Webinar Transcript - Ask the Expert: From Criminalization to Cultural Competence in Mental Wellness

Welcome to the National Criminal Justice Training Center webinar, Ask the Expert session-- From Criminalization to Cultural Competence In Mental Wellness. My name is Greg Brown, and I will be moderating for you today. This webinar was provided under awards from the Bureau of Justice Assistance, Office of Justice Programs, US Department of Justice. The opinions expressed by the presenters in 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 Opioid, Stimulant, and Substance Use Program and Coordinated Tribal Solicitation Purpose Area 3 grantees and other tribal communities in implementing responses to alcohol and substance misuse. Today, I'd like to welcome our main presenter, Dr. Anjali Nandi. Anjali is an associate with the National Criminal Justice Training Center and a human service 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 Addictions Counselor. Anjali has authored numerous publications, including tribal-specific resources for BJA's COSSUP, and TPRA tribal grantees.

As I mentioned, my name is Greg Brown. I'm a program manager here at the National Criminal Justice Training Center. And joining us on the panel today is Kevin Mariano and Kevin Poleyumptewa, both project coordinators from NCJTC, and Stefanie Wyatt, chief probation officer, wellness court coordinator, and family court coordinator with the Southern Ute Indian tribe. Their full biographies will be shared in the chat box. And thanks for joining us today. Dr. Nandi, the time is now yours.

Great. Thank you so much, Greg. And welcome, everyone. Wonderful to have you all here in this follow up. We call these sessions, Ask the Experts. But really, you all are the experts. There are several of us on this panel. We bring a lot of our own experiences and expertise, implementing different programs and working for quite a while in the criminal justice system, trying different ways of supporting folks coming back into our communities.

So while we do have a lot of experience, my hope is that you all bring your expertise and also, your questions to us during this session. The content is not new. We did a webinar. I think it was last week or the week before on this very topic. And I covered all of this material already. So I'll just provide a really brief overview and then, hopefully, answer your questions about, how do we implement programs?

In a well thought-out evidence-based way, how do you put together a program, a reentry program, for example? How do you figure out what the needs of your community are? And then how do you stand up a program that might be successful and might serve the needs of your community? So that's really the hope, is to get as practical as possible.

I'll cover a little bit of information, including some steps to developing a program, one of the steps being a needs assessment. So we'll talk about that and what that looks like. And then, how do we make sure that we engage our community and all of our stakeholders really well throughout this process?

So regardless of what our programs are, our goals remain the same. Our goal is to reduce recidivism. We know what helps to reduce recidivism. And so that's the overarching goal. Oftentimes, people will say the goal is community safety, which sure, absolutely it is. But we can only improve community safety by reducing recidivism.

The old way of thinking is we increase community safety by locking people up. And unfortunately, not only is that not correct, it's not sustainable. Over 90% of everybody, about 95% of everybody, who goes into prisons or jails, they come out, and they come out back into our communities. And so if we're not really paying attention to how do we bring these folks back into our communities in ways that they can be successful, we're not going to hit our goal of reducing recidivism.

So ideally, we're paying a ton of attention to this reentry process, This. Process of helping people come back into our communities. And that process actually starts way earlier than when people are coming into our communities. By that, I mean that it starts way before they're released. It starts with the community understanding deeply what it takes to have people be successful in our communities.

It starts with the community doing a needs assessment and looking at, what are things that are available, supports that are available, in our communities for folks who are returning? And what are we missing? And if we are missing things, how do we fill that gap?

So we don't have to wait until we have folks returning to our communities. We can start now. And we start in a variety of different ways, but really paying attention to, what is it that folks need when they come in?

So I'd love for you to type into the chat. So open up your chat box and type into the chat. Fundamentally, when people are returning into our communities, whether it's from incarceration, periods of incarceration, or it's from periods of maybe being in inpatient treatment or those kinds of things, when they're reintegrating and returning to our communities, what do they need in the community in order to be successful? What kind of programs do they need or mindset? Or what needs to be in the community in order for them to be successful?

So Brittney says, they need advocacy. So this is such a great example. They need somebody to be there, to be their advocates and help them navigate all of the systems that they will encounter. It's quite overwhelming for folks, when they're reintegrating or returning into the communities, for them to be able to navigate all of the things that they have to do.

And sometimes, we're starting from ground zero. We're starting with no identification, no Social Security card, no housing, no lots of different things, lots of just lack of resources. And so advocates are exceptionally helpful.

And so advocacy would be a program that you would develop if, let's say, you had all of the pieces in place. You had a lot of supports, but they were disparate, meaning they weren't really communicating with each other. You had great supports. You have lots of opportunities in the community. But it's difficult to navigate them.

So speaking of advocacy, what we have done to really support this reentry process is we have a team of what we call navigators, which are, I think, Brittney, similar to what you're thinking about in terms of advocates. But these navigators, they help folks navigate not just our system, but the community in general. And our motto in this navigation program is that we do not stop until the service has landed with the client.

So it's not where we just make referrals, meaning we say, oh, go talk to this person. We actually take the client to the person. We take them to the Social Security office, for example. We take them to the DMV to help them get their identification card and license, and whatever else they need. And we don't stop. We don't say that the service is done until it's actually landed. So that's an example of a program that you could develop around what Brittney is talking about.

And then Star shares, we need support from re-entry programs, yes. And then you also said, compassionate probation officers, which would be a great-- Yes, Greg?

I was just going to say, also, for those of you who don't have re-entry, it doesn't mean you're not doing this work, or you can't do this work. I mean, ideally, in the old days, when a probation officer had a small caseload, they were doing reentry work. They were helping them look for housing. They were looking for jobs.

But one of the reasons this whole profession was created is because of the really poor outcomes we were seeing from jails and prisons. And clearly, parole and probation had gotten away from being able to do that work, for a variety of reasons. So if you don't have re-entry, you still need to be doing this. And if you are blessed with a really small caseload, and you have the time, then this is critical stuff.

I mean, just because it has that label of reentry doesn't mean it isn't a need for a person who hasn't gone to jail or prison as well. I mean, you're going to run into this in a variety of different ways. And remember, every one of the clients that we deal with, their lives are changed. They've now gone through the criminal legal system, and they're coming out a convicted misdemeanant.

They've done jail time. They've lost a job. They've harmed the community in some way. Or they've been put away for a while, and they've lost those skills or never actually had skills to be pro-social and successful. So think about we have a label, the title Reentry. But these are things that everybody needs to be thinking about, whether you have a re-entry program, which is great, or you don't.

Yeah, really good points, so I don't want anyone to feel like you're being excluded in any way. You're absolutely right, Greg, that whether we have something called a re-entry program or not, we're all doing this. So that's really important.

And Star just shared that your reentry program, you said, that follows clients for over a year, which is fantastic. And then you have eligibility criteria. But you meet them where they are, and you start right at ground zero. And you start with an assessment. But it sounds like you're really trauma informed, which is wonderful.

Arlan shares that we need nonbiased support. Yes, very, very true. That no matter what your role is, that the support that you provide ideally is non-biased, non-judgmental, with the goal of really supporting this other human being to be successful in whatever way they might define success. So that is the other really tricky thing, is sometimes, our own stuff gets in the way of us being able to be supportive of people.

Our definitions or our morals or values or those kinds of things sometimes get in the way. And being able to provide non-judgmental support for whatever the person's goal is-- so if their goal is perhaps to get housed, but maybe continue to not work while they figure themselves out, or whatever it is, really trying to support, ask the questions. So sure, we'll help you get housing. And how are you going to make a living? And what does that look like? And asking those questions would be helpful, but really supporting them and starting them where they're at.

Lisa says, resources and supports to assist them in getting their basic needs met-- yes-- and then work or school or training or those kinds of things, really, really helpful. Wonderful. OK, these are great. Yes, Greg?

Well, I was just wondering. The other thing that you've talked about in the past, and I know Kevin Poleyumptewa, he does the fatherhood program. But until people get these basic needs met, they may be unavailable to work on some of the things that get them into trouble and fuel their mental illness and fuel their addiction. When I think about them, Maslow's hierarchy, before you can think about others, it really can impact empathy and their ability to understand their impact on their community when they are causing harm and crime.

Yeah. And Maslow's hierarchy of needs is really about our basic needs. It's also about safety, so safety first. Yes, Kevin?

Yeah, what Greg was saying is definitely true. And part of that, assisting them to try to be successful in this reintegration process requires us to help the individual understand that hierarchy in a realistic way. They may be coming out and saying, "oh, I need to get a job. I need to do this."

But if there are underlying issues that are going to eventually hinder or destruct those activities, then that is something that we need to also help them to realize, too, OK, well, there's some other things that we need to do, focusing on things like housing, stuff like that, food, shelter, those basic needs, and then really starting to make a plan, so that they can see the picture and create those steps. And I think creating those small victories is also important because it helps.

I mean, it's like paying off your credit. You're going to pay the lowest bill or the lowest amount that you have because that's more attainable. You're not going to pay your $12,000 credit card debt off. You're going to pay the little $500 credit card off and then get that. Because now you're seeing success. So it works that way, too. And that can also be a good way to think about that process of reintegration.

Stefanie?

I was going to add to that. Here, if they're sentenced to probation, we don't wait for them to be released. We can go back into the detention and start those interventions now and start connecting them to resources before they're ever released, so that they can start seeing some momentum and have a plan in place before they're ever released from detention.

And it's also important to make sure that while they're working on their selves and they're in detention, is to make those connections. If they have children, making sure that we have resources in place, that they are aware their children are being provided for, cared for, to ease their concerns through those types of interviews, to make sure that a child's basic needs are being made while a parent's incarcerated, so that we can take away some of those barriers.

So when they are released, maybe while they're back there, they've obtained their GED. Or we've already connected them with behavioral health and got the assessment done, and they've got started. So that when they're released, they're hitting the ground running.

Yeah, that's really great, Stefanie, that you offer services before they even return to the community. And Stefanie, if you don't mind sharing a little bit more, you had said that you might maybe start assessments, that you might get them connected with providers in the community. What are other things that are helpful to get started, even before they return to the community, while they're still detained?

So when I talk about completing assessments, because they've already been sentenced to supervision, all our releases are in place, and we will have a behavioral health assessment completed, which is drugs, alcohol, and the mental health assessment through our tribe's behavioral health program. They can go back and start services with them.

But in that, we always do a referral to our clinic, where they can meet with a doctor to talk about medically-assisted treatment. They, at times, can begin that while incarcerated. So when they're released, they're already on that program to meet those needs medically.

We can also connect them with higher education, GED service programs, and then also, connect them with our vocational rehab. So they can fill out the documents and prepare all the programming. So when they get out, they know exactly who they're going to. They've already met these service providers. They're comfortable with them. And they can start preparing for a job or whatever else, whatever service they deem as an important service for them.

Yeah, that's great. Because it really reduces the amount of fear also. Because then they're familiar with who these folks are. They've already met them. And now when they come back out into the community, there's less just fear around making some of those connections. That's really wonderful. Greg?

I think the other piece, when you think about systems, is that jail and prison sentences are our most expensive resources. And just simply using those to house people until they get out again and get back into trouble, oftentimes, let's use that very expensive, contained resource to the advantage of the community and to the clients to do as much as we can while we know that they're reasonably sober.

They're reasonably safe in that setting. They're going to show up for appointments because they're there. We've got a captive audience. But for every community, that is probably the most expensive resource. So let's use it for more than just punishing people or trying to contain them, until we get them to the next place or try to set something up for them.

Stefanie, did you have more to add?

Yeah, I wanted to add to that, is one way that we're blessed here at Southern Ute is our judges are very open to, if they're starting these services toward the end of their sentence, they can have their attorney motion to allow them to complete their sentence at residential treatment. So if they have 90 days left on their sentence, and they wanted to go to a 90-day residential treatment facility, they could be transported from our detention to a residential treatment facility and where they can be given day-for-day credit only on the condition that they complete the residential treatment program. If they don't complete, then that time is not done away with.

Stefanie, how did you develop this relationship with the bench?

We're a small court. And our judges are very open minded, and they want to see long-lasting change for individuals. This is a small community, so it turns into a snowball effect if somebody's not receiving the services to make long-term change. Our judges have been very open even to really identifying those trauma needs and taking care of those individuals that may have issues with childhood trauma or that we're able to focus on counseling or around trauma. Our judges are very open to making sure that we're a trauma-informed court in the way that they communicate with individuals within the courtroom as well.

Yeah, that's fantastic. When you talk about being trauma informed, Star just put something into the chat, which I think reflects what you're talking about, which is about not just being trauma informed, but helping people understand that the trauma that they experienced was not their fault. Because oftentimes, there's a lot of shame associated with trauma. And to be able to minimize that helps build a lot of trust. So that when we're doing assessments, they can be more honest with us, and we can get more accurate information.

And then, Greg, I know you wanted to add something. But I just want to point out. Keith added to the chat and talked about his probation department's philosophy of restorative justice through cultural reintroduction, which I think is really fabulous and thinking about, how do we really understand folks, so that he can get them connected? And they use the Language Department, Education Department, the Tribal Employment Rights Department, and Wellbriety Community, which is fantastic. Greg, go for it.

I was just going to say, I think the other piece, which we all know if we've done this work, is that many times, people are more motivated, when they're in jail or prison, to look at change. So when you think about stages of change and where we have them, they may be much more motivated to get engaged. And that magic 90 days of doing something, where it's much more likely they're going to continue doing that, we really improve that, those outcomes, just by doing that.

Because they are so motivated, they're sitting in jail, and their life isn't going the direction that they want. So let's tap into that motivation, as opposed to, "oh, I've been out of jail for a month. Now I've got to go to probation. What are they going to want me to do? I mean, I think that's a very different mindset for clients. And it's just human behavior. There's nothing wrong with them. It's the way we are and to pay attention to that, when we're thinking about reentry, reintegration, and integrating their culture in, if there's some opportunities to do that as well.

Yeah, very true. It goes back to what Kevin was talking about around getting small wins. Let's start with whatever we can achieve really rather quickly, relatively quickly, so that we can build that motivation, based on these small wins that we're having, before we tackle the really tough stuff, which takes a while. And then Star shared something really sad, which is that you all have an epidemic where many of your clients are getting drugs and using while in jail, which is really, really tough, and in particular, the use of fentanyl.

So when you are getting clients, many times you have clients with zero clean time, just so hard. I'm going to take just a very, very quick detour here. But we're learning so much about fentanyl and in particular, how difficult it is to use, to get the medications right. With opiates in general, we have-- [COUGHS]-- sorry. We have been able to really understand how much Suboxone or Sublocade, or whatever buprenorphine combination you're using, we've been able to figure out what that dosage is and start people up on the right doses.

With fentanyl, because it's so fast acting, and it has such an incredible impact, the impact of fentanyl compared to any other opiate, I mean it's in a completely different ballpark. And so sometimes, the physicians who are prescribing medication-assisted treatment, when there's fentanyl on board, have to really experiment with the client to figure out what the right dosage is, to be able to manage some of their symptoms of withdrawal and craving. So it's really, really hard.

And there are many different recommendations in the medication-assisted treatment world that are coming out right now related to, do we microdose? Do we really ramp up the dose initially? And yeah, Vivitrol is great. We're missing a component in Vivitrol. Vivitrol is naltrexone. So it's an antagonist, and we're missing the agonist component. So it's a blocker, but no agonist. Go for it, Greg.

Anjali, as you're talking, I mean, are we really seeing a specialty area for doctors who understand medication treatment and helping people with addiction? And if so, if you've got a local doctor working at the clinic, is it worthwhile to approach them and figure out how to help them get that training and that support?

Because I know psychiatrists and other LPNs that can prescribe, they're reluctant to do things that they don't have some support or somebody with some more experience until they get it. So I'm wondering what you're seeing in that area. And how do we help doctors get more comfortable or med-certified nurses to get more comfortable with understanding how the differences between these drugs, and how we need to approach them, and what we're learning from that?

Yeah, it's definitely a specialty area for sure. And there's additional not just certifications, but additional regulations that physicians need to abide by when they're prescribing these medications. However, the piece that you said is really important, which is the relationship matters. And physicians are more willing to engage in this extra work if they know that they have the relationship with you, where you are going to provide them additional information.

I cannot tell you how frequently some of our physicians will be so grateful for the information that our probation officers share with them. Because they prescribe the drugs to the clients. And then they have no idea how the client is doing until the client comes back to see them again. And so in the interim, we're seeing them quite frequently, so we're able to share with the physician or the prescribing person how they're doing, whether they're falling asleep in group or falling asleep in meetings with us or what kind of reactions that they're having. So that relationship, I think, really matters.

And then we received the grant to be able to have a physician on site. So she comes in once a month in each of our locations, so once a month in one location, once a month in a different location. So our clients have access to a physician on site, which has been extremely helpful, so that they can get not only bridge medications, if they're struggling with mental health issues, but really, all of their medical needs met, which is really wonderful.

And so just to go back to Vivitrol for a second, so Vivitrol, which is now naltrexone, Is an opiate blocker. So it's called an antagonist, which is great and wonderful. And it's a nothing against the drug. Don't get me wrong.

What we're missing there is the agonist piece, which is what buprenorphine provides. So when you combine buprenorphine with another antagonist, that's where you get things like Suboxone or some combination drugs. So Vivitrol works. But you might get clients who struggle with Vivitrol and naltrexone only because it blocks their opiate receptors, but it provides no relief.

So it's actually pretty uncomfortable. And people will report higher levels of craving, higher levels of symptoms, of withdrawal, those kinds of things. So again, not a bad drug, very helpful for lots of people, many, many places prescribe it and continue to. So again, just take it with a grain of salt. Great. And if it's working, wonderful, keep doing it. Awesome.

So let's go back to implementing the program. Ideally, you start with the needs assessment. Ideally, you start with figuring out, what are the services that exist in your communities? And where are there gaps?

So a needs assessment might take on several different components. A needs assessment would include just understanding, what is the purpose of your needs assessment? And what is the scope? Because your needs assessment needs to be targeted onto something. So maybe re-entry is the purpose.

Maybe it's figuring out what services are available to those who are unhoused. That's an even narrower purpose and scope, so just making sure that you're really clear about what you're looking for. And then how are you going to collect the data? Are you going to collect it by calling each of the individual places? Are you going to do a web search?

What are the data collection methods? Are you going to do focus groups? What exactly are you going to do? What areas are you going to focus on when you're gathering your data? How are you going to analyze and interpret your data?

And then the really important part is, what does your report look like? And what do you do next? So ideally, a needs assessment ends with sharing the information that you have gathered and then figuring out the next steps.

So in here, we've provided a sample of what this might look like. So this is just an example. So here might be the purpose or scope to identify the needs of folks who are formerly incarcerated so that we can develop a reentry program. So that might be an example of the purpose.

And let's say you attack it in many different levels of focus. You focus on health. You focus on employment, housing, and cultural needs. So maybe that's it. Or maybe you really get narrow, and you focus only on, what kinds of supports are there for substance use and mental health? So that would be a really narrow focus.

So you figure that out, whatever areas. And then what were your findings? So maybe the finding is that there are high rates of substance use and untreated mental health. Maybe that's the finding and that people don't have access to health care. So they don't have the ability to get their needs met.

Maybe it's an employment issue. So maybe there are significant barriers to employment. Maybe there's just lack of resources. Or maybe there's lack of training. Or maybe there's people hiring, but for some reason, they're not hiring our folks with records.

And so one of the things that we've done a lot of is to do a ton of education for employers so that they understand that it's actually in their best interest to hire folks who are being supervised because we're on top of it. We are supervising these folks. We're doing new ways. We're meeting with them on a regular basis. We're helping them with skills, all of that. So we try and really convince them that it's in their best interest to hire folks.

We're very lucky to have many folks who used to be in the criminal justice system who started their own businesses. There's a restaurant, in particular, that I'm thinking about. And he employs folks who've been formerly incarcerated because he's somebody who has been formerly incarcerated as well. So that's pretty cool, developing some of those relationships.

Housing might be another example where there's just not enough housing options. Or maybe you find that housing isn't the issue, that you all have some wonderful kind of transitional housing opportunities in your community that meets that need. And then what are the cultural needs?

So Denita just put a question in the chat. How would the summary report differ for juvenile clients? Not by much, honestly. So we could do an example for juvenile clients. So maybe the purpose would be to identify the needs of clients between the ages of-- you can come up with whatever the ages are. So maybe you do 12 to 18, and then maybe you do something different for the transitional age youth, like 18 to 24, 25.

And in your findings, I would absolutely do something about school. Because for juveniles, school matters. Relationship with family really matters. So that would be another section that I would do. If we're focusing on juveniles, what is their relationship with family or connection with family? Or maybe it's broader family. It doesn't have to be biological family. So what supports do they have?

Also, pay attention to after-school supports. If school isn't really something that you notice your juvenile's interested in, then what are training programs that get them ready for employment, maybe what that exists in the community, maybe GED programs, those kinds of things? So your focus would shift slightly, but the report would follow a very similar pattern. Denita, pop a question into the chat if you need more information. And if that was enough, just let me know.

So once you have done that, once you've reviewed what exists, then you start to prioritize needs. So let's keep with this juvenile example. Maybe we find that the schools are great. They're really wonderful about taking kids back, reintegrating them, et cetera. But there are no after-school programs. Maybe that is what we prioritize.

Or maybe there are community groups that exist, but they don't have a component to include our young ones. So maybe that's the place that we go to these wonderful community-based programs, and we ask them to create something that's youth specific. So that might be a priority as an example.

So you prioritize what your needs are, based on your needs assessment. And then you develop some kind of an action plan. And the action plan ideally has short-term, medium-term, and long-term ideas in it. So keeping with the juvenile idea, maybe the short term is establishing partnerships with existing programs and getting information from them about what it would take to have a youth focus, so short term, medium term, and long term.

And then what are your very next step? Maybe the next step is to present that at a community gathering or a community forum, get some community input, and then refine your plan. That would be something. Great. Thanks so much, Denita. Greg and Lynn, it's in the chat, if you don't mind reaching out at some point about a juvenile risk/needs assessment; so needs assessment.

And then another step would be to survey what exists and what partnership opportunities might exist. So, Stefanie, Kevin, I'm wondering if you have examples of partnerships that you have seen work successfully with our clients. So an example of a partnership might be we have a mental health center that's actually focused on the community, in general.

And then we've developed a partnership with them to have a program that's very specific for our criminal justice clients. So that might be an example. But I'm wondering, Kevin, Greg and Stefanie, if you have other examples of partnerships that you've seen developed or that have worked?

Who would you like to go first?

Stefanie, you start.

We currently have several partnerships that are working, but they haven't been developed just within a few days. So our Healing to Wellness Court's been around since 2001, I believe. And in those partnerships, I believe the other day I was talking about MOUs and establishing those partnerships through MOUs and what our roles at each are.

And we get to come back each month. And we work on those programming and what each department has to offer. Because sometimes, those MOUs need to fluctuate or change, depending on who's working there, what services can be provided.

A great example-- and I think this might have been one of the questions around culture from someone last time, is we have an amazing partnership with our Culture Center. So anybody that's going through our family treatment courts or Wellness Court, when they're establishing their cultural plan, they go to the cultural department, meet with them, explore a museum, meet with the culture department. They may not be Southern Ute, but that cultural director would be able to identify or connect them with someone within the community or a resource to connect them back to their tribe, so that they can participate or be a part of something that's culturally fulfilling to them.

It might be something as simple as making a ribbon dress. Well, we happen to have went and bought all the sewing machine and everything. So they can sit here and come do something culturally appropriate for them. So your connections are as broad as your imagination. When someone's talking about what's really important to them, for our positions, it's, how much effort do we want to put in to our community and helping folks make positive change and connecting?

So your limitation is you as a department, that there are no limitations if you really want to provide the services. Another cool thing that has been established, a lady that is no longer employed here, she's moved on to a different area. She created a very large book of every resource within the Four Corners area, that we can flip back through. And when we're looking for something that we may not be able to provide, we're able to try to figure out where this resource is to call and connect and update.

Those are great examples. It brought another example to mind, which is we have a boxing gym locally. And then we also have a climbing gym locally, that people really-- it's well-known in the community. And so we partnered with them. And some of our folks go into the boxing gym and have developed such great relationships with other people in the community, people who are not involved in the system, people who have these successful lives.

And they've been so inspired by that, but also, have felt reintegrated. Because now they're hanging out with folks who ordinarily, they would never have been exposed to, which is pretty cool. Kevin, go for it.

It's funny that you say that. You talk about boxing. That was one of the things that we integrated into one of the programs that we had with working with our men and women. If they wanted to learn how to box, they could do that. So our staff were able to go and actually work out with them for an hour each day.

And we're able to do that because the gym was literally just down the hall, maybe about 50 yards from our office. So we were able to work out with that. And that in itself not only helped to strengthen that relationship between our staff and our participants, but it also helped to give them a little bit of motivation also. Because now they had something to look forward to, something that made them feel good about themselves.

We do as best we could to really just wear them out, so that when they left, they were feeling good the next day, so those types of things. But relationships with many different areas, like you said, is also very important to having a successful reintegration for individuals, working with behavioral health, working with your cultural resource department, having them come in and be a part of whatever program they may be in, whether it's maybe an IOP program. Or you have a fatherhood program or a parenting class that they have to go to.

There's a lot of different things that are available for them. And working together definitely helps the individuals be more successful. Because not only are they maybe having to do the required IOP class or program. They may be attending a community program, whether that's a fatherhood program or parenting program or something else to get additional support to what they're learning in IOP and then also, building those community relationships with the other individuals that are in that program.

And then getting behavioral health involved, having them come and do simple presentations at these particular groups and talking about the benefits, not necessarily trying to recruit clients, but just giving information, sharing information-- even those relationships with staff in your social service department, your health department, whoever it may be, coming in and sharing maybe their individual experience with going through counseling and helping them to understand that just because you go to counseling doesn't mean there's something wrong with you.

We all have stuff that we're going through each day. And this is how it's helped me as an individual. And you have somebody who may be a MSW or a PhD, who is coming in and talking about, well, I went to counseling, too. And I still go to counseling. So there's so many different types of relationships that can be utilized. It's just a matter of having that motivation to go out and build those relationships. And sometimes, it takes months or even years to do that. Until you get that right person, then you just have to keep trying.

Yeah, it takes a lot of tenacity, like you said. And both you and Stefanie said, it takes effort. And it takes a ton of creativity. I think, as well.

Dr. Nandi, I just want to add a little bit more in there. Sometimes, I think the unforgotten side of things is from the-- somehow, the cops are forgotten about, law enforcement and all that. But we build in that connection with individuals that need some help and services along the way there, whether it's through some sort of intervention or deflection of some sort.

But we also partner, and we also-- when I was still doing the work in law enforcement, we had a program that was put together to help those individuals that were returning back into the community. I think we had a person that returned from prison. And the folks, the ladies that were in the reentry program, which were part of our program with law enforcement, they were able to connect with the casino, their employment there, to actually find employment for this person that was returning back to the community and find him employment there.

It took a while to get everything arranged for this individual. But he was able to be employed-- of course, in a different area at the casino. But they were actually able to get him employed when he came back into the community. So there's just those several different areas that they had some focus in and also, using the cultural and the language community, as well, to help these individuals build that connection back in from that side. So I just wanted to mention that there, too, to you and everyone there.

Thank you, Kevin. So a couple of things that I wanted to address. One was we frequently get the question, what comes first, mental health stuff or substance use stuff? What do we address first? And I would love for us to not think about it in binary terms, but to think about the individual as a whole. It's very difficult to separate what's driving the problem behavior right now.

And it's very individualized. So ideally, we pay attention to the individual as a whole and attend to, what would be most supportive for this person? And the answer will be different from person to person. So you might have some folks who, for them, even though they started using substances in order to deal with a mental health issue-- so let's say they were using substances to manage some symptoms.

Even though that's the case, now where they are right now, the substance use has really taken over. And it's what's ruining their lives right now, what's causing the most amount of pain. And so we might start with an intervention there. But we wouldn't forget. We wouldn't miss the mental health piece.

So it's really important to address the person as a whole. So what initially started the behavior may not be the one that's killing them right now. And from a harm reduction perspective, we really view the person as a whole. We start ideally with both. But if you really were forced to choose, we start with what's going to bring them the most amount of relief.

So I'll give you a few examples. It could be that the person right now is so addicted to meth or opiates, or whatever they're using, even though they are having some mental health symptoms, that addiction, they're struggling with so much that they need some support there. But while we give them that support, let's say the support is to start them in detox or an inpatient program.

While we're giving them that support, we're paying attention to, what are the mental health symptoms that are coming up? And how do we address those, whether it's through medication or through skill building or a combination of that? So we're looking at multiple things at the same time.

Unfortunately, lots of providers will say it's one or the other. I only do substance use. And therefore, I want to start with that. But that sometimes is a mistake because we might need to address some mental health symptoms. And the substance use stops because you've addressed the symptoms that have brought them there in the first place.

So it's actually to Denita's point. From your perspective, you have to address substance use first. But we've seen exactly the opposite, where when we put people on the right mental health medication, they don't need their substances anymore. So we've seen that piece as well.

So what I encourage everyone is to keep an open mind and allow the client to inform us about what needs to be done first. In an ideal world, we address the person holistically. But really trust the wisdom of the client. Really listen to what might be going on.

And when Greg says, sometimes, it's really difficult to figure out how to address that mental illness, sometimes their mental illness symptoms are so big. Here's an example. We have somebody who is in active psychosis, who is also using. They're using meth, but they're in active psychosis.

Now, maybe Denita and Greg would say, work on the meth use. But I would say, maybe we start with antipsychotic medications. Because once we can get their psychosis under control, it could be that those symptoms are so big and so strong that that's why they're using the substance. So you get that under control, and then the substance use diminishes.

We could give a counter example, as well, where you address the substance use, and the mental health diminishes. So ultimately, we cannot tell you, address this first, then that. The client needs to tell you that. The client's assessments will tell you that.

The client may not verbalize it to you directly, but they will share with you what is harming them the most or what is the most difficult thing for them right now. And you follow their wisdom. You really trust, how do we provide them the most relief as quickly as possible? So, Star, Denita, Greg, I hope I answered some of that. And then, Kevin, talk to us.

I just wanted to add a little bit to that and emphasize the importance of the assessment. Because in some situations, you'll have an individual who really doesn't know, who has no idea. They may think it's the substance misuse or the substance use that they have that is the issue, when there are really other things that they have going on within their mind, some sort of mental health issues.

And so that is the type of information that you can get in the conversation with them, but also, the questions you have on your assessment to help you pull that out and give you a better picture than maybe the client or the individual can give you themselves. Because there are a lot of times, we've talked with individuals. And they come out and say, yeah, I want to stop using drugs. I want to change my life, and all this stuff.

But they don't share with you the things that are going on in their head, things that are affecting them mentally and emotionally. They don't want to talk about that because it's maybe embarrassing. They might be afraid to share that stuff with you. So that makes that assessment so important.

Yeah, yeah, very true, very true. So takeaways from that assessment, really, really pay attention to your assessments. So that's one of the questions that we get asked a lot. Greg, what are some other questions that came up related to this particular session?

Sure. So the other thing I want-- and I'm sure this, for Denita, we're on the same page with this. And maybe this isn't as important. I mean, I'm not a clinician. But what if the source of the psychosis, the voices, and all that is substance abuse, versus an underlying mental illness? I think that's what we're trying-- I it's like diagnostic.

That's where, I, think the two of us are trying to approach it, as is clearly, there's a substance abuse issue. And this person, as long as they're abusing or not, is not going to be very available for a lot of other stuff. Plus, no psychiatrist is going to prescribe-- my experience is they're very reluctant to prescribe when someone's actively using.

So how do you do that? I mean, how do you juggle those balls? Or what kinds of questions do we ask in that process? And, Denita, I don't need to speak for you. But Anjali and I go back and forth on this a lot. So I'll let her answer it, and maybe we'll get some guidance. I'm sure we'll get some guidance on what questions we should be asking ourselves, maybe not the answer.

Yeah, so one of the questions to ask is, is there a history of mental illness? Because if there is a history, then that gives you some information about whether the psychosis was induced by substances or whether it preceded the substance use. Most often, people with psychotic disorders will use substances to manage voices.

They won't use meth often. They'll use THC or something that quiets them down. So there's frequently that piece. But part of what you're asking is when substances may have induced something.

So two substances, in particular, that tend to induce psychosis are meth, of course, which we're familiar with, and then high-potency THC. So high potency THC, there's unfortunately a lot of research coming out that cannabis can induce psychotic episode, especially when it's high potency. So those are a couple of substances.

And, Denita, yeah, you're answering Greg's question. When was that first experience? What led to the psychosis? Those kinds of questions are incredibly helpful. And they are part of our assessment.

And in the end, as long as we are addressing the whole person, you're going to be OK. So don't do, "I'm sorry, our clinic only does this thing." That, we need to avoid. Ideally, for our clients there's no wrong door. When they come to us, we provide them whatever support we can, and we make connections with other resources, so that they can get their needs met. Greg, I know there were some other questions as well.

There were. Good answer. I think I have some guidance. And, Denita, who's a clinician, I'm sure it made a lot more sense to her, too. So one of the questions we got is, will this session address historical trauma ground zero for mental disorders?

And I would say, I think we put a lot out there. We've got a whole series on our website on historical trauma that it's great for people to review or great for people to become familiar with how important it is to understand historical trauma. I think the answer to this question is we've got a lot of resources on that. And Anjali, I'll turn it over to you to tie it into today's session.

Yeah, so trauma is one of the buckets of mental health disorders. The bucket in the DSM is called trauma and stress and related disorders. Now, you don't have to actually have a PTSD diagnosis to know that somebody has experienced trauma.

Ideally, we have a trauma lens, meaning that we look through a lens that allows for an explanation of their behavior that includes trauma, meaning that they might be reactive to us, not because they're trying to be pushy or defensive, or whatever, but because they're triggered. They're having a trauma response. That's what's happening.

So having a trauma lens, I think, in our field, is absolutely necessary, is the place that we start. However, you can have people who have a mental health issue that don't have trauma symptoms. So not terribly often, but you will see that.

So I want to just separate a few of these buckets. Mental health is this big umbrella. But you could have trauma and stress-related disorders. You could have a mood disorder. You could have a thought disorder. You could have a combination of all of these. You can have anxiety disorders, substance use disorders.

So under the umbrella of mental health, I think all of these fit in there. And just to be clear, in the DSM, you have substance use-related disorders as a whole chunk or section. So I think that would be just helpful for our brains to be thinking about.

So one more piece around trauma in terms of questions that frequently come up is, do people have to have experienced trauma directly in order to manifest the symptoms of trauma? No. You could have historical or intergenerational trauma. So what we know in the research is that trauma that's happened in previous generations impacts the way genes are expressed. And we call it epigenetics. Exactly. Thank you, Stefanie.

So the research is that it alters the way our genes are expressed, meaning it alters the way things turn on or turn off when certain things happen. So some of the impacts of historical trauma look like certain things. They look like a reduced resilience to stress. They look like greater levels of impulsivity, for example, higher likelihood for mental health issues, higher likelihood for depression and anxiety, in particular. So those are some of the things that could be a result of historical trauma.

Thanks, Rachel, for putting that in the chat. That would be great. Perfect. Awesome. I love it when we answer questions. This is great. I was going somewhere. No, answer that question. OK, check. Next, Greg.

So the next question is, what resources for competency evaluation would you recommend for tribes that may have issues with the state? And, Anjali, we talked about this as a group earlier. And just a couple of thoughts that came from my perspective and my experience-- and maybe, Anjali, you can talk a little bit more about this, too-- is in our state-- and every state is going to be different. We understand that. So we're throwing out ideas here.

In our state, our state hospital is supposed to do all competency evaluations for the court, specifically if you're talking about evaluation to determine whether the person is competent to assist in their defense. And our state actually contracts with private psychologists in the community. Maybe they don't have to go to the state hospital. It can be done in the community, the evaluation, or more often, in jails.

And so they're already pre-approved by the state. And so possibly contracting with those doctors independently of the state would be a way to do that. It'd be pretty hard for the state entity to argue with somebody who's on their list that does competency evaluations. It becomes an issue of payment for those.

And the other piece-- and this is worth researching, depending on your state and your tribal code-- is, do you have funds to be able to actually do that? Do you have a way to get an evaluation done to do that? So those are just a couple of ideas that I had around navigating when you're looking at competency as an issue, if we're on track with this question. And that's what I thought of when competency was mentioned. And maybe, Stefanie, you can weigh in after Anjali, too, about how you address this with your tribal courts and the state that you're in. Go ahead. Anjali.

Awesome. Thank you. If the person who put that question into our system, if you're on the call and want to clarify, just type it into the chat. So if we're going off in the wrong direction, please just definitely let us know.

So there are few ways to think about this. So let's start with competency. When we say a competency evaluation, it's very different from a mental health evaluation. A court-ordered competency evaluation is an evaluation to figure out whether the person is competent to understand-- whether they understand court proceedings, whether they understand the interaction with their attorney, whether they understand what they're saying yes and no to, whether they understand the process of court.

A competency evaluation does not mean whether they have a mental health issue or not. You can have all kinds of mental health issues. You could have active schizophrenia and still understand what an attorney is, who a judge is, and what's happening in court. So competency evaluation is something very, very specific. And it's to see whether you're competent to go through the court process.

Let's say the person doing the-- so let me back up for a second. The person who does the evaluation, for the most part, needs to be approved to be able to do competency evaluations. The rules around that will differ from region to region. So it's really important that you check what your code says and what your rules and regulations allow you to do.

But people have to be approved to be able to do these competency evaluations. Let's say in the competency evaluation that the evaluator says, no, you are not competent. Things don't end there. You then go through what's called a restoration process. So the client goes through a restoration process.

Some people call it a competency restoration. Some people just call it a restoration process. And during the restoration process, you're, essentially, taught what happens in court. And you're helped to understand what the process is. You then go through another evaluation. The evaluation may say, yep, you're competent now. Or it might say, nope, still not there. And then you go through the restoration process again.

Until you're declared competent, the courts can't proceed because you're not understanding what's happening. And so the court cannot proceed until you're deemed competent. Once you are competent, then things start up again. So long story, I'm sorry, but I just wanted to lay the groundwork so all of us were on the same page.

So the question that someone asked was, what are the resources for competency evaluations? And if you don't have a list that's provided to you in your area, and you're looking for others, there are places that do virtual competency evaluations. But you'll have to check what your courts allow and don't allow. Stefanie, what would you add to that?

So we find funding for those competency evaluations. It depends on what tribe they're from. Our tribe, the tribe that's located within our exterior bound, we're at the Southern Indian Reservation. But we might also have someone from the Navajo Nation within our tribal courts. We have funding set aside in different, various grants to pay for those.

And we do allow some virtual. The gentleman that we contract out of Denver a lot with, he will come for the first initial. And at times, we've had to have followup evaluations on some individuals that have a lot of mental health issues. So we try to add it into a lot of our grant funding.

Awesome.

That answer your question?

Yeah, it totally does, Stefanie. And thanks for bringing the PSOP around. Sometimes you can do part in person, part virtual. So the first appointment might be in person. And then you could do the rest virtually. Or you could do the entire thing virtually. So, Stefanie, thank you. That was really helpful. And, Lucinda, thank you for that comment. Great.

Well, hopefully, we answered that question. If the person's on that asked that question, if you could let us know, were we on track or off? And we're always happy to provide other technical assistance and brainstorm ideas with these kinds of challenges.

I think the third question, Anjali, that came in was a person asking challenges with dual diagnosis, clients in the SORNA program. And I read this, and I don't know if you read it differently. We talked a little bit about it.

I read this as perhaps a person who's responsible for registration for a tribal community when a sex offender is coming back to the community-- and maybe there aren't other resources in place. Maybe they're not on probation, not on parole, not in a reentry program. And you can clearly see, or you suspect, that the person may have a substance abuse issue that's reoccurring or a mental health issue that's not stable. What do you do about that? So I'll throw it over to you. And I know we only have you for a few more minutes. But if you'd like to tackle that, and then we can finish up after that.

Sure. Thank you. Yeah, let's talk about that. And while I'm talking about that, Kevin, if you're OK with us switching right now, I'll stop my share. And wow, Kevin, you are just so on top of it. This is impressive. Amazing. Thank you so much.

So I'm just going to make sure that is not my computer. Oh, look at that. Thank you. So dual diagnosis and SORNA. So SORNA is Sex Offender Registration. And frequently-- well, not very frequently, but sometimes, you will be asked to supervise folks who are only required to register. And there's no other court requirements.

And let's say they also have mental health or substance use issues. When there's no court order to provide services, it becomes a really interesting position that you are put in. So all you're supposed to do is monitor sex offender registration. And now you're noticing that this person needs additional services.

So when you're in that process, ideally you still provide them with the resources that they need. So whether it's mental health or a treatment provider that does co-occurring disorders, that provide services for both substance use and mental health issues, you can connect the client with that. Just know that the client will be there on a voluntary basis.

So it's just really important that we use our skills to encourage the client to get the services they need. Because otherwise, we're missing an opportunity to connect the client to their community and to receive services in the community. So whatever you can do to support that or provide incentives for them to engage in services to address those needs would be great.

Just know that you won't have much of a hammer. You don't have a lot of muscle if it's not part of their condition. So all you have is the relationship and really encouraging them to receive these services. Stefanie, in your department, does that happen a lot, where you have folks that you're supervising only for registration purposes, and they have no other requirements?

So I've only had a few sex offenders under supervision here. What has happened is usually, the federal government will prosecute those cases. If they refuse to prosecute, and we prosecute and win, and they're placed on supervision, with our sentencing orders, judge may order to go get and comply with a sex offender registration, like their evaluation, and to follow those recommendations. So in our court, on our sentencing orders, it's super important. He says, follow recommendations.

So if that evaluator has identified other issues and lists those things as part of their recommended treatment, then they have to follow those. So if I'm also getting updates from their provider and saying, I'm noticing this many positive tests, that's actually a violation of maybe a contract they've come into an agreements with that provider. They can add on things that may be required for their treatment, like a new evaluation, or whatever. So that's where we're to be able to provide extra services.

That's awesome, Stefanie. Thank you.

Thanks, Stefanie. Anjali, I know you're probably going to have to jump off pretty quick. So just to answer the SORNA question, I do a lot of SORNA training, registration, and sex offender management. And this is really common. And it usually happens. The person kills their number, and they don't have any supervision. Or they've successfully completed their period of supervision, but they've got to register for 20 years. And in Colorado, it's 20 years to life for some people.

And so a lot of registration people end up doing entire case management. I mean, they're only hired and responsible for the registration piece of it. But you can clearly see that this person is struggling in the community-- housing, mental health, substance use. They're still coming in to register, but you don't necessarily have resources for that.

And so what we've seen SORNA programs do is really cultivate relationships. Go back to parole, probation, maybe your reentry programs, and talk with them about, do they have any ability to help out? Go to your behavioral health and talk with them. Because any citizen should qualify for behavioral health services. But really cultivate those relationships.

So you can make referrals. And you can't force the person to do it. Obviously, they don't have any conditions. But you certainly can, as you develop this relationship, which a lot of SORNA officers do, that they may listen to you. They may tell you, I'm really struggling.

And then you've got some ideas about where they might go. And you certainly can follow up with them. You can't direct them to do anything with it. You're only responsible for registration. But you certainly can support them in that process.

And I mean, that's really the work that we're all doing with probation, parole, reentry, Is. We're planting seeds. We're helping people access what's available in their community. And hopefully, some of those things are available to them, whether they're on supervision or in formal reentry or not, that these are resources they can go back to throughout their life if they start struggling.

But we're planting seeds and showing them, areas that they can get support and services from, whether they're on supervision or not. So that would be my comment on the SORNA question.

I did want to come back to the title of this and the purpose of this webinar and this Ask the Expert session and ask the panel, how and why is cultural competency and sensitivity important to you in the work that you do? Kevin Mariano, I know you're doing a lot of work with law enforcement and deflection. Kevin Poleyumptewa, I know you do a lot of work in fatherhood. Stefanie, Stefanie, you do a lot of work on the probation and diversion and pretrial work.

But how and why is cultural competency or sensitivity important in this process to you? Why have you decided to make sure it's included and maybe even a centerpiece of the work that you do and have that lens on, if you will? Kevin Poleyumptewa, how about starting with you?

Sure. Thanks, Greg. The reason that it is really important to me in the work that I've done is because primarily, because we as Native people, men specifically, but also, women in many of our native communities, we've lost that transition from childhood to adulthood, those coming of age ceremonies and traditional practices that were in place since time began. And those have been lost in a lot of our communities now.

So that in itself creates a difficulty for that transition of that individual from childhood into adulthood. Because a lot of those traditional teachings are not being passed along to them, the traditional responsibilities. And so as a service provider, it's important for me, going into any community, to really try to understand as much as I can about that particular community.

I understand and know a lot about my culture and growing up on the reservation and having those experiences. But as we all know, every single tribe is different. And so there are different practices. There are different things. They do things differently. But also, location has a lot to do with it as well.

So being able to be competent enough to be able to understand the needs of a certain community is very important. So you can't just go into any place and assume, like you said at the beginning of this webinar, there is no one fix for everything. Everything is different. And so to be able to create something that is going to be successful, you have to have some level of competency in regards to understanding that community and the people that live there.

Stefanie, you want to weigh in on this question?

I think Kevin hit the nail on the head. It is important to be able to understand the community that you work with. But also, you need to understand each family within a tribal community has their own cultural practices as well.

And so here, we believe that part of that trauma-informed approach is also having an understanding of the culture, and where the family comes from, and what their beliefs are, and meeting them there, having an elder part of your teams, relying on them to exchange information or provide you with information on an appropriate response, a culturally appropriate response, as far as sanctions or incentives go for individuals going through our system.

I also feel like it's important that if you have an elder that's willing to put in the information, we have a whole-- we had an elder create us a whole, in every season for the Southern Ute tribe, what was acceptable or appropriate and our staff reading it and understanding what goes on in each season to prepare.

I think it's really important what you said about educating staff and making sure you're staying connected with the community and being open to other communities. It's not that every community is the same, no matter where we are. Kevin Mariano, you want to weigh in on this question? You have some comments?

Sure, there, Greg. I'm going to kind of follow what you just mentioned, along with Stefanie there, with educating staff. I think it's really important for them to know the cultural side of it there, of why we do things, the way we do things. My background is law enforcement. I did that for 20-some years, so I mention that quickly.

Why I speak heavily on the law enforcement side, that's because I did law enforcement for many years and retired as the chief of police. And building that connection in with your own community, I had the opportunity to work in three communities, two of them being my communities. I say two of them just because I'm half Acoma and half Laguna. And I finish out in [INAUDIBLE].

And just being able to see and work with the community and see the issues that were happening at the boots on the ground level there and see the families of what they were going through and how some of them, wanted to learn the traditional cultural ways and figuring out, What can we do to assist individuals that were moving towards that side of it there to learn more about traditional settings and language and other areas and all that? in one way that we looked at it was building those partnerships with other programs that we could partner with.

And we were able to do that with reaching out to those folks from behavioral health services to the cultural committee to include tribal leadership, tribal council, the governors, and others, to let them know that this is what we're working towards. And I always told the officers that we want to work our way out of a job and to do the best we can to help out our community, to do the best we can to offer that assistance.

Because we knew that everyone didn't have to go off to jail, that they needed some guidance along the way that would put them back on that right path. And how we could do that was build these partnerships with the programs that we were working closely with and all that.

But it is important, as far as building that tradition, that culture, in with the work that we do as service providers and to find ways to incorporate that to put out there so they understand that there is some hope. There is some need. There is some guidance along the way there to make it effective for everyone and all that. So that's all I've got there. Greg, Thank you.

Thanks, Kevin. I think it's pretty close to wrapping up. I'm going to put one more, and if any of you guys have thoughts about this question, feel free. Just one more what to leave, what's been the biggest barrier you faced in integrating culture or helping people work towards mental wellness in the programming that you've done? Maybe it's staff training or anything. What's the biggest barrier? And how have you overcome that barrier, as an example for us as we leave today?

I would say for us, it's turnover. When we put those connections in place, and someone leaves their position, just trying to rebuild and reconnect those cultural pieces.

And how do you address that, Stefanie? I mean, what do you do, knowing that you're going to have turnover? It's part of the world that we live in. What do you do?

I just make sure that we reconnect. So some of us are lifers, and we will be in our position till-- that'll be the last one till we retire. But then there's those that this is a stepping stone. So it's really depending on those individuals and those community members that find it important work that we're doing that you re-engage.

So say someone at the Culture Center that we depend on changes positions. It's important for us to walk over, introduce ourselves, and share with them what we've been working with with the prior person, and where their stance is on it, and how they would like to continue to work with us to provide those services. Same with when we have a new elder sitting in on our Wellness Court, always being out there in the community, that's the most important thing when there's turnover.

If we're a part of the community here-- it's a checkerboard reservation. So it's a lot of us Native, non-Native, and just being a part of that community and making sure that we're always sharing what's going on within our community and keeping those connections.

Thank you, Stefanie. Kevin P?

Well, I think probably a barrier that we've encountered a couple times is trying to create that connection between the elders and the men and women that we were working with is the reluctancy of some of the elders to want to participate, to want to pass on that information. And I've mentioned this in some of the webinars that I've done in the SAT.

Some of these elders don't feel that the younger generation is worthy of the information and some of the traditional stuff. We've had men and women that have sought out certain elders to ask to learn from them some of the traditional practices. And then they've come back and told us exactly that, that they don't want to help, because they don't feel that I deserve that the information, based on who they are in the community, their reputation.

So in that, it's a great teaching moment for them, a great learning moment for them, to realize that, OK, well, maybe we need to change that reputation that we have. So how can we do that? And on the other side, we would always seek out other elders within the community.

Thankfully, we did have a few that were willing to participate and actually, really wanted to volunteer their time to be able to teach a lot of these wonderful things to our participants. So again, it just goes back to that tenacity and just continue moving forward. If this doesn't work, let's try something else. Where else do we go? And then just keep going and doing that.

Really good points, I hadn't even thought about that. But some reluctance to share our history and culture based on worthiness or the harm that the person has caused to the community, and how do you work through that barrier? So that's great. Kevin Mariano, I'm afraid I'm going to have to skip you. Otherwise, I'm going to break my rule of trying to end these webinars on time. So I apologize.

An extremely valuable resource is the COSSUP Resource Center. And a screenshot of the Resource Center and a web link are shown on your screen. We'll leave that up for a second so you all can see that. You all have this PowerPoint, as well, so you can get that information there.

Featured resources available include funding opportunities, COSSUP grantee site profiles with the data visualization tool, information about demonstration projects, peer-to-peer learning, and recordings of all previous COSSUP webinars covering a wide range of substance use disorder-related topics and strategies. The COSSUP TTA program offers a variety of learning opportunities and assistance to support tribal, local, and 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, whether you are a COSSUP grantee or not. So everyone is eligible to ask for services. TTA can be requested at the link shown on your screen. So join the COSSUP community by subscribing at the link shown on your screen. And again, you all do have this PowerPoint.

So I want to thank our entire panel for the great discussion today. Thank you, all, for your questions and contributions. We learn as much from you all-- and I've reached out to a couple of you to learn more about your programs-- as we think that we give. So thank you for that. We hope to see you again in future webinars. And have a great, great rest of your day. Thank you, all.