CASAT Podcast Network

Hello and welcome to season four of CASAT Conversations.

I am your host, Heather Haslem.

This season, we will explore the impact of trauma on those who work in human services.

You’ll hear from researchers, authors and people with lived experience.

We hope you enjoy today’s conversation today.

I’m delighted to welcome Dr. Charlie Smith.

Charlie is the regional director at SAMHSA with the Department of Health and Human Services.

Welcome Charlie.

So happy to have you here today.

Thank you, Heather.

And it’s a pleasure to be with you.

So as we get started, please share with us about yourself and all the good work that you do.

So as Heather indicated, I’m Charlie Smith, I serve as the regional director for the US Department of Health and Human Services, uh substance Abuse and mental health services administration.

It’s a big long word.

Um Everyone knows it as SAMHSA.

Uh and trust me, I will withhold doing a virtual cheer.

Um but SAMHSA really stands up and, and um serves as the nation’s authority for mental health and substance abuse.

Um and most importantly that authorities really to kind of recognize the importance of substance use and mental illness across the age continuum, from birth to death, as well as the entire service spectrum.

I’m kind of thinking about what do we, what do we mean?

And where does government sit for emotional health and well-being prevention, um clinical treatment and clearly supporting individuals in their recovery.

Um I’ve been in this role since SAMHSA established uh 10 regional offices which was 11 years ago and I’ve been honored to serve in that capacity across three different presidential administrations.

Um I serve as the lead Federal Authority for mental health and substance use for region eight, which is based here in Denver.

Uh And it includes the States of Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming, as well as 33 tribal nations and communities within that geographical area.

Um And while we may be uh neighbors to Nevada, which is considered region nine, clearly, we’re very, very closely aligned.

Um My background is I’m a licensed psychologist.

Uh and I’ve worked in a variety of different clinical health settings both here in Colorado as well as in New York City.

Uh And prior to joining Samp’s, I served as the director and commissioner for mental health and subsidies in the state of Colorado um where I was in actually able to stand up uh really a lot of Colorado’s innovative activities regarding mental health and subs use uh for the entire state uh for about five years.

Uh in the mid-2000s.

And so it’s, it’s really a pleasure to be with you and kind of share at least some of those reflections and include that, that background.

Yeah.

Well, we’re so delighted to have you and thanks for making the time to join us and share about all the important work.

Um You know, you mentioned something interesting.

I loved your phrasing about where does the government sit when it comes to mental service or mental health services um and substance use.

And I’d love for you to just share your perspective on that.

Yeah, it’s, it’s really a very, it’s a very interesting role that the federal government plays.

Um But I think you, you have to take a step back and actually look at it, not from the government’s perspective, but really from the individual, the family, the community that really experience and struggle with issues concerning chronic health illnesses such as mental health and addiction.

Um and as a family member, as well as a parent of a child with severe anxiety.

Um That system is really complex um to find good care, to believe in that care, to actually follow through an appointment.

Uh to understand when clinicians actually may change.

What’s your role of your primary care provider versus your special uh special therapist that works with kids with anxiety.

Um that in and of itself is anxiety producing and complex for a for a kid, for a family member as well as the community where the government plays is actually in a lot of different areas to try to make that system as smooth and seamless as possible.

Now, it may not immediately feel like governments on the side of the individual and family, but we really are.

Um so part of it is making sure there’s adequate funding.

So there’s good insurance.

Um There’s insurance that’s covering issues concerning mental health and substance use.

Um There is additional funding uh that can backfill some of the insurance as well as making sure that there’s good provider, networks.

Uh There’s enough providers and they’re skilled to provide high level um uh high quality clinical care for our family members or loved ones.

Um C MS A plays a critical role in setting and working with many of the policies that support Medicaid and Medicare.

Um some of the work for veterans, um many of the uh services that are provided through Indian Health service as well as established of the standards that really our health care system is trying to do a much better job at particularly with mental health and subs use which over the years, over the decades has not been adequately seen as an equal partner with other physical health care conditions.

And to be a part of that, I think the federal government, in this case, SAMHSA really helps carry the message that we need to treat mental health and subs use just like any other chronic health condition and we’re really seeing some of that change take place.

Can you share with us some of those changes?

Yeah, I, I think one of the things we’re seeing is that there’s a lot more coverage when it comes to um substance use prevention, substance use treatment and substance use recovery services for individuals who have Medicaid.

Uh we know that through the um um health Care Affordability Act, Pipa, a otherwise known as Obamacare, that really made an initial change to give states an opportunity to expand their Medicaid to make sure that mental health and subsidies were equally available to anybody um who is receiving Medicaid now, not all states have done that and that’s clearly their prerogative.

But I think that that really demonstrates that we are now seeing in many states um the importance about mental health and subsidies that has to be delivered on by parity.

Um And there must be equity within that system.

We’re seeing that there’s a lot more providers available to actually deliver mental health and subsidies care in our communities through our community, mental health centers, through our comprehensive substance use treatment programs.

And we actually now are seeing many of our county public health agencies doing a lot of health promotion and literacy about what is mental health uh addressing issues for older adults that may have struggles with regard to sadness and depression.

Uh And making sure that care is actually coming to their homes and, or their nursing homes wherever they may be living.

Whereas 10, 20 years ago, earlier in my career, we had a real difficult time in actually growing those, uh, growing those programs.

So, I, I do think that there’s a major shift that’s taking place and uh we used to call it that individuals with mental health subsidies would struggle and be in the shadows.

I think finally, we’re actually putting some light in those areas and there are fewer shadows, but there’s still a lot of work to do.

Mhm You know, and you also mentioned you just talked about older adults, but you mentioned that uh you really work from a lifespan perspective and so curious if you can shed some light on what are you seeing today as the needs um in different areas of the lifespan, it’s a big question.

I’m sure you get that, that that is a big question.

It may, it may require a completely different um podcast to actually dive into it pretty deeply.

But um I I think we, we’ve been struggling as a country, particularly in the last three years, a multitude of crises if we look at it from a large scale perspective, um We’ve been struggling as a nation with a significant crisis regarding depression and suicide.

And that’s been really longstanding.

Um We’ve been struggling with uh a significant um uh crisis around opioids and drug overdose deaths um which um really began to spike about 10 years ago, but we know that that spike continues.

Uh As of last year, I think we lost over 100,000 individuals to drug overdoses in the US.

And then on top of that, we’ve had enorm enormous turmoil from the pandemic.

If we think about um really the, the secondary and tertiary impacts of a wide scale pandemic being COVID.

Uh We’ve recognized that um we’ve had to change our life.

Um We’ve been much more isolated, we’ve been um our sense of normality has been turned upside down.

And as a result, it’s really triggered a lot of difficulty for our young adults, for adults, for older adults with regard to kind of how to um manage the uh disruption, how to kind of reclaim some of that sense of normality.

At the same time, some of the things that they have lost, I lost loved ones, lost connections and just being disengaged from what uh life used to be.

And then on top of that, I would say there’s probably this fourth kind of struggle that we’ve been really going, going through.

And that is a change in our social conscious and awareness about how we as human beings kind of interact with each other.

I mean, clearly the, the challenges from the George George Floyd murder from um the difficulties with um other interactions between law enforcement and many of our bipap populations um has really kind of raised our consciousness with regard to what does it mean to be human?

What does it mean to mean to have really strong interactions with each other, to support each other, to understand each other from our own perspectives and that in and of itself causes turmoil.

So all these things put together are impacting our youth and young adults.

Uh those that may be more vulnerable or from marginalized communities under resourced communities are really feeling a lot of that strain.

Uh And that we know that individuals who are transitioning in whatever phase of life are going through a lot of different struggles, whether it be depression and sadness and isolation, anxiety, there’s a lot of effort that uh we need to be putting into those areas that have been more uh impacted around the country.

Yeah, a lot of work to be done and a lot of support out there that’s needed.

Um I’m always struck as I look at different statistics and watch mental health over time and um it doesn’t seem like our mental health is getting better as a country.

And, and I think you, I think you have good reason to actually have that perception.

Um And, and in many cases, even in my position, not only in, in my my current professional role, but also as a family member and, and seeing how my Children have actually kind of grown up and, and experienced um their development and their changes in relationships and so forth.

It does feel more, um, tenuous yet at the same time, um, where I’m seeing is we have an opportunity.

People are talking about mental health and substance use in ways that were never talked about when I was growing up.

I frequently tell the story about, um, when my Children turned 13, um, they were asked by their pediatrician about um their feelings, um, whether they were feeling depressed, whether they’re feeling like they wanted to hurt themselves, whether they were smoking tobacco, drinking alcohol, using drugs and having sex.

Those are questions I was never asked and probably until I was around 30 and just to kind of see that change and that acceptance about having those social dialogues, whether it’s with a pediatrician or a family member or a um leader within one’s uh church or going to school, those dialogues are healthy.

Um And I do think that that is changing and allowing us, I think as humans to talk more openly about that and as a result, it feels like, wow, there is a lot of pain, but imagine if that pain didn’t have an opportunity to be expressed, um We would really not know how much pain is there and actually may be actually contributing to it.

And so I do think there’s, there’s some healthy interaction that’s taking place within our society, which is also causing us to be very forthright um to make sure that we’re building new systems and being more responsive, particularly for those who are struggling.

And I know one of the things that we wanted to talk about um is 988.

And really, that is an example of where the federal government really has been putting a lot of emphasis around crisis services.

Um and 988 as a way to provide people a easy free 24 73 65 place to go, particularly if they don’t have another place to go, that’s trust them.

Yeah.

And so these new systems, you know, I think we think that 988 is new.

I mean, that’s kind of a common, I think misperception that we’ve discussed.

And so, but if you’ll just share with us a little bit of the history of 988.

Sure.

So 988, if your listeners may not be immediately aware is the new three digit number uh for the National Suicide and Crisis Lifeline.

Um, that Lifeline is available throughout the country.

Um, it’s 24 73 65.

You can call, you can text, um, and you can chat to 988 Lifeline.

Um, and actually get connected to a crisis counselor, um, anywhere in the country any time of the day.

Um, 988 is not new.

Well, the three digit number is new.

Uh, the actual system is not.

So for about 16 years ago, um, the federal government, uh with a great support by Congress established the National Suicide Prevention Lifeline.

And some of you may recall there was the number was 1 802 73 talk or 8255.

And I think that logic, the musician Logic a couple of years ago at the Grammys actually performed the song 1 802 738255.

But that national Suicide Prevention Lifeline was the first again 16 years ago, uh to provide that national place where people who were really struggling with, willing to hurt themselves, uh and potentially commit suicide, had a place to go.

One of the things that we, we relied on that system for a long time, SAMHSA, my agency was the one that actually is responsible for that system.

Um And one of the things that we realized about four or five years ago is that system, the demand on that system was increasing substantially.

Um And some of the things that I was talking about earlier actually contributed to that increase.

Um But a system designed 16 years ago was designed to handle around 40,000 calls a year.

Um Two years ago, we handled 3.6 million calls and that system had never been adjusted.

And so when we think about just the demand and utility of that system to offer somebody a place to go to be connected, particularly in their most distressing periods of life, to have a trained counselor to be available to them, to talk with them on the phone and then hopefully get support and maybe even connected right into a system to make sure that they stay alive.

Um The importance of that was substantial and we had lots of evidence about how effective it was.

Um Congress then made a decision that we need to think about really expanding this system.

And about three years ago, um, there was a, um, a piece of legislation passed to form, uh, an expanded system with a three digit number which would be a little bit easier to remember than 1 800.

And so the number 988 was designated uh and then this past July, so July of 2022 the 988 number uh went live and by live, it means that it required all telecom country companies to have 988 as part of their quick dialing system to directly go and be calling or texting or checking, chatting to 988 would go directly into the National Suicide and Crisis Lifeline system, which then would direct the caller to one of over 200 lifeline centers across the country to include Puerto Rico, um as well as Guam and many of our Pacific territories.

Um And that system, even since July has managed over 2.1 million uh calls, texts and chat, which compared to a year ago, we’re already seeing a significant greater use in demand on that system.

But at the same time, our ability as a system to respond to those callers, um, has gotten much more efficient, um, and very, very quick.

Um, so we’re actually responding to calls faster.

Uh, individuals are getting connected to um, uh people when they’re in distress.

And the fact that we expanded the suicide prevention lifeline to be suicide in crisis means that it’s a lifeline system available for anybody experiencing any type of distress to include mental health and substance use and concerns about loved ones.

It is available to anyone anytime anywhere.

That’s awesome.

Um And really incredible the amount of lives served.

Um since July, that’s Incredible 2.1 million.

And I’m curious with that, like, what changes have you seen or how have you seen the implementation of 988 help to address um the mental health crisis we’re seeing here?

Well, I think probably the most important thing it really um is giving individuals another place to go and in some cases, a place to go.

Uh we know that um there are not enough clinicians, there are not enough um counselors, there are not enough uh clinics and even hospitals for people to go when they’re really struggling in some cases.

Uh when we’re struggling, we may not need that level of care, but we just need someone to talk with um and having that trusted friend or family member or somebody that we rely on not being available, who can we go to in our most precious and intense times of need.

Um And having that 988 number gives us that place to go.

Uh And I think that it really offers uh the US and everybody here that place to talk to somebody when we’re, when we’re in need.

And so I think if anything, it’s one, it’s not the only solution, but it gives us an opportunity to make sure that we’re building a network where individuals in crisis have a place to go.

But also having the opportunity to make sure that we do have enough clinicians and we’re educating people to come in enough clinics to support the people who are in need, supporting our schools and our faith based organizations and our workplaces to make sure that they have the with capacity and resources to support individuals in those systems.

And in many ways to kind of even hopefully at some point reduce the reliance on 988.

But still knowing that is that is a tremendously important backbone, just how we think about 911 as a backbone for somebody experiencing a physical health crisis or a public safety crisis.

And I was thinking about this with 911.

Has there been a change in the amount of people who have called 911?

Um Now calling 988 instead, that’s a tricky question.

I think one of the things that we do know that before 988.

And even while we still had a 1-800 number 911 typically managed around 20 to 30% of their calls were related to a mental health and, or substance abuse issue.

And we’ve worked very, very closely with the Department of Transportation at the federal level that supports 911 for the entire country.

And even though most 911 agencies um and call centers are actually in individual counties.

Um, there is an oversight agency for 911.

And in some of our projections as in planning the development and turning on of 988, we saw that we would be able to actually support the 911 system by diverting some of those calls directly into 988 rather than 911 having to manage them.

Now, I think it’s also really important to know that 911 is a three digit number for individuals in a medical and or public safety emergency situation.

988, it is a three different three digit number, but it has a very different purpose than 911.

988 is actually a live um crisis counseling center.

Much like what we think about for ems or law law enforcement or fire to respond to somebody in crisis.

9 88 is a place that can respond to somebody in crisis by using telephone chat and text.

And should somebody call 988 and require emergency medical on site services.

The 988 team would coordinate with 911 to get those resources to that individual to make sure that their life and safety is responded to immediately.

So there are some differences between 988 and 911, 911 has seen some um different flow of calls coming in because of the growth of 988.

And it’s, it is balancing the system.

Um And then the other thing that is really interesting, we were thinking that a large percentage of callers to 988 would not need the 911 services.

And that’s held true.

Only about 2% of that 2.1 million calls needed a referral to 911.

So most callers into 988 are talking with the crisis counselor, getting the support they need, getting the connections that they need um to make it to the next day, to make it to the next week and they don’t need a 911 intervention, which is a very good thing and it shows great promise about the effectiveness of the 988 crisis counseling system.

Yeah, that’s incredible.

It makes me think about the power of human connection and being able to talk to another human being in a time of need.

Um And with a human being with skills, right.

To be able.

Uh but the power of that is incredible in saving lives and that, and that human to human connection is one of the most therapeutically powerful things that we can offer.

Um and 988 is just that and you know, I know that you’ve, that you’re building a crisis care system and 988 is a piece of that.

Can you describe your long term vision of our crisis care system and any anticipated outcomes?

Yeah, I so Samsung clearly is at um in a leadership position at the federal level uh concerning really trying to put the pieces together for a very robust, comprehensive mental health and subs use care delivery system.

And 988 is one of those pieces of the puzzle.

Um The federal government does not do this alone.

Uh So every state plays a very significant role when it comes to organizing and supporting um the lifeline centers for the citizens within their state.

And so Samsung works very closely, is able to provide its resources to the states to support and anchor those 988 services.

But when we think about what is that robust system, it does mean a 988.

So someone to call the second is someone to respond, that we know that when people are in crisis, particularly that 2% who really need someone to respond um in person uh when somebody is in need, um there is an opportunity to think differently about mobile crisis services.

Historically, the mental health and subsidy system has really relied on law enforcement ems and fire to be that response system, that mobile response system.

But we also know that having somebody in a uniform showing up to someone’s house or location, um, can be pretty traumatic and pretty scary.

Um, we also know over time that there’s been great efforts to do, um, cores responder models otherwise, meaning that uh psychologists would actually ride along with the law enforcement officer to respond.

And actually early in my career, I did that both in New York City as well as here in Colorado.

I would do ride alongs with law enforcement all the time.

I did not carry a weapon.

I was not wearing a uniform and it give, gave them an alternative um to supporting an individual need rather than a law enforcement officer coming um uh to the scene and be the only one there.

Um building that infrastructure and building new mobile crisis responses where law enforcement is not involved at all.

Actually having mental health clinicians be the only responders is something that SAMHSA is actually making available through funding to states to build that mobile crisis response system that’s going to be easier in some places than others.

We know that many of our rural communities don’t have a lot of mental health clinicians or psychologists or social workers to be able to do that and still need law enforcement.

And many of our communities, law enforcements are very trusted entities.

But how can we support them to really most importantly, support individuals in crisis.

The third area that we’re very focused on is if, if somebody is in crisis and they have to go somewhere after that crisis, we have to think differently about crisis stabilization programs.

Um A lot of times and sadly, jails have been that default.

Somebody with a chronic illness or in crisis for a mental health or substance condition should not be going to jail.

They need to be getting good health care.

We do have many emergency departments and emer and hospitals that do excellent work for individuals experiencing a mental health or subsidies crisis.

But in some cases, those hospitals may not have the right skills and or setting to really support somebody experiencing a psycho pediatric disruption.

And so we’re actually looking to build more crisis stabilization programs for mental health and sub in our communities to work alongside hospitals.

Um and also to work a lit with many of our mobile crisis programs.

So people have a safe place to go in the period.

We’re having a significant period of distress because the last thing we want anybody experiencing a uh a medical crisis, a psychiatric crisis is to go to a jail.

Uh and to know that we need to make sure that we have good ample support for them.

Uh Immediately following that crisis.

And then the other two pieces I would really emphasize is we’d have to be doing a lot more with regard to putting funding and resources into prevention.

Um How do we support our communities before a crisis even happens?

And SAMHSA along with many other federal agencies are really creating a groundswell, a lot of groundwork to focus on emotional health and well-being um to identify some of those um social impacts on our health and well being to include stable housing and um having access to economic development, having food on the table, um having safe places to go and being connected to the community.

And the other piece is making sure at the back end that we have a strong therapeutic clinical system for those people who are struggling with chronic illnesses that they get the treatment that they need and in some cases be identified early and then be able to be supported through that care um rather than experience a crisis or a disruption of that care that can lead to a crisis.

So if we think about all these different structures, and again, it’s really complicated.

We know that 988 serves as a foundation.

It’s alongside mobile crisis, a strong crisis stabilization system and then a larger network to include health promotion and prevention, good clinical care and clearly supporting individuals who are in recovery from a chronic illness.

That’s awesome.

Um I’m so glad you brought up prevention.

Um I come from public health, the Gerontology background, human development and family studies, background and in our world, in our medical model.

When we talk about health, we’re usually talking about illness.

Um And there’s this continuum of mental health and mental health needs and um we don’t tend to focus on what can I do preventatively with the food that I’m eating, the amount of sleep that I’m getting that stable housing piece, even just all the lifestyle pieces that go into it.

Um And then I think about the social ecological model, right, that the policies impact.

And so it is a very complex system.

And um I think for our brains, we always want like the answer, how do we fix this?

Uh But it’s, it’s never that easy I find and we also seem to be a society that expects that fix to happen immediately.

Um And I think that that is also a hard reality when you know, some of the illnesses and, and some of the disorders that we struggle with, whether it’s psychiatric and or physical um take time.

And for us is to be patient, to be humble, to um kind of understand all the different kind of impacts to how we are, how we are feeling and how we are doing is important that we actually support the entire person.

And so much of actually what, where I come from and from philosophically is, is also where SAMHSA stands.

So we have to be thinking about the whole person and seeing that whole person from their background, their culture, their ideology, their perspective on life.

But also how does their environment and all those things impact, what does it mean to be healthy and how to achieve a healthy lifestyle?

Um And all those things are connected.

Yeah, I think about it as a ripple effect, you make one change and there’s a ripple effect of either positively or negatively really for our physical and mental health.

Um You know, the vast majority of our listeners are human services providers or behavioral health providers.

And so from your perspective, what is most important for them to know and take away based on the work you do another really big question honing in a little bit on kind of 988 because I think one of the things I think it’s really important to know that in this very kind of new environment of this new system and how do we kind of elevate crisis care?

I think probably most important for your audience to know is everybody has a role, uh everybody has a role to actually support each other, to support themselves and the people around them.

Um But understand that they have a, a great opportunity to kind of uh with their knowledge and position um to be able to support individuals in need, uh to be able to understand where people can go for help.

And in some cases, it may be that person’s coming to you for help but know that you are not alone uh that there’s a lot of kind of resources around um you to support you.

And I think it’s kind of building that sense of community where you can kind of have your professional life lines.

Um but also to help that individual create their own personal lifelines when things get sticky or tough.

And then also kind of really be an advocate.

I think that we join these professions in either health care and or human services to, to really support humans.

And this is an opportunity to be part of that larger network, to offer your perspective, to think differently, to help systems, think differently about how to do a better job and to really kind of understand where resources like 988 and the local lifeline centers are and how can somebody reach them?

Where are the specially care providers in mental health?

And um who are those people that you can lean on for um education and advancement in your own knowledge?

Um And how can you be stronger in your position to connect with an individual, be present with them and understand their experience of their illness?

Um that takes time, that takes energy.

But the ripple effect to your point is enormous.

Uh It gives that person on the receiving end a sense of being heard.

Of being in uh included and connected which in and of itself can be therapeutic.

And you mentioned professional lifelines and I’d love to hear how SAMHSA can be a professional lifeline.

A MS A, a lot of our resources um uh support um professional development um and training.

Um So across the country, uh there are technical assistance centers, centers of excellence uh focused on prevention um for mental health incentives focused on addiction and focused on mental health specifically um that exist in each of the 10 regions.

And so here in region eight, uh the University of Utah, the University of North Dakota and the Western Interstate Commission on Higher Education work across those three centers of expertise, offering free training um and classes and professional development and webinars and learning collaboratives on a whole host of different topics that are available to anybody, whether you’re in the mental health and re sepsis profession, or whether you’re working in the human services, social services and education and so forth.

I believe in Nevada, the University of Nevada Reno is one of those very critical centers of excellence regarding prevention as well as actually work with region a on the addiction side of professional development and training in addition to all.

And you can actually go to SAMHSA’s website www.samhsa.gov.

And you can actually look up all the different training and education, technical assistance centers that are available across the country but also within your state and your region.

SAMHSA also funds more targeted or specialized centers of excellence focused on youth and young adults.

We even have one for 0 to 5 year olds, specially designed for early childhood identification and support for family members for Children showing very early signs of psychiatric disruption.

And yes, you can identify early psychiatric disruption in the first couple of years of life.

We have centers of excellence for eating disorders and the LGBT Q plus community and focusing on those that are peer specialists, working as peers and community health workers in the field of mental health and substu and again, a number of different areas that can be very effective to each of your list and there’s work and intersection for professional development to kind of grow that lifeline, but also that kind of robust infrastructure that you have to be a stronger professional, as well as person working with individuals with mental health and such.

So we have a whole bunch of resources and by the way, we’re not the only federal agency that’s doing this.

So the National Institute of Health, the CDC Health Resources and Services Administration, the Administration for Children and Families, all these other federal agencies are doing a lot of similar work to include mental health and sub use.

Sams is just fortunately working with all of them very closely and coordinating all allows free technical assistance, training and really kind of lifeline development for all professionals.

Yeah.

And it, I, there’s the saying it takes a village.

Um, that strikes true here, I think, and sometimes, um I’ve heard from behavioral health providers, it can feel overwhelming the amount of work that needs to be done and the amount of people who are trying, who need support.

And yet there is this larger network that we’re all a part of.

Yeah, the network is huge and, and as a clinician, um it can feel very overwhelming and I really resonate um with um the people you’ve interacted with and probably some of your listeners.

Um the workforce is, is struggling.

I mean, we are struggling.

Uh we don’t have enough providers to actually meet demand.

Um uh We are oftentimes feeling very burnt out, overused, um stretched really, really thin.

Uh I was giving a talk a couple of years ago um really at the, at the very beginning phases of the pandemic.

Um and we were talking about how professional development attending a webinar attending classes, um can actually in some cases be um self soothing and a little bit of a break from the normalcy of chaos, uh particularly in the workspace, it can be a healing experience, getting some additional training.

Um And if you’re able to kind of structurally kind of form that within, within your organization, again, that can help build some resiliency, developing, expanding that work network as well as your knowledge base.

Um And if we are able to do that, we’re often times able to actually help our patients a lot better help the people that we’re working with a lot better.

Um, now there are some other things that have to change along with that.

Uh, there’s a lot of effort to kind of grow the workforce, really kind of leaning heavily into how community members, how peers with similar chronic illnesses can actually be joining the workforce from that peer perspective.

Uh, but we have a lot of work to do there.

Hm.

Yeah.

And you know, this season that we’re wrapping up, um, you’re actually, our final episode is all about secondary traumatic stress and the impact of witnessing other people’s trauma.

And so I’m so glad you spoke to how even sometimes professional development can be a sense of retreat.

Um, and a sense of healing for when, uh you’re feeling burnt out.

I think that’s a really important piece and, and, and I guess I, I would be maybe I might use a different word than retreat because I think it’s a bit of rejuvenation.

Uh because I don’t think, I don’t think we’re giving up.

I think if anything, uh, we’re trying to stay in the game and still uh be uh effective and, and present that requires self-care.

Um And we have to make sure that we’re really constantly being attentive to our own personal needs, um, and making sure that we are keeping ourselves our family or our personal community as healthy for us and about us.

Um because that way, if we’re doing that well, we’ll be able to actually uh effectively care for others, support others be responsive to others.

Uh even more importantly, uh and effectively.

Hm, uh I’ve talked with a couple of colleagues this week and um this phrase keeps coming up.

It’s, and it’s coming up here too, which is interesting.

It starts with you, right?

As the clinician to be grounded and healthy and, well, um it does start with each of us taking care of ourselves so that we can show up for others.

Couldn’t have said it better.

Well, Charlie, as we wrap up today, is there anything else that you feel is important for our listeners?

Well, um you know, I, I think get to know 988, if you’re not familiar with 988, Google it, check it out.

988 lifeline dot org is the website W W W 988 lifeline dot org.

Um I think it’s really important and I didn’t emphasize this earlier as much as there’s a lot of um effort and infrastructure being built around that crisis service system.

Um There’s a lot of work to that still has to be done to get the word out.

Uh I was actually talking with um some colleagues in Alabama, the University of Alabama Birmingham earlier this week and they hadn’t heard of 9 88.

And so one of the things actually, we are interestingly doing in this region is focusing on getting information, materials, marketing information out about 988 to all of our college campuses and universities where as a closed system oftentimes, they may not be as dialed into some of the things that may be happening in the larger community.

Uh But for all of you think about how best to kind of capture what’s happening around a, a making sure that that becomes a resource um for you in your work.

I think the other piece is, is be, be attentive to where you may need additional information, literacy about mental health and substance use um in that no matter what field that you are working in.

Um It’s, it’s in that field, it’s in the people that you’re serving.

Um There may be quiet struggles, there may be hidden struggles.

Um But there may be issues concerning mental health and sub use either within the folks that you’re working with and or your colleagues or families that your greater knowledge around that would be helpful.

And then finally, just know that SAMHSA uh as a federal agency with regional offices are always available to kind of support you either with information resources and or support the work that you are doing.

So, while I’m here in Denver, which is not part of the Nevada region, um you definitely have myself to reach out to.

But your regional director for SAMHSA is based out of San Francisco and her name is Emily Captain Emily Williams.

Um But Emily and myself and a number of the other colleagues are always here to support um any of your listeners and any of your communities uh thinking about the entire health care spectrum, particularly around mental health and substitute.

Well, thank you, Charlie.

I can’t wait to maybe have you back someday.

There’s several other things I’d love to talk with you about and to really hear about, you know, since it is 988, the launch of it and the um impact I would imagine you’re gonna learn a lot over the next couple of years that we can learn from too.

So I’d be happy to and it’s really been a pleasure heather to kind of visit with you and um talk about some of these really important things and I’d be more than happy at any point in time to dive into some other kind of uh critical topics and, and most importantly, continue to, to champion the importance of uh everyone’s health and wellness.

So, thank you very much.

Thank you Charlie.

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