Transcript: Evidence Based Co-Occurring Disorders Treatment

Presenter: Mark Sanders
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JEN WINSLOW: Welcome, everyone. We're just going to let people get settled in and we'll start in just a moment.

Well, good morning, and welcome, everyone, to today's webinar, Evidence Based Co-Occurring Disorders Treatment, with our presenter, Mark Sanders. This training-- this webinar, I'm sorry-- is co-sponsored by the Great Lakes MHTTC and SAMHSA. The Great Lakes ATTC, MHTTC, and PTTC are funded by SAMHSA-- the following SAMHSA cooperative agreements.

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A few housekeeping items-- if you are having any technical issues, please individually message me, Jen Winslow, or Alyssa Chwala in the chat section at the bottom of your screen, and they will be happy to assist you. If you have questions for the speaker, please put them in the Q&A section at the bottom of your screen. That helps us keep questions organized so we can make sure Mark can get to them, because the chat can move kind of quickly.

We will be using live transcription during this presentation. At the end of the session, you will be automatically redirected to a very brief survey. Certificates of attendance will be sent out via email to all who attended the session in full, and it can take up to two weeks.

Our presenter today is Mark Sanders. Mark is the State Project Manager for the Great Lakes ATTC, MHTTC, and PTTC. Mark has worked for 40 years as a social worker, educator, and part of the SUD workforce.

He is founder of the Online Museum of African-American Addictions, Treatment, and Recovery, and Co-founder of Serenity Academy of Chicago,

the only recovery-oriented high school in Illinois. He's also an international speaker, trainer, and consultant in the behavioral health field, whose work has reached thousands throughout the United States, Europe, Canada, the Caribbean, and the British Islands.

Recently, Mark Sanders was named as the 2021 recipient of the NAADAC Enlightenment Award in recognition of his outstanding work and contributions to NAADAC, the field of SUD Services and Study Professionals. He's also the recipient of the Illinois Association for Behavioral Health's 2021 Lawrence Goodman Friend of the Field Award in honor of the many years of dedicated service Mark has provided to communities throughout his home state of Illinois.

Thanks, everyone. And, Mark, I'll turn it over to you.

MARK SANDERS: Thank you, Jen. Thank you, Alyssa. And thank you, Rebecca. And good morning, everyone.

Would you repeat this long sentence to yourself? The flap of a butterfly's wings in Brazil can cause an earthquake in Texas. Would you repeat that to yourself? It's a scientific fact that long sentences have a way of waking everyone up.

So as Jen mentioned, I'm in my 40th year as a Certified Alcohol and Drug Abuse Counselor-- 40 years. That even sounds like a long time to me. And people ask me how have I done this work for 40 years?

The answer is recovery. So I'd like to share with you two stories. I always like to share two stories because even a story needs a friend. I'll find out who's with us today, and then we will start to go through our PowerPoint slides.

The first story happened in March of 1986. I was sitting in my office downtown Chicago. The phone rang, a man called me collect. He was in tears, he was crying.

He said, I need to see a counselor today. I looked in the appointment book and I said, I can see you in one hour. He said, it will take eight hours.

My office was located downtown Chicago on Jackson and State Street. He lived on 103rd Street South. He walked 103 blocks to meet with me.

Was he motivated? He had gotten paid that Friday and spent his whole paycheck on drugs. So he called me collect 9:00 on a Monday morning. He showed up exhausted.

I did the assessment, the intake, and I said, are you ready to get help for drugs? I'm ready to get help for drugs. I said, if you leave my office and go and stand on the corner of Jackson and State Street, a bus will appear.

Take the bus to the end of the line. At the end of the line, there's a drug treatment center. He said, I don't have bus fare.

So I talk to my supervisor and we decided we would pay his bus fare. I left my desk. I went downstairs and waited for the bus with him. I paid his bus fare and I whispered, end of the line, there's a drug treatment center.

He came back a year to the day that I gave him that bus fare-- on the anniversary, the one year anniversary when I gave him the bus fair, and he gave it back. And he said he was grateful for his recovery. What I've learned in my 40 years is that when you help someone with their recovery, eventually, they become grateful. Gratitude kicks in.

Once they become grateful, they start helping people. Then the people they've helped out of gratitude start helping people. The ones they've helped out of gratitude start helping people.

It basically means that your work, your great work, never ends. It really is true that the flap of a butterfly's wings in Brazil can cause an earthquake in Texas. Every little bit you do to help is magnified.

The second story happened just a few years ago. I was leading a therapy group with these seven teenage girls. And between these 7 teenage girls, they had a grand total of seven days of recovery.

In other words, the only recovery they had was that day. And I heard in a residential facility where they were receiving services there was a 19-year-old emerging adult woman walking around the same building with three years of recovery. They had seven days. She had three years.

So I was thinking what you're thinking right now. We need her in this group so that her recovery could rub off on them. Did you know that recovery is contagious, that sometimes all you have to do is put a client near recovery and they can catch it?

I called her therapist, can she join our group? She said, no, she's doing fine all by herself. She has three years of recovery.

I called a second time, can she joined the group? No, she's doing fine all by herself. I called a third time. Maybe there's something magical about three.

The therapist says, OK, she can join the group. Turns out, she wasn't doing fine. She attended her first group and said, I was going to get high today. She was going to get high that day. Our timing was impeccable.

The second group she attended, she says, Mark, I want to be a social worker. I want to help girls. And I said, you can be a social worker, you can help girls.

She came back the following week, and she said, when you said I could be a social worker last week, I cried all week. I had four therapists before. I told them all I wanted to be a social worker, not one said you could be the social worker. You were the only ones that I can deal with.

And I told her, my friend, there's only two things that qualify a person to do the work that you do. You're either an expert, meaning you went to school to study it, or you're a witness [INAUDIBLE]. She was a witness.

She witnessed domestic violence. Her father would abuse her mother in front of her. And she was also abused by an uncle. She was a witness. She lived it.

After I said you can be a social worker, she was in community college majoring in general studies. She declared her major social work. She received an associate's degree in social work.

She went to a university and she received a bachelor's degree in social work. It was March of 2018. She called me and said, I'm in the lobby. Would you come to the agency's lobby? I have a surprise for you.

When I arrived in the lobby, she was wearing a sweatshirt from one of the most prestigious universities in the world. She showed me a letter where that

university honored her with $50,000 in scholarship money towards her Master's Degree in social work.

It was June 15, 2019, we attended her graduation ceremony and I saw her walk across the stage where she received her Master's Degree in social work. It's been those kind of experiences of recovery that have kept me going for four decades. So the year that I reached year 10 as an addictions professional, I shifted to mental health.

I left the addictions profession and I went to work in mental health. What I quickly discovered, as you know, that over half of the clients that we work with that have severe mental illness, also had a concurrent substance use disorders-- substance use disorder. So my background is that I developed in that program the first comprehensive Co-Occurring Disorders Program in the State of Illinois.

And for the last 30 years, I've been a consultant on helping programs develop comprehensive Co-Occurring Disorders Program. That's my background that has prepared me for this presentation. I'd like to meet you.

Can you find your chat feature and just let us know what you do? Because if I understand your work, then I can tailor this to your unique needs. So what do you do?

And Alyssa and Jen will let us know what you put in chat. What's your occupation? Who's your clientele?

ALYSSA CHWALA: We have a substance abuse counselor, a dental hygienist at a psychiatric hospital, social work nursing home and skilled rehab, a peer specialist, a job developer with MI.

MARK SANDERS: Yeah. So it sounds like we have that nice range-- very good. Our title today is Evidence Based Co-occurring Disorders Treatment.

All right. So by definition, a Co-occurring Disorder is two coexisting disorders, independent of each other, but yet interacting with each other. Each is characterized by denial or ambivalence and is treatable. When mental illness and substance use disorders coexist, both should be considered primary, and treatment for both disorders is needed.

So here's your question. When you are working with a client that has co-occurring disorders, that is, mental illness and a substance use disorder, where do you begin? Do you begin with the treatment of the mental illness or the substance use disorder? You can weigh in in chat. Where do you begin? Any responses so far or are they thinking?

ALYSSA CHWALA: Yep, we have-- someone put both/and, another person put whichever has more severe symptoms, but both.

MARK SANDERS: OK. Yeah, those are really great answers. My answer to that question is you start the only place where you can start, and that's where the client lets you. So my experience has been if you start where they let you, then you're more likely to have rapport.

Now, I would ask you to which came first? People have debated that forever. But here's what I think in 2022.

You see, if I were to respond to that question in like, I don't know, 1989, I would have said the addiction came first. And the reason I would say that is because the people who taught me how to be a counselor in the '80s, that's what they told me. But now, I've been at this for 40 years and here's what I think.

I think most of the time, the mental illness comes first, and the symptoms can be seen in childhood and adolescence. But because of the stigma of mental illness, the research says that when someone has a mental illness, there's often a 5 to 15 year gap between when symptoms first appear and when the family reaches out for help. A 10 to 15 year gap between when the symptoms first appear and when the family reaches out for help, because of the stigma of mental illness.

So some individuals start medicating psychiatric symptoms at an early age with the use of alcohol and illicit drugs. Another reason why it's hard to see the psychiatric symptom is because often the symptoms are subtle in the beginning, right? Teachers don't recognize it. Parents may not recognize it.

OK. Let's go back up to the top of the definition. Two coexisting disorders, independent of each other, but yet interacting with each other. So here's the question and let us chat.

When a person has a co-occurring disorder, that is, severe mental illness, and a substance use disorder, how do the two interact with each other? How do they interact with each other? Is there a response there, Alyssa?

ALYSSA CHWALA: Yep, we got a self-medicating, make each more troublesome, poor treatment response.

MARK SANDERS: Yes. And they're absolutely right. I'd like to add to the list.

OK. How they interact with each other. Marijuana has been used to medicate psychotic symptoms. Out of Europe, they've done some studies where they have extrapolated CBD. CBD being a cannabinoid found in marijuana, from marijuana, right?

And what they found in medicinal form, that CBD often does a better job in psychiatric medication in reducing psychotic symptoms without the side effects of psychiatric medication. You see, I work with some young fellows who sell drugs, and they smoke marijuana every day. And they swear to me that marijuana calms them down. And I believe it. It has CBD. And at the same time, I talk to them about the fact that it has THC, which can lead to addiction.

Alcohol used to medicate the grief caused by mental illness. Years ago when I was working in mental health in a shelter program, we had 25 clients with mental illness. And every night, this one client-- they called her the cheerleader-- she would wake up at 3:00 in the morning, she would put on a cheerleading outfit, pick up some pom poms, and she would start to cheer at 3:00 every morning.

She would wake up the other 24 clients that were asleep, and she would also wake up the counselors that were asleep on the midnight shift. They always sleep, no matter what they say, on the midnight shift. Then the counselor would go into her room, the cheerleader would start to cry, and then the counselor would call her psychiatrist, and the psychiatrist would say, let's increase your medication. This went on every night.

So one day I had a conversation with the cheerleader, and she shared with me her story. When she was a senior in high school, she was the valedictorian of her graduating class. She was number one out of 1,000 students. And she was also captain of the cheerleading team.

So she went from a Chicago Public School to UCLA in California on an academic and cheerleading scholarship. She was a star. At age 19, she started hearing voices and schizophrenia set in.

She went from UCLA to a shelter. And most of the other individuals in the shelter had been homeless before. I figured it out.

When a cheerleader would pick up the cheer of the pom poms and put on a cheerleading outfit at 3:00 in the morning, and then she would start to cry, she was grieving. She was grieving the life that she had before schizophrenia set in. She was grieving.

And I also figured this out. They would always say increase her medication. There's not a pill in the world that can treat grief. She was grieving. Some people grieve losses connected to mental illness with the use of alcohol and other illicit drugs.

Drugs used to avoid the side effects of psychiatric medication. So we work with a client, and they told us that before bipolar disorder set in, she was on par to be a supermodel. And she didn't like her medication for bipolar disorder, she said, because it made her thirsty and she would drink a lot of liquid, and she started gaining weight.

And then she started gaining weight, she said, I can't be a supermodel, right? She said-- and then she said, the side effect of the medication, it made her walk stiff, right? So supermodels can't walk like that, so she gave up the psychiatric medication and she turned to alcohol and cocaine. After all, she said, cocaine helps me control my weight.

Alcohol minimizing the effectiveness of meds, increasing the risk of overdose. So the organ in the body that breaks down, that metabolizes food and pills is the liver. Given the choice between breaking down the alcohol or metabolizing the pill, the liver will always choose the alcohol first because it's a liquid.

So while the liver is breaking down alcohol, the medication might be piling up in the body at toxic levels, leading the person vulnerable to overdose. Drugs use can exacerbate psychiatric symptoms. It's real simple.

If you are working with a client that has depression and they take a central nervous system depressant, like Valium, anti-anxiety agent, alcohol, they can become more depressed. If they're anxious and they take anti-anxiety drugs,

the withdrawal from those drugs can make them more anxious, right? People using stimulants, like crack cocaine, right, methamphetamines, that they're already paranoid, these drugs can contribute to pure paranoia.

Alcohol and drug use, making it difficult to follow mental health and co-occurring disorders treatment regimens. So we're going to begin with the discussion of evidence-based engagement strategies, right? And in the midst of this, I'm going to share with you just a few best practices I've learned on my own.

So in this section on engagement, we'll talk about evidence-based and best practices to engage and retain clients with co-occurring disorders in the helping relationship. So I read a book called The Heroic Client, and it changed my clinical practice. And the authors of the book shared some research that indicated that clients make most of their progress within the first six sessions of counseling.

Some of you are listening to us today, and you're saying to yourself, hum, my clients stay with me for two or three years. What do you mean six sessions? What it basically means according to the authors of the book, if your clients are staying with you for two or three years, it means that you convinced them within the first six sessions of counseling that you're really good at what you do. So they stay with you because the relationship is significant to them.

Dr. Pat Love says that we all need three to five people in our life to have a sense of community. So now, the client who's been meeting you for three years, she says to herself, I get my hair done on Saturday, I go to church on Sunday, and I see my therapist on Monday. Once I looked at the research that said that clients make most of their progress within the first six session of therapy, it changed my practice.

Let me ask you a question. What's the reason that counseling is every week? Why do we tend to do weekly counseling?

I know for the past 40 years, I've been encouraged to do counseling sessions every week. Why is that?

ALYSSA CHWALA: Someone put in there to strengthen the treatment relationship and build consistency.

MARK SANDERS: OK. And we wish that they had given more thought to that. Any other responses there, Alyssa?

ALYSSA CHWALA: Someone has tradition.

MARK SANDERS: All right. Well, let me tell you this-- thank you, Alyssa. Whoever said tradition is absolutely right. The reason that counseling is every week is because it's always been every week.

Sigmund Freud saw his clients every week. If they had the right kind of money, he would see them three times a week. So once I looked at the fact that clients make most of their progress within six sessions, I started wondering what would happen then if we spread these sessions out when clients are not in the crisis?

So I work with emerging adults 18 to 25-year-olds with co-occurring disorders. Most of them have traumatic stress disorders, and some kind of heavy drug use. And they would come in-- you know 18-year-olds-- I'd have some come in, the minute they walked in the office, when is this over? It hasn't even started yet, right?

And so counseling is boring, they would say. So what I discovered is that if I spread out the sessions instead of meeting with them every week, I would contract with them to meet every other week, right? Suddenly, they would come in and say, counseling is no longer boring.

Let me tell you why. What I've learned clinically is things don't always change in seven days. But everything changes in 14 days. I see them every 14 days, everything will change.

I remember once working with a woman who couldn't decide what to do about her marriage. We met two weeks later and she says, I've already filed for divorce. She figured it out without me.

In other words, what I've discovered in meeting with clients every other week who are not in a psychiatric crisis, what I discovered is that they can be the solution to their own problems. So I learned to ask clients in between sessions, what has changed since the last time we met, right?

Every other week-- now, there's a little bit more science. I will then contract with clients that we would ask them, what will you do the week that you don't meet with me? We would contract things like they would go to like NA meetings the week they didn't meet with me, or AA meetings, or they would go to a therapy group, or they'd have a meeting with their co-occurring disorders case manager, or their recovery coach, right?

So they were meeting with me, and then they were getting some self-help in there, right? And here's the science. SAMHSA has shared some research on what's called an effective therapeutic dosage of recovery support.

That is, the number of consecutive days of recovery support that a person needs to be launched on the path of recovery. What the research says is that most people seeking recovery need 90 days of consecutive recovery support to be launched on the pathway of recovery-- 90 days. That's three months.

Here's what I figured out. If I met with a client once a week for six weeks, that's 45 days of recovery support. But if I met with them every other week, right, that will be 90 days of recovery support. They were actually getting longer recovery support from me by meeting with me every other week.

Here's the second question. What's the reason that counseling is an hour? Historically, counseling has always been an hour. What's the reason?

I shall respond to my own question. Counseling has historically been an hour because it's always been an hour. I imagine that when the many of you went to school to learn how to be a counselor or helping professional, they told you that counseling sessions were an hour. There's nothing magical about an hour.

So I did what my professors told me to do for three decades. Then I started thinking for myself. You ever work with a client who has so much agitation or anxiety-- that's the mental health side of the co-occurring disorder-- that an hour feels like a year?

They get up and they start pacing the floor. So I decided that if I want you to come back to a second session, and a third session, and a fourth session, right, ideally, I'd figure out at what point can you not do any more counseling? So I started ending sessions when clients were at a peak, right?

Here's what I discovered. Most adolescent and young adult males that I've worked with, they reach a peak of counseling after 30 minutes, about 30 minutes of counseling, then they become antsy and when is this over. So I would contract with so many young men for 30 minutes a session.

The teenage girls and young adult women were good for 45 minutes to an hour. I usually always meet with adults for an hour. My preference is to meet with married couples, couples for 90 minutes. Here's why.

What I discovered about couples, they like to argue in therapy for about an hour, right? What if we ended at that hour point? It would end like bad.

So they like to argue for about an hour. And at the end of the hour, they're tired. Now, I have 30 more minutes to help them change.

I met with a young man 22 minutes once a month for five years-- 22 minutes once a month for five years. After he graduated from high school, he smoked some marijuana and started hearing voices and seeing things that were not there, right? He was on a college scholarship.

These voices were so strong he dropped out of college, right? I can tell in our first session that he felt a little antsy, so I said, well, what time frame would work with you? We agreed upon 22 minutes, right?

Now, within that five year period in the first year, he tried to smoke marijuana again, and both times, he wound up in the hospital in a psychiatric facility, right? Then he decided marijuana can't work with me. 22 minutes once a month for five years-- this wasn't therapy. These were checkups, right?

Within that five year period, he put together 4 and 1/2 years of recovery, right? He graduated-- went back to college and graduated with his bachelor's degree, was gainfully employed, a really good job, and engaged to be married-- whole life transformed. So during our findings at the final session, I asked him, what would have happened if we would have met once a week?

He says, I probably would for an hour. He said, I probably would have worked with you for about two months. Because before you and I were together, I never stayed in counseling more than a couple of months, right?

A man called me and asked me if I can meet with his wife and his mother. They didn't get along. And it was like December 23, a holiday was two days away. I had no other appointments in my schedule that day, so I did an experiment, right?

So the wife lived in Florida, and the mother lived in California, and they were visiting in Chicago. So I met with them. Don't throw anything at me, this worked. For five hours, there was nothing else in my script-- five hours.

The first hour, they were yelling and screaming at each other, the mother and the daughter-in-law. The second hour, they were yelling and screaming at each other. The third hour they stood up like they were ready to fight, the mother and the wife.

The fourth hour, they were crying. 4 and 1/2, they got up and they hugged each other, right? They spent the rest of that time talking about how they were going to work together as mother and-- as grandmother and spouse to help their family become stronger, right?

That was 15 years ago. If I would have met with them and ended the first hour, things would have gotten worse. Second hour, worse-- third hour, worse. We stayed with the process. That was one of those rare occasions. I had nothing else scheduled that day.

I've received either a Christmas card from the mother-in-law, or the daughter-in-law every year for 15 years. If we want clients to stay engaged more than two sessions, right, then we have to figure out how much therapy, how much counseling, they can handle.

I work with a group of youths who were heavy marijuana smokers. And nowadays, marijuana is laced with everything, and they had psychosis, right? What we did is-- sitting still was too agitating for them.

We took a walk every-- five days a week for 10 minutes each time, right? And we did counseling standing up for 10 minutes, right? How much counseling can be planned?

The research says, the majority of clients do not reach session six. 50% of adults and 60% of adolescents will miss their second outpatient session. So let's talk about the reasons clients with co-occurring disorders resist mental health counseling.

Number one, the stigma of mental illness. Number two, misdiagnosis, overdiagnosis, and treating clients as if they are their diagnosis. Are you sitting down?

Let me share this with you. Research says that people who make diagnosis-- psychologists, psychiatrists, licensed clinical social workers, licensed clinical counselors-- only agree upon diagnosis 30% of the time. Let me repeat that.

The research says that people who make diagnoses only agree upon diagnosis 30% of the time. You see, if your nephew broke his wrist and 100 doctors looked at that X-ray, 100 doctors would agree that's a broken wrist. But when it comes to mental illness, they only agree 30% of the time. Meaning, there's lots of misdiagnosis, and there's a lot of people with severe mental illness, right, who have been prescribed medications for conditions they don't even have, right?

My mentor said, when he had cancer, he said that addiction, mental health, and co-occurring disorders treatment programs can learn a lot from cancer doctors about how to deal with diagnosis. He said, when he was diagnosed with cancer, the first thing the doctor said was-- requested was to go get a second opinion, go get a third opinion. When was the last time someone diagnosed a client with a mental illness and asked them to get a second opinion, or a third opinion? All this misdiagnosis, right?

A psychologist-- one day I was talking about this in a seminar. A psychologist told me, I understand exactly what you're saying about misdiagnosis. He said, there was a kindergarten girl that the school was concerned about, because when it was time to color with crayons, she colored everything in black-- a snowman in black, snow in black, water in black, the sun in black. Everything she colored black.

So they asked a psychologist to do an observation. They had some clinical impressions. What do you think that they felt the school thought was wrong so that this girl was coloring everything in black? What'd they think was wrong?

You can put that response in chat. I'm curious what you think the reason they thought she colored everything in black.

ALYSSA CHWALA: Depression, abuse, depressed.

MARK SANDERS: Yeah. So we have quick impression of depression, right? Here's what he told me, the psychologist. He said, Mark, I showed up to make observations in the classroom. It turns out they thought that she had been traumatized, or that she was depressed, right?

It turns out she was a well-mannered child. He said, every morning at 10:00 AM, the teacher would say, it's time to color, and all the kids would run to the table and grab the coloring books and the crayons. He said, Mark, she was so well-mannered, she would wait until all her classmates got the coloring books and crayons.

He said, and every day by the time she got to the table, there was one color crayon left, the black crayon. Nothing was wrong. She didn't have a psychiatric disorder.

The second story is a little closer to home. How many of you by a show of hands have kids? You know how our kids are always saying to their parents, I'm smarter than you? Kids are always saying to their parents, I'm smarter than you.

I have a child who's smarter than me. And I knew that he was smarter than me when he was three years old. You see, I give speeches on the road.

First off, he was reading when he was three years old. I knew he was smarter than me. And when I really became aware, extra aware that he was smarter than me, was one day when he was like 3 and 1/2 years old, he said, dad, I don't like your work because you're always out of town.

He knew that I traveled to give speeches. He said, when you come home from the road, every time you come home, I want you to tell me your every thought while you're on the road. I want to know your every thought while you're on the road.

I said, son, not every thought. I have the biggest number of thoughts in the history of the thoughts. I have millions of thoughts when I'm on the road.

He said, dad, million, he said, that's not the biggest number. I said, well, what's the biggest number? He said, a Google.

I said, what? He said, a Google. I said, what's a Google?

He said, it's a one with 100 zeros behind it. I said, did they name that company after that number? He said, yes. I knew he was smarter than me.

So at preschool, he would go to class and the other students in his class were saying their alphabet-- A, B, C, D. They were saying their alphabet. My son, at three years old, knew he wanted to be a physicist. Not a scientist-- more specific than that-- a physicist.

So while they were saying their alphabets, he would sit in the corner-- or near the window, I'm sorry-- near the window and he would read books, and sometimes he would stare out the window. And he didn't interact much with his classmates. So the staff in the preschool were leaning toward some psychiatric diagnosis.

What diagnosis do you think they were leaning towards for my son? Would you put that in the chat?

ALYSSA CHWALA: A couple of people guessing autism, ADHD, autism.

MARK SANDERS: So we got two diagnoses happening like this, right? Someone said that we should start calling the DSM 5, right, a book on how to do diagnosis, right? Because in order to be reimbursed by insurances, we often make these quick diagnosis.

Yeah, they said he's autistic. He's not interacting with his peers is what they said. My wife being a social worker like me, she said, let's go get a second opinion. And she had our son meet with a therapist that specializes in working with children who are gifted.

My wife thought our son was gifted, right? So they ran a battery of tests and found out that my son was gifted, right, intellectually gifted, right? And then the therapist asked him, when you're looking out of the window, what are you thinking about?

You know how Albert Einstein said that an ounce of creativity is more important than a pound of intelligence? What my son was doing was he's creating a nine story science museum in his head. We had gone to my grandmother's neighborhood, and there's lots of poverty in my grandmother's neighborhood.

My son was like, if these kids were into STEM, right, then they would like do really well in school and have really good paying jobs. And so he was so young, right, but he-- so he was building a science museum in his head. And here's what the therapist said.

He said, the problem is not that your son can't bond with a peer group. He doesn't have a peer group. He's reading volumes of books. They're learning the alphabet. They're not his peers.

They happen to be the same age. It wasn't until he went to high school that he found his peer group, right? It was at that point. Overdiagnosis, right? So I met with a 16-year-old girl-- I may say something about her later-- and she had been receiving counseling since she was six years old, right?

She had 16 different diagnoses, right, in a 10 year window. And sometimes she was carrying like more than one diagnosis at once, right, over diagnosing. And treating clients as if they are their diagnosis. Was there anyone that you looked up to when you were in high school?

When we were in high school, me and my friends, there was a man that was two years older than us. He was a senior when we were sophomores. He was our hero. We looked up to him, right?

He was an all city baseball, basketball, and football player. He was a top 10 athlete in the City of Chicago in three sports. Not only was he a great athlete, he dated the prettiest girl in the world.

And more important than that, he had a perfectly round Afro, the Holy Grail of a hairdo, and it was beige. I don't think you all understand what I'm saying. His Afro, his beige Afro, would blow in the wind when he dribbled the basketball. One of my friends said that he believed that God gave it all to our hero and cheated all the rest of us males in the community.

Anyway, our hero tore his ACL when he was in high school, and he lost his scholarship, didn't get his scholarship to play basketball in college. Back then, a knee injury was a knee injury. Now, they can repair them in outpatient surgery. He messed up his knee.

He didn't go to college. He became extremely depressed. He started drinking alcohol heavily, right, started using cocaine and heroin.

And at least seven times a year, I drive down the old block just to speak to him, because he was our hero. And if you saw him, you would know he was depressed. You'd look at his clothes, you'd say, oh, he's homeless.

And then there's the alcohol, the crack cocaine, the heroin. And every time I drive down the street to pay homage to him, he says to me, hey, cousin, it's my birthday. Can you give me a few dollars? Nobody has seven birthdays a year.

So the last time I drove down the block, I stopped to see him, our hero. He said, hey, cousin-- I didn't let him finish the sentence this time. I said to him, me, Tony, and Daryl, when we see each other, we talk about you. And you were our hero then, and you still are.

So I could visualize this guy going through intake, and addictions, and mental health for co-occurring disorders facility, and people looking at him, and that he has a look that he's homeless and very little education and not much of a work history, right, and just concluding, ah, he's depressed. He-- he has alcoholism. But he's more than his addiction.

He's a hero. And I always try to tell our clients that you're more than what you do. You're more than your diagnosis.

Another reason that individuals resist mental health counseling is that counseling is often not their idea. Many view counseling as strange. You ever think about how strange counseling is? I've been a counselor for 40 years. Counseling is strange.

You get to ask people everything that you need to know about them, but they can't ask us a whole lot of questions. Sometimes their paperwork precedes them. We know all of this stuff about them. They know nothing about us.

Matter of fact, someone told me the only relationship that's stranger than the counselor, client relationship is the doctor, patient relationship. You know how you get that new doctor, they walk in the room, take your clothes off and start touching you, right, with no relationship? And then this big bill shows up. There are no prices on the wall like an expensive restaurant.

Yeah, counseling is different than any other relationship. Some clients might view it as strange, so they resist counseling. Oh, they were harmed in previous counseling or it was unhelpful.

Did you know that the research is that 10% of the clients that you work with-- that 10% of the clients that you work with get worse as a result of your working with them-- 10%. I know it's true for me. Here's how I know it.

Because approximately 10% of clients who I've worked with in outpatient settings need inpatient treatment while working with me in outpatient. They've had too many previous counselors. Do you ever think about that fact?

I was working in a program that was considered a trauma-informed system of care. And one client said to me, why should I talk to you? I've had four therapists this year. They all quit, too many [INAUDIBLE]. I don't want to start this again. You may not be here next month, and I'll give you my whole life story.

They believe counseling will be a waste of time. They may view the presenting problem as a solution to their problem. So some of our clients who have mental illness, they view their substance use as a solution to their problems.

It's natural for clients to resist any effort to get them to stop using drugs because drugs work. I'm the anti-dare. I now believe drugs work. They numb emotional pain, and they simmer rage.

Yeah, the first impact that drugs have is they numb you and they simmer rage. I work with young male clients who suffer from what I call father hunger. What I mean by father hunger is when the boy grew up and he didn't get enough fathering, right?

There's an incredible story about this boy who played Park District football. He was a fifth string running back on the football team. What are the chances that he'll ever get in a football game as a fifth string running back on the team?

I'll answer my own question. If you're a fifth string running back on the football team, you would have an easier time finding a penny in the Sahara desert than ever getting in a football game. If you're a fifth string running back on the football team, you'd be more likely to be struck by lightning five times in the

same day and live. Your whole job as a fifth string running back is to watch grass grow on the football field.

The boy's father died, and they held the funeral on a Friday. And he walked in the locker room the following Saturday morning, said, coach, I want to play the whole game. And the coach did what you'd have done, let him play the whole game. And the boy scored five touchdown.

The great Walter Payton never scored five touchdowns in the football game. Coach said, what got you? You're a fifth string running back. He said, coach, when my dad was alive, he was legally blind. I figure that since he died and went to heaven, he could see me. He said, I want him to be proud of me.

You know Howard Stern? He's in the Rock and Roll Hall of Fame as a radio personality. So I'm considering him to be the best because he can go on radio for hours without playing one song and keep his audience captivated.

So he was being interviewed by David Letterman, and he pretty much told David Letterman that he suffered from father hunger. He always wanted his father's attention.

And he said, when he was a boy growing up, he would sit next to his father and try to get his attention, but his father was always listening to the radio. And as a little boy, Howard Stern said, if I could just get inside of that radio, if I can get inside of that radio, I would have my father's attention, right? Then if I was really good on the radio, I'd really have his attention.

I read a story yesterday about a little boy who said to his busy father, he said, dad, how much do you make an hour? And the father says, I make $100 an hour, son. And the son said, dad, will you lend me $50?

His father lent the son $50. The son went underneath his pillow and he pulled out another $50. He said, dad, here's $100. I want to buy an hour of your time.

So these young men suffer from father hunger, and you'd meet them between the ages of 5 to 10 years old. Mr. Sanders, can you find my father? Please find him, please find him, please.

Age 11, have you found my father yet, please? Age 12, I think about him sometimes. Age 13, I never think about him. Age 14, I wish he were dead.

Lots of these young men are doing is medicating their rage at their father with the use of drugs at an early age. Drugs work because they can often medicate psychiatric symptoms. They provide relief for moral injury. You know about moral injury.

I first became aware of moral injury working with soldiers coming home from battle. And they would suffer from moral injury because sometimes they did heinous things in battle that they would not have done had they were not in battle. And so, of course, the treatment is like-- for moral injury with military veterans is confession with clergy of their denomination.

Then I realized, lots of clients I work with who had a co-occurring disorders suffer from moral injury, like the ones when they were actively psychotic took off all their clothes and ran down the street. When they stabilized, they begin to feel a lot of moral shame connected to that.

I worked with a young man 11 years old. He started serving. Some of you are thinking, what restaurant?

He started serving cocaine, selling cocaine. His mother [INAUDIBLE] a felony. She had a hard time getting a job, so he would sell cocaine. And-- but he had a moral dilemma.

There were two women on his caseload-- two women that he sold cocaine to that were pregnant. And there was a third woman that he sold cocaine to was his best friend's grandmother. So he felt this moral dilemma.

So he smoked marijuana every day to deal with that. Just when you feel like you've heard it all, there was a woman who said to me, I'm so happy that I don't get high anymore, because now, I don't have to sleep with any more pit bulls. The drug dealer would give her money on credit if she would sleep with his dog-- have sex with his dog first.

But here's what turned out OK. She went to a women's group and she shared her story. And other women shared similar stories, right? And group therapy helps with moral injury, right?

But people will medicate moral injury with the use of alcohol and the drugs. They provide constant companionship. They are predictable. You know exactly how they'll make you feel. And they provide relief from trauma and abandonment, which I believe is at the core of addiction.

So then how do we engage? The research says that if you possess these naturally therapeutic qualities, that you will do a better job of engaging clients in a helping relationship compared with others who do the same work. As a matter of fact, psychologist Scott Miller called client engagement the number one evidence-based practice.

In other words, you can do 10 years of training on CBT or EMDR, and if you can't keep clients engaged beyond three sessions, it doesn't matter what you know. Jacquelyn Small wrote the book called, Becoming Naturally Therapeutic. And she said that children are born naturally therapeutic.

You ever seen like what small-- what happens when people-- when adults who say they don't smile, when they see a kid, suddenly, you realize that he can smile, she could smile. When my godmother was in the fourth stage of lung cancer, her number one wish was to see my son. He was three years old at the time. She said, he's like medicine.

Jacquelyn Small said that children are naturally therapeutic. They're born empathetic. What do small children do when they're on the playground and they see other children crying? They console them. Mom, is he OK? Dad, is he OK-- like little social workers.

Children are more naturally empathetic and warmth. And by the way, warmth is of the heart. Part of a story I saw on ESPN, 30 for 30, about a boxer from Humboldt Park on the Northwest side of Chicago who was undefeated. He was going to be the next great fighter.

In this short film, took a turn for the worse. He was killed by an intoxicated motorist. The good news, this great future fighter was an organ donor. So the short film was about his mother meeting the people that received his organs.

A man walked into the room that received one of her son's kidneys, the mother partly-- politely smiled and shook his hand. A woman walked in that room who received her son's other kidney. The mother politely smiled and shook her hand. A man walked in that room that received her son's lungs. The mother politely smiled and shook his hand.

And then the woman walked in a room that received her son's heart. With tears in her eyes, the mother lost and she ran over and asked this woman, can I give you a hug? Can I put my head against your chest? Because she wanted to hear her son's heartbeat one more time.

Research by Jacquelyn Small says that when counselors are empathetic and warm and want is really exuded through a loving and caring heart and genuine, that we will engage clients more effective than others. University of Rhode Island had a PhD in clinical psychology, and they measured students the day they entered the program for the PhD on a nationally therapeutic qualities scale.

How naturally empathetic were they? How warm were they? How genuine were they? How kind were they?

And what they discovered on a five point scale is those students that scored on the lower end in terms of empathy, warmth, genuineness, and kindness, a one or a two, the low end of the scale, by the time they finished their five years of study, they were less therapeutic than when they started. In other words, they were so deficient in things like compassion and empathy, their book knowledge made them even less effective.

But those who scored 3 or higher in empathy and warmth and realness, 3 or higher, they were more therapeutic than when they began. Techniques alone have no therapeutic value. According to the research of Dr. Stephen Bacon, techniques are only valuable if the client finds them credible, and you have a good relationship with them.

In other words, again, you can become a master at EMDR, and if the client doesn't trust you, right, they might not be able to do it. Or maybe you're a hypnotherapist and they don't trust you, you'll be struggling to hypnotize them. Psychotherapy is a process driven by expectations and suggestions.

Charisma and believability is what makes some therapists much more effective than others in engaging clients and facilitating change. Let us go backwards. These five qualities-- empathy, warmth and genuineness, charisma and believability.

If you have a pen, work along with me. I'd like to take a moment to define charisma. There are five things that Dr. Bacon consider charisma, if you jot these down.

Number one, empathy is charisma. And number two, a sense of humor is charisma. You might have clients with co-occurring disorders that are resistant to the ultimate relationship. If you can get them to laugh, it's like what Maya Angelou told Oprah Winfrey, the shortest distance between two people is a good laugh.

Empathy is charisma. A sense of humor is charisma. Energy is charisma. Genuine enthusiasm is charisma-- empathy, genuine enthusiasm.

And Number 5 is a deeply held belief in the capacity for clients to change and grow-- a deeply held belief in the capacity of clients to change and grow-- and believability. So early on, I share with you that story of my client who went and got the MSW and we went to her graduation ceremony. She asked me, how did I know-- how did you know I can do it, and why did you believe-- why did I believe you?

So let me tell you how I knew she could do it. What I'm about to share with you is true for many of you. It's because I'm a trauma survivor, and I knew how much I've overcome, how resilient I am having survived trauma myself.

So having survived so much trauma makes me believe in what human beings are capable of doing. Of course, you can do that. If I overcame all of that, you can do that, you can get that MSW.

Number two, I believe she believed me. It's because of the conviction in my voice. And I said, you can do that.

OK. So how do you know when you and a client are in rapport? They'll have more comfortable body language, more relaxed breathing, unforced laughter. They will volunteer information that you did not ask them about.

You know how you know when you and a client are in rapport? They'll give people in their life real names. So early on when they don't trust you, they say my brother might, they say my brother, my sister, my girlfriend. But now if they trust you, my brother-- my sister Sheila, and my girlfriend Marilyn. When they give people real names, you're in rapport, slightly more eye contact.

And when they're comfortable enough with you to correct your understanding of their content, no, that's not what I meant, this is what I meant, then you're in rapport. So the research says that clients make most of their progress within the first six sessions of therapy. Again, how do you help someone recover

from a co-occurring disorder if you can't keep them engaged beyond two sessions?

The National average is that 50% will miss their second session. I started asking my clients who didn't want to be there, would you be willing to meet with me for three sessions? And, usually, I would work with like 20 clients at a time. I asked the question for five years.

Here's a question-- and, Stephanie, yes, you have your hand raised? Yes. Is there a question for Stephanie?

JEN WINSLOW: Stephanie, can you-- if you have a question, can you put the question in the Q&A section? Or maybe-- sometimes people accidentally press the hand.

MARK SANDERS: OK. So then what I'll do is I'll finish the statement and I'll see if Stephanie has something that's in Q&A.

All right. So I started asking my clients for the last five years, would you be willing to meet with me for at least three sessions, out of curiosity? Let us take a moment to chat. What percentage of my clients do you think has said yes to the question, I'll meet with you for three sessions?

What percentage said yes, and what percentage actually did that over a five year period? What percentage said yes, Mark, I'll meet with you for three sessions, and what percentage actually did it? Would you put two numbers in chat?

JEN WINSLOW: Somebody said 75%, 90%, more often than not, I'm thinking, yes, 100%, 50% actually did.

MARK SANDERS: Yeah.

JEN WINSLOW: 75% and 35%.

MARK SANDERS: OK. So here's what happened. Thank you. Thank you, Jen.

So 100% of my clients that were a five year period said, yes, I'll meet with you for three sessions. How many did it out of 100-- out of everyone that said yes? All but one over a five year period-- all but one.

I shared that at the seminar, that finding. A man ran up to me with tears in his eyes and he says-- he says, where were you? I said, what do you mean where was I?

He said, my son just overdosed and died and no counselor could keep him engaged in therapy more than one session. I'm guaranteed three. That puts us over the National averages.

If you want to engage individual co-occurring disorders, it's helpful to minimize confrontation. If you look at like the research from William Miller from motivational interviewing, William Miller said, the more heavily we confront those that we serve, the more likely they are to drop out of treatment prematurely.

Looks like we have two raised hands, right? Byron raised his hand. We can see if there's something that's in Q&A.

JEN WINSLOW: Stephanie's was an accident-- that happens often. Don't worry about that, Stephanie. And the other person--

MARK SANDERS: Byron.

JEN WINSLOW: --Byron, can you put it in the Q&A section?

MARK SANDERS: OK. And we'll come back.

Connect with peers-- sometimes people don't connect with therapists, but they'll connect with a peer. There's a program out of Michigan that works with people in mental health crisis, and they've tried psychiatrists connecting with them, and psychologists, and social workers. But who engages best when clients are in a crisis-- our peers.

I've been here before. I received services here. Let me be here to support you.

Help with needed resources early, even if they're not ready to take medication, get treatment for mental illness, or addiction. If you're a resource broker, you become known as a helpful change agent. So here are the two things I wanted to share with you, and then we'll look at our evidence-based therapies after talking about engagement.

So there was a program that worked with pregnant teenage girls, and they were having a hard time engaging these girls in counseling. I said, well, can I see your intake? I said, the problem is your intake.

You're asking these teenage girls who are pregnant, do they get along with their parents? No, their parents put them out of the house. How are their grades? They all dropped out of school.

You're asking these girls questions like, have you ever had a venereal disease? I said, will you try these questions, too? Tell the girls that you want to know who they are as a human being, right?

You're going to ask them the questions about their uniqueness to find out who they are as a human being. If you had three wishes, what would they be? When are you happiest?

What do you do on a Saturday afternoon? Who are your heroes, your favorite food? What kind of things are funny? Do you like to hear jokes or tell jokes?

And what they told me is that by asking these girls these questions, they engaged them better in their helping relationships. These questions are about who you are as a human being, not have you ever had herpes or syphilis before. So one day I was doing a presentation with HIV service providers.

And I divided them into like twos-- two people interviewing each other, asking each other these questions. One man looked at the questions, got up and stormed out of the room. So I'm thinking, he's thinking these questions are stupid.

If you had three wishes, what would they be? When are you happiest? He came back into the training room and said, I went in the bathroom to cry. He went in the bathroom to cry.

He said-- because he shared his story-- he was born HIV positive and his T-cells haven't changed since birth. So the medical community considered him to be a walking miracle. He's 28 years old. They've been studying him for 28 years.

He's been an HIV test case manager for six years. He said, I went in the bathroom to cry because I realized in 28 years, no one ever asked me, what's your favorite food? What do you like to do on a Saturday afternoon? He said, they see me as a subject, not as a person.

What we found is that these questions about who you are as a human being can help with engagement, along with asking clients about their strengths, right? So much of our work is deficit-based-- we begin with a diagnosis. We begin asking questions early on like, what brought you here, which is like, how you messed up your life.

What drugs do you use? How many times have you relapsed? Ever been treated for mental illness?

Have you ever attempted suicide? How many times? Do you have any felony arrests?

How did you mess up your life? How much medication have you taken?

But I discovered if you ask clients early on questions like, what do you do well, how have you been able to endure so much, what's the best thing you ever made happen, that question assumes that maybe you had a life before bipolar disorder and before opioid addiction. There's more to you than that. What's the best three moments you can recall in your life?

We asked a man that question that drank alcohol is so heavy, and he was mandated to meet with us, what's the best three moments you can recall in your life? He said, I sobered up for the birth of all three of my daughters. That one question engaged us.

If I could ask clients one question, it would be the next question, a very hopeful question. What is your previous life suffering preparing you to do with the rest of your life? That's a purpose question.

What have you learned from what you've gone through, right? It means that whatever struggles you've had, it wasn't for naught. And when you face that special challenge, what sources of strength did you draw from? And which of your experiences has taught you the most about your own resilience?

And what we've learned is that when we focus on strength, right, it creates therapeutic walls-- bridges, I'm sorry-- as opposed to therapeutic walls. All right. So let's talk about evidence-based co-occurring disorders treatment.

Evidence-based practices are therapies that have been studied by researchers and replicated by more than one investigator. The approach is proven to be effective with a range of client populations. And there are three important questions to ask ourselves about evidence-based practices if we're thinking of using one with the clients that we serve.

Who conducted the research? My good friend, Dr. Joe Rosenfeld, said that we should look at like, who did the studies? Because often, when we are introduced to evidence-based practices, you'd be shocked how often the person who developed the model, actually hired their own researchers to prove that the model was effective.

Where was the research conducted? Years ago, they did studies that indicated that gay men and lesbian women had higher rates of alcohol use than heterosexual individuals who drank alcohol. But where were those-- where were those studies conducted-- in gay bars. People drink more in bars.

And then the third question is evidence-based compared to what? You see, a fair comparison would be the outcomes of like CBT versus motivational interviewing. That's a fair comparison.

But often, the comparison really is between an evidence-based practice and sitting on the waiting list, right, or business as usual. You want a more fair comparison.

Varieties of Evidence Based Practice-- the ones that have the most evidence of being effective where they've done the most research are the various types of cognitive behavioral therapy, these here and now approaches that are used to address depression, to help with the self-talk that increases depression, thought disorders like schizophrenia, right-- using CBT techniques to help clients to address delusions and loose associations, substance use disorders using CBT to help clients deal with cravings and urges to use, personality disorders like antisocial personality disorders, helping clients with like those

thoughts, right-- feelings of entitlement, the world owes me, right-- traumatic stress disorders, dealing with the symptoms of PTSD using CBT techniques, and then, of course, co-occurring disorders.

And there are a variety of cognitive behavioral therapies, like cognitive processing therapy, dialectical behavioral therapy, acceptance and commitment therapy, exposure therapy, and trauma-informed CBT. Let us chat. Which evidence-based practice do you think is most-- which cognitive behavioral therapy-- I'm sorry.

Which cognitive behavioral therapy do you think is the most effective in working with clients who have mental illness, addiction, or co-occurring disorders? Which is the most effective? Would you put that in chat?

JEN WINSLOW: Somebody said DVT, ACT, trauma-informed CBT, trauma-informed CBT, DVT, trauma-informed.

MARK SANDERS: OK. So are you all sitting down?

All right. So in the book, The Heroic Client, the research indicates that evidence-based therapies are equal in their effectiveness-- they're equal in their effectiveness. But every clinician using that approach is not equal in their effectiveness. A colleague of mine has clients-- works with clients coming out of the criminal justice system.

Their drug use got them into treatment and they have traumatic stress, and so they're using an approach in their program for these individuals with co-occurring disorders coming out of prison, they're using an approach called cognitive behavioral therapy, right? He said, Mark, all of our therapists has been trained in cognitive behavioral therapy. He said, one therapist trained in CBT has three client no shows per day. Three clients miss sessions per day.

Another one trained in the same approach has one client no show per month-- one a month. He says, we should talk less about evidence-based therapies and more about evidence-based therapists. Some therapists are better evidence-based than others. We talked about it earlier.

No matter what model you use, if you're empathetic, warm and genuine, have charisma, and clients believe you when you tell them they're capable of doing things, then you'll engage quite effective compared to others who do the same work. There's an evidence-based practice that's called 12 Step Facilitation.

How many of you have ever made a referral to a 12 Step group? I bet you that only a small percent of you have 12 Step meetings on the premises.

So I made 1,000 referrals to 12 Step groups. Here's the story. There was a flight attendant who developed alcoholism drinking those small bottles of liquor they used to serve on airplanes. Remember those small bottles of liquor? They were small, but they could get you drunk, especially, if you're in the sky.

So her employer smelled alcohol on her breath, and the flight attendant almost lost her job. She took a short flight after she went to treatment. She had to go to some drug abuse treatment to keep her job.

She took a short flight from Las Vegas to the International Airport in Los Angeles. When she got off the plane in Los Angeles, she was at Terminal 12, she looked to her left and she saw all that alcohol to her left. She's about to go have a drink.

And then she looked to her right, and she saw a woman holding the microphone to her white-- to her right and ran over to the woman, said, would you make an announcement? The announcement was, will all the friends of Bill W-- and Bill W is the Co-founder of Alcoholics Anonymous-- please report to Terminal 12? She said that within 20 minutes, 20 people from all over the world showed up and reported to Terminal 12 and said they were friends of Bill W, the Co-founder of AA.

She said that they had a 20 person AA meeting right there at Terminal 12. A friend of mine was early in her recovery from her alcoholism. She decided she wanted to find God. Lots of people get in recovery start looking for God.

She was convinced that if God existed, God would have to be in the four corners. There's a region in the Southwest where there are these four corners, and each corner is a different state. Standing on this corner, Utah-- this corner, Colorado, Arizona, New Mexico. She was convinced that if God existed, God would have to be in the four corners.

So she left her house one hot July [INAUDIBLE] looking for God, and she got to Missouri-- she was driving from Chicago to the four corners. It was 85 degrees out. All I can think of was having a drink.

She's about to pull over in Missouri and have a drink. And a voice came into her head, and the voice said, don't do it, don't do it. You ever heard that voice when you were about to do something that you will regret later? That voice says, don't do it, don't-- whose voice is that?

One time I did a speech at a youth prison, and I asked these teenagers that were incarcerated if they ever heard the voice say, don't do it, don't do it. Mr. Sanders, we hear the voice all the time. I said, whose voice is that?

Half said the state's attorney, the other half said the judge. Anyway, my friend held on. She made it to the four corners. And she's standing in Arizona about to have a drink.

She said, there was a Native American woman standing in New Mexico selling beads. She said, the Native American woman walked across from New Mexico to Arizona and stood in front of my friend and said, it's so good to be clean and sober by the grace of God, and the fellowship of Alcoholics Anonymous. And they held a two person meeting right there in Arizona.

You see, 12 Step groups answer the question. What does the person do if they're craving getting high and their therapist is asleep or on vacation? There's somebody in the 12 Step programs that are awake all the time.

Here's the problem. There's a couple of them that I'd like to share with you. The research says that 90% of individuals who we refer to 12 Step groups will stop attending within 90 days.

Thus, there's an evidence-based practice called 12 Step Facilitation, right, where you meet with the client individually for 12 sessions. Before you refer them to 12 Step groups, you have 12 steps. Now, before-- you have 12 sessions, and in between each session, they're given a homework assignment, a task.

So one task might be, would you go to two different meetings and-- so to compare the difference between the two? Or go to a meeting and listen to the stories of somebody-- people in the meeting and decide if there's somebody whose story that you like enough you might ask them to be a temporary sponsor? What they discover is when you meet with clients and teach them how to work a 12 Step program, right, before they actually commit to it totally 12 times, the results indicate that they're 3 times-- 3 times more likely to still be attending meetings at the 90 day period.

Now, having said that, know that I know before we look at the next evidence-based practice, that there are multiple support groups for people who have co-occurring disorders. There's SMART Recovery, there's faith-based recovery. There's a program called Refuge Recovery, which is meditation involved in recovery. There are religious programs, like Celebrate Recovery out of Saddleback Church.

Years ago, I started the first MIRA Group in Illinois, the first and second MIRA Groups in Illinois. And back then, MIRA stood for Mentally Ill Recovering Alcoholics. We've changed the language. I'll talk with you about that in a moment. That was years ago.

The way MIRA came about was that there was a woman in California who was going to 12 Step Group meetings, and she told her sponsor that she was taking lithium for bipolar disorder. Her sponsor didn't know the difference between lithium and librium. You know the difference-- lithium being medication for bipolar disorder, librium, like Xanax and Valium, are anti-anxiety agents.

The sponsor didn't know the difference between the two, said, you should stop taking those drugs. The woman stopped taking her lithium, became really depressed, and she committed suicide. And her friends responded to her death by forming the organization MIRA, a self-help group where people who have mental illness can talk about both their mental illness and their substance use disorder, and their medication.

They've changed the name to DDA, Dual Disorders Anonymous, having less stigma than mental ill with alcoholism. The use of motivational incentives is an evidence-based practice. The use of motivational incentives is in the SAMHSA registry as an evidence-based practice.

I'd like to ask you to pretend that you're stranded on a desert island, and they're going to come and get you, for sure. But while on this island, you can have one piece of candy. If you were stranded on a desert island, you can have one piece of candy, what candy would you want on the island while you waited to be rescued?

Would you put that response in chat? What candy would you want to have with you if you're on a desert island? I'm curious.

JEN WINSLOW: Peanut Butter, Snickers-- I like those, too-- Chocolate, Payday, Gummy Lifesavers, Almond Joy, Twix, Caramel, Caramel.

MARK SANDERS: You know, Jen, if we could see their eyes while they're talking about this candy, some of them, their eyes are so big thinking about this candy, you'd almost think they'd just smoked crack cocaine.

All right. There was a doctor who worked with heroin users. And by definition, heroin dependence-- another name for heroin dependence is medication of trauma. According to Dr. Gabor Maté, and the author of the book Chasing The Scream, that the core of addiction is trauma.

And so he was working with people addicted to heroin, and he started offering his clients a piece of candy at the end of the sessions. And he found out, if you offer clients a piece of candy at the end of the session, they were more likely to come back to the next session. So he started offering every other client a piece of candy, and found that those who received the candy were more likely to come back than the rest.

So he wrote an article. He received a phone call from the National Institute of Drug Abuse and they commissioned him to do a study where they would offer every other client a piece of their favorite piece of candy at the end of sessions, and those who received the candy were more likely to come back than the rest. I was asked to do an educational group in the Public Housing Developments in Gary, Indiana with women who were living in public housing who had co-occurring disorders, traumatic stress disorder.

Now, the research says that 70% to 90% of women who have addictions, are either sexually abused as girls, or sexually assaulted as women. And the research-- women who work with women counselors will say the numbers for their clients are more like 99%. So they were medicating the traumatic stress disorder with either heroin, or cocaine.

So what they decided to do was put the treatment facility right in public housing, making it easy for the women to get access to the facility. It was right there where they live. And the first day I showed up to teach this educational group, one of the clients reached for a bottle of water.

And the staff snatched the bottle of water from her hand and says, we don't give clients bottles of water. And that pissed me off. It was nothing but stigma. So I took matters into my own hand.

Near my home was a grocery store. And every Friday before I would drive to Gary, Indiana, I would go to the grocery store and I would bring the women

donuts, right, from Dunkin' Donuts, and I'd bring them orange juice and water. Attendance tripled-- attendance tripled on Fridays.

Women started coming to me saying, I don't know why, but when I go to bed on Thursday night, I find myself dreaming about donuts, right. Donuts was getting them there-- triple the attendance. Then we started offering bananas and grapes, right, and apples and pears, right, a healthy version of the snack. Attendance remained the same.

So I'm going to share with you an evidence-based practice that falls under the umbrella of the use of motivational incentives called The Fishbowl Technique. And a colleague of mine used The Fishbowl Technique with her clients that were quadruple challenged. All of her clients were HIV positive, all of their clients had a psychiatric diagnosis, all of her clients had a substance use disorder, and they were economically poor.

They either had SSI for their funding, or no funding at all. In other words, if her clients got high one day, they may wind up trying to escape homelessness. So what do you think group attendance was like in her program?

10% of her clients attended group on a regular basis. 90% did not. And she heard about an evidence-m based practice called The Fishbowl Technique. Whenever clients would come to group, they could draw raffle tickets from the fishbowl.

And there were 250 raffle tickets in the fishbowl. And every time clients showed up, they could draw a raffle ticket from the fishbowl. What was written on 125 of those raffle tickets is, congratulations for attending the group today, keep up the good work.

Any of her clients who drew that particular raffle ticket, the rest of the group would clap for them. And she learned that that in itself was reinforcing, because her clients had so much stigma of mental illness and substance use disorders and HIV, that no one had given them a round of applause in years, meaning, that there was a 50% chance that her clients would not win anything that day.

50 raffle tickets out of 250 read, congratulations, you win a small prize. The value of the small prize was $5 in value. 50 raffle tickets, you win a medium-size prize, $10 in value.

24 raffle tickets, congratulations for coming to the group today, you win a large prize. And the large prize value is $15 to $20. And then there was the grand prize, a flat screen TV.

And all of the prizes sat in the group room on the table, and they worked as quick as drugs work. If you won the prize, you got to bring it home that day. What was her attendance like?

When she introduced the fishbowl and the prizes, the incentives, her group attendance shot up from 10% attending regularly to 90%. And why were they showing up? To win the prizes, right?

Now, some of you who are like old school, like I was old school-- I'm getting more new school the more I learn about the stuff-- some of you are saying to yourself, I'm not going to pay clients to do what they should be doing anyway. I'm not going to offer them incentives. They should be doing this anyway.

Except two things-- all of the incentives were donated by Walmart. They were all donations. They paid nothing for the incentive, that's number one.

Number two, the use of these incentives increased their group attendance from 10% to 90%. And number three, her clients were at great risk of like drug-related offenses, right? It costs in my state $35,000 to incarcerate an adult for a year. But these incentives were free.

Attendance increased, recovery rates increased. Now, what are the chances that someone will actually win that flat screen TV? 1 in 250.

The day that the funding source filmed The Fishbowl Technique, a crack user won the flat screen TV. They followed up and said, what did you do with that flat screen? I know what some of you are thinking. Some of you are saying to yourself, you sold it for crack.

Actually, he donated the flat screen TV back to the program. You know why? Because he was in recovery for a year, and what the research says is that when these incentives are most valued by the members is the first 90 days after the last time they've gotten high. These incentives are most reinforcing the first 90 days after the last time someone is trying a new behavior.

But him being in recovery for a year, a new incentive kicked in called gratitude. He wanted to give back to the program that saved his life and so he donated it back to the program. So I became curious, what would happen if we use The Fishbowl Technique with a group of African-American and Latino Hispanic young adults and adolescents who are very resistant to any kind of substance use disorders treatment? They had co-occurring disorders.

And what we discovered is that this could work if we introduce them to incentives that they valued and what they prized, right? So here's what they value. They wanted gear that had the Nike logo.

When we did this in 2016, they wanted Cubs-- Chicago Cubs gear. That was the year the Cubs won the World Series-- anything Yankee, even though they were in Chicago-- anything with Michael Jordan's name on it. And we have these gift certificates to Target and 7-Eleven. These were the most prized incentives.

You know why? Because the program where we introduced The Fishbowl Technique was directly across the street from a Target and a 7-Eleven. So they can leave the group, right, and they can go right away and purchase something.

So they study the outcomes of the group. What they discovered is over a five year period, young people involved in this group, that 90% of them either decreased their drug use, or they stopped completely. The purpose of the incentives was to get them there and then we use an evidence-based curriculum to help them once they showed up.

All the resistance that you tend to see when working with young adults around mental health and addiction and co-occurring disorders, all the resistance that you see amongst young people, there was no resistance, zero resistance. Because they could say to themselves, I don't have a problem with mental illness. I don't have an addiction, but I'll show up for the things to win the prizes.

And when they showed up, we helped them. By the way, all of these incentives were donated to the program. They had people who did outreach, and they received all these donations, right?

And even if they paid for them, even if they pay for the incentives, we found that it was cheaper than these young people winding up in the criminal justice system. Because in my state, it costs $90,000 to incarcerate a juvenile, or a

teenager, for a year. That Jordan Jersey cost about $60, the gift card $5. But 90 grand to incarcerate a teenager for a year.

Drug courts aren't evidence-based practice. They're similar in principle to the use of motivational incentives. Instead of incarceration, we want you to go to treatment, right?

We want you to get help. We'll have graduations, we'll have incentivize you. We can reduce your sentence, right? It's cost effective. It reduces substance use and recidivism. Drug court as an [INAUDIBLE] practice.

They also have prosecution-- prostitution court, trauma court, mental health court, veterans court. I'm fighting for co-occurring disorders court. Structural family therapy-- if I didn't know better, I would think that clients with mental illness, addiction, co-occurring disorders, don't have families.

Because we do so much group therapy, so much individual therapy, and so much case management, but very little family therapy. Why is that important? I share stories, and people stay at the end of my seminars and they share stories with me.

So a woman told me the following story at the end of one of my seminars, that she and her husband had a baby. She asked her husband to go home, to bring her some clean clothes so that she can wear clean clothes home from the hospital. She told me her husband was gone for two days.

And his sister showed up. The sister said when her husband went home, there were men robbing the house. And her husband went and got the family gun and held these men at gunpoint and called the police.

The sister said when the police showed up and they saw her husband holding the gun, the police didn't know if her husband was the good guy or the bad guy. So the Chicago Police accidentally shot and killed her husband. And this woman was to receive the largest settlement in Illinois history wrongful death, police killing her husband.

Said, Mark, I was in the courtroom, and the judge opened his mouth and the judge said, you will receive-- she said, before the judge finished his sentence, there was a woman in the back of the courtroom who stood up and said, wait a minute, Your Honor, he's not her husband. I married him first, we never divorced.

The second woman received the settlement. Now, the woman who told me the story could be in our webinar today. She was this great probation officer before she got the news of betrayal from her husband.

Before she got this news of betrayal, something like 35% of her caseload went back to prison.

But after she got the news of betrayal, the number swelled from 35% going back to prison to 65%. You believe you can have some experiences that can affect your work and affect your heart? She was so bitter having been betrayed by her husband who never divorced his first wife.

She said, Mark, one day I was at home feeling bitter, and there was a ringing out at my doorbell. And I opened the door, and there was a 13-year-old girl standing there. And the 13-year-old girl said, the woman who won the settlement is my mother, and the man who you married is my biological father.

The girl told her right before her mother received the settlement check, the state went into the background check, found out her mother had been receiving public assistance illegally from forever, a felony in all 50 states. The girl said they put my mother in prison.

She neglected me. She started using drugs, and she got out of prison. I stopped going to school. I've been smoking marijuana. Can I live with you? Can I live with you?

She said, Mark, against the recommendation of all my family and friends, I looked at that girl and I said, you can live with me. She said, Mark, I mothered that girl and love brought me back, and it brought her back too. She's now a college student.

Love is the most important ingredient in all the recovery. And the research says, if you involve the family in the person's treatment but their chances of recovery increases times 2 or times 3. So let me share with you some information about a program, and then I'm going to ask you a question.

You can find the answer to the question in a book that's called The Family Therapy With Drug Abusers by Thomas Todd with two D's. Thomas Todd wrote this book and talked about this research study. So there are a group of Vietnam veterans that all have post-traumatic stress disorder from the war, from the Vietnam War. And they medicated their psychiatric symptoms with heroin.

So all the men in the study were Vietnam veterans with post-traumatic stress disorder and opioid-use disorder. They were addicted to heroin. So the researchers, they wanted to go about the process of recruiting family members to be involved in these men's therapy. They recruited family to be involved in their therapy, but they only consider their recruitment efforts to be successful if they were able to involve both of the men's parents in the therapy if they were alive and all of their siblings over age 12.

Let us chat. In what percentage of these cases do you you think they were able to successfully involve both of their parents in the therapy and every sibling over age 12? Would you put a percentage in chat. How successful were they at engaging the entire family in the therapy? What percentage?

JEN WINSLOW: 75%, 50%, 80%, 20%.

MARK SANDERS: OK, so the answer is 85%. Let me tell you how they did it. They redefined their program as a family therapy program. They asked the veterans that will go into the VA, we want you to bring one relative with you. And what they found is that by engaging one relative, that relative that was engaged to perhaps to persuade the other ones to come.

If I can just give you an example up close, my father died smoking crack-cocaine May 29, 1986. A month later my uncle Isaac went in front of a judge and pleaded for treatment. He was the first person in our family to get into treatment.

We count 30 relatives in our family who are now in recovery. I went from a drug-using family to a family in recovery that began with one man's treatment. The counselor called my uncles, brothers, and sisters and invited them to participate in therapy and said, we don't like them. He stole from all of us when he was using heroin. He stole from all of us.

The counselor called several more times. Finally, the council says, OK, we're going to have a feast. They had food. They said, OK, we'll come.

So all 13 of our aunts and uncles participated in my uncle's family night. And then they invited the nieces and nephews, 26 of us participated, and his family were 39 of us and all. My uncle told me that when he saw his whole family participate in therapy that he had this belief that if he turned his life around, if he'd stopped using heroin, he could get his family back.

It was the love that did it. It began with one council's persistence, right, with you all participating. Second finding is that given the choice between the client inviting the family to participate in the therapy, or the counselor, or the recovery coach that you are far more a better recruiter. And the reason is because you've never stolen from the family.

They never attended mental health facilities or driven you to the emergency room. When you stopped taking your medication, they're not angry with you. They've never gone to prison to visit you. They've never had to take a collect call from you. And so you have more leverage.

So who should invite the family to participate in the therapy? You. Third finding, those counselors who are the most enthusiastic and who believe the most in the value of family therapy are better recruiters of the family than those who are burned out and who don't believe in family therapy all that much.

Fourth finding, they found that if you were able to engage the family by phone first, before inviting them into therapy and you allow them over the phone to talk about their anger, their hurt, their pain, their resentments, their frustration, if you bonded by phone first, they were more likely to say, yes, to the request to participate. The next finding, if you are able to get the family on the phone, while the client was sitting in your office, they almost always said, yes, to the request we will participate.

The next finding is that if you wanted the families to participate, the most important rationale you could give them in the beginning was for them to come in to help the client, right, because if you said come in and help yourself, they were less likely to come in, because after all, we don't have a problem. It's him. And then as you build rapport, then you can stretch the union the service from the individual client to the entire family.

They did a 15-year follow ups study, found out that those clients that they work with, where they were able to engage the entire family were three times more likely to be in recovery 15 years later and more likely to be alive. It speaks to the value of structural family therapy. It's family therapy as an evidence-based practice.

Why we're at it, I want to mention another evidence-based practice. It's called behavioral-couples therapy. Did you know that lots of couples are more likely to divorce when the person gets into recovery then when they're using or when they're like acutely with mental illness then when they get into recovery? You know why? Because once in recovery, the spouse might view you as a stranger.

I don't know you. I don't know this person. This is not who I married. So there's an evidence-based practice that's called behavioral couples therapy. And with behavioral couples therapy, there are three clients.

The one with the substance use disorder is a client. The spouse, the partner is a client, and their relationship. So the individual with the substance-use disorder or the co-occurring disorder make a commitment as to how they're going to do-- what they're going to do to maintain their recovery. The spouse or partner makes the commitment to take care of themselves. And then the third client is the relationship, behavioral strategies to nurture their relationship as well.

The use of recovery coaches, it's the wave of the future. I know that there are a few of you who identified yourself as recovery coaches. Recovery coaches engaged in what's called pretreatment engagement, to reach out to the 75% of individuals who have co-occurring disorders who will never seek treatment voluntarily.

More and more recovery coaches are being hired to do outreach for individuals who wouldn't come in on their own. That's 75%. In treatment recovery support, to help create seamlessness from the community, or from treatment into the community, and post-treatment recovery support, at least 90 days of recovery support when the person is released from a hospital, from substance-use disorders treatment, from mental health treatment, or from prison 90 days of continuous recovery support, of all the evidence based practices that we do, you talk to clients who have co-occurring disorders, the final two on this particular slide are the ones that they value most, supportive employment.

I know that there's an employment specialist that is with us. That is the evidence-based practice that individual co-occurring disorders and mental illness value the most. Give me a job that will give my life meaning and purpose. I'll have a reason to get up in the morning. I might even be motivated to take my medication, because I have a job that gives my life meaning.

Housing first, there's a program in Chicago called Threshold. The largest freestanding mental health facility in the country. Well, they do have employment specialists, but they also have these programs where they've taken abandoned motels and rehab these abandoned motels.

And they're housing clients in these abandoned motels that have co-occurring disorders. And their clients were putting together 7, and 8, and 9, and 10 years of recovery. Housing first, Maslow was right, housing first as an evidence-based practice.

So, Jen, we're going to give everybody a moment to put some questions in Q&A. I'm going to pause for a moment. And then we want to know your questions. You can put those in Q&A.

JEN WINSLOW: Yeah, as Mark said, there's the Q&A section at the bottom of your Zoom screen. And so we're just going to take some time to have some Q&A time. So please put any questions from the whole webinar this far in that section. And we will start to answer them.

MARK SANDERS: OK, Jen, see if anybody has a question.

JEN WINSLOW: Yeah, we have one in there, but a while back in chat somebody had asked if you could share the five characteristics again. That was a while ago.

MARK SANDERS: Charisma. Say that again, Jen.

JEN WINSLOW: The five characteristics.

MARK SANDERS: Yeah, yeah, yeah of like the clients councils who engage best. They include empathy, and warmth, and warmth is of the heart, and genuineness. Our clients experience a lot of stigma out there. So they're gauging whether or not you're genuine, empathy, warmth, and genuine, charisma, and believability, for whatever reason when clients believe you when you say things to them, they trust you. Those matters as at it pertains to engagement.

JEN WINSLOW: A quick one is, what was the title of the last book you shared with us?

MARK SANDERS: Yeah, it's called The Family Therapy With Drug Abusers by Thomas Todd, Family Therapy With Drug Abusers by Thomas Todd. It's one of those kept secrets.

JEN WINSLOW: Another one is, how do you learn to do family therapy if you are working full time?

MARK SANDERS: Yeah, very good. And so when I went to college, I didn't take any classes in family therapy, but there was an organization called The Family Institute. And they have these courses where they taught you the working with families. I take a lot of workshops on working with families, because we need to get CEUs anyway.

I take workshops. And so I develop a certain amount of proficiency. I would learn one model really, really well Right and then learn another one really, really well, because what I forgot to tell you, what I forgot to mention to you, is that the best clinicians, according to research, are the ones that know more than one way of working with clients.

Can I share something with you? I was a therapist for 38 years. I was average for 33 years. I was average therapist for 33 years. I was good the last five.

How do I know I got better? It wasn't because my supervisor told me so. It was because my clients told me that I was good at what I did the last five years more than all the other years combined. And they stayed in counseling longer than they did before.

I got better at it. What changed? For seven years, I taught at a university, a course called The Theories of Counseling. And the book was called The Theories of Counseling by Gerald Corey.

So I taught 16 different counseling approaches from that book for seven years. I took seminars on every approach. And I had a private practice. And everything I was learning from teaching and from the seminars, I was utilizing with my clients.

So all of a sudden, I didn't have just one way of working, two ways of working with clients, all I had before was motivational interviewing. And the client-attention approach. You know what client-attention is where you nod your head a lot, I see, tell me more.

Now I have 18 ways I can work with you. So if this is not working, I have another way, and another one, and another one. The best clinicians are the ones that have more than one way of working with clients.

I like to read what the theorists have to say when they turn 80 and 90 years old. My favorite is Irvin Yalom, the father of group psychotherapy. Irvin Yalom said, "if I did therapy at my best, every session would be a new therapy. I'd figure out what my clients need it today, and I would give them what they needed that day."

Take a client that has addiction plus mental illness, right, and traumatic stress disorder. So one week they're talking a lot. The next week they come in, they are emotionally dysregulated. They're like a deer in headlights. They're frozen, because of fear.

The approach that you used last week is not going to help them this week when they're not talking. Milton Erickson, the great therapist, the great psychiatrist Milton Erickson said, I invented a new therapy every day based upon what my clients needed, more than one way. Jen, is there another question?

JEN WINSLOW: There is. We have two more at the moment. One of them is, any suggestions on how to get donations for incentive programs?

MARK SANDERS: Yeah, so it just so happens that because both of these programs are 501c3 they get their tax exempt status. They make those calls. They make those calls and say, listen, we're doing this work.

We're doing this work, and so can you donate? Look at what Walmart can donate. As a matter of fact, in a small town in Southern Illinois, Walmart recognized that they had quite a few employees that had substance-use disorders. And so they invested in the annual substance-use disorders conference.

We just simply asked. That program with the adolescents they called the Chicago Bulls, and Chicago Bears, and the Chicago White Sox, and the Cubs and the Blackhawks. And they got all those donations. That 501(c)(3) status helped.

My big sister knew about that group I was doing in Gary Public Housing. And so she volunteered to do a group where she would help these women in

recovery get jobs. She went to those high-end women's clothing stores on Michigan Avenue, you know those clothes stores where the clothes are so expensive nobody's carrying bags.

They say ship those clothes to my house. And she said, what do you do with your regular clothes? Why don't you give them to us? We're a 501(c)(3), and I want to be able to offer these women dresses and suits for interviews and shoes.

These women are in recovery, and we wanted them to be able to be gainfully employed. And those closed doors on the Magnificent Mile donated those clothes, those new clothes to that program. The incentive was that once the women completed the employment program, they can receive three new outfits and two pairs of shoes.

We asked in our 501(c)(3)-- by the way, that was a prison in Central Illinois where the women, the mothers were able to keep their children in the prison for two years. There was a section just for the mothers and their children. All the churches in that town got together and donated two years of clothes to that mother and her child so that when the mother left prison she wouldn't have to worry about affording the clothes for the child for the first two years. Is there another question there, Jen?

JEN WINSLOW: Yeah, the last question right now is any gender-specific EBPs that you recommend for individual co-occurring disorder?

MARK SANDERS: No, but there are best practices. And best practices are Women For Sobriety and best practices like men's groups and women's groups. So let me expound upon that answer.

All right, so there's not been one evidence that practice that I've ever seen that incorporates culture into the model, not a one that I've seen that in corporate culture, right. But you know what Carl Bell said-- Carl Bell said, Dr. Carl Bell said, that any practice in the hands of a clinician that striving for cultural competence can be culturally competent. And let me answer my question a little further.

Any evidence-based practices in the hands of a clinician that is learning gender competence, i.e. How to work with effectively with a client as it pertains to gender, where there's gender competence that an evidence-based practice can be useful, if the clinician doesn't have any gender competence, then they can actually be harmful. So that would be my answer, is to either

develop such a model, utilize best practices, or for all of us to strive for these competence, gender competence, cultural competence, et cetera. And, Jen, is that the final question?

JEN WINSLOW: That is the final question.

MARK SANDERS: OK, so then let me share some more information with you. Thank you for being with us for these two hours. I so appreciate it.

Let me go to the next slide if I can. So motivational interviewing is evidence-based, because it allows you to stay with clients where they're at. There's an evidence-based practice is called feedback and form treatment. And what they found is that too many of us wait too late to get feedback from clients.

We wait too late, because the reason we know we wait too late, it's because research says that half of our clients will miss their second session. So the best time to get feedback is at the end of each session. Let's mirror great hotels.

Have you ever stayed in an expensive hotel? I would ask you how expensive, but one time that question was asked at a webinar, someone raised their hand and said they stayed in expensive hotel. Someone said, how expensive? They said $39 a night.

We decided that how expensive is relative, but I want to thank you so very much. I have stayed in my life in the Ritz-Carlton Hotel five times. And every time I've ever stayed in the Ritz-Carlton hotel-- the federal government put me in the Ritz-Carlton Hotel. And, you know, it's so beautiful, so clean, you could live in there.

I want to retire in the Ritz-Carlton Hotel, or the Kalahari Resort in the Delta. And so the first time I checked in the Ritz-Carlton Hotel, the phone rang. Someone from the hotel called me immediately, how's your room? Would you care for some truffles? Would you care for some truffles?

I didn't know what truffles were. In other words, the best always wants immediate feedback. Maybe what the Ritz-Carlton Hotel knows if you don't like the service, the research says you will tell 21 people. Each one of them will tell 10 people.

Each one of them will tell five, one, stay away. I have stayed in the Holiday Inn and Doubletree. They've never called me immediately in a Holiday Inn or offered me truffles.

The Doubletree, they'll offer you a warm chocolate chip cookie, which you'll never forget. Even if you don't eat it, you'll never forget it. And then they'll send you an email two days later. The Ritz, immediately, the Doubletree, two days later.

There's a steakhouse in Chicago called Ronnie Steakhouse. And most people have never heard of Ronnie Steakhouse. For $7, Ronnie Steakhouse will give you a whole cow, a baked potato so large you would think he was shot with silicon, a glass of lemonade from the floor to the ceiling, and one slice of bread bigger than a whole loaf.

For $7, most people out of Chicago have never heard of Ronnie's, but they've heard of Ruth Chris and Gibson Steakhouse. You know the difference, the $7 runnings gives you the whole steak, that's it. But at these high-end steakhouses, they have cut into it as soon as the steak arrives, because they want to know if it's to your satisfaction immediately, knowing that if you don't like the steak, then you'll tell 21 people. Each will tell 10, five stay away.

The best always gets immediate feedback. So what they've discovered if you get immediate feedback from clients and make changes accordingly, then you can keep them engaged longer in the helping process. If you've never studied feedback and for treatment, I encourage you to take a good look at it.

And, of course, an evidence-based practice is integrated co-occurring disorders treatment is when you treat substance use disorders and mental illness under the same roof at the same time. The next time we get together next month, our whole session is going to focus on integrated co-occurring disorders treatment and how to keep clients who have co-occurring disorders from slipping through the cracks, that is going back and forth between the substance use disorders, mental health hospitals, prisons without ever fully recovering. We want to talk about how to keep individuals from slipping through the cracks.

What I've learned over the years it's much less about anything I teach but more about the action you take. So let us chat one last time. What's the one action you're going to take when this webinar is over as a result of the time that we spent together today? What's the one thing you're going to do as a result of our time together today? What's your action?

JEN WINSLOW: To the survey, ask more human question during assessment, incentives, identify strengths, hang out with some clients. I'm finding motivations for clients and beginning to utilize that. Attempt the fishbowl incentive.

Focus on client strengths, move away from traditions and treat each client as an individual, be more empathetic. Find one of the books you mentioned, explore the therapies, invite others to come to the series. Teach my peers what I learned.

MARK SANDERS: Yeah, they say that in order to learn anything, you teach others. And when you teach others solidify what you know. I Imagine that some of you have seen the program Monk.

Monk is a walking DSM-5, and the world's greatest private eye. He's living proof you can have a lot of problems and still be successful. Monk has obsessive compulsive disorder, a fear of heights, germs, dark rooms. I watch two episodes a month. The first episode I watched, Monk was on the plane. He hadn't flown since he was nine years old. So he's trembling in the air. He's shaking in the air.

When the plane landed, the passenger next to Monk, he thought Monk was kind of odd. And so he demanded his business card then. Well, luckily Monk has his assistant.

Everyone in the world can use an assistant like Monk's assistant. The world thinks he's kind of odd, but his assistant understands money. The second episode I watched, Monk's brother called. The assistant answered the phone.

She said, Monk, you never told me you had a brother. Hang up, he said. I haven't seen my brother in seven years. I haven't talked to my brother in seven years. Hang up. He'll stop calling. And three weeks went by, and Monk's brother never stopped calling. Finally, he called again. He said to the assistant, there's an emergency. I need to see my brother Monk right away.

So she dragged Monk over to the brother's house. And as soon as she met Monk's brother, she felt like she understood Monk better. Monk's brother had a condition called agoraphobia, the fear of the marketplace. He hadn't been outside in seven years. No wonder Monk hadn't seen his brother. The door was open. And Monk's assistant took his brother's hand.

She was guiding his brother outside for the first time in seven years. And the brother backed up and whispered, I'm scared to go out there. And the assistant whispered, you don't know this, but your brother Monk, he's scared all the time too.

What does he have that you don't? And the brother looked at her and said, he has you, and I don't. He has you. What separates the clients that you work with from the ones that you don't work with is the fact that the ones that you work with, they have you. And that's a big deal, and that's important. Thank you so very much. And hopefully, we'll see you next month part two of our three part series. Thank you so very much.

JEN WINSLOW: Thank you so much, everybody. You're going to be redirected to a very short survey. It helps us continue to provide free trainings to you all.

So we'd really appreciate if you just took a quick minute to fill that out. Please keep looking on our MHTTC website and our Facebook page that are in the chat for information for upcoming events. Thank you so much, Mark. And thank you all for being here today as well.

MARK SANDERS: Thank you.

JEN WINSLOW: Bye-bye.

MARK SANDERS: Thank you, everybody. Thank you.