Webinar Transcript - Working With Mental Illness in the Criminal Justice System

Welcome to the National Criminal Justice Training Center webinar-- "Working with Mental Illness in the Criminal Justice System." My name is Greg Brown, and I will be moderating today's webinar for you today.

This webinar was provided under an award provided by the Bureau of Justice Assistance, BJA, Office of Justice Programs, US Department of Justice. The opinions expressed by presenters and their oral or written materials are theirs alone and do not necessarily represent those of the National Criminal Justice Training Center of Fox Valley Technical College, or the Department of Justice.

I am pleased to introduce today's presenter, Dr. Anjali Nandi. Dr. Nandi is an associate with the National Criminal Justice Training Center. 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. Anjali, thank you for joining us today. And the time is now yours.

Great, thank you so much. And welcome, everyone. I'm excited about this material. It's so interesting when we work with the population that we do, just how many folks struggle with mental illness. And so I think it's just important for us to be familiar with some of the signs and symptoms, some large buckets of diagnoses. The purpose of this presentation is not for you to walk away with the ability to diagnose anyone or even know what to do in terms of helping people resolve or attend to their mental illness.

What it does do, hopefully, is provide you some understanding of these diagnoses, make you feel just a little more comfortable when you experience people who are either coming into the office or you're talking with who are experiencing mental illness, and then matching your responses to whatever their needs are. When you think about the cross section between mental illness and then the corrections and maybe probation, reentry, those kinds of things and our Native American population, what are some things that come to mind?

So when you think of the cross section of this population, what are diagnoses you think of or some frequently held misconceptions? Or what are some things that come up when you hear the words mental illness, reentry, probation, criminal justice, and then our Native American population? Type it into the chat. What do you think about? What comes up for you?

Good. That there's some misconceptions. Sometimes your thought is, gosh, where do I start? And Sofia's question is a really, really important one because sometimes people present with so many different issues that for you, as a practitioner, it's sometimes hard to figure out, where do we start? And Jennifer, you put it in there too, saying, gosh, there is so much, so much to work with.

Sometimes it's instability that you're thinking about. And interestingly enough, you all may not believe me, but having a mental illness does not correlate with being in the criminal justice system. Meaning, having a mental illness is not a criminogenic need. It doesn't predict crime. All people with mental illness do not commit crime. Just having a mental illness does not increase my likelihood for committing crime.

What happens is, because I have a mental illness, it sometimes increases the likelihood of me engaging in other behaviors if I don't have the kinds of support that I need. So if I have a mental illness, and I don't have the kinds of support that I need-- I don't have, let's say, social support, family stability, housing stability, all of that, it creates a level of instability that increases my likelihood of being involved in crime. So when Valentina says, instability of the person, that's really what we're talking about.

Hillary mentioned trauma, which is really, really important and a huge overlap. Oftentimes, we mistake trauma symptoms for other mental health symptoms. And it's kind of hard to pull apart. Sometimes there's a lot of co-occurring issues. So you have multiple diagnoses, like PTSD, for example, or some kind of trauma- or stress-related disorders, but then also depression or anxiety or substance use issues. So trauma is definitely a big one.

Substance use disorders, we see a lot. And there's a big overlap between substance use and mental health as well. And unfortunately, when there's this overlap, I'm not sure if you all experienced this. But at times, we come up against providers, treatment providers who might say, ah, you need to deal with this first, and only then can we see them. So we specialize in substance use issues. This person has mental health issues. They need to go address their mental health issues first before we can address substance use issues.

And that actually is a real misconception. We need to address them together. Frequently, they're feeding into each other. So it's an important kind of one to just be thinking about. And I think Nicole is pointing towards this that it's sometimes difficult to coordinate across all service providers.

Just, I love all of the stuff that you all are putting in the chat. Thank you so much. This is great. I'm sorry I'm not caught up yet, so I'm just still going through some of your comments. Jane mentions that sometimes we question the truth of their statements. Yes, I appreciate you admitting that. So honestly, that's so true. And sometimes I think that-- and this might just be me-- it's easy for me to get a little frustrated because I have certain expectations.

I want them to comply with their conditions. I want them to do certain things. And they don't follow through. And I start to get frustrated. And I forget that sometimes they need me to slow down, or they need things provided to them in a slightly different way that's more palatable for them. So an example might be, if they are super anxious, it's going to be very hard for them in my office to hear what I'm asking them to do. When we're anxious, it's very hard to hear. It's also very hard to remember what we're supposed to do.

Our frontal cortex, the thinking part of our brain, is not engaged when we're experiencing high anxiety. And so perhaps they need me to write things down, or they need me to repeat things, or they need reminders. And so it takes a little bit of extra from us in order to really attend sometimes to people's needs. And I forget that sometimes. And it causes me some frustration.

So Brianne said, sometimes the question comes up is, what is the best way to manage? Philip thinks about adverse childhood events, which is really, really important. Adverse childhood events actually predict a whole host of things. So adverse childhood events are really trauma that happens as a child, right? Some examples could be that there's mental health issues in the household or substance abuse issues, or there's criminal justice involvement or racism or bullying or emotional abuse, physical abuse, sexual abuse, those kinds of things.

So there's stuff that's happening to them as children that then predict long-term outcomes. So adverse childhood events impact the life course of this individual, increases the likelihood for them to have symptoms of depression, anxiety, substance use issues, impulsivity, just a whole host of things, so really, really important. Sometimes we don't have enough resources, someone says, at our disposal.

I'm not sure if I'm going to pronounce this name right, but "Sal-my" says jails and prisons are the biggest mental health hospital in the nation. And unfortunately, our criminal justice system is frequently being used as a mental health institution. We have tough folks who we don't really know how to deal with. And unfortunately, our society tends to criminalize that behavior. So I really appreciate that you said that.

Melissa says that there's a lot of stigma for mental illness. And that's so, so true. Cody says court systems not understanding that mental health issues don't drive crime, but we do need to attend to those mental health issues. Otherwise, we are not providing people the likelihood to succeed, so really, really important. Trauma, stigma, addiction-- fantastic.

So Greg was interacting with Cody. I'm so sorry. I'm so behind you all. So Greg said to Cody, great point. Can you provide an example? And Cody said, right now, youth with autism are being placed into the courts, and often they have secondary mental health issues that have them struggle with normal regulatory cognitive abilities. This is not a court issue. Nor does it relate to their criminogenic need. It has to do with mental health and their disabilities.

OK, so let's slow down here for a second because this is really, really important. Unfortunately, it is really common that, when we don't understand what's happening with the other person, when we are perhaps a little afraid or we don't know-- the other person is behaving in a way that seems different to us, we tend to react in a non-supportive way. We tend to think that there's something wrong with them rather than recognizing that we have to expand our ability to serve these individuals.

So we're seeing this actually quite frequently where people on the spectrum are coming into the criminal justice system at a higher rate. And folks are not trained to work with people with neurodivergence, who think differently, have different social skills, who process emotion in a slightly different way. They process social skills in a slightly different way and have different needs from us.

I'll give you a very, very simple example. When I'm working with a teenager, for example, who's on the spectrum, I frequently will verbalize things that I won't have to verbalize for other people. For example, I will say, we're going to meet for 30 minutes, during which I'm going to ask you a bunch of questions. You can take a break at any time. I will know that you need a break if you use these red and green circles.

And so I have these red and green circles on my table. And I say to them, if you start to feel like I'm asking you questions that are making you uncomfortable and you don't want to answer, or you need a break, just slide this red circle forward. And I'll check in with you occasionally. And if you're doing well, you can either give me a thumbs up and tell me you're doing well, or you can slide the green circle forward.

So I'm very, very explicit. And I not only use words, but I use visuals to convey to help them convey their needs to me. Another example would be, when we do take a break, I say, we're going to take a five-minute break. During this break, feel free to use the restroom. You can walk around. You can play on the floor with those toys if you'd like. You can write. I'm very specific about what we can do during a break, which I wouldn't do ordinarily with other people.

If I was giving you a break, I'd say, let's take a five-minute break and leave it up to you to figure out what you do with that time. But if somebody doesn't actually understand what they are allowed to do during a break, they'll just sit there frozen. So it's really, really important that we understand some of these issues rather than criminalize it.

Greg, also, gosh, Greg and Cody are just chatting away. Greg says that we're seeing elderly people in the criminal justice system with memory issues, health issues. Yes. So part of what Greg is bringing up is, sometimes our criminal justice system is not just used as a mental health institution. We're also used as a medical institution, right?

In our probation department, frequently, we are having to navigate some huge medical issues for clients that really hospitals should be taking care of. But we're having to do a lot of them, the navigation for them. And so Sofia said they were expecting kids with mental health or substance use diagnoses to follow rules and sanctioning them if they don't. Because we have to start with the least invasive services. Very true.

But what they don't do is address issues right away. Absolutely. Sofia, you're on to something here. Because we really need to meet people's needs as quickly as we can rather than keeping them in the system longer. Unfortunately, the longer we keep people in the system, the greater the likelihood that they'll actually stay in the system, especially if they're lower risk. If they're high risk, we have a different conversation in front of us.

Yes. And sometimes there's not enough planning for people. Yes, Melanie is bringing up puberty, hormonal issues, adolescent changes, how their behaviors sometimes escalate in a way that they're acting out trauma or patterns or those kinds of things. And we tend to criminalize it. Yeah, very true.

And then, Yolanda says services are ideal, but at times, a timeout is necessary. And so part of what Yolanda is bringing up is, how do we know? How do we know whether what people need is what you're calling a timeout or whether they need services? So this is something I would love for you to keep in mind. And we actually talk about this in a different webinar, but I'm going to cover it here, that, in our criminal justice world, we're focusing on three different things at all times. Like you're thinking about these three different things.

You're thinking about structure. You're thinking about skills. And you're thinking about safety and support. All right, so I know I said three, and I'm I'll tell you why I'm giving you four and said three. So structure is the bigger umbrella for structure and safety. Structure is about containment. Does this person need to be contained because their behavior is spiraling out of control?

For example, somebody is actively experiencing psychosis, and in their psychosis, they are acting out in a pretty aggressive way. The most immediate thing is to help contain them. And we contain with whatever structure we can provide. Either we take them to a crisis mental health or something like that, so we can get them on some kind of medication to manage their psychosis before they hurt themselves or hurt someone else. So that would be an example of structure and safety.

Another example of structure could be that somebody is actively in withdrawal or actively using so much that they could overdose. And so we want to put structure in place because safety is an issue. And that could be detox or something like that. So those are examples of structures/safety skills. Do people just need to learn how to manage some of their symptoms? So that's about skills. And then about support. Do they have support in their community? Do they have what they need in their community to stay stable and safe?

So those are some of the things that we're constantly thinking about to address that timeout that Yolanda talked about. And then, Cody says the biggest thing with a timeout is sometimes the people that you're giving a timeout to don't get a voice in the decision because people don't trust their voice. And it's really helpful to give them autonomy. Yeah. Yeah. And Sofia responds with sometimes officers think that kids are in their offices only to be told what to do and what not to do. And unfortunately, that's a huge problem. As soon as we start telling people what to do and what not to do, we've lost. We've lost the relationship. There's so much wisdom within the people who we serve.

Sometimes the wisdom might be buried under a few things, and we have to develop a relationship, a trusting relationship to be able to get to it. But their wisdom, their autonomy really is where the answers are. So being able to get to those I think is really helpful. So let's start to define mental illness because sometimes we throw around the word. We say, oh, gosh, I need a mental health day. Or I'm having some anxiety right now.

We'll throw around these words. And when we're talking about a diagnosis, it's something a little bit different. What it means is that there are a set of criteria that are established that we need to meet in order to meet that particular diagnosis. So mental illness, whatever it is, there are certain set criteria, and it's diagnosable by that criteria.

Now, we could have a very long philosophical discussion about who gets to decide what those criteria are, how those criteria change over time, how maybe sometimes these criteria are not terribly culturally sensitive. Sometimes the criteria are just missing things. So all of that is probably true. And right now, what we have to go on is what's called the DSM, or the Diagnostic and Statistical Manual of Mental health disorders.

It's in a text revision, so DSM-5-TR is where we're at. And it outlines all of the different kinds of mental illness diagnoses we have with the criteria listed. And you have to meet these criteria as well as meet the criteria for a certain amount of time.

And so it's diagnosable, but it also impairs my ability to function. So you and I have probably all experienced anxiety. We've probably all been depressed at some point in our lives. It becomes diagnosable when it impairs our ability to go around doing our daily lives. So I say this because I don't want you to diminish the intensity of the struggle or pain that somebody might be going through. So it impairs their functioning, and also creates distress. And it's difficult for them to regulate the symptoms, to manage the symptoms without some kind of intervention.

The intervention might be medication, but it doesn't have to be. It could be cognitive behavioral skills. It could be something different. It could be just somebody listening to them, any of that. But it's difficult to regulate without some kind of an intervention. Of course, it could be a wide range of symptoms, but it impacts cognitive functioning, stability, decision-making, all of those things.

And it also-- and this is important for us in our field-- it increases the risk for becoming victims. And very frequently-- I'm not sure if you all have experienced this. Frequently, our clients with mental illness get into the system sometimes because they think that they're defending themselves from being victimized. So just something to think about, that folks with mental illness are actually are at a higher rate, higher likelihood to be victimized.

So here are some frequent misconceptions. And so I just want to clarify some facts around this. Mental illness has nothing to do with intelligence, meaning, people who have a mental illness, it's not an indictment of the intelligence or morality or any of that. It can happen to any of us. It can happen at any time. And it's not always visible. So you never know what somebody else is experiencing, right? You never know what's happening on somebody else's insides.

Mental illness, having a mental illness is not inherently dangerous. And this is hard sometimes to convince people about because, most often, the memories that people will have are of somebody having a psychotic episode and acting out or being really aggressive, et cetera. But that's rare. The number of people who have a mental illness who actually are completely not aggressive-- in fact, they're at a higher likelihood to be victimized-- it far outweighs the number of people who might feel unpredictable to you, and therefore, you worry. So just really important to be thinking about that.

It's a psychological condition, so mental, emotional, behavioral. It doesn't have to be permanent, though. Sometimes it is. And we'll talk about what distinguishes those things. But there are many times where somebody can experience depression, for example, for a period of time. Things change in their lives, and then they no longer are experiencing those symptoms. It can really go from anywhere between any mental illness, mild mental illness, all the way to severe.

And frequently, when people will talk about severe and persistent mental illness, they're referring to things like schizophrenia or psychotic disorders in general, perhaps bipolar disorder with psychotic features or those kinds of things. It's not self-inflicted. Meaning, I'm not creating it. I didn't do something wrong, and therefore it happened to me. And it's very different from psychopathy or sociopathy.

So when we talk about psychopathy in our social world, people have a particular view of what psychopathy is. And people will say things like, a psychopath could be anyone on the street. And it's so common, et cetera. But it's actually not very common to be diagnosed as a psychopath. So I want you to guess, if you guessed in a maximum-security prison, what percentage of people would be diagnosed with psychopathy?

Give it a guess. What percentage of people-- nice-- will be diagnosed with psychopathy in a maximum security prison. OK, so notice this. We're going all the way from 0.5%, all the way to 75%. That's awesome. Yeah, so many of you are quite right. It's actually low. It's probably 5%, maybe up to 8%, but it's really, really low. And we're talking about a maximum-security prison. So the likelihood to experience it out on the street is even lower because, in our maximum-security prison, of course, we have the cream of our crop, right?

Psychopathy is something a little bit different. What's happening in the brain of a psychopath, somebody with psychopathy is that they are processing emotion in a different part of their brain. They process emotion as a thought, not as a feeling. So for you and I, if I show you a picture of puppies, you'll have an emotional reaction, like, aww, it's so cute, or something like that. And for somebody who has psychopathy, they will look at you and your reaction to figure out what emotion they're supposed to express.

So emotion is experienced as a thought as opposed to emotion. Frequently they're charismatic, manipulative, they lack empathy, deeply lack empathy. They have a moral disregard for things. Now, you might be thinking about several clients and think, oh, well, that is true for many of my folks. And they might have some of these traits, but not all of them. And the way you diagnose somebody with psychopathy is by using the Psychopathy Checklist Revised. It's an instrument by Robert Hare.

You have to be trained in it. It's like a four-hour interview that you do with somebody to be able to see if they are diagnosed that way or not. So a little bit different. And then Greg is throwing in some brain development stuff, which is very, very true and just highlighting the difference between youth and adults. And I'll try and point out what diagnoses you can only identify once people are an adult. And what diagnoses people can have when they are younger.

OK, so here are some quick statistics, just so you know the importance of this. 1 in 5 people, 1 in 5 adults in this country lives with a mental illness. So it's way more common. And this is not just-- not in the criminal justice system, but in our population, our U.S. population in general. It tends to be higher among females than males. However, whenever I see these statistics, I always wonder how reporting influences these statistics.

Is it more socially acceptable to somebody who identifies as female to say that they're experiencing some of these symptoms, and maybe it's less socially acceptable for males, not sure. So I wonder about that reporting. But tends to be higher among females, tends to be higher among ages 18 to 25, and lowest for folks who are 50 or older. So there's something about getting older that seems to reduce the amount of symptoms we experience.

Among our Native American population, 2 and 1/2 times more likely to experience some kind of a psychological condition, some kind of a mental illness, twice as likely to experience PTSD. And unfortunately, suicide is the second leading cause of death among Native American youth, which is 2 and 1/2 times the national average or the national rate. So something to pay attention to, that we do have folks who are struggling in a variety of different ways more frequently than we think. And perhaps it's worth our time to slow down a little bit and find out about what people's symptoms are and how we can further support them.

OK, so here are some general signs. And I'm curious if there are others that I've missed on this slide. So if you're someone who's just a lay person-- you're not a physician, you're not a clinician of some kind, you'll still be able to tell that somebody might have something going on. And here are some of the ways that you can tell.

You just sense that something's off, like something is not right. Maybe they're exhibiting confusion, or they're disoriented, or they're looking back and forth, or they're talking to themselves or talking to somebody who's not in the room. Or you ask them a lovely, beautiful, open question, and they respond with just a couple of words, or they respond with all the words that come out all at the same time. And it feels like they cannot speak fast enough.

Maybe their behavior changes over time or they seem just withdrawn or flat or their affect, their motion, doesn't match the content of what they're sharing with you. So they're sharing with you something sad, but they're flat, or they're sharing with you something really exciting, but they seem kind of sad, so there's an incongruence there. Or maybe they're just having a panic attack in your office, or they're complaining about a whole lot of aches and pains, but they seem-- it doesn't seem to match what's happening.

Or maybe poor hygiene, or sometimes they're not dressed appropriately for the weather. It's super hot outside, and they have multiple layers on, for example. So all of these are signs. They're not diagnostic criteria. They're just things that make you wonder, do I need to attend to something? And Sofia, you're laughing, but frequently, we provide our folks with some hygiene items, some care items. I sometimes have to spray Febreze in my office when people leave. Oftentimes, our folks are living on the streets, et cetera.

So yeah, it's one of those many signs and symptoms. Again, you said you're laughing-- oh, I'm not laughing; I'm crying. Yeah. Yes. OK, so my question then is, what am I missing? And Melanie says dissociation-- that's brilliant. I'm going to add it, absolutely right. So dissociation is where it seems like they've left their bodies. Their bodies are in front of you, but they're not home. They've left. So that's dissociation.

And frequently, we dissociate when something feels triggering or traumatizing. It's a trauma response. And it's a way of protecting ourselves, to leave our bodies. Cody says subject jumping, yes and easily distracted, easily taken off task, yes, great. This is a great example. What else? What else are we missing from this slide?

Dissociation we're missing-- maybe I'm missing emotional lability where the emotions just come and go, and it's all kinds of emotions. They ask to repeat something several times. Yes, yes. Changes in appetite. That's brilliant, Melanie, changes in appetite, changes in sleep-- yeah, good. Good, awesome. So we're constantly paying attention to some of these things. Quick to emotions, quick to anger, quick to react, and frequently, that kind of high emotion is also-- could be, not always-- but could be a sign of trauma.

Hypervigilance, hyperreactivity, hyperarousal is all signs of trauma. And then the opposite end is also a sign of trauma, which is numbness or this experience of just being shut down. Kimberly says it takes a long time to process thoughts or answers. Yes.

And sometimes it's hard to piece all of these things apart. Because every so often-- I don't know about you all, but we have a high percentage of our clients who experience traumatic brain injuries in their lives. And they come in to our offices, you know, with these TBIs that they don't even remember sometimes how they had this brain injury.

Maybe it was an assault from a long time ago or a bike accident or whatever it was. But they come in, and their symptoms look sometimes like a cognitive issue, but it might be a traumatic brain injury. So they need me to repeat things. They forget things a lot. They're sometimes not able to track what I'm saying. So those are some examples, so just sort of paying attention to.

And then, some family behaviors contribute to some acting out. And Sherry is sharing that sibling favoritism. Sometimes you've noticed, in some families, and then the other child becomes rebellious. And so, I think, Sherry, you're bringing up a really good point. Like what is just normal part of development? And then, where do we get into some of these symptoms of mental illness?

So let's talk about some of these big categories, broad categories of mental illness. I'm not going to cover everything that's in the DSM, of course. So these are just broad buckets that you will frequently see. And one of the buckets that you will probably see the most frequently is substance-related issues. So in the past two versions of the DSM, we moved away from calling things abuse and dependence, and we moved to this continuum of substance use disorder, so alcohol use disorder or cocaine use disorder or whatever it is, mild, moderate, and severe.

So that's the continuum. But those are substance-related issues. And then you can also have things added on to that, like a substance-induced psychosis. So you could have somebody with an amphetamine use disorder with psychotic features, for example, that there was something that happened as a result of using substances.

But that's a huge, big chunk. And we can talk about addiction at a different time. I think we have a webinar. We just did a COP, a Community Of Practice, on addiction. But that's an hour and a half conversation that we could have. So substance-related issues are one broad category of things that you will see.

The other is thought disorders. And when we talk about thought disorders, what we're saying is that people are experiencing what we call psychosis, which is characterized by two things, hallucinations and delusions. So somebody type into the chat, what are hallucinations? Cody's asking-- so while you all respond to that-- Jane, yeah. OK, awesome. Great. Look at this. OK, great, we've got awesome answers in here.

But Cody asked a question related to psychosis. Can a large traumatic event spur a psychotic episode? It could in certain folks, yes. Anything can spur a psychotic episode. What a psychotic episode is is where we're experiencing hallucinations and delusions. But it is an organic issue in the brain where neurons are connecting with each other in a way that doesn't represent reality. And so, every so often a traumatic event could create that. So yes, you're absolutely right.

And there are different kinds of hallucinations. Jane says seeing something that isn't there, auditory or visual, yeah seeing things, hearing things. OK, great. So yes, you're absolutely right. And it's a little bit bigger. It's a misinterpretation of all of our senses. So you all have said seeing, so eyes, and hearing, your ears. But it's also a misinterpretation of other senses, like feeling things that aren't there, tasting things, gustatory hallucinations, tasting things that aren't there. So it's really-- yeah, tactile. Jessica, you put that down.

So yes, it's an interpretation of our senses that there's something amiss there in the way our neurons are interpreting whatever we're sensing from the environment. Something that appears real to them, it appears very, very real. That's so, so true. OK, great. So I'm just going to double check that I didn't miss any questions there. Great, wonderful.

So hallucinations are something that happens with our senses where our brain misinterprets what our senses are picking up as something that isn't there. So tasting, smelling, seeing, hearing, feeling, all of those, we can have hallucinations around those. When somebody has a hallucination, it's really important that we not argue with them. So if somebody says, oh, my gosh, I have spiders crawling on my skin, it's really important to not say something like, no, you don't.

If they say to you, do you see the spiders crawling on my skin, it's very important not to lie. So you say something like, you know, quite honestly, I don't see them, but I do believe that that is what you're experiencing. So really important to state that you believe what's happening to them. Because what you don't want to do is to get into an argument about their reality because the truth is that their brain is misinterpreting in a way that it feels real to them.

And just for you-- for all of us on this call, if you say this is reality, and somebody says, no, it's not, you immediately have a reaction to it. I mean, we could have all kinds of reactions. But it drives me bonkers when what I know is happening, somebody says, no, that's not happening. It makes me feel like I'm going crazy. And that feeling is really scary. So very, very important when somebody is having a particular experience, we don't lie. But we also don't fight with them about it because that's really besides the point.

What is the point is helping them either manage the symptom or get some kind of relief for the symptom. So we said psychosis or thought disorders are divided into two parts. Experiencing psychosis is about hallucinations, and it's also about delusions. So what are delusions? We talked about hallucinations already. What are delusions?

And yes, Sheila said drugs can cause some of these symptoms. Alzheimer's, yes. So dementia is actually something slightly different, Crystal. And dementia falls under its own category. I actually didn't list it here. Probably should have, but it's one of its own categories, for sure.

So when I asked the question about delusions-- ideas of grandeur, believing one is something that we are not, misunderstanding or misinterpreting the reality, unrealistic thoughts that they believe are true. Yes, like a fantasy, a belief, yes. So delusions are faulty thoughts, and they feel very true. They're beliefs about the way the world works or something that's happening that is informed somehow by these misfiring of our neurons that feels really true.

And several of you have given examples and these, are great examples, that they might have superpowers. Or frequently, very common delusions are paranoid delusions, that other people are out to get them, or other people are doing things to them. Oftentimes, our clients think we've bugged their house, or we've installed something in their brain so that we're constantly watching them.

I have a client who frequently will reach out to me asking if I have the cops surveilling him the whole time. Because every time he sees a police officer, he thinks that police officer is watching him. So he is under the impression that I have the cops surveilling him at all times. We have clients who, every time they see a drone, they think probation has sent a drone after them, so those kinds of things.

We have folks who believe that they're part of the SWAT team, the CIA. And I'm sure you've experienced all of these. So the thing about thought disorders is it is an organic issue in the brain. By that, I mean, it's a misfiring, a miswiring of certain neurons. The research is still looking into why it happens. We're not entirely sure. There's some genetic component to it.

But sometimes it's triggered by a particular event where these neurons can connect with each other. Sometimes it's triggered by substance use, for example. So something happens that triggers these responses, but it is an organic brain issue. And because of that, medications can help tone the volume down, but medications cannot rewire or reorient some of these neurons. And so we can tone down the volume, but we cannot always fully fix this.

So just keep that in mind that, when you have people with schizophrenia or schizoaffective disorder or psychosis on your caseload and they're on medication, they might appear really stable, but there's still just a hum happening for them. So they're having to manage quite a lot in order to appear like everything's OK. So I just want to give you that piece of information so that you can have just a little extra compassion for folks who are struggling with thought disorders.

Imagine that the only way I can try and explain it is it's as if somebody is constantly whispering or talking to you in your ear while you're trying to pay attention to something else. So imagine the amount of energy it must take to quiet that voice down or not be distracted by it. So those are thought disorders and frequently managed with medication, in fact, most often managed with medication. And again, medication turns the volume down.

Most often, the medications are called antipsychotics. Or sometimes we'll have more interesting, newer medications that are able to have fewer side effects when people are using them. And there's an overlap in terms of antipsychotic medication and anti-seizure medication. You'll frequently see anti-seizure medications being used in this way because of the impact on the brain. So those are all organic brain issues. We talked about thought disorders.

Mood disorders are not organic. They're more chemical. So mood disorders are chemical imbalances in the brain that result in not being able to experience certain emotions because we are lacking certain chemicals. So the simplest example is depression. Anyone want to guess, what is the chemical that we are missing when we experience depression? What is the chemical that we're not able to produce enough?

So Anna guessed dopamine. Selma guessed dopamine as well. One more guess-- serotonin, great, yeah. So it's really both. It's serotonin and dopamine, more serotonin than dopamine, but, yes, it's both of them that we-- and Bobby, you're right. It's both. It's both that, in depression, we struggle with. Serotonin is easier to medicate because there are fewer side effects when we provide somebody serotonin.

When we provide somebody dopamine, the side effects are pretty significant. And they look like Parkinson's disorder if you provide somebody excessive amounts of or when you try and medicate somebody with dopamine. So most often our depression medications are serotonin. And they work in a couple of different ways. One of what they do is they provide the body with serotonin, but they also prevent the receptors from taking any extra serotonin back in.

So we just get left with excess serotonin, which, I'm using the word excess. But for somebody with depression, what medications do is they bring up their serotonin levels just to normal. So I frequently will say to people, when my clients don't want to get on antidepressants and they're really, really struggling, I will say-- they'll say things like, well, I don't want to be fake happy. And I say, I promise you, it's not going to make you happy.

Life is hard. And it's going to bring you up to the regular hard level because right now, you're life is excessively, unnecessarily hard. And so all that medication is going to do is bring you up to the regular level of hard. It's not going to make your life easy in any way. And yes, so am I saying that the medications that I was talking about, they're called SSRIs, Selective Serotonin Reuptake Inhibitors.

With the newer medications, I'm not sure if some of you can give me some indication of, is there an increased use of ketamine where you are for depression, for the treatment of depression? Is that happening for you all around you? Are people prescribing ketamine for depression? So some nos, a yes, for trauma. OK, lots of nos.

So ketamine, I'm sure you're all familiar with the drug. Ketamine is an anesthetic. It's a pretty strong pain reliever. It's also a very safe pain reliever. It's frequently used with kids. It's used in war because of the level of safety involved with ketamine. What ketamine does is it gives us an experience that we are separated from our bodies, our pain, our whatever.

So it gives us that experience, but it doesn't depress our breathing, which is what a lot of significant painkillers that people will use during surgery, for example, that depresses your breathing, which is why frequently, an anesthesiologist has to really be careful and monitor your breathing. So I'm not saying ketamine is all wonderful because people can absolutely abuse it. But what they're finding in the research is that ketamine seems to support this-- reducing the symptoms of depression when people are not responding to SSRIs.

So they call it treatment-resistant depression. And there are some studies that support the use of ketamine for that. Now, of course, it gets really complicated in our population because, if our clients are seeking substances and just want to use substances in order to get high, then using a medication that could potentially be a medication that they then abuse just puts us in a really tough spot. So I do just want to say that there is research support for using ketamine with treatment resistant depression as well as PTSD.

And I think one of you had said that. I think it was Heather, yeah. So trauma, there's some major studies on trauma and depression. However, no studies with our population, with folks in criminal justice. So the jury is still out about that.

So we talked a little bit about depression. That's one of the mood disorders. Another mood disorders is mania. So mania shows up in a few different ways. It can show up in hyperarousal, very impulsive behavior, lots of shopping, lots of spending, lots of sex, lots of whatever. It's just this frequently depicted in the media, the manic episode, but it doesn't have to be that big. It could sometimes even just be higher irritability, higher sense of anxiety sometimes that comes after depression.

And when you get both depression and mania together happening in the same individual, we call that bipolar disorder. So there are two kinds of bipolar disorder, very fancifully named bipolar I and bipolar II. In bipolar I, mania is more significant. It's prominent, it's more-- the person is more frequently manic and then sometimes depressed.

Whereas, in bipolar II, the person is more frequently depressed and sometimes manic. And then you can have other mood-related conditions like cyclothymia where people are cycling through some of those moods. And so, in depression, what's happening is we don't have enough serotonin and dopamine, so that that's the medication. But in bipolar disorder, what's happening is we lack certain chemicals that quiet down our brain.

So we have, in our brain, we just cannot stop what's happening. The particular neurotransmitter that does that is GABA. And so the medications that people will use for bipolar disorder are called mood stabilizers as opposed to antidepressants. So an antidepressant will bring up certain levels as opposed to what mood stabilizers do, which is help quiet down the brain. So those are mood disorders.

If you have questions, pop them into the chat, for sure. Otherwise, I'll keep moving. Oh, one more thing about mood disorders, because they are chemical, they can be managed chemically. So you could put people on medication for mood disorders for them to be symptom-free. But medication is not the only way that we can manage mood disorders. There are a lot of different techniques, therapy, natural ways of bringing up dopamine and serotonin, that seem to be really helpful for mood disorders.

So type into the chat, apart from medication, what are other things that seem to help people with mood disorders, things that you could talk to clients about? Yes-- exercise, hobbies-- oh, my gosh. I love this. DBT-- so DBT is Dialectical Behavioral Therapy, and it's kind of like cognitive behavioral therapy with mindfulness. So it's a lot about paying attention to our thoughts, paying attention to our needs, our feelings and really, really helpful.

In fact, there's some really cool research both on DBT and DVT that say sometimes it's just as successful as medication. Greg, you put your hand up.

I did. I thought maybe this would be a great place to talk about the question of-- and this comes up. You know, we do the Probation Academy. We do some other trainings. But around mental illness and how to look at case planning, I was asked, should we consider sweats or smudging or even yoga as evidence-based or research-supported activities that can help people manage mental illness. And I wanted to get your thoughts on that, but thought it fit in here.

Yeah, yeah. There is so much research on the very things that you're mentioning. So many of you actually have put it in the chat. There's a ton of research on exercise. There's a ton of research on spiritual engagement, providing people relief from mood-related symptoms. Now, I'm not saying this is for everyone. I'm not saying it'll fix everyone. But it has support for reducing symptoms.

What has a ton of research support is social connection, so things that we do together, things that support our feeling of hope. Things that support connection, connectedness, gratitude, those kinds of things, really seem to increase our sense of well-being and reduce these symptoms. So yes, absolutely. Hillary, nature, yes, there's lots of support for nature as well.

And really, engaging in any hobbies-- so Anna, you put in music. What becomes difficult is, if I'm experiencing depression, it's really hard to find the motivation to engage in the things that I know will make me feel better. And that's where social support is so important to help somebody move into doing the very things that might make them feel better. Joan says, laughing. And absolutely, when we laugh, we actually release higher levels of serotonin, dopamine, oxytocin, so really, really important.

And when we laugh with other people, when we laugh with people who we love, it's even better. Being active, yes, art therapy, cognitive behavioral therapy. Journaling is huge, Filipina, you noted that, yeah. Sheila asks, are mood disorders lifelong? They don't have to be. People can go through episodes of depression or episodes of bipolar disorder and then find episodes of stability in their lives. So they don't have to be lifelong. Some people do struggle all their lives, but they don't have to be lifelong.

Yes, Marv says animal-- so there's research about dogs, in particular, and how cuddling with our animals increases the amount of serotonin and oxytocin that we have. Tara says support groups-- yes, absolutely, brings up the issue of community and the importance of community-- nature, healing practices, faith-based activities. Yes. Lucinda says doing something outside, caring for a pet, traditional healing, helping others.

So I'm going to butcher your name. I'm so sorry, but I think it's Jean who's saying, a feeling of purpose. Yes. And sometimes, when we feel lost in our own purpose, looking outside and helping other people seems to help us engage with purpose. There's this incredible book called *The Book of Joy.* And it's a conversation between the Dalai Lama and Desmond Tutu. And they talk about a variety of different things. But this piece around purpose and other oriented care comes up quite a lot in that book. It's pretty cool.

Talking circles, Wellbriety, yoga-- yes, lots of support for yoga and depression with many, many studies. Combination of medication and therapy-- yes, for sure. Great. Let's see. Sherry says our court offers wellness for family, adults, and juveniles, lots of options, talking circles, retreats, sweat lodges-- amazing. Crafting, yes, engaging in some kind of activity together, wonderful. OK, so lots of different options.

I'm not saying all of these will work for people. But it's helpful to talk about other options that people have besides medication. Sometimes medication is the only thing that does the trick. And other times, medication helps, but only so much. And they have to make some lifestyle changes in order to sustain some of the reduction in symptoms. OK, all of these examples that you have just given are also true about anxiety.

So anxiety disorders are a little bit different than mood disorders, so completely separate category. Anxiety disorders are where we experience an event, something triggers us that makes our brain feel that we are completely unsafe, and that, if we don't manage these feelings that are coming up from within our body-- the increased heart rate, increased respiration, all of those things, that we will die.

So even though it's something that triggered us-- it might be something from the outside. What feels that's going to kill me is what's happening in my body. The reaction that's happening in my body feels so huge that it's what terrifies the person. So for anxiety disorders, it's really important to help people learn how to manage what's happening in their bodies.

And one of the ways that Nicole is talking about is grounding exercises. Yes. Because it feels so overwhelming, whatever those reactions are. Fast heart rate, can't breathe, can't catch my breath, and then it just compounds. Oh, my gosh, I can't catch my breath. I'm going to have a panic attack. Now I'm having a panic attack. And all of it just feels like I'm going to be annihilated. I'm going to die, for sure.

And so helping people reground, get back into their bodies, get comfortable in their bodies, helping people learn how to bring down their heart rate, to bring down their blood pressure-- and one of the ways that's so helpful is through breathing and, in particular, exhaling. Because when we exhale is when we reduce the amount of cortisol in our bodies, when we're able to bring a sense of calm to our bodies. But it's easy for me to say this and very hard to do when we're in the middle of an anxiety attack.

So, yes, there's medication, which we should talk about. So, yes, there's medication, but we also have to learn how to manage these symptoms. So it's really helpful, even if you're not a clinician and you're a case manager or a probation officer or whoever you are, it's really important to be able to support our clients learning how to manage their anxiety when they're calm, when they're not having an anxiety attack. So talking about these skills is incredibly helpful.

So medications for anxiety disorders frequently look like a mood disorder medication. So it'll be an antidepressant of some kind. But if the person is experiencing a panic attack or something like that, doctors will prescribe benzodiazepines.

And the problem with benzos is that they are pretty addictive. So if you have somebody who has a substance use issue, who also has anxiety, it's really important that you talk with-- that you have cross-collaboration and that you're talking with the prescriber to make sure that they're not making their addiction worse, that we're not prescribing things that actually put our clients in further danger.

Great. I love these conversations that are happening in the chat, so cool. OK, let's talk about trauma and stressor-related disorders. We could spend an hour and a half or maybe two days talking about trauma. But the cool thing about what happened in the DSM-5 is trauma used to be a part of anxiety disorders, and they pulled it out to its own section called trauma and stressor-related disorders. So PTSD is one of those things underneath it.

But it frequently looks like depression or anxiety or some kind of impulsive disorder sometimes too. So important to be able to distinguish it and pretty complicated. Because what's happening in the moment is, when people have experienced trauma, their brains are working overtime to try and keep them safe. And so they experience pretty much everything as a threat because the brain is just trying to keep them safe.

And by everything, I mean, you as well, unfortunately. So they'll experience you as a threat sometimes as well, even though you're trying to be so helpful and calm and supportive. So one of the ways to help-- well, I'm going to ask you all, how do you help people feel safe? Whether you're talking to them in your office or you meet them on the street or whatever it is, what are what are things that you do to help people feel safe when they're having a reaction to you? What do you do?

Yeah, Sheila says tone and body language, very good, very good. So a calm tone, being empathic, yes, having them breathe, acknowledge their feelings. Yes, acknowledge their feelings. You don't have to fix it. You don't have to argue with it. Just acknowledge their feelings. I hear that you don't feel safe right now. Or I really believe that you don't trust me right now. Or it's 100% OK that you don't trust what I'm saying. And I'm right here.

Being empathic, listening, and validating-- the 5, 4, 3, 2, 1 technique-- it's a grounding technique that Stephanie's talking about. And Stephanie, correct me if I'm misinterpreting what you're saying. But, one of the techniques to help people reground is to say, name five things that you see, four things that you hear, et cetera, so really bringing them back into their senses, which helps people reground.

Michaela says, ask them if they want water. Yes, rapport, huge. Let them know we're here and acknowledging them, offering food or drink. And sometimes it's just it's having a different conversation until they're ready to have whatever the triggering conversation is, so waiting until they are ready to proceed. And Melanie, that's such a beautiful, respectful way of having these tough conversations.

Active listening, giving them space to speak, not problem-solving-- oh, my gosh, If there's one thing you walk away with, I hope you walk away with, we do not have to solve the problem. Empathy first. Compassion first. Yeah, acknowledge, give them space, tell them I'm here. Yeah, perfect. Not meeting their energy and not taking it personally. Yes, I actually think I have a slide where we talk about those very things too. That's great.

Talking softly, yeah. Fidget toys, hugely helpful. Yes. Form a connection. Before addressing-- yes, so Melanie had this. This saying that I frequently think about connect then correct. I always try and connect first. So connect then, correct. Beautiful. Beautiful. All right, so trauma.

And then, the last big bucket-- and yes, I know there are a whole host of other mental illnesses, but these are the ones that you'll most frequently encounter. Personality disorders-- so personality disorders are not things that can be managed with medication. In fact, the most support in the research for how to work with personality disorders or manage a personality disorder, if I have it, is through Dialectical Behavioral Therapy, DBT or even CBT.

But what a personality disorder is, it's a reaction that was formed at an early age to not getting attachment needs met. Meaning, something happened at a pretty early age where I had needs to feel cared for, loved, empathized with, all of these things, and my needs weren't met. And so, in reaction to that, I formed certain ways of being in the world. And we divide personality disorders into three clusters-- fancy terms, cluster A, B, and C.

Cluster A has ways of thinking that tend to be paranoid. Cluster B is ways of thinking and behaving that tend to be dramatic. And then cluster C is ways of being and thinking that tend to be a little bit disorganized. Miranda is asking, a TBI caused by childhood traumas or neglect. Miranda, make the connection for me. I'm not sure what you mean by that. So type into the chat just a little more information.

Are you talking about-- oh, maybe you're asking, does a personality disorder occur-- got it. Because of-- yeah, you know, that's a really interesting way of thinking about it. I never thought about it as a brain injury because personality disorders, when you look at a functional MRI of somebody's brain with a personality disorder, you won't be able to notice a difference. Meaning, there won't be an actual injury to the brain, which you can see when somebody has a TBI.

But I love the analogy that, essentially, there's been an injury. And I would say that the injury isn't the brain. Or maybe it is. This belief around how I get my needs met, that's where the injury is. And it is through childhood trauma and neglect. You're absolutely right about that. And it's shifted how I try and get my needs met. An emotional attachment injury, Melanie, that's absolutely right.

So let's get super concrete. Let's say I'm a baby, and I am crying for my caregiver, and sometimes my caregiver comes and comforts me. Sometimes I cry, and my caregiver comes and smacks me. And sometimes I cry and my caregiver doesn't come at all. So for this baby, then, it's very confusing to know, how do I get my needs met? And so they start to form different ways of trying to get our needs met that are, unfortunately, not very productive or helpful in the world.

So an example might be, I now get my needs met by being extremely dramatic or crying all the time or making a big deal out of nothing, something like that. Or maybe I try and get my needs met by always talking about me, being really me-focused. So some of the examples that I've given you are certain personality disorders-- narcissistic personality disorder, histrionic personality disorder, borderline personality disorder, antisocial personality disorder.

Personality disorders, we tend to diagnose only in adulthood because we're never sure what's happening. Is it just normal sort of childhood adolescent development? Or is it an actual attachment issue that has shown up as a personality disorder? But sometimes you'll see disorders like conduct disorder that will later on look like antisocial personality disorder. So there's a little bit of that.

But I love this analogy that both Miranda and Melanie are using. It's an emotional attachment injury that results in a personality disorder, right. So what do we do? We're familiar now with these buckets. What do we do? What we do is we start with ourselves, and we start with our own awareness of what's happening for us. Try not to panic.

Try not to take it personally. I think one of you said that. Keep the goal in mind. And the goal is to be able to provide whatever support you can for the individual in front of you, and then make the connection between them and the next place that they have to go. So let's say we're trying to make a treatment referral or we're trying to get them connected with housing. That's the goal, right? So keep the goal in mind.

Don't try and fix a problem. You're not going to fix their symptoms. And there's no self-destruct button. Meaning, don't overly worry about saying the wrong thing. If you say something, and they escalate, apologize as quickly as possible. I'm sorry. I said something that clearly upset you. Let me try that again.

Don't take it personally to the best of your ability. Keep things simple. Short sentences, really clear, patient, and to the best of your ability, as consistent as possible. But definitely start with you, and make sure that you feel OK. Because if you're starting to panic, they will pick that up, and they'll start to get even more anxious. So make sure you're breathing, you're feeling comfortable in your seat. And that will help them quite a lot.

Also, prioritize the how. Don't worry about the what. Prioritize the music. Meaning, come from a place of empathy and warmth and care. That's what helps people calm down. So the how that you're engaging with them-- using motivational interviewing, if you're familiar with that. Think about safety skills and support, which is what we talked about.

Focus on the next steps, and don't hesitate to make a referral. Meaning, if you are really worrying about something, you feel like something is up, but you want to make sure to get them an evaluation, make the referral. So follow up with whatever the next step is.

Now, sometimes people might be having a crisis in your office. A crisis is something that requires your immediate attention and requires immediate action on your part. I frequently say that there are very few crises. Now, of course, if somebody is being violent towards you, you've got to react pretty immediately. That's immediate action, requires immediate response. But sometimes people might feel like they're in crisis. And what they need really is just listening to them.

That's awesome, Nicole-- education for everyone, super important. And the mental health first aid class is fantastic, so really, really wonderful. And then making sure you're balancing empowerment with whatever your structures or rules are. So for example, let's say you want somebody to reach out to complete an evaluation. You can give them some kind of empowering statements like, would you like to call, or would you like me to call for you? You're empowering them, giving them choice, but you're ensuring that it's actually getting done.

And then, knowing your resources is really, really helpful. Making sure that, you know, is there-- do you have a crisis center? And if you don't, is there something online that can be helpful? Or is there somebody in your community? Or if there's nobody, and you have nothing close to you, are there social supports that you can get somebody connected with as quickly as possible? So just knowing your resources.

And also, knowing that you are a limited resource-- so what is your capacity to support other people? And then what is their capacity to respond to you? And not asking people to do things that are beyond their capacity-- frequently, we have co-occurring issues. We've talked about that. Always prioritize basic needs. Some of you said, right when we started, gosh, there's so much, how do we know where to start? And we start with basic needs.

If our basic needs are not met, it's very difficult to focus on other things. So does the person have a safe place to sleep? Do they have some food? Do they have access to medication? So just prioritize those basic needs. Make whatever accommodations are necessary. We frequently do different kinds of things for our folks. Like we provide a little calendar. Or I will help people put reminders into their phone if they have a phone.

I help them set up calendar reminders for appointments, alarms for different things, notes that pop up onto their phone. So there are just a lot of different apps that really help people. So make whatever accommodations are needed. And when you're responding to their behavior, keep in mind what their capacity is.

It's not fair to expect somebody who's trying to manage a thought disorder to be able to respond in the same way that a client who is not struggling with a thought disorder. So just keep that in mind as you're responding to the behavior. All right, let me check where we are. Great. We have a few minutes for questions.

Anjali, I think a question that often comes up is, we have people who aren't very honest with us and want to keep secrets and have some lifestyle issues. How do we sort out manipulation, criminal thinking, and maybe a symptom of a mental illness? I mean when we're interacting with one of our clients, what are we looking for? How do we go about that process?

Yeah, that's a really good question. How do we separate some of our patterned behaviors from our clients from symptoms of trauma or symptoms of a mental illness? And I would recommend that we have a lens that is trauma-aware and that's aware of mental illness in general, that we look through that lens first. So rather than assume that somebody is being manipulative or trying to get around the system or those kinds of things, rather than starting with this sort of negative assumption, we start with a lens of trauma. And we look through that lens first.

And then we move forward. So if we're worried that somebody is being manipulative, for example, it'll look very different. When somebody is experiencing trauma, they will not be able to track the story correctly. They'll say one thing, then they'll say another thing, which could look like manipulation, but really isn't. It's a trauma response in the brain. So helping people feel safe first is usually the way to go. And then you'll be able to see, is it a trauma thing, or is it truly a pathological thing.

I see a couple other-- oh, great. OK, this is an awesome question. Suggestions for parent education from Kimberly. There are lots of support groups, but sometimes the parents don't understand the diagnosis. Their expectations are skewed. And sometimes, you know, Kimberly, I've noticed that parents themselves are going through a tremendous amount of grief sometimes because they think that they did something wrong, or that they're part of the problem, or they don't even understand what's happening.

There's so much stigma, I think, in our society. So I think it's really, really tough for parents. So I love that you're thinking about support groups. And yes, there's so much information available online. So NAMI is really helpful. It's a great resource for family members for understanding medications. The National Association on Mental Illness, very, very helpful. NIDA also has some information on mental illness.

And then, if you go to SAMHSA's website, S-A-M-H-S-A, they have, not a book necessarily, but a manual on the interplay between being involved in corrections and mental illness. They have another manual on adolescent mental illness that's really helpful. And sometimes I find those are helpful to just help parents come along and be supportive of their children as opposed to engaging in behaviors that are actually detrimental. Adolescence and mental illness-- yes, I'm just going to type in SAMHSA here.

All right, well, I think this might be a good place to end the webinar. I don't think we have any other questions. So for additional information on general TTA services, links to featured offerings, and to request to, TTA, please visit our website. This is going to conclude our webinar for today. Thank you again, Dr. Nandi for sharing your time and knowledge with us. And thank you to our attendees for the great engagement and questions this week. We hope to see you in future webinars and communities of practice. And have a great rest of your week. Thanks, everybody.