health Equity here at SAMHSA. I am wearing a cream-colored shirt, and I am talking to you from my cubicle in my office. I'm joined by my colleagues in SAMHSA's Office of Behavioral Health Equity, members of the Achieving Behavioral Health Equity Initiative, and our amazing panelists today. Just a few brief housekeeping and zoom etiquette reminders. Please, put your questions in the Q&A box and use the chat only for the purpose of introducing yourself and event related communications.

Daniel Fishbein:

Again, please, put your questions in the Q&A box at the bottom of the screen. Please share comments in the chat and keep any chats related to the event. Closed captioning is also available through zoom using the closed captioning button or full live transcript option at the bottom of the screen. And we also want to remind folks, the Achieving Behavioral Health Equity Initiative seeks to use affirming, respectful and recovery-oriented language and all activities. We ask that participants practice doing the same. That language is strength based and hopeful, inclusive and accepting of diverse cultures, genders, perspectives, and experiences healing centered and trauma responsive, inviting individuals participating in their own journey, person first and free of labels, non-judgmental and avoiding assumptions and respectful, clear and understandable. Consistent with our actions, policies and products.

Daniel Fishbein:

I will now introduce our opening remarks. Tenley Biggs is the deputy director in the Office of Behavioral Health Equity here at the Substance Abuse and Mental Health Services Administration. She is coordinating SAMHSA's efforts to reduce disparities in mental, mental health and substance use disorders across racial, ethnic, LGBTQI+, and underserved populations. She is a member of a workgroup dedicated to implementing the Health and Human Services response to the Memorandum on Condemning and Combating Racism, Xenophobia and Intolerance against Asian-Americans, Native Hawaiian and Pacific Islanders in the United States.

Daniel Fishbein:

I will also introduce our moderator, Dr. Patricia Strach. Dr. Strach is a professor in the Departments of Political Science and Public Administration and Policy at the University at Albany, State University of New York, and a fellow at the Rockefeller Institute of Government. Also, with the State University of New York. Her research examines the opioid epidemic in local communities, engaging people on the frontlines, including local officials, law enforcement, health and other service providers, community activists, and people who use drugs and their families. It is now my pleasure to pass it to Tenly Biggs to deliver opening remarks.

Tenly Biggs:

Thank you, Dan, and good afternoon, everyone. I'm Tenly Paw Biggs and I use she and her pronouns. I'm an Asian woman wearing a black top with a chain like pattern, and I have shoulder length black hair. I

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thank you all for joining us today. The Office of Behavioral Health Equity works to reduce disparities in access to mental health and substance use treatment, particularly for underserved populations. Our mission is to ensure that everyone regardless of race, ethnicity, sexual orientation, disability, or geographic location has equitable access to behavior health services. We achieve this in a variety of ways, including working to expand culturally competent care, partnering with community organizations to reach marginalized groups, advocating for policies such as our Disparity Impact Statement to reduce service and access barriers.

Tenly Biggs:

Today we're focusing on how to break down service silos, fragmented systems that hinder people from receiving comprehensive care. These silos create challenges, especially for people who use drugs and those seeking recovery, particularly underserved communities. Research highlights the challenges and opportunities in bridging care gaps and providing valuable lessons for improving service access. Our goal today is to explore ways to integrate services, reduce barriers, and improve access to care for all individuals.

Tenly Biggs:

You'll hear insights from research on the overdose epidemic in New York state, where researchers interviewed approximately 300 individuals, including local officials, law enforcement providers, and people who use drugs and their families rural, urban and suburban areas. We have an incredible panel of experts consisting of researchers, service providers, and individuals with lived experience. Our speakers will share their perspectives on how we can address the systemic barriers that prevent people from accessing services that they need, dismantle service silos, and build a more equitable system of care.

Tenly Biggs:

We encourage you all to engage in today's conversation. Please ask questions. Diverse perspectives and collaboration are key to finding solutions to these complex issues, and your input is invaluable to this process. Thank you again for being part of this important conversation, and without further delay, I will turn it over to our moderator, Dr. Patricia Strach.

Daniel Fishbein:

Thank you so much, Tenly. Before we move it over to our moderator, we do want to ask a few questions. We would like to know more about who is in our audience today. So, we will be launching three polling questions. You can select multiple choice in your response for each of these polls. For the first question, let us know which US state or territory your organization serves. And we have the states and territories listed out by region, and each question will be open for approximately 30 seconds.

Daniel Fishbein:

Already, the results are in, and it looks like region three is really showing out. We have 16% of our audience calling in from region three, which includes Delaware, the District of Columbia, Maryland, Pennsylvania, Virginia and West Virginia. We'll now move to our next question which is about your

organization's focus area. Please select one or more of the options. And again, the questions will be open for approximately 30 seconds. Already the results should be coming in any moment now.

Daniel Fishbein:

It's a very even spread between mental health and substance use, 53% of our respondents are in the mental health area, and 47% are working in substance use. And we will go to one last question, which is about which disparity vulnerable populations served by your organization. Thank you again everyone for voting and for engaging with each other in the chat and introducing yourselves. We will now be looking at the last poll. Quite an even quite an even spread of who we're serving and that's so reaffirming to see. Again, thank you everyone for participating in our polls, it helps us have a picture of who's in the room today. Now, without further due, I'm happy to pass the webinar off to our moderator, Dr. Patricia Strach.

Patricia Strach:

Thank you so much, Danielle. My name is Patricia Strach, and I am a professor here at the University at Albany. My pronouns are she her. I'm wearing a gray dress with a blue jacket. And I'm going to introduce the panelists and then we're going to kick it off and start talking about some of the parts of the discussion for today. So, we're going to start with Awilda Torres. Dr. Awilda Torres is the comprehensive outpatient addiction program unit director at Inwood Community Services. She has a doctoral degree in rehabilitation counseling from New York University, as well as certifications in mental health counseling and substance abuse counseling.

Patricia Strach:

We also have Dr. Tiffany Lu, who is a board-certified general internist and addiction medicine specialist and associate professor of medicine and psychiatry at the Albert Einstein College of Medicine in Bronx, New York. She is currently serving associate director of addiction services at New York City Health and Hospitals Jacoby, where she is leading the implementation of an addiction consult service, substance use disorder, walk in clinic and opioid treatment program within the Safety Net hospital. She's also co-director of the Einstein Addiction Medicine Mentor training program. We have Jesse Chapman who is a peer engagement specialist at Rensselaer County Department of Mental Health. He is a person in recovery and began using substances as a teenager.

Patricia Strach:

All right. So, I want to have us start off by welcoming all the panelists and thanking them for being here. Today I'm going to have them introduce themselves, kind of just tell you their pronouns describe themselves, and then start off by answering the first question which is to tell us a little bit about their experience in or with supports and services for people who use drugs or those seeking recovery. So, if the panelists could turn on their cameras and answer that question we'll start with, Dr. Tiffany Lu.

Tiffany Lu:

Hi. Good afternoon, everyone. Thank you for having me. So, as I was introduced, I am the addiction services medical director at the New York City Health and Hospitals campus Jacoby. I work in a public

hospital safety net system, and my day to day consists of seeing patients who are coming to our emergency department after a nonfatal opioid overdose, some with fatal opioid overdose. Others are intoxicated and are fearing withdrawal, so they are coming to our emergency department for care. They are not currently being plugged into outpatient substance use disorder treatment. I also see our patients who have connected with outpatient treatment, and I see them in our outpatient program where we provide patients with access to medication, treatment and psychosocial treatment.

Tiffany Lu:

And I have been working in the Bronx for the last ten years. My experience is that are the patients we serve which in a very high overdose prevalence area are predominantly folks who have public insurance, are predominantly identify as Black or Latinx. I do see a heavily, cisgender male population and of all these patients I serve, the one biggest barrier that my patients will tell me they face is oftentimes when they have sought care, they're given a message of this is not the right place for you. You have this or that condition you want, you need this and that, and we don't do it here.

Tiffany Lu:

In other words, that culture and historical legacy of what I would say high threshold treatment has been the norm. And really to meet the demands of what patients with substance use disorders need in this day and age, we have to be super intentional about lowering the threshold and having a no wrong door approach. I can speak to that later, but that is the biggest thing all my patients tell me is that if things don't work because everything requires so much of me, I'll stop there for now.

Patricia Strach:

Thank you, Dr. Lu. I think that was a great point about high threshold treatment. And that's the point of what we're talking about today, is how difficult it is to get into treatment or care more generally, and the barriers between that. Dr. Torres, would you like to contribute?

Awilda Torres:

Hi. You my pronouns are she her and, I describe myself as a woman, 65 years old, Hispanic, Puerto Rican ethnic background. I am bilingual and I speak both English and Spanish and wearing a blouse with white and black spots. In terms of experience, a little bit about my background, I have had the privilege of working in the substance use treatment field for the past 40 years. And I say privilege only because a lot of times it's even been stigma for people who work in substance use treatments that's not always spoken about enough. I have worked in communities usually underserved, like East Harlem and Lower East Side. At this point, I have had also the privilege of working in Inwood Community Services comprehensive outpatient addiction program.

Awilda Torres:

I've been here for almost 35 years. I am the unit director of the Comprehensive Outpatient Addiction Program (COAP). One of the positive, very important things in this clinic is that the founder is still the executive director, that's Dr. Charles Corliss. And that kind of helped set the tone because this is a clinic located within the community, and it’s an Outcome and Assessment Information Set (OASIS) licensed

clinic. We service an underserved community. The majority of our clients are both either Hispanic and also black, and we have other subgroups, but those predominantly. We have a large group of individuals whose language are mainly monolingual initially, where they mainly speak Spanish only. And I know that, there's a lot of different changes that are happening in the field about that.

Awilda Torres:

We offer treatment for individuals that themselves have substance use history, but also to significant others, individuals that they do not have substance abuse issues but been impacted by a loved one's addiction. Our clients range from ages anywhere from 12 to 85 and even more. We're seeing more and more older individuals in treatment, and we see the gamete of different substances. We provide individual group and family counseling. This emphasizes a lot on family work. And we offer psychiatry services to them and also medication assisted treatment and last, but most equally important, peer services. Our all services here in the clinic are provided in English and in Spanish. And we have both a day and evening track to accommodate a lot of the people scheduled, who come here for services, and we provide transportation assistance.

Awilda Torres:

We have metro cars for those that are eligible. One of the most important things that I would just like to say before I end about this part, is that. While we accept insurance and the uninsured, we also service individuals who are unable to pay. So, no one is turned away because of that. But we have deficit funding where very fortunate to have that. And that's one of the unique things that we offer in this clinic besides the culturally sensitive treatment and the staff. And that is a big thing that's needed more and more in the field. Thank you.

Patricia Strach:

Thank you. And I'm sure we're going to get back to that big point you made about stigma, especially when we talk about equity. I'd like to turn next to Mr. Jesse Chapman, who will introduce himself and then tell us a little bit about his experience.

Jesse Chapman:

Good afternoon, everyone. My name is Jesse Chapman. I use he him pronouns. I am a person in recovery. I'm currently wearing a gray shirt, and I'm in my office as a background. So, my experience with this is I'm a person with lived experience with substance use. I have been to inpatient treatment, outpatient treatment, incarcerated. I've experienced homelessness. I've been in mental health facilities, recovery centers, I mean, you name it, I've been there on my own journey. I was very hardheaded. I didn't learn quickly. And now I have the privilege of getting to help other people like me planting a lot of seeds. Also getting to see some success as well.

Patricia Strach:

Jesse, I don't know if you see all the emoji reactions coming up on the screen so thank you. I'd like to start with the first question and, the first question is really thinking about the effect of COVID on service provision. Things were humming along in a particular way, services are provided in a particular way, and

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COVID caused disruptions across the board. When we think about service provision for people who use drugs, I wonder if we could talk a little bit about how COVID 19 shed light on how we provide supports and services for people who use drugs or who are seeking recovery. So, can you tell me a little bit about what changed as a result of COVID, and what lessons can we take away from what we learned from COVID? And I'll start with Dr. Torres, if you would like to answer first with this one.

Awilda Torres:

Yes, thank you. Well, a lot of change, and one of the most significant ones were things that change was that we moved for in person only type of work that we were doing to providing all social services to remotely during the pandemic. At that time and now we provided services both in person and remotely. And the benefits of being able to do it remotely has made it possible for individuals that either because of medical issues or parenting responsibilities etc. can't come in person to treatment, that has or based on where they live, distance traveling that has made it possible for them to participate in treatment in a positive way. And that's been very helpful. Did you want me to share about the challenge you at this time?

Patricia Strach:

No. Let's talk about what changed? Yeah, it was interesting. I'm doing my own research and one of the things that came up is there was variation because rural communities really felt like they benefited by the move to online services where distances are so far and it's so hard. Transportation is always an issue there so it's nice to see that given all of the bad things that happened with COVID 19. Some of the policy changes that came about as a result of programmatic changes may have been helpful. Jesse, did you want to chime in about the effects of COVID?

Jesse Chapman:

Sure. And I'll take it a little different approach with COVID. With COVID, I participated in a lot of fear-based decision making. My addiction, right. When I think about addiction, it's a life based on fear, right? That's what it is. We're scared of getting sick. We're scared of the consequences of our actions, and we're also scared of feeling the way that we felt before we use the drugs. That's kind of why the drug use took place for me. I mean, meetings are closed, right? Walk in clinic, stop taking walk ins. It reminded me in my own recovery journey how important it was for me to get out of that fear-based living, right. Because when I think about recovery-based living, what we're really talking about is a way of living based off of love and hope. And that is so important.

Patricia Strach:

Thanks, Dr. Lu, did you want to jump in?

Tiffany Lu:

Yeah. I just love that I get to go right after Jesse because sort of that spirit of here we have this whole legacy of this is not the place for you. Not only do we message that people are not morally good characters because they use substances. Then we say when they want treatment, they have to go through lots of hoops. Then we say they must always be cautious that they might fail. So, its very fear

based. I will say though, during COVID 19 the entire world was scared together. So, all of a sudden, all the things we said we couldn't do before we started doing so, Dr. Torres talked about telehealth.

Tiffany Lu:

So now before when we said, you know what, I can't really give you services over the phone. Well, guess what? Now we can do initial, physical triaging, initial medical assessment for medication prescribing to help people with cravings and withdrawal over telehealth. We can now do individual and even group counseling over telehealth. So that was a huge deal. And the second thing I will say that very specific to the treatment of opioid use disorder is that we do know we have now seen this huge dramatic increase in access to buprenorphine, which people will use as a very effective way of managing their opioid use disorder. And the other thing that we have seen is changes in the way that methadone is delivered and opioid treatment programs.

Tiffany Lu:

And so, regulations finally were updated. The federal rules were updated earlier this year and finally after decades of operating in the same way, COVID 19 pushed the envelope and said, guess what? When we finally were offering increased flexibility around accessing methadone treatment because of the pandemic, people liked it. People did well, the sky didn't fall. Our federal regulations changed to match that. So, I think COVID 19 had all these positive impacts in the field of equity in addiction treatment. I will just say the one thing I do see constantly is will patients will tell me about their sense of grief, loss and social isolation that became more magnified since 2020, and I have in my work, and it's evidenced in the prevalence rates I see is increased severity of substance use disorders and even more of a bimodal peak. I see a lot more older adults also struggling with substance use now because of that social isolation. And I think COVID 19th may have really impacted that trend that may have been brewing for a while.

Patricia Strach:

I wonder if I could just jump in because one of the things that I heard a lot of people say was, wow when COVID 19 hit all these things that people told us forever couldn't be done happened right away. And so, when governments want to take on something, when they want to do something, then it happens. And so, it was really clear to a lot of people watching, you know, the how COVID 19 was being addressed versus how vs drug use was being addressed, that it wasn't the same kind of resources. And it wasn't the same kind of speed. And are you seeing are you seeing that either with the people that you work with or with your colleagues in terms of a sense that either COVID 19 did things that were positive, or it brought to light things that maybe we all knew but it made it very clear and evident to people in terms of stigma.

Tiffany Lu:

Maybe I'll go reverse order and take that and pass the baton on. And I'm so curious as to what Mr. Chatman has to say. I will say the one thing about stigma is when you're using it alone in isolation the entire experience is really stigmatizing. So, I don't think COVID 19 helped in that in that sense. I recognize I do work in a bit of a bubble in New York City because in New York City the overdose Prevention Center that's been sort of publicly operating, has been and functioned for the last 4 to 5 years now. So, I do think I'm working in this sphere now where the more we talk about substance use,

the more we're talking about it with a harm reduction approach. The more we're trying to make a dent on decreasing the amount of stigma associated with substance use.

Tiffany Lu:

I also think because of COVID 19 and the shift I've seen in SAMHSA and other federal agencies talking about harm reduction now we're able to kind of normalize talking about it in the service sector for addiction. So nowadays when I'm going around talking about harm reduction with my patients, I'm not necessarily the only one doing it. I'm being encouraged to do it with that mindset and so I think these are all the positive parts of COVID 19. But the way I also just want to end with saying, we have so much work to do to chip away a stigma that's structurally baked in, and publicly perpetuated and internalized on the individual level that we are finally starting to make a few chips at this really big load.

Jesse Chapman:

And I agree, I do think we are making tremendous work especially on stigma. And yeah, there were a lot of positive things that came out of this as well that increased telehealth is fantastic. Something we did locally in Rensselaer County, we allowed people to text the word Narcan to 28,000, and then we would mobile deliver them a Narcan care. So, I spent a lot of time out there. Why didn't we have that before? Like Virginia said. So, there are a lot of these really good things that that have come out of it too. And overall, I am left with a feeling of hope. I really do think that we are making tremendous progress and just hearing about some of the things that are happening in the city.

Jesse Chapman:

Again, we're upstate and we don't have as many resources up here in Rochester down in New York. The telehealth was great. We've lost some of our telehealth, so we had an overwhelming amount, we had different options for people. Now we're kind of narrowed down a little bit. So yeah, I do feel very hopeful and that we are moving in the right direction without a doubt.

Awilda Torres:

I would just like to add to what Mr. Chapman said and not delude. I agree with them both that a lot of improvement has happened and positive things as a result. During the pandemic, that we found were possible, like Dr. Strach said that we thought we would never be able to do, such as telehealth and things like that became the norm. However, at least from where I am at in New York City, in Inwood, I find that we almost still are lacking significantly on taking a very proactive action based on the number of overdose and the epidemic that's happening. For example, right now in many communities if you are not insured, you don't have insurance and you're not able to pay. Getting that is a real problem.

Awilda Torres:

If we're really facing an epidemic, it should be like everything should be out there. I should be able to go to CBS or Rite Aid and get my med. Not oh well, you don't have insurance, you're not able to pay. So, it's almost like we need that same sense of urgency that we had during the pandemic. We need to do telehealth. We now have Narcan available everywhere. Well, we need to do the same thing with med because we have a lot of people dying as we speak. I am sorry to sound so intense about it.

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Patricia Strach:

Building on what you're saying. So, COVID brought a lot of things to light. We got to see things that we knew but suddenly they're kind of brought more to the fore. If we expand beyond just thinking of COVID, what are some of the things that work well for people who use drugs for people who are seeking recovery, for people providing services? What works in the current system that we have?

Jesse Chapman:

Can I say peers work? Can I say you're right, but I do believe it with all my heart. Again, I love what I do. I'm passionate about it. I enjoy every single day I meet the most amazing people, and I learn a tremendous amount from them. And I think that's kind of something I've learned over time, is that they're the experts. They have just as much to offer me as I have to offer them.

Jesse Chapman:

I struggle a lot with planting seeds in the beginning, early on and doing this work, because you don't get to see the thing grow right. But in time I've come to piece that sometimes, a conversation coming from a place of love and kindness with another human being, you know, you'd be amazed at what happens to people if you love them right wherever they're at. Just offer them acceptance and love, and you will be absolutely amazed at what they accomplished.

Tiffany Lu:

I love how positive that is. I will say this idea of treating people with dignity and respect is the foundation of that love. I mean in clinical speaking I don't necessarily go around as an intern as saying, love your patients. But I do say treat each person as an individual who deserves to be regarded with dignity and respect. And I think that it's kind of crazy to be like, hey we should be doing that in health care. You know, toward addiction. But I have to say, a day in and day out because it is not the norm. So as a physician, I want to shout out one thing I have noticed. So, in my last nine years or so, I was providing addiction medicine care in a federally qualified health center.

Tiffany Lu:

And in that role really took for granted that people were coming to me as a, primary care based addiction specialist talking about medications. My patients were kind of already buying into a model of taking care of their substance use disorders. Thinking about it as having a neurobiological and mental health side attached to it as well as medical side. So now I'm sitting at a dedicated addiction program, and I've noticed that my team is great. Everyone wants to be here for a reason, and people enjoy this work, but they haven't always had historically had the tools to optimize our services. And what I mean by that is that historically, we haven't had as much medical capacity.

Tiffany Lu:

The counseling has been amazing, actually. We've kept our groups open throughout COVID and continue to operate very strongly. But I think the medical model is important to integrate. Why? Because this idea that people have to have the willpower to address their substance use or have the willpower to practice

harm reduction is one that completely ignores the rules of the body, the brain, and the mind on substance use disorder recovery.

Tiffany Lu:

So, to me, that's a huge policy point because we can't begin to make our addiction treatment more person centered without actually bringing in science in everything we do. And my last point about medication-assisted treatment (MAT) to me is the medication treatment and that treatment includes medication. So, I really want to encourage everyone to use an even more nuanced term which is not necessarily calling it medication assisted treatment, it's just treatment. It's a form of treatment that a patient can benefit from for their specific condition. So, I really want to shout from the rooftops, let's normalize whatever form of treatment works for that person instead of trying to put a label on it.

Patricia Strach:

You're getting as many emojis as Jesse Chapman. So, thank you for your comments. Dr. Torres, did you want to jump in on this? What works for people seeking services?

Awilda Torres:

What I find usually works best in my experience has been that treatment is available and accessible when the person's looking for it. That moment, that time, and that it be ideally in the community as much as possible where they may feel but more comfortable and, and not to be told where you don't have this documentation, you don't have this paperwork, you don't have this insurance, you got to go somewhere else or whatever, or turn away or come back tomorrow to day, that moment because that's the moment that they need. So it's like treatment on demand and just real quickly I just like to say that one of the models that I find has work best is models such as Certified Community Behavioral Health Clinics (CCBHC) model that we had the privilege of having one of those programs here in grants which is a certified community behavioral health clinics designed to ensure access to coordinated treatment required to service anyone who requests care.

Awilda Torres:

And what I find very special about this is for mental health and substance abuse, we cannot separate them enough. Not that everyone has them. We don't want to generalize, but they come in sometimes so often together and we need to be able to offer these services when people show up regardless of their ability to play, pay a place of residence, how old they are, and to provide also to include crisis intervention 24 hours a day. People don't just need 9 to 5, or 9 to 7 and CCHBC have those components. Also, comprehensive behavioral services that include case management because people come with all these other needs. We get a client who is homeless, doesn't own a cell phone, doesn't have insurance. So, there's multiple needs that these individuals have that need coordinated treatment services.

Awilda Torres:

This and we don't want to send them in a fragmented way too many other sites to get those services. We'll lose them and they won't get help. So we need not only to provide clinical service, but also the coordinated case management service that includes physical health also.

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Patricia Strach:

I think you brought up some really good points, and you're starting to get to my next question of the webinar today which is some of the barriers and challenges to services. You had talked about some of that difficulties in accessing care in terms of whether the facility is open and what hours it's open and do they treat people and is it seamless to go from one kind of care to another? I wanted to ask the panelists to open it to the panelists to think about the challenges facing people who use drugs, the challenges facing those people seeking services, and the challenges facing people providing services. So maybe we'll start with, Dr. Lu, do you have thoughts on that?

Tiffany Lu:

Yes. So, building off what the panelists said and some of the questions I already see in the chat. I want to say part of the fallout of uncontrolled chaotic substance use, but also using an unregulated, increasingly poisoned drug supply as people's lives get wrecked and now their bodies may also have medical complications. So, what I see a lot is this idea of a one stop shop currently doesn't exist a lot. I mean, CCBHC is awesome, but it's not available everywhere. And so, one stop shop means really trying to wherever it is you deliver services, you have to anticipate that patients have a co-occurring medical need, a co-occurring mental health need. People have a co-occurring social need. And so when you start having that one stop shop, aka no wrong door approach, we have to balance our policies and our operations to match that approach.

Tiffany Lu:

I came from this as a federally qualified health center practitioner for many years as I provided HIV primary care in the Bronx, and we actually have a huge lesson to draw from the playbook of HIV care. It took decades for us to really talk about this as a human experience. We need to treat patients across their lifespan with dignity, no wrong door, one stop shop setting really trying to have comprehensive care in one place. And I think for substance use treatment for so long, we focused on the levels of care. Oh, you know, inpatient, outpatient, this and that and that we forgot about, like, how to really build a continuum of care that is truly about that one stop shop.

Tiffany Lu:

So I know this is a bit abstract to say, but I'll just shout out a few things concretely I have seen that helps. So Dr. Torres refer to that concept already but to shout out that in addition to building your medical and psychiatric care capacity in one place, we need to make sure that when patients are doing their intakes. In my program, we do a fairly rapid psychosocial intake where comprehensive enough, but yet we don't dwell on details because we're trying to address that patient's urgent need. If we need to have them come back a second day to finish the rest of the more detailed questions, we will. We're not going to say pleased to hear for four hours to finish your paperwork before I even talk about the fact that you don't have housing and you don't have a phone. So for us is really about, that rapid assessment to triage what the patient is needing.

Tiffany Lu:

I think that is a frame framework that needs to be taught clinically to our treatment settings, that needs to be incentivized. It needs to be built into the way our regulators for addiction services help us navigate the intake process. And then secondly, to integrate billable services to sustain some of these programs that are offering peer support services so valuable as well as community health workers, that are so integral to navigating social needs. I'll just stop there and turn it to my panelist.

Patricia Strach:

Thanks. I want to just make a note for everyone who's listening that we're going to take a break after the end of this question to for your questions. So please think about those and put those in the chat now and then we'll take a couple of questions and then we'll continue on with the panel discussion. So, it'll just be a little bit more interactive than talking for a long time and then taking questions at the end. Mr. Chapman, would you like to jump in on this? So, what are the challenges that you think face people seeking services, people providing services, people who use drugs more generally.

Jesse Chapman:

So the poison drug supply was brought up. I think that is a huge challenge and that's why I'm passionate about harm reduction. We need to keep people alive. Right. I am someone who Narcan has saved my life a few times, right? I wouldn't be here speaking with everybody today if it wasn't for those harm reduction efforts made by individuals in that community. I think that's, that's really important part that we can't put too much focus on. Also, the no wrong door approach. I agree with that 100%. The one of the most common things I'm told is, this person's too high mental health, they need a mental health facility. And then I talk to them, and they say, well, we want the substance use address first. And it's just back and forth all day. No wrong door that will help tremendously.

Patricia Strach:

Well, thank you. Dr. Torres, did you want to speak to this?

Awilda Torres:

Besides adding about the whole comprehensive and coordinated services, I think the feel in substance use treatment without at the risk of generalizing has moved a lot into fee for service which really pressures and puts a lot of pressure and responsibility for billing and people having insurance etc. I think to field needs to move somewhat back into more like deficit funding that makes it possible for people to get help regardless of their financial status or etc. if not, I get calls from referral workers desperate almost pushing me to take a client because there's no other place that will take them without insurance unless it's in a hospital where they are already there. That cannot be. When we have an opioid epidemic we need a different kind of funding, such as deficit funding, more citywide and worldwide.

Patricia Strach:

Thanks. I'm going to open it now to questions. So, if you have questions, please put them in the question box. It looks like some of the questions that we're getting are about telehealth and so how telehealth services have increased access to clinicians and have they addressed some of the provider shortage. So, if we think about the difficulty that people have accessing services, one of the reasons people can't get

into services is there's not enough people working in substance use disorder services. The last number I saw was a 2-million-person shortage in this field. So has telehealth improved provider access? And then has that made it easier for people to access care? Do you want to start off Dr. Lu? Has telehealth made it easier with all the shortages we have in the workforce, has it made access easier, and more ability for people to receive care.

Tiffany Lu:

Yes, in general, absolutely. Telehealth has definitely helped with people who need to be somewhere else at a time that they also need to access their follow-up care or initial care for that matter. So, I really can't say enough about telehealth. I will also say two things telehealth is not enough. Because of all the complex needs we're talking about, I think that for telehealth to work, telehealth needs to partner with or be embedded in a place that can offer in-person services. I say that just because I do know that from COVID, there was sort of as all of a sudden like, you know, very a huge interest in spinning off lots of telehealth only service providers. And while I think that can work for many individuals who are a lot more socioeconomically more advantaged, and even more health literate and language literate so that can work.

Tiffany Lu:

I've seen data showing that it's improved access from rural settings so all of that can be great. And but I don't want the message to be that telehealth will solve our problems. In my clinic, I am based at a safety net hospital, so I get to take care of patients who are under-insured, uninsured, and insured. But I mean by in large what my patients tell me is my ability to access walk in hours as well as literally a place that's safe physically for patients. Before I hopped on this webinar, one of my patients who just came out of the hospital and lost her phone, and she's in a very unstable housing situation came here just to eat in our waiting area and to sort of touch base with us and that is that just is so unspeakable.

Tiffany Lu:

I'm sorry, you can't just quantify that by a measure of how many people did we engage that day? But it goes to that measure and beyond. So, it's a yes for me that telehealth helps and then let's make it a telehealth and approach instead of a telehealth in place of approach.

Awilda Torres:

Yeah. I just want to say that I'm 100% in agreement with this. Sometimes I feel like an out in this that I do think with, and I'm in agreement with what Dr. Lu said. There is a need to be met by telehealth and it's very important. However, I'm personally concerned that it's could almost seem like the easy solution to everything that needs policy changes and different funding things, etc. For example, there are times that we find that it's very important to also have in person treatment and meet certain unique needs that need to be addressed in person. We have a lot of clients that don't have all this technology. There's 7 or 8 people living in a room in an apartment, they have no privacy to even talk via telehealth, etc. so there's a lot of differences very unique things that we need to look at.

Awilda Torres:

But I think there is very important to kind of do both and not to see the other one as a fix all for a problem that we are facing. There is a shortage of people working in substance use treatment, at least in New York. And I do relate that a lot to stigma and sometimes discriminatory policy, sometimes I'll look at salaries for other positions in a clinical field compared to a substance abuse treatment and it's like so significantly different. It's almost like even the person who works in substance abuse treatment also gets stigmatized. The field profession, people are not running to go into a profession and there's many reasons why.

Patricia Strach: Mr. Chapman.

Jesse Chapman:

Dr. Lu very well said, and I couldn't agree more. I don't really have much to add to that.

Patricia Strach:

Okay. I want to, to just kind of move. We're going to have a little bit more panel discussion after this question. We will again open it up for more audience questions. So please put those in the question-and-answer box. So do your answers change when you think about what works and what doesn't work in service provision, if we think about equity, that is, is it more difficult for some people to access services than others in what where did those cleavages lie? What are the important differences in why do you think that might be the case? So, the question is, does it matter when we think about equity, what are the key kind of lines along which we're seeing inequitable treatment if that's the case? And why do you think that's happening? Dr. Torres, do you want to lead us off with this one?

Awilda Torres:

What comes to my mind quickly is that the issue of equity does affect the lot that a lot of people that need treatment or may want treatment. For example, I think we talked about before not even have a cell phone to have telehealth, may not even have the money to travel to the program. So, there's almost like a need for more community-based programs. Do they have Metro cards to go back and forth to do this? And some people may say, well, they have money for drugs or alcohol but that doesn't work. That's not a good analogy. So that, to your question is a lot of people that need it are not having quick and easy access to services and treatment in my experience.

Jesse Chapman:

I think what I see more than anything is what was just mentioned, the lack of funds, the lack of money, the lack of transportation. So, it's really a poverty issue. I see a lot of that. It's like we have the haves and have nots in this country, right? And there's different types of treatment, there's different facilities. There's a lot. So, I see a lot of that. I also see it with the dual diagnosis. And again, when we're looking at communities, they know what they need. They'll tell you just a lot of times if we ask the experts, the people that live there, the individuals involved, bring them in, involved them, put them on board. Getting people involved is their community, they have a vested interest in improving it, and they want to and they got great ideas. We just have to listen to that.

Tiffany Lu:

Maybe a way of talking about equity, I think there's three ways to talk about equity. So one thing is about equity, by building in services that address the disparities we already know about. Dr. Torres at the beginning alluded to how language access is at the forefront of how her program addresses that. For the clinic I work at, because we are a public hospital system that intentional matching of our services to the demographics, we serve is so important. So, we have a video relay service for interpretation and sign language interpretation. We have the machine literally here in our unit in the treatment room so that we can use it right then and there.

Tiffany Lu:

We have another telephone option for all staff to access. And I do recognize that this might be hard to build out for standalone community organizations. But even if it may feel hard at the beginning, I think naming that as an operational need is important so that's just like the structural way of ensuring equity. The other thing people have talked about is making sure that hours are designed in a way to meet the needs of your clients. So many of our clients prefer to come first thing in the morning, and they start their day kind of feeling like they got that thing done that they needed to. So, I think early morning hours may be important. But then on the flip side, offering later in the evening hours for folks who do have obligations during the day is important.

Tiffany Lu:

So doing a survey of who your clients are and designing the hours around that are all that helps with equity of access. Now I just want to mention, because people have brought up the workforce shortage, I think there's a huge equity to train up our addiction professionals including our peer specialists. And I say that because now the field has exploded, we know there's a crisis. We're trying to step up services, but equity and training has not been there as much as I'd like to see. I am a physician, I spent many years training. It was about getting precepting, I get mentoring, I get coaching, it's a very regimented process of ensuring that I have the support that I need to function.

Tiffany Lu:

And in addition to services what I see is that in the race to step up services even though there are webinars like this and it's not available in every state. I'm not sure if every state is necessarily bringing together learning collaborations, learning communities, office hours, sort of ways for addiction professionals to really feel like they are too supported. But one of the policy things I want to mention has to do with the way opioid settlement dollars and SAMHSA development grants can be used. So, in New York State, I'm lucky to be a program director of an interdisciplinary substance use disorder workforce training program where we are trying to develop a medical physician pipeline from medical students to residents, to fellows who are not in addiction medicine and to early career physician professionals.

Tiffany Lu:

So, we're partnering with our state agency to utilize opioid settlement money to really bring up the addiction workforce who are going to be taking care of people with addictions and also inside and outside of addiction treatment settings. So, I want to shout that out because again I'm working in a state

that is using the opioid settlement dollars in that way. But equity has to start with things like taking care of your patients and your staff so we can meet people where they are.

Patricia Strach:

So, when we think about equity, one of the interviews that I did with a service provider in New York City who was harm reduction services was going around and like providing water and socks for people. And she was saying, we expect people to go to a hospital and leave all of their unhoused in their living, somewhere they leave all of their belongings. And when they get there, they might not be back. And another thing is to say, I'm going to go to a hospital, which is the place at least is accepting of people who use drugs, who are unhoused.

Patricia Strach:

So, in also coming into the chat, this is related to the questions that have come up a couple of times in the question and answer is about the role of mobile care and especially for an unhoused population. So, to what degree should we be using mobile care, and does that help address something like the equity issues that we're seeing when people can be seen exactly where they live or exist or spend their time? Jessie, do you want to start us off?

Jesse Chapman:

Sure, absolutely. I don't have a whole lot on this, but I will say yes. Obviously, we should be increasing, mobile care. I do believe we've seen the value in our community with a lot of those, the street warriors and the street outreach and things like that. I've seen the positive effects. A lot of those seeds get planted during those interactions as well.

Patricia Strach:

Dr. Lu or Dr. Torres, did you want to add to that?

Awilda Torres:

I just have to say anything that could provide support and services, such as mobile care is wonderful, but we have to be careful not to put band-aids some bigger problems i.e. unemployment. Besides going to mobile crisis mobile homes, people need to be able to get jobs, a place to live, to afford to live, you know, so there is maybe that's part of it, but there's some much bigger underlining needs that need to be addressed, connected with poverty, unemployment, etc.

Tiffany Lu:

I see a lot of audience chatting about their own experience working with mobile care. So yes, I think it is a no brainer that mobile care is such an important piece of this, effort. I think that I'm just going to put my physician and medication access hat on. If it's the state updates regulations to allow for mobile care to more easily provide medication as well as other non-medical services, then that's a huge policy vote in the right direction. And so, in New York State, our Office of Addiction Services and supports have been really stepping up mobile units for methadone access.

Tiffany Lu:

So that's literally making medications available, you know, through programs that are licensed to have a mobile unit operating. And these units will circulate either in a community with, with high needs versus, a partner with, for example, outside a housing program. So, they're trying to create a one stop shop experience. And so I think that's great. I don't work in a rural setting, but I can see mobile care being potentially limited in places that are very geographically spread apart. But again, I think it's a move in the right direction.

Patricia Strach:

Thanks so much. I wanted to move back to a question that I'm seeing both in the question and answer and one of the questions that we had wanted to address in the first place. So, we know that there's things that work and we know that there's things that don't work so what do we do now? So, do you have examples of policies or programs that make it easier for people who use drugs to seek, care? What lessons can we draw from that? So, either policies that you see or just programs that you've witnessed that you think that's a step in the right direction. Dr. Lu, do you want to respond?

Tiffany Lu:

Yeah, I think some of this is definitely building on what we've already talked about. I will just go in a little more into what I've seen work. So, the number one thing is to have a strategic plan. It is one thing to kind of be in crisis mode. I think COVID 19, sometimes we weren't necessarily even thinking what is the strategic plan? Because you just had to deal with everything that was flying at you. But now we have some lessons learned. So, what is your strategic plan to integrate a no wrong door approach? That lowers the thresholds that try to address disparities with an equitable lens.

Tiffany Lu:

And so for, for us here at the hospital facility I work that's part of the bigger New York City health and hospital system. I think that on a central level, there's been a ton of intentional strategic planning. And then on a facility to a level, what I can speak with is we are thinking about the moment the person hits the door, where are they coming to? We start in the emergency department. We move to the hospital, medical units, the ICU, the labor delivery floors to inpatient medical psychiatric units. What is it that they need to make sure that their withdrawal is treated adequately, their pain is treated adequately even if they have a substance use disorder history. And then when we link them to care, what does that look like in our hospital?

Tiffany Lu:

Outpatient services and having levels of care in our outpatient programing so that we create a walk in access approach, so people don't have to be told that they need to call and get an appointment etc. It's just Monday through Friday we are open and all the ways from this hour to that hour and then when people come in, we'll do a rapid triage. We will facilitate referrals to any other services they need. Anything else that we don't do in-house, we provide a safe space. And we're also very strategic about linking up with our neighboring services. Whether or not it's right now, we don't have an opioid treatment program in our hospital, but having a hospital based opioid treatment program, I would argue is such an important way of addressing a community's need and not just looking to a community opioid treatment program to address that on their own.

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Tiffany Lu:

But while we don't have an opioid treatment program (OTP) here in my facility where we're collaborating with our neighborhood OTPs. One thing that hasn't come up yet as a strategic part of our equitable service planning is about partnering with correctional health facilities for reentry care. And so, within the New York City health and hospital system, one thing that's been done for a long time is providing opioid maintenance treatment in our city jail, so it is Rikers. So, for a long time, there's been reentry services coupled with the way that the jail based OTP will try to link people to care as they're getting released so that's been around in New York City for a while. I'm seeing it happen throughout New York State in terms of linking, making sure people in jail and prisons have access to medication treatment, but also when they're getting released, linking them to care.

Tiffany Lu:

So that has to be a strategic part of how we address equity in our, addiction services. So I start with mapping it out is a really important thing. And that thinks about the continuum of care and where we fit in that.

Patricia Strach:

Mr. Chapman.

Jesse Chapman:

This is a big question for someone like me, can we all just agree? I mean, if I'm going to sum up what I would say decriminalization, right. I would just say that, and I think I'm done.

Patricia Strach:

Okay. So, we can think about reducing barriers to care. We can think about decriminalization. Dr. Torres, what other thoughts do you have?

Awilda Torres:

Related to everything everyone has mentioned already, I find that while we want to help a lot with medical treatments like what's mentioned have alternative treatment for substance abuse issues, we need to partner more or have partners that are willing to coordinate with us and work with us. For example, giving clients Suboxone, who wants it we need to be able to have bigger partnerships like that that make that possible. But more importantly, going back to how this discussion started, I had the privilege of seeing here not in my program but a program that we have for three years recently, which was a CCBHC program, I think that's the way programs need to be.

Awilda Torres:

They had the clinical part; they were able to treat people who specialize in substance abuse issues and mental health. They had case managers, they had people actually going with clients, to places helping them with housing. It was a very comprehensive type of program, and we need that. I saw that firsthand here for the first time in three years. And unfortunately, at this point, due to funding issues we have temporarily paused that. But I used to think, I wish I had that in my regular comprehensive outpatient

treatment program. So, it has been one of the things that we do that it's very important we're open 9 to 9 and hours that are available and accessible. But going back to that CCBHC model it's very important

Patricia Strach:

We're talking a lot about continuum of care so that whatever my organization provides works with the other kinds of needs and the other kinds of programs that somebody might be accessing or using, are they inter internal barriers to care with providers? So, if you think within an organization, is it attitudes of service providers or lack of coherence within programs, do you think there's anything that runs internal to organizations that might make it difficult that we could also think about? Dr. Torres?

Awilda Torres:

I think, sometimes there is a differentiation or some stigma about or does mental health treatment and oh, that's a substance abuse issue that's different and almost a separation. And one, it may look more like a moral willpower issue or more in a stigmatized way compared to mental health. And oh, that's a substance abuse treatment youth counselor compare it to a social worker working in the mental health field. And, even if it's within the same clinics and it needs to continue changing and moving and it needs to start at the educational level in universities and colleges, teaching and training, etc.

Jesse Chapman:

I could just speak about this briefly. One of the things that I've seen is that a lot of people that work in this field are in recovery. A lot of them are in abstinence only recovery so they I think we need to open things up a little more to truly, you're in recovery when you say you're in recovery like the SAMHSA definition of recovery is my favorite definition of recovery “It's a process of change throughout which individuals live a self-directed life and strive to reach their full potential” I got it memorized since I like it so much. And it doesn't say that you have to go to Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) meetings or refuge recovery.

Jesse Chapman:

It doesn't say you can't smoke a joint with your friend once in a while it doesn't say any of that. So, I think we really do need to open it up more within the organizations or stigma the people and we all do it right. I have my own personal biases criminal justice got me into recovery. So, I'm great. We all have it. We all protect what works for us, but we have to remember it might not work for somebody else. It might work differently.

Tiffany Lu:

I may have lost my understanding of the initial question, but I am going to piggyback on what Dr. Torres said, and Mr. Chapman said. So, one thing to make sure we are providing less stigmatizing care is to make sure all our documentation, so a lot of us who are using, electronic medical records or even paper forms, they're updated with the kind of language that literally cues us to be more person centered. So, some of the really old language that I still see in my paperwork here is built off from two decades ago. Our old program name still has the word chemical dependency in it, it still uses the word substance

abuse in all our screening tools. I've mentioned my strong belief about adopting the term medication treatment is still says a medication assisted treatment.

Tiffany Lu:

I think we need to like literally structurally update what it is we do in our treatment center so that we motivate ourselves, we normalize the culture that is less than enticing in our language. The second thing I will say is I oftentimes I teach medical trainees, and I work with interprofessional training, and people love frameworks. Because with a framework, they're able to apply it to their documentation the way they're counseling a patient. So, I would really like to have us remember that recovery is a biopsychosocial process and that it is a continuous process. So, every time we see a patient we really need to assess biopsychosocially how they are doing.

Tiffany Lu:

So, we don't necessarily just focus on the social or just the psycho or just the bio and we are able to kind of meet people where they are in those domains. And then I like to think of biopsychosocial as the needs, but it's always delivered with a harm reduction approach. So where if the fact that someone is trying to access care is already better off than over 80% of people who are not in care, for example. And so just literally have that, that framework. I always tell my trainees, memorize this framework, you too can take care of a patient with addiction no matter what you are. Do not wait until the addiction specialist or addiction health care professionals shows up and saves the day. And in fact, the biopsychosocial model with a harm reduction approach is what we do for coronary artery disease, for diabetes is for hypertension. Like, why do we know how to do that? But we don't know how to use the same framework for addiction care. So, I'm just going to keep saying that over and over again and normalize that.

Patricia Strach:

I think we're almost out of time. We have about five minutes of our discussion before we conclude. And I just wanted to open it up to ask you just to think broadly, if we were to say how can we kind of reduce the silos, bring down the silos, at the same time we promote equity. And I want to say you can think about this maybe this is a practical policy solution that you've seen, or maybe this is just something that's sitting in your brain that you want to say, this is the direction we should be going in. What kinds of things can we do to make, services more equitable for folks, for people who are trying to access them or for people who are using drugs more generally, and things that you think might, might work or that shouldn't be on our radar screens. We're going to start with Mr. Chapman.

Jesse Chapman:

Well, you gave me a question, I have to answer it the same way. We need more peers. I do think that's a very good solution to the equity situation as well. I also liked what Dr. Torres said before, one of the struggles with peers is the reimbursement of peers and has someone who is very blessed, I am grant funded right now thankfully, so I don't have to worry about that insurance reimbursement piece. But I have counterparts in the area that do, and they spend much less time with clients, much less time in the community, much less time meeting people where they're at because now they're focused much more on paperwork. So, I just wanted to echo what Dr. Torres said about deficit spending as well.

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Patricia Strach:

So, your advice is people over paperwork and peers if I were to summarize. Dr. Torres, did you want to jump in?

Awilda Torres:

Yes. I would say there's so much that we could say, and it may sound too simplistic, but I have to go back to how we started about the issue of stigma. I think everybody on the panel kind of alluded to this and said it directly, but it really needs to sink in at all levels that substance use disorders are chronic treatable medical conditions. And studies show people who have them often face stigma and discrimination, in part because others do not understand this disorder or how they can be effectively treated. That sounds like such a basic thing. Well, everybody kind of knows but not really. I've been in the field for 40 years, and I find this is more like in the last five or so years. This really needs to sink in at all levels, from the ground up all the way to policies and everything. It's almost like if I told you I have diabetes, that you want like what's wrong with her or in a judgmental I think once that really starts for one, substance use really starts being seen like another chronic treatable medical condition at all levels that will change the whole field in general. And the needs meet the needs of the clients more.

Tiffany Lu:

There are a couple things that I think people are already saying in the chat. And so, one person talked about explaining the differences between peers and community health workers. I think just for those we're not familiar with. So, peer specialists and Mr. Chapman, correct me. So, peer recovery coaches and advocates are certified professionals who have lived experience and then peer specialist themselves if they don't have the certification they have lived experience. Community health workers may not have their own lived experience as a community health worker if you really look at the comprehensive menu of social needs they can address.

Tiffany Lu:

It is really a specialist that is trying to link folks with services that affect their social determinants of health whereas a peer specialist can help with that but then they can also provide a ton of navigation and support around folks who are navigating services in recovery that are unique to that idea of having someone with lived experience to get them through that. So, the two of them are complementary I think we really do need to talk about if you do work in a locale that is does not currently know how to implement these services and create a way to either build for or utilize grant funding it needs to be otherwise, we couldn't address equity law head on. So that's my big service delivery side.

Tiffany Lu:

The second thing is equity and changing hearts and minds, starts with making sure that it's part of our medical or health care professional training. So, I want to really shout out the work I have seen even from SAMHSA funding to other state and local funding to really get addiction or harm reduction related education embedded in our health care early education. I like to joke now that my medical students are so much more woken than their attending physicians who they're going to work with as supervisors and that's actually really important because I don't want to say that this way especially Dr. Torres who's

been in this field for so long, right? Sometimes there's so much more is so much harder to change our hearts and minds and the outlook that older people who have been much more entrenched in the field, it's harder to change their mind sometimes. I really work on the earlier part of the pipeline and focus on that, so we don't lose track of the fact that we need to have a hopeful spirit, and we also need to take care of ourselves to keep doing this work and continue to focus on equity.

Patricia Strach:

Thank you so much. I just wanted to say that I'm currently writing a paper so I'm right in the deep, in the thick of things looking at the disease framework and finding that it's a very kind of unstable framework thinking about substance use as a disease. So that's the language that everybody's using but people's own perceptions often don't run very deep. So, the bad side of that is you can go back to this criminal justice approach, and these are bad people doing bad things or the good side of that is there's a lot of persuadable people out there who don't have strong feelings. They do use these words.

Patricia Strach:

I do think thinking about stigma and thinking about hearts and minds of broader communities is something that we need to think about if we want broader policy change. And I need to turn it back over now to Anne-Marie Gomez to wrap things up.

Anne-Marie Gomes:

Hello, everyone. On behalf of the SAMHSA's Office of Behavioral Health Equity and Achieving Behavioral Health Equity Initiative, we want to acknowledge and thank you all for joining us today and being part of this critical discussion on breaking down serving silos to create a more equitable system of care. Special thanks to our moderator, which is Dr. Strach, and panelists Jesse Chapman, Tiffany Lu, and Awilda Torres for sharing your insights in valuable time. Today's webinar highlighted the need to address the challenges of fragmented care, particularly for people who use drugs and those seeking recovery in underserved communities. We learned about the impact of service silos and the need for an integrated approach that prioritized equity access and culturally responsive care.

Anne-Marie Gomes:

The research from New York State further illuminates the gaps in service delivery and emphasized the importance of involving community voices especially those of people with lived experiences and creating solutions. At the Office of Behavioral Health Equity, we remain committed to addressing disparities in behavioral health and ensuring that everyone regardless of their background has access to the care that they need.

Anne-Marie Gomes:

Today's discussion is a vital step forward, but it's clear that there is more work to be done. We must continue to work together to break down barriers and build a more unified, equitable system of care. As we move forward, I encourage everyone, all of you, whether you are a service provider, policymaker, researcher, advocate, to think about the role you can play in bridging these care gaps. Take the knowledge and strategies shared today back to your communities and organizations and continue these

conversations about how we can better serve individuals who are often left behind by fragmented systems.

Anne-Marie Gomes:

A recording of today's webinar, along with additional resources, will be shared with you in the coming days on the NNEDshare site. And please provide your input on this event and help us to plan for future offerings and stay connected with us through SAMHSA and all these websites for updates on future webinars, events, and opportunities to engage. I wish you all a great day, and we look forward to continuing this important work with you. Thank you so much.