# Ask the Expert - Co-Occurring Disorders Simplified - Webinar Transcript

Welcome to the National Criminal Justice Training Center webinar, "Ask the Expert-- 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's 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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Today I'm pleased to introduce you to our presenter, Dr. Anjali Nandi. Dr. Nandi is an associate with the National Criminal Justice Training Center at 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 as panelists today. 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 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 Assistance Planning Program, which helps grantees plan and develop responses to address justice-related issues. She has expertise 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 at NCJTC.

Prior to working with NCJTC, I worked in community corrections and probation for about 30 years. I want to thank everyone for joining us today. And Anjali, the time is now yours.

Great. Thank you so much, Greg. And welcome, everyone. I really enjoy these Ask the Expert sessions because the entire presentation is really driven by your questions. We tend to have a slightly smaller group. And ideally, your questions, your tough questions get answered, or at least discussed-- maybe we don't always have the answers, but at least we can have a discussion about some of the things you bring up.

So the focus really is on understanding mental health disorders and then how those interact with substance use disorders. How do we work with people with what we call co-occurring or comorbid conditions? We say they are comorbid or co-occurring when you have both a mental health issue and a substance use issue. So how can we sort of work with folks like that?

People often will ask questions around them. How do you work with people when both are present? How do you prioritize them? Those kinds of things. So today, we'll start with just understanding some of the common mental health disorders. And then we'll very quickly jump into some questions.

Several of you sent questions when you registered for the webinar. So we'll actually start with some of those. And then my hope is that you all use the question-answer or the question box to pose additional questions. So please don't hesitate to put those questions in, and Greg will just help organize those questions. And we'll answer them as we go along.

So let's get started with defining what we're talking about here. Let's define mental illness a little bit. So we say that somebody has a mental health disorder or a mental illness when they have something that is diagnosable. By that we mean that it meets certain criteria, certain established criteria. And most often when we're talking about these criteria, we're talking about criteria that have been established in the Diagnostic and Statistical Manual of Mental Health Disorders. This manual goes through several revisions, et cetera. It's in its fifth form. But that's generally where all of these sort of criteria are held.

But just because we meet criteria or don't meet criteria doesn't mean we sometimes have symptoms that might look like mental illness or even those are really important to pay attention to because fundamentally, they impair functioning. So it creates enough distress to take away from my ability to manage my life, meaning these symptoms are getting in the way of me having a job or me engaging in a relationship or me being social or whatever it is. These symptoms are really getting in the way.

So sometimes, we talk about ourselves as oh my gosh, I have trauma from that experience, or oh, I'm feeling anxious today, or I'm depressed. And while you might be experiencing several of those symptoms, it's a disorder, it's something that needs to really be attended to when it impairs your functioning and creates enough distress and that it's really difficult to regulate or manage without some intervention.

And the intervention could be a medical intervention, meaning medication. Or the intervention could be therapy or some kind of coping skills, whatever intervention that you're using. Without an intervention, you're really not able to manage or regulate. So that's sort of the components of mental illness and things that we need to pay attention to when we're talking about mental illness.

But I do want to clarify several things because sometimes when we think about people with mental illness, we think about worst case scenarios. We think about things we've maybe seen in the media. And really, there's quite a range from any mental illness, mild mental illness, all the way to some severe and persistent mental illness. So it exists on a continuum.

And just remember that having a mental illness has nothing to do with my intelligence. Those are two entirely different things. So I can have a significant mental illness, and I can be quite intelligent. So one has nothing to do with the other. One doesn't influence or direct or impair another, unless we're talking about very few disorders. So dementia is one of them, et cetera.

It also has nothing to do with morality, meaning just because I suffer from a mental illness, it doesn't make me a bad person. So this is really, really important to understand. So mental illnesses don't cause me to be immoral. They don't cause me to get involved in the criminal justice system.

Sometimes, as a result of manage, or trying to manage my mental illness, I might engage in behaviors that get me into trouble, yes, absolutely. But having a mental illness has nothing to do with morality. So I hope I'm making that clear. If there's some confusion about that, please use the question box, type your question in, and I'll be able to answer it.

Mental illness can happen to anyone. There is a genetic component, but there doesn't have to be, meaning I could have-- it could go both ways. I could have parents with mental illness, and I not exhibit any signs or symptoms of mental illness. Or the reverse could also be true, where my parents have mental illness and sort of that genetic component is awakened in me, and I develop a mental illness as well.

Or they have none in their history, and I have symptoms of a mental illness. So it can really happen to anyone. It is not driven by income or race or gender or any sort of sociodemographic factors that we frequently talk about. People with mental illness are not inherently dangerous. And this is a really important one to understand.

When we work in the criminal justice system, we see a small slice of a much bigger population, right? We see people who are in trouble. And therefore, it's very easy to say, oh, all people who struggle with mental illness or who have substance abuse issues or co-occurring disorders are involved in the criminal justice system. And therefore, they must be dangerous.

But there is a great number of people in our general community not involved in our criminal justice world who also suffer from mental illness or substance use and don't engage in crime. So people with a mental illness are not inherently dangerous. We will talk about some diagnoses. If you want, you can ask these questions about, what are some diagnoses that we just have to take a little bit extra caution and make sure that people are really stable on their meds, et cetera?

So we can talk a little bit about that if you all are interested. But fundamentally, having a mental illness doesn't mean that the person is inherently dangerous. It is a psychological condition. So it's not a character thing or a personality thing. It's a psychological issue. And we'll talk just a little bit more about that.

And I think I said it exists on a continuum from mild all the way to severe, and it's very different from psychopathy, which is more characterological. So psychopathy is about the brain developing in a different way. Psychopathy is about processing emotion in a different part of our brain. A psychopath processes emotion as thought.

There are very limited emotional functionality in the brain. And therefore, they exhibit certain characterological things, like a complete lack of empathy and inability. It's not just that they have low empathy. It's really an inability to have empathy. Those structures aren't present. So a profound lack of empathy, manipulative, not taking responsibility, et cetera.

So as I say that-- if you're working in the criminal justice world, you're probably thinking, oh, those are several of my clients. And yet, the likelihood that you have a psychopath on your caseload is relatively low because those are really, really low numbers in our general population as well as in our outpatient population. And those numbers increase slightly when we talk about prisons.

But it is-- even in a maximum security prison, we're not talking more than maybe 5% of a maximum security prison. So very different-- mental illness is very different from psychopathy. So before I start to talk about the signs of mental illness that you might see, Greg, are there questions that are coming up so far?

So many people think that mental health disorders cause criminal conduct. What really are the facts around that?

Yeah, that is really the crux of the question that people often will ask. Does mental illness cause criminal conduct? And here's the thing. We do have a high percentage of people who are in the criminal justice world who do have mental illness and substance abuse issues or co-occurring disorders. But we also have a large number in our regular, general, non-criminal justice population who suffer from some of these symptoms.

So it really isn't that mental illness drives criminal behavior. It is sometimes that there are certain needs that the person is trying to meet to maybe stabilize, so I'll use a really concrete example. You could have somebody who is really struggling with anxiety, or maybe they're struggling with some voices in their head, they're struggling with some psychosis. And in order to manage, perhaps, they start using substances in order to self-medicate.

Now they're using substances to self-medicate that mental illness. And using substances, they get in a car and drive and get a DUI, or they steal something from the store because they're trying to fund their substance use. And now they're involved in the criminal justice system, right? But was it that the mental illness caused criminal behavior?

No, it's one of those stability factors, meaning when we're working in the criminal justice system, we really need to get clear and assess what are people's needs, what helps them get stable. And so-- and by stable, I mean living-- the ability to live prosocial lives. So we notice that, OK, this person has these symptoms.

They probably need some medication or maybe some intervention. It's not always medication. It could be therapeutic support. And so we provide therapeutic support or medication, and now their symptoms are cleared up. And they go on and live prosocial lives. So it isn't the mental health symptoms that's driving the criminal behavior.

However, if you have a client who you provide medication to, mental health symptoms clear up, but they're still engaging in criminal behavior, there's something else that needs to be attended to. And so what we look at are what we call criminogenic needs. Criminogenic needs are things that drive criminal behavior. And interestingly enough, mental illness is not one of them. So it's just kind of interesting and important to be able to distinguish between those two. Greg, what would you add to that?

No, I think that that's accurate. I mean, I think that one of the things, working in probation and corrections for so many years, is trying to figure that out. And then the question we're all-- that we always have to answer is, what risk do they pose to the community and to themselves, and how to manage that?

So I think that-- and a large percentage of the people that we see, because I think our assessments have gotten better, and we're seeing higher rates of co-occurring conditions, people self-medicating and things like that, that it really is pervasive throughout any type of caseload or clientele that you have, whether you're working with victims or you're working with offenders. I mean, it really seems to be a major issue in our criminal justice system that we're not very good at addressing at this point in time.

Yeah, very true, very true.

I do have a couple more questions. I don't know if you want to take them now. One of the questions is, did you differentiate between psychopath and sociopath?

Yeah, that's a great question. Thank you for asking that. So again, psychopaths and sociopaths, those aren't diagnoses. They are a set of traits. And clinically, a psychopath and a sociopath are the same. So clinically, they're the same. However, in our general-use sort of colloquialisms, we will sometimes differentiate between a psychopath and a sociopath. But psychopathy and sociopathy are clinically the same thing. So I appreciate you asking that question.

In the criminal justice world, we know that psychopaths, or psychopathy and sociopathy are the same thing. But oftentimes, in sort of the general public, people will use them differently. And just as a reminder, not a diagnosis, but a set of sort of clinical traits. What is a diagnosis is antisocial personality disorder, which is a little bit different. Greg, you were going to say something?

Yeah, I was going to ask you, again, about what we see a lot more of is antisocial personality disorder or, when you look at the risk assessments, that whole thing about criminal thinking, attitude, and orientation. And then for juveniles, obviously, it's conduct disorder. So if you could talk a little bit about that, those are diagnosable, or some of those are diagnosable, and kind of the difference between this whole kind of continuum of looking at antisocial personality disorder versus psychopathy and conduct disorder.

Yeah, so antisocial personality disorder is a disorder that falls under the personality disorder continuum. And it's frequently found under cluster B. So under personality disorders, we have three clusters, A, B, and C, and B tends to be more of the dramatic type. So under this cluster, you'll have histrionic, borderline, antisocial personality disorder, and narcissistic.

So those are-- so that that's the cluster that you'll find underneath there. They are behaviorally defined, not just character, characterologically defined. So you'll see under the criteria certain behaviors that they will exhibit. And that's what helps us diagnose somebody with antisocial personality disorder, or if they are younger than 18, conduct disorder, which can occur in children and teens.

And again, those are behaviorally defined. So some of the criteria will include aggressive behavior or destructive, deceitful, violation of rules, those kinds of things. So that helps, I think, a little bit, just to understand that. And then I just noticed another question, which is a really good question around-- this person shares that she works with adolescents in recovery and that a lot of them have mental health issues as well as years of trauma.

And all of this exists with their substance abuse issues, and most of them have only ever known substance use issues and self-harm as their two primary coping mechanisms. And the person is asking, how do we develop new coping skills? What a brilliant question because that is exactly what we need to do, right? Develop healthy coping skills.

And frequently, people will say, oh my gosh, I have a trifecta here. I have mental illness, I have trauma, and I have substance use. What do I do? Do I focus on one first and then the other? What do I do here? So we have this concept of no wrong door, meaning when our folks show up, no matter what door they knock on, whether they knock on the mental health door, they knock on the substance use door, we say welcome. And let's try and support you to the best of our ability because you cannot take a human being and piece apart their trauma from their substance use, from their mental health, right?

It's all surrounded and connected. And so ideally, we work with the whole person, and we don't bounce them around from one agency to the next, saying no, no, go deal with mental health issues, oh, no, you have to deal with your substance use issues first. So we really try and attend to all of it, and we come at it from a harm reduction model, ideally, where we say what-- of their symptoms, whether it's trauma symptoms, their mental health symptoms, or substance use symptoms, what is harming them the most right now, causing them harm or causing other people around them harm? And let's start with that.

And in terms of coping skills, we generally develop coping skills in three different buckets, primarily three areas. We develop coping skills in terms of thinking skills, cognitive skills, the ability to manage some of my problematic thoughts. So I'll give you an example-- somebody with anxiety might have repeated thoughts in their head, oh my gosh, I'm not going to make it. This is not going to be OK. Nothing's ever going to work out, whatever that repetitive thought is.

So managing our thinking-- somebody who struggles with depression might struggle with certain thoughts, I'm worthless, I'm useless, there's no point. Those kinds of thoughts, we really need to develop some agency around those. So the first bucket is thinking skills. The second bucket is emotional skills.

And emotional skills have to do with the ability to name my emotion and then regulate my emotion. So some research has found that when we have an emotion, whatever it is, whatever's happening in our brain, and we're able to name it, we drop in cortisol level, meaning we get less stressed as soon as we're able to accurately name our emotion. But frequently, our folks don't really know how to name their emotion, right?

At least the folks that I work with, they're either fine or they're pissed off, right? Those are the two sort of emotions that they most frequently will name. And so part of our work with them is to be able to help them increase their emotional vocabulary. And that's another coping skill. Another sort of set of coping skills is how do we name our emotions and then manage our emotions, regulate our emotions, so that's another bucket of coping skills.

And then the third bucket of coping skills have to do with social skills, so thinking skills, emotional skills, and social skills. And social skills are about refusal skills, they're about boundaries, they're about empathy, they're about being able to have a conversation, or deal with conflict, or those kinds of things. So those are sort of the primary coping skills that we really need to work on, whether they're juveniles or adults.

When we work on these skills, essentially, what we're doing is we're helping knit back together different parts of our brain. And when we struggle with trauma, when we struggle with substance use issues, our limbic system, sort of this lizard brain, this fight-flight reactive brain, impulsive brain, gets disconnected and sort of runs-- it gets hijacked, it runs the show, compared to our frontal cortex, which is more the decision-making, executive functioning brain.

And we really need to strengthen the connection between these two brains. And so when we work on some of these skills in a context of a caring relationship, meaning I convey to the person that I actually care, I have empathy, et cetera, in the context of a caring relationship, we're able to develop these connections-- we're strengthening the connections between the limbic system and the frontal cortex, and thereby really supporting the brain coming out of some of the neurological impacts that substance use and trauma have had. So I hope that answers the question regarding coping skills. And if it didn't, please don't hesitate to type in more questions.

Anjali, something just came up. Yeah, I was just going to say, you know, you've talked a little bit about trying to sort this out, and there's no wrong door. I wonder where the client fits into this. What about their level of motivation and what they think? Where does that fit into this as we're trying to figure all this out?

Yeah, their level of motivation is huge. So there are times where people present with so many competing issues. And we have to figure out, where do we start? So we have to be strategic, and we really-- we have to focus on prioritizing. What informs our prioritizing is harm reduction, which I mentioned already-- what's killing the person first? What's harming them the most?

Another thing that informs that prioritization is, what does the client want to change? What are they motivated to change? And this is where your question comes in. What's their motivation in order to make some significant changes in their life? Another way to prioritize is to think, are there things that are interconnected?

So is there one thing that if I push on, one area that if I really support will positively impact multiple other areas? So that could be the place that I start. So there are multiple ways of prioritizing, and taking the person's motivation into account is really, really important.

Thanks, Anjali. We do have a question, and maybe this is the place for it. Can medications create new memories in a person, things that didn't happen, but through medication and questions, these thoughts become reality?

That's a really interesting question. So I'll take this in two different directions. One is, there are certain mental health symptoms that fall under the category of psychosis, where we see and hear things and believe things that are not there. So we have-- under sort of psychosis, we have both hallucinations and delusions. Hallucinations are about our senses, feeling something, tasting something, hearing something, seeing something that's not there.

Delusions are about our thinking, so really believing certain things are happening that may not happen. So when we have folks who have some of these hallucinations or delusions, it's important to just remember that they may or may not be connected to reality. They are coming from somewhere else.

And part of what's going on in the brain-- unfortunately, we don't know enough about psychosis. But part of what is going on in the brain is organic, meaning organically in the brain, there are certain connections that are happening that don't happen in what we would call a normal brain. So certain things, there's an over-activity, which is why the person is feeling things, seeing things that aren't there, or having some of these thoughts.

Now, your question is, could taking medications contribute to psychosis, meaning, could, as a result of taking certain medications, could I start to believe things or think things that aren't reality? And there are certain drugs that will do that. It's oftentimes an adverse reaction, though. It's a problematic reaction.

And we call this drug-induced psychosis. So if you take a certain drug and take too much of it, it might have a toxic effect, and it'll produce either sort of paranoid delusions or some kind of a psychotic episode. So it's definitely something to pay attention to. It's infrequent. It's definitely an adverse experience.

But it's happened enough where there's a term for it, and it's called drug-induced psychosis. So let's talk about the general signs of mental illness. And before I do that, I just want to say thank you for your questions. These questions are really great. Love them, keep them coming.

Whatever questions you want to ask, we'll try and sort of work them into the webinar. And if I don't know the answer, we can always get back to you about whatever the answers are. So please don't hesitate to ask them. So some general signs of mental illness-- this sounds very simplistic, but honestly, when you're sitting with somebody with mental illness, you'll notice that something is off.

There's something different. Something's not-- something's not clicking. Maybe they have flat affect, or maybe they seem depressed. Maybe they seem anxious, they're shifting in their seats a lot. So it's just helpful to kind of notice what their behavior is.

They may seem withdrawn, or they may not be talking enough or much at all. But they sort of want to talk, but they're kind of withdrawing again. Or maybe they're talking to themselves, or they're complaining about lots of aches and pains. Or when they talk, it sounds like they're trying to get all their words out at the same time, and it feels a little pressured.

There's something about their behavior-- maybe they seem confused or disoriented. Maybe they're dressed inappropriately. Maybe they're not dressed appropriately for the weather. Sometimes we pay attention to that. So those are some of the sort of signs and symptoms that you're kind of watching for.

It's helpful to just keep in mind and know that it's not-- unless you're a therapist, it's not your job to diagnose, right? It is your job, though, to say, something's up. Maybe we need to refer this person to a psychotherapist or an evaluator of some sort in order for us to get additional information about what might be going on.

And there are times where just knowing what the diagnosis is or what the collection of symptoms are can help us organize, us as service providers, can help us organize and provide them with the support that they need. So it's not that when somebody has a diagnosis, now we've put them in a box and we send them away. It's, now they have a diagnosis.

We can organize our support in that direction. So that's why it's sometimes helpful. And I've had lots of clients say to me, gosh, now that I know what's going on with me, I feel like-- I feel so much relief. I feel like I'm not the only person who is going through this, et cetera, et cetera. So really kind of helpful, sometimes, when people receive a diagnosis and can understand what's going on with them and what they can do about it.

So in terms of mental illness, we have many broad categories. We have thought disorders. Thought disorders are around psychotic disorders, schizophrenia as an example, schizoaffective disorder, psychotic disorders, mood disorders. Mood disorders are depression, bipolar disorder. There are two kinds of bipolar disorders, bipolar I and II.

Bipolar I is characterized by mania. Bipolar II is characterized primarily by depression. So those are mood disorders. Mood disorders can really be attended to with medication because what's happening with a mood disorder is it's chemically driven. And that's true about anxiety disorders as well.

They can really respond well to medication because what's happening with somebody with a mood or an anxiety disorder is they are not producing a certain amount of a particular chemical that we need. So the chemical is frequently serotonin, and so oftentimes the medication that's provided has to do with preventing the reuptake of serotonin. They're called SSRIs, selective serotonin reuptake inhibitors.

And these kinds of medications really help with either stabilizing mood, but also supporting the production of serotonin in the body. So medication for mood disorders and anxiety disorders, they're not making people feel happy, for example, if I have depression. They're just balancing out the chemicals for the individual.

So I tend to say that a lot to people because they will frequently tell me, I don't want to feel different. I don't want something to be-- I don't want to take something that makes me feel not myself. And it really just allows the person to come to baseline. So mood disorders and anxiety disorders are chemical.

Thought disorders tend to be organic. We can provide a lot of medication, but it's difficult to take away all the symptoms of thought disorders, whereas with mood and anxiety disorders, much easier to manage them chemically. We talked already a little bit about personality disorders. PTSD or post-traumatic stress syndrome, there's a lot more research now on trauma and understanding trauma. And so it sort of falls in its own bucket.

A large percentage of our population in the criminal justice system suffers from trauma. So it's really important for us to be well-versed in trauma-informed care, recognizing when people are struggling with some symptoms and making sure to use a trauma-informed lens. Other categories include attention and hyperactivity-related issues, so ADD, ADHD. Eating disorders, you're probably familiar with.

Dementia, which has to do with cognitive impairment, and progressive cognitive impairment, and we can talk about that more if you all are interested. And then impulse-related disorders, and of course, the huge category of substance-related disorders. Greg, how we doing with questions?

Great. I think one of the questions that comes up often, and I think it's in here somewhere, is substance abuse seems like, to many of us, to be a choice. And yet it's listed as a disorder, and it's listed in the DSM. So can you talk a little bit more about that?

Yes, for sure. So starting to use substances, absolutely, a choice. I mean, I suppose we could complicate even that, but maybe not for this webinar, maybe in a different webinar we can complicate that, that potential. So maybe the first time I use or the second time I use, but the problem-- when it becomes a mental health issue, when it becomes a disorder, is when we have developed-- when our bodies are now, sort of their homeostasis has shifted.

And by that I mean that normalcy is now with the drug versus without the drug. So it becomes a disorder when there have been certain biological and neurological changes, meaning body and brain changes that have happened, that result in a loss of control over the use of the substance.

So it no longer becomes a choice. Things have changed in my brain where it is no longer a choice, in terms of using. It becomes an imperative. It becomes as important as my survival. It occupies our minds, we think about it all the time. We keep orienting towards whatever the substance is. And so choice becomes very, very complicated because when we think about choice. That's a very frontal cortex issue.

And one of the neurological impacts that substance use has is to disconnect the frontal cortex from the limbic system, impair that highway, and really prioritize the limbic system. So we get stuck in impulsivity, which really sort of problematizes the whole concept of choice.

And that's impulsivity, not just related to substance use, but impulsivity in all kinds of behavior.

Yes, yes, and impulsivity related to risky behaviors.

Another question is, how important are de-escalation skills and techniques when working with someone who's highly escalated?

Oh my gosh, they're incredibly important, such an important question. So when people are highly escalated, unfortunately, we tend to escalate too. So somebody's escalating, we end up escalating as well, sometimes, through no fault of our own, because our nervous system, our neurology is picking up what's going on for the other person.

These are called mirror neurons. So mirror neurons go both ways. We can pick up sort of the escalation of the person in front of us, or the person in front of us can pick up a calmness from us. So de-escalation skills and techniques are incredibly important because the first step is for us to manage our own level of escalation.

As soon as we de-escalate, it allows the other person to de-escalate. So there are numerous verbal and nonverbal de-escalation techniques that are really, incredibly important because if we escalate along with the client, usually things get worse. And we reinforce power over, which is a very destabilizing, frightening experience for the client, right? It's a re-traumatizing experience for them. So it's incredibly important that we learn some good de-escalation techniques in order to work with somebody who-- who's quite escalated.

Thanks, Anjali. How about addressing co-occurring disorders with low cognitive ability? Different strategies there, different things we need to be paying attention.

Yes, so for folks with low cognitive abilities, and I'm guessing you're not talking dementia when you're talking about low cognitive ability, we utilize some similar skills. But we really concretize them. So we work hard to keep our skills concrete and practical because it's still about skill building. It is also about medication management if that is needed.

So it's a combination of using medications, building skills, and the ability to sort of manage the symptoms that are showing up for a person. But with low cognitive ability, we tend to be very concrete. We tend not to use metaphors when talking about skills. We might do things really practically, like in play therapy. Or we might go through specific examples.

We might even do the skills with the person and do a ton of role-playing. So all of those things will really help somebody with low cognitive ability. Also very helpful, very similar strategies with folks who have traumatic brain injuries. So another area where we can make some accommodations so that the person with a traumatic brain injury can still stick with and learn from some of the skills that we're providing. And then also very similar with folks who are very young. So if you're working with a very young population, five-year-olds through nine-year-olds, also really sort of similar skills.

Yeah, Anjali, we have a question about people who have fetal alcohol syndrome and the fast-moving world that we live in, the challenges that they face. And the question is, how do we support these individuals and educate providers, employers, service agencies, people like that?

Yeah, fetal alcohol syndrome, such an incredibly important thing to talk about. And we could spend probably a whole hour and a half just talking about fetal alcohol syndrome. So fetal alcohol syndrome has a huge impact on not only as a child, but even as the person grows up. They'll experience certain signs and symptoms of maybe physical stuff, but there's also intellectual and cognitive things and the inability to sort of manage certain social and behavioral issues.

So really important to educate people around what they're noticing. So I'll give you a concrete example here. Oftentimes, people will exhibit behavioral issues. They'll get into trouble, they won't get along with other people, they have poor social skills, they aren't able to stay organized. Those are some of the signs and symptoms of fetal alcohol syndrome.

And if we're not educated about that, it's very easy for us to say, you're being antisocial. You're a problem person, right? You are not-- you are not doing what I'm asking you to do. There's something wrong with you. And so it's really, incredibly important that we have the training and the education to be aware of what might be happening, that oh, this might be related to fetal alcohol syndrome.

And therefore, what can I do to be more supportive than punitive, right? So again, we can definitely spend a lot of time, but I would start-- because the question was focused on how do we support individuals and other people, I would say education is the way to start, to educate people to understand this lens of looking at people's behavior, not from a place of being a problem.

And so the question shifts from, like, you know, what's wrong with you? Why are you doing this? The question shifts away from that to, what may have happened to you? What might be going on? Because they can sort of show up with so many different presentations. And unfortunately, there's no cure. There are some medications to help with symptoms.

There's a lot of skill training that we can do to help people with symptoms. But the impact is pretty significant and can be lifelong, so something to just pay attention to.

We have someone who wants you to go back a little bit and talk a little bit about the mirroring of emotions based on what biological function in the brain.

So there are neurons in our bodies called mirror neurons. These mirror neurons are long neurons that run from our brain in our head all the way down to our gut, so in our tummies. So these neurons are pretty long, and they're connected to our gut. In fact, that's probably why we use the term, I have a gut feeling about this.

So these neurons are called mirror neurons, and they were discovered because people wanted to understand, what's happening when I yawn, Greg yawns, right? If Greg sees me yawn, he yawns as well. What's happening there? And then they found these neurons that mirror what's happening in front of us if something feels good.

So yawning feels good, stretching feels good. But then they also discovered that it is these mirror neurons that pick up empathy, meaning they are responsible for empathy. They pick up the emotion that's going on in front of you. So if I'm standing with somebody in a grocery store, for example, there might be-- they might be feeling a certain emotion, and I can pick that up because my mirror neurons are on fire.

That's a really amazing thing about us as a social-- as social human beings. We can pick up the emotion of other people. That means we can calm people down just by hanging out with them. You probably had this experience with some of your friends where just by being with them, you feel better. They don't even have to say anything or do anything. Just by hanging out with them, you feel better.

And those are your mirror neurons picking up on sort of their emotion. But then you probably have people in your life who, as soon as you come into their space, you start to feel anxious because they're so anxious, right? And again, those are mirror neurons. So just a really important kind of thing to pay attention to, that we all, as human beings, have what we call a window of tolerance within which we stay regulated.

As soon as we get out of this window of tolerance, we are dysregulated. And so my job is to help a client come back into their window of tolerance. And I can do that using mirror neurons, et cetera. So I hope that helps clarify that a little bit more.

So can you talk a little bit about the PTSD shot, a new shot for PTSD administered by anesthesiologists with good results who reported so far?

I think what they're talking about is a ganglion block. It's a local anesthesia that's provided into a certain part of the brain. It impacts this group of nerve cells that limits our fight-flight response. So it's about really calming down some of our trauma responses, whether it's being really hyper aroused or hyperactive or hyper focused on different things, having kind of this fight-flight reaction.

So that's maybe what the person is referring to. And if the person said it's administered by an anesthesiologist, I'm guessing that that's what we're talking about. So it's called a ganglion block. It's really new, so awesome that you know about this. And things are still being studied around it. But so far, the studies seem pretty positive.

So I think, Anjali, one of the things-- we've got a mixed audience here, people who do clinical work, administrators, law enforcement, people who are in corrections. What are the different roles in here? Because it sounds like some of this is for mental health professionals and psychiatrists to prescribe. But a lot of it seems to be things that we can do. Could you talk a little bit about that?

Yeah, it's a great question. And I mean, my first response is that it's really important for all of us to stay in our roles, right, to really understand, what is my role here and how do I kind of really hold that role? That being said, it's important for us to also know that we are all in the business of long-- of supporting and facilitating long-term behavior change so that the people that we serve don't end up coming back in through the system over and over again.

So whether you want to frame this as community safety, whether you want to frame this as recidivism reduction-- whatever the frame is that you want to use, all of that can be met if we really support people learning skills and changing behavior in the long term. So then, based on your role, it's helpful to consider, in this role, how do I achieve that goal?

So if I'm a probation officer, how do I achieve recidivism reduction and long-term behavior change? By doing good assessments and then focusing on skill building, right, providing the right support, et cetera. If I'm a therapist, I work from the treatment aspect in a similar way. But I'm really working towards-- maybe it's trauma resolution, maybe it's skill building, whatever it is.

If I'm a medication provider, then I'm providing medication and ideally receiving feedback from everybody else involved, whether it's probation or treatment about how the person is doing on whatever the medication is because probation and treatment probably see the person more frequently. If you're in law enforcement and you're a law enforcement officer, maybe your role is to understand that so many folks that you deal with probably have a lot more going on than shows up on the surface.

So really, really helpful to have this frame of understanding, how do I work with people who have trauma, mental illness, substance use issues, that tend to be escalated, that tend to have-- that tend to be very fearful of authority, and sometimes for good reason? So it's really helpful to kind of pay attention to some of those things, from whatever the role is that we're sitting in.

And Anjali, it seems like some of it may be just observing and making sure that that information's passed on, whether you're the investigating officer and you do the arrest. What did you observe? What did you hear? What did you see? Or the corrections professional that's trying to help sort this out and make referrals to mental health professionals, substance abuse professionals, but really just observing and appropriately recording information so that group of people that needs that information has it from the beginning of the law enforcement of the criminal conduct all the way through, how are we going to respond to this and help this?

Yep, yep. Very true, very true. So we may have covered some of this, but a co-occurring disorder is essentially when you have both a mental health, substance, along with substance use issues, right? Two things are happening at the same time. And the mental health issues could be anything. They could be depression, anxiety, bipolar disorder, PTSD, whatever it is.

And the substance could be anything. It could be alcohol or opiates or cocaine or meth, could be any of those things. So a co-occurring disorder is when both are present. And oftentimes, people will say, well, what comes first? And what should we attend to first?

And I mean, bottom line, it doesn't matter which came first. We need to address both. Now, sometimes it can be helpful to know so that we can-- maybe if you're a treatment provider, it would be helpful to know. But if we're just trying to support the person and help them kind of move forward and learn certain skills, then working with both is really incredibly helpful.

Now, they can make each other worse, meaning the more substances I use, maybe it increases my symptoms of depression. Or my depression is getting worse, and therefore I'm using more so they can exacerbate each other. It's very difficult to tell what comes first. But again, both need to be attended to.

I think we already talked about the no wrong door piece. And fundamentally, it's really helpful for us to think about a recovery focus, that ideally we are trying to support people's quality of life. So let's focus on recovery, and maybe they're never going to be symptom-free. But how can we support improving their quality of life? How can we help them develop some supportive systems?

And then how can we help sort of provide education, not just for them, but also for their families or everybody involved because it's really important to kind of pay attention to not just the client, but the impact that they're having on their family and their community, et cetera. Greg, any questions about this before I move to the next one?

With a thought disorder, could neurological retraining take the place of medication. If neuroplasticity could work for that, could it work for other disorders in lieu of medication as well? And maybe talk a little bit about the role of medication and the role of therapy.

Yes, for sure. So let's define a couple of terms. Neuroplasticity is the brain's ability to grow and retrain itself. And the really cool thing is that we have very pliable, plastic brains, meaning our brains can change and grow and reorganize and adjust all the way through throughout our life.

It's easier when we're younger, but it continues throughout our life. So the cool thing is that we really can support brain development. With thought disorders, what is tricky is that it's not just developing new connections that we need to do. It's the killing off of other connections. It's the killing off of problematic connections that have organically occurred in the brain.

And that's what makes thought disorders so much more difficult. So it's not a question of adding to. It's a question of taking away. So neurological retraining can be really extremely beneficial. With some people, it could take the place of medications, but not if their psychosis is pretty severe.

I still would try it, right? I would still provide a lot of support and skills and training around it. But I wouldn't hold my breath if their symptoms are pretty significant or severe. Other questions, Greg?

I think, Anjali, one of the things that comes up-- I mean, many people on this call, you have people under a court order for a certain period of time. How do we know when the court order and that period of time really has served its purpose and they need to go back to their lives with the skills and services and resources that we hooked them up with, but not under the threat of going to jail or prison?

Yeah, I think, I mean, in some ways you're the best person to answer that because you have a saying that there are some clients who are just C students. And they will never be A students. They will always be C students. And that's OK. So it's really important for us to establish criteria or expectations that match the person in front of us because otherwise, we're just setting them up to fail.

So we might need to sort of work with, what can we expect from this particular individual? And when we get that, when a certain amount of progress has been made. And we're kind of-- come to that point of diminishing returns, it's really important that we get the person out and back into the community to move on.

What would you add to that, Greg?

Well, thanks for reminding me of my saying. I said it so many times, I probably should have said it here. I think that is one of the struggles, which is there's a certain-- there's a certain limit to what we can do and that we need to be clear on our expectations. And we're not going to always create perfect citizens that get their high school diploma or get their GED and are stable in employment and have their own house or in a good relationship.

So we've got to be really measured about that and figuring out when we've done the best we can to address those presenting issues, those criminogenic needs, and connect them with services, but also paying attention to if they fail, then we're often looking at taking their freedom away and that balance. Have we achieved, reasonably, what we could achieve.

And have they really-- have they done the best they can, given their individual circumstances and capabilities? And I think that's just so hard for us because we're always worried about, if I let them go and I didn't do this for two years or whatever, and they do something bad, it's going to be on me. And I guess I would argue that getting a person to a point where they have access to resources, they're reasonably stable, they've gotten that C to get them through is good enough. And sometimes over-supervision or supervising them too long, we're actually doing damage and causing harm and making them worse.

Yes, yes, we definitely make-- can make people worse if we're not careful-- very, very true.

So another question we have, which I think is a great one. It has come up in several other trainings. Shame is often tied to mental health and substance abuse. How can we begin to dismantle the stigmas, besides the shift from, what is wrong with you or what's happening to you?

Yeah, shame is a huge piece. And it is woven into the fabric, unfortunately, of our society. I mean, we treat certain conditions, certain mental health, or-- not mental health, but physical conditions, medical conditions, very differently from how we treat substance use, for example. I mean, type 2 diabetes is a great example.

We tend to have so much less shame around that, even though a person with type 2 diabetes does make certain choices along the way that makes their symptoms worse. Same could be said for substance use. So it's really interesting that as a society, we shame certain things and not others.

So the question that you're asking is a really tough one because what you're essentially saying is, how do we shift a cultural understanding of mental health issues and substance use issues? How do we shift it out of this-- out of hiding? There's something wrong with you, you have caused harm, you shouldn't say anything out loud because people will think there's something wrong with you.

You won't receive the kind of help. There isn't as much support. Even treatment providers or-- there isn't enough financial support to receive services. All of that is slowly changing, and it's changing through education. It's changing through research. Nora Volkow, she is the director of NIDA, the National Institute on Drug Abuse.

She has done such an amazing job really supporting the research, conducting some pretty amazing research, and trying to educate people around what addiction and mental health are really about. So there was a series that she put together. It's a little old now, but I still think it's fantastic. It's called "Addiction." And it's an HBO series that NIDA, so the National Institute on Drug Abuse, worked with HBO to produce.

And because HBO's involved, it's pretty fancy, really nicely done. And it has a lot of researchers and a lot of people with lived experience sharing what we've learned. And it's quite amazing that there's been so much improved understanding around substance use and mental illness. So there are times where I use portions of that to educate communities, community members, but really taking an active stance on having these conversations seems to be really helpful.

So I hope that starts to answer the question around dismantling shame and dismantling stigma. I know it probably isn't sufficient, but I think the more mainstream we can get it, the more people write about it, talk about it-- the more we can talk about it with our kids or our young ones, I think the more it'll move out from the shadows and into mainstream.

Anjali, we have a question. If mental health professionals know about co-occurring disorders, why is it so hard to get help for people with substance abuse issues who are in crisis and intoxicated? We, the person who's asking the question, has several people who have been taken to the hospital for a mental health crisis, only to be told they don't meet requirements for commitment because they're intoxicated.

Yes, that's because we're mixing policy with-- that, I mean, what you have just said is a clash, it's sort of a collision of policy with reality, right? So there have to be certain sort of criteria for commitment. There has to be certain criteria for insurance to pay for certain things.

There's criteria that people need to meet in order to be admitted to certain facilities. And unfortunately, therein lies the clash between reality and our expense reality and then what the policies and procedures are. So from my perspective, one of the successful things that we've done in our community is really had conversations with community members and community treatment providers to say, look, these are the needs that we have.

And so if you're going to use whatever this criteria is, you're not going to be able to serve the population that we are sending. So either change your criteria, or is there a different way that we can provide service for these folks? So maybe they don't get committed, but maybe we can provide them other support so that they can at least detox. And yes, they're free to leave, et cetera, but they can at least get some support while they're detoxing. So it comes down to a really strong and important conversation with community members regarding what needs are being met in the community and what the gaps are.

Well, and Anjali, I think the other thing that happens in that scenario is we often tend to think about hospitals, residential facilities, in medical terms. And the one that I love that people use is, this isn't your son or daughter going to the hospital for a broken arm that's going to heal in 8 or 10 weeks and be fine. These are very complex disorders and that there needs to be a continuum of care. And they're not going to get fixed in the hospital or a residential facility.

And oftentimes how the community responds and services that are available is far more important than what those facilities can offer. And so having those conversations and working with people is really so critical. I think that Kevin may have a question from the law enforcement perspective. So Kevin, I'm going to throw it to you.

Great. Thanks, Greg. Yeah, my question, Dr. Nandi, was-- I heard this from the law enforcement, some officers that mentioned about individuals who are on some type of medication, that have mental illness. They are in search of trying to find something else that is going to help them in some way. So they end up turning to illegal drugs, and they start abusing that. Do you hear that happening a lot, or is that true to that statement there that's mentioned?

Yeah, the statement that people will resort to substance use in order to manage their symptoms? Absolutely. I mean, here's the-- to put it really plainly, and I hope-- if this doesn't sit right with folks on the webinar, please just put in more-- put in comments because I want to make sure this is clear. So let's say, I'm struggling with symptoms. In order for me to get some support, I would need to go to a doctor.

Let's say I don't have access to a doctor. Maybe I don't even know a person I can reach out to. I have never been to a doctor before. My family-- let's say I grew up in poverty. We've never gone to a doctor's visit. I don't know who to turn to. But I do know that my neighbor has been talking about smoking pot, and maybe that'll help. So let me try that, right?

So unfortunately, we have a lot more easier access, and maybe some of you will be really mad at me for saying this, but unfortunately, access to illegal substances tend to be slightly easier than access to a physician. The other thing is when we do go to a physician and we pay a lot of money to receive an evaluation, et cetera, the person might not give us a perfect response.

They might say, oh, well, you need to do this and that. And what about this medication? I try the medication, I feel like crap, because the medication has so many side effects. At least illegal drugs have some positive effects. Yes, they do have downsides as well. But the substances or the medication that I might take might only have side effects.

And so I hate how I feel on it, so I go back to the doctor. And I say, OK, this is not working. They try me on something else. I have even other side effects. Unfortunately, there is no one perfect drug that supports somebody's-- that supports them out of certain symptoms. And so it's a lot of trial and error. And we have to be so patient in the process.

Now, I do want to be clear, I am absolutely not saying that illegal substances are the way to go. Please just-- I want to make sure that that is not the message that you're hearing. But the message that I do want to provide is it is so much easier, from a client perspective, to reach out to illegal substances versus prescription medication. Kevin, does that answer your question?

Yes, it does. Thank you, Dr. Nandi.

Thanks, Anjali. How can we best help elders or other adults who have struggled to get treatment or other programs have given up on them?

Yeah, a really important population and a population that frequently gets neglected. So again, really important to build services for our elders, for sure. I mean, I hate providing this answer. But it is about the community getting clear that this is a gap and a priority and therefore trying to provide services for that population. There are sometimes grants that are available to support financially standing up a program that's more elder-focused, but incredibly, incredibly important.

Thanks, Anjali. How about, what are some approaches to working with individuals who are resisting?

Approaches to help people who are resistant to services? Yeah, so let's just say most people will be resistant to services. We're human, and all of us resist at times, right? There are some times where we are so ready for services. And when we are ready-- if you have a person who is ready right now, grab them and respond to them because oh my gosh, if we strike while the iron is hot, we get so much more bang for our buck, right, when the person is motivated, and we happen to catch them right there.

But frequently, people are not-- I mean, in the criminal justice world, people are forced into talking with us or treatment or whatever it is. And so we are not doing our jobs, if we don't learn how to work with people who say no, I don't like you, I don't like your services, I want to leave.

Those are the folks that we really need to work hard to learn how to work with. So there are a lot of different strategies. Motivational interviewing is one of them. Cognitive behavioral support is another. But fundamentally, I think what it boils down to is just remembering that the person is upset and angry, not because of me. So you really have to be-- have to not take this personally to understand that that's normal. This is a part of the change process and to work with wherever they are.

So if they come in saying, I really don't want to do this, great, OK. Tell me why somebody would have even said that you need to do this, and let's start to have a conversation where I can develop a relationship with you where I express empathy and concern and create a safe enough space that you will start to feel that it's OK to admit that maybe things are not going so well, or maybe you're struggling a little bit. So that's really where we start. But that is a lifelong process, for us to be able to focus on working with people who are tough because that's a majority of our population.

Thanks, Anjali. I want-- we are winding down on time. I want to invite Justine in. A lot of these questions that have come up so far are clearly in your wheelhouse, Anjali. But Justine, in the work that you do with tribal communities and helping them develop responses to criminal conduct, substance abuse, mental health disorders, are you successful-- are you familiar with any tribal interventions for individuals with co-occurring conditions?

Thank you for that question. And I'm really enjoying the education I'm getting too with you, Anjali. So I'm grateful for everybody else's questions. In the communities that I'm working with, I think what makes them more successful is when everyone in the community does understand their roles. And Anjali, you mentioned earlier that it's important for professionals to stay in their role.

And that can't happen until you come together as justice professionals or community professionals so that whatever door that person comes through, it doesn't continue to lead them down a tunnel or a pathway that doesn't go anywhere else. The important thing is for justice professionals to be knowledgeable through things like this kind of a webinar and to understand what my role is when somebody comes through my door versus what somebody else's role is if they go in through that door.

And then behind the scenes, door number 1, 2, or 3 doesn't matter because behind those doors, the professionals are all collaborating and working together. And I think that's why you see so much potential with drug courts and veteran's courts and things of that nature because it's a whole community who know what their role is, and they know how to sort of provide those wraparound services to address somebody holistically instead of for the one reason why they walked through my door. Does that make sense?

Does. Thank you so much. And I think what you said is so important. I mean, one of the questions has to do with real-time services when a person's saying they're ready right now and to ask for help and accept it instead of waiting for a list of services that impedes them and they get angry because they're not available.

So key is-- and you know, what the drug courts and mental health courts and veteran's courts have picked up on, one of the key components obviously is rapid assessment and access to treatment because that is when people are motivated. They've gotten into trouble, they've gone to court, and they often are more motivated then. And so we need to create those pathways and opportunities for people, for particularly our higher risk people.

Greg.

Yes, Kevin.

Greg, if I can add more to what Justine was saying, and I think she mentioned, and what Dr. Nandi also mentioned about staying in our roles from the law enforcement side, you know, being able to understand mental illness a lot more. And I saw some of the struggles that we had as far as law enforcement goes.

I mean, we had officers responding out to locations where they didn't really have that knowledge at the time. But I think being able to educate and understand a little bit more clearer helped them out with identifying individuals that we could divert or route these individuals into some type of treatment services other than jail and all that.

But I think it's just being able to understand what we're doing and how we approach this. And I know it was mentioned about de-escalation, which is really important because I saw an incident that I went out to. And the individual that we were dealing with, it seemed like the uniform being authoritative in some way, they reacted to that and just turned in a different direction.

And you know, it just escalated the situation more. So we had a detective who was not in uniform talk to the person, and it really brought down that person quite a bit with our approach to them. And we saw that as a way of, maybe we need to relook at our whole approach in working with individuals with mental illnesses and all that. So it really helped out of that side of it there. But yeah, great for mentioning all that. Thank you.

Thanks, Kevin. Anjali, if you have a response to that, I'll let you go. But I'll also throw out another question to you. When we think of treatment efficacy, we hear you can take multiple treatment experiences, particularly with people with substance abuse. Is that the same for people who suffer from mental health disorders? And obviously, it might be the same for people who have co-occurring conditions. If you could address--

I want to make sure I understood that. So when we're dealing with people with substance abuse, we can take people with-- it doesn't really matter what the substance is, whether it's heroin or opiates or meth or cocaine. Is that the same for mental health disorders? Is that the question?

And we know from the research that it can take multiple treatment experiences for people to actually experience long-term stability. Is that the same with people with mental health disorders, and can we expect that also with people with co-occurring conditions?

Got it. You're so kind. I completely misunderstood your question, but you were so kind to me right now. Thanks, Greg. So yes, what Greg is talking about is it does take multiple opportunities of treatment in order to truly sort of support somebody who's struggling with substance use. And that is true about all behavioral health issues and mental health issues for sure.

If any of you on the webinar have ever tried to go on a diet or lose weight or eat in a healthy manner, you know many times you have tried and failed. And that's just one behavior, right? It's one-- in the grand scheme of things, at least in terms of how it impacts the brain. It's not actually a really tough behavior. And yet we all struggle with it.

Imagine that with a behavior like substance use or something different. So it takes multiple, multiple treatment attempts. With mental health issues, sometimes we provide the right medication and some coping skills, and people do really well and they move on and never look back. And for others, you know, it takes several rounds of getting better and then getting off of medications and then coming back to the medications, et cetera. So yes, lots of patients, multiple rounds of services, for sure.

So one of the-- I think one of the most important things that I've learned from working with you is this whole idea around, how do we respond and proximal and distal behavior. And it seems like these-- people with co-occurring conditions, they're going to have lots of different things that we need to evaluate, whether it's a proximal behavior or a distal behavior. And most importantly, how do we respond to it? Can you talk a little bit about that?

Yeah, so it's really important when we're looking at people's behaviors and trying to figure out, what can we expect from people to know the difference between things that we can expect in the right now and things that we need to be really patient and that we can't expect right now, but will slowly come later on? So if somebody is really struggling with anxiety symptoms, it's not a fair expectation to think that they will come into our office and sit still and present in a really calm manner, right?

That will take a while. But-- and maybe the expectation that they even show up to the office is a lot initially. But maybe the-- so that would be a distal goal. A proximal goal, meaning the things that I can expect right now, is for the person to maybe call me, right, or for us to meet outside so that the person feels a little safer.

Maybe they get-- their anxiety really kicks up in the office or inside a building or something like that. So it's really helpful to think about the individual and think about, what is-- what can I expect right now, and what can I expect later on? With substance use, if somebody is truly addicted to substances, abstinence is definitely a later-on thing. But maybe showing up to the appointment is a right-now thing. So distinguish between proximal and distal behaviors, and set expectations accordingly.

OK, I think that I'd like to close out-- you know, you've presented a ton of information. And I know Justine and Kevin have been involved with you throughout the series as they've kind of learned about the expertise that you bring. I'd like to ask each of you, starting with Justine then Kevin and then you, Anjali, what's one takeaway from this training for our attendees that you would say you remember nothing else about this hour and a half and all the information that you've put out, what's the most important thing to remember?

Thank you for that question. I think the most important thing is to remember that this is a process and to help your clients understand the process that they're going to be going through so that they can start to make these connections with what they're experiencing, what may be so-called normal, as they are working through their addiction and formulating new connection points that would bring a healthier kind of pleasure and a healthier, I guess, role in the community without the stigma of that shame. But just, it's a process. Be patient with them, help them to be patient with themselves.

Thanks, Justine. Kevin.

I think my takeaway would be understanding mental illness as a whole. In the time that I've been able to be part of this, all the sessions and presentations and webinars and all that really has opened up my eyes as far as what's available for individuals as far as treatment goes.

There are many ways to-- working with individuals who have mental illness and other ways of how you would approach the person as well too. But a lot of good information that was provided and all that. Thank you, Greg.

Thanks, Kevin and Anjali.

Yeah, it's such a good question. And I wish we could ask the participants this what's one thing they're walking away with. But if I were to pick one thing that I want you all to walk away with, it's that when we work with these people who are in front of us, who've come into the system, it is such an incredible opportunity to make a difference in their lives.

But that is our job. Our job is to serve and to make-- to help make a difference, to help make it even 1% better. And so whatever we can do to help make it 1% better, to drop all the, oh my gosh, this person's being so difficult, or they're being defensive, or they're being so annoying, or they're being rude, or whatever comes up for us to drop that and really think about, how can I help make this person's life 1% better? Maybe that will be something I would love for you all to walk away with.

And by doing that, we're serving the community because that's connected to why they get into trouble and cause harm to other people. And so we're doing both things at once, and they're very interconnected. So I want to thank everybody. This is going to conclude our question and answer portion for the webinar. 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 3 grantees and non-grantee tribal agencies focused 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-- the 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 onsite and virtual training, regional training, conferences, webinars like this series, peer-to-peer support, on-site 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 and 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 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 a data visualization tool, information about demonstration projects, peer-to-peer learning, and recording of all 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're a 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 projects in building and sustaining multidisciplinary responses to the nation's substance abuse crisis.

For more information, you can contact COSSAP at cossap@iir.com. So in closing, I'd like to thank you, Dr. Nandi, and our panelists Justine and Kevin for your excellent presentation today. We thank you for attending this webinar and hope that you have a wonderful day.