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NAADAC

ADOLESCENTS WITH CO-OCCURRING DISORDERS: ALREADY IN OUR CARE

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>> Hello, everyone and welcome to today's webinar on Adolescents with Co-Occuriring Disorders: Already in our Care, presented by Michael Fox. It's great that you can join us today. My name is Samson Teklemariam and I'm the director of training and professional development for NAADAC. I will be the organizer for this training experience. In an effort to continue the clinical professional and business development for the addiction profession, NAADAC is really fortunate to welcome webinar sponsors. As our field continues to grow and our responsibilities evolve, it is so important to remain informed on best practices and resources into our professional but develop, especially in times like these where we are all quickly realizing the importance of how technology can access and helps us adapt and control in an ever changing environment. This webinar is Spencer by Time2Track, a Liaison company. It's the easiest way to track your dog states licensure. Stay tuned for instructions on how to access the CE quiz toward the end of the webinar and immediately after a brief demo from our sponsor. After the permanent homepage is www.naadac.org. Please be sure to mark this webpage so you can stay up to date on the latest in addition education. Closed captioning is provided by Captain access. You can check your most recent confirmation email or Q&A in the chat box for them to use closed captioning. You can see we are also using GoToWebinar for today's it. You'll notice the control panel but a little bit like what you see here on my slide. You can use that orange arrow anytime to minimize or maximize the control panel. If you have any questions for the present or, you can type them into the questions box. We will gather the questions and give them to the presenter during the live Q&A. Any questions we don't get to, we will type in a Q&A document and post on our website in a few weeks after the live webinar. You can also take a look at the handouts, which should be under the questions box or about the questions box depend on your browser, you can download the PowerPoint slides from that handouts to any three slides per Page PDF format. There is also user friendly instructional guide on how to access our

online CE quiz and immediately earn your CE certificate. There are really clear instructions on how to do that in the tablet.
And lastly, you will see a resource from our sponsor, Time2Track.
Now, I'm happy to welcome our webinar presenter today, Michael Fox. Michael works in -- systemically and teaching with the research driven data to assist students, professionals and communities in decreasing risks to youth and helping families. Michael provides educational training, tech assistance, and consultation to youth who have substance use needs. He intentionally integrates attention to multiply, overlapping areas of substance use, mental health, trauma, and develop metal trauma, juvenile justice and adolescent specific development. NAADAC is really delighted to provide this webinar, presented to you by this with experienced trainer. So Michael, whenever you are ready, I will hand us over to you.
>> Thank you, Samson picked sense and I have never met in person, and preparing to do this webinar today, if I had none to do this, I would never have agreed to do this to different parts, he didn't stumble, he just flowed right through everything. He belongs on some national radio program. And now you're stuck with me. I'm going to sample a lot in my voice will probably start to grate on you. But the information that we talk about today will resonate. It will make up for anything else involved in this.
My name is Michael Fox. I work include the – in Cleveland, Ohio. I didn’t go to a large university at any point and now I work at one. It took a while to understand the arrangement, but ultimately, I work for the center for innovative practices.
Where we focus on use and family quite a bit. My background was in adult drug and alcohol work for a really long time, and it was so long ago that things were very siloed. There was no integrated care. There was very little integrated perspective. The systems were very separate. Clients were forced to enter into drug or alcohol treatment or mental health treatment. There was no combination.

We started on the adult side, and found a niche there, had an opportunity then to it to do integrated work in a home-based perspective or setting. With adolescents. And I thought that the transition would be pretty smooth. I understood, from my perspective, I understood drug and alcohol work. And I was bothered by the fact that we could not do integrated work. Integrated mental health, and so I was really looking forward to it.

And the learning curve for integrating mental health and substance use within a single assessment and a single path forward, was not all that difficult of a learning curve. The big learning curve for me was working with adults to working with adolescence and the expectations that I had.

So the underlying theme today, and really a lot of what I talk about comes from the great big and ever-growing book of how I've screwed up in the past, so learn from my mistakes.

Understanding adolescence diagnostically systemically, from mental health perspectives, from drug and alcohol perspectives, was nothing like understanding adults. So that learning took quite a long time. Took quite a bit of attention to really recognize adolescence as a developmental period unto itself.

So the theme for our time together today is adolescents, if you're working with adolescents, you obviously know that they are in your care. But if you're working with adolescents on one side or the other, primarily the mental health side, the substance abuse side, either one of those side predicts that there are going to be needs on the other side and beyond that. So they are already in our care, but the underlying thing is going to be the very specialized approach and understanding of the period of life of adolescence.

So what I'm hoping to touch on today, and this is just to touch, this is just an introduction, I could ramble on for hours and hours just on the topic we have today.

But luckily for you, Samson has the ability to just turn me off, and that will happen in a timely fashion.

But in our time together today, to really point in the direction of what is the current research regarding youth with co-occurring disorders. From a prevalence perspective and how you would differentiate understanding the perspectives about adolescents from adults. In addition, and really this is building on that physical social personality develop until factors during adolescence can be genetically impacted by substance abuse. By various forms of trauma, and we will touch on those in mental health. And how adolescents don't necessarily have life experience, they are just growing into these things.

And lastly, screening and assessment, we are not going to touch on that is heavily. It's more about the recognition piece in the screening and assessment is an advocacy for regularly screening issues across all sides when you are working with adolescents.

So one of the themes for today is working with a perspective towards co-occurring disorders. I have kind of gone back and forth here recently in regards to working with adolescents in co-occurring disorders, moving more towards using needs rather than disorders just because of the development aspects. This could just be a semantic thing, but what I'm wrestling with is probably the same as a lot of you, but I'm working from my home office and I had too much time with that. To start wrestling with these semantic things.

But I do think it is a developmental thing with disorders, certainly adolescents experience and live with full-blown disorders. But they also have a lot of things that look like symptoms and understanding them at other times is framed by an adult understanding. So I will I will use interchange we today disorder and need.

So simply and globally, talking about co-occurring disorders, co-occurring needs, is something acting at the same time. Something on the mental health side, something on the substance use side. More specifically, this comes from a dopey center for substance abuse treatment, SAMHSA is the substance abuse mental health of menstruation. Both of these are

really good sites to visit to get more and more information about co-occurring disorders, co-occurring needs. CSAT, it often outfalls more on the SAMHSA website, but they are linked. So if you're not familiar with SAMHSA as a resource, I would encourage you to do so. All other products are open domain. They are in a language that is really easy to understand.

Is primarily from an adult perspective, and although it is the substance abuse mental health services administration, it very much comes from substance use perspective. All that being said, it is a resource.

But coming from CSAT, when at least one disorder of each type can be established independent of the other. And it really thing that should be independently, independently of the other and is not simply a cluster of symptoms resulting from a single disorder. That is important. When I first started doing clinical work in the adult world of the drug and alcohol side of things, and it was very much that, side of things, things were very separated.

Often, all the time really, people would come to see us and we would recognize that very clearly there were mental health needs in addition to the substance use things that were being sought after in our clinic. And we were very frustrated because we could not identify it we could duck we couldn't diagnose it, couldn't put it on a treatment clients because things were so separated at that time. And even when things were very clear that there was a clear case of depression, a long history of anxiety. Whatever is, at that time when we would try to refer people to the local mental health clinic, that serves adults, very often we were told after you get them stabilized on your side of things, then we will be looked willing to take them. Because then we will know what the real symptoms are. Until they get cleaned up, that with the language of those days, the drug use, it looks okay lot of mental health symptoms. A lot of experience is that we understand that drug and alcohol needs are there. Mental health needs

are there. They do interact with each other in mutual ways. But they exist independently and can be identified independently of one another.
So that's what this slide, this very high quality graphic, is illustrating that when you have co-occurring mental health and substance of use disorders, they exist independent from each other and they can be identified independently at each other. But they don't exist in an academic that can.
The truth is, this is in a single individual, so they are going to have this intertwining interaction with each other. So the mental health will influence the substance abuse and vice versa. And I'm sure that this is true for every single client that you could work with that would have needs on the co-occurring side, not just adolescent clear. I am guilty of saying especially for adolescent clear, because of what's going on in that period of life. This intertwining, from my admittedly biased perspective is even more pertinent the pertinent in adolescents because of the developer to factors that are very, very active during adolescence on the mental health side and substance use side and mutual influence that these things exert on each other.
That being said, it's almost too simple. But it's kind of an ironic statement because it's very complicated with those interactions. But just like we don't want to consider this in an academic vacuum, teenagers don't exist in a vacuum themselves. And the presence of one thing predict the presence of another and so on. Very often when we are serving and as a adolescent who has clear mental health needs and substance use needs, this is not the case all the time, but we find more often than not that there is some level of trauma needs there as well. Not every kid is living with trauma, but it occurs often enough that we should be very aware of it and we should be looking for it. At the same level that we are looking for substance use and mental health needs. Substance use all by itself predicts the likely road of future trauma because of situations that especially, if you count, especially in teenagers, situations that teenagers will find the cells and put

themselves in around drug and alcohol use has a much higher risk of having some sort of traumatic experience associated with that. Whether that's car accidents, assault, sexual assault, witnessing violence, anything like that. So it predicts an increased likelihood of being a traumatic situation coming up.

But trauma also predicts future substance use and an adolescents is nothing we need to be very aware of his Department of trauma, and I will talk about that in a bit coming up.

But with this being said, mental health concerns predicts substance use and adolescents. So if you're serving them on the mental health side of things, the presence of identified mental health disorders and symptoms in adolescents predicts that there are some level of substance use involvement as well. Research says it's about 40%.

Substance use involvement far more strongly predict the presence of a mental health needs, too. You're serving adolescents in a primarily substance use treatment setting, the likelihood of there being a co-occurring mental health disorder or mental health need is a lot higher. It's about 70% when substance use is identified first. There is over a 70% chance that there is an identifiable mental health need there as well.

The co-occurrence of these two things predicts trauma pretty highly, and trauma predicts everything. If you are familiar with the ASIS research, and research note resources available at the child the moment network, trauma predicts everything bad. So the presence of one predicts the present of the next, and the next. And it is a vicious cycle.

So working with adolescents, and especially ones on the higher end, higher acuity of meeting mental health of the substance use side, predicts previous and current or future trauma. So when we are working and serving adolescents and involving the families in their treatment as well, when we are serving youth with these multiple overlapping needs, how do we consider them separately, and in recognizing all of that overlap?

It gets to be very complex and very difficult. I will bring up some -- there is one really simple tool for that.

But with these thoughts in mind, this is one of the ways we can conceptualize that there are identified mental health needs that are separate, can be identified to depend on, same for substance use, same for trauma. Substance use will influence mental health. Substance use can influence trauma, and there is that overlap were all three are influencing each other.

So there is a lot of really complex consideration in understanding what is driving some of this risky behaviors for the adolescents we are serving when these are identified.

Just a couple of things to mention about these different areas and we will move on, half of all lifetime experiences of mental illness start by the age of 14 peer we will talk about that in a moment. Over 14% of adolescents experience a major depressive episode in the last year. We will touch on that. Alcohol is the most commonly used substance. One intent youth report binge drinking in the last month. That's a really big deal. We will talk about that in a minute.

And 8%-12% of America youth have experienced at least one sexual assault. Think about that number. 1 in 10 adolescents have experienced at least one sexual assault in their lifetime. Anywhere from 9%-19% have experienced physical abuse by a caregiver. And that is the really significant part when we overlap from attic experiences with complex mental trauma, but it somebody who was responsible for caring for us that it has even after significance associated with it.

So the prevalence in terms of the areas that can potentially be there when we are working with adolescents, they are all pretty high, and they indicate and reinforce why we should be -- on a regular basis all the things.

So we will be talking about statistics, it's probably a little bit boring, hence the no yawning cue here. But it's important to understand how prevalent a lot of these issues really are to bump up our regular recognition for doing

the regular screening and moving into the regular assessments. And not just that in our direct clinical work, but also in terms of the information that we share with others and in terms of interactions with others and other systems, other clinicians in our own agencies, and advocacy that we will do.

There are three really good national resources for the prevalence, more strongly on the substance use side, but they all do have well, part of the three do have mental health things included. There is Monitoring the Future, MTF that is sponsored by NIDA. There's a link there for that. There is the Youth Risk Behavior Surveillance System, YRBS, this is conducted by the CDC. The CDC investigates all the things that are risky for us that directly impact our health and lead to death. It's a bit of the direction they take. Monitoring the future is based on mostly the drug and alcohol side. CDC is very strong on the risk side. The last one, the National Survey on Drug Use and Health, NSDUH, this was conducted by SAMHSA. Includes two major depressive episodes in addition to drug and alcohol use percentages.

So we are going to start out by talking about prevalence of some of the more common areas of drug and alcohol use for adolescents.

But before we do that, we are going to poll your knowledge.

>> Thanks, Michael. The question is, what is the most commonly used recreational psychoactive substance by adolescents in the United States? You will see five answer options there. About a quarter of you have that in. The poll is active now. Select what you think the answer is. Just a reminder, this webinar is sponsored by trying to track, a Liaison company. Time2Track is the easiest way to track your supervision hours for state licensure. Stay tuned for instructions on how to access the CE quiz. We will give those instructions to you towards the end of the webinar immediately following a brief demo from our sponsor. If you have any questions for Michael, we have some great questions in the questions box. Go ahead and hit the GoToWebinar panel and tapped the orange

arrow. You will see a questions box where you can type your questions and we will ask those two Michael, our presenter, towards the end of the webinar. About 5 more seconds, then we will close the poll. To also much for about 75% of you voted. Some were coming in. I'm going to close this poll and share the results. And I will turn this back to your presenter.
>> Thank you. I'm really glad that it turned out this way. This was a little bit of a trick question. And I sneaked in the answer two slides ago. I'm glad it turned out this way because a slight majority voted for cannabis. And that is the most recognized psychoactive substance for adolescents. It is not even close to beating the most commonly used psychoactive substance. And the trick part of it was that recreation thrown in. So week we just talk about what is the most commonly used psychoactive substance for adolescents, the trick part is it's caffeine. Over 92% of adolescents use caffeine on a regular basis. 90% use it on a daily basis. That custom coffee, soda, and other sources. And this is true for most adults in the United States as well. Caffeine is the most widely used psychoactive substance. So the trick product is the recreation part. So that takes caffeine out. The other ones are considered recreational, and alcohol far and away leads that list. We don't necessarily think of that too often, when it comes to adolescents. We think about them smoking tons of weed. But alcohol is the most commonly used recreational psychoactive substance. All three of those studies that I pulled up our going to be cited when we go through these lists. All three of them just updated their prevalence publications. I think it was this summer, all three of them came out with their reports. I think all three of them are from 2019. I don't think any of them are left over from 2018. So for 2019, the Monitoring the Future study, this is the one I think I used the most because it comes out every year and it has been coming out every year since I think about 1975.
It asks really great questions about drug and alcohol use, not just have you ever tried or do you use this or get asks, and that say about alcohol,

have you use alcohol more than once in the last week, in the last 30 days? In the last year or ever in your life.

It also asks, how dangerous do you think alcohol is? How easy do you think it is to get alcohol? And it does that for all of the substances. And the interesting question -- they are all interesting -- but the one that can be really useful is we track year after year is the one that asks how dangerous do you think this substance is? And over the past couple of decades, when it comes to cigarettes, we have seen the response increase. The recognition that cigarettes are dangerous and this has been matched by cigarette use decreasing in adolescents. How dangerous do you think vaping is, that's asked, is not perceived as being very dangerous, and vaping is on the rise of -- among adolescents. Alcohol use kind of goes up and down. It has its up and down swings. Currently, it is perceived as being fairly dangerous. So the good news is alcohol use is that pretty much historically low level of use among high school students. That being said, a lot of high school students still use alcohol in a very regular basis. It is the most commonly used recreational psychoactive substance.

So that kind of wraps several things up in there. So a little bit of a blurb about the Monitoring the Future study. And the reason I think it's useful. In the last year, 40% reported at least having wondering 20% report of being drunk in the last year. This is 8th, 10th, 12th graders combined. So of it, 10th, and 12th raters combined, 1 in 5 of them reported not just having a drink or two, but having been drunk in the last year. The older you get, it's lower on the 8th-grade side, maximizes on the 12th grade side.

And when just 12th graders are considered, these numbers jump to 52% and 33%. 52% had at least one drink last year, 33%, one in three, had been drunk in the last year.

So we are at historically low levels as measured by Monitoring the Future going back to the mid-1970s, but still a lot of kids drinking a lot.

In 2019, the YRBS, the one from the CDC, 29% all high school students reported having at least one drink in the last 30 days. In the last 30 days is what most studies consider to be recent or current use. So it's not just in the last year, this is currently drinking alcohol. One of three high school students said yes. Nearly 14% acknowledged binge drinking in the last 30 days.

The measurement of the drinking in these surveys, there is one exception, and I don't know which one it is, but they use adult male definitions of binge drinking. An adult male that is of binge drinking is 5 or more drinks on a single occasion in the supposedly last two weeks, but really it anytime in the last year's can that significant for teenagers.

So almost 14% acknowledged binge drinking in the last 30 days. So five or more drinks in a single occasion in the last 30 days.

More than one in three high school seniors drink to intoxication last year and more than 1 in 10 engaged in binge drinking in the last month. It's among the lowest levels measured in a long time, but there is still a lot of alcohol use going on.

And think about how teenagers already process information. They are more impulsive in their decision-making. And they are list self protected from risky decisions. And think about what alcohol does on top of that in terms of decision-making. So alcohol does represent an enormous risk.

Marijuana, cannabis, is the one that we most often associate or most often associate with teenagers. It is number 2 on the list. But it is significantly well that from alcohol. So last year, Monitoring the Future, one quarter of all youth reported use of cannabis at least once in the last year. It ranged anywhere from 12% for 8th graders to 36% of high school seniors. Vaping of cannabis has increased significantly over the last three years, when they have really started to track that. And nicotine use through vaping has significantly increased as well.

The education and the prevention strategies that have been in place for decades in terms of the dangers of cigarette use have paid some slow

dividends, but they have paid dividends. Most teenagers do not smoke cigarettes and they consider them to be very, very dangerous. On the other side of things, vaping is not perceived as being that dangerous, and numbers for nicotine use which had been very, very low for several years now are increasing pretty significantly, associated with vaping. Vaping is also very strongly associated with ways to get cannabis into your system. And vaping very often is a way to get cannabis in much stronger concentrations into your system. So it's not really comparable to, say, smoking leaf and but marijuana in 1980 compared to vaping THC oil in 2020.

I just got a notice that said I might be experiencing network connection difficulties. Hopefully, I'm not glitching out. If I am, hopefully someone will tell me.

>> You are doing great, Michael. You have to click on the side again because I move the mouse fit but it looks great and sounds great.

>> Some of you may be wishing I am glitching out because of the numbers. The YRBS found that 22% of high school students said they use cannabis in the last month. So that’s over 1 in 5 that smoked weed in the last month. And both of these surveys it is worth mentioning for the cannabis discussion, these surveys gather information from youth who were in school to take the survey. They do not try to capture kids that were maybe not there that day, but a lot of the youth that the programs that I work with serve were not in school either one of those days to take these surveys.

As soon as you reach a certain level of multisystem involved youth and the multi need, the multi risk youth, very often, they are not in the public school system to take the survey. I don't know what that is going to mean this year. Because so many kids are not in physical school. There is some kind of hybrid. Or they are all online. So I don't know what the survey is going to look like this year. But that's not our consideration right now.

Cannabis use by youth has remained mostly unchanged over the last decade. If the baking vaping that is really going up. And that has changed the experience of using marijuana. It's not comparable to where it was before. The blood and the leaf in the 1970s and 1980s was anywhere from 3%-10% THC concentration. Now, it's 90% and above THC concentration. So the experience is much different than it used to be.

We cannot talk about adolescence and drag it out a whole use without touching on opioids. And actually there is good news in this in that for the most part, teenagers will not touch opioids. For the most part. There are always exceptions. And we see cycles of this period when I started in the drug and alcohol work, on the adult side, it was in the midst of the crack cocaine explosion. And so many families were so significantly impacted by crack cocaine that the youth coming up that were seeing that use by transition adults, wouldn't touch crack cocaine, no matter what. It doesn't mean that it scared them away from drugs and alcohol, it just scared them away from crack cocaine.

And we saw a cohort effect in that in that the kids who saw the impact and the great toll of crack cocaine, they have grown up into adults and now older adults who wouldn't touch crack cocaine. We are hopeful that we are going to see the same thing with the current cohort of youth who just absolutely well not touch a painkiller or an opioid because of the great impact that they have seen.

So the incidence of use with youth and opioids is pretty low. The YRBS, this reported the highest numbers of all. 7% of high school students reported use in the last month. That's pretty high. 14% reported any misuse during their lifetime. So that 7% is kind of high as compared to the other two surveys. The Monitoring the Future, this is in the last year. What is that, 0.3% have tried heroin, 1.7% of high school students had said they had tried OxyContin, 1% had tried Vicodin. These numbers are as low as they have ever been measured on the Monitoring the Future site. Crack of the use of prescription opioids, the only did for 12th graders, 2.7% said

that they had misused any prescription opioid. So that would capture OxyContin, Vicodin, and any prescription opioid by high school seniors. That number is very low compared to what has been historically.
That being said, there are adolescents out there who are using and will be willing to use opioids, whether it's heroin or diverted prescription stuff. Sometimes they wind up using it accidentally, because there are a lot of different things they are using. So opioids themselves are not very common. But we talk about in terms of very low prevalence, but very significant impact. So when a teenager does get into using opioids, the impact is very significant for that teenager in that family. And the treatment needs to be equally as high.
To take this very seriously.
All of that being said, opioids impact the lives of a lot of adolescents that we are serving very significantly in terms of adults in her life who are actively using or have lost their lives because of using opioids. There is a lot of develop metal trauma, a family member is using a substance, it really increases the odds of the children were winding up using.
There is a lot in my rambling there for the most part, fewer teenagers are using opioids. When they do, we need to address that very strongly, not that we wouldn't anyway, but also in consideration, a lot of the youth that we are serving in our programs have been impacted by opioid use.
Just a few other psychoactive substances to mention before we move on. And I think the mental health consideration is next. The national survey of drug use and health from 1918 estimated that about one in six youth aged 12 to 17 had use in illicit substance in the last year. And all three surveys, I never really understand this, they all define illicit substance as anything passed alcohol. So nicotine and alcohol don't count. But both of those are actually illicit for adolescents. But they use the adult definitions for that.
So 1 in 6 12-17, that’s 8th grade through junior, senior year have tried marijuana or above in the last year.

Monitoring the future estimates slightly higher prevalence of any illicit substance use, 1 in 4 student, and Monitoring the Future, just to throw a few other substances in here for consideration, this is in the last year, hallucinogens, about 3%, inhalants, about 3%. Inhalants is the only one that shows they reverse prevalence. That is the younger ages are more likely to be using this than older ages. Every other substance that is talked about, 8th grade has the lowest incidence of use, where 12th grade has the highest. This is reversed. Inhalants, if grade is the highest, 12th grade the lowest. It's in red because any psychoactive substance that we would talk about, you can have these different ways. My perspective is inhalants are the most dangerous of all the psychoactive substances.

Because one of the mechanisms of action for inhalants is that it replaces oxygen in the hemoglobin and then what does that do? Really, if the same thing as drowning. It winds up killing neurons, both in the central nervous system and the peripheral nervous system. And that doesn't come back. That's permanent.

When I was growing up, people would say that every time you take a deck of alcohol, it kills a couple of brain cells. But as long as you are not a big drinker, you've got brain cells to spare. I don't know about you, but I don't have any brain cells to spare. The good news is that none of the other psychoactive substances kill brain cells. Alcohol does have that potential, but it's difficult.

But none of the other psychoactive substances can actually kill brain cells. They decrease the ability of neurotransmitters and they decrease these receptor sites for neurotransmitters. They have a major impact that way and that that is significant. But they don't actually kill brain cells. Inhalants can kill brain cells. It does kill brain cells.

So that is one that we need to be up very attentive to especially with our younger adolescent clients.

Amphetamines, 4.5%, ecstasy/Molly, a little less than 2%. Over-the-counter cough suppressant, dextromethorphan, this would be Coricidin

and Robitussin, things like that, has a very dissociating effect. Under 3%. Tranquilizers and for the most part here, think benzodiazepines. The big one on this list was Xanax, that that was very popular, Ativan can be thereto, about 3% in the last year. Benzos are very dangerous as well. Just another little semantic point here the differencing between comorbid and co-occurring, Co-occurring is the coexistence of something on the substance use side and think on the metal health side. They are occurring the same at a vigil at the same time. Comorbid captures a broader range refers to the presence of any two areas of overlapping need. Could be diabetes and depression, anxiety and ODD, any two from the biomedical side and the mental health side. So that's a very broad term. Occurring refers very specifically to mental health and -- outside of alcohol, cannabis, and nicotine, adolescent drug use is comparatively low compared to how it has been in the past.

However, comorbid issues compound quickly and recognition of one area of need strongly suggests regular screening for other areas.

And we will talk more about that coming up.

So now we will move into some prevalence discussions on the mental health side of things for adolescents.

And we're going to start out revisiting the slide with the three big circles, mental health, substance use, and trauma, it made mention of this. So 2005 doesn't sound that long ago to me, but it's already a decade and a half ago. But there's no reason to believe that these numbers are really going to change. Because this is any prevalence thing, this is an onset thing.

So large study supported by the national institutes of mental health, about prevalence and severity of mental illness. And they noted that unlike most disabling physical diseases, mental illness begins very early in life. Half of all lifetime cases begin by the age of 14. And that is significant lag was in that because it says all of lifetime cases. Just because somebody is living with depression right now does not mean they are going to live with

depression for their entire life. It means it's active right now. So if they live with depression during the teenage years and then it remits and they don't have another experience of depression at all, they still have had a lifetime experience or case of depression. So if at any point in our life we are going to live with a or more mental health needs. I'm capturing everything on that, the whole DSM, substance use, have all these lifetime expenses will start by the time we are 14 years old. Three quarters have begun by the age of 24.

So if somebody is going to experience and live with at any point in their life, a mental health disorder, mental health need, three quarters of these have started before we are even done with our full developmental process. Current understanding of the brain development of those cortical areas, they continue to develop until two to five, 26 years of age. Three quarters of all lifetime experiences of mental health needs have initiated by that point.

And I like how they frame this. Mental disorders are really chronic diseases of the young. I kind of stand up on a soapbox about this a little bit because so much attention, so much money, so much research and so much of the definition, the definitional understanding of mental health disorders is based on adult understandings. But really where should we be putting our time and effort and research? It should be in children and adolescents in terms of understanding what is really going on, understanding the etiology, how can we have an significant impact during these very, critical formative years that can decrease the severity moving forward.

The likelihood of being able to take it away completely is not there, but even small trajectory changes during this critical period of development can have very significant impact moving forward.

Sorry, I'm being interrupted by a teenager. Don't you love teenagers? If anybody would like a teenager, I'm offering won.

In terms of my soapbox piece on this, whenever we are working with teenagers, they are growing into whatever their mental health need is. They don't have any experience with this previously. So polling question number two, this is the last polling question, and I'm going to turn over to Samson.

>> Thank you so much. Yes, everyone you see this polling question popping up on your screen or just a moment. The question is, what is the most commonly experienced mental health area for adolescents? You will see five answer options there. And it looks like already 25% of you have voted, so you understand how to vote on these polling questions. The webinar is sponsored by Time2Track, a Liaison company, we are fortunate to have Time2Track here live during this webinar. They will do a live demo towards the end of this webinar. Medially after the demo, we will give you some instructions of how to access your CE quiz, how to get your continuing education. Time2Track is the easiest way to track it your supervision hours for state licensure. I will give you about 5 more seconds to answer the polling question. 70% of you have voted. So about 5 more seconds here. Thanks so much, everyone. I'm going to close the poll and share the results. And I will turn this back over to our presenter.

>> Thank you. Okay. I am resending my offer that you can take my teenager. But just like the last pole, this one has the last poll, this one has a bit of a trick to it. And depending on how you interpreted this, you really got in the ballpark with the two highest areas. I'm thinking that a lot of you do not work with teenagers on a regular basis or conduct related with have been higher.

The trick part is, and we will talk about this in a second, that symptoms related to anxiety are very high in teenagers. And that mix sense in a lot of ways that we will talk about in a second.

In terms of crossing the threshold, depression is just a little bit higher. We are going to see how that plays out in just a second.

So coming from a decade ago, which isn't long ago, but in October of 2010, this is coming from the national comorbidity study, the adolescent supplement, NCS-A, there was this very large study where they wanted to investigate the prevalence of comorbid conditions. And that's what this was really looking for. Not just co-occurring, mental health and substance use, but comorbid. And they were taken just from the mental health side. So what is the presence of one mental health disorder, and that's how they were framing this, disorder, how much is that predict, then, the likelihood of a second mental health disorder? And the whole DSM, DSM-IV, was included. So this included the substance use Chapter with all the other chapters.

So they designed this great big study, and submitted it the governor came back and said this is great, this is exactly what we want, but you didn't include adolescents. So as an afterthought, they included adolescents. But there afterthought included 10,000 adolescents. You do research, that's a great big number to have. And I think that we can draw some pretty good understanding from this from this number.

So the national comorbidity study took randomly selected teenagers, these were teenagers that were referred from Dr. Not referred from local clinics, these were randomly selected teenagers, they did a kind of a modified DSM-IV based assessment with randomly selected teenagers. On the other side of that assessment, they found, and this would have been a good polling question, what percentage of randomly selected teenagers were found to have diagnosable -- this just isn't symptoms, this is crossing the threshold into diagnosable mental health perfect -- disorders, 49.5% were full-blown diagnosable.

The researchers looked at this and they concluded that maybe this number is a little high. Half of all teenagers in the United States do not have an identifiable mental health disorder. For those of you who have a teenager at home, maybe that's understandable. Half of all teenagers -- probably cross that line will push us to cross that line.

But that is definitely not the case. What they very quickly realized is teenagers are difficult to understand from a diagnostic perspective. So of all the slides in today's discussion, this one might be the most pertinent for working with adolescents, working with teenagers.

If we apply strict adult diagnostic criteria to our understanding of adolescents, we are going to over diagnosed by a lot. The diagnostic criteria for the most part are normed on adults, and has the expectation, the personality has been developed.

Personality is not done developing in adolescents peer they are really into transition, more so in transition. But in adolescents especially, with the development task, the task is to practice what their personalities going to be in the future, and what is personality? It is descriptive and it is predictive. So it is set. Teenagers are practicing with that, and so there is an expression in their consideration that we consider to be symptoms in adults, and they are kind of par for the course in adolescents. So when they went back and reset the threshold, and they said not just meeting of criteria to be diagnosable, but also crossing the line that says that these symptoms, then, are causing difficulty in functioning to the point they were going to say they are severely impaired. Then they cut that number in half. Got just down to just over to 1 in 5.

That makes sense because we know about any given time, about 1 in 5 Americans are living with some form of mental health need or diagnosis. So that fits. It really fits when we think about half of all lifetime cases starting by the time they are 14. So really makes sense that we would see that in teenagers as well.

Here's the piece that the polling question maybe was a little bit intentionally tricky. In that their results from the study, they broke out in terms of here is the number that we identified, that would be diagnosable without using that line of severe impairment, and when we apply that percentage. So when you look at that just diagnosable without that consideration, look at how high you can see -- look how high anxiety or

disorders are. 32%. 1 in 3. I can do math in my head. 1 in 3 teenagers is living with anxiety to a level that in an adult could be diagnosable.
When it crosses the threshold into severe impairment, it drops down to just over 8%. When we compare that to just over 8% with major depressive and that's severe impairment so major depressive symptoms, diagnose ability just slightly edge out anxiety.
I thought it was interesting that they could also do this with ADHD and conduct, too. So there find that threshold of understanding with his is really causing severe impairment. So with ADHD, it's cut more than half, in there are a lot of kids out there that have trouble paying attention or sitting still. But is it really impairing? Then it's only about 4%. That's even more difficult with oppositional and especial conduct disorder. If you work with teenagers on a regular basis, you see a lot of ODD diagnosis, because all teenagers are at some level supposed to be a little bit ODD. Oppositional defiance.
I have suspicions, this is my personal opinion, I'm not saying this from any affiliate at all, I have personal suspicions that ODD is not really a diagnosis but is descriptive of a lot of other things. It's a descriptive diagnosis, but not necessarily a -- one. Substance use disorders, they decided with adolescents, they were going to split it between this is a variant -- severely impairing or this is just diagnosable. They kept those numbers.
Now,, when we think about how to apply diagnostic understanding and how to apply our standing of need two overlapping areas of need with adolescents, there are a lot of different developmental formulas, a lot of different developmental conceptualizations that we can use.
I thought back more on Erikson. If you remember Erikson. His psychosocial developmental theory, which really is -- it's pretty old at this point. He was a contemporary of Freud, and adapted Freud's psychosexual developmental model. So if Freud did nothing else, he did, with the first will formulated development model. So he adapted that

across the entire lifespan said we are social beings and adapted it in that way. The interesting thing is with current brain mapping technology and biological understanding, Erikson's different stages, where we face a crisis at each stage and we have a task to achieve at each stage, it matters very well with our understanding of brain development. So for teenagers that is very descriptive of what is going on with our adolescents. They are figuring out their identity. If they don't successfully achieve that task, they are left with the conclusion.

When we bring develop metal trauma considerations into this, too, you think about the very first stage of Erikson, trust versus mistrust, if that is not achieved successfully, how that informs really all the development that comes after that. So if you work with adolescents who were adopted, and they came from very difficult situations and got into stable families, they can still have areas of difficulty and why is that? Because their needs weren't met. So you can really take a life develop metal perspective in terms of working with adolescents.

That understanding overlaps well with our understanding of the cortical developer, the prefrontal cortex, in the way that the cortical areas, they are finding the most efficient pathways working with other areas of our brains. When you think of Piaget, you remember Piaget uses the cognitive development period so teenagers are moving from being concrete thinkers to more formal operation thinkers. In the way that we have conversations with teenagers. Sometimes this is true with families, too, but with teenagers, they don't just magically moved from concrete operations into formal operations, it is a long process. Longer than Piaget really gave it credit for.

So they are still pretty black-and-white in their thinking in a lot of ways. We may need to have conversations with them, then, the more we can they help for them, and approach were regular a lot of reflection and a lot of summaries that help them see some of those shades of gray.

So in addition to these considerations, then teenagers are also living with sexual and physical maturation and the pressures that go along with that. And the genetic component as well.

So there is a lot to consider in our work with adolescents from a develop metal perspective.

This is one of the ways that we use to conceptualize this visually. Just different areas that we are talking about.

So if you are feeling more strongly on a social side, this is true for all of the helping professions, but coming more strongly from a social side of things, you think systemically, this is a combination, eco- systemic approach. The systemic approach is the family is a system and it has interdependent members within the family. You can identify the boundary, but then the members within that. And the family exists in a broader ecology. So that's how we try to conceptualize the various areas that are existing within a single use. For example, we have a youth with more than one area of -- at the same time. period there is the current needs. So on the mental health side, there's one thing and something on substance use side. In the mutual influence from those areas, in addition to all the rest of the stuff that is going on with the youth, with the sexual maturation, the physical maturation, the brain maturation, and then we can draw and develop metal trauma is a possible consideration, too. And that youth exists within a family structure, within family boundaries and a really high need, multisystem involved youth can have rigid boundaries.

And then the youth and that family goes to a broader ecology with considerations as well. There is school and work considerations. There is community. Sometimes for the kids that we serve that community involves criminal justice, juvenile probation. Peers. Peers can be the most difficult of the areas and ecological consideration when it comes to working with adolescents.

This is one of the tool that I mentioned pick this is something that we have developed that we use in terms of helping to conceptualize in a visual way all of the different areas that are surrounding the single use.
So this is one of the forms that we use. All it takes is a pencil and a piece of paper, really. And this isn't like some secret clinical tool that we use to dissect for an academic understanding, is something we use with youth and the family in a collaborative fashion to understand what is going on individually with the youth. In the mental health needs are the substance use needs. What other resilient factors, what are the risk factors, and in consideration of readiness to change for these different identified areas. We could do that exact same circle for the family. And in consideration of for the family is, it's a very important as well. But the risk factors under the different ecologies around the youth.
Look at all the words on the slide. Good heavens. We are getting close. We are almost done. This is coming from NASEM, the National Academy of Sciences Engineering and Medicine. If you are not familiar with NASEM, I would encourage you to do so, for the two publications that they have. This one is first and foremost. This is the go to resource for understanding adolescents. This just came out last year. The promise of adolescents, realizing opportunity for all youth. You have to go to the site and become a member, that costs nothing, you become a member and you can sign up for the different areas of interest. That could be science, engineering, or medicine, from our perspective today, we are on the medicine side, the clinic the clinical mental health side of things here and we will send you updates on the publications they come out with.
This one does a fantastic job of considering adolescence as a very purposeful stage of life. It cannot be considered from adult prospectus and cannot be considered from childhood prospectus. I haven't seen any other publication as intentional, directive, is this one is. And it is packed full of really great information. I will read this quickly, and I'm not going to stop because I want to make sure we have enough time to wrap up.

Neurologically, throughout adolescents the connections within and between brain regions become stronger and more efficient, and unused connections are pruned away. Such develop metal plasticity means adolescents brains are more adaptive, they become more specialized in response to environmental demands. The timing and location of these dynamic changes are also important. The onset of puberty brings about changes in the limbic region of the brain, resulting in greater sensitivity to rewards, threats, novelty, and peers. In contrast it takes longer for the cortical region, which is indicated in cognitive control and sulfur collection, to develop. We can have a long conversation with just that paragraph. And you need to let it sink in and come back to it.

Consequently, adolescents' brains are not simply advanced child brains or immature adult brains, but have evolved to meet the needs of this stage of life. That's huge. Indeed, the temporal discrepancy in the Special Agent up and connections between brain regions make adolescents unique. The developmental changes-sensitivity to rewards, willingness to take risks, and the salience of social status, propensities that are necessary for exploring new environments and building not familiar or relationships. They are supposed to be where they are. They are supposed to be risky. They are supposed to be a pain in the butt. That is the purpose of adolescents. And this publication really emphasizes that. It talks about using this perspective in the different areas of ecology that I mentioned. But moving onto some considerations that I want to wrap up with. I'm right on time. So co-occuring and multiply-occurring needs are the expectation. I don't think that I really got into using the term multiply-occurring needs. I may have introduced it a little bit in the beginning. When I started at the center where I am, we started being the first in our state or one of the first in our state and nationally to pay attention to youth with co-occurring needs. That attention had been there for adults for some time, but the perspective and the uniqueness of working with adolescents with co-occurring needs wasn't really there.

The longer we did this work, the more we realize that co-occurring was really oversupply finding what was going on. A better term is multiply-occurring needs.

Because as soon as there is an adolescent boy teenager on the substance use side, chances were very good that there were needs in the family realm, that school can be suffering. It predicts a higher likelihood of justice involvement, and riskier decisions associated with peers. And as soon as that is involved, has moved well beyond anything like a simple academic exercise, how does mental health influence such as use and vice versa. Now, we are talking about the whole systemic and ecological perspective.

And again, my highest perspective in working with adolescents is the thing a best time to work with a human being. Because they had a lot of the resources in place, that is as cognitive functions have been practiced and those pathways have been laid down, but there's all that plasticity left, that risk/reward, impulsivity kind of decision-making, there's a ton for them to be influence in their specific ways to move forward, and even small alterations, small movements toward increased protected decision-making during adolescence. If you can do this is arbitrary -- if you can help them make a 10 degree shift, as that moves forward into adulthood, that becomes enormous. It plays out not just for that in the individual, but for the family so that it a jewel this well. So again, biased perspective. I think working with adolescents is the best time, especially when we are talking about coworker and multiply-occurring areas of need.

So with that little introduction to the slide, 70% of youth entering subsidies treatment or identified as having a co-occurring mental health disorder. So it very strongly predicts the onset or presence of a mental health need if co-occurring substance use is there as well. 40% of youth reason receiving mental health retreatment work I did I just having a co-occurring sentence use disorder. So if you're working with adolescents in a primary mental health setting, whenever you get stalled out, things don't seem to

be progressing, that is a huge key that this is time to be doing some continued screening for substance use needs.
After 59% of adolescents with post-traumatic stress develop drug or alcohol problems. A similar correlation in the other direction, too. Substance usually predicts future trauma.
67% of youth in center for subs abuse treatment, this would be kids who are referred for drug and alcohol abuse, reported experiencing victimization in their lifetime. There's some sort of trauma-based experience, very, very hard. So the presence of one predict the presence of another very strongly.
So if you are serving adolescents kind of on a one-sided approach, more so than other sides, just about every program right now has some level of integration, some level of integrated approach, but don't let your screenings and just during intake. When you are working with adolescents, screening should occur throughout treatment, and you should be screening for mental health, substance use, and screening for individual trauma experiences and more complex, expenses as well. Juvenile justice increases the likelihood of everything happening. And the deeper than a kid goes into the justice system, the more these go up.
This one is a decent resource. Most of what SAMHSA writes adult oriented peak this one very specific to children and adolescents. This is a free resource that you can download from SAMHSA. Identifying mental health and substance use problems in children and adolescents. It's a decent starting resource. My difficulty with it is, this is not an exaggeration, it dedicates 1.5 pages specifically co-occurring disorders. And that was the title of it. It's a good starting resource.
I'm not going to go into this This was kind of a time filler if I needed it. Talking about previous methods of treatment. Most places at this point are at some level of integration.
Advantages to an integrated approach. Regardless of the primary focus of how you work with adolescents, evolving at some point, but the greater

degree of integration, we can incorporate in treatment with adolescents, the better dividends is going to pay. The more intentional the intervention, and are attention to intentional integration, the better the results are going to be.

If we can do this in a single intake session, we can do this under a single treatment plan with a single provider, that increases the likelihood of treatment engagement, treatment retention, it would not engage in retention. We can have any kind of clinical effect. So the more we can do this on days though under a single integrated heading, the better off the youth and that family are going to be.

Closing considerations very quickly, adolescents are not children and adolescents are not adults. They don't exist in a vacuum. They are not just a problem to be solved. They are not a piece of paper with tools in terms of an academic exercise. They are parts of families and parts of the community and all of these have mutually influencing interactions with adolescents. Mental health needs suggests alertness to substance use and trauma. On the other side, substance use needs strongly suggested alertness to mental health needs and trauma. Trauma strongly suggests alertness to mental health and substance use needs. No clinical work as possible without engagement. Because if you not do not engage, it won't work well. Integrated care really increases engagement. That is, if we can provide care in a single setting, it's more efficient for that family and is going to increase the likelihood they are going to come back.

And we didn't really touch on this, the motivation silent communication is the best mess with our families.

There are references if you want to look for some to resources in the reference section for the slides will be available to Samson will tell you about that, and I'm going to turn it over to Samson.

>> Michael, thank you so much for that incredible presentation. My page is filled. I appreciate the expertise you shared. And we will come back to you in just a moment. We've got some great questions from the audience.

Everyone else, as a reminder, we are really fortunate to welcome sponsors like Time2Track here we are altogether in this transition, trying to learn how to use technology and help us adapt and control this ever-changing environment, especially when it comes to professional development. This webinar is sponsored by Time2Track, he Liaison company. And we have with us today Alyssa Holbrooks. I'm giving you keyboard and mouse control. And I will turn this over to Alyssa, who is the account manager for Time2Track.

>> Thank you, Samson. Thank you for the training today. Hi, everyone. My name is Alyssa and I am with Time2Track and excited to be with all of you today. I imagine most of you are having to log your training hours, your supervision hours, if you're getting a degree or records of licensure. This transits into spreadsheets, notebooks, and calculators, but hopefully you are not one of the unfortunate ones who lost a notebook or had a hard drive crash. Many of you are probably still working under license and I am happy to share there is now a way to keep track of your hours. After Time2Track is a handy app that gives student separate licensed professionals they with attractive training supervision hours securely online. Just like the details of your daily activities and Time2Track totals everything up for you to include in your licensure application paperwork. Practitioners who have been through licensure process and share Time2Track them, we often hear I wish I had known about Time2Track a lot sooner.

So now we want to spread the load and get time to check in the hands of even more pre-licensed professionals. Starting this month we will be releasing brand-new state licensure guides. These guides will include summaries, checklists, and infographics with key things you need to know to get licensed in your state. Along with each guide we will release a customized version for Time2Track for your state license.

To invite you to sign up for the licensure to tell us what state and license you are looking toward, we will notify you when it's available. You'll get a

free 30 day trial trying to track plus 820% coupon for any prescript in. Visit the website to sign up and get out -- access to this offer.
Feel free to ask any questions you have about Time2Track in the questions box that will help be happy to answer them. Thanks so much for having me today and we will look forward to helping you prepare for licensure.
>> Thank you so much, Alyssa. That was so great. Everyone in the chat box right now is the link that Alyssa mentioned for that trial. They are creating those new state specific licensure guides for prelicensing professionals. They have given us this offer for A free 30 day trial and 20% off any Time2Track suspicion. So we make sure that that's is on the same website used to register for the webinar for you see it here on the side. I will leave it there for a moment as I welcome back Michael. Alyssa, and Maggie Wilkerson, also from Time2Track going to say on. If you have any cousins were Time2Track, feel free to submit in the questions box on the GoToWebinar control panel. Right now we will go through some of the questions that were sent for Michael.
Michael, I'm going to jump straight to the first question. Our first question is from Stephen. How do you assess and diagnose bipolar disorder look -- bipolar disorder in adolescents?
>> That's a five hour answer, Stephen, it's a good one at a common one. Because from a superficial perspective, and are not saying you’re superficial, but from a superficial perspective, teenagers are all bipolar. They are all living with bipolar disorder. From kind of that excitation about well, it seems like it's kind of manic, kind of depressive. But if you think about the prevalence that is going on with adolescents, and that one Slide we had were 1 in 3 are living with a lot of anxiety and 1 in 5 are living with symptoms of depression and depression is pretty common.
1 into 3 adolescents experience a depressive episode in the last year. So these areas are pretty common for teenagers. Within somewhat normal bounds.

Differentiating those normal bounds from maybe something else that is going on is depression and it doesn't look like the adult discussion, in that adolescents with depression typically stay more physically active, more socially active, they can act out more angrily, which is sometimes perceived as something on the manic or hypermanic side.

Taking time and not jumping to a bipolar diagnosis, and taking a strong development of perspective, that is the starting point. The DSM, when they came out with the V, they created out of nowhere that the ODD diagnosis was there to capture a significant portion, to capture adolescents who were on the surface, presentation of bipolar, but they found through research, were probably more on the depression side of the bipolar side.

You have to consider with adolescents being willing to use a wider range of substances, and we can talk about that. But as a youth may be abusing diverted Adderall or they are not touching very much opioids. We didn't get into methamphetamine too much, but these things can really give the appearance of a manic episode as well. So take a very strong development of perspective. And that's a 90- second answer of what could very well be a 90 minute or full day exploration. But a great question.

>> To be continued training, I think that is what you're saying. So Michael the next question comes from Mary, and do you think are there any signs that the 2020 MTF report will reflect a decrease in ETOH use, given how make kids are not in school settings due to the pandemic? There are a lot of questions about what is the impact of social interaction with peers, not being in school, maybe not being exposed, but having access to things at home.

>> We don't know. That is -- it's a huge area of consideration. My expectation is that we are going to see drug and alcohol use tick up for 2020. We have certainly on the adult side, no, especially on the alcohol side.

Adolescents will remain social whether they are in lockdown or not, whether or not they are in school. So their day-to-day interactions or exposure have decreased peer certainly that is having an impact on everybody in the world right now. But everybody right now is experiencing higher levels of stress and that can develop to anxiety, depressive areas, increase impulsivity. So we are not going to see decreases in any of the risk areas whatsoever because of 2020. We will all be happy when it is 2021. I'm somebody who never wishes my life away, but I will not be sad to see 2020 in the rearview mirror. And I think we are going to see a lot of areas.

>> Hear, hear to everything you said have. There are about 12 million memes agreeing with you now. I guess will try to squeeze in one more here. Mary from Canada asks, what age are you referring to when you say adolescents? In many first Nations, in Canada that's indigenous or original citizens, many first Nations, identify to age 25 because of brain develop.

>> That is a great question. Three questions, two of them named Mary. That's a significant measure. That's a great question to end on thank you. Typically, at least in my head, which nobody wants to be in, I think about adolescents being anywhere from 11-12 through the teenage years. Not ending at 18. Going to 20, 21, that area. But the nice piece of this is, this takes us back to that publication by NASEM, with the promise of adolescents, they define adolescents starting with the onset of puberty. Which doesn't show secondarily. You don't know that puberty is starting on the outside. It's more of a measurement of internal hormones, starting with the onset of puberty and lasting to the very end of brain develop, which would be 25, 26. So it sounds like that's how you're already considering that. And the public's and I recommended identifies that same way.

>> Awesome. Thank you so much, Michael. I was speaker gone with the rest of the questions. As we mentioned, we will send in some of the

question to Michael in a Q&A document and work with him to get those answered at a later date. Maybe within the next few weeks or so.
As a matter, every NAADAC whether has its own webpage that houses everything need to know about that particular webinar. So everything you need will be on website you see on my screen here. That the same one you use to register. This webinar is for 1.5 CEs period when you go to the website you will see the online CE quiz active for you. You will also see a link that gives you a PDF with an instructional guide on how to go through the CE process.
Here's a quick look at a schedule of upcoming webinars. You can join us later on this week, Friday the 20th at 12 noon Eastern, ironically, a presentation by Cheri DeMoss, on ADHD. We touched on that with Michael. I think she will be saying a lot more on this webinar, Always During Distraction. Make sure to bookmark this webpage, it's tremendous information there. Really pertinent to the work we are doing this year and planning next year. Also the webinar with the highest number of attendees and NAADAC's history, is available for free on that cultural humility resources webpage.
We also have a COVID-19 resources page. We are going to keep alive now going for another year. There are six excellent free webinars they are addressing top concerns from self-care in a crazy time like this to technology in a time like this.
And as a NAADAC member, just a quick review of some tremendous benefits of being a member with us. Well over 145 free CEs, access to our adventures in addiction recovery, a magazine that comes other scene 50 politicians comes out soon. As also eligible for CEs and has incredible new research being released this year by the APA division 50, tons more benefits of course. Including discounts for conferences and things like that.
Everyone, a short survey will pop up at the end. It will also be in your thank you email from gotowebinar. Please take some time to share

information with us, share notes for the present up here and the other question about the sponsor, you can place them there, to be a pure feedback is important to us as we continue to sharpen and evolve with the times and improve your learning experience. Thanks again for participating in this webinar. Michael, think you for your valuable expertise and leadership and support in the field. Many thanks to her webinar sponsor, Time2Track for sharing their innovative and user-friendly solution for those of us working on our licensures. I encourage you all to take some time and browse our website. You can learn how NAADAC helps others stay connected on LinkedIn, Facebook, and Twitter.