**WorkforceGPS**

**Transcript of Webinar**

**Implications of Substance/Opioid Misuse and Addiction for the Workforce Development**

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JON VEHLOW: Welcome to Implications of Substance/Opioid Misuse and Addiction for the Workforce Development System. Without further ado, I'd like to kick things off to our moderator today, Amanda Ahlstrand, administrator, U.S. Department of Labor, Employment and Training Administration. Amanda?

AMANDA AHLSTRAND: Great. Thank you, Jon. And welcome everybody. We are glad that you're joining us here today. And we are grateful for the introductions you are making via chat and filling out that poll. It's always helpful for us to know where our audience comes from and who and where we're reaching folks. We are excited to host this webinar today. And consider it part of the beginning of the conversation among the various partners of the workforce system at the local, state, and federal level.

We see the opioid misuse and addiction issues across the country are impacting our work. We have a lot to learn. And we hope today's webinar helps you learn some things that you haven't had a chance to learn before. And I do want to acknowledge that we here at ETA consider ourselves in learning mode on this topic as well. But we are investing in this important topic through both financial resources and assistance in things like this. So we all have a lot to learn. But we have a challenge on our hands we're all working to address.

I'd like to introduce some of the other speakers that are joining us here today: Reed Forman is from SAMHSA – you can see what that acronym is there for – at Health and Human Services. Reed is the lead public health advisor at SAMHSA.

We have Holly Hagle, from the University of Missouri, Kansas City. She's the co-director of the Addiction Technology Transfer Center in the Network Coordinating Office.

Next, we'll hear from our YouthBuild USA partners, Pat McNeil, who's associate director of substance use intervention for YouthBuild USA. And we have David Clauss, who's the program director for YouthBuild in Austin, Texas. Thank you all for joining us. We're looking forward to hearing about what resources you have and learning you've had along your paths in addressing the opioid issue.

So today's objectives are listed here. As I said just a minute ago, we do hope this webinar is the start of an ongoing conversation on how the workforce development system can develop a human-centered approach to delivering training and employment services to individuals that are in recovery from substance abuse disorders. You'll hear from our featured speakers today to learn more about the current landscape of substance abuse in the United States, including some of the latest information and data on the issue.

And we're going to share several resources that can support your community, including the Screening, Brief Intervention, and Referral to Treatment tool, or the SBIRT. This is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. So we're anxious to hear how that's been applied locally. Again, we hope this can be one of several resources, this webinar in and of itself. But that SBIRT tool is just one that you might not have heard much about and may want to take a look further after you hear about it today.

So before we get into the conversation with our partners here today, I just wanted to share a few comments from the perspective of ETA and the overall White House and the Administration. Certainly, we have made addressing this crisis a high priority. We're making significant investments to support the treatment and recovery services target availability of overdose reversing drugs and train first responders and more.

Last October – just about a year ago, October 26, 2017 – the Secretary of Health and Human Services, at the White House's direction, declared a national public health emergency regarding the opioid crisis. This public health declaration has continued to be renewed since then, which quite frankly, opens the doors here at ETA given the disaster situation where we're able to invest some resources directly to support how we address this crisis.

Opioid abuse impacts both employed and unemployed workers, of course. Research has shown that the number of opioid prescriptions correlates in many areas with the reduction of labor force participation rates. Additionally, lost workforce productivity in U.S. businesses as a result of opioid abuse, as demonstrated through diminished job performance, absenteeism, incarceration, and even death, has approached $20 billion annually.

MR. VEHLOW: I'm going to pull up a poll right now. Please take a second to answer this: Is substance abuse or opioid misuse/addiction a problem in your community? First answer: No, it's not a problem that I'm aware of. Yes, it's a problem, but it hasn't impacted my work as a workforce development professional. Yes, it's a problem and it's somewhat impacted my work as a workforce development professional. Yes, it's a problem and it has significantly impacted my work as a workforce development professional to the point that my organization is addressing the issue. So please take a second and answer that poll right now.

MS. AHLSTRAND: So it looks like a very small proportion of you do not see this as a problem right now. But a lot more of you see it as a problem – about 25 percent, no impact yet but it's a problem; and then the rest of you, 75 percent total, is either it's already somewhat impacting or significantly impacting your work. So I think this gives us a good sense of reality out there that this is something real and you're working to address it.

Just a little bit of background on substance abuse and misuse impact on individuals – individuals with substance abuse disorders, especially with regard to prescription pain medication, generally may not realize they're misusing their prescription drugs for quite some time. Over the years, these individuals not only experience diminished physical and mental health, but they could potentially lose their homes and their jobs, become separated from their families or loved ones, or become involved in the criminal justice system. And unfortunately, we're all seeing evidence of this in the newspapers and in our service delivery centers and offices on a regular basis.

We know the road to substance abuse recovery is a long and winding path. It's a continuum of care that involves the medical community, public health and behavioral health organizations, treatment and recovery centers, but also the community itself – families, nonprofit and charitable organizations, faith- and community-based organizations.

The path to recovery, of course, depends on the individual and what their needs are. We know that all of you who have joined us today are serving individuals who have varying levels of substance abuse disorder. And we are interested over time through today and subsequent conversations about helping to identify resources in your community to serve these individuals.

A little bit on the employer side here – we are hearing. And I think you are as well. Businesses and employers across the country are being heavily impacted by this health crisis. Some industries, like transportation and construction in particular, have been heavily impacted by the opioid epidemic bringing renewed attention to the dangers of public safety if someone is impaired on the job. In a 2017 survey from the National Safety Council, around 70 percent of employers have seen some impact of prescription drug use on their workers ranging from missed shifts to impaired work.

However, fewer than 20 percent of employers said that they felt prepared to deal with the issues related to addiction, such as knowing how to approach the issue with their employees or how to get them help. Somebody's approach to addressing drug use is usually through mandatory drug testing usually at the time of hire or during key milestones of employment. However, that same survey found that the companies that report testing for drug use were much more likely to screen for marijuana rather than synthetic opioids such as oxycodone or hydrocodone that are major contributors to the current wave of addiction and death.

That same survey, again, showed that the vast of majority of employers said that they want to help workers struggling with addiction, but the most common employer response is that suspected drug use is a serious offense for immediate dismissal. So there's not much room in between wanting to help and letting someone go.

So employers are also having challenges given this crisis particularly in rural communities where the existing workforce is already limited in finding ways to address vacancies that might have been created by this crisis. So that's another aspect of what we're trying to address here in helping to look for other viable labor pools in the community, but also bring people back into the workforce who may have been impacted by the crisis.

I acknowledged a little earlier that ETA is on a learning curve here on this topic as well. But some of the things we're able to do is talk to our various grantees. One of our programs has done sort of an informal inquiry with some grantees to get a sampling of how the workforce system is addressing this issue or what issue we're all facing.

So a number of them talked to us about the screening for drug use that employers have in place, and that over time, finding marijuana use in those drug tests has been an issue. But it's going back to that gap of if there aren't tests for the opioids that things are going not found with the employers themselves or those that are working to support getting people jobs.

They are finding that recreational and medical use of marijuana is not acceptable for occupations that involve the possibility of serious injury, death, or damage. So by extension, the same is true for the opioids that are getting used across the country. What does this mean for grantees? Some adjustments that are getting made out there: Grantees are building into their orientation processes some presentations that ensure all potential participants understand the impacts of failing drug tests and how they're employability factors become limited by those.

One grantee told us that their employer partner keeps a list of applicants that have failed a drug test and then subsequently puts them on a no-hire list for future hiring opportunities. And obviously, grantees are talking with participants about the realities of this situation. And they're also having to not enroll individuals in grant programs because they're not passing drug tests.

One grantee indicated a requirement of participants that have failed drug tests, they start sending them to required weekly drug counseling sessions until they're able to pass it or complete the program. So we have kind of both ends of the spectrum – either not enroll or provide some assistance to get people back in the right direction.

We've also seen some grantees that are starting to focus in on building the capacity of communities to support people returning to work after an addiction issue. For example, some are sending more people into two- to four-year training programs in healthcare careers around behavioral health counseling, for example, to address the opioid crisis in their community.

MR. VEHLOW: All right. And we're going to bring up a forum question. So we have a chat question we want you to answer into. What else are you challenged with in serving participants with perceived or known substance use or abuse issues? And you can just let us know in that open chat below. Please put your answers there. I see we got Kelly and Stacy writing in right now. Excellent. So we're going to look at your answers now.

MS. AHLSTRAND: Great. Thank you, you all. This is so helpful for us to see the types of issues you're facing – just basically navigating legal issues, underlying mental health issues, attendance challenges, people's opinions on what drugs could qualify for abuse when some of them are legal and others are not, problems with maintaining employment. This is a lot of great information. Thanks for sending in your issues.

So a little bit about – I guess I'm tipping off the conversation about some of the federal initiatives and resources here before I turn it over to my colleague, Reed. But again, the Department of Labor has started making some initial financial investments in this area.

After the national public health emergency declaration, we've done a couple of things, basically a two-phased approach. This March 2018, we announced a national health emergency demonstration project and then in July, awarded six grants worth a total of $22 million to the following states: New Hampshire, Pennsylvania, Washington, Rhode Island, Maryland, and Alaska.

This demonstration was set up to test innovative approaches to address the economic and workforce related impacts of the opioid epidemic. It's designed to provide training and support activities to dislocated workers, new entrance in the workforce or younger people, and incumbent workers, including those individuals and populations who have been impacted by the opioid crisis. So we took kind of a broad approach to that either at the individual level, someone who's personally been a substance user or someone impacted by them.

And then we are working to support investment and training that builds the skilled workforce and professions that could impact the causes of and treatments of the opioid crisis, including addiction and substance-abuse treatment, mental health, and team management; so kind of like some of the examples we've observed in grantee activities there.

We're particularly interested in looking through this demonstration that the role the workforce system plays in serving the needs of communities facing the opioid crisis. We're looking at how employment and related services and partnerships with health, justice, and other community-based organizations address this holistically. While these grants just started a couple months ago in July, I can highlight a couple of things that some of these states are doing or beginning to do.

In Pennsylvania, they're going to work with integrating reemployment services offered in the American job centers with the services offered by Pennsylvania Centers of Excellence, which is a statewide network or 45 drug treatment centers. Pennsylvania's also going to work to increase the number of certified specialists in the treatment of opioid addiction and integrating community employers into the recovery-friendly workforce initiative that support retaining or bringing back to work recovering addicts to the workplace.

In New Hampshire, they're going to work with community partners to identify participants, which I think is a challenge, too, but also to develop protocols to establish carefully timed steps between treatment and recovery that help facilitate successful employment outcomes over time. And they're really focused on taking a whole-person approach and individualized plans through this demo.

In Rhode Island, they have a project called a Recovery Through Opportunity, or RTO. This is a statewide initiative in Rhode Island, and they're extending some work that has started to be done by the state's overdose prevention and intervention task force. So that was what we kind of looked at as Phase 1, that initial investment in some specific demonstration grants.

And then just a few weeks ago – September 14th to be exact – we issued a policy around the existing resources that we have through the National Dislocated Worker Grant because there is a nationally declared health emergency disaster. States, tribal organizations, and others are eligible to apply for disaster recovery grants in a similar vein to what we've funded disaster grants for a hurricane or wildfires or flooding. So again, that national declaration enabled some activity to our (labor ?). But I did want to flag that that's ongoing, and we know there is interest across the country in accessing some of those resources.

Some other things we have here at DOL or ETA that I want to flag are the Federal Bonding Program. This supports employers in hiring at-risk job applicants who may include substance abusers. So that's a resource. You can learn more at bond4 jobs.com. That's the number 4 in there. But that's an existing resource. And then of course, the Work Opportunity Tax Credits that support employers for target populations – that may include people at risk of drug addiction. So the bonding and WOTC areas are two other resources to think about.

I think now, though, we're going to hear from another federal partner about some of their resources. And I hope in the future we're able to share more about what's happening over at DHS, but also some of the other parts of the federal family that are working to address the opioid crisis. But for now, let me turn it over to you, Reed.

Walker Reed Forman: Well, thank you very much, Amanda. I'm glad to be here. I'm Reed Forman. I'm from Substance Abuse and Mental Health Services Administration. And we've been involved in promoting screening, brief intervention, and referral to treatment, commonly known as SBIRT for 13 or 14, maybe 15 years now. I think this is a really timely topic to bring up at this point, particularly around workforce development, because it affects almost everybody in almost every setting that we see, that is substance abuse, substance issues, and substance use disorders affects almost everybody in some form in almost every kind of a setting.

I won't go into SBIRT too much, because I think that's going to be covered a little bit later. But just briefly, let me put it this way: Most people with substance use disorders are from a mild to a very severe level are not regularly identifiable by simply looking at them or seeing their behavior. You may notice some behavior that might be indicative of it, but many are never identified by anybody just by looking at them. That's why you need technology or you need an approach that is determined to ask questions that can identify individuals who may be experiencing these problems, and that's screening and brief intervention.

So the idea behind screening and brief intervention is the early identification of people with risky substance use – and that includes alcohol – in fact, it includes alcohol mostly – and also intervention with those who are apparently involved at a level with maybe either hazardous or actually show dependency or what we used to call addiction. So the idea is early intervention so that we prevent the negative aspects of substance use disorders from continuing to direct havoc on the workplace, families, medical issues.

So again, in brief, SBIRT starts with screening, screening with a validated screening instrument, because you cannot simply eyeball a person and tell if they've got a substance use disorder or even a mild substance use disorder. You have to ask pertinent questions and specific questions or you will not be able to identify those who are at the beginning stages of having problems. These screening instruments will give you a score which will allow you, most importantly, to begin to have a discussion or an intervention with the person that you're working with to discuss their levels of use, reductions of use, or seeking help.

So the screening tool will lead you to have a discussion. And the discussion is the all-important aspect of this intervention because it allows interaction that the individual would not normally have had. And then if you find individuals who have an extreme problem, you should have the ability to refer them to what we call specialty treatment or the traditional addictions treatment system. So why was this developed? Well, it was developed mostly because we've had a specialty treatment system for many, many decades, but most people even with severe problems never access it.

So then it was decided that the best place to start something like screening people very early and screening everybody, which is critical, is best done in a medical session or in a medical system, because the idea there, lots of people won't seek specialty help for a problem but everybody sees the doctor. That's more or less true. But I think what's relevant today is most everybody goes to the medical system at some time or another, which is a perfect place to screen people for their use of substances and any problems. But everybody goes to work, at least almost everybody. Everybody goes to work. This is the place that's probably impacted most outside the family for individuals indicating substance use problems of any kind of.

In fact, I just got finished reading an article a couple weeks ago about opioid overdoses on the job. Nobody on the job knew that had the problem until they found the person in a very dire situation. So it's probably even better in the workforce, finding people on the job, present certain difficulty that you don't experience in a medical setting.

But this is the perfect place to begin to look at the workforce to address workforce substance use issues and to keep valuable employees on the job. It can be assumed that there's lots of employees may be having risky to hazardous use of substances, but most are all very valuable employees and we want to keep them. Intervening and offering assistance is the way to do that.

With that in mind, we've promoted programs in probably 32 states individually. We've set up SBIRT programs in primary care clinics, hospitals – (inaudible) – some federally qualified health centers. We've been in student health centers, dental health centers, mobile. We've expanded this to many, many, places including ambulatory and urgent care locations. However, one of our luckiest breaks came when the Department of Labor YouthBuild contacted us with an interest in doing early indication interventions with youth and emerging adults who may have already had some difficulty with substance use issues.

We thought this was a fit because this would have a – it was going to be ground approved that if you interviewed early, you would get good results, you'd keep future employees in the training program, you'd get a better hiring rate in that they would stay on the job longer. These were the objectives that we had.

I think we have somebody that's going to talk about that more specifically later in the day. But again, the results seem to have borne out that on the job – particularly through an EAP setting – is the perfect place to begin to tackle this problem of early identification and the retaining of valuable employees even if they are beginning to evidence some level of substance use disorder.

So with that, what I'm going to do is I'm going to go ahead and turn this over to the detailed presenter for today, and that's Ms. Holly Hagle, from our Addiction Technology Transfer, Center, and she will give you the details and nuts and bolts in how this actually works in various settings. So thank you all very much for having me on to introduce the program. And I'll turn it over to Holly.

HOLLY HAGLE: Thank you, Reed. All right. So we're going to just begin by briefly touching on the current epidemiology of the opioid crisis, which has been referred to as a public health crisis several times. And here's some of the statistics underlining that, although many of you may be well aware of this. All of these factors in cohort together have really shown our country that we have a very serious problem that we're trying to address regarding opioids in particular, but also with substances in general, as Reed mentioned.

And so the combined use of Americans who have a diagnosed opioid use disorder related to painkillers and those using heroin with an opioid use disorder in relation to a really huge increase in emergency department visits and hospital stays really brought this to the attention, of course, of the entire country.

And unfortunately, the hallmark of this crisis is the jump in overdose deaths, which these are lives that could be saved. And that is the hallmark of what we want to present by using simple and evidence-based techniques, intervening early with people, and implementing safety measures. We could have an impact on these lives.

And I always like to say that these are wives and husbands and daughters and sons of people – it's not just the statistic that you're looking at on the screen of in 2016, 64,000 drug overdose deaths, which is the largest recorded increase in our U.S. history as reported by the CDC, and then the more recent statistic of 72,000. The Substance Abuse and Mental Health Services Administration, SAMHSA, has a line, a five-point strategy to address the opioid crisis. Those points are outlined here.

And I hope you'll see that in this other slide that I cover that we are impacting this on a five point: having a public health approach to opioid use disorders and also surveilling public health data so we could predict areas that need recourses; advancing the practice of pain management and understanding that people are in pain and that we have to have better guidelines around prescription opioids; improving access to treatment and recovery services targeting the availability of safe medications for overdose reversal and supporting research.

I always like to take a moment to reflect on the fact that a person is underlining every one of the statistics that we just talked about and that we have to be reflective of that by having affirming language. And we put the person first always before their substance use disorder. And so we just want to reflect on the fact that addiction does have a stigma in our society and that we want to consciously put the person first. And we do that through our words.

I wanted to bring to your attention – I'm not sure if many of you follow the Surgeon General's report – but this was a phenomenal report that really transformed the nature and conversation around addiction and our understanding of it as a disease, a neurobiological disorder of the brain. And this report was a landmark report. It's available to the public. You have a link to it in your Power Point as a resource. I would encourage you to look at it and the website because it has a lot of wonderful information that you could use with your participants in your organization. And it covers prevention, treatment and intervention, as well as recovery.

So this really lays a foundation for a lot of work that we're doing now, this report. I just want to reflect for a moment. I'm not going to read all these statistics, but you guys are probably predominantly working with young adults, 18- to 25-year-olds who are transitioning from elementary or high school and into the workforce and that this population has had an increase in serious mental illness.

So we are not just looking at in particular just maybe substance use, but also the co-occurring mental health component. And they often go hand in hand. And somebody who does have a mental illness is at a higher risk for a substance use disorder. So that is something to really pay attention to in your population.

Do you want to pause here to see if there are any questions in the chat? And if you have, please just put those in and I can address them. Time to take a brief moment to take a breath – we went through a lot of information. And I do know that we were a little short on our time. So I'll monitor the questions in the chat, but I'll go on to the next slide. Is that OK, Moderator?

MS. AHLSTRAND: Sure. There's one question we're wondering if you could address. There are a ton of them, Holly. But there's a few questions out there about why do we call it an opioid use disorder or abuse disorder rather than an addiction? Can you talk a little about that?

MS. HAGLE: Yeah. Absolutely. And that goes back to the slide about language, language matters. "Addiction" had come to be known as a somewhat stigmatizing term. Opioid use disorder or alcohol use disorder or substance use disorder is much more specific. It is more scientific language, so it's talking about the disorder first. For instance, we say somebody has diabetes or a cardiac condition. It's on the lines of other medical terminology, and so we prefer to be more specific in our language about the disorder a person has.

MS. AHLSTRAND: Great. Thank you so much.

MS. HAGLE: Absolutely. OK. I'm going to go on, but we will revisit questions throughout. We could maybe even ask some of them on the task panel. So I wanted to talk about substance use and wellbeing, because we don't want to read it with such grim information. We know by science that people can and do recover. We also know from science that the primary prevention works, and that we have scientific and evidence-based approaches to preventing substance use disorders and intervening early, and effort is one of them.

So I'd just like to talk about a prevention intervention, understanding people's risk protective factors. There's a citation – again, this is from the Surgeon General's report I referenced earlier. So we know that many in our population that your organization services do have high risk – maybe poverty, socioeconomic risk, family history risk for substance use disorders.

But there's also resiliency and protective factors that you could be utilizing to mitigate that risk. And that is just a very brief overview, understanding risk and protective factors. I would really suggest that people look into that, too, as a strategy of understanding your population.

I notice that somebody put the ACEs – that's understanding childhood trauma issues. Often in our population of clients who are in job placement programs or educational programming, they have history of trauma that could be addressed. That's a risk factor. But addressing that trauma is a protective factor. So I would encourage you to look at risk and protective factors.

And then just understanding that if somebody is using a substance, it is a disease of the brain. And it takes time to return from heavy periods of use – it does take time to heal and return to health. We must understand it as a disease. And I also wanted to highlight that we have effective evidence-based strategies that we will review and that people can and do recover and that the recovery movement offers a variety of pathways to recovery. Here are a lot of resources that SAMHSA has specifically put together that you have in the Power Point presentation. I'm not going to go over them here.

And I'll just take some time to talk about community resources for a moment and know – (inaudible) – much more time I have. OK. Thank you, guys. So first, the community – No. 1, we want to dispel the myth that maybe the old myth that might have been around saying, oh, people have to hit rock bottom before they're willing to make a change around their substance use. I noticed in the chat panel that people listed motivation as a factor that is a barrier to getting maybe some of the clients in your programs to address their patterns of substance use.

And we don't want them to hit rock bottom. Our evidence-based strategies are help people earlier in their course of use, so intervening when people are using in a problematic way. They may not have a substance use disorder. They just might have problematic use, say, related to employment or school settings. But we want to intervene them so it does not keep on the trajectory of being problematic that could lead to a substance use disorder.

I wanted to talk about – especially because in light of the statistics around the overdose deaths that we are experiencing across the U.S. – that we have a safe medication that's designed to rapidly reverse opioid overdose. It was mentioned at the beginning of this webinar. And this website, which you also have access to on the Power Point presentation resources, it's an online informational course and website that explains how naloxone is used. And we are encouraging safe use so that we can lessen people's risk so that they do not overdose on that. So I would encourage you to look at this resource.

And then I want to take a moment to talk about medications, because we do have safe medications that could help people regain their lives who do have an opioid use disorder. They're listed here. These are the FDA-approved medications of methadone, buprenorphine, and naltrexone. And we are advocating that medication can restore people to health and wellness while they can resume other areas or domains of their life, like employment, housing, child care, etc.

All right. And then I'm going to spend the last couple moments of my time with you talking about assessing risks through the evidence-based factors of screening, brief intervention, referral to treatment. I'm only introducing it. My colleagues that are coming up next are going to speak about it a little more specifically. But it is a public health approach. I'm going back to those five strategies I mentioned earlier to address early intervention for those who might be using substances in a risky way or those who are having a substance use disorder for further assessment.

I like to say that we are planting seeds for people to access services hopefully earlier in their trajectory of use. So if you are using a validated screen, which is model advocates, then you will be finding people across the spectrum of use. And we would like you to tailor your approach to that use the result of their screen or their use patterns to the intervention. So for those who might be using in a severe zone, we would refer them for their assessment to potential treatment. For those who might be using in a less severe zone, like moderate to mild, then we would ask you to intervene as appropriate for your organization.

And that's what you'll learn about coming up next here with my colleague Patrick McNeil, who will be talking about YouthBuild and their substance use prevention and intervention program.

PATRICK MCNEIL: Thank you, Holly. So good afternoon, everybody. My name is Pat McNeil. I'm with YouthBuild USA. And I am thrilled to be able to spend a few minutes with you and tell you about an actual practical approach that we did with SBIRT in a community-based setting. So we've been doing this – YouthBuild has been doing SBIRT for the last eight years, and we're one of the pioneers with introducing it in a community-based setting as opposed to just in a healthcare or hospital setting.

I'm going to tell you a little bit about YouthBuild first. So I know that there's some YouthBuild programs that are on the line. Thank you for participating. Also, YouthBuild is a national and international nonprofit that has a network of 250 YouthBuild programs across America.

We focus on a target population of what's called transition-aged youth, 16-24. And we're basically a training program that helps young people that are in need of further education, career development, leadership skills, and then also jobs, work. So I'm really happy to be here and to kind of tell you what our experience has been.

And by the way, YouthBuild has been around for 40 years. And we have programs in 44 states and even 23 countries internationally. So we really have a vast amount of experience in trying to transition young people from training programs into gainful employment.

So one of our challenges has been over the years, just like other programs, I know there's (Child Core ?) on the line. There's Workforce Centers. There's all kinds of different training programs that struggle with how to best address substance use among its participants. We've been focused today on opioids.

But I'm here to tell you that opioids are not the only problem. And I'm sure a lot of you are nodding your heads with me right now because it's not just opioids. Opioids are killing people. Holly said there's 72,000 people who died last year. Unbelievable. It is an epidemic. It's a crisis. We need to address that.

At the same time, we need to be mindful of the fact that substance use includes more than just opioids. So let me just tell you a little bit about what our experience has been. For most of our YouthBuild programs, substance use has been an impediment to: whether or not they can complete the program; definitely a safety issue, because we are a job training program that does a lot of on-the-job training; barriers to achieving outcomes in the classroom; and then, of course, at the end of the day, successful post-program placement.

So most YouthBuild participants that use illicit substances we have found have a substance use disorder that are generally masking hidden problems and use drugs as a coping mechanism most often from these ACEs or trauma or childhood trauma issues that people are dealing with. So people are self-medicating.

So here are some of the reasons – and there's many, many, many more – of why people are actually using drugs in our society today: first and foremost, a coping a mechanism; to escape from school and family; to be accepted by their peers; just because everybody does it; curiosity, which we find a lot in the rural communities.

We live in a pill-popping society. We take a pill when we have a headache. We take a pill to get up. We take a pill to go to bed. We take a pill for a backache. Everything you can imagine. Our society is a pill-popping society. So we shouldn't be surprised when our young people succumb to that. At times it's a gang influence or a criminal justice issue, but I think that's a lot overblown.

One of the ones that really kind of jumps out at me is when I hear young people or I hear people say that, hey, I smoke a blunt to feel normal. And when they don't – when they're not under the influence, they actually feel abnormal, which is a real head-scratcher. And then of course, a lot of times it's just an ethnic culture influence.

So here are some of the most commonly used illicit drugs that we have found: Alcohol is not on this list because it's not illicit unless it's for underage, but marijuana first and foremost; the opioids that we've been talking about a lot today; cocaine is still around – for those of you that think cocaine has disappeared, it's not; the LSD; cough syrup; methamphetamine; heroin. And heroin has made this tremendous resurgence because of its affordability and even its accessibility.

We're still seeing a lot of things with club drugs – Ecstasy, Mollys. And then of course, a lot of the things that are really scary with some of our younger participants is the K-2 SPICE, and synthetic drugs. Those are the main things that we're seeing. But guess what? In your community, it could be a drug of the month. So it can be something very different just depending on what part of the country you're in.

I want to give you a little bit of update around marijuana. So as you guys know, our societal norms are changing. Marijuana is now legal for recreational use in Colorado, Washington, Oregon, Alaska, California, Nevada, Massachusetts, Maine, and Washington D.C. It's legal for medical use in 30 states and counting. It's been decriminalized in almost every state. So it's really clear that our societal norms have changed regarding marijuana.

But what does that mean as far as our marijuana messaging, especially as it relates to the workplace? So our goal – all of the people on this line – our goal is to move participants into a career pathway that will offer them a living wage and growth potential, so if drugs or alcohol are an issue, that's not possible. We must have a consistent message that conveys that they will not get hired or they will lose their job if they're consistently failing drug tests or show up to work under the influence of any substance, including opioids, marijuana, alcohol, you name it. The legalization of marijuana does not change this.

I also want to say something right here about drug tests. For those of you that may think that drug tests are far and few between, they're actually on the increase. They're on the rise. There are many, many, employers that are seen as actually increasing their liability by not drug testing. So we're seeing drug testing on the upswing, especially with these societal norms changing around marijuana.

All right. Let me stop for a second and take any questions. And anybody that has any questions about what may be going on a national level around what we're seeing, what we've been seeing across our 44 states, feel free to type any questions you may have right now.

MS. AHLSTRAND: Pat, I don't think there were any questions specific to you right now. I think there's a ton for and/or our next conversation. But let's keep going.

MR. MCNEIL: Great. All right. So I want to talk a little bit about SBIRT. So our next presenter is going to talk about what they're seeing at their local program. I want to tell you about SBIRT a little bit in a community-based setting that we introduced and we've been doing for the last few years. I want to tell you that SBIRT is a new tool that you can add to your tool belts, and we're going to give you a lot more information how you can find out and maybe even start to implement SBIRT.

So what is SBIRT? First of all, it's an acronym. It stands for screening, brief intervention, and referral to treatment. The screening, as Reed and Holly kind of briefly mentioned and I just want to emphasize, is a universal administration of a validated screening tool to identify risk. There's a lot of different screening tools out there. And as long as it's a validated tool, then it's something that you can choose whichever one you like. The brief intervention part of it is it's not actually grabbing them and shaking them.

It's actually having a conversation with them – and a lot of you mentioned having challenges around motivation – but a motivational conversation typically incorporating feedback advice and goal setting. So we used to take this approach that we could scare people into changing their habits. We can threaten them into changing their habits. And we have found over the years that we really do need to have a conversation in which we're listening to people and we're actually trying to be empathetic about their journey and what they've dealt with and how they're trying to cope, and then help them find reasons to change instead of us wanting to change more than they want it.

Then, of course, the referral to treatment portion of SBIRT is the process of connecting people with problematic use with appropriate assessment treatment and additional services. So that's SBIRT. I also wanted to give you some visuals that kind of help you understand the phases. So there's four phases of SBIRT, kind of taking it step by step. The first thing is to establish some kind of rapport. People will talk to you if they trust you, if they know that you're authentic and you really do care about them.

And you notice that we talk about assuring confidentiality. Well, we can assure that in some respects. But of course, if they share something with you that is a danger to themselves or to others, then of course, we have to follow the proper procedures to make sure we help them and we take that information on. The second part of it is just asking the questions, eliciting thoughts, and providing some brief feedback.

The third part is the enhanced motivation – you kind of assess their readiness to change and enhance their motivation that they can do it. And let them know that, talk about harm reduction a little bit. Talk about how it's so important to keep their job and to be that breadwinner for their family and to have this self-sufficient lifestyle and not be dependent on anyone else. And then Phase 4 is to negotiate a plan on how we're going to move forward, understanding that for some people it's not going to be an overnight thing. Change sometimes takes a little time.

So this is another visual that you can take for SBIRT. The first part of it where it says assess is the screening part. When you screen, typically people that come into your offices or come into your training centers or come into your location, you're going to find that a percentage of them are abstinent. They have no issues whatsoever. Or whatever they're doing really doesn't register as problematic.

The majority of the people you deal with are in that middle category of moderate. Those are the ones that can really be at risk of losing their job, having things start to snowball in their life. And the third category are those that probably have some sort of dependence issue. And then you take that accordingly basically as you see the boxes that flow from there. So when I was a program director and actually running programs, I always thought to myself, now I know that they have a problem. Now what? Now what do I do? So SBIRT provides an answer to some of those "now what's"? And I really, really like the tools. It's been very meaningful for us.

So here are some of the results we've seen over the last three or four years of doing this. So for those programs that are doing SBIRT with a YouthBuild, the non-SBIRT programs, the completeness in those programs showed significantly lower results for those that did SBIRT, whether they could actually complete the program, whether they could attain a high school diploma or a GED, whether they could get a job or an educational placement, and then whether or not they could actually keep the job after they got the job.

So those are the things that we saw. And we're just really enthusiastic about the results today. And we're enthusiastic about taking this even a step further. So for those of you that want more information – I didn't take a deep dive into SBIRT or motivational interviewing – but for those of you that want more information, we're going to kind of share some resources with you about how you or even some of your training providers can actually try to implement SBIRT in your local programs.

All right. So I'm going to turn it over to my colleague from YouthBuild Austin. His name is David Clauss, and he's going to talk you to about what their experiences have been on the ground in Austin, Texas.

DAVID CLAUSS: All right. Thank you, Pat. And it's great to have this opportunity to talk with all of you, and greetings from Austin, Texas here. I am the YouthBuild program director at American Youthworks.

American Youthworks is a local nonprofit that started back in the 1970s and quickly moved to incorporate education and job training services in what we do. We've been doing YouthBuild here since before it became part of DOL back in 1994 versus part of HUD and then moving into the Department of Labor and the ETA family here.

And so YouthBuild, as Pat mentioned, is a program for young adults, 16-24 years old, that have barriers to education and employment. And we provide a blended wrap-around combination of services that include education and workforce development. Here at American Youthworks, we have what's called a construction-plus model. So we offer construction training in the oldest part of YouthBuild, but we've added on to that. And we now do IT training and also healthcare training as part of that.

And we also have the Texas Conservation Corps, which now has offices here in Austin, Houston, and Baton Rouge doing conservation work, such as building trails and planting trees and doing (fuels ?) reduction across three states. And so I've been doing this now for a couple of decades with YouthBuild. And one of the things that has been a constant throughout this time is the fact that one of the things that we see in substance use and substance abuse in young adults. And the drug of choice has varied over the years, but use there remains a constant.

And I think if you're working with young adults, you know that you're going to see that across the board. Demographics show us that substance use by people in America peaks when you're a young adult. And for many people, it tapers off there later in life if you get kids and jobs and other adult responsibility. But it's always there. And over the years, we've tried a number of different approaches to zero-tolerance types of programs where you had to pass a clean drug test in order to get into our program. We've done random drug testing, testing for cause, and tried a number of different types of policies to deal with it.

Over the years, as we've developed towards more of a positive youth development frame work, we've really moved from less of a law enforcement, like catching somebody doing something wrong type of approach to substance abuse, to taking more of a mental health and harm reduction approach to this. I hope you'll excuse my slide. They're mostly just an excuse for me to share pictures of my kids with you out there in the program doing such a great job. In the background, you can see one of the houses that they built as part of our YouthBuild Program and a little bit of the IT training going on there.

At any rate, as we were saying, approaching it from a mental health and harm reduction frame work, we understand that a substance abuse, substance use is relatively normal for this age group. We know that even with the tremendous impacts of opioids right now, tobacco use still kills many more people in the United States.

So we look at this from a mental health standpoint. We see, in addition to recreational substance use, we also have taught ourselves that how substance abuse is related to stress and trauma and mental health issues. And so we've taken more of a – gone away from a zero-tolerance approach to looking at how do we control, manage, and reduce their substance use so that they can be successful in life?

And we do this, as Pat mentioned, through conversation is the biggest part of that and through this screening and also through setting what we call intrinsic or their self-motivated goals identifying – helping them identify with their own goals and making sure that they're setting realistic goals for themselves in working with that. So anyway, into this kind of new attitude that we have developed over the years, we first were introduced by YouthBuild USA to SBIRT and the possibility of incorporating that into what we do. And SBIRT has been a great fit for YouthBuild.

And I can just tell you that I've seen a bunch of questions about grant writing out there. If you're going to be writing grants related to this, we know that using evidence-based, research-based practices is something that they're increasingly looking for in grant writing. And I think that in addition to that, perhaps even more importantly, evidence-, research-based practices means that there's a high likelihood that it's really going to be effective in doing that.

And so that's the reason that we really incorporated SBIRT into what we do. And I think a big part of what we're trying to do with this webinar is let workforce development professionals learn about and incorporate SBIRT into what they're doing. As they've said, it's something that was developed in the medical setting to have doctors to be able to quickly screen for substance use and substance abuse and think about how many people does the workforce development system touch?

And if we can be doing brief screening and interventions as part of that system, we can really be getting people the help they need in helping them get to a place where they can be successful. So I'm really hoping those of you in a position to think about incorporating SBIRT into your practices and into your program will give it a good look-at. So as Pat mentioned, the first portion of that is the screening. We use a number of different screening tools. I think there'll be links to them later on. And a lot of them are available free and online.

Use the AUDIT, which is an alcohol screening, and DAST-10 that are for drug use. We also combine that with, they mentioned earlier, the ACEs, the Adverse Childhood Experiences screening tool for early childhood trauma. And of course, we also ask them to pee in a cup as a way of something that we can compare against their answers there. Again, this isn't something we use to screen them out of the program – it's to be able to have conversations about their substance use and ability to impact their ability to be successful in YouthBuild and after YouthBuild when they're going on to post-secondary education or employment.

So we use these screening tools, and then we sit down and have that conversation. This is almost the beginning of that brief intervention to say, hey, this is what I've seen in your tools, in your tab and the screening tools. What do you think of these results? And as we talk about this motivational interviewing – which is a big part of the brief intervention portion of SBIRT – the key here is having an attitude of nonjudgmental curiosity so that you can really have that kind of honest, real conversation.

If they're trying to cover up their substance use in a way that's preventing you from having an honest conversation about it, then that's going to be difficult, because you're never going to get to the real goals and motivation that's impacting their substance use. And so I think one of the things we've found it's really important to have somebody to be able to have these conversations that isn't that supervisor, that someone that's in that hire-and-fire potential over them, but can be somebody, a caseworker who's working with them on that. That's been something that's been important for us.

I think the motivational interviewing tools for us beginning in the assessment is in addition to assessing their drug use, you're also trying to assess their readiness to change, or motivational interviewing has a great model for assessing their level to change. Anybody who's been doing this work for a while knows that somebody who doesn't think their substance use is a problem is going to be very unlikely to change. And so working then from those stages of pre-contemplation where you're just pointing out facts to them and kind of trying to plant those seeds that this might be something you'd want to think about and doing it in a nonjudgmental way and trying to get at what their goals are.

And the key to motivational interviewing is that you're listening in that nonjudgmental way. You're listening for that change-talk. You're listening for that, their inner goals and how their substance abuse is impacting it. Motivational interviewing is another research-based, evidence-based practice. A lot of the research on there is done in trying to help people quit smoking or lose weight.

So if somebody is using substances and wanting to change, motivational interviewing can be a really powerful tool for helping them through that process. But again, it's a very collaborative process, that nonjudgmental thing, listening for that change-language, and then listening is an especially important part of that.

I've told many of our caseworkers how important that is in terms of if you're doing all the talking, that's a lecture – not a conversation. And lectures don't often change people. But really getting at the heart of what their goals are in life and how their substance use could be impacting that and then really talking through: What is their desire to change? What is their ability to change? What are their reasons for changing? And then reflecting back to them what you hear.

We often see young people who are smoking marijuana. It's very common in our population, so just talking to them about, well, so you smoke marijuana. You obviously like doing this. What do you like about it? What don't you like about it? And then comparing that: Is it having any negative impacts in your life? Is it slowing you down from your goals? And then exploring that with them.

I'll take a conversation I had with a young man who had been in our program. We had to ask him to leave for a while because of problems he was having. He came back and I ran into him in the restroom actually. And he was there and he says, Mr. Clauss, I just passed one of my GED tests. And I said, well, that's great. That's great to see you come back and do so well. And he goes, yeah. It's amazing how much easier it is now that I'm not stoned. And you can see that kind of impact from the program.

But I think the question is until they have that desire and can see that impact for themselves, it's going to be very challenging. Again, these are techniques that SBIRT – one of the advantages of SBIRT, too, is that it's something that can – it has a set of techniques that can be taught, a question that can be learned that we can spread out to a number of workforce development professionals that can be able to have these kinds of conversations. You can use it as a tool for when you see other problems. Similar to doctors, if somebody comes in for a health problem, you can use these screening tools to explore their substance use.

If you have somebody in the workforce development system that's showing problems with tardiness or absenteeism, then you can use these kinds of questions in this frame work to see is substance use something that's impacting your ability to show up on time, your ability to be here every day? And how is that going to impact your ability to complete this training program to get a good job afterwards? And then connecting with their goals to meet those goals in their life.

I think then what I'm going to say is that we talked about this bell curve of substance use and how using these screening tools can help you identify. The motivational interviewing is great, goes with a low risk of substance abuse. It's hard to talk about young adults with no risk for substance abuse, but with low and moderate risk of – or amounts of substance abuse. For some in that bell curve, their drug use is probably never going to drop down throughout their life without some kind of significant intervention, those with some high risk of substance abuse. And then, too, those are going to need referrals to outside resources.

And so developing your network for your program of referral sources is going to be very important to this process, because there's few things worse than being able to identify somebody with a high risk for a substance abuse disorder compounded by mental health issues perhaps, and then have no resources to help them. So developing that network of resources is a key part of that. We are lucky here in Austin to have some resources, though not nearly enough. And I know there's lots of parts of the country where there aren't nearly enough resources out there.

We're also lucky to have a partnership with the University of Texas here in Austin, Hook 'em Horns, and to work with their school of social work and their school of nursing so that we have social work interns that can meet with students one-on-one and help with that referral process. But we also have mental health nurse practitioners that can do some of that screening for us and provide some additional counseling and also help with that referral source.

So as I wrap up my part here, I just want to – speaking as somebody who's been in workforce development with young adults – I really think for those of you out there in the field who haven't heard about SBIRT, give it a good hard look. I think it's something that can really impact your outcomes, can really have an impact for the people that you're working with of identifying these issues in helping people address their substance use in ways that's going to help them be successful in life, which I think is the reason all of us got into this work and are still doing it today.

And so I get one more picture there. And so that's my part. And I think I'm handing it back to Pat to give you another couple of pointers on implementing SBIRT.

MR. MCNEIL: Yeah. As we kind of close out – this is Pat McNeil again – I just wanted to make a few tips for you guys to remember. So first and foremost, change is difficult for almost everyone. It takes time. And it's important, I think, to try not to be impatient. Also, counseling is not possible when someone's high. I've had many instances when people have called me and said, this person is under the influence. It's like you almost have to take a timeout. Under those conditions, you can only manage the behavior until those drugs have worn off.

And then also, understand that stopping the use of drugs is not about having information or using willpower. Sometimes it takes time. People have multiple issues and multiple baggage that they bring into it. Think about how hard it is to find people that say they want to lose weight but they can't do it.

And then last but not least, there's no one approach. SBIRT is one additional tool, but there's no one approach to solving this problem of substance use. But the change is more likely to occur if the client or the participant owns their change. That's their intrinsic motivation that David talked about. And then you, as a caseworker or counselor or program assistant, are supportive of the change. Thank you.

MS. AHLSTRAND: Great. Thank you so much, Holly, Pat, and David. We really appreciate all of the information you gave us. And I feel like it's always the tip of the iceberg. We could probably spend hours with each of you talking more and more. We do have some time for questions that have been coming in as you've been speaking. And I'm going to go to Holly right after I address a couple of quick ones regarding some of the funding opportunities that ETA put out there.

So a couple things: We are still pretty early in that demonstration that I mentioned. We awarded six grants to states this summer. So we don't have a lot of detail there. But we'll be looking to provide information on that set of projects as we go forward. If you're interested in looking at that space to disaster grant, the guidance, it is TEGL 4-18. So if you're familiar with the training and employment guidance letters, I would say google TEGL 4-18 and open that up. We are following the eligible applicants for that set of disaster resources that is in statute; and same with the eligibility for participants.

So I do want to flag that, because there were a couple of questions about who's eligible to apply and who can be served with those funds. So we are following the law on that one.

But let me switch over to Holly. We've got a couple questions for you. And then I think we've got time if we try to do two for Holly, two for Pat, and then two for David here at the end. But, Holly, starting with this first one, this is about the appropriateness of SBIRT in the employment situation: If it indicates the need for an intervention or treatment, who is responsible for making the referral? And is there liability of the employer or of the referral provider? Do you have any insight into that kind of concern?

MS. HAGLE: Yeah. Sure. There are many demonstration projects and employee assistance programs that have adopted SBIRT. I'll put in the chat panel a link to an article that people could look at about SBIRT and employers. Obviously, for liability purposes, I would recommend that you would have to talk to your organization's administration and their legal department. There are quite a few employee-based SBIRT programs. And ETA has adopted SBIRT. And it's in the literature and their online resources.

MS. AHLSTRAND: Great. Thank you. And then a little bit more about the medical realities here. There are some FDA-approved medications to address opioid use. People are also wondering if these drugs present on a drug test as positive as well. Or is there a distinction that shows it was something that was to address the issue versus the opioid itself? And I think people were also asking about does a traditional drug test right now detect opioid use?

MS. HAGLE: Well, I think – (inaudible) – should address that. I think Pat may have addressed that. Most drug tests do not actually address that. But if people – and I'm not an expert on urine drug testing – that is literally a whole science in and of itself – but my awareness is that those three medications are not standard to be tested on a urine drug test, and should not come up as illicit. That is my awareness and knowledge of that topic.

MS. AHLSTRAND: Great. Thank you. And Pat, I don't know if you want to weigh in on that. We've also got the next question for you: Although marijuana is legal in some states, can an employer legally refuse or terminate employment if someone is found positive for marijuana use? Do you have experience there? Especially in the employment that involves here of people in these situations?

MR. MCNEIL: I do. So first, weighing in on the drug test – so there's a lot of different drug tests that are used across the country right now. Very few employers are opting for the simple screen urine test. That does not detect opioids. Most of them are opting for a more comprehensive test that may identify opioid use, but it may not be illegal. So there are a lot of different drug tests. And we don't know. Every employer has the right to choose whatever drug test they may want to use.

The other thing, when it comes to employers on whether or not they can either refuse to hire or even terminate someone that tests positive for any kind of substance – so even though the legalization of marijuana is a recreational marijuana is happening across the country and even the legalization of some medical marijuana is happening across the country – every employer is not bound by some kind of state legislation, that the employer retains the right to make their own rules and their own guidelines about how their employees are to report to or be on the job.

So our message is that working under the influence of drugs presents a problem that can – presents a harm to an employee that can cause them to lose their employment. The first thing that happens when there's an accident on the job is a drug test. And I promise you employers are scared to death about their liability and in that regard. So the employers retain the right under their personnel guidelines to determine and to mandate how they want their employees to report to work.

MS. AHLSTRAND: Great. Thank you so much. And then another question for you – you mentioned the motivational interviewing and effort. Can you talk a little bit more about that or give any specific tips and tricks?

MR. MCNEIL: Yeah. So for those of you that are not familiar with motivational interviewing, it's kind of a different approach than trying to tell someone what they need to do. It really is a more balanced approach to listening and to finding a client or a participant or a potential employee their own reasons to change and then to help guide them to their own reasons and readiness for change. So it's more than just listening empathetically. It's also listening with a quiet mind and kind of tuning into that person's meaning and kind of where they are.

So for those of you that can incorporate motivational interviewing, there's a motivational interviewing training provider in probably every community across the country. I would implore you to try to incorporate or to advocate for bringing in some kind of motivational training interviewing into your particular locale or your particular company or organization. So it is definitely a critical component of SBIRT.

MS. AHLSTRAND: Thank you very much. Go ahead.

MR. CLAUSS: This is David. I just wanted to say if you look in the file-share portion, there are some great motivational interviewing, a brief overview that gives you a good look at that. And there's also the stages of changing is also a good one to look at for more information. And there's a lot of resources out there for training.

MS. AHLSTRAND: Thanks for that reminder about the resources, too, David. And we will be posting here in a minute a slide that has some additional links. And as always, after the webinar, those will be available. But let's turn to you again, David. There's a few questions here about the screening tools, how you incorporate them into programs. And then maybe you have some experience where students don't want to be screened and don't quite understand why you're doing that and why it's related to a training program. Maybe you can talk a little bit about that process and how it's played out.

MR. CLAUSS: Certainly. I think first on the screening tools, the first one is called the AUDIT, or the Alcohol Use Disorders Identification Test. If you google audit screening tool, you'll pull up a bunch of information about it. The other one is the DAST-10. I forget exactly what that stands for – drug and alcohol screening tool, perhaps. These are both available online. And you can get access to them. I would certainly recommend a little bit of training on how to implement them. But they are pretty easy to use.

In terms of the reluctance to be tested, I think occasionally you see that, including "I just can't pee" statement where it takes a little patience to wait for that and a lot of glasses of water. But I think the important thing is to say this isn't a punitive thing. This isn't something – this is just for informational purposes just in the same way that we want to do a literacy and numeracy test.

We want to do a criminal background screening so that we can help connect you with employment that you're going to be prepared for and able to access just in the same way a convicted felon is going to have a hard time finding a career in the healthcare field, because a lot of employers will not accept that, or just what kind of convictions you have.

So the drug use is just one thing. If you can't do a clean drug test, that's going to be hard to get some jobs, certain jobs. So it's just part of our information in helping connect you to good jobs. It's part of the information we need. And so I think when you approach it with that kind of attitude, it's also just a standard part of our enrollment process. And so I think that kind of the normality of it and then having a reason for it in terms of our ability to get you ready for the workforce, I think combining those two things usually minimizes most resistance to the testing process.

MS. AHLSTRAND: Great. Thanks, David. I know we've just got a couple minutes left, so we'll close out. There are so many more questions. I think this gives us here some next steps to take care of compiling some resources and hopefully address some of those questions or many of them that we've seen come through. Holly, do you want to talk for a minute about a few of the resources on this slide?

MS. HAGLE: Oh, sure. I already mentioned the Surgeon General's report. But in specific information on SBIRT, I would encourage people, we have several free, self-paced online courses that you could take. There's a nice one that's a 1.5-hour overview of SBIRT. And there are longer ones or even shorter ones on the Addiction Technology Transfer Center website. And that's specific to SBIRT resources.

And then the IRETA website has a lot of specific SBIRT information. And that is a direct link. They have a lot of prerecorded webinars that you could look at on SBIRT, and it's being implemented in a multiple of settings. And then you could learn about the specific screens and the techniques around motivational interviewing that have been utilized in SBIRT.

MS. AHLSTRAND: Great. Thank you. I think it's been great for more and more people to hear about SBIRT today from you and from Pat and from David, and to hear some very big picture applications, ideas, and techniques, but then on-the-ground views. So this was very helpful.

Before we close out, we have one last polling question for the audience. And we would like to hear from you on this poll if you can take a few minutes before you sign out. And then I'm going to turn it to Jon to close us for the day. But again, thank you so much for joining us. Thank you to our presenters. This has been very helpful. And we look forward to continuing this conversation.

MR. VEHLOW: And that poll there is up. Thank you, Amanda, by the way. Our community has been impacted by this national epidemic. There are some things that we've done to address this problem. Your first answer is we've assembled a task force or forces in our community to tackle this problem. We've identified resources in our community and are referring people that need support. We're providing training service specifically for individuals impacted by this crisis. We've developed training programs for behavioral health occupations and peer counselors to tackle this crisis in our communities. So if you could, please, just answer one of those, choose one of those answers.

And if you're doing something else, if there's an "other," please let us know in that Q&A. Type in if you have a different strategy.

All right. Great. So here's some contact information for our presenters. Again, you can download the PowerPoint in that file-share window. It's at the bottom right-hand side of your screen. Just click PPT and then click download. Here's the contact information for our other presenters as well. We'll have all these resources and the PowerPoint uploaded to the event page, as well, by COB today.

And then once again, must say, if we're closing out –

(END)