Using the Guiding Principles of Recovery to Cope During Physical Distancing

Key Note Address: VISN 2 2020 Mental Health Summit

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Dr. Anjana Muralidharan: Appreciate the introduction. I appreciate the invitation. Um, as you heard Tony and I are from VISN 5. That's the network that covers Maryland, Northern Virginia, D.C. and West Virginia. So we are guests here. Thank you for inviting us. Uh, thanks also for allowing us to record. So, um, you know you're welcome to turn off your video if you don't want that to be in the recording, um. So I guess I'll jump in and I'd like to start by giving us all a chance to, to do a little breathing together.

So just breathe in and out. Bring your attention to your breath. Focus in on this present moment, which is a really beautiful moment to see so many faces coming together with this shared mission. Um, it's really beautiful.

So the title of my talk is "Using the Guiding Principles of Recovery to Cope During Physical Distancing." Um, and I'll be co-presenting with Tony DiNicholas. uh. I have about maybe half an hour or so of remarks and then Tony's got maybe 10 or 15 minutes of remarks, um, and then we'll have some time at the end for Q&A. So, uh, next slide please.

Just some disclosures, umm standard disclosures and very deep gratitude to other folks at my research center. We have some non-VA people here, right? So, uh, the MIRECC stands for Mental Illness Research, Education and Clinical Center. Um, so, that's a research center affiliated with the VA and we do a lot of research on SMI and recovery, severe mental illness and recovery and so this this talk is really a group effort. Many, uh, folks at our center contributed materials and ideas. Next slide please.

So let's start here. Um, so, so, these are our guiding principles, yeah? Principles of recovery. The SAMHSA definition of recovery is

"a process of change through which individuals improve their health and wellness, live a self-directed life and strive to reach their full potential." And, you know, this, this framework of recovery is really profound. It's very important. Um, and it's something we should all be sort of turning to in this time of upheaval to help guide our path forward. And so in that spirit, back when the, um, the pandemic first hit, my colleagues and I put together this handout, um, that provides some tips and strategies for how this sort of individual level framework for recovery can inform how we might be able to cope during physical distancing. So, um, yes, we will definitely be, uh, sending the slides out to everyone because there are lots and lots of links and resources in them. So, I, I definitely want it to be out there for y'all. So this is the very first link, which is a link to our handout on this topic. And I want to move beyond what's in that handout today in our talk, um, to really kind of diggingdeep and thinking back to where this framework came from in the first place. Um, you know, what are the roots of the recovery framework? And, uh, the answer is that this framework and, like let's be honest this is sort of a professionalized and sanitized version of this framework, grew out of struggle. It grew out of struggle, a civil rights struggle, where consumers, psychiatric survivors, um, who experienced dehumanization at the hands of mental health care and society stood up and said, "this is not right," "this is not okay," "we are human beings," "we need to be treated differently." Um, and from that struggle and from that deep wisdom came this framework. So how lucky are we that we have this, right? Um, that we have this very deeply rooted framework to turn to in this time of upheaval in our society. And so, it's kind of from that framing of what recovery is, that I want to proceed in my talk. So we can go to the next slide.

Um, and so, so, let's start there, right? Let's start with the wisdom of lived experience, the wisdom from folks who, who experience what it is to have a mental health condition and be sort of "othered" for it, right? Um, so I really recommend this article, uh, and props

to my colleague, Peter Phelan, for bringing it to my attention. Um, it is written by some service user researchers who, you know, who themselves are people with a mental health condition and who, uh, you know, brought together, uh, other folks with mental illness for a series of focus groups to kind of discuss, um, what was happening with them in this pandemic and in this era and just some really, really deep teachings and nuggets of wisdom came out of those focus groups. So, I'm just going to quote a few, but I really recommend that folks download and read this article because, um, it's really short, also, and, um, there's a lot of really deep teachings there. So, I'll just share some of the quotes, "so to recover is not to restore or reclaim a former state of normality, but to forge new pathways and create one's life within and beyond the constraints and limitations in this case imposed by reality itself." So, if we think of of the recovery framework not just at an individual level but at a societal level, um, there may be some part of us that wants to kind of go back right. Let's go back to normal when we weren't worried about a virus, we weren't worried about contracting or spreading a deadly virus, um, let's just get back there. But what this article is really emphasizing and what I also want to emphasize today, is knowing what we know now about the fragility of our social fabric, um, based on what this virus has done to us, I mean how could we ever go back, right? It is time for us to pick up the pieces and move forward and forge a new reality - a new way of taking care of each other. Um, and guess who has experience with this? [laugh] Uh, people with lived experience. So that also came up in the article. “Particularly noteworthy was the realization that some of those who have had a previous experience with extreme states found themselves to be better prepared for this journey than their counterparts, having had to reconstruct their lives in other ways on previous occasions." Next slide please.

One more quote, “Coping with uncertainty is challenging and is often dealt with in two ways; responding with a sense of urgency to

“get back to normal” at whatever cost or tolerating some not-knowing with hope that something better can emerge.” So, I love the name of the summit, "Leaning into Uncertainty." This is where we are. We are in a in a space where we do not know what's to come. We don't know how we're going to cope. We don't know how we're going to get through it. But, I think we know that the only way through it is forward, towards something new and something better. Um, so it's with that framing, that I want to continue with my my remarks today.

Uh the next slide please. Uh, so I've been asked to make some remarks about social isolation, um, which is something we're all sort of experiencing in maybe a different way right now because of physical distancing. So I'll share some of the literature on, uh, social isolation, mental illness and interventions, um from the quote-unquote "before time" [laugh], on, on that. Um, I'll talk a little bit about the impact of COVID and then I'll, um, share a number of tools and ideas and resources from the field that might perhaps be helpful to you. And then we'll move to Tony making some remarks about his own experiences, uh, clinically in this time. So next slide.
So let's talk about, uh, social isolation. Social isolation [inaudible] definitions of course, so, um, objective social isolation is kind of more quantifiable. It's how many contacts do you have? Umm, how big is your social network? How many people are in it? And then subjective is that more your perceptions, right? So, um, it could be broken down into loneliness, which is kind of the emotional experience of distress related to this discrepancy between a desired and perceived availability and quality of social interactions. Um, and it could also be broken down into perceived social support, um, which is sort of a more cognitive like evaluation of, you know, do I have enough support in terms of social resources? And we know and there's tons of research on this that both objective and subjective social isolation have negative impacts on health and well-being for all of us including people with mental illness. Next

Slide.

We also know that both objective and subjective social isolation is more common among people with mental health conditions, especially people with severe mental illness. So, next slide. So, let's talk a little bit about the contributing factors. So, I think frequently as mental health providers, certainly as psychologists, you know I'm a psychologist, we focus in on the individual level factors that contribute to social isolation and loneliness. We think, "you know folks that have the skills they need to strike up conversations and make friends, um, and their symptoms get in the way. They're not motivated. Um, they have negative symptoms. They have flat affect. Um, and uh, you know, they're depressed, et cetera. These things get in the way of being able to, um, forge meaningful relationships and social [inaudible]. Um. I would want to, I would like to challenge us all to also think about more macro-level contributing factors, right? Societal, structural and socioeconomic factors are huge contributors to social isolation and loneliness. And I say this because, really I'm hoping that it will be validating. Because these are really hard, this is a really hard not to crack like helping people feel less isolated, having a rich and supportive social network, feeling less lonely. It is really hard to touch those constructs. And it's because there are these really huge, kind of, intractable factors that contribute to those outcomes, right? So, um, stigma being a huge one, um, and uh, uh, you know, the the internalized sort of trauma that folks with mental illness might carry with them around the way people reacted to their symptoms and mental illness and psychiatric events in their lives, right? Huge. Um, another is poor [inaudible] integration, right? Like, you know, we have really high rates of homelessness, um, you know, unemployment in folks with serious mental illness and these are really major networks where we make a friend, right? Where we meet people is where we live in it, we meet people where, um, where we live in a certain neighborhood or through our jobs. Um, so

denial of access to these networks is a major source, a major contributing factor. Um, and another is poverty. Um, I think this is really important to emphasize and, and talk about, um, you know, having friends costs money, [laugh] but can cost money like spending time with people. Um, you know, spending money on social activities, uh, having a home that you don't is in good enough shape that you can invite people over. Feeling like you can present yourself in a way that's, um, you know, you feel confident to spend time with other people. Um, and of course, you know poverty comes with a lot of, um, uncertainty a lot of, uh, maybe transience or lifestyles. You don't have time, like, to be in one place and settle in and make roots. And, so, so the material conditions of the Veterans' lives that we work with are huge contributing factors to social isolation and loneliness. Um, so again validation, right? [laugh] Um, I think a lot of times when we're alone and lonely, we blame ourselves, but it's important to have an awareness of these broader contributing factors. The other thing that's really interesting that's happening right now, is that all of us are having the experience of what it means to have structural, outside of our control factors, constricting our ability to socialize, right? We're all experiencing it now because of COVID and because of physical distancing restrictions. So, um, you know this is actually a really great time for empathy and connection with, with the folks we work with to say, "hey man, uh, it's really hard to connect with other people when you've got these external constraints, you know?" And, uh, and from that place of understanding and validation and connections you know, can we work together to build something better? um.... You know? And outside of our individual work with Veterans another thing we can think about for ourselves is, are we working to address stigmatizing and ignorant attitudes in ourselves and our communities around mental illness? And what are we doing to advocate for improvement in the material conditions of the Veterans we serve? Because if you're not doing that stuff we're not addressing the whole picture here in terms of social isolation and loneliness. Next slide please.

A quick quote from a qualitative study of low-income folks with serious mental illness in a small town in Sweden. They interviewed people about the intersection of poverty, social connection and mental illness. um...I'll read parts of the quote, so, "I try to adapt as best I can … But what can you do when you don't have any money? You can't just sit around all day and stare at the wallpaper; you have to get out, take a walk. That's what saves me. But at the same time, if I'm out walking… I get all these ideas… I see a boat, and I know someone who has a boat, what if I got in touch with him? But no, of course not, that wouldn't do; I don't have the means to get out to his place. Why should call him and found out they're going to do something that's a lot of fun and I can't go with them because I don't have the money … and so instead I think, why did I go out on this walk in the first place?" Next slide please. Okay. So that's some framing. That's some context. Um, I'll move now into sharing a little bit about what we know from the research on how to intervene on social isolation. Um, the next slide.

So, maybe not unsurprisingly based on what I was just talking about [laugh], there's not great research support for one or two interventions that really address these issues. Um, so here I'm, I'm basically summarizing, um, findings from a systematic review that was done this year that reviewed 30 randomized control trials of, uh, interventions that tried to address social isolation among people with mental illness. And, the, if you go to the last bullet there you could see the research is really not strong enough to support concrete recommendations on this. However, there are some caveats. So there's a few things. First of all randomized control trial-based evidence is a pretty high bar to set, um, right? We have other kinds of evidence from other kinds of programs that, you know, might guide us, provide us some help and guidance. And the second caveat is that sometimes there's a measurement issue here. So, um, you know there might be interventions that, uh, target socially, social isolation adjacent outcomes, like similar to social

isolation, but they don't actually measure that. Um, and I'll explain what I mean by that in a minute. So they're either not explicitly measuring or they're not explicitly reporting on those things. Um, so that's a little bit of a caveat, too. The third caveat that I'll share is that a lot of these studies have short follow-ups and I think we know that moving from a place of feeling isolated and lonely to moving to a place where you feel supported and, uh, connected and not lonely, is probably a pretty long process, right? Probably takes years. So, um, uh, you know in some [laugh] these kind of studies like randomized control trials with short follow-ups and um you know very clear measures they're not always the best, um, although they're the gold standard for like empirical evidence, they're not the only source that we can turn to for guidance. But anyway with all those caveats said, let me just go through these bullet points. So what we find from the RCTs so far is that when you use cognitive modification-type strategies, um, that can be promising for impacting loneliness and subjective social isolation and I'll share an example of this later. Um, and then when you use, uh, group based interventions like social skills training, psycho-education that's group based or supported socialization, um, there's evidence that that has impact on objective social isolation in trial. So, you know, of course they're being connected to more people so maybe that's expanding their social network a bit. So, yeah, OK go to the next slide, 'cause I'm just watching the time.

So, I want to highlight one of the supported socialization studies that I think is really good. Um, I just personally really like which is a befriending model. Um, so, there are some various different models of befriending and one is the Compeer model. Um, so Compeer is a nonprofit organization that matches community volunteers with people with serious mental illness.

The volunteers get a training and, uh, they, um, are sort of trained to become friends with [laugh] the person with serious mental

illness. Very short training. It's like a couple hours. Um, so a study of this model showed that people who were assigned to compeer as opposed to waitlist control had improvements in social isolation and subjective well-being and that that continued to increase through one year, which is sort of more evidence for the idea that a friendship takes time to develop. Next slide please.

Um, and when they looked at the qualitative interviews from 20 people who participated in the befriending, they found that the friendships really deepened over time, they became mutually beneficial. Some of the volunteers had mental health conditions themselves so they found that they benefited in a lot of different ways and the participants with serious mental illness became more socially active over time. So, you know, it may be that our our literature, um, is not quite capturing the promise of these kind of supported socialization interventions. Um, and I think that's especially the case with things like mutual self-help and support groups, um, which we know from like decades and decades and decades of them happening [laugh] that people say they go to those support groups and they feel less alone, right? So just because we don't have sort of the rigorous RCT level evidence, um, doesn't mean that we just you know throw those, uh, interventions out. So next slide please.

Great. Um, so let me talk briefly about the impact of COVID. The next slide, um, we know that folks with serious mental illness are vulnerable and there are disproportionate risks for the negative impacts of COVID and here are a couple of publications of many that are out there that talk about that. So, I just want to provide links. So next slide.

Um, another couple of articles that I recommend around concrete recommendations that are being made by folks around, you know,

practical clinical strategies for health care mental health care delivery during COVID as well as policy reforms. Next slide.

So how are folks with mental illness doing right now? Um, of course, I think research is like emerging every day on this because this is happening in real time, but one study that I found surveyed 198 people who self-identified as having a mental illness from an online peer support community called ForLikeMinds. And, you know, perhaps not unsurprisingly they, um, identified a lot of major concerns during COVID including...

Unknown speaker: Your mike just went down and you went up high and then went down. So it might be hard for people to hear you.

Dr. Muralidharan: Hi, can you hear me now?

Dr. Muralidharan: Um, hello.

Unknown speaker: It's very soft.

Unknown speakers: So well it might be on your end because it's fine on our end. Yeah. Yes. It's fine on my end.

Unknown speaker: I can hear you fine. You're clear.

Unknown speaker: I have no problem.

Dr. Muralidharan: It's really wonderful to hear everybody's voices. So, I'm actually glad that that happened. [laughter] Hi everybody! Okay.

Unknown speaker: Hello!

Dr. Muralidharan: Okay. So, um ,yeah so perhaps not unsurprisingly folks identified a lot of major concerns during COVID um including concern about disruption of services feeling socially and isolated and disconnected. And what they really preferred in terms of being connected with others is the use of text messaging, first, followed by phone and then social media. So, important to keep in mind. Um, these of course are people who are already on an online peer support community so they are people who are into, you know, the internet, so, Uh next slide please.

Okay. So what do we do now? First I want us all to take a big, deep, deep breath because I have a bunch of tools and resources I'm going to throw at you and it might be overwhelming. So, take a deep breath. Okay. Next slide.

What do we do now? So remember how I told you, right? that, um, in the research evidence uh there's evidence to suggest that

cognitive modification can be helpful so I'm going to share an example of a cognitive modification intervention. And that supported socialization and group-based support can be helpful so I'm going to share a few different resources to kind of get those sorts of connections going. And then I'm going to share a tool about how you can help Veterans make decisions around socializing safely. So, thank you. Cognitive modification. So, uh, the cognitive modification tool I want to highlight are called Connection Plans. Connection Plans are similar to safety planning they take about 30 minutes and you don't have to be a mental health provider to create one. Basically you have a brief conversation with someone about how loneliness is showing up for them: What does it feel like? What's going through their mind? And, uh, you know, what are they doing as a result of feeling lonely? And then you make a plan to shift these so it's real basic cognitive behavioral principles you have that initial conversation; you have a brief follow-up later. This approach was published earlier this year by Kim Van Orden. You can go to the next slide.

She's a researcher in your VISN. So maybe reach out if you like. Um, she does research on social isolation in older adults. Very open to collaborating and in fact uh some investigators at our MIRECC are going to be getting some training with her and doing Connection Plans. And we just received word yesterday that we got funding to do a clinical demonstration project partnering with our local GRECC as well as our VISN 16 GRECC to roll out connection plans to about 600 Veterans, uh, across our our two VISNs. So very excited about that. And we're excited to see like what kind of impacts it has. Next slide.

Um, connect your folks to mutual self-help and support groups. There's tons of them everywhere. [laugh] Next slide.

Okay. Here's a really beautiful example of supported socialization that i just wanted to highlight. They're called Veteran Coffee Socials and they're happening in VISN 1. So a Certified Peer Specialist started this. It was very informal. Basically they started a weekly gathering at a coffee shop or restaurant where any Veteran can show up and just chat and hang out. It's not a clinical service. You do not have to be enrolled in VA Healthcare. You just come and hang out. And from that one coffee social, it grew to lots of different coffee socials. In the abstract that I have linked, there they report on one nine-month period that had over 2,000 Veteran contacts across socials taking place in seven different towns and they really reported that Veterans formed relationships and accessed resources just naturally from coming to these socials and hanging out with other Veterans. So I thought that was really just a beautiful example of, um, supported socialization and next slide please.

They've gone virtual now, [laugh] so you can check out that article. Um, if you're interested in starting this up the folks are quite collaborative and so you can reach out and ask about you know how they got this going. Next slide, please.

Um, I've gone, I'm going hopelessly over time, so I'm going to pick up the pace. So I just want to debunk the myth or idea that people with serious mental illness don't use mobile phones or the internet. They do. There's high rates of use of mobile devices, the internet, text messaging, social media and they use these platforms in the same way all of us do. So, this is a really important avenue for connectivity for our folks and something you can help them get connected to. Next slide.

A little bit of information about getting Veterans connected in case you're not aware. These first two bullets are for folks who are

receiving VA healthcare. So if a Veteran is receiving VA healthcare and they need access to a device so that they can access telehealth care. There's something called a Digital Divide Consult that you all might be aware of. A VA provider can place this consult. A social worker assesses the Veteran's device and connectivity needs and Veterans in need of a device can, are mailed an ipad with a data plan. So talk to your facilities' telehealth coordinator for details. And the other thing that's growing right now are these non-VA telehealth access points. So in community locations like Walmart, for example, there are they're trying to implement more places that Veterans can walk in, use a computer and access telehealth care. So you can check that out at the link I, I looked yesterday and it looks like there's a new one coming to Gowanda, New York. So if that's in your VISN ...anybody from there? Um, upstate New York, uh, you can check that out. And then I just also provided a link to lifeline which is the federal program for providing connectivity for low-income folks. Next slide.

So, apps right? So we saw before that folks with SMI, lots of them have apps, and I'm sorry, have mobile phones. So, um, the VA has tons of vetted high quality mental health apps that are available for free. So go check them out at the link and, you know, if you, if a Veteran receives an ipad from the VA they can use it to also access these apps. Uh, next slide. Um, if you're overwhelmed and you don't know how to choose apps and you don't like the VA apps here are some links for how you can choose apps based on quality, credibility, privacy, etc. And there's also this really great link to an organization where Peer Specialists are vetting apps that for, for mental health recovery. Remember that use of technology for things like healthcare is enhanced when there's a human factor. So, next slide.

Um, the other thing I'll say is that a lot of folks with mental illness and serious mental illness use the internet to find online community. So there's been some stuff written about this that there can be potential benefits to that: greater social connectedness, group belonging, etc. Of course there are potential risks like misinformation and stress that this is the future, right? Like we need to think about all the different ways that our Veterans can be connected an online community is out there for people. Next slide.

Um, now of course a person might get online and get totally overwhelmed and have, get way too much information, um, and too much bad news. So, I wanted to just highlight one, um, handout from the whole health repository. So, first of all this is an incredible repository of resources that are available for free for everyone. Lots of different handouts about taking care of your whole health. So check out the link. But one of the handouts is "Too Much Bad News: How to Do an Information Fast." So, you go to the next slide.

Um, it's just a couple of pages that talks about how bad news can affect your health and different ways to set limits on how much you're exposed to the news. Next slide.

And the next one.

And the final tool that I will share is this really cool kind of decision-making tool to help Veterans make informed decisions about safely socializing. It was created by Pat Deegan and her group um. She's a person with lived experience who's also a researcher. It's called "My Coming Out of Quarantine Safety Plan" and it kind of helps people think through the socializing that they want to do and

make sort of informed and, uh, balanced decisions about socializing and trying to do it safely.

Whew. Okay so let's take another breath.

Go to the next slide.

And I just want to end with a quote. Um, I really think, I really believe, that we are on the precipice of something new, like a path towards something new. Um, and I think that this poem captures that, so I will just read it. Um, in our tears and agony we hold our children close and consent the truth the future is dark. But my faith dares me to ask: What if this darkness is not the darkness of the tomb, but the darkness of the womb? What if our America is not dead that a country still waiting to be born? What if the story of America is one long laser? What if all the mothers who came before us who survived genocide and occupation, slavery and Jim Crow, racism and xenophobia, and islamophobia, political oppression, sexual assault, and I, Anjana, would add dehumanism-dehumanization of our minds and bodies. Perhaps what if those folks are standing behind us now whispering in our ear: You are brave? What if this is our great contraction before we birth a new future? Remember the wisdom of the midwife: 'Breathe,' she says. And then: 'Push.'

Thank you. So I'll hand it over to, uh, Tony now. I'm sorry I went overtime, Tony. [laughter]

[laughter] It's all yours.

Tony DiNicholas: [inaudible] for going over time.

[laughter]

Mr. DiNicholas: Could we go to the next slide? So, um just to give a thought up front, I don't know if everyone is familiar with E-RANGE MHICM. It's simply a MHICM program that is in a rural community. So our Veterans very often live in rural homes and can be an hour to two hours away from our office to go to [inaudible]. I know in other areas that are much, uh, larger, maybe upstate New York, certainly out in the west, it's much greater distance, but that's what it means in our community. Um, what services we are providing? We are doing our best to not only stay in contact with Veterans through the internet or [inaudible] or FaceTime, but we are visiting [inaudible] where we have specific needs. You can see it says we deliver food. We have created a relationship with one of the churches that are in the food bank and I'm able to access a certain number of bundles of food and store them at the office and then, all of us are able to bring them out to our Veterans. You know, leave it out the front door, kind of get away and move away in a COVID environment. At least we feel like, or they know, they're getting some food support. We also do take some to the grocery store. And it's very important we have in our team, which is made up of myself, two social workers, a physician's assistant, our physician's assistant has committed herself to continuing to fill pill boxes through COVID. What changed? Instead of going once every two weeks, she's going once every four weeks, which is a big difference. She had to get a medication to everyone. She had

get pill boxes and it's a new commitment for the Veteran to be willing to comply. Because, as you all know, it's challenging for a Veteran to maintain his medication routine and we completely agree with the Veteran's rights of self-determination. So, it's important that we understand it is a great challenge for them and support them even if they're not willing to, kind of, stay up to speed as they were when we're able to visit more often. How are Veterans doing? Well I think it's really a cross-section. The isolation to some Veterans has been over, perfectly fine. They feel that it's a time where their relationship with MHICM is not trying to get them out of the house. We're not trying to encourage them to be more social. So, it's actually been a time of, almost, solace for them. Other Veterans who are significantly impacted by messages, everyone that deals with SMI Veterans knows this reality, they are finding a much higher need for some sort of contacts. They are getting many more messages. They are feeling they can't leave the house for many more reasons than are the rest of us may be aware of. So, we have increased contact with them. They were being seen once a week previously. Now we're able to do contacts with them five, six, well, eight, nine, ten times a month by more than one person in the team. So, that's been a pretty big change and quite successful. Um, a third type of Veteran that we deal with was feeling some depression from not getting to go out and participate in society that they were used to. So their answer was to take a much higher risk profile with respect to COVID and re-engage in the activities they needed to have to cut down on the feeling of depression. All we can do is go back to education. We can go back to support, but again, they have the right to do what they do and especially in this environment, it's very important that we're much more supportive and focus on risk or harm reduction rather than trying to be too assertive.

Can we go to the next slide? The experiences in the field, I've talked about a few of them. It's harder to keep Veterans engaged on

the phone. I think the onus is on us as a support team to use more of our own tools to try to engage with the Veteran so that they feel that the phone call is a positive environment; not one where they're being talked to only about the clinical concerns, only about medication or specific answers to depression. Um, so, we work harder in trying to maintain and establish that engagement, And there are appointments where we feel it's very important to be seen by the Veterans. One of our clinicians has actually gone out in one of the VA vans. The Veterans sat in the back of the van with the door, back door open. The clinician stood a few feet away in PPE and they had an hour conversation. Anything that we can do, any ways that we can try and create a relationship in a new form that still has, let's say, the comfort that we've established with some of these Veterans over the last six years. It's difficult to watch Veterans engage in unsafe behaviors. We talked about that for a second. But, if we are willing to understand their need and willing to discuss those needs with them without judgment, I think we have a better opportunity to keep that contact at a level that really benefits them. Uh, next slide.

So, we're going to…

So, I'm reading the slide a little bit. There's a lull in my conversation. And it's important some of the things that I talked about before, is I'm reiterating here and that is doubling the social contacts, more engagement, the therapeutic relationship. And it's very difficult as we face going into winter, because there may be times where even the small amount of physical involvement that we have now we're just not capable of having it because of the additional impact of weather. I also want to mention that we care for ourselves in the team so one of our clinicians may be going out to a specific Veteran quite a distance away that we all know can be challenging, they

will text to the whole team when they're leaving for the appointment. They will text to the whole team when they're returning from the appointment. In a MHICM program of this type, it's important that the team knows where each other is and the team is capable to support each of us in our own roles in our particular day. The other thing I wanted to mention is that without the physical contact with Veterans, some of the programs in the community, um, we're not able to truly understand the challenges that they're facing. Personally, I have been in a Veteran's home a year or two ago where we realized he had a weapon we didn't know about. I was able to convince him to allow me to put a gun lock on that weapon and secure it safely and put it back in his hiding place. Those kinds of opportunities don't exist now. But, we're doing our very best to make those contacts and go back to a physical relationship as soon as possible.

That's all I have. I hope I have some thoughts for everybody.