# YTWC Monthly Meeting Notes – December 21st, 2021

**Attendees:**

| Name | Organization | Role |
|---|---|---|
| Henry Solares | Yurok Planning and Community Development Department | Grant Writer/Planner II, Meeting Facilitator |
| Lizzie Moore | Yurok Tribe Public Health Department (YTPHD) | Intern/MPH Student, Presenter |
| Ben Moradi | Yurok Tribe Wellness Coalition (YTWC) | AmeriCorps VISTA, Presenter |
| Rahmad Perry | California Rural Indian Health Board (CRIHB) | NorCal MAT Champion, Presenter |
| Ethan Makulec | YTWC | AmeriCorps VISTA, Notetaker |
| Alita Redner | Yurok Temporary Assistance for Needy Families program (TANF) | ICWA Director |
| Amanda Ammon | Yurok Tribe Office of Self-Governance (OSG) | Assistant Director |
| Amanda Colegrove | United Indian Health Services (UIHS) | Health Promotion and Education Supervisor |
| Ashley Gephart | Humboldt County Public Health | Program Coordinator |
| Bessie Shorty | Yurok Tribal Court (YTC) - youth at-risk program | Program Manager |
| Caleb Hare | Victim Services Program – Bear River Band of Rohnerville Rancheria | New Victim Advocate |
| Celinda Gonzales | Yurok Health and Human Services (YHHS) | Youth Prevention Specialist |
| Chris Starets-Foote | Del Norte County Behavioral Health | Clinical Services Manager |
| Daniel Norton Luna | YTC | Community Outreach Specialist |
| Elidia Adams | UIHS | HPE Specialist |
| Erin Butler | YTWC | AmeriCorps VISTA |
| Hollie Strahm | YTPHD | Public Health Officer |
| Holly LaRocque | UIHS | Health Promotion and Education Specialist |
| Holly Reed | Yurok Opioid Affected Youth Initiative (YOAYI) | Prevention Specialist |
| Jessica Carter | YTC | Tribal Court Director |
| Jessica Cedillo | YTC | Wellness Administrative Assistant |
| Lau-Lei Lawrence | YOAYI, Client Services Department (CSD) | Prevention Specialist |
| Laura Woods | YTC | Community Outreach Specialist |
| Lila Knott | YTC | Community Outreach Specialist |
| Lori Nesbitt | YTC | Opioid Program Manager |
| Madison Green | CSD | Director |
| Marie Decora | YTC | Wellness Outreach Counselor |
| Melissa Banks | Ke'pel Boys and Girls Club | Program Lead |
| Naome Workman | Del Norte County Behavioral Health | Program Coordinator |
| Patti McCovey | YTPHD | Case Investigator |
| Robin Johnson | UIHS | Specialist |
| Ronald Bates | YTC | Senior Outreach Specialist |
| Rose Sylvia | Yurok Tribe Human Resources | HR Director |
| Sarah Nelson | Humboldt County Public Health | Administrative Assistant |
| Shayna McCullough | YTC | Youth Case Worker |
| Tamara Honrado | YHHS | Deputy Executive Director |
| Theresa McQuillen | YHHS | Prevention Specialist |
| Tony Wallin-sato | Project Rebound HSU | Program Coordinator |
| Wendy Rinkel | UIHS | Unspecified |

**Next Steps: Yurok Public Health by Hollie Strahm & Lizzie Moore**

- Purpose of presentation: plant the question of what the Yurok Public Health Department's (YPHD) focus and goals should be going forward.
  - Public health department started in response to COVID. As the situation changes with COVID, the public health office is looking for some additional/new goals to focus on.
    - Should YPHD focus on issues that are already being worked on to provide additional support or begin work on "new" issues that are not currently being addressed?
    - Decisions will be made in next couple months, seeking top 2 issues to focus on.
    - Should focus be on upstream (historical trauma, economic inequity, etc.) or downstream (substance abuse, child neglect, etc.) issues? *[diagram in presentation]*.
      - Both upstream and downstream issues present problems and solutions for YPHD work, as they are potentially very broad or very specific concerns, respectively.
- The plan is to conduct an email survey, in addition to key informant interviews, focus groups, and more, with district representatives and those already involved in this work like YTWC.
  - Will also collect and review statewide data and other documents to make decisions
- All available options for YPHD focuses are good choices, but we also want to make sure these focuses and priorities are in line with tribal values.
- The "Ask": Who else should YPHD reach out to? Any initial thoughts about question for top 2 issues? What should be on the list of choices? Open for discussion/questions now.
  - Lori Nesbitt: Big ask, but, if possible, a full-time 24hr location with public health services, basic supplies (raincoats, food, substance use/mental health services/referral, etc.). Somewhere for people to go to besides the police. A place where resources can come to them, or they can be given the time and support to decide to seek out treatment. Places for people to go talk to someone with respect, support, and cultural competency.
    - Alita Redner: Hopefully all our offices should be able to offer a coffee, a place to go, someone to talk to. However our referral services are lacking, may take time to get treatment services, and what does someone do while they wait days/weeks?
    - Lori: One facility has a place where someone can stay for ten days if they can control themselves and are not violent. Provides a place to feel safe and get resources, with ten days being enough time to find somewhere they can go or seek treatment.
    - Daniel Norton Luna: Just to double-check, is it the plan to continue this conversation and discuss again at the next coalition meeting? Just so we don't have to have all our ideas now, and people can have a month to think about it.
    - Lizzie Moore: Yes, we're just looking for some initial reactions with regard to upstream/downstream focuses, but we don't need specific decisions right now, though any thoughts and ideas are helpful.
  - Tamara: Home and healthcare needs for many foster youth are not being adequately met, so YPHD assistance would be helpful. Also, some kind of fentanyl declaration of emergency/crisis could be useful for helping address the epidemic.
    - Lizzie: Substance use issue on upstream/downstream diagram could be focused on fentanyl, or it could be its own issue/focus. Also, one downstream issue being considered is child neglect, which could include the concerns Tamara mentioned.
  - Bessie Shorty: YPHD should focus on upstream issues. All families could use education on colonialization, historical trauma, etc. There is a confusion on what is traditional or

not, i.e. negative behaviors are viewed as traditional when in fact they are post-colonial behaviors. Grandparents raise grandchildren due to the opioid epidemic, but don't know how to be grandparents. We need strong mentorship that addresses Yurok traditions and distinguishes from colonized behaviors.

- Lizzie: Everyone continue thinking about this question! Please reach out with any suggestions or additional people we should ask.

**The Brain and Addiction by Ben Moradi**

- Addiction is defined as a chronic relapsing disorder, as characterized by continued drug-seeking despite harmful consequences. Goal of presentation is to provide a brief overview of how brain works, explain the science behind addiction to show the difference between an addicted vs. non-addicted brain, and to show why understanding this is important.
- Each region of the brain has its own set of functions corresponding to certain tasks. Within each region are neurons, which are responsible for all our thoughts, functions we don't have to think about like breathing, etc. Receptors and neurotransmitters at the end of each neuron to communicate with other neurons.
  - Key components of reward system are the nucleus accumbens (NAC) and the ventral tegmental area (VTA), which are particularly important when talking about addiction.
  - Other regions have functions relating to cognition/planning, drives/emotions/memories, or decision making/regulating inhibitions.
- Neurons receive signals through dendrites, and send out signals from axon at other end, synapse is the space between each neuron where signals are transmitted.
  - Cocaine blocks reuptake of some neurotransmitters carrying signals between receptors.
- How does an opioid cause a high if it's shutting down receptors? When a synthetic opioid enters the brain, it fits into a natural opioid site, supercharging the opioid receptor's effect.
  - During an overdose, the opioid overpowers normal bodily/neural functions and can cause someone to stop breathing.
- After enough time, the opioid "hacks" the brain's reward system so that the only reward you can receive is by using the drug, and no longer from family interactions, love, exercise, etc.
  - *[graphs/diagrams available in presentation]*
- Methods of scanning the brain/observing changes induced by addition: fMRI, PET, etc.
- Example: methamphetamine addiction. The damage of addiction disrupts decision making and the ability to regulate inhibitions, making it harder to begin and stay in recovery.
  - This damage can begin to heal in six months and can be mostly fully healed in 2 years.
- Cocaine addiction also disrupts decision making, and cocaine-dependent brains show a depletion of natural opioids, making them more susceptible/sensitive to opioid abuse.
- The three most common drugs of abuse (alcohol, tobacco, cannabis) are all special cases as their effect on reward system is different than methamphetamine, cocaine, opioids, etc. They are not as addictive or are addictive in different ways. *[diagram showing relative number of people meeting criteria for addiction or not for each substance]*.
  - Tobacco does not damage the reward system the way something like meth can, but it does release a small amount of dopamine in the NAC, and it can destroy the enzyme that destroys excess dopamine, further contributing to addiction.
  - Alcohol does not immediately hijack the reward system, but eventually after enough use it can take over the reward system, but it must become a learned behavior first.

  - Cause of cannabis use disorder still unknown, schedule I status means little research has been done to identify how it works. Can cause more significant effects/damage too young brains that are still developing. Comparatively it is much safer than meth, opioids, etc.
    * Botanical cannabis safer than concentrates/vaporizers/edibles/etc. which can much more easily cause hospitalization or health damage.
- Learning to understand addiction helps reduce stigma, understand the brain-body link, and explain why different MAT options work differently for different drugs & different people.
  - Contributes to our understanding of addiction as a disease
- Lizzie: can you go over the slide with the numbers/graph of addicted vs. non-addicted people for each substance again? Those numbers are really surprising.
  - Ben Moradi: The numbers are a collage from the NIH, CDC, and HHS.
  - Lori: I know what you mean Lizzie, I think many people are home-drinkers and are never reported until they get caught as a heavy drinker and have to face the word addiction. I think we meet them on the medical side with liver disease.
- Caleb Hare: any difference for how addiction/these substances effect neurotypical vs neurodivergent people?
  - Ben: Not the focus of this presentation, but some studies show the utility of low doses of cannabis for overstimulation issues for autistic people, and some stimulants can have effects more like medical Ritalin instead of an "amped" feeling.

**Naloxone Administration Train-the-Trainer by Rahmad Perry, CRIHB**

- Objectives: baseline understanding of prescription opioid problem, how opioids work, how to identify an overdose, and how to respond to an overdose with naloxone.
- What are opioids? Drugs that come from opium poppy plant, usually synthetically made, either illegally (heroin) or prescription (oxycontin etc.), or for MAT (buprenorphine).
  - "Opiates" are natural, come from plant, used to create opium, morphine, heroin, codeine.
  - "Opioids" include opiates as subcategory but also include synthetic opiates like fentanyl.
  - Opioids bond to receptors to generate a "high", but many factors impact how drugs are processed and effect any given individual, such as: metabolism, BMI, age, liver/kidney health, body fat content, amount of water in body, quality of the drug, tolerance, etc.
    * Normally, exercise or other rewarding activities generate dopamine in the reward system. Over time, if someone continuously uses opioids, they saturate and overload receptors, and reward system receptors withdraw and get weaker, causing withdrawal and dependency on opioids for reward/dopamine.
  - Long-term medical effects of opioid dependence include psychiatric, muscular, and many other types of effects including fatigues, depression, hallucinations, etc.
- Why do people get addicted? Brain records feelings of pleasure caused by opioids. As tolerance increases, people need to take more of opioid to get desired effect. Eventually natural opioids deplete, and brain becomes prone to seeking out opioids to achieve past effect/positive feeling.
  - When tolerance develops, risk of overdose increases, and continues to increase over time as people rely on greater and greater amounts of drug to achieve the same effect.
- Unfamiliar supplies/changes in quality increase risk of overdose. If a supply runs out, people may seek out different/stronger drugs, new dealers, and drugs may eventually be "cut" with other substances.

  - For instance, many other drugs like cocaine are being cut with fentanyl. Someone may think they are taking a normal amount, but it is actually much more powerful than they know and includes other substances, potentially causing an overdose, even a fatal one.
  - Even a very tiny amount of fentanyl/carfentanil is enough to kill someone.
- AI/AN communities are particularly impacted by opioid overdose death. Overdose numbers continuing to increase to this day, due to fentanyl almost exclusively since it is becoming increasingly prevalent recently.
  - This leads to children being born addicted or parents dying and leaving children behind, causing enormous amount of foster children.
- What is an opioid overdose? Too many opioids lead someone to stop breathing etc.
  - May appear like a very deep sleep that they cannot be woken up from. Short breaths, clammy skin that may have lost color, limp body, slow heartbeat, unresponsive.
- Naloxone is a safe antidote to an opioid overdose that has no risk of abuse or dependency.
  - An opioid contender used to counter overdose effects. Takes ~2-3 minutes to work. Only works against opioids. Displaces/"kicks out" opioids from receptors for 30-90 minutes.
  - Has no effect on person without opioids in their system, no other risks, almost just like shooting water up someone's nose.
- *[Video summarizing what overdose looks like and how to use Naloxone to revive someone]*
  - The majority of overdoses occur away from medical help, in a private home or place where professionals will not be on hand available to help.
  - Narcan not a substitute for emergency medical care, must still call emergency services
- Video review: Safely perform an assessment of their condition to confirm if it is an overdose, then immediately call for help. Place in recovery position on their side with head cradled so they can't roll over and end up on their back or choke on vomit. Then administer Naloxone as trained by tilting head back, inserting Narcan up to fingertips, and pressing plunger.
  - If they do not respond to first dose after 2-3min, administer second dose in other nostril.
- When someone wakes up, they are likely going through withdrawal symptoms and craving opioids. Explain to person what happened to them and that emergency services are on the way. They will likely feel sick and may be aggressive initially.
  - Discourage someone from taking more drugs because if they do use again, they may cause themselves to overdose again.
  - The effects of an opiate outlast the effects of Naloxone, so stay with someone until emergency medical services arrive.
- Aftercare protocols:
  - Do leave alone: they could stop breathing. Don't put in bath: they could drown. Don't indue vomiting: they could choke. Don't give them something to drink: they could vomit. Don't put anything into nasal passages besides Narcan, could cause damage
- Calling emergency services: you can simply say someone has stopped breathing if you are concerned about sharing that it was an overdose.
- Legality/Liability: In CA it is not a crime to report an overdose, both you and overdose victim will not be arrested for drug or paraphernalia possession.
  - Good Samaritan law protects against arrest or prosecution when reporting an overdose

        - DOES NOT protect you if on parole/probation, if you have more/other drugs for personal use, especially if selling/trafficking, or if you obstruct emergency or law enforcement personnel.
    - Overdose treatment liability act: allows for prescription and distribution of Naloxone. Permits individuals to possess and administer naloxone, protects medical professionals who prescribe or distribute naloxone. A prescriber may issue a standing order authorizing the distribution of Naloxone to personnel in a position to witness an overdose
- Storing Narcan: not in direct sunlight, keep at controlled room temperature, not below 41 degrees Fahrenheit or above 104 degrees Fahrenheit during transportation.
- Examining psychosocial issues: a lot of stigma associated with those who are struggling with a Substance Use Disorder (SUD)
    - SUD/opioid epidemic as a whole is connected to a wide variety of other issues like mental health, suicide, genocide, lack of jobs, self-medication, limited access to healthcare, etc.

# Next Meeting: January 18th, 2022, 1 – 3pm