Disability:IN NC Wellness at Work conference

Please stand by for real-time captions.

Good morning, everyone my name is Margaret Millet at work it MetLife and it is my pleasure today to welcome you to the disability in North Carolina and carried of her stability network work and have to say what a difference when you're makes and I remember last year [Indiscernible - static] and it was well received and we had about 75 people there I believe and very well attended and here we are now today all logging into this event from the comfort of our home and I guess the one thing we have to be grateful for is that in 2020 we have the technology to be able to host virtual meetings and we are still able to move forward with this and to be agile to adapt from in person meetings to doing this virtually. One unsung hero I would love to give a huge color to is Cris Rogers from MetLife he will not hear or see Cris today but he does not like to have any fanfare so Cris, I am sure you're blushing an angry at me. Huge cull out to you for you and thank you for making this work because we were so well on the way of doing in person meaning when COVID-19 hit. It is my hope that we will see you next May in the MetLife campus and be able to do this in person again. For those of you who are not able to attend in person please know that we are thinking of everyone and we do hope everyone is doing well at home and adjusting to the social distancing so with that I just want to again say huge shout out to our panelists for coming out and making this happen and without further ado I will hand this over to Tom bars and thank you to everyone for this event.

Good morning, everyone and welcome and greetings from UNC Charlotte and the master public administration program payment on behalf of the [Indiscernible - static] disability in North Carolina which as you know is your business partner for disability inclusion I am delighted to be here and so proud to be part of this organization and the staff and as Margaret just that we do not let COVID-19 stop us. We have a beautiful agenda here today and thank you to Dr. Dooley and Mr. Kepler in the roundtable later just looking forward to a great day and thank you for being here. Looking forward to it. Thank you.

Not sure if you are on mute.

Go ahead, Beth.

Thank you, [Indiscernible - static] Tom and thank you, market, it is an honor to be here my name is Beth Butler, Executive Director of disability in North Carolina and two markets., while, what a difference a year makes we are adjusting but so excited that we were able to

bring this event to you virtually. Again a huge shout out to Cris Rogers NTU, Margaret, and to the leadership at MetLife and the diverse ability employee resource group for your partnership in making this happen. It is a pleasure to serve as Executive Director of disability in North Carolina and I want to take a few minutes to share with you if you're not familiar with the organization I do want to share with you a little bit about who we are and what we do and so I will give you a brief overview of who we are and disability in North Carolina was founded in 2012 we are a business to business network that helps businesses with creating their disability employment inclusion strategies. That happens both in the workforce in the supply chain and across the marketplace disability IN North Carolina is a proud affiliate of disability I kept in is a national nonprofit resource for business disability inclusion worldwide payment and includes a network of over 180 corporations or corporate partners as well as 30 affiliates across the country that are devoted and committed to creating opportunities for individuals with disabilities across enterprises and businesses across the country. Disability in North Carolina also provides a collect voice for business leaders, for community leaders, for human resource executives and other stakeholders as we work together to create again more inclusive cultures across corporate America for individuals with disabilities. We are a membership organization and this next slide will show you some of our members and sponsors. We are very, very proud of our members and sponsors. We could not be here today if it was not for the commitment of these companies. If you are not a member of Diability IN Carolina I want to encourage you to visit our website at www.de i- and seatwork and talk us out and we have opportunities for both sponsorship and membership or we could do none of this without you and also while you are out on our website do not forget to follow us on Twitter, LinkedIn and Facebook page. So I want to share with you a bit about the national program that we have and first I want to point out the disability IN supplier diversity program and we believe and we know that individuals with disabilities are not only tremendously talented as employees, but a number of individuals with disabilities are champions of entrepreneurship. This disability program is an opportunity for businesses to become registered or certified under our certification program to promote entrepreneurship among individuals with disabilities, as well as our service disabled veterans. So if you are a small business and you are listening today, please take the opportunity to understand and learn more about her certification program. This creates bigger opportunities for the small businesses to engage as a first, second tier supplier within the supplier diversity programs for larger corporations. Looking to diversify their supply chain and include individuals with disabilities in doing that. The disability equality index is another opportunity but it is a

national program that we are so proud of, because it is the first benchmarking tool that was created for companies that are interested in understanding where they are, in this disability inclusion journey and the survey opportunity for companies to walk through a series of questions and then they receive a score and those companies that are or that score 80% or above are ranked among the best employers, best places to work for disability inclusion. We have a number of our member and sponsor companies that are among those companies that are ranked the best places to work for disability inclusion and I do want to highlight as well and Accenture report here that was done in 2018 and basically the question was asked when a company pays attention to this work, when a company begins to focus on disability inclusion strategies and really makes effort to create environments for individuals with all types of disabilities does it matter, right? Is their return on that investment? And the Accenture report that was again released in 2018, the outcome was absolutely yes, and companies that are more inclusive and are champions among people with disabilities see 28 percent higher revenue, to a times higher net income and enjoy a 30% better performance on academic profit margins. That is compelling and so for those that are listening today that our representatives of businesses whether it is a small business, or a large corporation, this is time well spent. The work that you are doing, especially now as we look at the impact of COVID-19 this work matters and it will continue to matter in we know now through the Accenture research that was done through this getting to equal report, that it is in fact profitable for businesses to pay attention to this segment of diversity.

And as we look at Diability IN Carolina here locally within our state, we have a number of different programs that I just want to bring to your attention. They are listed here, commune ability consulting and that is where we walk alongside essences that have perhaps taken the disability of equality indexed and want to do better and based on that information that they learn about their culture you know what programs can we help them develop to create opportunities for individuals with disabilities and we have a commune ability business mentoring program where we correct or connect Callistus with disabilities with career mentors across the state that are interested in engaging with these young students to give them the network an opportunity to listen and learn from each other while they are still in college so they can use that as they continue to launch their careers into the professions of their choice. We have a number of different programs as well. Our next event will take place on July 21st and that will be our ADA celebration, 30 years it has been since the Americans with disabilities act was passed and we look forward to celebrating that with all of you. Our annual fall conference will be October 1st and that will be hosted by train technologies,

formally Ingersoll-Rand and I will take place here in Davidson, North Carolina. Our ability jobs portal and if you have not checked that out, please do that and visit our website D INC-.org and that [Indiscernible - static] post positions to create and again have an opportunity for sourcing talent individuals with disabilities to join their organizations. And finally our podcasts, check us out on speaker we have a series us podcasts under the title let us have a conversation. And those are just a few of the resources that we have available so with that again I want to encourage you if you have not checked us out, please do that and I challenge you to join us because believe me, there are companies across the state and leaders across the state that are in, with IN North Carolina and thank you for attention and we look forward to see you at future events.

And with that I am going to move into introducing our keynote speaker, and you are in for a tremendous treat, Dr. Thomas Dooley is a scientist, a serial entrepreneur, author and inventor with three decades of research and development experience including 21 years of leadership at the vice president to the CEO levels. Employees have included Upjohn, Southern research, Integra Durham, meta-quest, a Gentile, and trained and former development. Dr. Dooley is author of 15 patent and recipient of numerous professional words including endowed chair. He is the author of 75 scientific articles and four books. He is the inventor of PAN X a class of drugs to treat anxiety and you will hear about that today during his remarks. Dr. Dooley's training includes BS degree from the University of Kansas, doctorate from Indiana University, and Helen hey -- Helen hey Whitney postdoc Doral [Indiscernible - static] cancer research fund in London. Dr. Dooley, it is a pleasure to have you with us today and thank you so much for your flexibility in joining us and we look forward to hearing your story. Dr. Dooley?

Are you still with us?

Yes, I'm still with you, sound check, are you there?

Yes,

They are, we can see you, that is what I was trying to do is a sound check and make sure we are life [Laughter]

, Thank you so much and appreciate the other panelist that are joining with us today and all of the folks that have decided to join in on the call. The message that I have for you today is the high cost of anxiety and we are going to look at this through the lenses of two current crises. The first crises being the opioid crisis and then most recently as of the turn of this year the obvious COVID-19 crisis and I am actively engaged in both of those as a research scientist and in business. Let us move into the topic of anxiety which is the overarching theme for

today's presentation. Obviously we will have it brighter than this when we talk about mental health generally when we get to the panel discussion but the focus of my talk is really around anxiety disorders. Anxiety disorders affect at least 40 million adults in the U.S., more accurate numbers probably about 45% based on annual privilege and it is broken down into a number of particular medical indications most notably social anxiety disorder that is also known as social phobia and that would include a condition for someone becoming a wallflower when they go to a party, a fear of interact with people and those kinds of things or somebody who just does not want to hang out with their mother-in-law on a weekend. So social anxiety disorder obviously is the or one of the major groupings followed by panic attacks which are grouped into panic disorder and a comorbid condition called acrophobia, the fear of being in public in the open forum and being with other people. Agoraphobic tend to stay home kind of like everyone of us on this call today. It is worth noting in there about 6 million people there. Followed by generalized anxiety disorder and that is a persistent condition of anxiety that last day by day by day, hour by hour. Where is social anxiety disorder and panic disorder their episodic in nature and pop up and go away and wax and wane. Finally things like specific of or specific phobias fear flying her fear of traveling fear of spiders, fear of balloons, there are lots of specific phobias. How common is this? I I'm not picking on women but I want to highlight there is a very recent study that was performed that just came out about two weeks ago, that demonstrated that greater than 10% of American women age 45 and upward are currently on prescription antianxiety medicines, extremely common and the preponderance of that is on the women's side, less on men. Anxiety, the comment comorbid feature in other conditions, such as posttraumatic stress disorder, obsessive-compulsive disorder, or mood disorders like depression. Next slide.

I want to friend the talk around the opioid crisis, which has tentacles into anxiety disorders. So why did 72 thousand people die in 2017 and most of them who passed away from overdoses, they died from opioids? What are possible solutions to this complex problem? Next slide.

I want to overview this really from three separate protect does and I am uniquely suited to do that. I want to talk about the opioid crisis personally and the impact it has had on my family. And then I will move beyond that to the professional view and finally a pastoral view. Go hit.

The reason that I am so heavily engaged in this topic is because of my son Thomas. My son Thomas died in early 2017 from an opioid overdosed death and pictured here on the top on the left, he is also a or to your left in the middle frame and in the center on the right frame shown with his siblings in the middle and on the right side where he is bearded, that was

shortly before his overdosed death where he is visiting his brother and sister-in-law. How did this happen in Thomas's life? As an adolescent, Thomas develop excessive compulsive disorder and in his case it manifested as County, he would enter her room and count ceiling tiles or chairs or bodies, he also had a cleanliness concern so he was a German phobias well. He was taken to a childhood psychiatrist by concerned parents really wanted to take care of his issue, and we did not even know what the problem was. We just knew he had 11 Sadie and he was diagnosed with OCD his primary diagnosis and immediately placed on benzodiazepine drugs and they are the go to antianxiety medicines that are PRN, fast acting, occasional use medicines for the treatment of episodes of anxiety and drug such as Xanax which is the number 1 leading product in that class and also Clonopin. Years later Thomas went to an oral surgeon had his wisdom teeth removed and for the first time in his teenage, young adult life he felt normal. So the opioids, the pain medicine, meant to deal with the peripheral pain in his mouth, actually worked on his mind and caused his mind to no longer have racing thoughts and ruminating thoughts so it actually inadvertently addressed his OCD. And then he eventually an transition to the prescription opioids from prescription opioids to Street opioids and then he died primarily because of fentanyl and heroin. And then at tramadol prescription at the age of 24.

The opioid crisis is incredibly complex and I do not want to spend very much time on each of the categories. But I have broken it down into a variety of topic areas, first of all overdosed deaths in themselves that is a major concern. We have the issue of pain management. Pain management by both ethical prescription pharmaceuticals as well as illegal substances, people who have pain very often use alcohol or illicit drugs to cope if they are not accessing prescription say opioid pain medications. The next category to the right is mental health where we see a problem with compounding addictive and dependent medicines, and that is also a very serious issue. A large percentage of people who struggle with opioid dependency have comorbid mental health problems. Another category, lower right, dysfunctional relationships, people who are actively engaged in substance abuse, very often surround themselves by other relationships that reinforce negative, even bad behaviors in their lives. I like to use this versatile a Proverbs 1320 and it says he who walks with Wiseman grows wiser but the companion of fools will suffer harm. The people that you associate with help to determine the patent trajectory for life and be choose to handle with people that are bad for you, you will be like them. It is who you associate with is a large aspect. Often if I'm giving this talk in a faith-based community I can also talk that about collapse of society and issues there as well. Towards the bottom of the slide we look at recovery from addiction. Many

approaches to recovery, they can be faith-based approach and it can be a medication assisted treatment, it can be counseling, Narcotics Anonymous, heroine anonymous, my son Thomas benefited from Narcotics Anonymous and I was grateful for that in the latter days of his life he was a regular tender and go nights to the sessions a step program with Narcotics Anonymous and grateful for that and it helped them. We also want to get at from a psychotherapy or spiritual perspective, how do you heal the historic roots of the causes? People do not just wake up with the SAG I want to be opioid attic payment they just do not do that and they read that usually from trajectory that starts with trauma in their life earlier in their life and trauma usually initiates a path and eventually they succumb to at the of substance. To the lower left was the issue with the supply chain that is coming in and primarily we are looking at fentanyl and synthetic opioids coming out of China, some of those being re-trafficked through Mexico, heroine is typically coming out of Afghanistan. And then up above that you will see access to information and we did not have that problem in the past. We all now carry smartphones with us and it is very easy to be hooked up with drugs in today's culture. It is very, very easy and you don't even have to leave your home and you just send a text and somebody drives by your driveway and drop something off in your front yard. Very, very simple. The last topic is justice and incarceration and I think that for my part of you that is an area I don't even want to talk about. I think it is just too late. We really need to address the issues on all the other areas of the quadrants of the diagram, next slide.

What are the addictive independent substances I'm talking about today? They are in the upper half of this diagram and there are four hundred so with opioid pain medications, in the upper left and most notably fentanyl, the main driver of the opioid crisis. That we also have a lot of pain medicines like oxycodone Hydro care don't and heroin on the street on the for right side we have and take Sadie medications in particular the benzodiazepine class drugs like Centex, and we will ignore the drugs on the bottom which also have dependent an addict of properties. Next slide.

How did the opioid crisis happened? The use of opium or heroin was established in the 19th and 20th centuries and that was well before any regulatory authorities like the FDA existed and people could do whatever they wanted and you could put opium into soft drink and you could put it into an elixir, and then we advanced to the 1960s and the 1980s where we had an urban crisis with heroin on the street. Followed by a number of pharmaceutical firms had developed high potency some attic opioids and things like fentanyl back in the 1960s followed by pharmaceutical firms came along in the 1990s and they started ramping up sales

very aggressive marketing tech six that were making people believe that these opioid medications were safe for long-term use. It had never been demonstrated in a robust clinical trial to be say but they were promoted as if they were safe and we are now seen a number of cases in the court over this examples would be like Purdue Pharma and other companies that are being taken to court over there false pleading promotion activities. The next thing that happened in sequence with the development of pill mills, pill meals were clinics established in certain regions where a patient could walk in the door, see a physician for a few minutes, three or four minutes and immediately be diagnosed as having a substance use disorder, opioid use disorder, and immediately given a prescription and then they would walk to the next room and next room would be the pharmacy that would dispense the pills directly for the and it was a way, I would say, a way of legally diverting medications that should not have gone to people on the street and it was the loophole that was open for a season and it drove a lot of people towards prescription drug dependency. Then we shifted from that to Street opioids, and then finally fentanyl came into the supply chain, fentanyl has been the primary reason that people have been dying. Next.

There is another problem in this and it is this relationship the comorbidity between people who have a mental health problem and they then become dependent on substances. And mental health disorders primarily anxiety and also secondarily mood life depression, they increase your likelihood of prescription use of opioids out adult or adults with mental disorders receive 51% of all opioid prescriptions and that is a skewing of the demographics of normal society so opioid medicines are not going uniformly across the demographics. They are clustered toward the people who have an underlying mental health disorder and one would speculate their pain is no worse than people who are not in that category. So the problem we have is that the standard of care drugs that are used to treat anxiety that are the Benzodiazephines, they also have safety concerns within the opioid crisis and we now have an opioid Benzodiazephines dilemma layered on top of the opioid crisis. So it is actually a new or evolution of that. So one of the problems on the streets, we see high potency synthetic opioids, fentanyl, 50 times more potent than morphine and takes the equivalent of about two grains of salt and that much material about two milligrams of fentanyl to produce a lethal effect and part fentanyl is 10,000 times more potent and you don't even have to see a trace of carfentanyl and it could kill you. And then unlike inherent drug dealers who cut their drugs to make them less potent on the market so they can sell more doses, today drug dealers go the other way around and they actually enhance the potency of their medications by including fentanyl because they want the street to recognize they are selling really good stuff. They also

want people to overdose and I know this firsthand and I talked to a lot of people who suffer from opioid use disorder every week. And they will tell you that this is true. They want to go to drug dealers who are selling really potent heroin on the street. And then finally we see the communication with cell phones exit very easy to access this. Next slide.

Back one. Back one, no, that one.

So the euphoria of the Dragon that is the high that one experiences while on opiate, is only part of the reason why people like it. Once a start using it they are drawn because the euphoria makes them feel good and they've tried it at a party or with their friends, indigo, I just feel mellow, feel calm and I feel like I'm drinking a martini on the beach and I feel great, I feel calm, but if they persistently use it and then withdraw, the withdrawal symptoms are horrible. With opioids, both of them become drivers behind addiction. The opioid high and the opioid low in combination creates a high level of drug dependency. Then we also see that persistent use of opioids can damage lesions in your brain and I happen to know the first time that I knew my son was an opioid addict, in 2015 I was called to an emergency room in Tuscaloosa, and my son was there, we were called by the emergency room Dr. Mack doctor and he said he's apprised meet your son is near dead and you need to get here very quickly and we have a very, very serious situation and your son has condition called rhabdomyolysis where the muscles are breaking down because he had been immobile for too long. And then he let me know, is your son an opioid addict? And he said not that I know of. And then when I arrived at the hospital he said well we did a brain scan and there is evidence in his brain of lesions in his brain. Cause from opioid use. It actually can cause what we would consider to be permanent damage to your brain. Then we also see heroin coming into the state and fentanyl comes into the state and if you bundle all of these problems together, you can quote me on this, we have never in history had more effective way to kill of her own people than with high potency opiates carfentanyl. We have never in history -- fentanyl we have never in the history of Western culture we would call this a man-made catastrophe.

Next. So one of the things that I've been working on as a result of watching my sons OCD and his acute anxiety for many years and I work on the pharmaceutical industry and I am at drug discovery scientists and for years I thought somebody needs to come up with something to replace drugs like Xanax and so I pondered this problem for a long, long time and I worked on it for or than one dozen years and eventually came up with a solution so the reason of the problem we have with Benzodiazephines is that although they work and they can work fast relief anxiety, they have potential for dependence and tolerance meaning you need more and more of the drug over time and they in some cases can lead to addiction. The FDA a few

years ago issued a warning for Benzodiazephines saying you cannot use them in combination with opioid pain meds. The solution I came up with is a combination of two classes of already approved drugs, I have been repurposed and patented together for the treatment of anxiety. The PanX medication combines beta blockers and helps your heart [Indiscernible - static] such as scopolamine and you put the two in combination, you get the benefit of slowing down your heart and also addressing your CNS, the mind as well and I can report to you that that is a program that is now or has been submitted to the FDA so we hope to have FDA guidance suit about our clinical development of the PanX drug so this is brand-new and we do have proof in patients and two kinds of settings are ready and we have tested them in psychiatry and Malibu clinics, and we have also tried them in pain management clinics as well and we have got evidence in patients that it has a calming effect without using a substance known to be dependent or addictive. Next slide.

Now I want to turn to really the faith-based component and this is the pastoral side of my life and I am a volunteer every Tuesday afternoon and evening and I spend a lot of time with the women of the Lovelady center in Birmingham and is the nation's largest faith-based residential drug recovery program, 400 women in what used to be a former hospital and most of these women have had histories with opioids. Next slide.

And the women in the center of the photograph with the red here in the front, her name is Brenda, Brenda spanned the founder of this organization. And I have the opportunity of being there and I'm one of the pastoral participants, invited in to help and 400 women in the program and they do a whole way house approach very often the women that we have have had incarceration past. Probably three fourths of the women have been in corporate or incarcerated probably about three force or more have had opiate histories and almost all of the women have had substance abuse problems in their lives. But the one thing that is common to almost every case is a historic trauma. One of the things I think that I learned and I personally learned from being with them, I had been around my son and experienced his struggles and his life issues, but to see it through the optics of a female struggling was different. It is quite different. One of the things I noticed in working with the women is that almost all of them started with an assault, physical assault or sexual assault early in life. All most every single woman. If a woman walks in the room I can already predict and prophesy to her, you probably have had this and this and this happen in your life because of the preponderance of the circumstances and later in the talk this will be discussed further. So we also have a Judeo-Christian emphasis and we have no government support, we have counseling, medical assistance, bent or dental assistant and we also have the women work

hard and are thrift stores so they help to generate income for the facility and it is a nine-month program and the ultimate goal is to establish them [Indiscernible - static] love doing this [Indiscernible - static] redemptive thing for me [Indiscernible - static] suffered a lot because of my son's life and [Indiscernible - static] in part hope to these ladies. Next slide.

One thing I want to say is when we are dealing with the issue of opioid addiction, I am a firm believer get all hands on deck and you don't have to be a person of faith to benefit from these procedures. You can be agnostic, AP is, whatever you want to be and my view is if Narcotics Anonymous works for you, great. Faith-based programs work, grade. Medicines work, grade. It is not A versus B but it is letter a and B approach to therapy. But whether some of the solutions we have for open crisis first? Develop new pain medicines that are non-addict, examples and researcher gabapentin which is used for peripheral nerve pain and ketamine which is being repurposed today and cannabinoids and things related to marijuana and they are being studied and I personally prefer the idea of redesigning opioids that bind opioid receptors but they lack the CNS activity, lack the you 40. We are also working to develop new classes of antianxiety medicines which is PathClearer excuse me PanX which I am working on. We are also working on my can, naloxone and that is an and taken is a compound that blocks the effect of heroin or morphine or opioid on the receptors and it can bring individuals back to life and this thing is a genuine lifesaver and it is getting into the hands of first responders and getting into the hands of policemen and firemen and EMTs, and it is doing a wonderful job of maintaining life until we can get a person into some kind of a subsequent treatment. Next slide.

There are obvious different kinds of different recovery solutions out there make it one can use medically assisted therapies like Suboxone or the patrol. And at present the best solutions that we have available for the treatment of opioid dependency is to use one of those medicines. And preferably one of those medicines in combination with counseling or some kind of accountability so there is very good evidence that they will help you. If you are addicted to opioids and do not take on MAT approach your probability of relapse of drug relapse is up to 80%, extremely high so you need to use this to help you mute those relapse weights. Counseling is outstanding and it is not just counseling initially but it is ongoing. Finally we need to address the issues of fentanyl reaching the streets. Had a wonderful opportunity recently, I was at a dinner and the former head of the Justice Department came in sat at my table any sat down and he says, Dr. Dooley, have we made any progress on addressing this fentanyl issue and is fentanyl the big deal and it was wonderful, I had a beautiful dialogue with former Jeff sessions was ahead of that, and I told him yes, there has

been some progress in addressing the importation illegal importation of fentanyl and hopefully that will help address this. Slide.

I like two of the things that I personally have been engaged in is a restoration of hope through two means and I would say since my or since my son died it was as if God put a fishhook in my mouth and pulled me sideways and I had never set out in my life to devote so much of my bandwidth of my time towards substance abuse. It was not really on my waiter and I was working on other things. But as a result of what I saw, the pain and the loss of our son, my life has been largely diverted and for the past three years plus, I have devoted a lifetime to redeeming the loss of that pain, one of the things is a book that ironically arrived before my son died called Hope when everything seems hopeless. This book was actually dedicated to my son when he was suffering from OCD. And then I also helped to establish PanX replacement for Benzodiazephines so we can take horrible experiences in life and we can be resilient over or over comers in spite of that. Slide.

Now we are going to transition into what is happening on the COVID front and I told you today, two for the price of one. We are going to quickly look at the issue of COVID. I actually work some in COVID too. It has been also adopted my plaint recently as a research scientist and I am delighted to be involved in its. Let us look at the COVID pandemic and its relationship to mental health. The issues that we are facing are multifaceted. We have economic drivers, loss of income, disruption of lives, all of us today, almost everyone of this on this color probably at home sitting on a computer or looking at her mobile phones, our lives have been disrupted and we have had loss of rights and freedoms. We have also had information flow that I think has not been good for us. We have had misinformation in media reports, misinformation from politicians, misinformation from social media. And at its core, it really addresses a lack of wisdom and the lack of knowledge. So we have got that it generates conspiracies and we have conspiracy same, 5G radiation, electromagnetic radiation is a contributor of the driver in the COVID as not a virus and we have people believing all kinds of silly ridiculous things and espousing them online. It is also producing a distrust of experts, physicians, politicians, that is not good. As result of this one of the consequences? Stress leading to anxiety. Confusion that is leading to worry, ruminating thoughts, obsessive or obsessions and compulsions and insecurity. Followed by trauma that can ultimately lead to posttraumatic stress disorder. You bundle all of those things up, what are people doing to address it? People are turning to alcohol and listen to the reports, beer is moving off of shelves faster than ever before and people are also going to become even more dependent on substances. It is my prediction as well as virtually every authority in mental health today will

tell you that anxiety disorders are definitely going to increase above the 40 million individuals already diagnosed. Next slide.

Let us transition the opioid crisis and the COVID crisis aspects into employment. This is my final slide and went to transition off from here. There are ways in which employers can help facilitate the mental health of their employees. We have external means to do that. Referrals can be made for medical, psychiatric or psychological assessments. There can be medical and or not medical treatments. And there are also residential programs for substance use disorders. There are also ways of doing psychological counseling, spiritual counseling, and in many cases grief support. Because there are families that a been affected. I have three people that I know friends of mine that of had COVID and I have a friend in Chicago who was intubated four weeks and recently taken off of intubation and I had somebody in England who has recently been released from I see you and I have another friend who was treated as an outpatient. So we are going to have grief as a factor as well. What are the things that can be done by employers internally? Employee assistance programs, where accommodation is made for mental health disabilities. What we have had here or here to for recent history, we have often had combinations for somebody who has an orthopedic problem, a person who is wheelchair-bound person who has trouble with their limbs. A person who is paraplegic. Those things are obvious because they are externally visible. Mental health issues are often not externally visible to coworkers and so we have to be aware of the fact that these can also be disabling. Some of the questions I want to kind of used to kick us off towards our panel discussion are will employees fear reporting a mental health condition perhaps to a supervisor or two colleagues? In view of the fact that they might perceive the rifts of some social stigma that comes from that payment if they are saying I am having panic attacks, will a coworker think less of them? Will their boss think maybe this person is no longer promotable. And so this is an issues, social stigma and fear of reporting. Second question, how well the employee confidentiality be honored yet while making an accommodation? And finally it is the flipside of really it would say the downside to the opioid crisis and that is I have already given you examples from my own life where I have taken a tragedy in my life and I have used those to go from bad to better, from a lemon to lemonade. There is this whole concept of bolstering resilience, resilience means that in spite of my pain, in spite of my trauma, can I become stronger, can I learn new skill? In spite of the tragic encounter? So one question for employers to really press into is how can you as an employer bolster resilience in the workplace? And we need to recognize that if you look at a population, broad population of people who all encountered the same event, they all encounter say, 911, not all of them are

going to process that in the same way with the same outcome. Some of them might develop PTSD, many will not. And so we need to know that people are different in their ability to develop resilience. With that I am done.

As expected, it was full, thank you so much for your willingness to join us today and this is an important topic and we want to transition now to our roundtable and have continuing conversation with her panelist but first I want to introduce to you our facilitator for today's roundtable. His name is Jonathan Kappler Senior advisor and Chief of Staff to the deputy secretary for behavioral health and intellectual and developmental disabilities at the North Carolina Department of Health and human services. In this role he leads special initiatives and supports a deputy secretary and other department officials leading North Carolina public behavioral health system. Jonathan previously served as Executive Director of the North Carolina free enterprise foundation, nonprofit organization that provides the states business community, nonpartisan political research and analysis. In this role he was widely recognized for his objective analysis and earned respect across the political spectrum. Prior to his role at and CFD at he served as interim vice president of federal relations and director of state government relations for the University of North Carolina system where he represented the 17 institutions that comprise the University of North Carolina in business before the North Carolina General assembly, state agencies, years Congress and federal agencies. Jonathan earned his undergraduate degree in political science and Spanish and holds a Masters of public policy from American University school of Public affairs. Jonathan is a past President of the Appalachian alumni Association, fellow of the North Carolina Institute of political leadership and a member of leadership North Carolina. Again, Jonathan, thank you so much for joining us today and your willingness to serve as our moderator and I will turn it over to you to introduce the other participants in today's round table. Jonathan?

Thank you, I'm so glad to be here and appreciate all the work that disability, Diability IN Carolina and the team does to bring these issues to the forefront and work with employees across the state and partner across the country to help collaborate individuals with different disabilities into the workforce and I will actually let our panelists introduce themselves and give you little bit of background about their expertise and the unique circumstances and where we could find ourselves here often working from home in the midst of a couple of crises [Indiscernible - static] Dr. Nadia Charguia.

Thank you for the opportunity to join IM Nadia Charguia psychiatrist with UNC [Indiscernible - static] done my training brought my residency Fellowship [Indiscernible - static] John in the panel today and have a couple of different hats that I think are relevant to

the discussion and certainly my background in mental health and also director of outpatient services for the Department of psychiatry and in addition [Indiscernible - static] which is a program that seeks to promote wellness specifically have been driven towards physician but in the midst of the COVID crisis and certainly with [Indiscernible - static] to try to meet the needs of our entire group of healthcare workers at UNC working with [Indiscernible - static] certainly it is a pleasure to be able [Indiscernible - low volume] amazing group today.

Appreciate you being here and expertise that you bring with us and is Cris on?

I believe so, are you on with us, Chris Hendricks?

Actually he is not able to join. I have not seen him.

Okay, all right.

[Indiscernible - static] Dr. Dooley hanging around for this portion of the conversation and appreciate his capacity to join us and add additional expertise and thankful for information that he shared and I do just want to double down at the beginning of the conversation here in a couple of points and one that mental health and behavioral health are really important for health issues and there's a lot of members out there that those issues can affect between the third and one half of Americans at some point in their lifetime. And then in the course of any one year, one in 10 Americans will suffer from depression, or in the course of their lifetime. The opioid epidemic which Dr. Dooley did talk a lot about is a big focus of us here in North Carolina at the North Carolina Department of Health and Human Services. Out of the 10.4 [Indiscernible - static] our data suggest that there are well over 400,000 individuals who misuse description or illicit opioids. But as I think Dr. Dooley really alluded to in his presentation, that opioids and this kind of current crisis is really part of a long-running data was substance misuse disorder and their are other issues behavioral health issues that really underline [Indiscernible - low volume] the specific crisis that we are in so mental health and of course physical health very closely connected and mental illnesses and life depression and anxiety can affect people's abilities to participate in healthy behaviors and similarly on the reverse side physical health problems can have a serious impact on mental health to decrease a person's ability to participate in treatment and recuperate. So this pandemic has shown I think that COVID-19 pandemic specifically has shown how to health is really central to how all of our ability to interact and hopefully in society generally as we are going on and what is this eight or nine? [Indiscernible - static] here in North Carolina so I do want to just quickly note before we get into the meat of the conversation here, that [Indiscernible - low volume] Health and Human Services at this time to do what it can to support not only individuals but also employers by providing specific guidance around how to respond to COVID especially

as we begin this process [Indiscernible - static] restrictions from our initial response phase and provide guidance that is overly communicated clearly and this goes back to something Dr. Dooley was a friend to which is that with so much information coming out of [Indiscernible - static] zero in towards the clear and reputable credible information. So we are working hard to not only disseminate that are cells in the Department of Health and Human Services but also to aggregate that for you. To communicate that information clearly and then where we can, seen that there are specific programs that can help individuals and employers and one I would like to highlight and I know there is work going on at UNC that Dr. Nadia Charguia can talk about but [Indiscernible - static] human services dealing with the mental stress in their profession and what we were for 24 [Indiscernible - static] mental health hotline and helpline resource for healthcare professionals broadly defined who are really on the frontline of responding to the COVID-19 pandemic and so they are under unique stressors in this environment so we have tried to develop resources so they can do [Indiscernible - static] have their mental health issues effectively addressed. So I will kind of pause there and in terms of my introduction and I will ask the first question [Indiscernible - static] referencing something that Dr. Dooley was [Indiscernible - static]

Jonathan, forgive me, participants are having a question and there's a Q&A panel that you can submit the question so just make sure that you enter it and click send and we will categorize them and bring them to our panelists. Thank you.

Thank you, Cris, appreciate that. I was speaking with her chief medical officer at the Department of Health and Human Services that oversees her [Indiscernible - static] ID system and she introduce the concept of thinking about our response to COVID-19 [Indiscernible - static] broadly through the lens of trauma and that was not something that I kind of initially thought of and it was something that [Indiscernible - static] specifically and Dr. Dooley's presentation around [Indiscernible - static] so hoping that you could maybe talk about that and as a way in which to view our reactions behavioral health reaction to COVID-19 and other behavioral health issues.

Sure, sure, happy to. It is a trauma that was not necessarily aware of as you mentioned I don't think globally we are nestling [Indiscernible - static] trauma any threat or harm to self or direct threat of harm to others who are in our closed network and when the threat is something either perceived or real, it is a reaction that we internalize. Elevator to experience a trauma is different than experiencing trauma disorder such as PTSD. However, anyone who is at risk of experiencing a trauma and unfortunately the current crisis that we face with COVID like opioid crisis, epidemics [Indiscernible - static] long-standing concerns, multitude

of other things are [Indiscernible - static] exposed to that we have a tendency to potentially internalize [Indiscernible - static] when I look at the lens as a healthcare worker, we are often in a pattern of just go and do and take care of and I think we are a group at I will not say that this is unique to healthcare workers by any means. Where we will often deny what we are going through and what we are experiencing [Indiscernible - static] knowledge and with that then I think fear is more of a risk if we are internalizing [Indiscernible - static] we are all scared at some point right now, right? This is unprecedented. We don't know what to expect and we don't know when it will and that we don't know what the best way to address it and where learning as we are going. We are learning the plane as we are flaying it, right? But if we are denying that expansive we are not processing it, we are not [Indiscernible - static] help us process it [Indiscernible - static] there is risk that there are some things that will help [Indiscernible - static] [Indiscernible - low volume]

Maybe you can speak to a little bit about what are some healthy coping mechanisms for individuals particularly is it something that maybe employees could help support as individuals are kind of reacting to the situation that we are in relevant to COVID?

Yes, absolutely and as Dr. Dooley pointed out are not of the mental health or want to say struggling and just the experience and the emotional experience is something that we do not necessarily want to carry on our shoulders and I think a lifting conversation and reaching out to our employees, leaders, both expressing our own vulnerability as well as letting others know that we are there for support, there is so much benefit and value in just soliciting these conversations, trying for the feedback and joining in what we know is a shared experience unfortunately we are all going through this but there is so much value and I greatly respect as Dr. Dooley pointed out, it does not take it or you don't need to have a psychiatrist or psychiatrist or [Indiscernible - static] there are so many they [Indiscernible - static] that sport can be elicited. Having these conversations and it is such [Indiscernible - static] when we look at who is at risk [Indiscernible - static] those who have support networks and we have to pull a little bit extra harder these days to make sure those are in place. Those are some things that any of us can do [Indiscernible - static] encourage all employers to provide.

Yes, I do want to double down on that point. As so many of us have transitioned into working from home, or just simply haven't our lives disrupted, personally and professionally, I think that it is more incumbent on us as colleagues, as managers beyond those individuals in our workplaces primarily in human resources space who have data days who is focus on employee well-being but really think about what our colleagues and employees are going through and kind of taking it on ourselves to ensure that we are maintaining this connection

that we get to day today in the sense of community that we are missing because of the situation we find ourselves in and I know some people [Indiscernible - static] teams that I have worked with is to really think about my job partly is trying to actively maintain those connections with individual so that you can have those conversations and make sure that folks are stable and in the situation that is healthy for them given that we are in such an unusual circumstance.

Now Dr. Dooley, you are talking a lot about -- I guess really your presentation the hookahs around opioids and COVID but you are really talking about anxiety and what that does as a primary driver of behavioral health issues in this country. I was hoping you could dive a little bit deeper into some of the aspects of anxiety [Indiscernible - static] physical ramifications of that and how it impacts her lives in ways that we don't even take about.

All right, let me do a basic biology lesson up front. The basic biology of anxiety is that we have neurochemicals or these hormonelike molecules, floating around in our bloodstream and they are really two main classes of compounds that are coincident with a high state of anxiety. One of those is cortisol so if you take hydrocortisone and you put it on your bug bites and swelling on your skin for eczema or dermatitis, that molecule is the same thing, it is cortisol. And cortisol is a protective molecule in her body and if we encounter some kind of a trauma, as Dr. Nadia Charguia was saying and if we have trauma are cortisol levels are checked up and then they provided long-term latent benefit of trying to protect us for energy storage and stuff like that so that is one molecule that is important but we do not want high cortisol levels all the time. We only want them transiently. That is important. The second is molecules that are called catecholamines, molecules like adrenaline, and adrenaline we know all of us have had that experience of we are startled, something or we hear a noise and a sound and immediately our hearts start racing very quickly and we receive palpitations and it feels like her heart is jumping out of her chest and her blood pressure checks up. That is due to adrenaline. It is a different part chemical pathway than cortisol is. However, the two together create a synergistic effect that can check you up into the clouds in anxiety. And so if a person experiences say performance anxiety, common thing, some people hate to be behind the microphone and cannot stand it and they can be a musician, speaker, whatever, and they get up there in the go, I am afraid of singing today, I am afraid of performing or taking a test in public today, and they get a spike of both of those chemicals. That sets the biology lesson and I usually do not do that, okay we have a basic biology lesson so the goal is how do we keep adrenaline levels down and how do we keep cortisol levels down. There are a lot of coping skills that can help us there. Many coping skills. Outside of using pharmaceuticals,

I've worked in the pharmaceutical industry since the 1980s and I worked on Rogaine, minoxidil [Indiscernible - low volume] Upjohn way back then and I've been in the industry a long time and many people do not realize that the difference between a drug and a tocsin is only the dose. They are one and the same and a drug in a tocsin are identical just dose-dependent. And so I am not an advocate for medicines as the first course and unless there is really good clinical evidence to say that it works., right? And there is mental health there are a lot of advantages to the classes of medicines we have out there today so medicines that seem to work for anxiety that works sort of the first tier of medicines we go after would be medicines call SSRI, they can help they can help prevent you from progressing into higher states of anxiety and then once you have acute event of anxiety then you can take control or if my drugs eventually prove you can take PanX so there are medical approaches but there are other ways to skin the cat and the other way that I like to think is really ought to be our first line, counseling, and dealing with root causes of your anxiety and that is an important factor. Another one would be exercise and just maintaining a good physical condition. People who get up and get off their butts and get out and walk around a mile or two a day and even in the course of our date sitting here on Chats of the get up and walk around some it allows our body to adapt to this very unusual posture that we are in and that can help destress us and what it can do is it helps us shift a couple of things in number 1 of the cardiovascular system is healthy and we have a good resting heart rate and that is good for us. Her blood pressure is lower and that is good for us. So just the exercise itself can benefit the heart but it can also benefit your dopamine levels and neurotransmitter that determines whether you experience joy or not life and we want to maintain good dopamine level so exercises one of the good ways to do that. Diet, under the category that we can focus in on. I would say exercise and diet are two things that are directly deployable in the workforce. Exercise and diet without medication, all employees could do that. They could tell their place, okay, we will have 15 minute break and go out and walk around the yard outside, some people use that for smoke breaks and I do not advocate that. But I would say the opposite of a smoke break payment a health break. And we could start advocating that at we could have activities based around exercise and events based around that. We could also have events based around healthy eating. That could also be an official because we need we have too many people that are stressed out and there cortisol levels are high and we have people that are eating diets that are prone to producing diabetes and obesity. And so by pulling back the reins on those things that Everson a person should be able to do something about we can address some of that, John.

You actually kind of led into an area that I want to touch on at some point in today's conversation, ways in which kind of managers and employers can kind of thoughtfully monitor their employees meant to help and tips about to go about that and then talk about that you are talking about physical elements that are so closely tied to our behavioral health wellness. And so maybe you can kind of dab a little bit further into that and some ways in which employees and managers can really kind of thoughtfully engage in that with their employees.

I will endeavor to Dr. Nadia Charguia, what you want to weigh in on that?

I think what was immediately coming to mind is, not off-topic but not quite you are looking for, I think even being just aware and if you see shifts or changes in an employee, activity perhaps or productivity [Music] or maybe their throughput is not what it used to be, I think eliciting the conversation of how are you doing rather than why is this going on? [Indiscernible - static] [Indiscernible - static] that could be a sign that emotionally they could be struggling a bit more. That is just one way, what is the one choice that we have when we are approaching any of our ways with their colleagues? Yes, I love the idea of the health break and hopefully that would be uncoupled from the smoke break. [Laughter]. Automatic moment to destress. Evenly chitchat in a meeting, starting with the five-minute icebreaker at the beginning or ending, from drying in that wellness flow, I think also can go a long way. Dr. Dooley, do you have other things to add?

No, you encapsulated my thoughts as well. Of the issues that we haven't talked about, and one that we can advocate for the will have a tremendous impact and anxiety status is sleep. Sleep is huge. If I took the 400 women at the Lovelady Center and had only one minute to tell them one thing, the one thing I would tell them to help them is have a regular sleep cycle and get eight hours of sleep. Very often people who are drawn into substance abuse they are doing it in the wee hours of the morning and there circadian rhythms are all whacked out and you cannot maintain good health without regular sleep cycle and a sleep cycle program is something that employers can talk about. You actually have a program in-house, not only a wellness break instead of cigarettes, but if you have a direct program and you advocate your employees and say okay to date we will have a psychologist, psychiatrist, and they will talk for 15 minutes on the benefits of sleep. It is simple. And you can do this and it is not threatening to people. The folks who have, let me say, the folks who have chronic obsessive thought patterns, they lay in bed at night and my son is a young teen laid in bed at night until three in the morning and he could not sleep and he would have this I will call it like a squirrel cage of thoughts, rolling around and rolling around and ruminating thoughts, over and over

100 times, could not get to sleep. With all of the nonsense that we encounter thanks to Steve Jobs and his colleagues, this is another thing we could do is we can advocate for cell free downtime at work so I have given you three, wellness break, program on sleep, and turn this noise off. How is that?

Smart, I will try to incorporate that myself [Laughter]. Getting a good nights rest, everything we would like for certain. One of the things that I am hopeful actually about in the context of this pandemic is that we have all experienced it in some way, if it is simply having to transition to working from home which is [Indiscernible - static] complications there are a number of individuals who can certainly have larger disruptions and they of lost their job and we have had individuals in our lives fall ill and some who have lost their lives and so we are all participating in this in a way in which is not difficult, I think, for most events even broad-based events in our society and so I am hopeful [Indiscernible - static] space the shared experience in some way and it being different for everybody but the shared experience early and allows opportunity a window of opportunity to kind of break through some of the issues associated with stigma as it really relates to behavioral health services and the barriers that they present to individuals kind of addressing behavioral health needs and so touch on this [Indiscernible - static] presentation and maybe you could divan a little bit more based on your research and experience around the problem that stigma presents to individuals seeking out and receiving kind of helpful and needed services.

It is an important issue and frankly the stigma aspect of mental health presented my wife and I four years from knowing what was going on with her son and her son was fearful of coming to us and just putting his cards on the table and say, I do not know what is going on, I'm struggling. He put on a man it up kind of approach as a young boy. And we were seeing signs of a mental disturbance and we did not know what it was. I will give you an example, he would take really long showers and I will go beat on the door in the shower and say, this is a household of six people and you're using up all the hot water and come on, come on, he was a teenager and I was like, you know, I understand girls usually take longer but boys do not need to be taken a shower for 14 minutes. I still did not recognize that that was a symptom of OCD. He was covering it up effectively. So the shame in his life, he never really wanted to come forward. I experienced it later in his life went or once he had become addicted to opiates, it took years for us to uncover that and once again shame driven reaction. And so they create patterns and especially when dealing with people who have developed a dependence on a medication, shame is a major driver and deceptive tactics become really comment. They arrange their life in a way to try to deceive you into thinking everything is

fine. And so that shame, deception matrix plays up so I have had or have seen that first hand and the consequences of which if I could roll back the clock and keep my son alive, let me tell you what, I would much rather have my son alive then be on this panel right now. Show it yes, I'm hoping we can double down on the implicated situation it is creating frankly I think the opioid crisis is starting to get us in that direction.

It was a place [Indiscernible - static] societal opinions about how to put some of these behavioral health issues but those issues still are there and I think it is a very pernicious problem that we continue to deal with as to how to remove that as impediment to individuals who are keeping her sick in the care that they need and I can imagine in your line of work, Dr. Nadia Charguia, you can see it with health professionals where individuals do not want to acknowledge some of the issues that they may be going through including if it has something to do with substance abuse disorder.

Yes, I indeed anyone and everyone, and it or there is not anyone that is safe from it by any means. [Indiscernible - static] hard to draw upon those healthier ways of coping and sometimes [Indiscernible - static] [Indiscernible - low volume] unfortunately times like these or times that addiction is a real risk. And folks who previously suffered from it [Indiscernible - static] time that is incredibly concerning for the entire risk of relapse. Dr. Julie, appreciate what you're saying in regards to shame, that shame cycle that is so blinding and isolating to individuals and yes, I think there is also a tendency is well for minimization where folks will minimize their own struggles and I think when you see this is a pandemic and this is a fact Dean everyone and there is also this tendency to compare my experience to the experience of others and to minimize my own experience. While it is not as bad for me as it is for them, I have no right to feel [Indiscernible - low volume] they lost someone to COVID and I have a family member that passed away from it so I should not be struggling. But that is an innate tendency I think especially when you work with professionals who have the tendency to have professionals often with the mort type A personality or perfectionistic type of personality so the struggle is real and the conversation around [Indiscernible - static] experience in the have a right to their motion. Trying to help encourage those conversations, share all of our vulnerabilities and sometimes can be await to [Indiscernible - static] just repressing it and talking it away and acknowledging it, where they just fester and they become something more [Indiscernible - low volume].

Nadia, Dr. Nadia, I am thankful. For those of you who are in the medical profession we have the liberty to call each other by first names. Peer to peer we get away with it so I have to elevate her title here today. So Dr., doctor I want to thank you, thank you for what you said

there. Can you weigh in in this current crisis one of the key issues that we have had is this physical separation and we know that physical touch and loneliness our drivers to psychosomatic issues. Would you please kind of weigh in, we are creating a real dilemma right now. And for these months that we have already passed through and the months to come where we are physically isolated and not touching people, you touched on it by saying people who are prone to substance relapse, they are having a hard time right now because they are used to going to an AA meeting or AA meeting or used to going to a counseling session or face-to-face, and I will also say for the sake of all of the participants in our call today, everyone of you has benefited because you got to spend time for free with a psychiatrist. You did not have to pay for it. Psychiatrist time is valuable and it is precious, they are hard to get, hard to get in front of a psychiatrist, but I will press back, setting that aside, let us look at the issues of loneliness and touch.

By all means, disconnected nature of this current crisis, yes, I think it takes the extra thoughtfulness to then force connection. I think it wasn't something that you said, there is a way to express connection, that does not require touch but we have to be more deliberate. Deliberate about it. I will add on a labor of disconnectedness that I think is something that our society is facing at this time [Indiscernible - static] text treatment we text, we don't call. We send an email, we don't Do we turn video off half the time when we are zooming so being more conscientious about taking the extra step to really [Indiscernible - static] recognize that [Indiscernible - static] what we are seen in the lot of her healthcare workers is also disruption of teams. We would gather in a conference room as a habit and talking about a patient's on a daily basis, on rounds, having conversations with nursing staff with OT and RT and a residents and students, and now we are all in our corners and I may have to have five different phone calls [Indiscernible - static] rather than that one just interaction that we would not even think about and that we all just have been taking for granted. Trying to lead more purposeful conductivity to really force the touch as it were and doing it professionally encouraging others to do it socially. Also.

Can you weigh in on this as well because my wife works in a retirement center. They are on lockdown. Fortunately their facility has not had any cases of COVID. And it is answered prayers, we are grateful, they have not. Many eldercare facilities are taking it on the chin right now. We do know that in geriatrics, physical touch, audible presence is important. What do you think is going to happen because we are very likely or I would predict we are likely to see nursing homes still in isolation for six months or longer. It is going to last a long time. It might be a year, I don't know, it could be way out there in the future. What do you think is

going to happen to the mental health of the patient that are in retirement? We are talking 60, 65 years upward? What do you think?

I think the risk of when you see the isolation and lack of connection [Indiscernible - static] risk of it, developing into more pathology and depression I think it such a huge, sewage risk right now when we look at their some data -- Cheech, sewage risk and right now we are seen some data there coming our countries [Indiscernible - low volume] depression rate sort and among [Indiscernible - static] upwards of about 50% of individuals in the Wuhan province [Indiscernible - static] look at the distancing measures and I think they [Indiscernible - static] I will not applaud much but we will not get into politics but I do applaud the different [Indiscernible - static] social distance, physical distance.

I agree.

Disconnect those are key --

[Indiscernible - overlapping speakers]

It is a misnomer and somebody should've cut that early on and said, no, no, we want more social connectedness, but it is a physical piece.

I think efforts and this is where too, local organizations, business leaders, that area organization, trying to help identify who are some of these groups and what are some of these at risk facilities and are there ways we can help in ways that we can help you in nursing homes, assisted-living facilities, group homes? Often these are individuals who are financially limited.

Right.

Not have access to technology to promote some of the connections happening at least in virtual realms. Are there ways that we can get computers [Indiscernible - static] ways that we can help [Indiscernible - static] technology so we can help [Indiscernible - static] different ways we can address that.

Yes, thank you. I know that the focus of this panel is really towards how do we assist employers who are considering these issues? But eldercare is important to all of us. We do not just take our eldercare responsibilities and set them aside just because we are at the workplace.

Right.

We have this pervasive concern that is my or like my grandparents, are they going to be okay? Are the at risk? And currently based on what we know about the pathogenesis and epidemiology of COVID-19, it looks that the elderly, people over age 65 are highly, highly at risk. And probably the wisest healthcare policy any nation or state or region can do is to

maintain isolation of the elderly. And especially the elderly who have comorbid issues and have obesity, hypertension, they have diabetes, I think it is number 1 on the priority list, we have got to Maine taint that policy. We are in a little bit of crapshoot right now because states are changing the policies and there is more laxity going on. But I will be the first to jump to the front of the line and say, do not, do not stop this policy of isolation of the elderly.

Right, important point is that especially serving in the process where there is an evening of restrictions across states in the country and the globe around the world, everyone is in a little bit of us different circumstance and I think we as individuals cannot control everything that is going on around us and we cannot control our reactions to individuals and I think that being kind and having an understanding that we may not fully understand, situations with or that others are in and what they are experiencing I think is an important lesson as it relates to COVID-19 specifically [Indiscernible - static] issues going on there but then also I think translates effectively into the conversation that we are having around individuals in the workplace and their colleagues minimum behavioral health needs is that we are frequently [Indiscernible - static] operating fully and approaching it with kindness and understanding and really like the way that Dr. Nadia Charguia references where you are asking questions and just trying to elicit the conversation, right? So you can bring someone into the fold, right? Especially if they are in the situation that we are in now [Indiscernible - static] connected. Something that stuck out to me and another think that I've been thinking about through the context of conversation is we in North Carolina and we have participants operably from all over here today but North Carolina we have a lot of experience in dealing with disasters in the context of specific events of mostly hurricanes lately so especially in North Carolina and those are kind of discrete events that last maybe hours or days and went we have been thinking about that trauma in these behavioral health issues that happen following those kinds of events we have noticed in our kind of policy responses that we really see a peak in behavioral health needs many marked after the individual event itself so in the context of COVID-19, pandemic that is so ubiquitous widespread and kind of slow moving, where we are really just now kind of in this still and of the crisis phase emergency crisis response phase, the behavioral health ramifications of this I think you do not really fully have our arms around, nor do we have that timeframe and understanding what the timeframe is going to be and so I want to maybe kick it off to both of you to see what your response was that you had along those lines but also plant that seed with those who are paying attention that this will not just [Indiscernible - static] concept of returning to normal may not necessarily mean [Indiscernible - static]

Can I weigh in on that first from the perspective of let us hope in you and versions that will bail us out of this? Is science going to bail us out of this? Not in the near term it is in. But I do know that there are advances ongoing some of which I have confidential information about clinical trials and things that are happening right now. There is some real hope I think for repurposed medicines where we take existing FDA approved products and we repurpose them for COVID and we just saw a week ago room to severe which is are in a replication inhibitor molecule that was developed in the past for different fibers being repurposed now and the FDA gave it emergency clearance for use here and that is an example of a repurpose drugs that is really on the shelf and there is hope there and I am aware of more than that story and there are good stories out there make that will provide long-term hope in the next months to year and we will help out there and we will not see it in vaccines, we are not the vaccine part of this is going to take at least I would say nine months to 18 months to see a vaccine that is in a condition where the of full-scale manufacturer and that is pushing the pedal to the metal payment in that time. So is it possible and it is conceivable that we might see an vexing site so we will have to ride the crest of this wave without a vaccine so that gets back to your point Jonathan, this is not hurricane that last for two days, you know, this isn't going to be just knocking some sand down on the beach and let us go deal with it but this thing is going to persist for months to years and back to Dr. Nadia Charguia we have the issues of what happens to Hardy process Thomas -- trauma and speaking [Indiscernible - static]

Speaking to some of the effort that you see as you mentioned, Jonathan, we don't know [Indiscernible - static] when is a four or six month period and when does it four or six months period and [Indiscernible - static] we need to increase the mental health support and there is going to have a lot of the support coming through other means and again as I stated before [Indiscernible - static] direct support of her just [Indiscernible - static] from a psychiatrist or psychologist, but we are going to need the help of all of our psychiatrist, all of our psychologists and our social workers across the board at all venues and at all avenues that they work in and we need to increase access and we need to help continue to create the message that is okay to get help and beyond that we all will need help. We all need to process, we all need to increase our network of [Indiscernible - static] for this but as it comes to trauma related services, we need to have robust development of trauma-informed and trauma related services. Where working on a few different initiatives [Indiscernible - static] thrilled to have the partnership with the state as well to think jointly about this issue. How are we going to be able to address it both [Indiscernible - static] which we are working on now but to think about what those numbers will be and how to make sure [Indiscernible - static]

I have --

[Indiscernible - overlapping speakers]

Follow-up for you, can you comment on front-line access to psychiatry right now? This is a real issue because psychiatrist bandwidth was already full before this crisis happened. So can you do that? I'm sorry, Beth, cut you off but I want her to follow up on that. Psychiatry is the top of the pyramid, can you discuss that?

You know I think there is need to try and utilize all of our mental health teams in a way that effectively but efficiently uses their skill sets payment I think with the ability to expand in telehealth, those endeavors, still focusing on team-based intervention, there are times to use the therapist and times two involve psychiatry but how can you really and that or maximize the skill for every level of professional? So that is requiring some rethinking, looking at also integrative measures to interweave mental health, primary care physicians, we too working partnerships recognizing the value that mental health has to offer and allowing more of those connections to really take place is something that thinking about state-level and federal level and resource in funding, it is really required a shift in how others value and recognize the need for mental health.

So this is Beth, Beth Butler, I think one of things that I would.out is, as well, when we look at this why we look at this event right here. The thought leaders lunch and this whole, this program came out of an effort for us to heighten awareness as we enter Mate for mental health awareness month, right? Where employees typically around spring and I spent over 20 years in the corporate side of things, right, so about this time of year we start talking about benefits, enrollment and we talk about the physical and you all have spoken to this earlier about the importance of physical activity and right around this time the fit bits when they came out and everyone is out monitoring their physical activity and how many steps have I made today? And it dawned on me as we started looking at programming to heighten awareness around this topic, we don't have a Fitbit yet for arc heads, right? We don't have anything that is strapped around her head saying, okay, you may look fantastic on the outside, right? Because that is the focus and that is what everybody sees, but how are you doing on the inside, right? And I think this event has magnified the need for us as employers to step back and say, okay, how are we doing as a workforce? How are employees doing and whether it is a caregiver role or whether you have a child with a disability or you are now homeschooling, right? As opposed to sending them to's school every day whether it is an aging parent that is in a skilled nursing facility where you are worried and anxious about their well-being, all of these things make up who we are as an employee, right? So we bring our

full cells to work and we need to make sure from an employer perspective that we are allowing conversation to happen as you said at we have some great champion companies out there that have been doing amazing work around creating opportunities for conversation and are you okay campaign, EY has done that for longtime. There is just a number of things out there so I think this is an opportunity for us to put that front and center in terms of our conversations around disability inclusion strategies and what is next in that area and the other thing I will.out too is the issue of self-disclosure and so what we have all talked about, right, mental health is a non-visible disability and I failed to mention this at the onset but I have a vision problem so looking at me you would not know that I was legally blind, right? But I am but I have a choice just like many others that I have an opportunity to disclose or not to disclose and what I think we're going to find is we are going to have many employees that come back that perhaps had diabetes and they had those underlying health conditions that they were able to manage before but now, as we transition back to work, they are going to be forced to disclose some things that they have not historically been forced to disclose so that will create some anxiety interest issues that maybe they are fearful of what we talked about earlier, right? Stigma. So I think this has been amazingly, amazingly rich conversation and I want to thank you all very much and any final comments before we wrap up?

I want to thank everyone, as well, I learn something you and I am not a behavioral health clinician and only [Indiscernible - static] in this kind of policy area and honestly it is been personally beneficial to me because [Indiscernible - static] made me much where where the value of pain attention to behavioral health [Indiscernible - static] and those around me and so I hope that folks are able to get into the conversation and I certainly appreciate Dr. Dooley's [Indiscernible - static] and certainly thank you, Beth and disability, Diability IN Carolina [Indiscernible - static] but also on disability inclusion and thank you.

Jonathan, thank you, thank you so much for facilitating such a rich, rich conversation. And as a reminder to those that are listening I want to thank each one of you for attending today's session and I know we are used to being in one room but I hope this was beneficial to you and please check us out again at DI-NC.org for more information we do have a COVID-19 resource page out there as well that house great resources and information specific to the needs of those individuals that you may be working with as well as employers as we move through this COVID-19 experience. With that I want to thank you all so much for joining us and again thank you to MetLife, hosting the diversities, Pat Keul, resource group and join us July 21st for our next event, we celebrate the 30th, cannot believe it, 30th anniversary of the

signing of the Americans with disability act and thank you so much and everyone have a great day.

Goodbye.

[Event Concluded]