Transcript: Integrated Co-Occurring Disorders Treatment

Presenter: Mark Sanders
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MODERATOR: I'm going to go ahead and start.

Good morning, everyone. We're just going to start in just a moment after everyone gets into the webinar.

Welcome, everyone, to today's webinar, Integrated Co-Occurring Disorders Treatment, with our presenter, Mark Sanders. This webinar is co-sponsored by the Great Lakes MHTTC and SAMHSA. The Great Lakes ATTC, MHTTC, and PTTC are funded by SAMHSA under the following cooperative agreements.

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A few housekeeping items. If you're having any technical issues, please individually message Jen Winslow or Alyssa Chwala in the chat section at the bottom of your screen, and we will be happy to assist you. We're going to do our best to have Mark answer some questions, so if you have any questions specifically for the speaker, Mark, please put them in the Q&A section at the bottom of your screen.

We will be using live transcription during the 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 this 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.

Mark is 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 SUD professionals. He is 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.

Welcome to you all, and I'll turn it over to you, Mark.

MARK SANDERS: And thank you so very much, Alyssa and Rebecca and Jen, and good morning, everyone.

I always like to begin with stories. I have two of them for you this morning. The first one happened in March of 1995.

I was giving a speech in Downers Grove, Illinois. And Downers Grove, Illinois is a Western suburb outside of the city of Chicago. And there was a woman who attended a seminar, and she sat in the front row center aisle seat directly in front of me. And she asked, are you the same Mark Sanders who worked at a detoxification facility in 1985, a decade earlier? I say, yeah, that's me. She said, I was a patient on that unit. You were my counselor.

Now, I don't always remember names. I remember faces and stories, so here's her story. Her drugs of choice were cocaine and heroin, and she supported her substance use disorder through prostitution. In fact, she sold her body not too far from where our facility was located, and I work the evening shift. Some nights as I was driving home at midnight, I'd see her standing on the corner. She'd gone from detox back to selling her body to pay for her drugs of choice.

And I remember looking at her, saying, she looks really bad. You know when a person goes back to using drugs, they stop eating, they lose a lot of weight? In fact, I said to myself, I don't think she'll recover. Am I the only one attending

this webinar today who's ever worked with a client that you thought would never recover?

What I learned in my 40 years is that we can't predict who will recover. It's not like you can feed information to a computer, who will get into recovery and who won't, although if the job of a counselor is about empathy, compassion, and patience, especially patience, patience, more patience, machines are getting really close to us.

Once I was staying in a Ritz-Carlton hotel in Washington, DC. I put a dollar in a pop machine, couldn't figure out what brand of soda I wanted. While I was standing there the machine said, sorry you are having a difficult time. Take your time. Sounded like a licensed therapist to me.

Anyway, there she was a decade later, sitting in the front row of my seminar. So I looked down and I saw the initials behind her name, LCSW, CADC, Licensed Clinical Social Worker, Certified Alcohol and Drug Abuse Counselor from street prostitution. So during the break, I said, well, let's talk.

She told me that after she left our facility, she went back out into the streets to do more research. Back then, we called relapse research. So she quickly made it back to detox. I did the assessment. And she left detox and she went to NA meetings. She went from NA meetings to a community college where she received her GED.

She stayed in the community college and she received an associate's degree. Then she went to university and received a bachelor's degree in social work. She went one more year and she received a master's degree in social work. Then she worked two years post-master's. And now she's eligible to sit for the licensure exam, the LCSW exam.

She said, one of the questions they ask on the application for licensure is have you ever been convicted of a felony. And she said her life was about honesty, and so she checked, yes, I've been convicted of a felony, and the state denied the right to take the exam. She said, but, Mark, I fought too hard to give up. She appealed the decision and she was able to sit for the licensure exam and she became licensed.

When she told me that story, I told her that she didn't make my day. She made my decade. I've had about 10 clients, right, who've done such miraculous things with their life, that they've allowed me or motivated me to commit to like four decades I've been doing this work, and it's about the recovery of my clients.

Somewhere in the middle of these 40 years, say year 20, I decided I would go and work in mental health. Guess what I discovered? That half of the clients receiving mental health services also had a concurrent substance use disorder. So in my state, I developed some of the first comprehensive co-occurring disorders program in the state. I'd like to share some of that experience with you today, along with some research. We'll talk about integrated co-occurring disorders treatment.

So here's the second story. How many of you by show of hands have ever seen the movie The Lion King? Sure you have. And what was the father's name in the movie The Lion King? Mufasa. And the son? Simba. And Simba was destined to be king. As a matter of fact, if you remember in the movie, he would dance around in the beginning, singing a song called "I Can't Wait to be King".

His father, Mufasa the King, had one piece of advice for his son. He said, son, whatever you do, stay away from there. And there was the forest, and Simba couldn't wait to go into the forest. And lurking in the forest were the hyenas. And they surrounded Simba and that little bird screamed, Mufasa, the hyenas are about to attack Simba.

And Mufasa roared. The hyenas ran away. And he scoops him up in his arms. He hugged his son. And that caught my attention because I hugged my father three times in my life. The first time I heard my father was when I graduated from undergraduate school. The second hug is when I graduated from graduate school. The third time I hugged my father was at his funeral.

Mufasa hugged Simba and Simba said, dad, are you as courageous as the hyenas? He said, no, son, I'm not always courageous. And in fact, I thought I would lose you today. He said, nothing frightens me more than the fear of being without you. I just muster up courage when I have to.

Simba had an uncle whose name was Scar. I think lots of kids have relatives like Scar. These are the ones that traumatize you, who abuse you, who neglect you. Scar was envious. He was jealous because he wanted to be king.

If you remember one point during the movie, Mufasa was killed and Scar said to Simba, it's your fault your father was killed. Get out of here. Filled with grief and depression, Simba ran away. And he stumbled upon a meerkat cat in the Ward Hall What were their names? Timon and Pumbaa.

And the first thing they did was they introduced Simba to a slimy substance to eat, and that wasn't where a Lion King ate, so he coughed it up. Remember the first time you tried marijuana, you coughed? I'm only kidding. And then they taught him a song called "Hakuna Matata", which means, don't worry about anything.

So picture this. There was Simba, destined to be king, hanging out with a pig and a cat, singing "Hakuna Matata" and smoking marijuana. Then one day, Rafiki, the little monkey-- we'll call Rafiki a licensed clinical social worker, certified drug counselor, a recovery coach, a case manager from Michigan. Rafiki was swinging on a vine and he spotted Simba hanging out with Timon and Pumbaa, using drugs. So you swung past and you gave him a gentle tap.

Simba said, who are you? And you said, no, the question is, who are you? You said, I know who you are. You're Mufasa's son. You're the son of a king, and here you are hanging out with a pig and a cat, using drugs, singing "Hakuna Matata".

So you took Simba to a body of water. You said, look in the water and tell me what you see. And at first, he saw his own reflection. But like a good counselor, you said, no, look a little closer. And he saw his father the king's reflection. And the voice said, Simba, you were meant to be more than what you have become. Go and take your place in the Circle of Life. And ultimately, Simba became king.

To me, that is more than a cartoon. It's really a story of recovery. There he was on the pathway of recovery. There was a loss in his family. He was deserted. He was blamed by his uncle, right? Feeling down, he ran away, started hanging out with the wrong crowd. And then that was an intervention, right? And he was able to reach his destined to become king.

Rafiki is really symbolic of you that help the clients that we work with, with mental health recovery, dual recovery, co-occurring disorders recovery. Thank you for all that you do.

I'd like to find out who's with us this morning. So if you could find your chat feature, would you put in chat the city that you work in and what you do, what

your title? That'll give me an idea who is with us. So where are you calling in from? What do you do?

JEN WINSLOW: We have a psychotherapist from Madison, a behavioral health manager from Sheboygan, a CADC from Hackensack, New Jersey, service facilitator from Dodgeville, Wisconsin, behavioral health case manager from Rockford, Illinois, an LADC from Baltimore, a nurse and congregant care director in Redmond, Oregon, outpatient mental health therapist in Kokomo, Indiana.

MARK SANDERS: Looks like geographically spread out, right?

JEN WINSLOW: Yeah.

MARK SANDERS: A range of services. Thank you, Jen.

All right, so our outline today is that we'll talk about the early years. Mental health treatment had humble beginnings. Then we'll talk about how we moved from those humble beginnings to what's called the new person-centered recovery movement, which really triggered evidence-based approaches to co-occurring mental health and addictions treatment, but also co-occurring disorders treatment. Then we'll talk about strategies for helping clients with co-occurring disorders avoid slipping through the cracks.

So mental health treatment, the early years. In the 1700s, our model for addressing mental illness was a moral model. And those who had mental illness were considered to be morally bankrupt. They were placed in asylums. They were institutionalized for life.

There were also beliefs early on that individuals with mental illness were possessed. You might remember hearing a reading about the women who were found guilty in the court of law in Winston-Salem, North Carolina, in the 1800s of being witches. And their punishment when they were found guilty was that they were burned at the stake.

Judith Herman, one of our nation's foremost trauma authorities, went back and looked at the transcripts of these women from Winston-Salem, North Carolina who were found to be witches and found out who these women actually were. They were sexual abuse trauma survivors who had features of multiple personality disorder, what we now call dissociative disorder. They were traumatized and they were burned at the stake.

There was lots of isolation and solitary confinement, again, for life. As a matter of fact, the United Nations had done some research that indicates that solitary confinement over two weeks is considered torture. These individuals were tortured for life.

There were lobotomies in our history. And up until right now, persons with mental illness have been in prison. As a matter of fact, all over this country, state psychiatric hospitals have closed. And whenever state psychiatric hospitals close, the center for mental health treatment become jails and prisons.

Let's take a moment to talk about substance use disorders, the early years. In the 1700s, we had a moral model which triggered a temperance movement. In 1783, we were in a war, the American Revolutionary War, fought over taxation without representation.

And lots of men came back from battle suffering from what we now call post-traumatic stress disorder from the war, and they drank heavily in order to cope with the trauma of war. So wives were concerned, including the first First Lady, Martha Washington, so she was one of the leaders of the temperance movement.

Again, men were awakened on Sunday by their wives taken to church, where they would confess all of their sins connected to their drinking. Then they would put their hands on their Bible and make a pledge that they would either cut down on their drinking or switch from whiskey to beer. Did it work? No, because they never addressed the trauma from war.

Individuals with substance use disorders that were considered moral weaklings were placed in asylums, just like those with mental illness. There were cases of frontal lobes being removed, thinking that would help the individual forget that they had an alcohol use disorder.

There have been periods in our history where women were forced to have their ovaries removed when they had alcohol use disorder. The belief was that if a woman had alcoholism that she would become promiscuous. Years later, what we learn is that what's more likely to happen is that women who develop alcohol use disorder, it wasn't about promiscuity. They were more likely to have been sexually abused when they were girls or sexually assaulted as women.

And then we have periouds in our history where there were therapeutic haircuts and heavy confrontation is our primary technique for addressing substance use disorders. There's was a man by the name of Charles Dederich, who started what was later known as Synanon. And he was a member of Alcoholics Anonymous in California, and he was kicked out of AA in California. In fact, Charles Dederich is the only person I ever heard of that was permanently kicked out of Alcoholics Anonymous because he was cross talking, talking negative about the members, so they kicked him out.

He moved to Lexington, Kentucky, in the 1950s, where there was an opiate epidemic, a heroin epidemic. And he started Synanon, the first therapeutic community for the treatment of opioid addiction.

And because back then they believed that people with addictions were bad people, right, the nature of these therapeutic haircuts and heavy confrontation is that Charles Dederich would bring their clients down. They would abuse, they would humiliate their clients, and then lift them up. We're going to tear you down and lift you up. Somewhere there had to be a belief that people with addictions were bad people.

You know, this is the only profession, the substance use disorders profession, where because of stigma, people want you to prove that you're in recovery by discontinuing your medication. If you really are in recovery, you stop using methadone.

If you really are in recovery, you stop using buprenorphine. Could you imagine what would happen if someone had cancer and then the world said, prove to me that you are in cancer recovery. Stop taking your medication, or diabetes. If you really want to prove that you're in recovery, then stop taking insulin for diabetes or medication for depression, where their stigma is high and people are told things like you're not in recovery as long as you take medication.

And then the criminalization of substance use disorders. And what I mean by the early years, it goes all the way up until recently. In 1985, there were 400,000 incarcerated individuals in the United States. They intensified the War on Drugs, and the numbers swelled from 400,000 to one million by 2005, and then-- by 1995, I'm sorry, and then 2.4 million by 2005. So when stigma is high, criminalization happens a lot.

And then a revolution occurred, the person-centered recovery movement of the 1980s. The person-centered recovery movement is an approach to mental health treatment in which the client is the director of their plan. Now, for those of you who have been doing this work for about a decade, this sounds like a

no-brainer to you. But in the 1980s, you'd be shocked how seldom persons with mental illness had a voice, a safe zone in their plan.

There are four events that led to the new person-centered the recovery movement. The first occurred in the 1980s, where there were many clients that did not respond well to traditional mental health treatment. Many of these individuals were homeless for years and had substance use disorders.

Let me ask you a question. Where you work, are there people in your state who have mental illness that would rather stay outside when it's 105 degrees in the summer, in July, or 50 degrees below in the winter where you're working, where you live, rather than go instead of a mental health facility and be told what to do? Are there are people in your state that would rather sleep outside year round than they go inside the facility and be told what to do? That's a yes or no question.

What do you see there, Jennifer?

JEN WINSLOW: Yes, for sure.

MARK SANDERS: Yeah, so where you have the absence of self-determination, there's a lot of people refusing services. Many of these individuals were not only homeless, but have also had substance use disorders. Did you know that in the 1980s that in some states, individuals who were addicted to crack cocaine, that they could actually qualify for SSI, for Social Security? Yeah, there were individuals who had substance use disorders, stimulant use disorders, cocaine, in some states who qualified for Social Security.

Here's a question. Where you work and where you live, if a person has mental illness and they could benefit from living in a nursing home and their primary source of income is Social Security, what percentage of their check does the facility get to keep, and how much does the individual get to keep of their own money? In your state?

Any responses there, Jen?

JEN WINSLOW: Not yet. well I'm sure there will be in a second

well halfway houses

someone says, I don't know. I would estimate 85% to 90% plus goes to their housing facility.

MARK SANDERS: So historically, these facilities would get, as someone just mentioned, 90%. As a matter of fact, early on in the '80s, the person would get to keep $25 of their check. The facility would get the whole rest of the check.

Could you imagine if that were you? If you were living somewhere and your rent or mortgage was your whole paycheck and all you got to keep was $25, who would want to go and receive services, right? And what they concluded, the federal government, was that homelessness was costly. We needed to do things different.

In the 1980s, there were audits by the federal government that revealed the mental health treatment was primarily ineffective. When John F. Kennedy was president of the United States in the 1960s, he had a sister who had a developmental disability and she died. And the president didn't know the difference between a developmental disability and mental illness.

So after his sister died, he passed a law that said that every county in the United States should have a local mental health center. And by and large, every county in the United States has a mental health facility. If you live in rural America, you might have to travel a ways to get there, but they all have these facilities.

So beautiful act lots of mental health facilities he was assassinated. And a few presidencies later Richard Nixon became president and he said, if we're spending all this money on mental health, you have to actually prove that you're doing the work. So they intensified the audits. And they found out, they concluded that not a whole lot of recovery, not a whole lot of treatment is taking place. What they're basically doing is warehousing people like a factory.

As a matter of fact, when I started working in mental health in the '80s, they were right. The feds were right. We thought that all people with severe mental illness wanted to do was scratch lottery tickets, pace the floor, watch TV, drink coffee, and smoke cigarettes all day. Clearly, a revolution was needed. The closing of state psychiatric hospitals all over the country increased homelessness and the incarceration of individuals with mental illness.

Then the fourth event that led to this new recovery revolution is former mental health consumers emerging as leaders in the field. I bring your attention to a woman by the name of Nanette Larson, from Illinois. Nanette Larson has a public story of bipolar disorder right and a master's degree in psychology. And Nanette Larson is the Director of Rehabilitation Services for the state of Illinois.

And it's through Nanette Larson that I first learned about the new person-centered recovery movement, right? Were consumers. People who previously received mental health services became leaders within the field. It was from Nanette Larson that I learned first person language.

So she was talking to a group of individuals who were diagnosed with schizophrenia. Here's what she said. Stop telling people you're schizophrenic. You are not schizophrenic. You have schizophrenia. That would be like someone who has herpes, syphilis, gonorrhea, and chlamydia saying that they are herpes, syphilis, gonorrhea, and chlamydia. There's more to you than that. There's a lot more to you than that.

She introduced me to a man who has schizophrenia who is the executive director of a non-profit organization that works with people with schizophrenia. The man still hears voices.

I said, what do you do when the voices show up? He said, I tell the voices to shut up, be quiet. I have work to do. Who would have ever thought in the 1980s that that's possible?

Let's talk about the tenets of the person-centered recovery movement. With this new movement, the client has ownership of his or her life, and is therefore the director of their plan. Clients have a greater investment in the change process if they choose their own pathway of recovery. So with this new movement, they made sure their clients had a voice.

Family and friends who believe in the client can be a great source of support. Matter of fact, the other day I was listening to Magic Johnson, Earvin "Magic" Johnson, the basketball great, who told the story when he was first diagnosed with HIV in 1992, 30 years ago. You remember 1992, those early days of HIV before medication was solid. Some people would get their diagnosis and they would just die.

Here's what Magic said two years ago. He said, when Cookie told me that she loved me and she would not leave me, I knew that I would survive this. Incredible story about this program in the prisons called Adopt a Grandchild.

There are these women between ages of 68 to 88 years old who volunteered to be surrogate grandmothers for the incarcerated in this prison. There's one woman who was 72 years old. She was 72 years old. She was invited to be the surrogate grandmother for the most violent inmate in the entire prison.

She showed up one day, hello, it's me, Grandma. Get out of here, lady, I don't want to see you. OK. Came back two days, it's me again, Grandma. Didn't I say I didn't want to see you? This went on for a long period of time. She kept coming back.

One day she brought him a cake. It had candles on it. She asked him to buy the candles. She sung "Happy Birthday" to him. Actually, it brought tears to his eyes. And her visits were the catalyst that helped him turn his life around. [INAUDIBLE] ask her, what does she do? That every time she showed up, she showed up with love.

If I didn't know better, clients with mental illness and addiction, if I didn't know better, I would think they had no families, because we do a lot of individual work, very little family work. What the research suggests is that when you engage the family and the family is part of the healing, then recovery rates increase.

With this new model, services are geared towards helping the client achieve a desired future and a meaningful life, purpose. In fact, this is so important that the next time we meet, June 7, we're doing a presentation entitled "Logotherapy, helping clients with co-occurring disorders develop purpose, meaning, and recovery".

The client is approached as a capable human being full of strengths. What the client has learned from previous experiences should be included in their plan. Helpers who work to view the situation from the client's perspective. So the mental health profession prides itself in one of its first evidence-based practices, called ACT teams, Assertive Community Treatment teams. And the team consists usually of a counselor or a case manager, a nurse, often a peer, who go out outside and meet clients in communities, often individuals who are homeless, right, say we're your ACT team. We want to help you. What do you need?

The purpose of this evidence-based practice was to reduce psychiatric hospitalizations by providing services within the community. So Nanette Larson shared with me that they surveyed clients who were diagnosed with paranoia about ACT teams. And what they said is that we don't like it because could you imagine waking up underneath a bridge and there are four people or five people looking at you, 10 eyes staring at you? And you're already paranoid, right? They said, no, we don't like that practice. We want a job that we can do that gives our lives meaning and purpose.

Wellness strategies chosen by the client are used. So I have lived to see a day in both addictions and mental health that we now have a credential, the recovery support specialist, the peer-based recovery support specialist, recovery coaches.

So about a decade ago, I was doing a training in Milwaukee, Wisconsin, preparing people to be recovery coaches. And I was introduced to a woman who was my co-trainer. And she told me in her introduction that was she was in recovery from alcoholism for 30 years, recovery from alcohol use disorder for 30 years, and stable from schizophrenia for 25 years.

So at some point, we started talking about schizophrenia and medication and she told me the number of pills she was taking. Let us chat. How many pills do you think she told me she was taking for schizophrenia? Did you put a number in chat?

JEN WINSLOW: 5, 8, 6. 15.

MARK SANDERS: By the way, could you imagine having to keep up with a daily regimen of 15 pills a day? I struggle with just taking vitamins, remembering to take vitamins, right? That could be an insight right there. Zero pills.

I said, well, what's your medicine? She said, purpose. I'm a recovery coach. I'm helping other people with mental illness become recovery coaches. Purpose is my medicine.

Because she was on purpose, she said, I haven't needed medicine in 15 years. I said, what else do you do? She said yoga and meditation. Those are my chosen forms of wellness.

Service planning should include the client's entire life, so you're working with a client who wanted to be President of the United States. They've got a severe mental illness. In recovery, they might decide that they want to get their favorite candidates elected. Purpose. The helper strives with this new movement to understand the client's unique hopes, wishes, dreams, and aspirations.

Incredible story about this boy who lived in the hills of West Virginia. The teacher gave the classroom an assignment to write an essay about what they wanted to be when they grew up. And the boy wrote a glowing essay about his desire to be a doctor, and the teacher put a red F on the paper and wrote, that's an unrealistic goal for a boy growing up in these hills. Why don't you write about your desire to be a farmer like your father, a coal miner like your grandfather?

Later that night, the boy talked to his father about the F and he said, son, I can't help you. I'm a farmer. I know nothing about what it would take to be a doctor. The boy walked in the classroom the next day and handed the paper back to the teacher. Teacher said, that was the same paper you handed in yesterday. The boy said, you can keep the F. I'm keeping my dreams.

Langston Hughes said that hold fast to dreams, for if dreams die, life is a broken-winged bird that cannot fly. What are your dreams and your aspirations in recovery? I promise you that in the 1980s we didn't ask that question. We asked questions like would you like to go to the zoo and feed the pigeons today and have a cup of coffee, take a walk around the block?

An end result of the person-centered recovery movement, this new movement, was an increase in evidence-based practices in mental health and the integration of mental health and substance use disorders treatment. So let us talk.

There are three types of co-occurring disorders treatment. One type of co-occurring disorders treatment is called sequential, where the person who has a dual disorder, they get help for each disorder one at a time. They go to an addictions facility, then they're discharged. They give them a cake and a graduation. They walk across the street and they begin mental health treatment in sequence, one at a time.

The second type of co-occurring disorders treatment is that second one should be integrated, integrated is in the middle, where both disorders are treated in the same facility at the same time. And then the third type of co-occurring disorders treatment is what's called concurrent. Both disorders are

treated in separate facilities at the same time. So Monday, Wednesday, and Friday, the client goes to mental health treatment at one facility, and then Tuesday and Wednesday and Saturday, they go to addictions treatment at another facility.

Here's your question. Let us chat. Of these three types of co-occurring disorders treatment, which is the least effective of the three? Is it sequential, integrated, or concurrent? Which is the least effective?

JEN WINSLOW: So several people have said sequential.

MARK SANDERS: And they, Jen, thank you, would be absolutely right. You know, because at least when you get concurrent treatment, at least you're addressing both at the same time.

But there's a problem. If you refer a client to both mental health and/or addictions treatment, ideally, you would attend the staff meetings where that client is discussed in both facilities, because I've discovered that a mental health and addiction facility can have a different opinion, a different approach to even something as simple as Valium, Librium, and Xanax, anti-anxiety agents, minor depressants, central nervous system depressants.

So the mental health facility, they might say that Valium, Librium, and Xanax anti-anxiety agents. They help with anxiety disorder. The addiction facility says, you know, actually, Valium, Librium, and Xanax, are central nervous system depressants like alcohol. And many of our clients who are addicted to alcohol, if they take anti-anxiety drugs like Valium, Librium, and Xanax, they'll develop a high tolerance for those, and there's a chance they'll become addicted to them as well. Who's correct? They both are correct.

Remember the Coke Pepsi Challenge? Do you remember the Coke Pepsi Challenge? Let's do it right now. If you prefer Pepsi, put Pepsi in chat. If you prefer Coke, put Coke in chat. We're going to do a little study right now. Coke Pepsi Challenge, what's your preference?

JEN WINSLOW: Mostly Cokes.

MARK SANDERS: Isn't that interesting? And you know what's funny about that, Jen? Most of them prefer Coke. But whenever they have the Coke Pepsi Challenge, believe it or not, Pepsi almost always wins. Because with the

challenge, there's one sip. And for one sip, Pepsi is sweeter than Coke. By the time you get through the whole can, Coke catches up and takes over.

You know why Pepsi can't catch Coke? Pepsi can't catch Coke because Coca-Cola is about eight years older than Pepsi, and they used to put cocaine in Coca-Cola.

So now, I worked at Northwestern Hospital, the Institute of Psychiatry. I was building co-occurring disorder services. And doctors from the University of Chicago, that great hospital sent a letter to doctors from Northwestern Hospital, psychiatrist to psychiatrist, the 1980s. They wanted some subjects-- interesting word, right-- to do this test. And those were the years where cocaine was so problematic in the United States.

So the nature of this test, they wanted subjects, they wanted patients to come to University of Chicago hospital, lay in a hospital bed. They would give them a stipend. They would feed them. And they would have these two IVs. And in one IV they would inject intermittently cocaine in the vein, the other IV, speed. And they wanted to know if people could tell the difference between a speed high and a cocaine high. In other words, they wanted to see if they can replace speed with cocaine, because cocaine was causing so many legal problems.

And I went ballistic, because guess who signed up for that study? People who were addicted to cocaine, right? And so your average addictions program would never do that. But mental health at that time saw no problem with it, and so I had to advocate. Again, if your client is receiving concurrent treatment, it's really important for you to know what's going on in philosophy of each program.

Let's talk about the elements of integrated co-occurring disorders treatment. Components include psychoeducation about mental illness, the biological basis of mental illness, right? Years past, clients were not even told their diagnosis. They were told you had a nervous breakdown. Why am I here, doc? I had a nervous breakdown. There was no such thing as a nervous breakdown.

What's happening now is clients are being informed of diagnosis, and some programs are actually teaching them how diagnoses are made. They're showing them criteria for diagnosis so that they can diagnose themselves, providing education about mental illness, about the brain, how mental illness works in the brain, right, how medication works in the brain. Family psychoeducation, that's one of the components of integrated co-occurring

disorders treatment, because the family has lots of questions, too. Intensive family case management, providing entitlements and benefits for the entire family.

Assertive community treatment is a component of integrated co-occurring disorders treatment. Supportive employment. In fact, when you ask people with mental illness of all the evidence-based practices, which do you like most? Supportive employment and supportive housing. Integrated group treatment for co-occurring disorders, peer-based recovery support, medication.

Let's take a moment to talk about increasing medication compliance. Some rough suggestions are here. The first one is continuous assessment. And why should clients stay in continuous assessment? Because of what we talked about the first time we met. The psychiatrist, licensed counselors, licensed social workers, people that make diagnoses, only agree upon diagnosis 30% of the time.

There are lots of people being prescribed medication for conditions they don't even have. When they refuse to take their medication, we often say they're in denial about mental illness. That's not always the case. Sometimes the patient knows they don't have this condition. It's kind of like Dr. Albert Schweitzer said. There's a doctor inside of every patient. I know I don't have this condition. so why would I take this medication?

Community, it turns out when clients have a sense of community, it adds to a sense of purpose and belonging, right? It increases the chances that I'll take this medication if it will help me stabilize. Supportive employment, give me a job that I can do, I feel good about myself, have a reason to stabilize. Making sure the client has a voice, right? It's also critical. If you want to increase medication compliance to match the patient with a doctor that they like.

Do you know that people are more likely to take medication when prescribed by a doctor they like, provide psychoeducation about mental illness, the brain, how medication works in the brain. We want to make sure that the patient has an adult to adult relationship with the medicating physician. Basically, doc, this is not working for me. I don't like the side effects. It makes me impotent. It makes me thirsty. Can we look at another medicine, adult to adult? we want to make sure we're on medicatio. Client has a voice.

I recommend that what's called a cost benefit analysis, where you take a piece of paper, you draw a line down the center of a page, and the patient is asked, what are all the benefits of this medication and what are the

drawbacks? The medication really helps me stabilize, but it makes me really, really stiff when I walk and I can't sleep, right? People are more likely to take medication when the cost is less than the benefits.

A medication hospitalization evaluation, you simply ask the patient a timeline as to when they were hospitalized in the past and in how many of those instances they-- did they stop taking medication before they were hospitalized?

The four essentials. Dr. Robert Drake from Dartmouth University said that if you're working with clients with co-occurring disorders, if you provide four things first. They'll try to stop using drugs.

What's significant about that is when I first became a substance use disorder counselor, we were taught not to do anything for a patient first before they stopped using drugs. And if we do that's, enabling. That's not what the research says. If you provide stable housing, a stable therapeutic relationship, a meaningful daily activity, something that the client does every day that makes them want to get out of bed, feel good about that day.

As a matter of fact, I was doing a presentation once with 300 mental health case managers, and I ran into a former client on my way to deliver the presentation, a man who had been diagnosed with bipolar disorder, and I asked him, what should I tell these case managers?

He said, tell them that when we have something to do that gives our life meaning and purpose, that we stabilize. He said, one day, I pulled out my computer. I wanted to learn how to type all-- like, get quicker at typing so I could get a job. He said, the council took away my computer and gave me crayons and paint and told me to paint.

Said, Mark, have you ever noticed how there are lots of people with mental illness that are really, really good artists? I said, I noticed that. He said, do you know what they do with our paintings when we leave the facility? They tear them up and throw them in the garbage. He said, tell those case managers if they would take us to festivals where we could sell our art, it would give us a sense of purpose. We'd have a reason to want to do better with our lives.

Significant interpersonal relationships. So here's your question. What is the number one reason that people with mental illness wind up back in the psychiatric hospital? What's number one? What's the number one reason that people with mental illness wind up back in the psychiatric hospital?

A colleague of mine named Dr. Dunn did her dissertation-- her PhD dissertation on the main reason that people with mental illness wind up in the ER, the emergency room in hospitals, to be hospitalized again. What she found is, the number two reason is discontinuation of medication. Number one reason-- a loss in a significant relationship.

I'll give you some examples. There's a client who I knew who had schizophrenia, and he ran into a friend. And the friend said, my condolences. And the client said, for what? He said, your mother's funeral. Your mother died. She had her funeral last week. His siblings never told him that his mother died-- stigma of mental illness. So once the friend told them, he isolated himself in his room, he started drinking, and he wound up in the emergency room of a hospital.

I was working with a 16-year-old client who started banging his head against the wall, and they called the hospital for them to hospitalize him. So I asked him-- because that wasn't-- I never saw him do that. What's the reason you started banging your head against the wall? He says, I was headed to school and my girlfriend was on a bus next to the other guy that likes her-- my competition. And they were headed to camp for a week. So he started banging his head against the wall.

I had a client who had been in a war, and he came home from battle and he found that his girlfriend was pregnant by his best friend. Then he isolated himself after that loss, barricaded himself, and started drinking and wound up in the ER. So if we do these four things as a part of integrated service-- stable housing, a stable therapeutic relationship, a meaningful daily activity, and at least connecting clients with at least one person who deeply cares about them, they have a chance to stabilize. Thus says the research.

Let's talk about integrated approaches to helping clients with co-occurring disorders avoid slipping through the cracks. And by definition, slipping through the cracks is going back and forth between substance use disorders treatment, mental health treatment, child welfare system, without recovering. This can include multiple medical hospitalizations and periods of homelessness.

We want to first talk about primary reasons that clients with co-occurring disorders slip through the cracks. And number one on the list is unresolved

trauma. You ever think about the fact that lots of psychiatric diagnosis, underneath many of these diagnoses is trauma?

For example, anxiety disorder. I had a client who had anxiety disorder. He said when he was a little boy, his father was always yelling and screaming at him, verbally abusing him, so he developed anxiety disorder. And how did he cope with anxiety disorder? The use of pills. Anxiety disorder, trauma underneath. Depression is often-- lots of trauma underneath depression.

And personality disorders, by definition-- by definition-- borderline personality disorder is trauma, neglect, abandonment. No wonder, when a psychiatrist goes on vacation, the person with borderline personality disorder calls their answering machine or their phone repeatedly just to hear the doctor's voice. They started medicating their trauma, those issues around abandonment and neglect, with the use of alcohol and other drugs.

By definition, antisocial personality disorder, at its core, is trauma, neglect, and abandonment, which leads to feelings of entitlement, like the world owes me, because of how harmed I was as a child. Dissociative disorder, which we used to call multiple personality disorder, at its core, is trauma.

Attention deficit disorder. Dr. Gabor Mate, a psychiatrist with attention deficit disorder, wrote in his book In the Realm of the Hungry Ghost that he believes that attention deficit disorder is high stress in utero in the first years of life. Women who were pregnant in New York City September 11, 2001-- women that were pregnant in New York September 11, 2001, their babies were five to seven times more likely to be diagnosed with ADD. When mothers have a high cortisol level because of stress, according to Dr. Gabor Mate, so does the unborn.

I read a book called Chasing the Scream, the second best book I'd ever read on addiction by Johann Hari. And Johann Hari wanted to understand the American War on drugs during two eras, the 1930s and today. And why did we have a war on drugs in the 1930s? I'm glad you asked because we had a prohibition amendment, where drinking was outlawed.

And what he discovered was that whenever you outlaw a drug, outlaws-- gang members-- will get involved in selling the drugs. So in the 1930s, bootleggers and liquor with Al Capone and his gang, and Bugs Moran and his gang. They also had a war on drugs in the 1930s-- Mexicans along the border, for political reasons-- and then Chinese in San Francisco, because they were so successful.

So Italian gangsters, Irish gangsters, Mexicans on the border, the Chinese in San Francisco. And there was a war on drugs in the 1930s with one African-American woman, singer Billie Holiday, after she sang the song "Strange Fruit." You ever heard that song, "Strange Fruit?" You could listen to it on YouTube. She talked about driving through the Southern states in the 1930s and seeing African-Americans hanging from trees. And Billie Holiday said, that's strange fruit. They were lynched.

And Harry Anslinger, the director of Federal Bureau of Narcotics, went to Billie Holiday and said, I heard you use drugs. You need to stop singing that song, because you'll incite a riot. If you don't stop singing that song-- I know you use heroin-- I'll strip you of your right to sing songs in clubs. Billie Holiday said, they silenced me when I was 10 years old, and they will never silence me again. She continued to sing the song "Strange Fruit."

So recently, Johann Hari flew from London, where he lived, to New York to understand our current war on drugs. And the first person he interviewed was a trans-- was Chino. Chino is a 16-year-old transgender drug dealer who also used drugs. So what he learned was that Chino came about through a sexual assault. Chino's mother was addicted to crack cocaine, and sold her body in prostitution to pay for the drugs. Chino's father was the police officer who arrested Chino's mother and then sexually assaulted her during the arrest, and Chino was born.

Then he asked, would someone drive me to Harlem? Because I want to meet the people who knew Billie Holiday when she was alive. And he found out that Billie Holiday was raised in a brothel, that her mother worked in a house of prostitution to make ends meet. And he learned that when Billie Holiday was 10 years old, there was a raid on the brothel. Her mother was arrested. And when she returned to the brothel from prison, she opened the door and there was a grown man having sex with 10-year-old Billie Holiday.

They let him go, and they put her in solitary confinement for a year. They silenced Billie Holiday for a year. And that's what she meant when she told Harry Anslinger, they silenced me when I was 10 years old. They will never silence me again. She was traumatized from the sexual assault and the solitary confinement, so she started drinking heavily to cope at age 11. Started using heroin at a young age. You know how Billie Holiday died? Of cirrhosis of the liver from her drinking while in the facility detoxing off of the heroin.

So next, the author, Johann Hari, decided that he would fly from New York to Juarez, Mexico, as a way of understanding the American War on drugs. Why Juarez, Mexico? Because Juarez, Mexico, is the city in Mexico where drug

cartels, such as Chapo Guzman and the other cartel, would kill each other in order to bring drugs into the United States to satisfy what historian William White calls "our insatiable appetite for drugs as a nation."

He found out that with all of those killings, all of that trauma, all of that gunfire, that Juarez Mexico was the highest ranking city in all of Mexico. So next, Johann Hari flew from Juarez, Mexico, to Vancouver, Canada, because what he learned was that in Vancouver, Canada, there are more people who migrate to that area from the United States that are using opiates in public-- more so than anywhere else in North America.

So he met with a famous doctor there, Gabor Mate-- Dr. Gabor Mate. And he asked Dr. Mate, why are people using so many drugs here, in Vancouver, Canada? He said, they're all trauma survivors. Dr. Gabor Mate said, the more severe the trauma, the more severe the addiction. So the author put it all together.

He said Chino, sexual assault, drug use. Billie Holiday, sexual assault, trauma, heroin and alcohol use. Juarez, Mexico, gun violence, trauma, heavy drinking. Juarez, Mexico-- I mean, Vancouver, Canada-- trauma. So he concluded that at the core of addiction was trauma.

So Gabor Mate wrote a book called In the Realm of the Hungry Ghost. In the book, he makes three bold statements. The first statement is that drugs don't cause a substance use disorder any more than a deck of cards causes compulsive gambling. Let us take a moment to chat. What do you think is the most addictive drug in the world? What is the most addictive drug in all of the world? You can put your response in chat.

JEN WINSLOW: Still waiting. Sugar? Fentanyl? Nicotine?

MARK SANDERS: OK. So are you all sitting down? In his book, Dr. Gabor Mate says no drug is highly addictive. You know, alcohol is not very addictive. So you're wondering why there are 23 million people in the US with alcoholism? Because so many people drink. Only 1 out of 10 people who drink develop alcoholism.

In other words, in a seminar like this, there's about 40 of you here. 1 out of 10 is about four alcoholics-- people with alcohol use disorder with us today. Talking about this live, you look around for the other three. I'm just kidding. Recovery is a great thing.

1 out of 10 people who use opiates become addicted to opiates. 1 out of 10 people who use stimulants become addicted to stimulants. 1 out of 10 people who drink develop alcohol use disorder. 1 out of 10. 1 out of 10 people who smoke marijuana become addicted to marijuana. As a matter of fact, Dr. Gabor Mate said that if opiates really did cause addiction, then most of our mothers would have opiate use disorder.

Because when you came into the world, your body weighed only four pounds when you were being born. Your head weighed [? 43 ?] pounds. Your mother tried to push and push and push, with no medicine. Where are my opiates? 1 out of 10 want more opiates once the pain wears off. Dr. Gabor Mate said, there needs to be a pre-existing vulnerability, like mental illness, like trauma.

They do lots of animal studies in order to understand humans. One reason, because mice have 99% of the same DNA makeup as human beings. So here was a study. They took these mice, these laboratory mice, and they put them in cages where they had only two things that they could drink, water and whiskey.

What they wanted to discover is, given the choice between water and whiskey, what do mice naturally prefer? What the researchers discovered is that some mice, given a choice between water and whiskey, prefer water. Other mice prefer whiskey. So once they discovered the ones that prefer the water, they bred them with other mice. They produce an offspring who also preferred water.

Once they discovered the mice who preferred water to, say, Jack Daniels or bourbon, they introduced trauma and electric shock. And these mice discovered, by trial and error, that the way you eliminate the trauma is to drink alcohol. And over a period of time, what the researchers discovered is that these mice that connected trauma with drinking, previously preferred the water, now they prefer the alcohol to the water.

You see, we do these animal studies to understand human behavior. So they took these chimpanzees and they put five things in the area for them to eat-- bananas, grapes, water, and a solid form of cocaine and a solid form of heroin. Bananas, grapes, water, a solid form of cocaine, and a solid form of heroin. Chimpanzees-- what they wanted to know is, what do chimpanzees naturally prefer?

Bananas, number one. Grapes, number two. Water, three. And they tend to leave cocaine and heroin alone. Researchers wondered what would happen if we removed their mother from the area, removed their father from the area,

removed all of their siblings, and then took away all of their playmates. In isolation, what they learned-- these chimpanzees, once deserted, once abandoned, they started chipping on the cocaine and the heroin.

In the book, Dr. Gabor Mate went on to say, for some people, the seeds of addiction is planted years before they use drugs. Remember baby Michael Jackson, the young Michael Jackson? When I was growing up, there were so many girls in my middle school that told me they wanted to marry Michael Jackson. My big sister, who shares a birthday with Michael Jackson, said we're born on the same day. He's going to be my husband.

When I was a kid growing up, I wanted to be Michael Jackson. It wasn't because he could sing or moonwalk-- those dances, right? It was because Michael Jackson had a perfectly round Afro, the Holy Grail of a hairdo. To have a girlfriend, when I was a kid, it helped if you had that Afro. I did not have that Afro.

Young Michael Jackson did not have a substance use disorder. But the Michael Jackson that did the music "Billie Jean" and "Bad," who left his brothers and went solo, he developed a substance use disorder to the opiates. You see, as I mentioned earlier, those of you who like Coca-Cola more than Pepsi, Pepsi has never been able to catch Coke in sales.

So at that time, Michael Jackson was the most famous face because he made that great music-- "Billie Jean," "Bad," et cetera. So they asked Michael Jackson to film a Pepsi commercial. You remember what happened? He showed up to film the commercial, he was holding a Pepsi can in his hand, his scalp caught on fire. They rushed into the emergency room of the hospital and they gave him an opiate for pain. Michael Jackson was like, where have you been my whole life? I've been waiting for you.

You recognize that Michael Jackson was 35 years old before he became addicted to the opiates? Here's a question. The clients that you work with who use drugs, at what age, on average, do they start experimenting with drugs? Would you put the age of experiment in chat? My client started at about 13. What about yours? What age did they start [INAUDIBLE]?

JEN WINSLOW: 11, 16, 13, 10 to 14, 12, 15, 11 or younger, 11 to 13.

MARK SANDERS: Isn't that interesting? Michael Jackson, 35. It's as if a substance use disorder, addiction, waited for Michael Jackson. We believe that he had four pre-existing vulnerabilities. One was the absence of a

childhood. You know how many clients develop a substance use disorder because they've been cheated out of a childhood? It's easy cheat a child out of a childhood. Divorce. In divorce, the son becomes the man of the house, the daughter becomes the woman of the house.

I work with single mothers a lot. And I say, try not to make them the man of the house. Let them stay a boy. You only have 12 years to be a boy, six years to be a teenager. You have to be a grown man for the rest of your life. I tell the mothers about the sons. I said, you know-- and I also say, if you're 12 years old, you're married to your mother-- I mean, and you were man of the house-- 12 years old, man of the house, it means you're married to your mother.

And you don't know my mother. If you knew my mother, you'd understand that statement I'm about to make. If I was 12 years old, married to my mother, I'd smoke marijuana every day. I'm just saying, that's a whole lot of pressure, to be 12 years old, married to your mother. You know a way-- another way children are cheated out of a childhood-- is childhood sexual abuse. Dating older people. Teen pregnancy.

So Michael Jackson never had a childhood. There was pressure to be perfect. I read that his father would press-- him-- do it again, Michael. Do it again. Do it again. Have I mentioned to you, the last time we were together, I am convinced at the core of addiction is childhood abandonment, childhood trauma, and a tendency toward perfection. Think about it.

When parents push their kids to be perfect, it's traumatic. That's what they're really saying. If you're not perfect, we won't love you. And that's traumatic. No self-concept. Michael Jackson's father told him-- said, son, you're a good singer, a good dancer, but your skin is a little too dark and your nose a little too big. And he spent years in surgery around that.

Father hunger and father wounds. Father hunger occurs when a child didn't get enough fathering or they were somehow injured by their father. You see, we've talked about the impact of father hunger and father wounds on sons. Lots of anger and rage, depression, medicate with alcohol and the use of other drugs. But what about daughters deserted by their fathers?

There's a book called Whatever Happened to Daddy's Little Girl? that tells the story of daughters who were deserted by their fathers. They're more likely to be depressed. And depression is that one mental illness that coexists with addiction with the greatest amount of frequency. Daughters deserted by their

fathers, according to the author, often go to what's called the search, where they're looking for their fathers.

There's a knock on the door. Is that my father coming to get me? The phone rings. Is that my dad calling me? Et cetera. Girls deserted by their fathers, at what age does the search end? Daughters deserted by their fathers, who are searching, at what age do they stop searching for their father? Would you put that response in chat?

JEN WINSLOW: Never. Never.

MARK SANDERS: Yeah. Some will search for the rest of their life. Girls deserted by their father, according to the author of the book, will often engage in periods of promiscuity. But the author says it's not so much about sex. It's about magical thinking. If I sleep with all of these people, maybe my father will discover how desirable I am and come back into my life. Girls deserted by their fathers often date older partners. For some of these girls, that begins their premature entry into adulthood-- early sex, early drug use.

Daughters deserted by their fathers are six times more likely to be sexually abused. And as you know, there's a link between childhood sexual abuse and substance use disorders. Daughters deserted by their fathers are 140 times more likely-- 140 times more likely-- to have a baby as a teenager. Her mindset is that he doesn't love me, but I will do something that will never be able to leave me. There's a strong link between daughters being deserted by their fathers and substance use disorders.

So some of you are thinking, what about mothers? Michael Jackson actually had a good relationship with his mother. He suffered from father hunger, father wounds. Children deserted by their fathers, according to one study out of Hawaii, are more likely to have more psychiatric symptoms. In a sexist society, and in cases where the mother is not there, the father is less likely to step up and do all of that parenting. When the mother is the one who is impaired, the reverse is true.

We're talking about mental-- about trauma because we think it's really that important if we are to help people with co-occurring disorders heal. Science weighed in. You know the ACEs study, where they asked 18,000 patients 10 questions about growing up in a home before age 18, were there any traumatic experiences they had? These 10 questions were divided along the lines of abuse, exposure to parental domestic violence, parental mental illness or substance use disorders, parental separation and divorce, loss of a parent through death, deportation, incarceration.

Of course, you know what they found. Compared to an ACEs score of 0, a person with a score of 4 is 8 times more likely to develop a substance use disorder. A score of 5, the person is 10 times more likely to develop a substance use disorder. Life expectancy of people living in America is age 85. For a person with a score of 6 or higher on the ACEs, their life expectancy is reduced by 20 to 25 years.

Found out, through research, that each ACE increases opioid relapse rates by 17%. And each visit to a trauma-informed program reduces relapse rates by 2%. So more programs and clinicians are needed that can integrate trauma-informed care in substance use disorders treatment. Would you put in chat yes or no-- or better yet, if you are a trauma specialist, would you put yes in chat? We want to know how many people with us today are trauma specialists. How many of you are trauma specialists?

JEN WINSLOW: So far, I have one yes.

MARK SANDERS: And you know, Jen, that's-- go ahead. I'm listening.

JEN WINSLOW: Another one. Yep. [INAUDIBLE].

MARK SANDERS: It's fascinating, because I've been asking this question for a couple of years across the country. The average is 1% of clinicians identified as being trauma specialists. And when I ask the question, what percentage of your clients have issues of trauma, they tell me 90% to 100%. And so if we are to really help clients avoid slipping through the cracks, all of us need to be trauma specialists, yet only 1% of people that I've interviewed [INAUDIBLE] trauma specialists.

So there's lots of different types of traumatic stress disorders, like post-traumatic stress disorder. The treatment of the cognitive behavioral therapies. Anyone know the difference between complex trauma and PTSD? [INAUDIBLE] you ask? Well, PTSD-- exposure to a specific traumatic event is required.

With complex trauma, exposure to a specific traumatic event is not required. All that is required. It's been years living with neglect, abandonment, multiple placements, parental substance abuse, adult emotional unavailability, multiple losses, exposure to domestic violence and abuse. And you are vulnerable-- and you are vulnerable-- to complex trauma.

If the primary symptoms of PTSD are hypervigilance, nightmares and bad dreams, flashbacks, the number one symptom of complex trauma is difficulty regulating emotions, when the person goes from calm to explosive. Living with these things for years makes it difficult for people to regulate their emotions. Interestingly enough, lots of clients who struggle to regulate their emotions will regulate their emotions through the use of alcohol and other drugs to calm themselves down.

63% of those with complex trauma have difficulty with impulse control. 62% have negative self-image. 60% have been diagnosed with attention deficit disorder. But it's really complex trauma for many. 56%, conduct disorder, because they act out the complex trauma with aggression. They're misdiagnosed. 12% of those with complex trauma also have PTSD. Then 10% those with complex trauma have a substance use disorder. So they're medicating this with the use of alcohol and other drugs. So the treatment of complex trauma is cognitive behavioral therapies.

Then we have historical trauma, a cumulative emotional and psychological wounding over the life span across generations, emanating from massive group trauma. There are many groups that have historical trauma-- Native Americans, Irish Americans, African-Americans-- who else? Just about everyone has-- so Latino Hispanics. Historical trauma, generational trauma.

Native Americans have done some of the most work in healing historical trauma. You know, Native Americans have the highest alcoholism rate in the world, historically, because of their trauma. So Coyhis recommends the group get together-- mass mobilization, mourn together, cry together. Talk about what happened to them collectively together. And then returning to the culture that was taken from them.

Native Americans are putting together. 40% and 50% and 60% recovery rate, some of the times, healing historical trauma, and returning to the culture that was taken from them. There's a group of Canadian First Nation Tribes called the Alkali Lake Tribe in British Columbia, Canada. This tribe went from 100% alcoholism to 95% recovery. And they've maintained a 95% recovery rate for 35 years. They healed historical trauma together, and they returned to the culture that was taken from them before colonialization. They've maintained a 95% recovery rate-- dual recovery rate-- over a 35-year period.

There's a trauma that I've coined myself. And I'm calling this trauma 24/7/365 terror. This is when you have clients that live in areas where there's lots of gun violence, lots of community violence. And the way 24/7/365 terror differs

from post-traumatic stress disorder-- in order to be diagnosed with post-traumatic stress disorder, you're someplace that's stressful, like a war zone or a prison, and then you go to someplace safer, and now, you're having the symptoms, when you're in the safest place.

With 24/7/365 terror, you never get relief. You feel like you can be shot and killed at any moment. We have some cities in the United States that have lots of gun violence.

So I was working with a young man that lived in my old neighborhood. And my own neighborhood in Chicago is called the gun capital, the shooting capital, of the world. And he was 20 years old, and he was in our residential facility. And he went on a weekend pass, and he came back smelling like marijuana. Have you smelled marijuana recently? I mean, you talk about strong stuff.

He had signed an agreement that he wouldn't use any drugs while he was in the facility. Man, I smell like marijuana. Said, what did you do? He said, I walked across the street to Target and I got a bottle of Febreze, and I sprayed Febreze all over myself. I said, then what did you smell like? He said weed and Febreze. So he went in the facility, they smelled the marijuana even though he put all that Febreze. You can't go on a weekend pass next weekend.

Now, I'm going. I don't care what they say. I'll be 21 years old next weekend. I'm not guaranteed to see my 21st birthday. I've had four friends that were killed. They were murdered in the streets. They didn't see their 21st birthday. And so he didn't expect to live long. So I asked him, can I negotiate on your behalf? I said, the staff is concerned with you going to [? all ?] neighborhood and coming back-- coming back having used drugs. If you go and they put you on the program, you go to prison because you're-- I'm going. I don't care what they say.

So I helped him negotiate it. The following week, we were ready. I share these different types of traumatic stress stories with you just to highlight the fact that they're not all treated the same. Historical trauma and complex trauma are not treated the same. What they have in common, all of these conditions, these different types of traumatic stress disorders, they overlap with substance use disorders at a high rate.

So I asked him a question when he returned. How long do African-Americans and Latino males live? I've been asking this question of young African-American Latino males for the last 20 years all over the country. What do you

think is the most common answer I receive when I ask this question? What do they tell me? You can put your response in chat.

JEN WINSLOW: 50 years, 60? 55. 60.

MARK SANDERS: You know what they tell me? When I ask African-American, Latino males, how long do most African-American and Latino males live, they tell me 21 years old. In other words, the 18-year-olds are telling me that they'll be dead in three years. The 19-year-olds will tell me they'll be dead in two years. 20, I'll be dead next year. Like my client said, I'm not guaranteed to see 21.

So the nature of the treatment of this particular type of traumatic stress disorder is to convince them that they can live. So the next time I met with him, I was dispelling myths. This was the approach. In Chicago annually, there are 500 murders-- annually-- and 40,000 births. So he quickly did some math. That means, for everyone that's murdered in Chicago, there are eight children that are born. I show them where there are 2.7 million residents in Chicago and 500 annual deaths-- murders-- in Chicago.

I showed him statistics from a suburb surrounding Chicago, Cook County suburbs. 9 million residents. 500 annual murders. In the neighborhood where he lived, Englewood, 112 murders over the course of 20 years, with 73,000 residents in Englewood.

I showed him Illinois Department of Public Health statistics that showed that the life expectancy of African-American men in Chicago is age 70. Latino Hispanic male is 73. When I showed him those statistics, he snatched the paper from my hand. So are you saying I can live? I said, it looks like it. He said, man, I have to smoke some marijuana and think about that. I haven't thought about the possibility that I can live.

The next step of this unique treatment that we establish for these young men is to give them some reasons to want to live, to help them identify a sense of purpose. The next time we meet, June 7, we're going to talk about that. How do we help clients maintain recovery by helping them connect to a sense of purpose?

There are three waves of trauma-informed care. The first wave was the psychodynamic approach, where the client shares their story in order to heal. They go back and revisit the trauma. The second wave was the approach that

has the most efficacy, the most proof of effectiveness, the cognitive behavioral, the here and now approaches.

The third wave are the experiential approaches, which I happen to believe that as soon as we start studying the experiential approaches like we studied cognitive behavioral therapy, we're going to find that the experiential approaches, the non-talk therapy, we're going to find that it will be the most effective. Are there any of you who are experiential therapists-- that is, a counselor-- that you do some approaches to counseling besides talk therapy? If yes, what else do you do besides talk therapy? You can put your response in chat.

JEN WINSLOW: Somebody said that they do EMDR.

MARK SANDERS: Nice. Yeah. And there's something that's kind of physical about EMDR, isn't it? Anyone else, Jen?

JEN WINSLOW: No.

MARK SANDERS: Here's why I think these approaches are going to be really important. Dr. Bessel van der Kolk wrote a book called The Body Keeps the Score. What he shares in the book is how trauma lodges itself in the human body.

As a matter of fact, September 11 survivors in New York were asked what helped them cope with their experience of September 11. Number one, acupuncture. Number two, massage-- therapeutic massage. Number three, yoga. Number four, any kind of movement. Number five, dance. Number six, EMDR. Because trauma lodges itself in your body.

When I read the book The Body Keeps the Score, I visited my grandmother's church. And my grandmother goes to an African-American Baptist church. Have you ever gone to an African-American Baptist church? Lots of singing, lots of dancing, lots of shouting. And after reading the book, I figured it out. When African-Americans go to church on Sunday and they're singing and dancing and shouting, what they're doing is removing historical trauma from their body through movement-- singing, dancing, and shouting.

After I read the book, I talked to a Native American woman who shared with me her story. She teaches Native American girls dancing-- Native American dance. She said, Mark, I was sexually abused at age six. I started drinking

alcohol at age 7 to cope with it. I went back to Native American dance at age 36. I got into recovery at age 37. Dance got me into recovery. It is my hope, by sharing this information, that if you want to help clients recover from co-occurring disorders, again, that all of us become trauma specialists too.

We're talking reasons that clients with co-occurring disorders slip through the cracks? Unresolved grief. Our clients suffer lots of losses. I consider, for example, schizophrenia to be kind of cruel, because when its symptoms show up, usually like 18, 19, 20, 21, right? So it affects your social and occupational functioning, but you have memories of what your life was like before. And so you grieve. I'm a grief specialist.

Here's the story. About 20 years ago, I was invited to a Commonwealth of the United States called the US Virgin Islands. It's so beautiful in the Virgin Islands, I said to God, if I don't get to heaven, you could send me to the US Virgin Islands. You ever been there? It's so beautiful-- the ocean, the palm trees. I was invited to the Virgin Islands to speak to a group of high school students that were cutting class. They were smoking marijuana cigarettes about the size of trees.

So I gave the speech. Someone invited me on a cruise on the Atlantic Ocean. I was on this crew, the sun was setting, the sky look really beautiful. I said, God, is heaven as beautiful as this? When I returned from the cruise, the rear light on my phone in the hotel room was blinking.

So I called the hotel lobby. [? Hurried ?] to the lobby, they said, call home. There's an emergency. Your wife called. And I call my wife, and she told me that our six-year-old son-- at that time, my only child-- had just died. And I went from what felt like heaven to what felt like hell. And I didn't think I could ever do my work again.

So that became my motivation to become a grief specialist. Because every time I help someone with their own grief, somehow, it helps me. Many of the clients that we work with that have addiction, mental illness, suffer what we call unspeakable losses. And that includes losses that contain stigma, like HIV/AIDS, suicide. But these carry so much stigma that they often don't get talked about. So they suffer in silence. Unacknowledged losses.

When my son died, he was six years old. He was six years old when he died. And there were so many women came up to me who said, I had a miscarriage before. You'd be shocked how many women have had miscarriages. You should also know that the women we work with who have addiction, mental

illness, and co-occurring disorders, they experience more miscarriages than the general population. They tend to suffer in silence.

So I would ask women who had miscarriages, how did the world respond? You see, when my son died, we received 250 cards of condolences in the mail. 250 cards of condolences. 50 plants came up and showed up in the mail. 50 plants. I gave away 49. I kept a cactus. I like my office with the cactus. 50 books on grief. I read all 50 books. That's how I became a grief specialist.

Women who have miscarriages-- and nowadays, an ultrasound, you can look at an ultrasound-- and they're in 4D now. When I was growing up, an ultrasound looked like unmolded clay. Today, they're in 4D. You can look at an ultrasound today and say, boy, he looks just like his grandfather-- in utero-- beard and all.

So she's bonding. She's named. And then miscarriage. Unacknowledged losses-- miscarriages, stillborns. Complicate grief, because we don't talk about these losses. So when I feel that women are hurting because of miscarriages, I say what people said to me. My condolences.

Ambivalent losses. Clients with addictions and mental illness often have lots of ambivalent losses. The great majority have histories of trauma in childhood, so someone that they really care about deeply died, but they're filled with anger and rage because the person traumatized them as well. Ambivalent losses complicate grief.

So this is so important that we're going to spend a moment talking about this. Let me ask you a question. The clients that you're working with right now, what losses are they currently experiencing? Would you put your response in chat? What types of losses are they experiencing right now, as we speak?

JEN WINSLOW: One said isolation from family and natural supports. A parent. Employment, housing, family, family death, parental loss, murdered friends, COVID deaths of friends and family, teachers.

MARK SANDERS: This is a lot. This is a lot of losses, all connected-- most of them-- to addiction and mental illness. So Elizabeth Kubler-Ross was, like, the mother of grief work. She is to grief work what Sigmund Freud is to psychoanalysis. Elisabeth Kubler-Ross created this model. She says that when a person suffers a loss, they go through denial, then they're angry, then they start bargaining, then they experience depression, and then acceptance.

With this model, acceptance-- acceptance-- is the fifth stage of grief. But truth be told, grief doesn't really begin until after you accept the loss. That's when grief actually begins. But with this model, they have it ending with acceptance. This is not what-- Elizabeth Kubler-Ross never intended for this model to be connected to death and dying. It doesn't fit. She called this model the stages that a person goes through when they get the news from their doctor that they have a terminal illness, like cancer.

See if this fits better. Patient, you have cancer. Denial. Why me, question mark? Followed by anger-- or, this couldn't be true. Denial. Anger. Why me? They're angry about it. Bargaining. Elizabeth Kubler-Ross said that people who believe in God, when they're given the news of a terminal illness, they start bargaining. If you let this tumor go away, I'll go to church eight days out of a seven-day week. I'll pray every day. I'll eat better. Bargaining.

Then she said they go to a period of depression, where they feel like they're dying of the condition. Then they gradually accept it Elizabeth Kubler-Ross said acceptance-- the difference between acceptance and depression is like living with a condition rather than dying with a condition. There's a book I read called I Refuse to Die Before I'm Buried. I'm living with this condition the final stage being I hope. It doesn't fit death and dying.

If you apply this model to death and dying, there are stages after acceptance. I call that stage the messed-up stage. You see, you've accepted the loss, but you're all messed up. You see, after my first son died, I didn't think I could ever do my work again. But several things happened. At my son's funeral, 250 certified alcohol and drug abuse counselors showed up. And I hugged all 250 of those counselors. You ever hugged 250 people? Nearly killed me. But it breathed life back into me. I felt love. We did the unthinkable.

The philosopher said it's better to have loved and lost than not to have loved at all. So 18 years ago, I had another child. He's a sophomore in college. That helped a lot. The second thing that helped is that my wife and I went to a workshop of bereaved parents. And there was a woman who spoke who was also a bereaved parent. And here's what she said. Changed my life. She said, grief is not about forgetting. It's about remembering with less pain. Grief is not about forgetting. It's about remembering with less pain.

And when you suffer a loss, you don't want to try to forget, because that which you try to forget has a way of haunting you. You want to hurt less. And one way you can hurt less when you suffer a loss is to be able to tell your story as frequently as you need to tell your story. So I start telling the story. You see,

our clients with co-occurring disorders suffer all of the losses that you mentioned, but often, they don't have a chance to share their story.

I'll share with you one more model by David Kessler. He calls it finding meaning as a way of healing from some loss. He said that the Elizabeth Kubler-Ross is correct. When we suffer a loss, we go over a period of denial, anger, bargaining, depression, acceptance. Then the sixth stage is finding meaning, a purpose connected to a loss. Kessler says that meaning helps us find a path forward. It helps us make sense of grief. Meaning can help decrease some of the pain of grief.

There are many ways that people find meaning when they suffer a loss-- gratitude. The client's grandmother died, but she feels grateful that the grandmother got a chance to meet the grandchild before she died. Lessons learned. So many of our clients that we work with-- so many of the clients that we work with-- so many of them have difficulty with relationships in recovery.

So what we do is help them find the lessons learned in failed relationships. And basically, it makes them feel like the loss was not for naught, because I've learned from this. I'm less likely to repeat this again. Finding a purpose or taking up a cause-- organ donation as a way of finding meaning in loss. Four people lived because my loved one was an organ donor. Contributing to a cause.

You might recognize Farrah Fawcett, one of the original Charlie's Angels from the sitcom of the '70s. She had cancer. And she put in her will that the only way you can show reruns of movies that she was in, and sitcoms, is you had to make the donations to cancer research. And cancer, taking up a cause.

There was a woman named Sandoval whose daughter was killed by an intoxicated motorist. And she started MADD as a way of finding meaning and purpose-- Mothers Against Drunk Driving. Every gang member that I've ever-- I've known many gang members that, when one of their fellow gang members dies, they get a purpose. Some of them become police officers-- they leave gangs-- and lawyers. And I've met some who will become doctors.

This is a scene from a movie called Cooley High, shot in Chicago in 1965. The storyline. The fellow on the left-- on the far right, I'm sorry-- was killed by a gang member. The one right next to him went to Hollywood and became a playwright as a result of his friend being shot and killed. Some people find God after suffering a loss. He's at peace now. She's at peace now.

There's a woman by the name of Nona Gaye who was the daughter of singer Marvin Gaye. And she dated Prince. And she believed that Prince was in a better place. I think Prince is in a better place now, up there with all of those who died early, like Michael Jackson and my dad. They're up there jamming. Then there's a story of rapper Tupac Shakur, who predicted his early death. He didn't want his mother to hurt when he died. And so he made about four songs that contain the lyrics "dear Mama, don't cry."

"Dear Mama, don't cry. Tell the homies I'm in heaven and I'm doing good. To my homies, I'm in heaven, and they ain't got hoods. There's no poverty in heaven, Mama, don't cry. I seen a show last night with Marvin Gaye. It had me shook. I was drinking peppermint Schnapps with Jackie Wilson and Sam Cooke. Then some lady named Billie Holiday sang, sitting there kicking it with Malcolm until the day came. Dear Mama, don't cry. I'm doing all right."

So what does it take to be an effective counselor around grief? Good listening and basic counseling skills. If you have no other skill, if you can listen really well, you can help clients with their grief. Boundaries. The ability to view grief as natural. Slow to prescribe, label as pathological. Grief is natural and automatic when you suffer loss. Ability to talk about your own losses-- just to get comfortable with it. Not necessarily with clients, but in your own life.

Some clients get angry with God when they suffer a loss. You can talk about it, which makes it OK for them to talk about it with you. Not treating everybody who suffers a loss the same. Slow to prescribe pills for grief, because it's automatic and natural. And supporting clients before you challenge them around their view of the reason they suffered that loss. So let me ask you, if you are a grief specialist, would you put yes in chat? Want to know how many of you are grief specialists.

JEN WINSLOW: Somebody said that they are heading towards it because of the [INAUDIBLE].

MARK SANDERS: Yeah. And thank you, Jen. And like trauma specialists, I think that grief, like trauma-- and there's some trauma connected to this. Traumatic grief. We need to integrate substance use disorder services with grief specialists and trauma specialists. Another reason that clients slip through the cracks is because they have a hidden psychiatric disorder.

You see, if somebody has schizophrenia you would know that they had a thought disorder. Sometimes, phobias, attention deficit disorder, depression, personality disorders, and traumatic stress disorder could be hidden. That is why I suggest to you, if you want to help clients avoid slipping through the cracks, that they should stay in continuous assessment. You're looking for that third, hidden diagnosis, which is more difficult to find.

Some clients that did the crack because they have an untreated process addiction. We're talking about a sexual addiction, compulsive gambling. Some client will substitute a chemical addiction, like opioids, with sexual addiction or workaholism, compulsive gambling, compulsive spending, cyberspace addiction.

Here's a question. Do you think, in the United States, that there are more people who are addicted to alcohol or sex? Are more people in the United States addicted to alcohol or sex? Would you put your response in chat? Alcohol or sex?

JEN WINSLOW: Couple of people-- a few people have said sex. Most people are saying sex.

MARK SANDERS: Yeah. And isn't it interesting? Because we talk very little about that. We have some clients whose primary addiction are not drugs-- it's sex. And what drugs do is, they give them permission to engage in sexual activities that they wouldn't normally engage in. If we're not specialists in process addictions, there are many clients that we work with who will continue to slip through the cracks.

Emerging into a drug subculture is one other reason why clients slip through the cracks. There's a book written by William White called The Culture of Addiction, the Culture of Recovery. And he's written this book from an anthropological perspective. I want you to work along with me if you have a pen. According to historian William White, in every society-- if you view this from an anthropological perspective-- in every society, people use three types of drugs. If you would jot this down.

One type of drug is called socially celebrated drugs. And a socially celebrated drug is the kind of drug that people use in society where the society's mindset is that this is the drug that you use in order to have a celebration. Socially celebrated drug, in that society, people could not imagine having a celebration without that drug. In America, the socially celebrated drug is alcohol. We celebrate anniversaries, weddings, graduations, even funerals with alcohol. Alcohol is a socially celebrated drug.

Then number two. Every society uses what's called socially tolerated drugs. And a socially tolerated drug is the kind of drug that people use in that society where the society says, you can only use these drugs where you see that sign and with a doctor's order. And what comes to your mind is a socially tolerated drug, where you see that sign and where the doctors prescribe this for you? Cigarettes and medical marijuana are socially tolerated drugs.

You know, drugs can actually change in status. There was a time when cigarettes were a socially celebrated drug. But as they started connecting cigarettes to cancer, it shifted from celebrated to tolerated. Only where you see that sign.

The third category of drugs is what's called socially prohibited drugs. And socially prohibited drugs are the kind of drugs that people use in society where they're taught, if you get caught with possession of these drugs, you'll be stigmatized. You'll be shunned in society. Your family won't have anything to do with you. You could possibly do a long prison sentence. What comes to your mind as socially prohibited drugs? Crack, meth, heroin, and fentanyl.

And using anthropological language, historian William White said that people who use socially tolerated drugs who are stigmatized and shunned in society, they'll go out and they find what he calls tribes-- tribes. People who are using the same drugs you're using who will support you when the rest of the world turns their back on you. And then he said, if the client is not careful, they can become as addicted to the tribe as the drugs that they're using. The addiction is to the tribe.

I have a nephew that used to smoke marijuana every day. He was gang-affiliated. He could stop smoking marijuana, but he couldn't stay away from the gang. And when he went around the gang, he'd smoke. Do you believe that a bar is a tribe, that a bar is a tribe-- that every bar has a different tribal feel? Yeah, some people move to a new town, they go from bar to bar the bar before they find their bar-- it's the right tribal mix for them.

I have a buddy who loves bars. He loves everything about bar-- the smell of bars. You could take the smell of a bar and put it in a cologne bottle, he'd buy it. The stale pizza, the buffalo wings, the jukebox. He loves everything about bars-- the darkness of bars. He also has alcohol use disorder. He can stop drinking, but he can't stay out of bars. And when he goes to bars, he drinks. That makes sense.

I had a client who was a member of the Hell's Angels, the motorcycle gang. He used methamphetamines. He could stop using meth, but he couldn't stay away from the Hell's Angels. And when he went around the gang, he would use meth.

So here's what we've discovered. If you have a client that's addicted to a drug subculture, the key is not to take them away from their culture, but to introduce them to new cultures. So if they decided to leave the current culture, they could segue into a new culture. Alcoholics Anonymous is a culture, a tribe. Narcotics Anonymous. The Clubhouse that they have in mental health is a tribe. School is a tribe. Work is a tribe. Et cetera.

Inadequate service dosage. Research says that individuals trying to get into ongoing addictions recovery, they need 90 days of continuous recovery support. Now, less than 25% of individuals with substance use disorders are actually receiving in effective therapeutic doses-- that is, 90 days of continuous recovery support. The good news is that we now have recovery coaches who provide ongoing peer-based recovery support. The minimum needed is 90 days.

Loneliness and addictive relationships. So a psychologist by the name of Dr. Pat [? Love ?] said that she believes that loneliness is at the core of lots of the problems that we help our clients with-- that loss of our clients are lonely, leaving them vulnerable to depression, increased alcohol and drug use. So community is an important part of recovery and for clients gradually to learn how to develop healthy relationships in recovery.

Let's talk about helping clients with co-occurring disorders avoid slipping through the cracks-- that is, going back and forth between various symptoms. We found that if we can help clients increase recovery capital-- and we're defining recovery capital with internal and external resources that they can bring to bear on their recovery-- then we can help them avoid slipping through the cracks and maintain recovery. If we can help them increase their education, vocational skills, establish relationships, and become gainfully employed, their chances of recovery dramatically increase. Increasing recovery capital.

Provide longer-term monitoring, similar to how cancer and diabetes are addressed. Again, when someone has cancer or diabetes, they're monitored for five years. We've discovered that the longer we monitor clients, along with helping them increase recovery capital, their chances of recovery increase.

If they work with peers-- we've found that 75% of individuals with substance use disorders will never enter their treatment for addiction. They'll wind up in hospitals and emergency rooms and cemeteries. So outreach from peers can help providing treatment-- in-treatment recovery support, because half of the clients we work with, they go through residential treatment, will leave treatment prematurely. But connecting with a peer can often help them stay in treatment.

Post-treatment recovery support when they leave a residential mental health facility, a substance use disorder treatment facility, or prison. Having contact with a peer post-discharge for at least 90 days is important, because we've learned that 80% of relapses occur within the first 90 days of leaving a residential program.

Integrating our services with specialty courts to help clients avoid slipping through the cracks-- drug courts, trauma court, mental health courts. Some states even have prostitution court and veteran courts.

And anchoring recovery in the natural environment. The use of peers in the natural environment. The city of Philadelphia has a lot of recovery drop-in centers, where people seeking recovery can drop in and have contact with other people seeking recovery. Some programs have anchored recovery within churches and libraries. As you know, lots of individuals who have homelessness, mental illness, and co-occurring disorders spend lots of time in libraries.

So some people are like having recovery coaches, case managers, counselors providing services in libraries and on college campuses. It's really important, if we are to help clients avoid slipping through the cracks, that our programs become trauma-informed, dual diagnosis-capable, and that we get really skillful at addressing process addictions-- sex, gambling, spending, et cetera.

It's important, also, to create seamless systems of care, to make sure there's collaboration between treatment and peers. Between treatment-- mental health and substance use disorders treatment, the child and the child welfare system, the criminal justice system, the mental health system, and the medical community. It's really important-- and I'll just repeat this again-- that for many of us, it's possible to become grief specialists, trauma specialists, and specialists in addressing process addictions.

So we want you to take a moment to evaluate the effectiveness of your program in addressing co-occurring disorders on a four-level scale. Level 1.

Our program is primarily specialized in treating substance use disorders, or our program primarily specializes in treating mental illness. That's level one effectiveness. Level two. It's called co-occurring disorders-capable. We have some training in treating co-occurring disorders, and one or two of our staff have worked in both fields. That's level 2.

Level 3 is called co-occurring disorders-capable. All of our staff have been trained in integrated co-occurring disorders treatment. We have demonstrated the capacity to treat co-occurring disorders effectively. We effectively utilize peers who are in recovery as a part of our approach. We are utilizing evidence-based approaches to co-occurring disorders treatment.

And then level four. In addition to treatment of co-occurring disorders, our program also has proficiency in addressing other co-occurring conditions complexity that clients bring to treatment, including homelessness, HIV, diabetes, other medical complications. You know there's high rates of diabetes amongst individuals with severe mental illness and addiction?

There's a program in Chicago that specializes in working with clients with co-occurring disorders who also have diabetes. It's a residential facility. They have their own chefs and nurses on staff. Nicotine dependence, cognitive impairment, learning disabilities. Is your program level four in terms of adjusting co-occurring disorders? Level 3, co-occurring disorders-capable? Level 2? We've had some training. One or two staff have worked in both fields. Or is your program level one? Would you put a 1, 2, or 3 or 4 in chat? What do you see there, Jen?

JEN WINSLOW: Someone said 1. 3. 3. Leaning more to level 4. My program [? return ?] to level 4.

MARK SANDERS: Yes. So I recommend that you use this with your staff or in the meeting and say, hey, we're level 1 now. How can we go level 1 to level 2? Level 2. What are our strategies to go from level 2 to level 3? And then how do we go from level 3 to level 4? Then I want to see if anybody has any questions or any comments.

JEN WINSLOW: Mark, we did have a question come in a little earlier. They were asking, since some inner city citizens encounter PTSD more often than soldiers, should there be free services available to those citizens?

MARK SANDERS: Yeah, why not? Why not? Because especially if our goal is to [INAUDIBLE] like the death connected to that, there are some really great

programs out there. There's a program in California by a priest by the name of Father Gregory Boyle. And he works with Latino Hispanic gang members in the Barrio. And he wrote a book called Tattoos on the Heart.

And his belief is that the greatest deterrent from a bullet is a job, so he's putting gang members to work side by side with their rival gang members. What he discovered is that once you're working side by side with this person, they're no longer your enemy. They're not your rival. They're your coworker. And they protect each other. This is the most successful prison release program in all of California.

I just wrote a curriculum for a program where we're using a combination of cognitive behavioral therapy along with offering individuals who are high-risk for gang violence jobs. And they're finding really good results. We also are incorporating ways of changing your relationship with chemicals, which often are medicated because of what someone called post-traumatic stress disorder. You bet. It makes all the sense in the world.

They've also found that when you have these community outreach workers-- often, individuals who are former gang members-- who go into the communities to broker peace in the streets, these programs are effective. And often, when they're achieving effectiveness, the city or town will cut the funding, and then the violence will go back up. Any other questions or comments?

JEN WINSLOW: Alyssa answered this question with a link in writing. But someone asked about the training you mentioned on June 7. So if you-- we can put it in the main chat too. But that you're referring to the integrating motivational interviewing and logo therapy?

MARK SANDERS: Yes. They help clients with dual recovery. Thank you.

JEN WINSLOW: We'll put that in the chat too.

MARK SANDERS: Any other questions, comments? What I've learned over the years-- it's much less about anything I teach, but more about the actions you take. So I have one question for you. You can put your response in chat. This will be the last time we'll chat. 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 your action? What will you do with this information?

JEN WINSLOW: Mark, while we wait for people to put their answers to your question in the chat, do you mind if I read one more question that came through?

MARK SANDERS: Yes.

JEN WINSLOW: OK. So someone asked, do you believe there are people who suffer with SUD without mental health diagnosis, and if not, do you believe all SUD facilities should eventually treat all individuals with co-occurring?

MARK SANDERS: Yeah. So I think that-- I don't think that everyone that has an SUD has a mental illness. But I tell you, it's high. And I mentioned last time we were together, I think often, the mental illness comes first, but the symptoms are so subtle that we don't spot it.

Look, the research says that it overlaps at the rate of 50% to 70%. And because it overlaps at such a high rate, Dr. Kim [? Minkoff ?] from Harvard said that it should be the expectation. We should expect it unless the client proves otherwise. But do I think that addiction treatment programs should be more co-occurring disorders-capable? You bet I do. [INAUDIBLE].

JEN WINSLOW: Mark, we had a couple-- I'm sorry. We have some comments on what people are going to take out of this training. Somebody said learn more. Continue to explore trauma history while working with clients dealing with co-occurring conditions. More active listening, empathy, compassion, and becoming more educated on resources in the area I work in. Another person said, I will use what I learned to help others and continue learning.

MARK SANDERS: OK. So I mentioned earlier, when Michael Jackson was the face of Pepsi so they could catch Coke, during the era when he made those great albums, they became number one albums, and he was outside listening to his music on a five-hour radio. His music producer, Quincy Jones, said, why are you listening to your music through this cheap radio? We have the best music equipment in the world in the studio. Why don't you come inside to the studio, listen to your music there?

Michael Jackson said, lots of the people that listen to my music, they will hear my music through something like this cheap radio. He says, I want to hear what they hear. You have the ability, as helping professionals, to feel the pain of other people, to hear things in people's stories that other people can't hear. You're blessed with empathy, and you're using that empathy to make the

world a better place. Thank you so much for all that you do to make the world a better place.

If my barber were alive, he'd be 100 years old. He cut this hair of mine for almost a half of a century. He told me these stories for years-- the same stories over and over. So I want to share with you the story he told me the most frequently. He started telling me the story when he was 13 years old-- when I was 13 years old.

The story is about a minister that lived in a small town. Seven days a week, the minister rang the doorbell of one of the church members-- at 6:00 PM, seven days a week. Why 6:00 PM? My barber said because it was dinnertime. And they would invite the minister to the dinner table.

And because they believed the minister was closer to God than them, whatever the family was eating, my barber said, they would give the minister the largest portion. A family of five eating a meatloaf this large, they would cut half for the minister, and the five of them would eat the other half. My barber said if the family were eating chicken, they would give the minister the largest pieces, the breast and the thigh.

He told me that story for decades, and I finally figured what that story was about. That story is about you. I think the work that you do-- case management, counseling, therapy, I think what you do is a ministry too. So I'd like to believe if you made a home visit, the family would offer you the breast and the thigh of the chicken.

But I also know your heart. Most of you would pass and say, no, give me the wing. You eat the big pieces. Some of you would say, no, family. Because you have a giving heart, you'd say, you eat the whole chicken. And so thank you so very much for being you and having the heart that you have. And enjoy the rest of your day. Thank you so much.

JEN WINSLOW: Thank you so much, Mark. As I said in the beginning, you will be automatically redirected to a very short survey. It's three questions. We hope that you would take it. It's how we are able to continue to be to provide free trainings to you all. Please-- I put in the chat. Please check out our events calendar for more trainings. Mark mentioned the one that he's doing June 7th. Please register.

And thank you, everyone, and have a wonderful day. Certificates of attendance will come out in the next two weeks. They'll be emailed to you.

Please check spam folders if you don't see it. And the recording and slides will be up on the Great Lakes MHTTC website within the next week. Thanks so much, everyone. Bye-bye.