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[00:00:02] Colby D'Onofrio: Welcome to *Stocking the Pantry*, a CalFresh Healthy Living podcast from Leah's Pantry. We'd like to acknowledge our funder, the CalFresh Healthy Living Program, an equal opportunity employer and provider. On this show, we discuss any and all things community nutrition, food equity, and nutrition security. This is a space for thought leaders to share success stories and strategies for equity-centered and resilience-building initiatives. We hope to foster collaboration and community, as well as leverage strengths among listeners, guests, and hosts as we share ideas and dreams of building a more equitable future where everyone has access to healthful, nourishing food.

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Hello and welcome to Stocking the Pantry. I'm Colby.

[00:00:56] Tee Atwell: I'm Tee, and we're your hosts.

[00:00:59] Colby: In today's episode, Tee interviews Annie Lindsay, a professor at the University of Nevada, Reno, whose research focuses on promoting physical activity and nutrition across the lifespan with a focus on women in recovery from substance use disorder.

[00:01:16] Tee: You may be wondering what a discussion about substance use disorder is doing on a podcast about community nutrition and CalFresh Healthy Living, but we promise it will definitely make sense. Professor Annie Lindsay has done some incredible research within the realm of nutrition and physical activity for people in recovery. The connection to Leah's Pantry and trauma-informed approach is made clear when we realize, like trauma, you don't always know who around you is living with a substance use disorder and/or in recovery.

[00:01:57] Colby: This episode will include discussion of substance use, incarceration, sexual and physical abuse, and eating disorders.

[00:02:06] Tee: We also want to begin by discussing the spectrum of substance use, and the choice to use non-stigmatizing language in hopes to better understand the power and impact of our word choice when discussing this topic.

[00:02:23] Colby: You might be thinking, eh, it's just words, people know what I mean, but word choice matters. When talking about this topic, people, even unintentionally, often use words that are stigmatizing or portray someone's disorder in a shameful or negative way.

[00:02:41] Tee: This is important, because using words that make people feel stigmatized, dehumanized, and misunderstood or just viewed negatively makes them less likely to seek treatment. This is even cited in research done by **[unintelligible**

00:02:57] et al and Yang et al. Links for more research papers can actually be found in our show notes if you are interested in learning more.

[00:03:06] Colby: First up, we'd like to lay the groundwork in understanding that substance use is a spectrum. Most people use substances. Personally, caffeine is a favorite of mine. I am a caffeine user. Now, not all substances have negative effects or consequences on our life, as is often associated with the term substance use. For example, if I don't get my morning cup of coffee, I tend to be a bit irritable and cranky, but it doesn't have a drastic effect on my day such as my ability to go to work, engage in positive social relationships, or eat a healthful diet. Many of us use some sort of substance, whether it be medically or recreationally, on a regular basis.

[00:03:52] Tee: In the middle of the spectrum is substance misuse, which is defined by the National Institute of Health as the use of a substance for a purpose not consistent with legal or medical guidelines. It's like the step after use that Colby was talking about. An example of substance misuse might be someone who consumes cannabis in a state where it is not recreationally legal. However, if it were medically legal in that state and that person had a medical cannabis card, then it is not considered misuse, even if they consume in the same way and frequency with or without that card in this sense. You can see how misuse is a bit of a gray area and can be influenced by circumstance.

[00:04:50] Colby: On the far end of the spectrum is substance use disorder, which is a term that we will be using quite often today. Abbreviated as SUD, this is a mental health disorder that affects a person's brain and behavior, causing a difficulty or inability to control their use of substances like legal or illegal drugs, alcohol, or medications. As I mentioned earlier, my caffeine use or lack thereof does not greatly impact my day.

For someone with a substance use disorder, their use can get in the way of them doing important things like going to work, interacting with and caring for themselves or their family, and engaging with their community. This term recognizes that what we used to call addiction is, in fact, a diagnosable and treatable mental health disorder. Other terms that might be used would be active addiction or alcohol or drug use disorder.

[00:05:50] Tee: When talking about people who have SUD, instead of referring to them as an addict, it is important to use person-first language. Instead, we can say a person with substance use disorder, with addiction, struggling with addiction, or living with active addiction. This creates space for things to evolve and grow. Addict is very finite, without room for growth. We are looking to promote lotus blossoms here, listeners.

[00:06:24] Colby: Absolutely. When we use terms like these and person-first language, like someone who uses drugs instead of a drug user, we recognize that those with a substance use disorder are people first. They may have a disorder, but they are not their disorder. They are humans.

[00:06:46] Tee: Yes. Hopefully recovery comes soon after experiencing substance use disorder. Some phrases I adopted during my time working at substance use prevention was person in recovery or in recovery, on the path toward recovery, or not currently

using substances. I would usually throw in a positive stepping stone or milestone as well. Instead of saying that someone is clean or sober, the word "clean" has been used for a very long time, but it implies that if someone is not clean, they are dirty.

That is very stigmatizing. Clean along with sober creates a binary where a person is one or the other, but recovery is not a linear path, nor black and white, so to speak. Relapse is often part of the recovery, and making space for this is an important step in understanding and supporting people on their recovery journey.

[00:07:56] Colby: Using the right language reduces stigma and opens up space for people to be their authentic selves, free of judgment and shame.

[00:08:05] Tee: When we keep respect and dignity at the forefront of the conversation, we reduce stigma and can offer better support to people with SUD.

[00:08:16] Colby: With a trauma-informed approach, we assume that anyone can and probably is dealing with the effects of trauma. Similarly, we as community health educators are probably working with people and communities that are living with and affected by substance use, even if we don't know it. Why not take an approach that is sensitive to and informed about substance use and recovery in the same way that we do with trauma?

[00:08:43] Tee: Yes. Thank you for taking this journey with us as we define these terms and discuss the importance of using non-stigmatizing terminology. There are so many nuances to substance use and recovery, and we are going to let today's guest tell you about her work and findings.

[00:09:05] Colby: Enjoy.

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[00:09:13] Tee: Annie, thank you so much for being here with us today. I am so excited to hear more about your experiences and research. Please tell us a little bit more about yourself, and share the why behind your focus as a researcher of substance use disorder, and the connection with physical activity and nutrition, and how your work evolved over time.

[00:09:36] Professor Annie Lindsay: I definitely started my career in Southern California in the nutrition and physical activity field. That's what I was really interested in. Worked with adult fitness centers, YMCA fitness centers, developed programs in nutrition and physical activity. When I moved to Las Vegas to get my master's degree, I began some work in the field in cardiology and realized that wasn't the place I wanted to be in clinical, that I really was passionate about prevention. Then I worked out at the Nevada test site for many, many years running health promotion programs for 13,000 employees out there.

I was super passionate about getting people healthy. When they had a moratorium out there, I ended up starting my own business on the outside doing the same thing, no longer as a federal employee, but my own business. I got a call one day from a substance use treatment center from a guy who started the drug court here in Las Vegas. I believe it was one of the first ones, which the drug court is where you-- it's an alternative sentencing. You don't have to go to jail or prison if you go through programming. He said, I really think we need some physical activity and nutrition treatment plan, to put something together.

Ignorantly or naively maybe, I said, yes, it can't be that different, right? People are people. I just put together a four-session, three nutrition and one on physical activity, and jumped in there with 50 or 75 people in substance use recovery. We all just talked about nutrition. They were excited about it and enthusiastic about it. I thought, yes, this is a great audience for us that are really anxious and excited to learn this stuff. That went okay until I got another contract about three years later with the women's prison here. The state women's prison in Nevada is here in Las Vegas where I'm located.

I went down there and I started doing programs for women in prison. Same thing. I thought, oh, I'll just take this and we'll make a nice program here in the prison. We did nutrition and we put in a bunch of exercise equipment. We really got them off of the yard and into the gym and exercising. Everything was going great. I was like, wow, this is great too. Until I started seeing things that bothered me. Some of these were I would see girls come out of their prison cells at nine o'clock in the morning, jump on the treadmill for 45 minutes. Somebody was waiting and said, she needs to get off because I want to get on.

She'd leave and then she'd come back at lunchtime and see if anybody was on there and then she'd run in and get on it again. Again, I was like, this is the third time down here. She's like, I know, I need to really exercise. I thought, huh. They're either really enthusiastic or there's something that's not right. Then I started noticing girls showing pictures of themselves, like this is what I looked like on the outside and how thin I was. I thought, okay. I guess they're feeling like they're gaining weight and they're trying to get it back. Still not really seeing it.

Then I started noticing things like trends around simple things that you don't think of, that people can be trendy in prison where they roll up one pant leg or something like that, so everybody does it then. I started seeing that. Then it really hit me when I started learning that women were going into their rooms and having their roommate cover for them and they would be throwing up in their cell area. I thought, wow, this is crazy. The policy there was that they put them in segregation. Some people call it the hole, but it was segregation to say, that's not right.

You can't throw up in your room. I don't care if you have an eating disorder, whatever's wrong with you, why you're doing that, you don't get to be with the general population. I started seeing this more and more. Then girls started being honest with me and coming to talk to me and saying, I think I have some issues here. I've developed an eating

disorder since I stopped using methamphetamine. I started just really putting it all together. I went to the ward and I said, let's make a deal here. You don't put them in segregation and you let me develop some programs for them.

If they're in the program, agree not to put them in segregation because that's making their situation worse. He was very open to it. We were very fortunate. That's how this all started. For the next five years, I was down there. The thing that's unique about this population that's where the substance use comes in is we ended up doing studies on them and 87% of our population had a history of substance use. If you look at Department of Justice data, you'll see the same thing. They generally say that substance use plays a role in incarceration in 80% of individuals in prison in the United States, and it's likely higher for women.

The numbers that we gathered exactly match that. Then I knew that this wasn't about prison. This wasn't about being skinny, going to prison and gaining weight, and then trying to lose it. This was about methamphetamine being a very popular drug for the women. Then they go into prison, they don't have access to the drug, or in some cases for the most part they don't and they choose not to. Once you stop that methamphetamine use, it is just natural that your metabolism is jacked up. It needs to recover, it needs to figure out its-- find its way back to the body.

Until that happens, weight is gained. We actually looked at the women in our studies. 74% of them were either overweight or obese by the term that the CDC uses for BMI. It was significant. Significantly different. Some of these women sadly gained, I think an average of about 18 pounds over the first three years of being in there. Then I think the highest one we saw was in the neighborhood of 98 pounds over 42 months. That's a problem. I think that that's where this all started for me. I actually contacted a exercise physiologist who I'd gotten my degree from-- my master's degree here in Vegas.

Then a woman out of Auburn University, Dr. Michele Olson, who was specialized in eating disorders and exercise. The three of us got together. That's how we started looking at this data and realizing this is a problem. Once I finished my contract there, the state stepped in and took over. We then now had contract with them through the university. I went back and got my doctorate and started research. Did my research on this population, and realized that there's a real problem here. Prison is just the housing. That's just the place where they're located.

This problem is amongst women with substance use disorder all over the country, all of our recovery centers here in town, in jails, in prisons, in our minimum security camps. It's a huge problem. That's how I got into this research. It's very nutrition and physical activity-related. I've dedicated pretty much the rest of my career to really providing resources so that-- a lot of these women in recovery are obviously also eligible. They're low-income families.

I thought, we've got to figure out how to help them, whether we know this or not, we've got to make a positive impact and not further harm them, which can happen if you are a

health professional and you don't recognize that this is a problem. If you treat them like an overweight male diabetic with heart disease, you talk to them in the same way, that's not going to work.

[00:18:24] Tee: Not going to work at all. Not going to work at all. How humbling. One, I want to just say, I really appreciate your enthusiasm and willingness to jump in to something that you really had no understanding of the population, so to speak, when you got into it. You went with excitement and enthusiasm and said, let's do it, That says a lot about your character, one. Then two, that you actually took a moment to pause and say, actually, let me really understand the community I'm working with and get to know them on a personal level, and also gather research and data.

Through all of this in connection, you were able to come up with an innovative and very creative program that was specific to your population. One, kudos. going all in and giving it the attention and respect that it deserves is very commendable. After all of that, I would love to hear about, in a perfect system, how can a community nutrition or physical activity facilitator best support women in recovery? Are there any nuances for women of color in recovery?

[00:19:45] Annie: Definitely, we need to look at women in recovery very differently than we look at women who are not in recovery for substance use. Even more importantly, we need to look at them differently from men who are in recovery. We know when we look at the data that's out there, women use different drugs than men use. There's a study by Brecht, B-R-E-C-H-T out of UCLA Integrated Substance Use Center. To me, it was one of the seminal studies that came out in this area. It came out incidentally while I was working down there at the women's prison.

The study showed that the top reason really that men and women use methamphetamine is energy, but for men, the energy is a little bit different than needs. For women, energy is right at the top and right next to that is weight loss. For women, it really is so that I can have energy and so that I can stay thin. The pressure that women have to look good, to have enough energy to take care of their kids, go to school, to do their jobs, they got to go be energetic from the time they wake up till after they go to bed.

[00:21:13] Tee: Oh yes. Full-time job on top of full-time job.

[00:21:16] Annie: Yes, exactly. When you need that kind of energy, and then you got to go look good when you're out there at the grocery store. It's just that pressure that we have. Methamphetamine is the drug that does that. It's not only destroys their lives, but it's deadly. Now we see it laced with new thing now, not new thing, but over the last several years, it's not just been methamphetamine, but also methamphetamine combined with heroin or now fentanyl where the methamphetamine picks me up. Now I've been up for a few days and I need to calm down.

I need to slow down. Then the heroin. If you think about, that issue in and of itself is a health issue. All the treatment that we do, if we don't also bring in how to be more

energetic and feel better, feel good about your body and eat healthy, and be more active, and all of those things, then there's a big gap missing in our treatment providers. That's how I think in supporting women recover, we need to, first of all, recognize that women use different drugs. They use methamphetamine and synergistically the heroin more so than men. Men, if you look at the data or at least what they go in for treatment, it's more alcohol, alcohol plus another drug, marijuana.

They still use methamphetamine, but for different reasons. Women and men also, they manifest themselves, which I won't get into, but how the drug manifests in their body is different. Different for men, lots of studies on rats and lots of studies on human and how these drugs function differently. Even nicotine and smoking. Why, when you're trying to quit smoking, men respond to gums and patches because it works differently in their body than it does for women. The last thing is that women and men relapse for different reasons, and they use the drug for different reasons.

All of that is to say if we're looking at women in recovery, if we don't address some of these things that I've talked about, we're missing this. What we see is women, whether they're in prison or they're in treatment, when they leave the treatment, they're like, that was great treatment, but the reality is I've got to get rid of these 45 pounds I've gained in the last year while I was in treatment. I'm just going to do this little meth diet or whatever they want to call it for a little while. You can't do that. It kills them or it just relapsed them and they're back in.

If we can, early on in recovery, look at what these issues are, then they're more prepared when they get out, and they're able to start addressing some of the things early on in recovery so that when they are home-- or sometimes they're actually outpatient. Teaching them, that's even better because you can teach them how to go to the grocery store and they're rebuilding relationships with their children. Maybe they lost them to CPS, so they want to cook with them and they want to eat with them and eat around the dinner table, and all these things that really are healthy and important for all of us, but we can actually teach them during this time.

As far the second part of your question about nuances for women of color. Women in these situations, as I mentioned, develop eating pathology, body dysmorphia, body image disorders, or body dissatisfaction. A lot of that is also because when you look at this population, the data says anywhere from 77% and 99% of them have a history of trauma, of rape, physical violence, sexual assault as a child, and as well as an adult with intimate partners and such. When we address this, there's this common thought that eating disorders is a white women problem.

Yes, I'm going to say that probably our women's prisons nationally and our substance use numbers, if you look at men, it's very different than numbers. We do see more black men in prison, maybe in substance use, but when you look at the fee-- I haven't studied the men, so I don't have any numbers on that. What I'm saying is I know that this is not the same situation in treatment. It tends to be that there's 60% to 70% of women in

prison in treatment for substance use are white, and maybe methamphetamine is a more white drug, so to speak.

However, if you look at the data, a lot of the data is on women either going to prison or they're going into admissions for treatment. Studies also show that not only is gap possibly narrowing, but maybe one of the reasons is that a lot of women of color don't reach out for that treatment, or they don't feel comfortable even talking about the fact that I might have an eating disorder. That's not acceptable. Or they just can't get help, they don't have access to help. We also see that in rural areas, the stigma that goes with that. If I walk into here to NA or AA, everybody knows this.

Stigma can play a role in that. As far as the history that brings them there, the trauma, the rape, the physical violence, African American and American Indian and Alaskan Native women are more likely than women of other racial and ethnic groups to be victims of rape, physical violence, and stalking by an intimate partner, not a total stranger. I think also, yes, we see higher internalization, body satisfaction and preoccupation with weight amongst white women, but that NAP, again, is narrowing, especially with eating restraint, that is tend to be more white, but that gap is narrowing, and so we can't make any assumptions about that.

Some studies we know for sure is that if you break that eating pathology down, anorexia is more common in white women, but the prevalence of eating disorders is similar among all races. African American girls are more vulnerable to developing eating disorders with the binge eating features. You can actually start to look, there are some pretty good studies that have looked at different race across eating pathology and stuff. I think it's just as minority women feel more comfortable asking or seeking treatment, and as we study more and make more access, I think we'll see that the problem is greater there.

[00:28:23] Tee: You brought up some really great opportunities and strategies that maybe can be implemented to support women in recovery and women of color in recovery. The population in our listeners, a lot of who we target is SNAP-Ed and FNEP implementers. Thinking about those implementers, what do you feel is the most important thing for SNAP-Ed and FNEP implementers to know about women in recovery in relation to physical activity and nutrition?

[00:28:59] Annie: I'm going to say we're doing a better job overall all the way around in this area. I know this isn't a shout out or shameless plug, but maybe it is that the work that Leah's Pantry does around trauma-informed, whether women have eating pathology or substance use, or not, that whole direction that we need to move more towards, I think is making a huge impact in this whole arena. Because I think we're seeing more and more that we have to take a completely different approach to nutrition. I was saying earlier, it sounds silly to compare women in this environment to the overweight male, diabetic with heart disease in a clinical setting.

Nutrition people, when they begin to understand their audience, then they have to make that shift. The shift for this audience, number one, is that trauma-informed, which I think that we've done a great job of starting to talk about that more and understand that, like I said, the work that Leah's Pantry does. Also digging in a little bit deeper and being cautious of maybe language that we use that can be simple things like, I think a good example would be when people talk about calories, for example. Everybody wants to talk about calories in relation to--

If you look at MyPlate. MyPlate says this is how many servings you should have, and this is a-- you see words like portion control and portion size. Maybe those aren't as harmless to somebody that you're working with in a clinical environment. Maybe they're actually trying to control their sugar intake and this and that. I don't know. That's not my real arena. What is powerful for this audience, though, is certain words like that can be a trigger. The word "control" is a trigger for women with eating pathology. I say eating pathology because you don't have to be diagnosed with an eating disorder to have illness around this area.

Disordered eating is what we call it, which is a whole wealth, things around eating pathology that we develop because of food. You don't have to be diagnosed with an eating disorder to have disordered eating. I use the word eating pathology because it covers a whole area around that. I like to use words like reasonable amounts because that doesn't say this is the portion. Go look up this portion and see what it says. That could be a difficult situation for somebody on either side of that portion, that number. We have to understand reasonable amounts and maybe use language like that, or weight is another one.

It's easy in some audience to say I need to lose weight or I need to gain weight, or it might be a casual conversation, but for a lot of these women, that is their trigger. I don't think we want to say don't ever talk about weight. That's not the answer either. I completely understand the whole concept of the weight stigma and moving away from the weight culture. I'm all for that. Trust me, we don't need to talk about weight or focus on weight to teach health. However, when you have women in treatment settings or recovery settings, if they're angry and the only person that makes them mad is their mother, you're not going to say, let's talk about anger, but I will never, ever mention your mom because I know that's a trigger.

I look at it that way. We don't want to talk about weight all the time, but if weight is what they think about, it's on their brain. They're thinking about that. They're worried about that. They're worried it's going to be a trigger, and our study shows that 70% of women in treatment have concerns about weight, and 33% of them stated that it would be a trigger for them to relapse. If they know that weight is a trigger, we want to talk about it, but we don't want to talk about it. We don't want to talk about the number, but we want to help them understand that we understand that that's an issue. I think it's just learning how to talk about weight without focusing on the number.

[00:33:34] Tee: Right, and understanding the multi-layers and multi-dimensional connections that come with it, which in turn will indirectly have an effect maybe on their health, physiological health, when we're able to really support that whole body well-being and looking at the opportunities for growth that are specific for that individual. Your focus on women in recovery is huge and so paramount, but I also heard you also mention that there are other groups.

This happens not just to maybe women that are in recovery or living with substance use disorder, but other groups that might be impacted or maybe overlooked within SNAP-Ed interventions may exist within the design of their programs for the general population. What would you recommend to implementers to help tailor their interventions for different identity groups? Because you did touch on them. I would low to that just a little bit more.

[00:34:37] Annie: Still related to substance use? Are you still referring or not necessarily?

[00:34:42] Tee: Yes, definitely focusing on women in recovery of substance use. Yes.

[00:34:49] Annie: First of all, we know there's a lot of data to support that all people in recovery, not just women, all people in recovery come into recovery with nutrient deficient issues. There's been some studies that have shown 88% of people in recovery need nutritional guidance. You know what? SNAP educators, we're here. This is what we're here for. Some of them are clinically deficient, and some of them are malnutritioned and may need a dietician. Many of those, if not a majority of them, we can make an impact on group nutrition education.

There's a lot of studies now that have also shown that we can make an impact in the same way in substance use, nutrition educators and implementers, that we focus on chronic disease. The results are the same. For implementers, just add chronic disease and mental health. Put them into the same category in terms of how I can make a difference. Then once you recognize that, then maybe like going back to my other conversation, instead of focusing on calories or focusing on how to count serving sizes and this, really focus on those nutrients, helping them find foods that they like that are high nutrient value.

For instance, instead of looking at calories and, focusing on serving sizes and calories, maybe we focus more on percent DVR so they can look at something and say, this has a lot of nutrient value. I'm going to really focus on nutrients. Across the board, we want to work with people in recovery on bringing back nutrient value. They're very deficient in nutrients when they come in. Then you have to look, I think, to your question, is what are the different types of audiences? If I have a mom with children, that child has been maybe taken away from me.

I'm trying to re-bond. Maybe with my moms that have children, I want to really focus on how to do these things together. I don't want to tell her you go to the gym. Get a babysitter, it's important for you to go to the gym. I want to say, instead of going to the

gym, let's figure out things that we can do with our kids that we're all going to be active together. Physical activity from a mental health standpoint does not take very much. The CDC says 10,000 steps we should take a day, whereas the mental health data says that first 5,000 has the steepest increase in mental health.

Just to get people out and doing something. I will mention this is very important with methamphetamine. It's a dopamine problem. That's what the drug does. It messes with that. When you're not taking that anymore, that dopamine level's low and it's tiring and you have no energy. To do something like go to the park takes a lot. Recognize that, validate that. Say, yes, I know it's going to be hard, but just take a few steps to do it. Do something and each day will get better. It's little things like that, or involving their kids. Don't give mom one diet and the kids another diet.

Teach them how to take the kids to the store. Who's going to pick out the green vegetable today and who's going to pick out the red one? Then it's a family thing. Definitely that. Involving the children. We mentioned rural areas, the stigma is higher. Again, implementers can make a big difference because people may not be in treatment. They may not be going to meetings, but they may be in your class. They may come to learn how to use their SNAP EBT card and how to make it go further. Then you may be the person that actually helps them in recovery because they're addressing these things from a different perspective, without the stigma. It's higher in rural areas, substance use.

A lot of them because it's a long drive to go to the doctor. Then it's easier to get it wherever. I think if we recognize even within that, the impact that we can make and know that many people in your classes may be suffering from substance use whether you realize it or not. I think you could make-- what do we say about trauma? We just assume everybody has trauma. We just treat everybody like there's trauma, especially with women. Almost every woman has had some type of trauma, so we can make that assumption. There's no reason that we can't make that assumption too that people may have some substance use. Let's just focus on really making an impact without doing further harm.

[00:39:41] Tee: I really appreciate you and the fact, bringing up that, really, one, meeting the person where they're at, but to not looking to add something. Look at what they have going on right now in their lives and saying, let's find ways to to get creative and incorporate.

[00:40:02] Annie: Exactly. You bring up a good point on that because a lot of them, if they are in recovery, they have to drop their-- they have to do a drug screen. They have to check in with their maybe parole officer. They have to check in with the judge, or they have to go in and meet with a counselor once, or go to a group. That's just added stress that they already have on top of their jobs and their school, and taking care of their family. If we can help them figure out how to incorporate healthy lifestyle and simple things, then at the same time as they're raising their family, they're reunification, re-bonding with their children, and actually helping them with their substance use.

We actually worked at jail yesterday. We asked 45 girls how many of them knew how to really cook for their families. Most of them had methamphetamine issues. I think maybe eight girls raised their hand that they knew how to do that. Four of them had taken our program where we taught them. I think they would really benefit from just learning how to prepare low-budget, not expensive, but healthy and simple. Not everybody can cook and has the time to cook, but there's a lot of ways to prepare that simple rather than stopping at fast food place on your way home.

[00:41:42] Tee: I thank you so much for sharing everything that you have, and all of the great strategies and approaches that you've been able to share with-- I've been inspired. This conversation has been very moving. I really thank you for your time. Before we wrap up here, we're going to shift gears a little bit. We're going to get a little personal now with you.

[00:42:11] Annie: Okay, bring it on.

[00:42:13] Tee: We would love to know, what do you stock in your pantry? That can be figuratively or literally.

[00:42:22] Annie: I have a pretty good fiber diet because I get lazy. I like a lot of cereal. Non-fat milk and cereal is a staple for me.

[00:42:33] Tee: Love it.

[00:42:33] Annie: I tend to buy a lot of things in the pantry and in the refrigerator that I can put together very quickly. They have frozen as well as pantry rice. That's just throw it in the microwave and you have rice. I love those steamers that you can buy, the frozen steamers, throw them in there 90 seconds. I have a nice little rice bowl. Throw some little, either a bag of frozen meatballs or a bag of frozen chicken and throw that in there. It's just my way of doing a chicken bowl overnight. Not overnight, but very quickly so that I don't have to spend the evening doing that time. I am so passionate when I see people that love to cook. I'm like, I'll take your leftovers.

[laughter]

Raise me your leftovers.

[00:43:23] Tee: The seasoning has bloomed. Then the flavors are--

[00:43:28] Annie: Exactly.

[00:43:29] Tee: Leftovers are the best.

[00:43:32] Annie: Exactly. I like to eat healthy, but I don't want to spend a long time doing it.

[00:43:38] Tee: You're still providing yourself nutrients and a well-balanced meal. When you were talking about all of that, I literally had an image of this bowl with just steaming from the chicken and the veggies, and rice with-- I'm a sauce person. I'd probably put a little gravy or something on it and just go to town on that bowl.

[00:44:00] Annie: My kick-around food, I love hummus and any cut up vegetable. I keep them handy and ready so when I get home-- guacamole, that's my other big thing.

[00:44:11] Tee: That's another spoon bowl. I don't even need you to do that. Same here.

[00:44:17] Annie: That's pretty much my diet right there.

[00:44:20] Tee: That sounded well balanced. You had veggies, you had the fat, you had the protein, you had the macros and micros in there.

[laughter]

Awesome. I love it. Thank you so much for your time and being with us here today, and sharing all of this.

[00:44:36] Annie: Thank you. Thanks for having me.

[00:44:39] Tee: Thank you.

[music]

[00:44:48] Colby: We want to thank you for joining us today. We hope that you enjoyed hearing from Professor Annie Lindsay just as much as we did.

[00:44:57] Tee: I get chills every time I listen and think back to that interview. Annie is such an inspiration in this field of work. If you are just as intrigued as I am or interested in getting more information about Annie's work, please visit our show notes for some great links.

[00:45:16] Colby: You can learn more about this interesting topic as well by taking part in Leah's Pantry's new training titled Nutrition, Food Security, and Support; Women and Simulant Use for SNAP-Ed Implementers. You can sign up for the self-paced course on our website under the training calendar tab, or check out our show notes for the link. We'll see you next time on *Stocking the Pantry*.

[music]

Ciao.

[music]

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[00:45:52] Tee: This podcast is a product of Leah's Pantry made possible by the funding from the United States Department of Agriculture, the USDA, and their Supplemental Nutrition Assistance Program, SNAP, an equal opportunity provider and employer. Visit calfreshhealthyliving.org for healthy living tips. Thank you so much for hanging with us. I want to ask you this question. Do of any thought leaders or someone doing great work in your community?

We would love to interview them and we'd love to hear from you. Find us online at leahspantry.org or on Instagram handle at Leah's Pantry, or email us at stockingthepantry@leahspantry.org. This podcast is a product of Leah's Pantry made possible by the funding from the United States Department of Agriculture and their Supplemental Nutrition Assistance Program, SNAP, an equal opportunity provider and employer. Visit calfreshhealthyliving.org for healthy living tips.

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