Webinar Transcript - Ask the Expert: Cultural Reconnection and Resource Resilience in Tribal Communities

Welcome to the National Criminal Justice Training Center webinar*Ask the Expert-- Cultural Reconnection and Resource Resilience in Tribal Communities.* My name is Greg Brown, and I will be moderating for you today. Before we begin the presentation, there are some items I need to go over. This webinar was provided under an award provided by the Bureau of Justice Assistance, Office of Justice Programs, US Department of Justice. The opinions expressed by the 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.

Today's presentation is part of a webinar series funded by the Bureau of Justice Assistance focused on supporting Tribal Comprehensive Opiates, Stimulant, and Substance Use program, and Coordinated Tribal Solicitation Purpose Area 3 grantees, and other tribal communities implementing responses to alcohol and substance misuse. I'd like to welcome our presenter, Dr. Anjali Nandi.

Anjali is an associate with NCJTC and a human services consultant. Anjali is a member of the International Motivational Interviewing Network of Trainers, a licensed addictions counselor in the state of Colorado, and a nationally certified master's addictions counselor. Anjali has authored numerous publications, including tribal-specific resources for BJA's COSSUP tribal grantees.

As mentioned, my name is Greg Brown, and I'm a program manager here at the National Criminal Justice Training Center. Paul Fuentes will be joining us today, and thanks again for joining us. Anjali, the time is now yours.

Great. Thank you so much, and welcome everyone. These*Ask the Expert* sessions are so fun because, really, this time is yours. We get to dig in a little bit deeper to some of the questions that have come up.

The information that is contained in this webinar has been presented already at a webinar that we did I think it was two weeks ago. And so the content isn't necessarily new. What's different about this particular presentation is we collate all of your questions that you ask and then we try and answer those during this time.

So that's the purpose of these Ask the Expert sessions. Not that we're the experts, you all are, of course, in the work that you all do. But it's just so helpful to think through some of the questions that you all ask.

And Greg has collated all of those. So we'll be going through those questions. And then if, depending on how you're responding to these, I will either put the slides back up or take them down, depending on how we're doing here, because a lot of this is just conversation.

But if you have questions that you want us to answer, please add that to the chat. I know that some of you added some of your questions already when you registered for this course. And again, we'll be covering our responses to those. But as time goes on, if you have very specific questions, just pop them into the chat, and we'll get to them.

So just as a reminder, the topic of conversation for today is around some of the challenges that folks face when they are reentering community from either being in an inpatient setting or being incarcerated. And it has to do with not only the process of addiction and trauma but also other really important things, like how ready the community is to receive them, what some of the barriers exist in the community, what are the resources, what kinds of community-based programming exists.

And so those are some of the things that this webinar seeks to address. What are some of these issues? And then how can we address them? So that's a high-level overview of what we're talking about.

And you probably remember that we talked about some of the unique challenges that many of you face, like remote locations, resource access, those kinds of things. And in the last webinar, we kind of covered something-- we covered information around trauma, the impact on the brain. We talked about adverse childhood events, those kinds of things.

So we'll continue to dive deeper into those topics. But I'm going to ask that Greg start with sharing with us some of the questions that have come up from you all that you're interested in knowing and hearing more about. And Greg, I'm going to stop sharing, and then I can pop the slides back up if you need.

One of the questions that always comes up, Anjali and Paul, is when clients return to the community, they often feel like they're starting over. They were in jail doing programming, they were in prison doing programming, they were in residential treatment, any number of things. But they move over to the reentry people, or probation, or parole when they come out, or even treatment aftercare-- or treatment. They go back to treatment.

And they've done a lot of work. But oftentimes, the changes in workers seem to lack-- the clients feel, and I hear this a lot-- there's any recognition for the work that they've already done. They've been locked up for a year or 30 days in treatment while they've been incarcerated or in residential treatment.

And that really doesn't feel like to them it's being considered in their planning. And they often say you're just fitting me into your program box. "Everybody has to do this. I'm just a number. You don't care. You didn't hear that I just did a year of rational recovery. You didn't hear that I just did Thinking for a Change that-- I did nine modules of that and here are my certificates." They bring their certificates because they're so proud that they're looking at recovery. They're looking at being better. They're looking at incorporating skills.

And we lose some opportunities there. But some thoughts on how we might want to do a better job with that. And I know there's program integrity and we've got to deliver what we say we're going to deliver, and this will be a nice refresher for you, but it doesn't feel that way always to clients. So, Anjali, start with you, and then Paul.

It's a really important question, because what you're bringing up is how clients need to feel seen and heard. So anyone-- and it's not just clients. It's all of us as human beings. We need to feel seen and heard.

And so when we discard or disregard any of the work that they've done and we plop them into what feels like a sort of a cookie cutter response, it gives them the impression that we are not seeing them and seeing the work that has been done. So it's really important to hear that. So that's one piece.

The other piece is it's very tricky for a program that's set up a certain way to then have to accommodate all of these sort of individualized needs of folks. And so one of the thoughts that seems to be pretty helpful is to immediately put people-- clients who are coming in in a position where they get to share the knowledge that they have with everybody else in the group.

So for example, let's say the client has already done Thinking for a Change, and the program that they're coming into is MRT, Moral Recognition Therapy, which is very, very similar to Thinking for a Change. Well, let's say they're coming in into some kind of a cog program-- again, very similar to Thinking for a Change.

It's helpful to help us-- the client to help us as practitioners provide this information to the other folks who are there so that we're sharing knowledge, because it's one thing to know the steps, to have learned whatever the skills are. It's a whole different deal to be actually practicing the skills and utilizing those skills in our work and in our life.

And so when we start to teach some of these things, when the client starts to teach some of these skills, they're actually integrating it a little bit more into their lives. So it's one of the strategies to really get people to help acknowledge all of the work that they've done, but then also have them continue their learning process through a teaching process. So those are a couple of thoughts. And Paul, I'm curious what you're thinking as you're listening to Greg's question and then some of my responses.

One of the things that I think about is, on the tribal end, say it's a reentry program. When people come out of, say, prison, for example, they could be going into a reentry program, or maybe they still have court obligations, or parole obligations, or probation. And I feel like one of the things-- and this is not a fault of theirs. It's more on the reentry side, or parole side, or probation, or the courts, that we don't give credibility to the programs that they attended in prison.

One of the reasons why we don't give the credibility is we just don't know about the program and we don't know, how often were they supposed to attend? Did they attend frequently? Those certificates, how are they earned? But I don't feel like that is their fault. I feel like that should put some-- I don't know if we'd call it some urgency or some obligation on the reentry side, the probation side, the court side, to get to know what's happening in the prison system better.

And also that in that correction system, that-- because a lot of times, they'll have a case manager when they're about to be released, and those case managers are calling the tribes. And they may be calling the tribe and saying, hey, who's your reentry coordinator? And then a lot of times, whoever's receiving that phone call at the reservation is like, I don't even know if we have reentry. And they pass these people on to all kinds of different programs before they ever find someone who kind of does anything reentry.

And so I feel like that's a failure on our part. When we're talking about reentry programs, I feel like they need to be in-- they need to have where they're going in and doing some cultural classes, or they're going into corrections facilities and teaching life skills, and they're meeting these folks before they're ever released.

And so I feel like the warm handoff part is what I feel like is missing. So there's the warm handoff part and that lack of-- we don't give them credibility. They probably don't give our program credibility. And that's where we need to connect a lot of the dots, I feel like.

And then the other things, Doctor, I think you were talking about that too, is the other reason why we may not give them credibility is because, say they're receiving some form of life skills or treatment. We know that the environment is a lot different in a corrections facility than it's going to be out from corrections. And so we're like, yes, redo this whole program again.

I don't think that that's fair and that we just discount it. I don't think that that's fair. But I think maybe messaging it a little bit different. Like, yes, you gained skills while in corrections. And what we're going now is taking those skills and we're going to try to build upon them now that your environment is a little bit different than what it once was.

So those are some of the thoughts that I think about. And again, I'm kind of putting a lot of responsibility back on us as a receiving program to make those connections with corrections, and also finding a way to, if we need a remessage program, but a way so that we do count what they've done, and we're able to take their progress and move forward with that.

Everyone hates taking a step back. I've already put all this work in. I don't want to take a step back. And so I would focus on those two things, a better warm handoff and the messaging.

Yeah. Yeah, that's really important. Yeah. So a couple of things to think about. When we're working with folks who are coming back into our community, like Paul was saying, understanding what they've done is really helpful. And then knowing that when they come back into our community, there are stability factors that we need to meet first.

So housing, employment, food, those kind of-- medication. Let's say there's a medical issue or a mental health issue. Medication. Those stability factors are key. And if we don't provide them the support for stability factors first, we end up losing them pretty quickly. It's very difficult to attend to higher-order needs like cog skills when our basic needs aren't met.

So kind of starting there is really helpful. And then allowing our assessments to drive what they need next. And I think it's in that assessment process that we can do some of the things that, Paul, you're talking about, which is understanding, what have they done, what do they need now? So that assessment piece is really key.

In terms of the assessment piece, what we're trying to figure out is, yes, stability factors, but then what is driving crime or driving relapse? And we know, in the literature, there's a lot of drivers that we know of crime that need to be attended to. A huge part of that is our thinking, which is why cog skills are so incredibly important.

I know we've done a webinar on cog skills, and perhaps there's more to come, but this piece is like a never-ending journey of really trying to help people understand, what is it that happens in my brain where I have an emotion and I immediately react, oftentimes in an unhelpful way?

So when we talk about cog skills, we're talking about thinking skills, emotional skills, social skills. All of those are a part of reducing future risk when we attend to those. Life skills-- extremely important. And again, like you were saying, Paul, helpful to find out, what skills have they already done, what have they been provided so far, and then where are the gaps? What else is missing?

When it comes to substance use issues, if that is the case, if that's one of the drivers of crime, then building skills to be able to manage relapse prevention, boundaries, being able to say no, how do I manage high-risk situations, those kinds of things. It's one thing to talk about it when I'm in inpatient or incarcerated in jail or prison. It's a whole different ballgame when my parent is right in front of me, offering me something to drink, saying, let's celebrate. It's a whole different ballgame, saying no in that moment.

So those kinds of relapse prevention skills, boundaries, all of that becomes really important if substance use is one of the drivers of crime. So kind of figuring out, what is the assessment telling us in this person's case, and then how do we give them credit for what they've done, but also help put into practice what they have to continue to learn?

So great job, guys. I think that's really helpful information. It kind of goes into this other question around case planning. You're touching on that. I wonder if you could touch a little bit on what case planning might look like and if there are those criminogenic needs, those things that are driving the behavior, as well as the client, what do they want? I mean, they usually have some ideas if they've done some work about what's important to them and what they want to focus on. So that's one piece of the question.

And then this thought about-- and I get this regularly with reentry programs, having phases, and phases create structure, and they're easy to measure, and this is where you start. But program flexibility. If someone really has done Thinking for a Change, do they really need to go in to another very similar program? So those two things. Case planning, what might that look like? And then some thoughts on program flexibility. I don't know what happened to my image here. There we are. I'm all dark now. It must be too much light--

You're in witness protection or something.

It's too much light behind me, or I'm, like, the secret person in the meeting. Anyway, case planning. Thoughts about that and how to join with clients, and then some thoughts about program flexibility so you really can accommodate some individual needs.

The program flexibility piece, it's the same theme in your previous question. And I'm wondering, folks, if you have access to the chat, if you can type into the chat what kind of flexibility you have in your programming. I'm just curious if many of you have these fixed modules or phases that you put people through or whether you have a little bit more flexibility. So I'd love for you to type into the chat just what kind of flexibility you have in your programming.

And while you're doing that, I'll answer Greg's first question about case plans. So oftentimes, when people hear the word case plan, or treatment plan, or service plan, they don't have a very positive reaction. Sometimes, they feel like, oh, my gosh, it's this piece of paper that I have to do within the first 30 days or something like that. And I do it and then put it away and then never look at it again.

And that's really, really a bummer, because ideally, a case plan is an agreement between you and the person you're serving, the client, about what you guys are going to work on together. It would be as if we go to a doctor and we say hey, here are my symptoms, and the doctor says, let's just go this direction and then let's go that direction, and there's no real focus to the conversation. There's no focus to the interventions that the doctor chooses. You would probably not go back to that doctor.

And that's what case plans are. They are an agreement between me and the client about what we're going to focus on. And the case plan, ideally, has in it the most important things that would be helpful right now. The case plan will change as time goes on. In fact, probably, it might even change every time. It might change on a monthly basis once we've achieved some of those goals.

But ideally, a case plan is a way of knowing, what is our most immediate path? So with that in mind, the case plan contains in it some of the goals that we have, the most immediate goals that we have, that tells us what direction we're going to move.

A case plan can be as simple as, here are the things that we are going to achieve in the next month. So in the next month, let's say housing is an issue. That's one of the things. And we're going to try and get you into treatment. So that's the second issue. So let's say those are the big buckets, housing, treatment.

Under housing, we have to be pretty specific in our case plan. What is the goal? What are we trying to do? Is the goal to find temporary housing, is the goal to find permanent housing, is the goal to find just a place to live for the next two weeks? What exactly are we working on?

And once we've established that goal, we then have steps underneath that to get there. And these steps are not just what the client will do. They could include what I will do as well. So the steps could be, make a referral to the housing agency next door, and then the client will follow up. Client will complete three applications or whatever it is. That just sort step by step so that the client knows exactly what the expectation is between now and the next time we talk about the case. So it's that practical.

Treatment might be similar. The goal is-- if the client is starting today and I'm setting up the case plan, the goal is not complete treatment successfully. That is nine months from here, a year from here. All I'm working on in terms of treatment could be something like, enroll in treatment, because there are lots of steps. I have to call. I have to show up. I have to get a bus pass or figure out transportation, all of those things. So it's that practical.

And if some of you are thinking, oh, my gosh, that's so basic, yes, that is what is the building blocks for reconnecting some of those neurons that we've missed, that our clients have missed, when problem-solving. So when you're thinking about a case plan, it's helpful to think about having some of the SMART components in the case plan. So I'm using the acronym SMART, S-M-A-R-T. I'll type that in the chat. I'm sure several of you know what I'm talking about.

I'm just going to take a pause before I go into SMART. None of you have put in the answer to the question that I asked you, so I just want to re-ask the question. What flexibility do you all have in your program to make some of the accommodations or changes that Greg just asked about? So do you all have very structured, 90-day program, here's what everybody receives, or do you have some flexibility? I'm really curious about that, if you don't mind typing it into the chat. And at least I can't see any responses.

I'm just scrolling here. So do, folks, I know there are several of you on this call. Great. OK, thank you, Claudine, thank you for responding. And you said, we don't have anything in place to be flexible. Makes sense. OK, a couple other folks. What kind of flexibility do you have, if you can pop it in there? Do you have a 90-day program, no flexibility, three phases, that kind of thing? Maybe some of you don't have a program.

We don't have any. Got it. Let's do one more response. Any brave soul who's willing to type into the chat? Linda, thank you for your response. Great. So Chantal said, there should be a good amount of flexibility and perhaps a process to staff with a supervisor. Yes. So that's really the key, kind of understanding what is it that the client really needs, and again, ideally, assessment-driven. And then how do we get that? How do we modify our program to meet those needs?

So yeah, with the supervisor, I also had a discussion with a judge about the need to be more flexible with the client. And this is what Paul was talking about. How do we, as a system, develop flexibility within our system so that even the judge's court order doesn't say blabbity blah treatment. It says treatment as recommended by assessments or something. So we've really had to work with our bench, where I work, to help the judges phrase their sentencing orders that give us a ton of flexibility and that we can use assessments to drive it.

Dennis says informal versus formal. Some counseling services are flexible within the program I work. Got it. So you're listening to kids and then directing them to services. Ada, I love what you put in. You don't have a program, but you're learning how to form one. That's really exciting. You're in a very exciting place, because you get to create what your program looks like. And there are tons of resources available. So if you want additional resources, reach out to Greg or Lynn or Paul. They're all on the call, and they can help you think through some programming.

Great. And then somebody asked, what do you mean by flexibility? What I mean by flexibility is, do you have the flexibility to tailor your program to meet the needs of the client? So let's say you are an outpatient treatment program. Do you have a 90-day, set curriculum, or do you do an assessment and then place the person depending on what their needs are? That's what I mean by flexibility.

And yeah, Eve, I love what you're saying. Word choices are really powerful. That's awesome. Great. OK. So let's go back a second to the SMART piece. Let me finish that, and then just talk about it. Sounds like all of you are in very different places in terms of program development. So let's talk through some of the really important things to think about.

So when we talk about SMART goals and kind of thinking through a case, S is Specific. Is the goal that I'm having really specific? Is it Measurable? That's the M. Can I check it off? Can I say, yes, the person did this particular thing, they called the treatment program or whatever? So that's M. Is it Achievable or Attainable for that particular human? Is it Reasonable for them? And is there some time associated with it, meaning, have I said in the case plan that they need to achieve it within 30 days, or 90 days, or whatever that time frame is? So those are some of the components.

So that's about case planning. And then we keep coming back to the case plan, or the treatment plan, or the service plan, whatever you want to call it. You keep coming back to that to see how you're doing. It's sort of a measure of your progress. It's also a measure of your commitment to you and the client about progressing, about moving together forward so that you both feel like something is happening.

So let's take a step back. Since several of you are in the process of creating a program, a reentry program, here are some of the things that are incredibly, incredibly important to be thinking about. So one of the things is when you have somebody exiting either inpatient or incarceration, whether it's jail or prison, those first couple of days are crucial.

It's where we lose people, because they are coming out of something pretty intense. And if they don't have a place to land, they're going to go back to previous patterns, previous unhelpful patterns. So the first few days are really critical.

So if you are developing a reentry program, one of the things to think about is what Paul said earlier. Before people even leave the facility, whether it's the inpatient program, jail, prison, whatever, before they leave the facility, make a plan for them. Meet with them. You know when they're getting released. Most often, we know when they're getting released.

And so let's come up with a plan. What's the plan for housing? What's the plan for treatment, continued support? What's the plan for case management, those kinds of things? So that process, the process of reentry, actually starts before they even get released. So that's one of the things to think about as somebody who might be developing a program right now.

The next thing to think about is the most important thing that you can work on is relationship. Relationship drives success. So make sure that you are developing these strong relationships with the people that you are trying to help. So that strong relationship-- incredibly important.

And that if you are referring them to other places-- so let's say you're just the coordinator, and you're helping them get connected to housing or them get getting connected to treatment. You need to develop the relationship, but also do what Paul had indicated earlier, which is that warm handoff piece, because what you're doing in the warm handoff is you're transferring your positive relationship that you've developed with the client to somebody else.

So that, again-- critical, that relationship piece. And then making sure that assessments drive your decision-making. And one of you actually said that. Jesslyn, I think you said, we do assessments, and you use assessments to place people in that proper level of care. So Paul, I feel like I went on and on. Sorry about that. What would you add?

Well, no, I didn't think you went on and on. I thought that that was really good. I will speak first to the re-entry part for those that are starting a new program, one of the things that I think is important, if you haven't already done it, and then I'll go back to Greg's question on the flexibility part.

On the reentry part, I think one of the key things, if you're just starting from scratch, would be, does your tribe have a corrections facility? And probably building a relationship with that department of corrections or that prison or jail is going to be a lot easier, I'm guessing, than it's going to be with the state.

But so, for example, if your tribe has a prison and they're going through there, then developing that relationship with them, making contacts there, knowing their case managers, knowing the stages that they go-- that the people that they're working with go through before they're released.

Now, if you're working with a state, I would find out, just depending on how many correction facilities your state has, I would find out where most of your tribal members or the folks that you're serving, what prisons do they end up going to? So some of that is just like regional or that county. So developing a relationship with that county, or if it's that region. And then other states, they go through a filter process, and they can be sent anywhere in the state. And so that will take some work, because you may have to end up developing a relationship with every corrections facility in your state.

And then I know some of our folks may be going to BIA facilities. And a lot of times, those can be out of state. So I feel like that makes it a little more difficult to build a relationship with them, whenever someone may got convicted in your tribal court that are serving time in Arizona or a different state when you live, again, in a different state. So trying to make those phone calls with those folks there and building a relationship with those corrections facilities.

I think that that's important for so many levels. Number one, if they're local enough, I want you-- it would be great to do, like I said, a class in there and to meet the folks before they can come out, even if, when they're released, you're doing more of a navigating or a referral. But going into there and doing, like I said, the classes, or meeting the folks that you're building a relationship with. So I think all those things are really important. And that's where, if you're building one from scratch, I would start there.

But the second thing is because when people are coming out of the state, it's unlikely-- unless they're coming out for a sex offense conviction, it's unlikely that they are making contact with their tribe directly and saying, hey, this individual is being released and they're saying that they're going to go back to their house because this is on tribal land.

And so you want to build that relationship to secure that so that you get the heads-up ahead of time. So those are, I think, a starting point for someone who's doing a reentry program.

Now, going back to Greg's question about the flexibility for us-- and again, I'm meshing, because we did so many programs, but kind of meshing probation and reentry and healing and wellness, so all those things. But so what I would say on the flexibility part is that if they were there as a-- voluntarily were attending our services, we had more flexibility than if they were court-ordered to do something.

But one of the things that I would do-- I think Dr. Anjali kind of said that-- but I would spend time with our judges, spend time with our prosecutors, and educate them on why it's important for them not to be so definitive on their orders, to allow for some flexibility, because it can vary a lot depending on those assessments that are being done.

So when it was voluntarily, that was hard. Even more is it important to develop that relationship with them, because you don't want to lose them halfway. And then when they were there by court order or attending those services by court order, it was a little bit easier to get their buy-in because the alternative was long-term time in corrections. So our flexibility was dependent upon how they came into our services.

One more thing that I'll talk about. Regardless of if they came in voluntarily or by court order, we still did the same intake process, which had a number of questions. And that was our best time to build rapport with that individual, ask them all kinds of questions, like Greg talked about, assessing their criminogenic needs, like, do you have family that support you? Do you have a place to live now?

What charges have you had in the past? And as it relates to substance abuse, what drugs have you used and their experience with those? So building-- I mean, doing that intake, but at the same time, trying to build a relationship with them and get to know them. And then, at the end, it was evident. There's a lot of areas here that they should work on.

But giving them that flexibility to say, OK, what do you think? These things are probably really serious to address, like, I know, the substance use thing. And you don't have housing, and all these things. But what would you think are the most important things? And kind of let-- give them the ability to set that agenda for themselves.

And then like you said, Dr. Anjali, being able to hold them accountable or-- I mean, it gave us purpose. When we met next month, it wasn't just like, oh, he checked into probation. He's good. When they checked in, we went over their goals. We would talk about them like goals and objectives.

And so I felt like they come away with a better positive experience than saying-- it almost felt-- and this is kind of-- I hope I'm not offending anyone that does this work, but it's almost like doing life coach stuff. And I mean, how many of us would like a personal life coach? I would love a life coach. And so to the extent that we were able to, treating it like that and building that relationship with them, especially if they're there for a voluntary basis. You don't want to lose them. So I took a long time there on that address. But those are my thoughts.

Yeah, love it. And yeah, sign me up for a life coach, for sure. I think you're pointing at so many really important things. One of the things is the importance of making every interaction that we have with them meaningful so that it's not just check in. Great, you're still alive. No new arrests. Wonderful. See you next time.

It's such a waste of the person's time, my time, and we have such an incredible opportunity. When somebody comes and actually shows up to an appointment, it is an incredible opportunity to engage with them in a meaningful manner. And that has to do with, what are the most important things that we can attend to to help people move forward in a particular direction? So making each of those interactions meaningful, I think, is incredibly important.

I did notice, Greg, that Marcella put an important question in the chat, so I'd love to address that real quick and then go back to your next question. So the question that Marcella put in the chat was, what can we do if state insurance doesn't cover medication once the client completes outpatient treatment or if the client cannot reach a counselor to refill medications that are really critical to their recovery? And it sounds like you've had an experience with a client who went through this.

So Marcella, I'll give you a couple of thoughts. And my answers might frustrate you, because part of what is needed is anticipating these issues. So I want us all to know that our clients are not ones who will think ahead and say, my medications are going to run out. They're not there yet.

Their brains, for a variety of different reasons that we talked about in the previous webinar, will not be able to look to the future to figure that out. That is frontal cortex thinking. And we have folks who are stuck in their limbic systems for a variety of different reasons, whether it's substance use, trauma, adverse childhood events, or even the trauma of just being incarcerated. So we cannot expect them, at least in the beginning-- we need to be their safety net. We cannot expect them to be able to think futuristically like that.

So what we need to do is build a system that does that for them or helps them do that. So an example, Marcella, is before somebody leaves a program, before they come out of an inpatient program or before they come out of jail, making sure that they have-- their prescription has enough in it to last at least a month, or three weeks, or something, before they can get connected to somebody who can then start to prescribe their medications.

So we sometimes refer to these as bridge medications. So we have worked a ton with our jails to be able to provide bridge medications, to bridge the time between their release and them getting into seeing a psychiatrist or seeing a counselor who will be able to continue that prescription.

So the reason I said you might be frustrated with my answer is, so much of this is communicating with the facilities to be prepared for these very situations. One of the things that our department does is we help transport people from jail, when they get out of jail or when they get out of inpatient, we transport them to their next place. And we do not pick up a transport unless we are confident that bridge meds are in place. So that's a part of our agreement with our jail. We're offering transportation, but you need to make sure that the person has enough meds, for example.

The other thing when you're doing an assessment is asking about these things, because it might be that your question is something like, are you on medication? The client says yes. And then we move on. We say, what medication? We write it down and we move on. Add a question in there in your assessment, do you have your prescription filled? When do you run out? So that you are helping the client think about that.

And the client might say, oh, I had it refilled about a month ago. I guess I have two or three pills left. That is a good signal to you you need to get on it right now with the client. So how do we get this refilled, et cetera, getting them into that.

We are very lucky. We've run into this very problem so frequently, Marcella, it's just tragic, because we have people who get off their meds and then spiral out of control so quickly and get into trouble. They engage in really troublesome behavior only because they're running out of meds.

And so we now have the opportunity for an urgent psych appointment that we can make, an urgent psychiatric appointment that we can make for folks to get in within 24 hours just to get one week's supply of medication. And again, that is about talking with your providers to see if there's anybody able to do this. So those are some of the thoughts, Marcella, that I have. Add to the chat if you want me to add anything to that. Paul, before we go to Deb's next question, did you have anything to add to Marcela's medication question?

The only thing-- I like what you shared. The only other thing is that we would do the direct transportation to IHS. And a lot of times, they had folders there. Sometimes, they didn't have a file. So that took some case management work. But just getting them into IHS as soon as possible.

And it was a long wait. A lot of times, we just sat with them and we were with them that whole time. So sometimes, it's a lot of hours there, and not everyone has the manpower. But we thought it would be-- our program thought that that would be important to be able to be there with them that whole time. And that was part of our building rapport with them and a relationship with them. So that's what I'd add.

That's awesome.

The medication piece is also a communication piece. So there's somebody who prescribes in the jail or in residential treatment. And oftentimes, just connecting them with a general MD in your clinic, or a med-certified nurse, so they know what process they went through to decide this medication was the right medication, and their documentation that it's working.

That makes it much easier than having to do a brand-new intake and for the doctor to assess, am I going to prescribe this same med? So just thinking about those connections is really, really important. Anjali, one other thing that you mentioned that I think is really important, if you could talk a little bit about, is-- and Paul mentioned it too-- making those contacts. Those are valuable interactions to have. And it's not just perfunctory checking the box. How have you done? Did you have police contact? Did you miss any UAs?

You want to talk a little bit about the black box study and what we know about the difference between having the kinds of conversations you and Paul are talking about versus what, oftentimes, has kind of been the standard in the corrections reentry field.

So the question that Greg is asking, there was a study that was done on conversations that we have in the criminal justice field, but the focus was case managers and probation officers, to look at the content of the conversations and whether the content of the conversation predicted recidivism in the future.

So this is a fascinating study, and I hope you all take this to heart. What they found was when our conversations are limited to terms and conditions kinds of things, like check the box-y things, any new law enforcement contact, did you complete community service?

Those kinds of me just checking on your compliance, recidivism rates increased, whereas when the conversations were about what is actually going on, how is it related to you doing well in life, you having a good life, a prosocial, positive, supportive life, which often has a huge overlap between criminogenic needs-- so supportive friends, supportive relationships, engagement in the community, work, managing my substance use, all of those things.

When we have these crunchy, deeper, more meaningful conversations, that's when recidivism reduced. So just to summarize, the study that Greg is talking about is when our conversations are just about compliance, recidivism rates go up. When our conversations are about meaningful things that people can change in their lives, that's when recidivism rates go down.

So when Paul says, use that time wisely, it's so, so important to have some of those meaningful conversations. Yeah. Paul, is it OK if we go to Deb's question next, and then I'll come to-- yeah?

Sure.

Deb's question is about assessments. So Deb, there are tons and tons of assessments available. It depends on what exactly you're looking for. There are a couple of different things that I think, in our criminal justice world, is really important. But perhaps there are folks on the call who are not only in criminal justice. Maybe you're in behavioral health more broadly and not criminal justice. So I'll answer the question in a few different ways.

One, it's very helpful to have a biopsychosocial assessment. Big word. What it means is looking at a variety of different things, looking at some of the basics like housing, employment, basic mental health stuff, substance use, previous involvement in treatment, those kinds of things, parole history, some of those. What do you do with your time? So just a wide assessment that looks at those kinds of things.

If you are thinking more criminal justice-oriented, there are many tools that help us predict recidivism and tell us who to pay attention to and who maybe to just provide support to, but that we don't need to supervise. So here, we're talking about risk and need assessments, risk being risk for recidivism, need being criminogenic needs that, if I attend to, will dramatically reduce my likelihood of committing further crime.

Risk and need assessments examples are the LSI, the Level of Supervision Inventory, the Washington Assessment, which is free, the ORAs. It's the Ohio Risk Assessment. There are several-- COMPAS, there are several assessments like that.

The key there, though, is it's important to utilize a culturally competent risk assessment, one that has been normed on the population that you are serving. So if you want more information about that, just say yes and Greg will get in touch with you. Greg, is that OK that I just said that? But Greg is just a master at resources and can help-- wonderful. Awesome. So Greg, Deb would love some assessment resource-- ooh, lots of people. Wow. This is amazing.

OK, Lynn, if you're still on with us, this might be helpful for you to capture as well. There are several people who are just wanting some practical-- wow, Paul?

Yeah, I was just going to say, it may just be helpful to delve into that in a webinar or ask the expert, because in my experience, having visited a number of tribes, and probation departments, and sex offender registrations, and all those, I don't know that a lot of folks-- some folks are using assessments, but I would say the majority are not.

It definitely is probably a bigger topic than just sending assessments out. And we do have some modules on assessment, Anjali, of course, that we can put together. And it is a big issue. And it doesn't have to be rocket science. I mean, some of these instruments, they charge for them, they're copyrighted. Some of them are not, but they have required training.

But if you just focus in on what the research tells us and have some kind of way to identify higher-risk people, higher-needs people, lower-risk people, lower-needs, and then what those areas are, you're way ahead of the game versus just what you think. The terminology is a lot better than just flipping a coin. Where do I start this person?

Yeah. So we could definitely-- Lynn, I'm not sure what the next steps might look like, but we could do-- several of you have said yes in the chat that you would love these supports. So we could do something like a webinar, like Greg said, or an Ask the Expert that focuses on this and then also provide you with just a brief risk assessment tool that you can take and perhaps add to if you need to.

And then there's also a request for a template for a case plan or a service plan, which is really, really--

We have some of those that I've stolen from other people, including your department, Anjali.

Yeah. Yeah. So perhaps we could send some of those out. That would be great.

Yeah, we'll make those available in the resources, for sure. But we hear you loud and clear. It comes up a lot. And it would be nice to have one that's validated on each tribal community and has good data behind it. That seems to be a huge challenge. But we can definitely get you down the road around what are criminogenic needs, who do they apply to generally, no matter who you are?

And then I think Anjali's talking a little bit more about, what are some other things that we're learning, like spirituality, connectedness? And those are things that are starting to come into the literature now that are very important that are not really captured in a lot of these risk assessments that Anjali is talking about. But they certainly can help you individualize them, look at what's important to this person, understand the resources in your community, and do things that we know are connected to recidivism. Absolutely.

All right. Where do we want to go from here? Is there a question-- there's another question, Anjali, about MOUs. Maybe you want to tackle that a little bit now, and that might be a bigger topic as well. And then we have several more questions that have come up over the last webinar, as well as have come in, to get to. So I'll turn it over to you to talk about that a little bit-- you and Paul. Paul has some expertise in MOUs. He loves them.

Oh, you're laughing too. So sure. So MOUs. MOU stands for Memorandum of Understanding. It essentially is just an agreement between you and whatever other organization you're trying to get into a partnership with to deliver certain services, or explain certain things, or whatever it is.

So an MOU is usually about service delivery. It could be about data exchange as well. Usually, we call those data sharing agreements, which is a little bit different. But it's usually about service delivery. In an MOU, there are certain things that are really helpful to be thinking about. What is the service that we are talking about delivering? What are my responsibilities? What are your responsibilities?

Let's say I'm a reentry program and I am trying to get a particular psychiatrist or a medication organization, a clinic, to work with us. You have to really think through, what is the expectation that you have and what is the expectation-- what can they expect from you, and articulate all of that in an MOU so that there's a ton of clarity and specificity about this particular relationship that you have with them.

So if it's this particular clinic, it could be that what we agree to is to provide assessment information in our referral, to provide x number of referrals per month, or to staff a case, whatever the clinic needs, or whatever it is. And then the expectation that you have of the clinic has to be in the memorandum of understanding. So it's an agreement that you both are making about how you will work together.

When we don't have MOUs in place, unfortunately, what happens is we have expectations that are not articulated, and then we get into trouble. We get sideways with each other where we thought that organization was going to do a certain thing, they don't, we are now bent out of shape, et cetera. So it just avoids these misunderstandings and missed expectations. But Paul-- oh, Greg, go for it.

I was just going to say the other thing related to the question about the person running out of meds coming out of the jail, we don't have to be experts in everything. So when you start having these discussions with clinics, they come up with ideas around free medication, reduced-cost medication, things that we're not experts in, and nor are we expected to be. But they know their world, just like we know our world. And so it can open up doors.

And so I can't tell you how many times a very expensive medication-- we had a social worker that would write to the company and say, hey, here's what we have. And the company says, here's three months of free medications. Go to this pharmacy. We will comp this, like they do with samples for doctors. So it opens up a lot of doors.

It's not just sitting down and just writing down who's going to do what and when, and what does this cost, and how do you get access, and then measuring that. It also is us learning more about worlds that we may not have a ton of information on. Paul?

Yeah. And don't take no for an answer. I mean, really, people, sometimes, their first response is no because it sounds like a lot of work, but really don't take no for an answer. We've had tremendous success just asking the same question in multiple different ways and then coming back over and over again and saying, how about now? Is now a good time for us to try and start this program with you or start this relationship with you?

And speaking about medication, Marcella put in the chat that you'll add that question to your intake, but also that you were thinking about, before graduation, making sure that the client has enough medication, which is awesome. Paul, talk to us about MOUs.

I love MOUs. Greg's-- I do talk about MOUs a lot, though. No, I felt like you covered it good, like, what it is. And then I would just say definitely-- I feel like just depending on what you're doing, sometimes, you can create one general MOU, and then the different programs who are contributing to that partnership can sign all under one.

But there are certain times when their roles really do need to be outlined specifically. And so just having a relationship with them. No, I thought you covered it good. I mean, the only thing I would say that I like about MOUs is-- well, two things. The first thing is that when it outlines each other's responsibilities, it's very evident who-- if there's a gap, if there's a mishap, it's very evident who dropped the ball, basically.

And then you can go into how we can make that better next time. When there is no MOU, no one will take responsibility because it's not outlined. And both you guys will just-- both programs will probably deflect and say, oh, they dropped the ball, and they're saying you dropped the ball, and then you serve client after client and that never gets resolved. So I like that about the MOU. I think there was going to be a second thing, but I don't even remember what it was now. But in general, MOUs, I feel like, are the way to go.

Oh, I remember now. Just the sustainability part. So if you lose one of the key employees, the next employee that comes in, you'd be like, hey, we have this MOU, it's signed, and this is what this is about and this is why it's so important. That's a lot easier than to say, hey, at times, we used to work with them. Are you willing to work with us too? And then they're like, well, I have no idea what you're talking about. And they're going to ask you to line out what that relationship was anyways. But if you have it all on paper, it's a lot easier to say this is what it was. It's already signed. These are our roles. This is what we do. This is what you do. It's a lot more easier to understand and to sustain that partnership.

Well, and Paul, I might have misspoken that you love MOUs. I think you love collaborating, and you see gaps in services, and you get your passion out of that. The MOU is kind of just a tool that you use. So that's what I wanted you to speak to, and you did.

No, I thought that was still funny. I mean, I still think that's funny, but I feel like I do-- I probably do like MOUs.

I think-- we have a question, and I think it kind of weaves into a bunch of stuff. How do we go about looking at people who are struggling with whatever compliance looks like with reentry or supervision and those-- and the question is actually reoccurring offenders, which I thought was a very nice way of talking about recidivism, but kind of those frequent flyers, people that are struggling at certain levels, people who are very dangerous and we need more containment around them, versus what just happens as people are looking at changing behavior, Anjali, and how do we tolerate that and manage that?

So frequent flyers and what do we do. If we have to overgeneralize, there are two different kinds of frequent flyers. One set is driven by lacking some basic needs, basic structure, and they continue to get into low levels of trouble but are problematic because they keep picking up new low-level charges. Frequently, these folks are unhoused. They have mental health issues that are not being addressed. They don't have some of their basic needs met. They don't have community support, et cetera. So there's those folks.

And then there's another bucket of frequent flyers that continue to commit crime not because their needs aren't being met, but because they have a high risk for recidivism as driven by certain criminogenic needs, one of which is kind of that antisocial thinking that Greg is hinting to us.

So we actually work with them very, very differently. In this population, where they're continuing to commit crime because of antisocial thinking patterns, antisocial values, attitudes, being surrounded by other people who commit crime, committing crime because it's fun, committing crime because they're getting something out of it, committing crime because they believe that it's OK to continue to do so-- you have a subset of that population.

For those folks, what's really important is supervision, is high levels of containment and supervision. So lots of structure, frequent meetings, occupying their time, not providing-- not allowing them to have a lot of free time in their day, occupying it with a variety of different things, whether it's meeting with you, meeting with a treatment provider, doing community involvement-type things, maybe community support groups, whatever that looks like.

But getting them involved somehow so that we're occupying their time with pro-social activities that we're providing, and that you're supervising, you're increasing-- sometimes it's called supervision, sometimes it's surveillance. But you're increasing the amount of monitoring that you're doing for these very high-risk folks.

The other bucket of folks, frequent flyers because they don't have their basic needs met, that is about developing infrastructures within your community to quickly respond to these folks. So one of the things that we've done in our community, because we have quite a few of these, and our police are getting very upset at having to contact these folks over and over and over again.

And what happens with these folks is they go into jail for a day and they come out, because frequently, it's petty offenses, municipal tickets, those kinds of things. So it's not high-level crimes, but it could suddenly turn dangerous, or they're a bother. They make the community less safe.

And so what we've done is we've formed something called a high utilizer group. By high utilizers, we mean these folks utilize a high percentage of our resources, our policing resources. And the community tries to respond as quickly as possible. So as soon as the police make contact with a high utilizer from this group, all of the resources start to flow from all of our different agencies.

So we first ask, do they have housing? And if not, we try and get them a bed at the shelter, or at one of the churches, or some immediate response so that they can be housed for that night and for at least three nights after that. We also try and put in medication, mental health support. We try and get them in emergency psych appointments, those kinds of immediate responses.

Many of them have medical issues as well. They're living on the streets. They have infections or different medical needs. Oftentimes, they're sick or they have sores. And so we try and get them, as quickly as possible, some medical intervention as well. And those kinds of things seem to help stabilize that group of individuals.

So when we talk about our frequent flyers, it's important to figure out, what bucket does this frequent flyer fall into? Is this the person who needs a lot of supervision and surveillance, that are continuing to commit crime because they believe that it's OK, or is it the person who keeps getting tripped up because they don't have their basic needs met? And then address the population accordingly. Paul, what would you add to that-- or Greg?

I think that that was a great response to folks that are in-- those folks. What I would say-- I want to probably take it more from a mental health perspective and say that-- well, two things. Some people, no matter what happens-- I hesitate to say this because I don't want us, when we have a difficult client, to put them in that box, because we should exhaust our services every time and do the best we can and treat everyone the same-- respectful, with kindness, with dignity.

But there are some folks that will find that, no matter our efforts, that we just can never save them, if you will. And I feel like that's OK. In our program, we learn from those things. But if we're doing the work day to day, we're all invested, we're all passionate, I don't want you to internalize that and feel like that's your failure if you're giving out those the services and you're doing it with the right heart and all those types of things.

So I would say there's some folks that- that will end up probably just going back to prison and being there long-term-- get out and then go back and be there long-term. But again, please don't use that as a cop-out. I just, I feel like, in some sense, that does capture some folks that are, like I said, very extreme.

The other point that I was going to make-- and here's where I'll go into the behavioral health thing-- is that success, when we're working with folks, success is scalable. What success is for one individual with very low risk may look a lot different than what success is for the high-risk person.

So a low-risk person, they're going to maybe-- you set out that they're going to own their own home one day or that they're going to have a great job. And those are all things that can happen, and your services are going to be there. And hopefully, that's one of the great testimonies that they look back on and say, your program made the difference.

But there are some folks that, for them, it's just that they stay on their medication. So I'm thinking of one of the folks that I worked with who had-- his schizophrenic was just so-- what he was dealing with day to day was just so intense that victory for us was just that he would stay on his medication.

And the community knew him, the law enforcement knew him. And so we were able to intervene real quick and say-- or talk to the family and discover how long he had been without his medications, or that his family would inform us, hey, he's been without his medications, or she's been without her medications. Being able to try to respond really quickly and get them back on medication.

So those are two different things where the low-risk, what their success looks like, and then maybe someone who's high-risk and then also may have some mental health concerns too, that success looks a lot different. But we should be proud on our end no matter-- with the guy that's got the job and the house, we should just be as proud in our work as the person who we keep getting him on their medication so that they can have less episodes or show up at the crisis unit less often. So that's my take on that.

Yeah, that's so true, that success is different for different people and needs to be defined by that particular individual, not by what we want for them, and that success sometimes is staying on your meds, whereas for somebody else, it might be something different. You're absolutely right about that.

Paul, I completely agree with you. There are those people, and-- it's something that Anjali and I talk about a lot. We don't take credit for their successes and we don't take full blame for their failures. Now, if we're doing our job to the best of our ability, there's something that's missing. And I don't necessarily see very many people that are unchangeable. At the point in time that we're interacting with them, there's not a lot of change, and so that leaves us with some limited opportunities, for sure.

And the reality is, there's some people-- the criminal justice system, reentry prisons-- we're kind of the dumping ground for all the problems that our society can't figure out. And so we figure more out. But sometimes, we just don't have the services and resources that are needed for this person. It doesn't mean we don't try to go out and get those, we don't try to fill those gaps. But sometimes, we just can't work that magic.

And our systems need to understand that. They need to see re-entry, probation treatment, as finite resources and not just a place that can take everyone all the time, and understand that there are choices to make here if you want to have effective resources and not burn people out, which I think is a big piece too. You just keep giving a person these high-risk, high-needs, antisocial people, and guess what you get? A pretty burnt out person that often starts behaving high-risk and antisocial themselves.

So we need to be cognizant of that as systems and administrators and people doing this work. You've got to be careful about who you interact with eight hours a day, and to protect yourself and create that resiliency. And Anjali's got a bunch of stuff on that as well.

Paul, I'm going to start with you on the next question that came in during registration, which is, how do you bring communities together to implement collaborative policies and procedures? And I know you've got some experience with that, and Anjali, you do as well. So Paul, do you want to speak to that question a little bit and then hand it off to Anjali?

Greg, you're talking about another thing I loved hearing, and that's policies and procedures. Yeah. So there's a lot of angles, but because we have the new programs developing, the reentry program, I think that that would be a good place. I'm going to speak to it from that lens.

But when developing policies and procedures for a new program, it can be really difficult. And that's why a lot of tribes, they begin to just provide services without having the policies and procedures or any form of structure. And some of that is because it's discovery, because they're trying to figure out what it is that they're going to do, they're learning theirselves what it is that they're going to do.

So there are a lot of tribal programs who are currently operating and have no policies and procedures, maybe no laws or anything that speak to their program. And so for any of those, I would encourage you to invest the time into creating your policies and procedures.

But on the reentry side, I think getting whoever-- getting your leadership involved in what they envision-- someone's envisioning this reentry program to do something. So what is it that they're wanting? And if it takes bringing in some of the community leaders to bring that to light, I think that that's a good place to almost do-- you could almost do a focus group. These are five questions that we have regarding reentry. Who do you guys feel we need to serve? And five questions that they're going to tackle.

And I assume, after that, you're probably going to end up with more questions than answers. And so to the extent that you can bring in the community to say, hey, we met with tribal leadership, this is what they envision. You guys live amongst people who are coming into our community. What do you see as the needs? And I would do some comparisons there.

And then, of course, I would do some data analysis as well. So how many people are coming out of corrections? How many of those folks are tribal? How many of those folks are coming to live on the reservation? How many of those folks are in our service area? And so I would do a lot of information gathering at first.

And then from there, I would create a vision for our program, a mission for our program. I would probably outline what confidentiality is, what services we provide. If it's a navigation, if it's just referring to services, I would outline what the folks who-- the navigator, whatever that role is, I would describe what that program is.

And I would, of course, describe too, who it is we're serving and what qualifications do they need. Do we serve everyone or kind of build that out? Who it is we're serving and what qualifications-- or what criteria do they have to meet to receive services? So those are some of the things that I would first begin to build out.

We did do a session not too long ago on policies and procedures, and we're currently rolling out a policies and procedures plan with another tribe. So if you're interested in policies and procedures, definitely feel free to let us know. And that's an area.

As long as it has to do with substance misuse in some form or fashion, if the people you're serving have that-- the population you're serving deal with substance misuse, then it's very likely that we could roll out our TTA program and provide you with some assistance with policies and procedures. That's really good, because if you go outside, those can be very expensive for an outside program to do or to get a consultant to do those. So I put in that plug there too. If you need help with that, that's something we can do, and can do it at no cost to your tribe.

Amazing. OK, you have takers already. Couple of things that I want to add to what Paul was saying. When he said think about some questions, questions that you're asking yourself about what is it that you do as a program, what is it that you do, here are some of the questions to think about.

Who do you serve? Who are the folks that you serve? And then who do you not serve? Because that distinction is really important in developing criteria for entry into your program and exclusion criteria.

So if you are a housing program, and let's say the people that you serve are folks who are coming back into the community after being incarcerated, but you're also housing families, then you have to be very careful about, who do you not take? Do you have a screening process for folks who maybe have sex offenses who are not allowed to reside in the same place that families are residing, or those kinds of things? So be really clear. Who do you serve, who do you not serve?

What service do you provide, and what is your goal, meaning what is the end goal that you are hoping to achieve? Getting clear about that will lead you to your next question, which is how do you know that you're effective? And for you to build a program, you need to be able to know whether you're actually doing what you think you're doing.

So if your goal, if your program goal, is to reduce rates of substance use, then you have to be able to measure how much-- what was their substance use in the beginning and at the end, and are you actually making a difference? So be thinking about what is your goal, how do you be effective? So those are some of the questions that will help you think through some of the mission/vision pieces that Paul was talking about.

When you're putting together policies and procedures for a program that involves other organizations and you're trying to put together policies for a collaborative process, one thing I'll encourage you to think about is listening for the needs of the other organizations or the motivation of the other organization versus the positions that people start to hold. I want it this way. No, I want it this way.

When people start taking positions, it's coming, perhaps, from a place of fear or a power struggle. The easiest way to get out of that is to say, what is the need underneath? What is it that they're trying to fulfill? Are they trying to make sure that they don't get overwhelmed with the number of referrals that are coming their way or something like that?

So just think about this concept of need versus position. What is the need? What is the position that they're taking? And position is very hard to argue, but the need is easy to understand. You can have a ton of empathy for their need, and then you can get them to move on the position. So those are just some things to think about a little bit, to add to what Paul was saying.

And then I'm loving what's happening in the chat. These connections are amazing. Chantal, you're also talking about the importance of knowing when to refer people. When is it beyond your capacity, your training, those kinds of things? And you're also emphasizing how important it is for us in the reentry world to make sure that we are trained in things like mental health, addiction, trauma, all of that, because that shows up in all of our populations.

And then Jesslyn is talking about how, sometimes, difficult it is for folks with felonies on their record to be able to find housing and employment, and frequently, will say it's much easier for me to be in jail because it's safe there-- it's relatively safe-- and I can get three meals and I have a place to sleep.

So Jesslyn, some of the things to think about-- you're right. We encounter this on a regular basis as well. We have been working really hard with employers to have felon-friendly workplaces to take on folks who are currently being supervised, because we develop the relationship with the employer.

So we say to the employer, look, would you rather have somebody you don't know about or somebody who you know we are supervising and we can assure you that they are under our watch? So there's a way in which I think you can frame it as, it's actually helpful to have somebody with a criminal record.

There's also funds available for employers-- insurance funds available for employers to be able to employ folks with a record. And if something goes wrong, for example, that person steals from that particular business or something like that, there are federal funds available to compensate that business. So those are some of the thoughts. And Greg, I know we are running out of time.

We are. I was thinking, if you didn't see any more in the chat that you wanted to respond to, there's one other question and then I'll close it out, which is, in tribal communities, many of our tribal clients go home to where multiple generations live under the same roof or in close proximity.

How do we assess if this is a good plan for them to go home? And what kinds of safeguards can we put in place? Because you talked about influences and peers and family support and all of that. Family support can be very positive. It also can be a pathway to them getting back into trouble and old patterns of behavior. So for the two of you, a minute or two apiece.

Yes. So I would just give a quick example, but we had an individual who was going back to a home where it was just a cycle. And there are multiple generations there of being high-risk folks and law enforcement attending to calls in that area.

And so this individual, when they came out of corrections, I mean, they really wanted a change. And you could just could see it all over them. And so one of the things that was difficult was, we spent some time, in our intake process, identifying another place that they could stay. And it was like, is there a family member somewhere else that you could stay with? And we cover nine counties in our area, and where they were staying was in one county, and they were now-- the family member that they identified was in the county clear the opposite-- like, two-, three-hour drive.

And so that person was able to really change their life around. And I don't know that we would have had the same results had that individual gone back to their home. So I was really glad that we took the time to discover that in our intake process and assessments, and that he was able to identify a family member that was able to take him in. I know that's not always the case, but it worked really well with this individual. So I think that's my time.

Yeah. So tough. It's so tough, because our families, for better or for worse, draw us back into old patterns. We go back to being the middle child, or the young child, or whatever it is, in our families. And we end up sort of playing out some of those patterns over and over unless the family is committed to helping support us change.

So when Paul says, during that assessment period, the intake process, trying to find out, what is the best support for these individuals, is time definitely worth spent to be able to figure out, is it more risky to put them back with the family where they were using, or should we try something completely different that's an experiment that may or may not work? So trying to make that decision, I think it's pretty tough.

Thank you all. Great conversation. I hope that the content and the scenarios and the experience that we brought to this panel was helpful to you all. But we're going to close out for today. And I have some additional training and technical resource information for you and some final reminders.

An extremely valuable resource is the COSSUP Resource Center. A screenshot of the Resource Center and web link are shown on your screen. Featured resources available include funding opportunities, COSSUP grantee site profiles with data visualization tool, information about demonstration projects, peer-to-peer learning and recordings of previous COSSUP webinars covering a wide range of substance use disorder-related topics and strategies.

COSSUP TTA Program offers a variety of learning opportunities and assistance to support tribal, local, state organizations, stakeholders, and projects in building and sustaining multidisciplinary responses to the nation's substance misuse crisis. Of particular significance is the ability to request Training and Technical Assistance, TTA, services whether you're a COSSUP grantee or not.

TTA can be requested at the link shown on your screen. Join the COSSUP community by subscribing at the link shown on the screen. And thank you, Dr. Nandi and Paul, for taking the time to answer our questions and bringing your expertise today. Thank you all for attending and joining us today. And we hope to see you again in future webinars and Ask the Expert sessions. Have a great rest of your day. Thank you.