- Good morning. Good morning. You are here. This is Saturday, July 1st. Can you believe it?

- No.

- Oh, I can't believe it either. Good morning. This is Amelia Headley LaMont. You are tuned into Ability Radio, You and Your Life. I'm joined this morning by Iris Bermudez. Good morning, Iris.

- Good morning.

- And how are you?

- I'm fine. Glad to be back on the air.

- Hey, that's, it's right. It's been a little bit of a time that we took a little break but we are glad to be back. We are joined from time to time by Archie Jennings who broadcasts this show from Saint Thomas. And I'd like to make a note that this program is brought to you by the VI Lottery, Making a Difference. Now today, you may recall or have, if you've paid any attention to the news, health has been an issue. And one of the concerns of course is, what is going to happen to the Medicaid program? And so I thought that today we've spend some time again exploring what Medicaid is, how, what it applies to, and I have the privilege of having a co-host who is an expert on Medicaid [laughs] and has spent a good bit of her professional career covering Medicaid as an issue. But let me also mention just briefly what I hadn't realize and I'm glad I've read this article a little bit earlier. Medicaid was signed into law by President Lyndon Johnson in 1965. The program originally covered four groups, four main groups, children, pregnant women, people with disabilities, and seniors or older adults who need long term care. Then in 2014, the Affordable Care Act or as some referred to as ObamaCare allowed states to expand Medicaid to cover able bodies adults who earned up to, would I say, a certain percentage of the federal poverty level. In 2016, it was, let's say if it was a single household, $16,394 but it's a lot less here in the territory, correct, Iris?

- Yes.

- Roughly for, I guess, a household of one, we're looking at about, and I'm just estimating, don't quote me like $6,500 or something.

- A year. Income level, yeah, federal poverty level.

- Right.

- Uh-hmm.

- So that's very, very low in order to be eligible for the Medicaid or the medical assistance program here.

- Right. It's because we don't meet the federal poverty level. We have to use a local poverty level because we are territory.

- And that's politics for you?

- Well, territories, all the territories are subjected to that same similar poverty level in the state. Each state has an, different poverty levels that they're did, they're dealing with. Well, similar poverty level but they're matching maybe different. Because Medicaid is a matching formula grant or program where the federal government pays, let's say even the Virgin Islands that pay 55% of the program and then the local government has to come in and pay the 45% for, in order for them to--

- Continue to receive?

- --continue to receive and to draw down their federal portion. So it's a program that like you started saying at the beginning, it was started for four categories of folks and with the Affordable Care Act it was

expanded to include single adults. I know in the Virgin Islands when I was a Medicaid Supervisor, we used to have a general category for single adults. But because it wasn't really matched by the federal government, the local government couldn't continue funding it. So they, you know, took the program away or had to be, couldn't afford it anymore. But now with expansion, it allowed for single adults to be a part of the Medicaid program. At this point in time, we don't know how the Congress is going to make a miracle and allowed this expansion to continue. We don't know what's gonna happen. I mean, there's been so much back and forth between the Republicans, and some of the Republicans, and the Republicans Party, the Democrats are totally against eliminating the expansion because they know that there are so many people who made the federal poverty level and the territories who have at least a little reprieve at this point because of the implementation of the Affordable Care Act. But take that away and we're going back to ground zero again where people aren't gonna be able to afford even in the Virgin Islands, won't be able to afford to, or won't be eligible for Medicaid because of the way it's being played out in Congress. And that's something that I know that a lot of the territorial commissioners or like, for examples, Congresswoman Plaskett who is trying to work in Washington with all her committees to not allow that to be repealed because honestly, people are very sick and we have a problem in the Virgin Islands where single adults needs mental health services. So that's gonna be a big, big problem if they repeal federal, you know, the…

- Affordable Care Act.

- …Affordable Care Act, yeah. And the reason it's called ObamaCare and people say, "Well, that's not Affordable Care Act." Yeah, it is. It's just that when it started out since it was the president's health care initiative, they named it after him and he continued it because it's, kind of, like, the…

- Right.

- …appeal, ObamaCare, yeah. But that is the federal, the Affordable Care Act.

- It's a little troubling why there is such an opposition to it where at least from where I sit, a good, many of the people who benefit from Medicaid for example, living rural community such as ours.

- That's true.

- And you'd find people who are in those community say, "I oppose ObamaCare." And they're the recipients, quite a few are the recipients of that kind of service.

- Right. Because the, because of the opposition to this, to this program, the Republicans, I know, there's have used it against the president because he was the one that implemented it or he worked hard to make it passed through the Congress. So it's like, his legacy. That's how they're looking at it. This president's legacy is ObamaCare and now realizing that it's the Affordable Care Act and then opposing ObamaCare, you're opposing the federal, the Affordable Care Act.

- Pretty interesting. There's, well, another point is in 2015, a new study found Medicaid covered 16% of adults and 45% of children in small towns and rural areas. I didn't realize how extensive Medicaid covered. You know, this is a pretty significant percentage of people.

- It is. Because although you have the federally qualified health care centers, there's a partnership that goes on with them and Medicaid so it behooves us to really pay attention to these programs because they are the ones that are out there providing services to children, the elderly, you know, the disabled…

- And pregnant women?

- …and pregnant women, yeah. And, excuse me. When we talk about all these children and all these adults receiving care, I mean, people who couldn't afford to buy insurance, those that are, we don't have the marketplace in the Virgin Islands but those that are in the marketplace, if this program goes away or if it's repelled, a lot of people who are receiving health insurance for themselves and their families in the

marketplace, they might see their premiums rise to like, maybe, if they're paying now $800 a month for insurance, they might see it double, they might see it triple. Not to say that it didn't happen in the Virgin Islands because it kind of did. Because we used to receive complaints about why is my premium going so high? Well, the Virgin Islands didn't go for a marketplace because they really couldn't afford it. They were given the option of doing the marketplace and/or expanding Medicaid. But there are a lot of intricacies and develop in the marketplace. You have to have the systems, you have to the insurance companies that are going to work in the system and then the illegibility criteria and the subsidies. So that takes, that took a lot of money and they couldn't afford it. So that's why they did their study, a feasibility study and turned out that the only, the other option they had that they could have gone into was the expansion of Medicaid. And even to that, the income levels, illegibility income levels went up and not that high either.

- I remember it was not, but, yeah, but it was better than…

- It is better than what it was before.

- …what it was before. Right.

- Right.

- Right.

- Right. So, yeah, and that's what happens when you're living in a territory.

- Okay. Well, thank you. We'll take a brief break and we'll come back to this conversation because this is very current and we need to be aware. You're listening to Ability Radio. And we're back. You're listening to Ability Radio, You and Your Life. I am Amelia Headley LaMont, Executive Director of the Disability Rights Center and I am joined by my co-host, Iris Bermudez. We're discussing Medicaid, and that is such a hot topic and it impacts all of us. And let me emphasize, the other thing that I think is very important to realize is that Medicaid is not solely for people who are poor or indigent. I mean, people who are working class, middle class, probably even upper middle class especially if you have an elder who is need of long term care are impacted by the Medicaid program. So, please don't shut your ears to this debate, it is a very important issue that impacts all of us. One of the things that, again, we are, first of all, I'm amazed that even the Affordable Care Act "Obama Care" passed, given the climate in Washington D.C. But as a result of the Affordable Care Act, the expansion, the Medicaid expansion played a role in reducing the number of Americans who don't have medical insurance. We went from, in 2013, 14.3% of Americans did not have health insurance. It went down from 14.3% to 8.3% last year. Now, that's significant, okay, but the cost of providing Medicaid is not cheap.

- It's expensive. That's right.

- State and Federal Governments paid 574,000,000,000 on Medicaid last year, okay? And other side that's why we're looking at the period of time in which, you know, as what happens in a lot of legislation, things come to their, what do they call it their?

- Sunset.

- Sunset, thank you. I was thinking twilight sunset, I knew It was something like that.

- Sunset.

- So by 2020, Congress has to get back together and say, "Okay, what are we gonna do with the future of this Medicaid Program?" But what I'm sensing, Iris, is that people are now who have it, who got it are saying "We don't want this to go."

- And that's what's happening nationally which is why need to pay attention to what's going on because nationally, even some of the individuals who supported the president, who support the Republican Party

are saying "Don't cut my Medicaid. What am I going to do? My mother is sick, she still needs to be in a nursing home. I have a child who has, you know--

- A disability.

- --a disability, what am I going to do? You can't do this." So they're getting resistance across the nation from their own--

- Constituents.

- --constituents. And from what we've been reading, a lot of, a lot of them have, are now holding town hall meetings because of that.

- They were worried about the blowback?

- The blowback. And the blowback is getting larger and larger all the time because now, you even have a coalition of religious groups that converged on Washington in front of the capital. I've just read about it. That they're saying "No, you can't cut the insurance programs. Don't do this. You're jeopardizing the health of the nation."

- Interesting.

- Yeah. I was interested too. And even the, that, I forgot what Congressman was it who went and sat on the steps of The Congress and little by little, groups started coming in and they started talking about this repeal. And lo and behold, they had a huge gathering before it was over. People are against this repeal. We know how expensive it is, we know they want to cut back on this but by the same token they want to increase the taxes. Well, how do they call it? They're gonna decrease the taxes that the rich pay, so, you know, you have to, I don't what's on their mind.

- I wonder myself.

- I'm just trying to be nice about it.

- Right, right.

- But, no, you know, it is expensive, it's an expensive program, and I think what's driven the cost up is that you took in a lot of people who became eligible for the Affordable Care Actually who hadn't had insurance before, who hadn't gone to a physician, who hadn't received any kind of preventive services. So, these people were in need of healthcare. So, once they got, they were, became eligible and they started visiting their doctors. You know, some of them had already conditions that required extensive and very expensive treatment because in order to keep your nation healthy, you have to practice preventive medicine and we all know that. That came from the Institute of Medicine. You know, we have to be preventive about everything we do in order to bring down the cost. And what I also read was that the Affordable Care Act was bringing down healthcare costs. You know, so it would start at, you know, to do what they was supposed to be doing with respect to people who didn't have insurance that couldn't, only were able to go to the emergency room if they had an emergency or if they felt sick because they didn't have any other insurance and hospitals are required by law to take care of them regardless of their ability to pay. So, the emergency room were flooded with people who didn't have insurance but who had medical problems. So, now we implement the Affordable Care Act to, you know, to change that situation. It's starting to happen but then now you have that resistance from, you know, the Republicans probably because it was the president who implemented it because all along, other presidents have been wanting to do something about healthcare. Clinton tried it. And you remember that fiasco. And now he did it, Obama did it, it happened, it passed Congress. There were hurdles, of course, you know, but it happened and people were getting healthcare, you know, and now they want to reverse that. So, you know, what are the priorities here, the healthcare or tax benefits for rich?

- Yeah. It'll be an interesting, thing to see what happens because obviously in addition to, you know, the healthcare debate, there are some issues which we won't go to any details that seems to thwart the focus. You can't wake up any morning without, you know, some communication we'll say that kind of takes you off the focus the healthcare or, you know, national security and the like.

- Right. And it's not just focus on Medicaid, it's focus on Medicare as well. Us, retirees have to pay attention to what's going on with Medicare. They're talking about Bernie Sanders talking about Medicare for everybody, that's national health. I mean, I don't know the intricacies of national health whether if it's similar to the Affordable Care Act, you know, we don't know it will work. But now, they're saying that's a socialist program. Yeah, but everybody will be insured and you'll have a healthier nation.

- I think Hillary Clinton was--

- She is.

- --a proponent of that as well.

- She was, she was. But the thing about it is that we all have to pay very close attention to what's happening with this conversation that's happening nationally because whatever happens nationally, impacts the territories. Let's be vigilant because trust me, whatever decision they make, they're gonna make it.

- Right.

- They're gonna make it and they're not gonna worry about your grandmother or you know, your disabled child. They're gonna, they're just gonna see where they can, you know, squeeze bucks.

- Wow. Well, there was a study that was, you know, how well does Medicaid work? And of course everyone would have, you know, Republicans would have one view, the Democrats would have a different point of view, they decided they'd report in Oregon where they did a study. Thy studied a group of low income people and the determination was that "Okay. Well, Medicaid didn't generate any significant improvement but what was interesting was that Medicaid patients did show substantial improvements in the area of mental health, which I thought was interesting. And that's a population that frequently either because of, you know, maybe not having insurance to begin with because of maybe employment issues or whatnot, that is certainly a population that has benefitted in this study from Medicaid support. So, that was a very, I thought that was a very significant thing. And again, mental health is a big issue here. And speaking of mental health, we have been joined by an expert in that area. Good morning, Dr. Copeman.

- Good Morning.

- How are you?

- I'm okay.

- Well, Iris Bermudez and I have been chatting about the battle over Medicaid. And how important it is to keep an eye on what's going on in Washington because what happens in Washington impacts us as well.

- It will.

- It will. It will. It certainly will. That's from an expert folks, it will.

- And the particular thing to look at, right? I hate to speak about Republicans, Democrats, Liberals, Conservatives but look at this particular phrase they're using. "We're going to give States the flexibility," right?

- We're not gonna talk about that.

- "By giving them formula grants, block grants."

- Block grants, right.

- Right?

- Right.

- It's all the same thing. But what they do is the first thing they do is they give you a block grant that is less than the money that you've been receiving.So that's the first way of cutting the money. See, we're gonna give you less money overall but you have the flexibility to do what you want to do with it, right? And then they're gonna set markers in there where the amount of money you get annually or every two years or every three years continues to decline. And that's a scam, and you can look--

- I love it.

- --and it's a real scam.

- It's the truth, right.

- Yeah. I mean, you go back to the days of let's say the Labor Department, they had the CETA program.

- Yes.

- I remember.

- And they had all these other programs and then they merged them, right, said, "We're gonna make this more efficient", right? They merged them, they gave you a block grant. "We're gonna give you the money. You do what you want with it, okay?" But see, the money got to be less and less and less. And that is what's getting ready to happen in Washington with, you know, health care, Medicaid. They're, if they're going to this formula grant business, block grant business, it's all over folks.

- It's all over.

- It's all over.

- Yup.

- Yeah.

- Because we have what? A hundred five thousand six hundred forty-five people in the Virgin Islands. And many people are leaving to go to the States. So, we see the dwindling down, big time.

- Yeah.

- Well, we'll be back to continue with this conversation. I am so glad that Dr. Copeman has joined us. He have given a very upfront and personal perspective. You're listening to Ability Radio. We're back. You're listening to Ability Radio, You and Your Life. My name's Amelia Headley LaMont, I joined by my co-host, Iris Bermudez, and we are joined this morning by Dr. Chester Copeman. Dr. Copeman is a native of Saint Croix, attended Howard University, graduated with double majors in Psychology and Zoology with a minor in Botany. He pursued a doctorate in psychology where he attended the SUNY, State University of New York at Stony Brook. Dr. Copemann, welcome, I'm glad you're able to join us this morning.

- Thank you so much.

- We were talking about systems, and block grants, and don't be fooled, let's go into a little bit more about that, please [laughs]

- Since you're talking about mental health, you know. Mental health has been a victim of the block grant scam. You know, back in the days when I was doing graduate work actually there was a move to, the term used was deinstitutionalization. It was determined that having mental health patients, chronic mental health patients in these large institutions that were built before the war, you know, was not good, not good, not good. We just needed to get them out into the community, let them live community based lives, and things would be so much better, right? So they started dumping them, right? The word was that States like New York when they've got folks that they can't deal with, they put them on a plane with the ticket to the Virgin Islands.

- One-way ticket, right.

- One-way indeed, right? So mental ill patients started appearing in communities because there was no set up, there was no infrastructure to help them to address them, to deal with their needs. And the scam that the federal government used was States would have the flexibility to better attend to these patients because State know their needs better than we the feds. And we shouldn't be [inaudible] their needs, right? So that was the scam that they used, and I use the word scam because it was indeed a scam. And what they did was fazed up all the grant programs relative to mental health. And they created these block grants, the same things that they're talking about right now.

- Right now.

- Right now, uh-huh.

- Created these block grants and if you look at the Virgin Islands mental health system they got, you got fewer and fewer dollars every year. We in particular being the territory, here's what they do to us. When they set up a block grant they set up a fail-safe. They say no State will receive less than a certain amount of money because they know. It's impossible, no matter how large you are, or how small you are. There is, you know, a bottom line amount of dollars that you need in order to provide services, even if you're providing services for 10 people, or 50 people, or whatever there is a bottom line level of services that I needed, and that will cost, right?

- Uh-hmm.

- But in the Virgin Islands and the other territories they say, no, no, no, no you don't get that minimum [inaudible] what you get is a per capita amount. That is we will give you a certain number of dollars per head in your community. Well, we have a hundred thousand people, how much money are we gonna get?

- A hundred thousand.

- Yeah. Sometimes, many of the times when I was in mental health we ended up with grants of like $20,000.

- Uh-hmm. Yeah.

- Ten thousand dollars, fifteen thousand dollars. I mean, this is the actual result of that block grant business, and this is what's getting ready to happen to us again, all over, right?

- You may have slip, it sound like you said a black grant [laughs]

- Block, block.

- Block, okay.

- Block [laughs]

- Okay. Let's look at a vision, what do you, what do you see as building capacity, what can we do here in the community, what do you see?

- Look if you have a family, and somebody give you a dollar to support your family, clearly you have to make decisions about how you're gonna spend that dollar. You've got to decide about rent, food, clothing, you got to decide how to, how you're gonna spend that dollar and how to spend that dollar most efficiently.

- Yes.

- But no matter how you decide to spend the dollar, no matter how you cut up that dollar you have to have the dollar before you can do anything, right? You cannot spend the dollar if you never get the dollar. And that's how a problem in the Virgin Islands. The mental health system has been denuded, stripped of the dollar resources that are necessary. And I don't care what you do, I don't care how many commissions you have, I don't care how many times forces you have. If the dollars are not there to support a minimum system then nothing will happen with mental health. The fact that a matter, that fact of the matter is you need money in order to do the work that needs to be done. In order to create a structure that needs to be created.

- Uh-hmm.

- And that's the long and short of it. And over the years mental health dollars have been stripped away. You know, when the federal government reduced their block grants, the local government did not step up, and fill in the loss. And that's, you know, that's the long and short of that. So without money we can, we can have a million commissions in task forces but we're just spending our wheels. It's not gonna anyway because without the resources you can't make it happen, and I, I'll be the first one to say. When you have resources no matter how big or how small you are you need to efficiently spend that money. I agree with that, I support that a hundred percent. You got make sure the people are doing what they're supposed to do. But you know what? You got to have the money first.

- Uh-hmm.

- So.

- All right. How would you implement a system? Again this is just very, you know.

- Very theoretical.

- Right, right, right. Okay, let's say you have the money, let's say you have the money. And we have a small population, and we're, let's estimate, right? If we went with twenty five percent of a hundred thousand people, what kind of system should be at least in place? What's your vision for that?
- Okay. Well, that's another small percent, that's a large percent.

- It is a large percent. My bad, no, it is a large percent. It is a lot, it is a lot.

- Yeah.

- Yeah.

- The estimate that anyone time, for the level of mental health cases in the community used to be about 10% of any given community. It's about, it's about I would think it's more like a 15% now over the years. So 25% is a lot.

- You mentioned that earlier, you talked about neglected care. I'll never forget at now.

- Yeah.

- Yeah.

- So, you know, you have to, you know, I was looking at a paper that I got in my email two days ago concerning a Webinar that's coming up. And this gentleman who's got good creds is going to be doing a Webinar on integrated care that talks of mental health, primary care, it was an integrated function. And, you know, I'm looking at it because I think that I'm gonna participate in that Webinar. And the whole Webinar, how do we make things more efficient, how do we make things more effective. Well, one of the things that you need to do, we need to do that if I have to do it, would be to start at the ground, and assess what we have. And then assess the population that we have, and by doing that understanding, you know, what our needs are for the population of people in need, right? We've got a big need for chronic care, right? And that's the stand out need but that's not the only need that we have. We've got some substance abuse need. I don't know how big the problem is locally, I mean, they're having, they're going, they're pulling up their hair on the main line because they're going bananas, right? And they've got some serious problems. I mean, this is as serious as I've ever seen. And when I came back home in 1977 I had been spending many years working exclusively in substance abuse. I mean, the last major drug that came up when I was there was Quaaludes and that was bad.

- Uh-hmm.

- Quaaludes was bad but this stuff that's going on now it is beyond bad.

- The opioid epidemic if that's what's you're referring to, yeah.

- Right? And we're worried about, we're worried about marijuana, right? But the opioid, the opioid epidemic is occurring because of drugs that are manufactured by drug companies.

- And prescribed by physicians.

- And factories, right? That are doing business. I mean, openly they're paying taxes. They're established businesses. But the opioid epidemic is fueled by the drugs that are made in these companies, and the internet because now you can sit in Ohio, and you can order your drugs from China.

- Right.

- It seems to me like we should be able to control that some way, somehow. But we've not been able to do that, right. And fentanyl as a drug isn't the first one that we've been having this problem with. I mean, before fentanyl they were other drugs, right? Percodan.

- Oxycodone.

- Oxycodone, right? And those were drugs manufactured in the factories, right? They were, you know, methamphetamine.

- Yes.

- Right? Those were drugs that were manufactured like, manufactured like bushroom, right? In put together factories, right? But the ingredients were produced by legitimate companies, right? And we either were not able to control it or weren't interested in controlling it, right? So it's just, you know, half of the problems we have is because it's a community, as a country, we won't take steps to deal with the things that we have to deal with. So, you know, we'll have a drug problem, right? Alcohol has been a long-term problem. The biggest problem in the military used to be alcohol. Because a military produced alcoholic for some reason. And alcohol was never been able to deal with. And alcohol is a legal drug, right? We in the Virgin Islands live and die on alcohol. We tax it, right? We make large dollars off of alcohol. And any given year, look at the sergeant general's report, the US Sergeant General's report, okay? Look at the number of deaths in this country that are due to alcohol. And it's just phenomenal, look at the number of deaths in that sergeant general's report that are due to tobacco use. Oh, it'll blow your mind. It will truly blow your mind, right? And here it is we'rehaving these big discussions over marijuana. And you wouldn't find in the sergeant general's report, one death.

- Attributed to marijuana?

- One death attributed to Marijuana, not a single death, right? But we're very concerned, this was a moral argument that we're making with marijuana. This has nothing to do with reality. It has nothing to do with true outcomes. It's a moral argument. And then, and we're gonna stop it. And, you know, rational people should discuss things rationally. And deal with the facts. What are the facts? Well, marijuana was placed as a Schedule I Drug. You know, the FDA schedules drugs, right? By the potential addictive capability, ability and marijuana was put as a Schedule I Drug, that's higher than cocaine, and cocaine is a Schedule II Drug, right? Marijuana is a Schedule I Drug. Now, how did it become a Schedule I Drug? The mix in administration, right? Political.

- So Schedule I means the strongest?

- Yes. All right. Yeah.

- Uh-hmm.

- Yeah.

- Oh, my goodness.

- So that's why if you'll look in the newspaper, you see all these arrest and all these busts, and all these convictions due to marijuana. Now, I'll been the first one to say that, you know, you catch somebody running marijuana, you know, tons of marijuana and boxes of marijuana and kilos of marijuana, you know, grab them, try them, and if guilty, put them in jail, right? That has nothing to do with use, right? But part of the problem why marijuana is so lucrative is because we've made it a Schedule I Drug and we said bad, bad, bad, bad, bad marijuana even though there's no science to support that this drug destroys people. There isn't. But that's what we've done. And so we've got wars going on because of turf and because fields, and because, listen, during prohibition, prohibition became a nasty period in American history. And the reason why was because of prohibition. You can't drink booze anymore, you can't make booze anymore, it's illegal. That's what they did. That's what they…

- Yeah. So you do it on your own?

- Right.

- In your home grown?

- Right. And you had shootings and massacres, you know, going on. And the minute that they end the prohibition, Al Capone and all of that stopped over alcohol, right? It disappeared. Now, crime continued, but that had nothing to do with alcohol. When last did you hear, right, of anybody attacking a liquor store because turf? "You're selling liquor on my turf." When last you'd heard of it? Somebody might rob a liquor store because they want the dollars out of the cash register. But they didn't even taken a bottle of liquor to go with.

- Because it's free and easy.

- Yes. Exactly. It, people, you know, as a citizen, you are allowed to produce a certain amount of wine and alcohol, as a, as a private citizen. You, the law entitles you to do that. Who produces their own booze? Nobody because it's cheaper to go to the store and it's less hassle to go to the store and buy it. So who's gonna fight of alcohol? Well, if you legalize marijuana, it's the same thing, people say, "Yeah. But we don't want to keep using marijuana." We don't want kids to be using alcohol either. We don't want little kids using cigarettes either. The extent to which they do means the parents had been slapped in controlling what the children do and the law has been slapped in controlling what the children do. So don't use that as an excuse by legalizing marijuana, we're not talking about making marijuana available to children. They shouldn't get it, just like they shouldn't get cigarettes and they shouldn't get alcohol. But, you know, to continue to have this issue on marijuana to continue to put these restrictions in marijuana, we're not gonna get rid of these gun battles that are taking place. Because we've made it illegal. And you know what? The Mexicans, I've listened to the Mexicans for years as the United States say to them, you know, "You need to do more to control the drugs that are coming across our boarder." And the Mexicans used to say, "You need to do more to reduce…

- To stop them.

- …the need by your people." If there wasn't a need, then we wouldn't have this problem.

- But we've been accused of inappropriately, rightfully, so if you're supporting guns to make, because guns are limited in Mexico more so than here. We will take a short break, you're listening to Ability Radio, You and Your Life. We're back, you're listening to Ability Radio, You and Your Life. This program is brought to you by VI Lottery, making a difference. My name is Amelia Headley LaMont, I'm joined by my co-host, Iris Bermudez, and our special guest this morning is Dr. Chester Copeman. Iris, you had a question for Dr. Copeman?

- Yeah. You mentioned the legal implications of, general implications of marijuana, what are the implications for the mental health community on marijuana?

- Well, I think like any substance. Any substance, whether manufactured or natural, marijuana can affect you in, on to wide waves. So if you are, have vulnerability because you have a mental condition, you shouldn't be smoking but you shouldn't be drinking any also, right? And you shouldn't be smoking cigarettes, right? Because cigarettes have a psychological property, if you talked to people that smoke, I tell you, you know, they--

- You're addicted [inaudible]

- When I smoke the cigarette, it's--

- It feels good.

- Yeah. Right. Like I'm calm and, you know, I can concentrate. I mean, so the implications is that it is a substance, it is a psychoactive substance. It's, will affect your perceptions and so forth. So you have a problem, you shouldn't start, you shouldn't smoke, right? But on the other hand, you know, say to the government, Virgin Islands Government, you should declare alcohol as a bad drug, you know, and you should outlaw it, step and stop taxing it and just outlaw it. We won't produce alcohol in the Virgin Islands anymore, say that.

- You don't dare.

- You, your future is behind.

- No more, as what, very good point.

- Uh-hmm.

- Very good point. I don't know where we are with respect to the status of marijuana here in the, in the Virgin Islands.

- It's sort of in limbo, reached the certain level and it sort of stopped there and, you know, they're having these focal debates that are basically moral arguments back and forth, back and forth, back and forth. While we continue to blatantly, you know, prove a, you know, in, with alcohol and cigarettes, you know, so…

- But one of the issues or one of the questions about marijuana is that it's good for people who have cancer or who needed medically?

- There has some legally sound reasons for the use of marijuana, name it it's gut properties, you know, not as much some people say and perhaps we don't know all the properties and the good or the bad that it does because, you know. The research has made, not widespread because the government has controlled access to marijuana for experimental purpose. But we do know that there are some things medically that marijuana is good for. So, you know…

- Well, this is a very interesting note I believe (laughs) I [inaudible] folks, please do not assume that this ability rights has anyway endorses marijuana use, but we do welcome this debate.

- Yeah.

- This has been very eye-opening.

- Yeah.

- It needs to be done honestly.

- And we hope--

- It could be better it should be done honestly.

- I think we will continue this discussion if you are willing.

- Yeah.

- This is Ability Radio, you and your life. Thank you so much for listening and have a good Saturday.

- The 4th of July.

- Have a good weekend. That's great.

- The 4th of July.

- Or 3rd of July.

- Third of July, 3rd and 4th.