NCJTC | Neurobiology of Addiction - Beyond the Basics

Welcome to the National Criminal Justice Training Center webinar, Neurobiology Of Addiction Beyond the Basics. Presented by Dr. Anjali Nandi. My name is Greg Brown and I will be moderating for you today. Before we begin the presentation, there are some items I need to go over. Today's presentation is part of a webinar series for the Bureau of Justice Assistance Comprehensive Opiate Stimulant and Substance Abuse Program and the Indian Alcohol and Substance Abuse Program for Coordinated Tribal Assistance Solicitation, Purpose Area 3 grantees and non grantees, focused on responses to alcohol and substance abuse related crime.

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So let's go ahead and try our first poll question. Which of the following best describes your role? Victim services/victim advocate, probabion/community corrections, law enforcement, child advocacy center worker, social worker, mental health worker, or other?

So Greg, our results today, 16% victim services /victim advocate, 23% probation community corrections, 4% law enforcement, 32% CAC, social worker, mental health worker, and 24% other.

Thanks, Rachel. So thank you for responding to the poll question. Today, I am pleased to introduce you to our presenter Dr. Anjali Nandi, Dr. Nandi is an associate with the National Criminal Justice Training Center of Fox Valley Technical College. She is also the Chief Probation Officer for the 20th Judicial District of the State of Colorado. Additionally, Dr. Nandi is a published author, having co-authored nine books.

Kevin Mariano and Justine Souto are joining the panel with us today as well. Kevin is a project coordinator at NCJTC, providing technical assistance related to community policing, sex offender management, law enforcement victim advocacy, and multidisciplinary, and multi-jurisdictional team development. Kevin has over 20 years of law enforcement experience and served as a chief police officer for the Pueblo of Isleta police department for over seven years.

Justine is a program manager at NCJTC and Justine oversees the Tribal Justice System Planning Project, which helps grantees plan and develop responses to address justice related issues. She has experience working with tribal justice systems, grant management, and interpersonal communications.

My name is Greg Brown and I will be moderating this webinar for you today. I'm a program manager at NCJTC. Prior to coming to NCJTC, I worked in probation for over 30 years, supervising offenders as well as managing a probation department. Again, thank you everyone for joining us today.

Thank you so much, Greg. Welcome, everyone. And welcome to this sort of second edition of Talking About Addiction. We have spent several webinars talking about aspects of addiction. We've talked a lot about the neurobiology. We've talked about craving, what it looks like in the brain, relative strengths of craving.

We've talked a ton about dopamine and what that means for us quite practically. And so today my hope is that we develop a little bit of a deeper understanding in certain areas. One is, how do we decide what to do when somebody is sitting in front of us or standing in front of us with addiction. Whether it's responding in terms of resources, responding in terms of support building skills, how do we make some of those decisions?

My hope is that we also develop a familiarity with some skill building that we can do with a long term focus in mind. And then that we implement strategies to really support behavior change out of a pattern of addiction. So that is our hope for today.

But just so we are all on the same page again. I know I covered this numerous times now when we've been talking about addiction. But addiction is a treatable issue. It is also a brain issue, meaning it's a brain disorder. You can tell when somebody is addicted to substances if you do a functional MRI and you will see some really significant changes that have happened between the conversations that happen between the frontal cortex and the limbic system.

And we've gone in depth over this. So I'm not going to repeat myself here. But it is a treatable, fixable brain disease. It does take a while and it is chronic. Addiction is chronic, meaning it's over a period of time. It's not an acute issue. It's reoccurring and relapse is sort of one of the pieces of the process.

You don't have to relapse. It's not a defining feature but that relapse is a part of what happens when somebody is working their way out of addiction. And of course every time I say that, I just want to provide the caveat that it's not a necessary part. So there might be a lot of people on this call who either themselves personally or know of folks who have made it out of addiction without any relapses, which is incredible.

But just sort of making sure that people know that relapse is not a sign that there's something problematic with the individual. Or that it means that the person will never make it out of addiction. It just means that it's a part of the process. And we need to do something differently.

Addiction is also characterized by craving for the substance and then seeking the substance. So actively spending time trying to look or obtain the substance and then addiction persists despite some pretty heavy duty negative consequences. And so unfortunately, it's not a solution for us to say, well, we'll just increase the negative consequences. Because addiction is a brain issue.

There are certain changes that happen in the brain that then persist despite negative consequences. The behavior is called an addictive behavior or is a problem because it's harmful. So, sometimes we joke that we're addicted to certain things, addicted to exercise for example. And we know it's a problem only when it's harmful. So, that's part of the definition of addiction.

And that it's diagnosable, meaning there are certain criteria that we can meet in order to be diagnosed with having a substance use disorder, whether that's mild, moderate, or severe. So throughout today, we'll be talking about certain things that help. But in general, when you come across people who are addicted to substances, there are certain folks who have better prognosis than others.

The folks who tend to have a better prognosis, and by prognosis I mean a better likelihood of being successful coming out of an addiction, better prognosis, if there's extensive social support. If they have access to health care and counseling and if they feel well supported. But unfortunately, those aren't always the people that we work with, right?

So, a lot of the examples that I'll be using are people who fall into the category of a poorer prognosis. They have limited social support, limited stability. There's a lot of trauma in their lives. They've experienced trauma or experienced adverse childhood impacts that result in some brain changes that then make it even harder to come out of an addiction and learn the skills in order to manage addictive behavior.

So there are folks who have poor prognosis. And it's these folks that we, I think, tend to deal with or at least I am most often faced with. So, we'll be focusing on this group, this group that tends to experience a poor prognosis. And one of the things that we will really spend some time thinking about is how do we make decisions?

So we have an individual in front of us struggling with addiction and there are so many things that we can do. What do we prioritize? And sometimes thinking about these four pieces it tends to be helpful when making decisions regarding the people that we serve.

So the first is structure. Does this person need additional structure? So structure can be a whole variety of different things. Structure can be anywhere from, do they need inpatient treatment? That's a high level structure or detox, high level structure. Do they maybe need to be checking in with me on a daily basis? Or do they need some kind of ongoing monitoring, whether it's scram or daily breathalyzers or random UAs throughout their time with me.

What is the structure? Or maybe it's just meeting with me more frequently. So structure really helps because it puts boundaries and expectations. It increases expectations around the individual. And that's the focus. And there are times where we have to prioritize structure over other things. So that's one of the pieces to think about. But maybe it's not structure that the person needs.

Maybe the person has structure in their lives and what they're struggling with is having some skills. And so today we'll focus a little bit on what are these skills that are really helpful to develop with folks. What are some of these skills that are particularly helpful in terms of helping people be more successful coming out of an addiction, so skill building.

And then motivation. Is it a motivation issue? Do they have the skills, they have the structure, but is it that they are just not motivated? They'll say things like, well, I could if I wanted to, but I just don't want to. I don't want to quit. I don't see the reason.

So is it a motivation issue and should I be spending some time working on motivation? Or is it support? Do they need social support, support in the community, positive peers around them. So, these are the four things. And sometimes what the person needs is all four.

And yet we have to prioritize. What do I start with? What does the person need the most? This frame also helps when we're working across different agencies and we all have different roles. Because there are times where we might have, and I'm just going to use some examples here.

We might have a probation officer working with a treatment provider and they're both talking about a particular client. And from the treatment provider's perspective, the client just relapsed because they were missing some skills. They were missing maybe some relapse prevention skills or some refusal skills.

And from the probation officer's perspective, maybe they're thinking wait, this client needs something more. Do they need detox? So they're thinking structure. And so it's helpful to have a similar frame so we can be talking about the same thing. And that way rather than fighting about, no, I think the person needs detox versus no, I think they need more treatment. We can come back to, well, I don't think it's a structural issue. Maybe it's a skill building issue. So it just provides us some languaging around this.

So let's see if we can engage you all as an audience and find out what you most see, what you see most frequently. Where do you find the people need the most assistance? Is it structure? Is it skills? Is it building motivation or social support?

And I know that you probably want to say all of the above. But I'm going to force you to make a choice among these four. Where do you find people needing the most assistance?

All right, so Anjali, the poll results for where do you find people needing the most assistance, structure 28%, 16% say skills, motivation is 19%, and social support is 38% of today's audience.

Wow, that's really interesting. Thank you all for doing that. So here's the interesting thing that social support, yes, incredibly important and helpful. And you are all right, in the long run, that is what it's about. That in the long run, what helps people stay away from falling into old patterns is strong positive social support. So, well done. 38% of you said that's a big area.

So, social support, incredibly important in the long run. And to help people stay away from addictive substances and change their patterns over a long period of time, social support is really what guides them. So well done, 38% of you said that's the big piece. Interestingly enough, skills, which was the lowest here, you all said 16%, is really where we find in the short term where people need support.

So that's an interesting piece. It could be that the folks that you are working with have the skills that they need, which is awesome. So, that's great. You probably need to focus more on structure and social support. But what we're finding in the research is these skills tend to be missing.

And sometimes as practitioners, we take for granted that people have certain skills. So we'll talk about those. And then I'll be curious to see what you all think.

All right, let's talk about MATs. So medication assisted treatment, and like Greg said, there's a whole webinar on this. Medication assisted treatments combine both medication and counseling. So skill building, support, therapeutic support, to treat a substance use disorder, and most often, it's used to treat an opiate addiction and an alcohol addiction.

So they are more successful at treating opiate addictions than either medications alone or counseling or behavior therapies alone. So combining medication with counseling seems to really help, particularly in the treatment of opiate addictions. And what's interesting is that this is widely supported as an evidence-based way of working with alcohol use disorders and opiate use disorders.

And so the kinds of medications that are used are FDA approved. For alcohol use disorders there are three that are approved, naltrexone, disulfiram, which is also known as antabuse and acamprosate. And for opiate use disorders, it's buprenorphine, methadone, and naltrexone. So those are some of the approved medications for the treatment of these two disorders.

And these are covered by Medicaid. So it would be important for you to reach out to whatever your centers or clinics are that serve clients who have Medicaid to see if they would cover MATs for them.

And Anjali, I would just say that we've got a related website on this. And you can visit NCJTC.org and look at medication assisted treatment to find one of our recorded webinars on the topic of opiate addiction and MATs. So just to get that in there. Sorry about that.

Yeah, no worries. But let's step back here for a second and start to kind of piece together all of the components that we need to pay attention to when helping somebody not relapse. So we spend several webinars just talking about the background, addiction, the brain, how do we manage some of the pieces of sort of attending to this disease as a brain disorder.

Today we'll focus on skill building out of the process of relapse. So, we'll break this model down into two parts. The first piece is the covert antecedents. Meaning, covert meaning hidden, antecedents meaning coming before. So before we actually have a relapse, there's lots of stuff that happens.

And it all starts with a lifestyle imbalance. But in the middle of all of this, we encounter a high risk situation. The stuff that comes before the high risk situation is called covert antecedents, hidden things that come before. And the stuff that comes after the high risk situation is called overt antecedents. They're more overt. They're more obvious.

So let's tackle the first section. And we'll start with a lifestyle imbalance. So Greg, when you hear the term lifestyle imbalance, and you're thinking about the people that we work with, what are some examples of lifestyle imbalances that our clients encounter that are the very early indications that maybe there's a relapse up ahead? What are some examples that come to mind for you?

I think people that become less responsible, they may be missing appointments, calling in late for appointments. They may look a little bit different. Their interaction with us might change. But some of the early signs, I think, are things like that. And really one of the keys as you know, is getting them to identify that as well. But those are the things that popped into my head right now.

Yeah those are fantastic examples. So, we know that something's up when people start to miss appointments, like Greg said. Or maybe a lifestyle imbalance is they're working more. They just got a promotion for example. Or maybe they lost their job and they are out of work. That's a lifestyle imbalance.

Or they're not going to AA like they used to. Or anything, or they're more stressed out. Anything, sometimes it's really small. Sometimes it's pretty overt. You can kind of-- you know it immediately. But I want you all to think about it for your life.

That if a relapse for you is engaging in some kind of negative behavior, whether the negative behavior is drinking, whether the negative behavior is not exercising or eating in an unhealthy manner or eating too much sugar, whatever the negative behavior is, biting your nails, et cetera, where does it start? And can you think all the way back to, oh, yeah, I started to get stressed or I was working too hard or something, right? There's something that just gets us a little off kilter.

And as soon as we get off kilter, our bodies want to come back to homeostasis. And homeostasis is this sort of normal where things are back in balance. And we want to come back to homeostasis really quickly. And the experience that we have is one for immediate gratification. I want what I want right now. I want to feel better right now.

And as soon as we start to have that feeling, a couple of things happen. Our body starts acting up and our brain starts acting up and they feed each other. So let's talk about our bodies and then we'll talk about our brains. So the way our body starts to act up, is we start to have these urges or cravings for whatever the substance is.

So let's do the substance for us on the call. I'll come up with an example. Maybe it's sugar. We start to think, we start to feel the urge to have sugar. We start craving it. And that is, it's a feeling. It's also something that's happening in the brain. There are certain parts of our brain that are firing in really interesting ways that connect to our reward circuit that say, oh. I could get this reward. I really want it.

We could ride that, except what happens is our thoughts kick in and reinforce the urges and cravings. So if we just had the physical urge or the physical craving, we could tolerate that. The problem is, it links to some thinking. And some cognitive errors might be, I deserve it, it won't be that bad.

It'll help me feel better right now. I've been so good so far. A little bit won't hurt, et cetera. And what we do is we make some kind of a seemingly unimportant decision that lands us in a high risk situation. So maybe we decide to go to the grocery store. Or maybe we make some kind of a decision, some kind of a decision like, we go out to dinner or I do this a lot.

I will go to the grocery store with my daughter and say, oh, yeah, let's have some mother daughter time. Let's bake cookies, knowing that there are so many other things we could do together, and yet that's what I'm suggesting. So we make the seemingly unimportant decisions, but it leads us into a high risk situation.

And once we're in a high risk situation, we either have a coping response, which you can see on your screen at the top in blue and things go well. Or we don't have a coping response. We don't know how to manage it. So now we are starting down the road of trouble. We don't know how to cope with this high risk situation, whether it's being at a party with friends or being in the grocery store in the baking aisle, and we don't have a coping response.

And we feel worse about ourselves, decreased self-efficacy, and then our brain starts to kick in again and says, oh, it won't be so bad. You can just have one. We'll throw the rest away. Besides you really need to spend some good time with your daughter. It's going to be fine.

And that leads to what we call a lapse. And a lapse is just sort of a stepping our toe back into an old pattern. And of course, we're talking about addiction here but really this applies to so many different kinds of behaviors. So we take a step into the old pattern. And maybe it's having one cookie. Maybe that's the lapse.

And then we experience what in clinical terms is called the abstinence violation effect. But if I explain it, I think you will know what I'm talking about here. And my clients have very colorful terms for the abstinence violation effect. But essentially, I've had one might as well have the whole bag. That's an abstinence violation effect.

I've had one cookie. Might as well go the whole way. Or sometimes clients will say to me, well I knew I was going to get a hot UA, so I just really lit it up. Those are statements of abstinence violation effect. And that's what sort of brings us to the lapse.

But every step of the way here-- and I'm going to go back in the slides for a second, every step of the way there are skills that we can build along the way that would help stop this process, meaning it could halt the lifestyle imbalance. So in terms of a lifestyle imbalance, a helpful skill is to recognize, I am out of balance.

And then what do I do? How do I help myself get back into balance? Or what additional support do I need so that I don't go down the negative behavior route. If I have thoughts of immediate gratification, the skill is, how do I delay gratification?

If I have urges or cravings, maybe the skill there is, how do I manage how do I tolerate some of these urges and cravings? Sometimes the term is tolerating discomfort or riding the wave of the urge or the craving. If I have cognitive errors, how do I stop my thinking and replace them?

If I do end up in a high risk situation, which high risk situations, no matter how hard we work, we will not be able to avoid, how do I develop some coping responses which will reduce the likelihood that I will have positive outcomes. Secondly is, if I do lapse, how do I prevent a full blown relapse by stopping the abstinence violation effect? So if I have one cookie and I have the thought, might as well have the whole bag, how do I develop the skills to stop it right there and to put away the rest of the bag?

So Greg, I'm going to just check in with you. As you're listening to this, what are some questions that you're thinking about or any comments that you have or examples that you have as you're listening to this and thinking about our population and the clients we work with?

Yeah, so I want to go back a little bit to the antecedents. And when you asked me that question, I was really thinking of the training that we've done to really pay attention to that and start inquiring with people. So really little things, like a missed appointment or being late or things like that.

I saw the loss of job or promotion as further down the line. So I was breaking those down a little bit more. Can you talk a little bit more about that? And maybe different interactions that we might take with people as we're trying to sort this out with them and help them become more aware of it?

Yeah, I like how you asked that question, because essentially you said, how do we help them become more aware of it? And that really is the key. The key is for us to get curious with our clients, but also for the clients to get really curious about themselves and increase their awareness.

So sometimes I ask this question. How do you know when to worry? How do know when you're going down a path that you know is going to lead to some problems up ahead? And then I ask it a little bit differently, when should I worry?

And very frequently, people have said, well, when I start withdrawing or I'm not talking with you as much or when I start missing appointments. So they have awareness of what that looks like. I mean, I could ask any of you on the call, how do know when you've just started down the path of going against whatever behavior you promised you would do, right?

So maybe, I'm choosing benign behaviors here, but maybe the behavior was sticking with an exercise routine. And if I ask you, how do you know, what's your first step that says, oh, you're starting down a slippery slope, maybe you say not sleeping well the previous night or not getting my clothes ready the previous night. Or maybe you say actually, it's when work starts to get stressful is when it happens.

So for different people it can be little things. And for some people it can be big things. So when Greg says, pay attention to all of it. Yes, pay attention to even the little cues that people provide, the missed appointments, missing treatment, not calling their sponsor or whatever to a program they're involved in. So it's really important to pay attention to those,

Yeah, Anjali, I have an example that I just actually went through a couple of days ago. Someone just got out of residential treatment. They've gone about six or seven times now and he's obviously looking for a job, right? And so he's looking for a job. And I said a couple of places like Walgreens and something like that.

And he said, you know, what I've learned is that my progression to using and abusing major drugs is having access to things like Sudafed and things like that. So I really can't work at any place that makes those available at this point in time. So, I thought that was a really great awareness on his part around paying attention to, I'm not going to put myself in this high risk situation and create-- if I have any imbalance, it's going to create another barrier or another barrier for me to relapsing.

That's such a great example and how great that the person was so insightful to know, you know what? I am not ready. I'm too early in my process to be in the thick of a high risk situation like that. So, yeah, it's a great example. Thank you.

Any questions from the attendees so far?

Few questions, I think for treatment providers, what's their role in supporting corrections professionals in this process? Because it's sounding like you're talking about, this takes a lot of teamwork and collaboration and discussion to be helping clients pay attention to these antecedents, particularly.

Yeah. It's such a great question because it is a partnership here. And so let's talk about that in terms of these skills, and sort of what to pay attention to when we're thinking about a relapse prevention model. So anyone, no matter what your role is, can ask these questions, can help the client become more aware of their patterns and their process.

You don't have to be the therapist or you don't have to have a particular role in order to have these conversations. Where the roles start to get more clear is, let's say the probation officer notices that there's something going on. And the client says, well yeah, I am getting really stressed. I notice that I'm kind of off my game a little bit.

I'm getting stressed. I think maybe, I'm not sure, maybe it has to do with my relationship. I'm just not sure, but I notice that I'm getting stressed. It's the probation officer's job to help develop skills related to stress, and then to provide that information, with the client's permission-- we have releases of information in place --to the therapist or encourage the client to talk with a therapist. And then the therapist can take it even deeper and talk about the parts of the relationship that are really hard and what the history is, whether there's some trauma, et cetera.

So the therapist can get to do some of that deeper work. But we're always building skills no matter, what our role is. So increasing awareness and building skill is true regardless of the role. And so in those ways, I think we stay in really good communication with each other, whether we're probation or treatment or whoever we are. It doesn't matter what the role is, we stay in good communication.

Because all of this needs to be highlighted in all the aspects of the client's life. So it's not that only once a week in the therapist's office does the client have to talk about some of these things. That way everybody involved is helping the client develop this sort of deep sense of awareness.

Thanks, Anjali, another thing comes up. I know that we have law enforcement professionals on the call. And when you see these high risk and, in my jurisdiction, we used to call them frequent fliers. They're in and out of the jail. They've got serious drug and alcohol problems.

Is there a role for law enforcement to play in this and to help this person in the process or make someone aware of it or things to pay attention to? Because we do know they have lots of contact with people where they are arresting them necessarily. But they're on the streets, they've got that contact? How can that play into helping people who are either under supervision or struggling with addiction get back on track from their perspective?

Yes, for sure. I think these are really, really important questions. I just noticed this. Justine has a response. And I'm guessing that Kevin does too. So Justine, would you go first and then we'll bring Kevin in, and then if there's anything missing, I'll add something.

Thank you so much for inviting me into this conversation. It's fascinating to me to learn the science behind this thought process of change and in relapse. And I really appreciated the comment that someone made about the collaboration and the coordination of efforts that might take across professionals.

And I would agree with that. And I wonder if people have an increased justification to relapse if they know that their service professionals are not talking to each other. They can get away with some things with their probation officer. But maybe they won't be able to get away with avoiding or just not addressing certain emotional aspects from their behavioral health therapist or counselor or group therapy.

And it just made me think about that structure, skills, motivation, and social support that you were talking about earlier, Anjali. And I always go back to this medicine wheel concept of holistic way of being. And I wonder if there could be just something as simple as a worksheet that the client goes through and you help them address what do they need physically and structurally to help them in their recovery?

What are some of the skills involved with that structure that they need to learn? And emotionally, what about their motivation? And how are they going to get motivated to be on a healthier path? And the spiritual connection, what sort of social support are they looking for? And if they can identify, the client can identify some of these things, then moving forward they would be held accountable according to their own admission and realization of what their needs are.

And I think about an example might be somebody who is in need of some structure. And maybe they just need a calendaring tool, because they don't know how to keep appointments straight in their minds. So it's something simple like that. But on the other hand, maybe they have something deeper. Maybe they have some kind of an imbalance.

Maybe they're diabetic or pre-diabetic and they don't have the proper nutrition. And when they were using, that sort of put them out of balance. So structurally or physically, their body might need education around their health and wellness. And they need to realize what a nutritional daily meal schedule looks like.

So I've heard people in recovery talk about how much they crave like fresh fruits and vegetables, and how much their body might need those things to help them in their recovery. Does that sort of make sense for the connections?

Oh my gosh, it absolutely does. And I love how you took each of those pieces, the four decision-making touchstones and linked it to the human being. What physically do they need? What emotionally do they need? What's socially do they need? I think it's a really beautiful way of looking at it.

And yes, fantastic. I so appreciate that you shared that with us, Justine.

Thank you. Oh sorry. Justine, keep going. No, go ahead, I'll come back to it later.

I actually was going to bring Kevin in. So before I do that Justine, if you want to keep going. And then we'll invite Kevin in to answer the law enforcement question.

OK. Well, thank you. I was just thinking about the structural support that the majority of the listeners today talked about that being a great need. And in terms of creating that medicine wheel with those four quadrants, I wonder what the person would identify as their needs for support and the referrals that you could be making as a probation officer or as a treatment provider, if you were sharing this sort of medicine wheel diagram of what the person's needs are, then people might know where the help is particularly in need for this particular person.

So another example was, if I knew that this client needed help in the spiritual realm, I might ask them, well, who do know that can support you in this spiritual realm of yourself? Like what do you need to make these spiritual connections? And they might say, well, I feel like I need to be closer to the Earth.

I feel like I'd like to learn how to garden or learn how to pick the berries or the medicines out in the woods that you need for different things in our tradition or in our culture. And so then their homework could be to identify the person who could teach them that. And they could reach out. Or you could help them make the connection to somebody in the community who can do that.

And if they need physical fitness to help with their wellness and fighting like their prediabetic status or whatever the case might be, you might have a fitness center in the area that could offer possibly free membership to your clients who can help them get into shape and help them appreciate the small victories as they get healthier and stronger physically. So the idea behind those different resources is that social support.

And then the client is learning how to advocate for themselves, reach out to the resources that they need so that they can get the supports in the different aspects of self. And then it's not just you being the only person holding them accountable and cheering them on for their recovery. It's a whole network of people related to their structure, skill building, motivation, and social support.

Yeah. Part of what you're saying is it takes a whole community. And we should involve the whole community. You're absolutely right. Great.

We have a comment from one of the participants that said, this isn't a question. But the medicine wheel can address the underlying issues that he or she can work on. Four direction model can be used as a wellness model in all areas with goals to obtain. So I thought that really nicely summarized you guys' discussion back and forth.

Thank you. Much more succinctly than I did.

They had time to think about it and put it together, but nice really nice comment. Thank you. Kevin, you want to jump in on that question, if you remember the original question?

I think I do, Greg. And hello to everyone. Thank you Dr. Nandi and Greg for mentioning the law enforcement section. And I'm going to kind of work off of-- thank you, Justine, as well too for mentioning the partnership. I think that's really important. And I think from the law enforcement side of understanding the addiction, more clear and how we can work with individuals, I saw some of the disconnect that we had in the community where I used to work at.

And trying to understand it more of how we can provide more services without obviously make an arrest. We couldn't really arrest our way out of a problem that we saw within the community. But how can we understand the side of addiction a little more clear, to where we can work and maybe even possibly refer individuals to some type of program.

And I think it's just kind of building those partnerships with, if it's behavioral health program, social services program, whatever program that's available as a resource that you can reach out to and refer individuals into is obviously nice. I know some of the struggles that we had from the law enforcement side, not everybody needs to go to jail or detention, whatever the case may be. But they just need some assistance somehow.

And being able to educate, be educated from the law enforcement side to refer individuals into some sort of treatment would help them out quite a bit. And it's just some of the things that we saw from the law enforcement side, there was how can we provide some more assistance to individuals that are having issues, whether it be addiction or maybe some other issues that they may have.

But it's just understanding and building those partnerships and understanding what we're trying to do with the whole situation at hand and so forth. So thank you for allowing me to mention that.

Thanks, Kevin. I think you touched on a really important point. We know that law enforcement and the corrections system really is the place where we don't have good answers for a lot of social problems. And then we kind of bring people into that system, hoping that they get the help.

Where if we can create some of these other connections and partnerships and multidisciplinary teams, maybe they don't even need to come into the system. Maybe they can access behavioral health services or some kind of support through a religious organization or something like that. But short of us having to handle these really, really challenging social problems and complex people with complex needs, maybe there are some ways to divert them from the system, where they can get the assistance that they need. And Anjali, I'll turn the time back over to you.

Great. Thank you so much. What a great discussion. So we've been talking a lot about skill building. But let's just get on the same page before we kind of move forward, just about skill building in general. So any time we're thinking about skills, no matter what kinds of skills they are, we have to identify what the issue is. What is the gap?

Why should we even be talking about this particular skill? When we identify the gap or the issue, what we're doing is we're making it relevant. We are helping the person see, oh, that's why I need the skill. This is the gap that I'm trying to solve.

So once we've done that, we clearly name the skill. And it doesn't matter what fancy term you call it. It doesn't have to be fancy at all. You just name the skill in your own way. But when you name the skill, you allow for that particular skill to be reinforced in that individual, in the client.

And you can come back to that particular skill later on when the client demonstrates it or when you're having a discussion about it. So it could be as simple as, great problem solving I noticed how you just problem solved that. That's naming a skill.

Or maybe the gap is that the client doesn't know how to take feedback. And so you're clearly naming the skill of receiving some tough stuff from people. How do you manage when people give you tough feedback, tough information? So maybe that's naming the skill. But just get clear about the skill. And then provide the person opportunities to practice with you, provide feedback, or maybe you can identify other places that they can practice whatever the skill is and receive feedback.

And then also have conversations regarding how they can transfer these skills to other scenarios. So let's make this really addiction specific. We know that there are three categories of high risk situations. Most high risk situations that we all get into can be categorized into these three buckets.

The first bucket is intrapersonal difficulties. So intrapersonal means inside me. It could be high emotion. It could be stress. It could be anxiety, depression. Something happened. I'm feeling really bad about it, my trauma, all of that stuff is all inside of me.

So that's one of the buckets. The second bucket is interpersonal issues. Interpersonal is, how do I deal with other people? How do I deal with conflict? How do I set boundaries? How do I give you feedback? How do I navigate when you are pressuring me into doing something?

So those are interpersonal skills. And then the third bucket is social pressure, meaning being with more people and everybody sort of socially, there's pressure to engage in a particular behavior. And sometimes this is covert pressure. Sometimes it's overt.

Overt means really, overtly saying, hey, come on use with us. Covert meaning, the cool people tend to use. Or if you were truly a part of this group, you would do what we are doing. So there's covert and overt social pressure. But those are essentially the three buckets of high risk situations.

So again, the three buckets are intrapersonal, so inside of me, interpersonal, and social pressure. And in these three buckets, there are a ton of skills that help us get better about managing these three kinds of high risk situations. So if I'm talking about intrapersonal, it's about managing my emotion, trauma resolution. It's about dealing with some discomfort, all of that.

If it's interpersonal then it's a lot of social skills. And if it's social pressure, then it's about saying no, having clear boundaries, naming discomfort, et cetera. So transferable scenarios means that if we learn skills in one of these aspects, we also try and clarify how these skills apply to so many other aspects of high risk situations.

So if I can tolerate discomfort or stress, maybe that means I can also say no to somebody and tolerate them saying, well, then I don't know if I want to engage with you anymore. I don't know whether you actually belong, et cetera. So transferable scenarios means making it relevant across a variety of different sort of situations that clients find themselves in.

So one of the ways, or one of the really concrete skills, to kind of focus on is restructuring thinking. And Greg just asked a really interesting question. He says, why is it so hard for many of our clients to learn to transfer skills to different settings? So you're right on, Greg. It is really difficult for clients to transfer skills.

Mostly because skill transfer is a frontal cortex issue. It's about our frontal cortex being able to connect to entirely what seems on the surface as disparate or different situations. And when we have an addiction, our frontal cortex doesn't engage us as well and clearly as our limbic system. And so part of why we have to do this is because those neural connections have been lost.

And we're trying to rebuild those neural connections. We're trying to rebuild cognitive flexibility. Oftentimes, when we get addicted to substances, we develop something called cognitive rigidity. Maybe some of you have experienced this with your clients, where the client seems to always think a certain way.

It's always or never or well, I did that because I've always done that, right? That's cognitive rigidity. And what we are trying to develop is flexibility in their thinking. And sometimes that's rebuilding thinking. Sometimes it's actually building it for the first time.

And an example of building it for the first time could be somebody who's sitting in front of you who never had to develop some of these skills, because maybe they grew up in a pretty chaotic environment with trauma all over the place. So for them, we're actually building it for the very first time. The analogy that I sometimes use is Swiss cheese, right?

So Swiss cheese, if you take a look at it, it's a whole block of Swiss cheese, and yet there are big holes in it. It's still standing. So the individual still looks like an adult. And yet they're missing these really key pieces that some of us tend to take for granted.

So sometimes it's rebuilding the skills and rebuilding the connections in the brain. And sometimes it's building it for the very first time. But either way, we have our work cut out for us. And it's really important to not take for granted that the clients have these skills already.

So when we're talking about thinking skills, we're talking about restructuring thinking, making sure that we're building these connections between the frontal cortex and the limbic system. And we're helping people identify their thoughts, be able to tell the difference between thoughts and feelings, be able to stop their thoughts, and challenge their thinking. Be able to start replacing their thoughts with more positive thoughts and tolerating some emotional discomfort.

So these are some of the skills that we tend to focus on. And I'll try and give you some concrete examples here. So some of our-- I think in the addiction world we frequently use this term stinking thinking. Maybe some of you have used this term before.

But what it means is, some of these thoughts that are really unhelpful. And so identifying the thoughts, it could be identifying an unhelpful thought, like using a little won't be so bad. Right, that's that the thinking. And it's important for me to be able to tell the difference between that thought and an emotion, which might be a feeling, and then stopping the thought.

So wait, stop. It might be that bad. Why do I want to use in the first place? What exactly is my need here, so sort of slowing that process down. And then challenging the thought and replacing it. Greg, you have a question.

So the question is, what do you recommend when someone clearly has an issue. It's apparent to you, others, and even the person themselves. But they will not accept the skills needed to solve the problem. In other words, they know there's a problem, but the denial will not allow them to accept the solution.

Oh, this is a great, great question. And essentially, what we are talking about is stages of change. So, the person is asking about, essentially about stages of change. So in the question, the person says, what if the client is not ready?

And that really is the first sort of step in this process. Is people are really not ready. They push back pretty hard. And we call that stage the precontemplation stage. People are not quite ready to even think about this, let alone think about the skills that you're talking about.

And 80%, some people say even up to 90%, of all people who come to us in the criminal justice arena come in precontemplation or contemplation, which are the very, very early stages of change. And so it's really important for us to get good at these stages. So what do we do when somebody comes in the precontemplation stage, which is that first stage?

And essentially the whole goal in the precontemplation stage is to just raise doubt by getting to know the person and asking questions. So we get to know them, help me understand this issue. You're saying it's not a problem. Say more about that. When would you know that it is actually a problem?

Tell me about a time in your life where maybe you thought, ah, maybe this is becoming a problem. How do you define what a problem is? What is really important to you? How does this behavior fit in or not fit in with those things that are important to you? So hopefully as we're asking these questions, the client is starting to give us information that has incongruencies.

So the client will say something like, my family's really important. Great. How does continuing to use support your family? Or how is it sometimes in conflict? So we're asking these questions with the utmost empathy and respect. It's not a process of gotcha, right? That's not the game I'm playing.

What I'm trying to do is just help the client in a really safe and supportive way, start to doubt their behavior, start to worry, start to think, well, maybe continuing to use is not such a good idea after all. And as soon as you have doubts, you're in the contemplation stage. And that's where the skills really start to help.

These skills help in the contemplation, preparation, and action stages. So our first bit, it's really important that we not do too much teaching in that precontemplation stage. But we really just get curious and kind of raise doubt. Greg, did I answer that question enough, or is there something else you want me to kind of comment on?

No, I think that's great. I think that when you were talking about that, I was reading the question. It feels like we want to be ahead of where people are at and we know what the solution is and what they need to do, which we all do. But it's so important to meet them they're at, and to stick with the science and the models.

So if it's not connecting, and they're not seeing it as a problem, go back to pre-contemplation and what are the strategies there? So I thought that was super helpful.

Yeah, beautifully said. Thank you. So similar to restructuring techniques that we just talked about, one of the techniques is thought stopping, that I just mentioned. And there are several ways that we can help people stop their thoughts. And maybe you have particular strategies that you use.

Because I know for me, there are times where I'll have some negative thoughts in my head that I really need to just stop. And sometimes I'll even say it out loud. I'll say stop, out loud. Or I'll just shake out my hands and switch my thinking. Or I'll turn on the music really loud.

Some of the clients will visualize a stop sign. Or they'll use a rubber band on their wrist or distract themselves or exhale really loudly. There are a lot of different techniques that people can use that's really helpful.

So Greg, questions now? Or do you want me to keep going?

Sure, I think we have a couple that are related to things that you've talked about. So it would be good to cover them. So here's one. If a client has a history of sexual abuse or other trauma that triggers their relapse, what treatments have you found to be most successful?

Lots. And I love that you are noticing the connection that the trauma has. Trauma has such an incredible impact. Because here's the thing. The way trauma impacts the brain is so similar to the way addiction impacts the brain. And so they have sort of this synergistic or multiplicative, that is not the word, something that essentially means multiply, unfortunately the negative impact on the brain is multiplied when we have both trauma and addiction.

And so, you're asking, what are some helpful techniques or helpful therapeutic techniques? There are several. Seeking Safety is one that is very helpful with folks who have experienced trauma. Any CBT curriculum, but not even a curriculum any engagement using cognitive behavioral techniques.

So that could be achieved through a probation officer or a treatment provider, anything that focuses on cognitive behavioral techniques. And here's why. We talk about this because one of the fundamental issues with both trauma and addiction, is the loss of connection between the frontal cortex and the limbic system that we've talked about in numerous webinars.

And so what CBT does is it repairs that very connection. So really, really helpful to kind of focus on CBT techniques. But CBT, Seeking Safety, any of the things that we can talk about goes out the window if we don't have a fundamentally strong, empathic relationship with clear boundaries, clear expectations, and a clear orientation towards a goal.

So yes, all of that is really helpful. And don't forget, fundamentally, it's about a good, strong relationship. Any other questions?

Thanks, Anjali. I think this is a good one that I want to make sure we get in. The issue that we are finding in our community is the stigma of addiction, not only in our council but also in our social workers. What is the suggestion to help educate and remove this stigma?

I so appreciate you asking that question because you're right. I mean, there's so much research to support addiction as a behavioral health disorder. So similar to whether it's diabetes or heart disease, and yet there's so much stigma around it. So sometimes just talking about it is helpful. And people will say, well, it's not the same as diabetes. It's not the same as heart disease. Because people are choosing to use. People chose to use.

But here's the thing. I can develop type 2 diabetes by making certain choices. I can choose not to exercise. I can choose to eat in a particular way. And maybe I'm really upsetting people on the call. But there are choices that we can make that will result in a behavioral health issue like diabetes, like type 2 diabetes or heart disease for example.

So yes, we're making the choice. And so did our folks who started to use substances. Do we say, therefore, that their choice was OK? No. No, no, we're not taking away responsibility. But we have to recognize that now that we've made the choice, after that, after the person has started using, they no longer actually are choosing to use, they're just trying to survive.

And survival means use for them. So in our previous webinar on addiction, I laid the foundation for why what happens in the brain that makes using the substance as important as survival, meaning as important as breathing and sleeping and eating. So the substance becomes that important because we have now created brain changes. And relapse rates across all of these behavioral health issues, diabetes, so type 2 diabetes, cardiac issues, stress management, managing blood pressure, relapse rates across those are so similar to relapse rates for addiction.

So I find it really helpful to just engage in that conversation so we can reduce some of the stigma. So it's important, I think, to have these conversations. Because as long as there is stigma we will not provide the kinds of services we need to support our community. One last piece that we can increase or reduce the likelihood that people will use based on what they've experienced before.

So people who have adverse childhood experiences have an increased likelihood of using substances later on in life. People who have experienced trauma, people who have grown up in chaotic households, people who, around them, there's not there's communities that don't support sort of after school activities and engagement and staying in school and all of those things, have a higher likelihood of engaging in substances. So perhaps this is maybe too edgy to say, but is it just the individual's fault or can we as a community also take some responsibility here?

Dr. Nandi, I really appreciate that. I think it's absolutely part of the community's responsibility because, especially in Indian country, we all grow up so close to one another and knowing each other so well as like family and relatives. And I wonder if part of the stigma or a challenge to stigma is exactly what you spoke about, with the generational trauma and service providers just knowing the families in these small communities that they work in.

And I think it's really hard and challenging to keep a fresh perspective that every encounter with an individual is like a first time encounter. Instead of that revolving door of, oh here comes so and so again. Their whole family is like this. There's nothing you can do because you always see them. That kind of bias that you think of when you associate the addiction with particular families.

Yes, Justine. Thank you. Thank you for sharing that. It is sort of this inherent bias right that's driven by the stigma that unfortunately addiction does have. So the person asking this question, I hope we've answered it at least a little bit. If we haven't, put another question in the Q&A section so that we can continue to answer it because it is so incredibly important.

And I think it is our responsibility, all of us on this call, to continue to address the stigma of addiction. So let's continue with a few more skills, and then we'll start to wind this down. So we've talked about some of those thinking skills. Some of the emotional skills are around building up an emotional vocabulary so people can express what's going on for them.

So often people will use substances to kind of manage some of their emotional world. And part of managing our emotional world is to be able to articulate what is happening. But we don't always have a good emotional vocabulary. So a few ways of kind of thinking about how to help people develop emotional vocabulary is for them to use emotion cards, which are available on the internet.

If you click on, if you Google search emotion cards that you could buy them or if you don't have the funds, you can print it out on kind of business card paper. You can buy those, the pre sort of, cut business card paper. You could print out emotion words on all of these. Or just print out a sheet of paper with those faces with all of the emotions and have clients kind of identify what emotion they're experiencing.

And using those words just helps build emotional vocabulary. You can also have them check in using their emotions, meaning check in talking about how they're doing today. Or sort of face they're experiencing. Help them separate thoughts and feelings. It's important for people to be able to name their feelings and name it accurately.

So I-- you know sometimes I've experienced clients who just struggle with using just a few words. They are either very angry or they're pissed off. They have really limited kind of emotional vocabulary. And imagine them coming to you and saying, I'm pissed off with you. Even though they're only slightly irritated.

It gives the wrong sense there. So it's really important to be able to identify what the feeling is and then separate it from a thought. So I feel like you are an idiot is not a feeling. It's a thought. And we have to separate those two and just sort of focus on what is the emotion there.

Or you could play emotions charades just to build the capacity for people to articulate their emotion. So emotional awareness and naming emotion is really important, but so is tolerating emotion, tolerating stress, tolerating discomfort, and helping people do that, helping them learn how to tolerate it. And to think about how does the emotion that I'm experiencing inform my action? And how do I self regulate without the use of substances?

So frequently you'll find people who can't manage their emotion. They'll use substances as a self-regulating technique. And so how do we help them kind of learn some of these skills to self-regulate.

So we've talked about thinking skills. We've talked about emotion skills. And here's some social skills that are really helpful to talk about. Social skills are about being aware of other people, and then managing our relationship with other people. So it's about understanding people, cognitive empathy, and then expressing emotional understanding, affective empathy. It's also about having conversations, or resolving conflicts, giving and receiving feedback, and really importantly, setting clear boundaries, being assertive in communication.

Part of the social scale piece is folks understanding who is their social network, and do they have the kind of social support that they need. So we're going into that social network piece, where we start by having people just map out what is their social network. And this can be done through either with a treatment provider, or a probation officer, or really, anybody, a peer support person can do this.

But by asking, if I'm in the center, if that's me in the center, who are the people I have daily contact with, and that goes in the yellowish circle. Who are the people I have weekly contact with, so that's kind of that middle one. And then the outermost circle, who are people I have monthly contact with. Are they friends, are they family? Sometimes, I'll ask people to write in their names, or just their initials, if they're not comfortable writing a name.

And then we start to shade people in, who are the supportive people, and who are the non supportive people when it just comes to this behavior. So I don't mean supportive and not supportive in terms of criminal activity, for example. But I'm talking about just this particular behavior, whether it's drinking, or whatever the behavior is that we're talking about.

So who is supportive, and who's not supportive. And it's such an incredibly interesting conversation to have with people. I mean, I've learned so much about who they surround themselves with just by doing this particular activity. So it's a really good one to start developing some ambivalence, and some sort of clarity for people, that who they surround themselves with matters.

Because those are the messages they receive on a really regular basis, right. They're inundating themselves with particular messages. And so let's say we end up doing a social network map, and we find that most of the people surrounding our clients are folks who are not supportive.

And so we can start to introduce sort of these mutual support groups, whether that's church groups, or community groups, or AA, NA, et cetera, whatever those mutual support groups are. Sometimes, people feel kind of worried about engaging in some kind of a mutual support group. So make sure you're providing a good rationale for them, so that they understand why you're suggesting this.

And explore their attitude around it, so that you can clear up any misconceptions, provide some examples, or information, ideas. And then encourage them to go to multiple groups, so that they're not just going to one and saying, nope, that one didn't work. So really encourage sampling, and then providing referral information, coming up with a specific plan.

And let's say you don't have too many, right. You don't have a lot of support groups around, maybe that's something that the client could develop. One of the things that we're finding is, when folks advocate for themselves, when they start to become activists in their own lives, it really helps shift their trajectory.

So this might be one of the places. We've had folks develop some really interesting things, like a sober bowling league, and things like that. So it might be some place that people want to develop something that supports them.

So this last piece is around how do we kind of support people's motivation, right. So we've talked about structure. We've talked about skill building. This is around motivation. We just talked about social support. So let me cover motivation, and then we'll do a poll really quickly.

So when we're talking about motivation, we are differently motivated for a variety of different things. So it's important to identify what we're talking about. Let's identify the target. And then start to develop some discomfort, some productive discomfort. How does this fit? How does this not fit? How is this behavior going to help you meet your overall goal.

Explore some of that ambivalence, and utilize this concept of friction. Like, how can we make some of this easier for you, so reducing the friction. And how can we make some behaviors harder for you, increasing the friction. And get the client to argue for making some changes.

Using rewards is really helpful, because you're engaging that part of their brain that's really problematic when it comes to addiction. So we're engaging the brain a little bit differently, and then definitely celebrating some really good successes. So any successful step, really celebrate so we can get dopamine starting to work again for our clients.

All right. So let's do a quick poll then. And here is, what barriers get in your way of providing some of the services? Is it resources, that we don't have enough resources in our community. Is it stigma? And I love that the person who asked the question talked about stigma.

On this poll, I called it assumptions. Is it assumptions that people make? Is it compassion fatigue? Are you just tired of sort of butting your head against the same issue. Or is it a lack of knowledge? So is it our lack of resources, our assumptions that we make, or our own stigma, compassion fatigue, or lack of knowledge?

OK. So the results of this poll, Anjali, are as follows, resources, 50%. That's by far the largest percentage of the audience today. Assumption, 17%, compassion fatigue, 14%, and then lack of knowledge, 19%.

Fantastic. Thank you so much. Yeah, resources, that's the really big one. And so here is what we are learning, that resources do matter. And yet, one of the biggest resources that the clients have is you and themselves.

So you, meaning, the relationship they have with you. Sometimes, you are the only person in their lives who actually shows them that they have hope. So really work hard, whether you actually have hope or not, to hold hope, hold the possibility of change for them, to help them have really clear expectations, and yet, the ability to kind of make mistakes along the way. That's really important.

And then when I say that the resource is also themselves. They're building their skills and motivation, which we know slowly, people can gain. We can help people change. And so yes, resources are so important. And remember, that you are one of the really, really important resources. We have just a few minutes left for some more questions.

I'd like to go to Kevin real quick. I do know we have law enforcement in the audience. And Kevin, could you talk a little bit about, if you have any examples of programming, or resources that have worked in tribal communities that you've worked with or in.

Yes, thanks, Greg. Yeah, we did actually establish one position within the law enforcement program there. And it was a case manager to assist us with some of the individuals that were identified, that didn't have to either be incarcerated. So we were actually able to create a real brief referral that went out to our behavioral health program, our other outside resource that we also identified as similar to a behavioral health program that we can refer individuals into and all that. So that one position really helped out quite a bit with some of the things that we were working with there.

Thanks, Kevin. Anjali, how can professionals work with families, family members that are addicted?

So including the family is incredibly important. Because family also, they have so many misconceptions as well. I mean, how many times have we heard family members say, well, if they really loved us, they would change their behavior. Or they just don't make us a priority.

And it's so hard for family members to understand that that's not it at all. It is not that family is not important. It has nothing to do with morality, or willpower. We're actually talking about a rewiring of the brain, that we need to unwire. And it takes a little bit of time.

So it's really helpful to gently educate family members, and to help teach them what behaviors of theirs are helpful, and what behaviors are not helpful. Because there are times where family members themselves can be pretty enabling of negative behavior. And so it's just, it's helpful to have these conversations with family members as well.

Thanks. And Justine, I'd like to tap into your expertise real quick. What kinds of resources or support might be common with tribal communities, and things for people to think about?

Thanks for that question. I think one of the bridges between different programs could be culture and traditional programming. Some communities have people that they go to. Some others might have an actual department within the organizational structure that are all about culture, language, traditions.

But I find that that's something that can help bring about balance for people. And there's no judgment there, and people are together learning how to do different things. And so that's a really great resource that is usually free. And it's grounding for people to be able to get back into touch with culture and tradition. It helps people discover, or rediscover, who they are, and that they have a purpose.

Thanks, Justine. Anjali, I think the next question, and it's a short one, but I think there's a companion question that goes with it. So bear with me for a second. So a safety plan for relapse question, and then, what is proximal and distal behavior, and how do we respond accordingly from a treatment and corrections perspective.

Yeah, so a safety plan, or sometimes, it's called a relapse prevention plan, is incredibly helpful. And that cognitive behavioral model will really help inform a relapse prevention plan. It's helpful to develop these, especially when the client is doing well. Sometimes, I've had clients say, oh my gosh, why are we doing this? I'm doing so well. Do you not trust me?

And it has nothing to do with trust. It's about us having a plan just in case things go sideways. And I say to the client, sometimes, my hope is that we never have to use this plan at all. And it keeps us informed, and it keeps us sort of on the same page.

So a good relapse prevention plan will have things like, how do I know when I'm triggered? What are my triggers? How do I manage some of my triggers? What are some early signs of relapse? What are my high risk situations? How do I manage those? What are my social supports?

If I find myself in a high risk situation, who do I turn to? Who can I call in case of a relapse emergency, et cetera. So all of those pieces exist in relapse prevention plan.

And then in terms of proximal and distal behaviors and goals, when somebody is addicted to a substance, expecting them to quit today is too high of an expectation. If it's truly an addiction, it's not going to happen today. It's going to take a little time.

So we call that a distal goal, meaning, it's far away. So complete abstinence for example, or even cutting down maybe, is a distal far away goal. There are some more proximal immediate goals. So maybe the immediate goal is to delete all the names of my dealers from my phone, right? That might be something that I expect more immediately.

Maybe the proximal behavior is for them to show up to appointments with me on time. Maybe the proximal behavior is making an intake appointment with the treatment provider. Maybe a proximal behavior is developing a list of all their triggers, et cetera. So it's really important and helpful to determine what can I expect right now, and what can I wait for later. So that's proximal and distal.

Thanks, Anjali. That's going to conclude our question and answer portion. So in closing, we'd like to share a brief information on additional training and technical assistance opportunities. NCJTC is a training and technical assistance provider for Coordinated Tribal Assistance Solicitation purpose area three grantees, and non grantees, tribal agencies focus on implementing system wide strategies to address crime issues related to alcohol and substance abuse in tribal communities.

We are also a TTA provider, assigned to assist tribal comprehensive opiate, stimulant, and substance abuse program grantees, focused on developing, implementing, or expanding comprehensive efforts to identify, respond to, treat, and support those impacted by illicit opiates, stimulants, and other drugs of abuse. TTA services for both programs include customized on site and virtual training, regional training, conferences, webinars, peer to peer support, on site, or virtual meeting facilitation, written resources, community planning, justice systems collaboration, and sharing grantee best practices.

For additional information on TTA services, how to request a TTA and featured offerings, including our recorded and upcoming webinars, please visit our program website as shown on the screen for more information. Finally, watch your inbox and our website for upcoming webinars and virtual TTA opportunities in 2021.

Another valuable resource is the COSSAP Resource Center. A screenshot of the COSSAP Resource Center is shown here, along with the web link. Featured resources available include, funding opportunities, COSSAP grantee site profiles with data visualization tool, information about demonstration projects, peer to peer learning, and recordings of previous COSSAP webinars, covering a range of substance use disorder related topics and strategies.

Of particular significance, is the ability to request training and technical assistance, or TTAs, whether you are a COSSAP grantee or not. The COSSAP TTA program offers a variety of learning opportunities, to assist and support local tribe and state organizations, stakeholders, and project in building and sustaining multidisciplinary responses to the nation's substance abuse crisis.

For more information, you can contact the COSSAP program at cossap@iir.com So once again, thank you, Dr. Nandi, Kevin, and Justine, for your contributions today, and for the excellent presentation. We thank you for attending this webinar. And hope you all have a wonderful day.