NCJTC | Co-Occurring Disorders Simplified - Webinar Transcript

Welcome to the National Criminal Justice Training Center webinar, Co-occurring Disorders Simplified, 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's 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. This project is supported by a grant awarded by the Bureau of Justice Assistance Office of Justice Programs, US Department of Justice. The opinions, findings, conclusions, or recommendations expressed in this webinar are those of the contributors and do not necessarily reflect the views of the Department of Justice.

Poll questions will be asked during the webinar. So with that, let's try our first poll question. Which of the following best describes your role? Victim services, victim advocate, probation community corrections, law enforcement, child advocacy center worker, social worker, mental health worker, or other.

And the results are as follows. Victim services, 16% of our audience today. Probation community corrections, 29%. Law enforcement, 1%. Child advocacy center workers, social workers, and mental health workers, 34%. And 20% are from another profession.

I'm 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's also the chief probation officer for the 20th Judicial District for the state of Colorado. Additionally, Dr. Nandi is a published author, having co-authored nine books.

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

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

My name is Greg Brown, and I will be moderating for you today. I'm a program manager with NCJTC. I've been with NCJTC for about two years as a program manager and about 15 years as a subject matter expert in community corrections. And I worked in probation for a little over 30 years. So I want to thank everyone for joining us today. And Anjali, the time is now yours.

Thank you, Greg, and welcome everyone. I wanted to start just by covering some of the learning objectives that we're hoping to get to today, to accomplish today. We will start, even though this is a co-occurring disorders webinar, we'll start by kind of establishing common mental health disorders and what their prevalence is in our communities.

We'll talk a little bit about symptom identification only so you understand what we're talking about. And then we'll really focus on how do we work with people who are presenting with mental health issues or co-occurring disorders. And we'll talk about some common biases. In fact, we'll get to that pretty quickly. And we'll talk about some of the impacts that these biases have when they're present.

So let's just start by defining what mental illness is and is not. We often throw the term around loosely, right? We say things like, gosh, this is really hard for my mental health. Or, my mental health is suffering. Or we'll say-- it's sort of part of our general vocabulary.

And while that's fine, it's important to distinguish what actually is a mental illness from what might just be symptoms but not a diagnosable issue. So we all probably can relate to lots of symptoms that I'll be talking about today. But a mental illness is something that is diagnosable, meaning it meets certain criteria. And it meets criteria for a certain period of time.

These criteria are different for different mental health disorders. And they are important to just be paying attention to. We're talking about, when we say certain criteria, is referring to something called the Diagnostic and Statistical Manual of Mental Health Disorders. It's the DSM, which keeps getting revised over and over again. And we're in a text revision right now.

So it is a diagnosable condition based on certain criteria, a certain length of time. And that it impairs functioning, meaning it impacts my ability to manage somehow, whether it's manage socially or at work or at home. But it impacts my ability to function.

It creates distress. It's uncomfortable. And without intervention, meaning without some kind of support, it's difficult to regulate. So those are the components of a mental illness.

Mental illness has nothing to do with intelligence. It has nothing to do with strength or morality, meaning just because I have a mental illness, it doesn't say anything about who I am. It just gives you one small aspect of something that I am struggling with.

And sometimes it's not that small, right? It impacts a huge part of my life. But it does not tell you the whole story about who I am. So it's really important not to assume that folks who have mental illnesses have lower intelligence or are not strong enough. It really can happen to anyone.

Another common misconception is that people who have mental illness are inherently dangerous. And that's not true. There are so many kinds of mental illnesses.

And yes, sometimes there is an overlap in the criminal justice world between people who we see and folks who have mental illness for sure. But having a mental health illness is not inherently problematic, meaning, inherently doesn't make me more dangerous. And we'll talk about some situations and some diagnoses where that might sort of lend to some kind of correlation there. So we'll talk through that.

It is a psychological condition. So it's not a condition of intelligence or morality, but it's a psychological condition. And it exists on a continuum from any mild mental illness all the way to a severe mental illness. So people can fall on any point of this continuum. And you'll notice where they are on the continuum based on the impact on their functioning.

And these mental illnesses that we'll talk about today, they're very different from psychopathy or sociopathy. Psychopathy, there's something different about the person's brain when we're talking about a psychopath. And here, when we're talking about mental illness, we're talking about something slightly different. We're talking about thought disorders, mood disorders, and a whole variety of things. But psychopathy is something entirely different and very focused on our criminal justice population.

So, I'm curious to hear from you all on this call. What is the most common misconception that you hear about mental health disorders? Do you hear people say, gosh, they just should get over it? Or, if they tried hard enough, they wouldn't struggle so much?

Or, just take a pill. It'll fix it all. Or, nothing is really wrong. It's all in their head. What are some common misconceptions that you hear?

All right, 15% said they should just get over it. 21% said they've heard, if they try hard enough, they won't struggle. 25% said taking a pill will fix it all. And 38% said nothing was really wrong, it's all in their head.

Thank you so much. I so appreciate that. Yes, these are misconceptions that we hear so frequently. And it sounds like you all experience these as well. And maybe some of us when we started in this work, we had some of these misconceptions as well.

So again, no problem. Just need sometimes for more education. And I noticed this a lot of times with people who struggle with mental illness also having these misconceptions about themselves. So sometimes there's so much shame around having a diagnosis and people really not understanding that there is no shame involved.

There's something different about the way their brain is working. And they need some support around that. So some education sometimes is needed, not only directly with the clients, but even the family members or their social support system, just to provide them the kind of support that they need. And Greg, please jump right in if you're noticing in the Q&A section or in the chat any questions that people are asking that might be relevant.

I think one came up, which is, why do so many people not like taking their prescribed medication? And that was one of the myths that's out there, just take a pill. I think they're responding to that.

Yeah, that's a really good question. It's a very valid question. Why don't they just stick with their medication?

Unfortunately, all medications have side effects. Some of them are tolerable and not a big problem. Other times, the side effects are pretty significant. The side effects might include a shift in the ability to sleep, weight gain, tremors, impacts on appetite, sexual functioning, those kinds of things, even feeling a little distant, like there's a cloud between me and the world. So sometimes it's because of those side effects that people will stop taking medication.

Other times, people stop taking medication because they feel better. So let's say I am depressed and I take medication and I start to feel better. I might think, why do I need to continue my medication? I'm feeling just fine.

There's nothing wrong with me. I want to be like everybody else. And that might lead to us kind of going off our medication.

It's very similar to any kind of routine that you and I choose. Some of us commit to going to the gym, for example. And then we lose some weight, and we're really successful, and then we think OK, maybe I don't need it anymore.

And we sort of stop, right? So it's really very similar in terms of the reasons why people might go off of medication. Yes, Greg? You had another question?

Yeah, here's a question and comment. I've heard all of those things with an addiction. They just need to stop using. When I explain that it's not that simple and in treatment they have to learn how to quit, they don't know how to because of the disease, I was scoffed and laughed at.

I'm sorry that you had that experience. You're absolutely right. When it comes to addiction, it's not as simple as just quit.

Because at the-- usually when somebody has developed a true addiction, there have been changes in the brain that make it really difficult to just quit because now we've developed certain neural connections that reinforce substance use. And that really-- that tell us that without the substances, we will not survive. So survival is dependent on using substances. So it's a really different situation that we're talking about.

And again, it's not about willpower, right? Just quit. It's not about morality or it's not about me loving my family enough or any of those things.

And if you're interested in the addiction side of it, we've done several webinars that focus on just addiction. So we talk about the brain, we talk about the impact, et cetera. So that might be a really helpful place too.

And I would just say that those are available in the NCJTC.org and the on demand library. And there's a whole series that talks a lot about addiction. One more question I think that's relevant and leads into your next slide. Do you think AMI is higher in females because males tend to not go to doctors more so than females so therefore they don't get diagnosed? And I think a companion question-answer to that is what about access to doctors.

Yeah, these are excellent questions. And I love the hypothesis about that. I think whoever asked that question is onto something.

The statistics that we have are based on reporting. So if people are under reporting, then our statistics are off. And I think you might be right that perhaps males under report having symptoms of mental illness, right?

Maybe culturally, we teach males to just get over it. Or perhaps we even-- perhaps we even provide ways in which the symptoms are manageable because they're limited to certain kinds of environments, for example. So I think there are cultural pieces here for sure. And there's definitely a reporting problem.

So I think the person asking the question is looking at right in the middle of the slide where it says that mental illnesses tend to be higher among females than males, that about one in five adults lives with a mental illness. So it's pretty prevalent in the US. That it's higher among the 18 to 25 group, so about 30%. And then it's the 26 to 49-year-olds, and then the 50 plus tends to be lower.

And again, this could be a reporting issue. It could also be sort of the stress in our lives at different times in our life. But among Native Americans, they are two and a half times more likely to experience serious psychological distress, particularly PTSD, which occurs twice as often in the tribal population. And suicide is the second leading cause of death for Native American youth, which is about two and a half times higher than what it is for-- in terms of the rate in the nation.

So after some of those sad statistics, let's talk about how we could recognize some signs that something might be going on. And now, please know that these are not all-encompassing. But these are just some general signs so that when you're sitting with somebody, or you're talking with somebody, these can alert you that maybe something else is going on as well.

So you'll notice that something is off. There's just something a little bit off that should tell you, wait a minute, this might be more complex. And I like to use the analogy of having a particular lens on.

And when we have a lens that there might be other things that make the situation more complex, it provides more empathy. And it allows us not to see the person as belligerent, or defensive, or not wanting to engage with me, not wanting to participate, or doing it on purpose. And rather than have all of those kind of negative thoughts, it allows me to be curious about what else might be going on.

So something's off. Maybe they have flat or depressed affect. Affect is kind of their mood or their emotion.

So it's either flat, they're telling you stories where normally ordinarily, you would see a smile or some sadness but it seems just flat. Maybe they seem withdrawn. Or the opposite could be true. Maybe they seem really hyper vigilant.

Poverty of speech, meaning they seem to want to say something, but they're only seeing a couple of words here and there. Or their speech is really fast and pressured. Maybe they're looking around in these really darting ways, or they're talking to themselves, or they seem really panicky.

Or they're complaining about pain, right? Different pain that maybe the pain changes from time to time. It was in the stomach, now it's the head, et cetera.

If you've known them for a little while, there's a change in behavior that you notice. So maybe they appear confused or disoriented. Perhaps they have poor hygiene or they're dressed inappropriately for the weather.

Those are some of the signs. And again, these are not all-encompassing. But it just tells us, it alerts us to maybe something else might be going on.

So let's talk about some broad categories. Let's talk about some broad categories of mental health issues. It's kind of buckets that we usually see.

So one broad category is the category of thought disorders. This has to do with some organic issues sometimes or interesting wiring of the brain that allows for us to either see things that aren't there, hear things that aren't there, feel things that aren't there, taste things that aren't there. So it's a disorganization of our senses. It's extra neurons that are firing as if we're seeing and hearing things, but the rest of us can't see or hear them.

So thought disorders are usually characterized by psychosis, which includes hallucinations and delusions. So hallucinations are a disruption in our senses. We're seeing things or hearing things that aren't there.

Delusions are having certain beliefs, having certain thoughts in our heads that are not quite accurate. So I could have a delusion that people are out to get me, or that Greg implanted a device in my brain so he can hear what's happening in my brain, or that I'm being spied on, or that there are drones that are hovering around my house that are watching me, and people are out to get me, et cetera. So those are delusions. Or I can have a delusion that I am the queen of the world or whatever.

So thought disorders, some examples of diagnoses that fall under thought disorders are schizophrenia, any psychotic disorders, or something called schizoaffective disorder. It's also a disorder that's commonly seen, maybe some of you on the call have clients who are diagnosed with schizoaffective disorder. Schizoaffective disorder is a combination of both psychosis and schizophrenia, but it's coupled with a mood disorder. So we have both a thought disorder and a mood disorder when we're talking about schizoaffective disorder.

So let's talk about mood disorders. We quite commonly see mood disorders in our population. Mood disorders include depression, dysthymia, bipolar disorder, cyclothymia. Those are some examples of mood disorders.

But essentially, what mood disorders are, are somewhere on the continuum of sort of happy to sad, right? And they're in extremes. So either depression or mania, but somewhere in the middle.

So it really is less important for you to know all of these names. I'm hoping that as you're listening you're not getting overwhelmed and thinking, oh my gosh, this is too much. It's really more important to just know what the buckets of disorders are so that you know how to best support the individual.

Of course, your first response is always safety and then making a referral. By safety, I mean making sure the person is safe, that they maybe have access to medication, et cetera, and making a referral. But it's also important to know what bucket of disorders do they fall into so you can tailor your conversation to meet them, right, to be most appropriate and supportive for them. So mood disorders, depression, mania, somewhere in between.

Anxiety disorders we're probably pretty familiar with, panic disorders, agoraphobia, those kinds of phobias. Anxiety, again, also commonly seen in our population. And it has to do with some kind of fear. But the fear is so intense that I feel like I am not going to survive this moment, right? That's how intense the anxiety is.

So here's sort of something to kind of think about, is that a lot of us experience being anxious. I know I get anxious sometimes before these webinars. Sometimes I get anxious during the webinars. And yet, I'm able, because of the way my brain is wiring, and again, no fault of mine or anybody else's, because of the way my brain is wired, I'm able to manage the anxiety in the moment.

But if I had an anxiety disorder, it would be so problematic that I wouldn't be able to manage in the moment. It would impact my functioning without some kind of intervention. So I think it's just really important for me to state that because it's important that we understand that it's not as easy as oh, just get over it and just manage it. It feels unmanageable. So saying things like, just manage it is not so, so helpful.

And as we're going through this, I think it's also important to keep those frames in mind, that we're talking about what are things that impair our functioning. Because the DSM, in a lot of ways, is a clinical, kind of a sterilized tool, right? It's a little bit removed and doesn't fully represent all of us as human beings, all the experiences that we've had, maybe the cultural components that are really incredibly important when we're trying to understand each other as human beings.

And so what's less important is trying to diagnose somebody. What's more important is understanding what is happening with this human being in front of me. What is happening in the larger context?

Can I see this human being in a bigger context? Where they come from, what their beliefs are, how they've grown up, what is influencing them, and how can I best support them in the moment. So in the grand scheme of things, diagnosis in and of itself is less the issue. It's more how do I intervene, how do I support this person in front of me to the best of my ability.

So we've talked about anxiety disorders. We've talked a little bit about mood and thought disorders. Personality disorders are a little bit different.

So whereas mood and anxiety disorders are a chemical issue, thought disorders are part chemical, part organic. By a chemical issue, I mean for mood disorders and anxiety disorders, the brain isn't producing a certain amount of a particular neurotransmitter. And so in those cases, medication is quite helpful. With depression, with anxiety, with bipolar disorder, if I can match the right medication to support my brain, it's quite helpful. I can experience a lot of relief.

Personality disorders are a little bit different. They're slightly more characterological. And medication doesn't help with personality disorders.

Examples of personality disorders are things like borderline personality, narcissistic personality disorder, antisocial personality disorder, schizotypal personality disorder, et cetera. So there are a lot of those kinds of personality disorders that you've probably experienced. And the way, the easy way, to kind of feel that somebody has a personality disorder is how you feel when you're in their presence.

So sometimes you're not sure if you're coming or going, like are we getting along well, are we not. It's really interesting, right, in that moment. So making sure that we're kind of tracking that piece.

And then PTSD, we're probably quite familiar with this. PTSD is related to trauma. It stands for post-traumatic stress disorder. But there are a lot of trauma-associated disorders, right?

And again, I even flinch every time I use disorder because disorder makes it sound like there's something wrong with the person. And it's not. This is the manifestation of some things that have happened to them. So symptoms of PTSD could be lack of sleep, that they're having flashbacks, night terrors, things like that. And that's how sometimes it'll manifest. So before I cover the rest of the categories, Greg, are there questions at this moment that you want me to address?

Yeah, I think so, Anjali. So related to psychological distress, the DSM and most mental health assessments were not designed for indigenous populations and don't address cultural factors adequately at all. Many Native Americans have been diagnosed with mental health disorders only based on beliefs. And I think a companion to that, that might be appropriate to expand on is perhaps clinical impressions versus testing that are done, who does that, who doesn't, what do GPs do versus psychologists, psychiatrists, things like that.

Yeah, excellent questions. So I'll try and piece this apart a little bit. The person asking, posing the question, you're absolutely right that these are not terribly culturally sensitive diagnostic criteria.

It does not take into account some of the cultural pieces that exist. And so we cannot diagnose somebody out of context. And this is where the rub is, that what if you have the person who's doing the diagnosis is of a different culture, let's say of a majority culture, and then you have somebody who is coming with certain symptoms and the person is not really attending to the cultural pieces that this particular client is bringing in, you could end up with a diagnosis that is absolutely inaccurate. So it's really important to think about, when we're providing diagnoses, that we do that in a really culturally-informed context.

So for example, if it is a part of the culture that certain things are done particular ways, or certain experiences, maybe seeing things, hearing things, tapping into a realm that the rest of us maybe cannot, it needs to be culturally bound when we're trying to conduct assessments of people and also when we're trying to interpret assessments that are done. But again, fundamentally, the diagnosis is less important. What is more important is this human being in front of me.

Are they suffering? And how can I support them? That is the driver of our interventions.

Because if the person in front of me, yes, they're experiencing what I would assume are certain symptoms, then I need to not jump to a diagnosis but ask, are these symptoms bothersome, right? If we go to that first slide that I covered, are they impacting your ability to function? Does it impair functioning? Is it creating distress? And is it difficult to regulate?

Because if the person says no to all of those, then who am I to provide a diagnosis, right? I mean, if there is no problem, why look for one? Justine, would you like to jump in?

Sure. I just saw a question that came up and somebody was asking, again, about the it's biased to determine who has a diagnosis or not. And I agree with you. I'm so grateful, Anjali, that you said it's really based on the individual, not on the diagnosis. I appreciate that.

And just one example of that might be somebody who is going on a vision quest. And they might do that according to their traditional values. They could do that through a sweat lodge, or through fasting and praying, or just other rituals that are traditional to their own culture.

And we can't determine if what they're seeing or hearing are simply hallucinations or if they're real responses to some individual's prayer to what they're seeking. So we don't know all of those things. So I appreciate that it's always in context.

And the other question I had seen says, so what happens when natives have a stoic face? And they worry about a provider having a bias that-- reading something into that. Like, some Native Americans believe that it's disrespectful to look somebody straight in the eye when they're talking with them. And some people don't-- they've been just taught not to show emotion.

And my personal belief is that's an outcome of the boarding school experience. And we sometimes confuse what could be culture and tradition with survival mechanisms that people have learned in order to survive their environments. And then they pass that on to their children and onto their grandchildren, et cetera.

But I think that's really important too for practitioners to understand that just because somebody doesn't make eye contact, or if somebody doesn't show emotion, it doesn't mean that they're not feeling those things. And it doesn't mean that they're disengaged or disrespectful by not making eye contact. So again, just getting to know who the individual is that you're working with.

Thanks, Justine. One of the things that pops up is as we're paying attention to this, we have obviously corrections professionals and we've got clinical people and we've got social workers and people who work in human services. Anjali, can you speak to what they should be doing? Obviously, two of those groups don't do diagnosis and aren't trained to do that. How can they be helpful in this process as we're trying to figure out what's going on for this person?

Yeah, that's an excellent question. So it is really important that we attend to what the person is bringing in the cultural context that Justine so beautifully gave us examples of before we make referrals. Because sometimes when we're making a referral, we're making a referral to somebody who may not pay attention to the full context.

So let's say I have a person in front of me and I'm a social worker, or a probation officer, and my job is not to diagnose but my job is to connect to the appropriate resources. It's important for me to try and figure out is this just the person's experience and they are not suffering as a result. This is just something that I need to pay attention to and match my interventions to meet their needs.

Or is it something where they truly need some support? And therefore, because they need support, I need to make a referral to a particular place. So that's really what we're trying to determine, right? We're trying to determine our next most supportive steps.

Is the next most supportive step to just tailor my way of functioning to meet their needs, my way of talking, the pace, maybe writing things down versus just doing it verbally, et cetera? Are those the kinds of things that I need to change? Or do I need to make some kind of a connection and referral to a community provider so that the person has some additional support? So that's a huge part of our role.

And Anjali, I did have another question to ask you. And I think one of the things you talked about is we have different roles. And while we're not doing diagnoses, it's important to pass on that information. So I wonder if Kevin thought that law enforcement had a role as they contact people, they're the first responders out there, they contact people in a variety of different situations, what might be the role of law enforcement and kind of informing the system and the professionals that may become involved with this person as a result of their contact?

Thank you, Greg. And yeah, I think as far as understanding mental illness and being able to help the individual out rather than obviously making the arrest and all that, but I think just understanding it more and having that training available to officers, police officers and law enforcement, as far as how you can actually take care of a situation and make it more of a situation where it's not going to escalate into something more bigger and all that. But I think it's just understanding more and having that training available for all police officers and law enforcement. Thank you, Greg.

Thanks, Kevin. Back to you, Anjali.

Great, thank you. So we've talked about several broad categories. Let's talk about just a few more that are common.

You all have probably heard, seen, talked with, maybe have your own diagnosis of ADD, ADHD. This is so interesting, right? Because there are some ways in which perhaps some of us on the call feel like this is an overused diagnosis with some of our teenagers or even in some of our younger ones where they're just being kids. And what ultimately should be driving whether we diagnose people or not is the extent to which they are suffering, the extent to which these symptoms are impairing their functioning.

Eating disorders have to do with anorexia, bulimia. You've probably heard about these before. Dementia is another category. Impulse-related issues, like impulse control disorders, intermittent explosive disorders. These are another set of broad categories.

And then the last, which is where we sort of tie-in the co-occurring piece is substance-related disorders. And in the latest DSM, we moved away from sort of abuse and dependence categories to whatever the substance is. So let's say alcohol, it's called an alcohol use disorder. And then the categories are mild, moderate, and severe. So you can have a cocaine use disorder, or polysubstance use disorder, et cetera.

And it's perfect timing for some additional questions before we continue with the content. So what questions? I just love these questions because it breaks up the content in a really nice way. So, Greg, any additional questions that you're seeing?

Sure. So we have a comment. And I don't know if you know the statistics on this. Native Americans also have the highest rates of abstinence.

Do you mean abstinence from substance use issues? Is that what--

I think that that's what-- yeah, I do believe that's what the question is. And the person who asked that question, if we missed the mark on this one, put it back in. But I do believe that's when it came in and what it's related to.

So when you say the highest rate of abstinence, I'm going to just make a guess that you're saying the highest rates of success in treatment, meaning the ability to stay abstinent once somebody has had a substance use issue. The rates of substance use issues among Native American populations are definitely higher in this country. It's a very complex issue because it's intertwined with trauma, it's intertwined with adverse childhood experiences. And so it's really hard to kind of piece it apart.

So as we're having this conversation, I don't want you to walk away thinking, oh my gosh, there's something wrong here, right, because people are using substances. It's a bigger problem. It's a societal, cultural, structural problem that's bigger than just substance use.

And it has to do with racial and ethnic structural issues that are sometimes, not sometimes, that are built into our country. And unfortunately, these tend to perpetuate certain-- the likelihood of getting involved in certain behaviors. So it is way more complex than just individual issues. And I think we have to take the bigger kind of context in mind.

So I'm curious from the folks on the call, what are some mental health disorders that you most commonly see? Is it anxiety, depression, bipolar disorder, PTSD, or psychosis? What do you most commonly see?

So Anjali, the poll results from this question, anxiety 41%, depression 32%, bipolar 7%, 17% for PTSD, and 3% for psychosis.

Anxiety disorders are what you're seeing most commonly. And that actually is true across the board. So it's definitely a pretty common experience, particularly in the criminal justice arena, to see a high rate of anxiety disorders. Justine, I noticed that you're off mute. Would you like to add something?

Thank you. I was just thinking as people were participating in the poll that this is all contingent upon somebody actually being diagnosed. There could be so many clients that probation officers are working with or treatment providers for depression, perhaps, people present as something and then the mental health aspect totally gets ignored. So there could be a lot of these things going on, well, which is exactly why we're doing this webinar, of course, but there's so many things that go undiagnosed that the substances have masked in the first place.

And I think part of the challenge too in diagnosing individuals to get them the help that they need is that they deny that there's any problem at all. And I'll use-- like you started alluding to that a little bit a few minutes ago when you talked about all the many factors, and that PTSD and the inherited anxiety that comes from being part of a culture of people that have had to endure and have had to survive historical trauma and even genocide. I mean, those things all build up and people don't even know why.

I know a lot of American Indians who don't understand historical trauma at all, but yet they're living it. They have alcohol or substance misuse. They've got the depression or anxiety or just aversion to even talking about these other things, which I find very interesting.

Like, why wouldn't you be open to hearing an aspect of your history and the truth? But yet, you'll suffer through all of the negative effects of the substance misuse. But that's, again, part of the trauma, I think, is when you just don't understand and you don't name what it is that you're dealing with. And if you can't name it, how do you treat it?

You make a really, really good point, Justine. And if I could just add to that the stigma that's associated with having a mental health issue. I mean, to me, ideally as we're going through this, if that's the one thing we can alleviate, just the stigma around it.

So often, people think having a mental health diagnosis is a burden, right? It signifies that there's something wrong with me and I need to hide it. And yet, what we're doing is trying to identify support, areas that you might need support, through nothing that you did. There's something in your brain that's either producing less of one chemical and more of another and because of this it manifests as certain symptoms.

We never-- we don't stigmatize people who have cardiac health issues, or who have diabetes, or who struggle with a whole host of other issues. We don't stigmatize them, even though their pancreas is doing something funky with their insulin production. It's so similar. Just chemically, if we have to talk about it, it's so similar to what's happening with mental health issues, right?

Depression, for example. Our brains are just not producing enough serotonin. That's the issue. And yet we stigmatize it and we say there's something wrong.

Whereas, we don't say that with diabetes or a whole host of other sort of health conditions. So the stigma too, I think, really impacts people's willingness to have these conversations. Yeah. Thank you, Justine, for bringing that in. Greg?

Thanks, Anjali. So a couple more questions, I think. Do you know anything about rapid cycling bipolar disorder?

Yeah. So rapid cycling bipolar disorder essentially means that we are going quite quickly between mania and depression. Most of-- so let's just kind of dissect bipolar disorder just a tad.

There are two kinds of bipolar disorders. There's bipolar I and bipolar II. Which even when I say it, it's kind of funny because surely we could have been more creative in our naming scheme.

But bipolar I means that mania is more present. So it's marked by the prevalence of mania and depression, but mania sort of is the marked symptom.

Bipolar II disorder is the opposite, where depression is what's the primary symptom. And there's some mania, but mania could be irritability or just increased energy. In the media, people tend to really publicize bipolar I disorder. So if you think about somebody who has bipolar disorder, you think about somebody spending a lot of money and being really creative and painting and having a lot of sex.

And those are the kinds of things, right? That's what we usually associate. And yet, bipolar II disorder is actually more common in the general population.

Rapid cycling bipolar disorder, and similar to cyclothymia, is where we're cycling rather quickly instead of having either a major sort of manic episode or depression. We're moving between the two quite rapidly. So that's some of the explanation behind rapid cycling bipolar disorder.

Thanks. Let's see, the next question. Why are there so many misdiagnoses of bipolar disorder when it could be PTSD instead? It seems to be such a conflict among mental health professionals.

Yeah, you're absolutely right. It is a conflict. And another piece that gets really worrisome is a misdiagnosis sometimes with depression, whereas actually what's going on is bipolar disorder.

And it's a particularly problematic misdiagnosis because if the actual issue is bipolar disorder, it's a different chemical. It's not just serotonin. It's the brain's inability to calm itself down.

So there's a problem in GABA response, which is a neurochemical that just allows us to calm down again. It's sort of the expression that we sometimes use is wired, like wired all the time. Wired but tired.

So the problem there is that if we prescribe somebody who actually has bipolar disorder, we prescribe them an antidepressant, we could make the bipolar disorder even-- the symptoms even bigger. So misdiagnosis is a big issue. And there's often sort of this confusion depression, bipolar disorder, anxiety disorders, PTSD. And it's really important to take our time to be able to kind of separate what is the best, most helpful intervention here.

And this is I think where the problem of access to care comes in. Because when we're trying to figure this out, it's not as easy as one quick conversation. So if-- let's say Greg goes to a provider, right, a medication provider, whether it's a GP or a psychiatrist, it's not as simple as one meeting and we get it figured out.

We have to try-- let's say it's depression that Greg is-- those are the symptoms that he's presenting with. We try a particular medication. In about six weeks Greg needs to come back and say, well, I'm struggling with these particular symptoms or these particular side effects. This is better, but this is worse.

So it's really important that this be an ongoing kind of relationship. But what if we don't have access to care? What if all I get is one shot? No wonder people don't stick with their medications. Because it's simply not working.

And so if all I have then are other substances around me, wouldn't it make sense for me to try and self medicate with THC or with alcohol or something like that? We can clearly see how we end up self medicating with unhelpful, in the grand scheme of things, unhelpful substance. But maybe it's actually the issue is lack of care or access to care.

Thanks, Anjali. I think that you touched on this next question, but I wanted to make sure it gets completely answered. The person says, as a behavioral health clinician, I believe that rapport is really seeking to learn a client before rendering a diagnosis. One cannot appropriately comprehend someone's issues and mental status if they've not established an effective clinical clinician-client relationship.

100%. Gosh, I wish I had said that early on. Yes, the way we get to an accurate diagnosis is through developing a solid, strong relationship.

Otherwise, you're still hiding from me. I'm not really able to truly see you. So absolutely. Relationship is key for sure.

So co-occurring disorder, sometimes referred to as co-morbidity, maybe also referred to as dual diagnosis, maybe you've heard any of these terms, is essentially one of those mental health disorders with a substance use issue. And I hate dividing it this way, because having a substance use issue is sort of-- it's underneath mental health disorders. But it essentially means that with a substance use issue, you also have something else going on. So at least either-- whether it's bipolar disorder or some kind of a thought disorder, PTSD, et cetera, with a substance use issue. So both are present.

So quite a high number of people have co-occurring mental health and substance use issues. It doesn't mean that one necessarily causes the other. And it's really hard to determine what came first, right?

Which came first? Is it did I have some mental health symptoms that I was struggling with and therefore used substances to cope and now I have a substance use issue? Or did I start using substances and that triggered some kind of other symptoms like depression or a thought disorder, for example? And ultimately, maybe it doesn't matter which came first. What matters is attending to both, which is really important.

And then you just have some other statistics on your screen as well regarding the number of people who have substance use disorders who also have mental illnesses, and then people with mental illness who also have substance use issues. So just a whole bunch of statistics on your screen. Unfortunately, not everybody who has co-occurring disorders, whether it's mental health issues, substance use, both, et cetera, not everyone gets treatment. Unfortunately, more than half of the people who have co-occurring conditions, over half of them never receive services.

And this goes back to something that Justine was talking about, right? That if I am unwilling to even say, hey, I'm struggling a bit, then the likelihood that I'm going to get services is pretty low. It also brings up the issue of access to care. So you have some percentages on your screen that talk about whether they receive mental health care, both, or substance use treatment only.

So like I was saying, these co-occurring disorders, or co-morbid conditions, are complex. They can make each other worse. Meaning if I am struggling with certain symptoms of a mental illness and I use substances, it could exacerbate my existing symptoms. And it's difficult to tell what came first. But both need to be attended to.

What's important, I think, in our field is that we really adhere to a no wrong door policy. And by that I mean that regardless of what it is that people are coming in with, I don't want to say, no, sorry, can't help you. We want to make sure that we are supporting them, attending to them, and getting them to the right place.

So we don't close the door. If we need to, if we're not equipped to provide whatever services we're talking about, we need to connect them to the correct provider. But that we don't close the door, we make a sort of an introduction to the next person.

So that whatever door they come in through, we say, yes, we can help. It's not going to be me. It's going to be this other person, but yes, we will get you the help you need. So that's the no wrong door concept.

And that we focus on recovery and quality of life. But that is what is ultimately important. It may not be that all your symptoms go away. It may not be that you ever entirely quit using substances.

But can we help improve the quality of your life? Can we provide education and support for families? That seems to really help when we're working with people with co-morbidity or co-occurring disorders, providing education and support for families. And then making sure that people have a strong social group or a peer support group, that seems to be incredibly important as well.

So we said that we were going to focus on what can you do, right? And I really believe that we start with ourselves. So when we're working with somebody who is exhibiting some kinds of symptoms, start with-- I start with me. I start with attending to me. I make sure that I don't panic and I make sure that I'm aware of any of my biases that are showing up.

I also try and keep the goal in mind. What am I trying to do by the end of this conversation? Am I trying to determine the best referral to make? Am I trying to just schedule the next appointment? Am I trying to get some paperwork signed? What am I trying to do?

I try and stay away from trying to fix anything. That sometimes when people are experiencing whatever symptoms they're experiencing, my goal is not to make things better or to fix it, but just to make space for them to know that they are welcome regardless. Whatever symptoms are showing up, they're still welcome.

And remember, there's no self-destruct button. Meaning, inadvertently you are not going to push some kind of button that causes them to completely self-destruct. So just trust yourself. And as one of the folks on the webinar said, trust your-- really focus on the relationship.

Try not to take things personally, which is incredibly important. And if somebody is struggling with staying with you or understanding what you're saying, really keep it simple and be patient. Be consistent in your responses. Those are the kinds of things that really help establish safety. They help people feel like they're welcome and they're safe with you.

Prioritize how you're engaging with people versus what you're doing. So the how is incredibly important, that you have empathy, warmth, genuineness, and that you are calm. And even if you're dying of the inside or you're really, really worried on the inside, you have a calm exterior.

Because there are these things called mirror neurons that pick up on the energy of the other person. So they're picking up on you and what you're kind of giving off through your own neurology. So stay calm because that's what their neurology is going to pick up on.

Use some motivational interviewing skills. And if you need more information on that, we've done some webinars on MI skills. But motivational interviewing essentially prioritizes the relationship and prioritizes getting curious about the person in front of me, being really interested in them.

Remember that when we're trying to make decisions, it's safety first. So is the person safe, right? Are they at risk of hurting themselves or someone else? And we'll pay attention to that here in a minute.

Do they need some skills to manage some of the symptoms that are showing up? So for example, do you need to help them ground themselves again? Or do they need some different self-talk?

So let's say they're stuck in a really negative self-talk cycle. Maybe they need some skills around that. Or do need they need social support? So safety skills and support, really important to pay attention to.

And make sure you don't leave before establishing what the next steps are. What's going to happen next? Are you going to make a referral? Are they going to come back? Just make sure that the next steps are really clear. So we're really focusing on the how, not the what.

And sometimes it doesn't go so well. Sometimes you have a crisis on your hands. So a crisis is, to me, something that involves a safety concern, right? They are either at risk of harming themselves or harming somebody else. And that's what requires immediate attention.

So try not to assume that everything is a crisis. And really stay calm and notice, like, OK, is this a safety concern right now. If it's not a safety concern, really focus on empowerment, meaning supporting them making their next decision. You can provide choices, but let the person in front of you make the decision. That's empowerment.

So let's say they think that they're having a crisis because let's say they are about to be evicted from their home. So that's the issue. And they feel like they're in a crisis. Empowerment is really important, so making sure that they know what their options are and that they decide their next step.

But if the issue is that they are at risk to harm themselves or somebody else, then I'm trying to balance safety, right, versus empowerment. So just keep those two pieces in mind. Know what your resources are. What is out there in your community?

And if there's nothing, that's OK too. But know that. So know that you're by yourself, you're going to have to manage this. And I think there's also a really important law enforcement perspective here when we're talking about managing crises. So Kevin, would you be willing to talk a little bit about the law enforcement perspective here?

Yeah, sure. Thank you, Dr. Nandi. From the law enforcement side, I think, again going back to that side of understanding the mental health side, training really goes a long way. And I can kind of give you the insight.

When I was still working with law enforcement services, we had a period where we were dealing with a lot of individuals that had some sort of mental health issues occurring. And not really knowing at the time mental health more really kind of had our hands tied at some point in time with how do we provide some services to these individuals. And we really didn't have the answer to that.

So going back and looking at what training was available and educating ourselves more with mental health, we were able to actually establish a position within the police department there where we had a case manager/police officer. And what that one person who was able to do was able to train themselves and also provide training to other officers to understand what mental health was all about. So again, we were kind of stretched with resources and knowing what was available and what was out there that we could send individuals to without having to send them to a detention center or jail or anything like that.

But we had the position there that was able to help us along the way there with individuals that were needing some assistance. So this position was able to really flow a lot of individuals to those resources such as behavioral health services and other health services. If we didn't have that, we were limited.

During a brief time there, it seemed like at 4:30 we didn't have any resources that were available after 4:30, that we'd have to figure out what were we going to do with individuals that we were dealing with that had mental health issues. So what the position was able to do was able to find some resources outside the area there where we were able to actually send individuals to and give them some assistance and hope that they would get better and return back into the community and all that. But I think this one position really helped us out quite a bit with understanding mental health and what it was all about.

Because officers that didn't really have the training behind them didn't really know what to do or handle the situation that was occurring, and it just kind of led into more or escalated into a situation that we had to call some additional resources. But again, just goes back to sort of understanding the mental health and what was available and what resources we could use. So this position really helped us out quite a bit.

And they actually were able to follow individuals once the incident occurred. They made a nice simple referral form. Obviously, we're not counselors [INAUDIBLE] from the law enforcement side, but we were actually able to use this referral to send these individuals out into whatever or receive some services.

In fact, I think we had one individual that really got connected into one of the officers. They were actually calling the officer up to help them give their medication and all that. So that's how close they became there and all that. Obviously, we couldn't really give the medication for the individual, but we were able to actually rely on resources where we were able to work with them more closely and all that. But it was really helpful to have that position available and work with those individuals that needed the assistance. So thank you, Dr. Nandi, for allowing me to talk about law enforcement services.

Yes, and thank you for sharing that. That's really helpful. It's so great to have actual examples of what's worked and what hasn't, so thank you.

So let's talk about suicide and then we will open it up for questions again. There's sometimes a misconception that talking about suicide increases the likelihood that somebody will engage in suicidal behavior. And that is just not the case.

In fact, talking about it reduces the likelihood that somebody will engage in behaviors that are harmful to themselves. So it's really important to engage in the conversation, share your concerns, and just ask. And you can ask in a variety of different ways.

You can ask in kind of a gentle way. I've noticed that you seem a little off. Is everything OK? That's a very indirect way of asking.

You can be a little more direct. I notice that you're really struggling right now. Share with me a little bit about what's going on.

Or you can get really, really direct and say something like, I know that you've been struggling a lot. And I'm just noticing a sense of hopelessness. Do you think of harming yourself or have you ever thought of harming yourself? Do you have thoughts of committing suicide? So that might be sort of a more direct way of approaching it. But start the conversation.

And then listen and assess. Listen for what the responses are. Don't argue with them. Don't use guilt.

And definitely don't promise not to tell anyone, because you will. We are required to tell. So make sure that we're not making promises that we can't keep.

So let's say the person says that-- they say, no, it's not something that I think about. I mean, yeah, sure, occasionally. But I don't know.

So they're not giving you really clear indications either way. Develop a safety plan. Maybe you provide some contact numbers to them, right? A crisis line or something like that.

And then make sure you're clear about your limitations. So if you only work from 8:00 to 5:00, make sure you communicate that to them and then who they need to contact or who they can contact after those hours. So really be clear your limitations.

And then document what you did. So in your-- whatever your charting is or your chrons, make sure you're clear about the conversation and what you did. So Greg, what are some questions that are coming up at this point?

Sure, Anjali. So let's see here. So what are some specific ways that drugs, such as marijuana and alcohol, affect medications for depression and anxiety?

Sometimes they can-- smoking marijuana, using marijuana can reduce the efficacy of those medications. So in order for those medications to function, they need to be able to target certain parts of our neurons. They need to increase the production of certain chemicals, like serotonin for example.

And what THC does is it sometimes can interfere with this. It can reduce the efficacy of these medications. So that's kind of problematic, right?

And so some programs say that you cannot be using marijuana if you're also using substances. Other providers will say, if you're continuing to use substances, that means we don't have the right medication. And I just so appreciate that frame, right? The frame of if you're engaging in-- continuing to engage in this behavior, there's something that we are doing that's not quite serving your need or meeting your need. So I think it's an important frame to have as opposed to a punitive frame like we're going to kick you out of the program if you continue to use. So it's just a really respectful way, I think, of looking at it.

Thanks, Anjali. So here's a question and the person needs some advice. Need advice for direction and success with our court-ordered treatment and convincing the judge to amend treatment and return the person to the hospital.

And I know I've done some-- worked with several jurisdictions on how to kind of move from the more traditional terms and conditions that we've seen ordering people into specific things and really creating conditions that give the professionals some flexibility. So for instance, asking for conditions that say you'll comply with treatment as recommended by your treatment team as opposed to I'm ordering you into inpatient treatment. But really giving some flexibility there and sounds like the person, the judge, is making some specific orders. And maybe Anjali, some strategies about how to approach the judge and some educational pieces that might be helpful.

Yeah, that's really hard because essentially you're saying to your judge, please don't do that. Please trust the-- trust your providers to make the determination. And so what we have done is we have done a ton of education with our bench.

And we're very, very lucky. We have an incredible bench here. They really listen to us.

And we've informed them, we've provided education regarding how important it is that we assess people to determine what the level of service is that they need. And that when the judge is seeing them, the judge doesn't really have all the information that the judge needs in order to make that determination and that that's what we're here for. So we really ask them to do what you said, Greg, which is maybe the order is a complete treatment as recommended by or as assessed or something like that. And that gives us a little bit more flexibility.

And I just think that any time we're talking with professionals, we want to give them an opportunity to learn. And so be careful about what you send back to public court and directly to court. And try to create those lines of communication either through regular like brown bag lunches where you have conversations about this, or can have a discussion with the judge in general about what's the most effective way to approach people with dual diagnosis, but create some opportunities for them to learn in other than reversing an order in court necessarily where they may see themselves as being wrong.

But create some opportunities for them to learn. And create those relationships and those connections. Because the more the system works together, the better outcomes you're going to have. Anjali, so this person said, I've noticed that I have a number of people on my caseload who focus on their diagnosis and use it as an excuse to not be able to move forward. What would you recommend to work through that?

Yeah, that's tough, right? Because essentially, what the person is saying is I'm not quite ready. I'm not quite ready to address some of these issues.

So I think I would go back to the relationship, that the more trust we can develop in the relationship, the better we can clearly see what the issue is. So that's, I think, where we need to return. And then once you have a relationship, you can say exactly what the person just said.

You can say to the client, here's my worry. My worry is that you're using this to not work on this other issue. Say more about that. Tell me what your perspective is.

And then just listen. And even if the person disagrees with you, you've started the conversation there. So I think, again, relationship and honesty in the relationship.

Thanks, Anjali. This person says, I feel like depression also comes out in anger often with men compared to women.

So that's really interesting, how we express emotion and kind of the cultural ways in which we are socialized into the expression of some emotion. And there is some research to support what the person is saying in this question, that oftentimes when we are experiencing difficult emotion, we either act in or we act out. And that we are socialized into acting in as women, and we're socialized into acting out as men.

And again, these are generalizations. This is sort of a pattern of socialization. So I don't mean that all women do this and all men. I just want to be really clear that's not what I'm saying.

But we will see those patterns. We do see some of those patterns present. So I think there is something to be said about not-- about making sure that we are viewing symptoms from a broad lens, that depression doesn't just mean sadness. And it doesn't look only a certain way. It can look a multitude of ways.

And in fact, mania oftentimes looks like irritability and anger and irritation oftentimes. So it doesn't always look like the media portrays. So I really appreciate that question.

Thanks, Anjali. So the next question, I believe, is I'm a probation officer. If someone is ordered by the court to get alcohol treatment and they follow the recommendations and maintain sobriety, can I then reveal-- can it then reveal a mental health disorder?

Sometimes. Sometimes that can be absolutely true that we-- that substance use was masking symptoms of something else. And I think Justine actually was alluding to this, that it's really-- it's complex because it could be that there are some symptoms that are underlying that have been covered up by ongoing substance use.

So that absolutely could be the case. And then the reverse also could be possible, that we start to address the mental health condition and substance use also stops, right? So the good part of that is also possible for sure.

Thanks, Anjali. I think this is for both you and Justine. We hear that AA and NA can be very effective. Is that true? And are there other similar programs for support that work?

Yeah, I'll start that and then Justine, please add. So part of the reason why NA and AA are so effective is because they provide social support. They provide a place where people feel safe and seen and heard. And there's a social system that's automatically developed.

But it's not just AA and NA that are successful in these ways. There are a lot of other groups that tend to be successful. And so the term that's frequently used is mutual support groups.

That's what seems to be really effective, whether it's AA, NA, church groups, community groups, whatever it is. But groups that intentionally come together with the purpose of staying sober and engaging in connection. Justine, what would you add to that?

I'm glad you said the word connection because to me that really-- a connection is that spiritual realm of being. And you've all heard me talk about the medicine wheel a lot of times addressing a person's physical body, physical health, their mental health, their emotional well-being, and their spiritual well-being. And that spiritual well-being piece isn't always about beliefs in a higher power. It is, definitely. But it's also about where they fit in the world, where they fit in relation to all of creation, where they fit in relation to their family or others.

So the groups that can-- like group talking circles that AA, NA, that is a spiritual connection when you can be with like-minded people who are all striving to bring out the best in you and in other people. So I really like that. That's something that's talked about and that is something that's beneficial.

As far as Native American NA or AA, the one program that I'm aware of is White Bison. And they try to address a person's whole well-being. And they have training for people related to the medicine wheel, those four aspects of self, and the 12-step program. And there's also family, youth, and men and women programs that help people to personally gain and journey and they understand more of that where they fit in the world.

So I really like that aspect of the traditional, just-- I won't say treatment, but helps support healing. Because in Indian country, you always say that culture is healing. And even for people who aren't necessarily traditional people within their own culture, the group setting, and the sharing, and that connectivity, like you said, is really where the healing is.

And then some other aspects too that tribal nations might offer, or anyone, any wellness center could offer, it's really therapeutic to engage in things that are creative or outdoorsy. I know of some tribes that have, like, camps where you go out in the woods for a week with a group of other men or a group of other women. And you learn more about your history or your culture and get that connection back to earth so that they help to understand not only more of their culture, but how they connect to the earth and the world around them.

There's also Reiki or other therapeutic type treatments that are available in conjunction with tribal courts or mental health and wellness or just as a community service that you can tap into. There's also some aspects of culture where they might use cultural and traditional ways of working with a person to help them know where their spirit fire is at and how they can get their spirit fire to burn brightly instead of raging out of control or being so dim that it's almost extinguished. So those are just some of my thoughts about therapeutic options.

Thanks, Justine. And I want to remind everyone that we do have an ask the expert section later in this series that will expand on these topics and allow you all a lot more time to ask questions. This is going to conclude the question and answer portion of this webinar.

So in closing, we'd like to share brief information on additional training and technical assistance opportunities. NCJTC is the training and technical assistance provider for Coordinated Tribal Assistance Solicitation Purpose Area 3 grantees and non-grantees. Tribal agencies focus on implementing statewide 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 focus on developing, implementing or expanding comprehensive efforts to identify, respond to, treat, and support those impacted by illicit opiate, stimulants, and other drugs of abuse. TTA services for both programs include customized onsite and virtual training, regional trainings, conferences, webinars, peer-to-peer support, onsite or virtual meeting facilitation, written resources, community planning, justice system collaboration, and sharing grantee best practices. For additional information on general TTA services, links to featured offerings, to request TTA, 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.

Another valuable resource is the COSSAP Resource Center. A snapshot of the COSSAP Resource Center is shown here along with the web link. Featured resources available include funding opportunities, COSSAP grantee site profiles with a 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 COSSAP grantee or not. The COSSAP TTA program offers a variety of learning opportunities and assistance to support local, tribal, 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 COSSAP at COSSAP@iir.com. I want to thank you again Anjali, Justine, and Kevin for your excellent presentation today and great information. We want to thank you all for attending this webinar and hope you have a wonderful day.