NAADAC PRACTICAL HARM RECUTION

DECEMBER 2, 2020

2:00 P.M. CST

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>> Hello, and welcome to today's webinar on harm reduction for the clinical setting presented by Kimberly May. It's great you can join us today. I'm Samson Teklemariam, the director for NAADAC. I'll be the organizer for your training today. In an effort to continue the clinical, professional, and business development for the addiction profession, NAADAC is really fortunate to sponsor webinar sponsors. As our field continues to grow and our responsibilities evolve, it's important to remain informed of best practices and resources supporting our work. Especially in times like these where we are all quickly realizing the importance of how technology connects us all. This webinar is sponsored by Halcyon Health, who provides addiction recovery support that adapts to your life by combining a proprietary software driven integrated care platform and personalized support from an expert team of providers, care coordinators, and certified peer recovery coaches. Halcyon is

there for you with every step of your journey towards lasting recovery. Stay tuned for instructions on how to access your CE quiz towards the end of the webinar immediately after a brief demo from our sponsor. Make sure to bookmark this home page so you can stay up-to-date in addiction. Closed captioning is provided by Caption Access. Please check your most recent confirmation email or our Q & A and chat box for the link to use closed captioning.

As you can see, we're using Go To Webinar. You'll notice that the control panel that accident /HRAO like the one on my slide here. You can use that orange arrow any time to minimize or maximize the control panel. If you have any questions for the presenter, just type them into the questions box. We'll gather those questions and give them to our presenter during a designated live Q & A towards the end of this webinar. Any questions we don't get to will be posted on our website at a later date.

Lastly, under the questions tab, you'll see a Tabitha says handouts. You can download the PowerPoint slides from that hand-out tab and a user-friendly instructional guide on how to access our CE quiz and immediately earn your CE certificate.

There's also an additional handout from our sponsor Halcyon Health. Please make sure before going into take your quiz that you use that instructional guide. If this is your first time with our CE process.

And now I'm so excited to welcome our webinar presenter today, Kimberly May, who is the founder of substance use therapy in Austin, Texas. She worked for many years of harm reduction you providing counseling services to those receiving medicated

assisted treatment. She also -- Kim also worked for the local mental health authority managing programs in the division of intellectual and developmental disabilities. In this role Kim established crisis programs and developed and implemented training for law enforcement about how to better serve the IDD population.

At Substance Use Therapy Kim works with couples, families, whose lives have been impacted by drugs and alcohol. She works with harm reduction model to meet people wherever people identify themselves on the continuum care use.

Kim, whenever you are ready, you can turn your web cam on, unmute yourself, and I will hand this over to you.

>> KIMBERLY: Hello. I think I've successfully done it. Can you verify you can hear me?

>> SAMSON: I can hear and see you. It's all yours.

>> KIMBERLY: Perfect. I navigated the whole part of this whole training. It's cake from here on out.

Well, first of all, welcome. I'm really excited to do this presentation. I'm really grateful for NAADAC for the opportunity for inviting me to present. I absolutely love harm reduction. I love talking about it. I could talk about it all day long, so we should probably get to it.

I am clicking and my slide isn't moving, so I'll give that just a second to catch up. All right. Samson, the slide is not clicking.

>> SAMSON: Just grab your mouse and click on the green E screen again, and then it will give you back control.

>> KIMBERLY: Okay. Let's see. And I'm clicking.

>> SAMSON: Go ahead and hover your house over the slide like where your name and your image is, and let's make sure I can see your mouse. One second. I'm going to step in for you. Here we go. You see the mouse here. Go ahead and move that for me, and that way we can make sure. Then click on that slide. One more time. We're on your first slide. If you can just go ahead and click right there. Don't move the mouse. Just grab it and click there. I think what's happening is it's moving off of the screen. Once you click, if you can see your mouse around your name, just make sure to move it around your name. I'm looking to see when it will allow you to take over.

>> KIMBERLY: Okay. Moving it.

>> SAMSON: I'm going to take it away and give it back. Sometimes that works. There we go. Sorry about that, Kim. Everyone, this is on us. We'll get this straightened out there. Kim, go ahead and grab that mouse and click right there. Yes. I see it. You're moving it. You've got control. Perfect. At this point you can use your arrows and go backward. Perfect. Yep.

>> KIMBERLY: All right. That's out of the way. We always know there's going to be some kind of technical issue. Always good to get it out of the way early.

Kind of first thing is first. What is harm reduction? So harm reduction really originated around the '80s in Europe, and it was largely a response to the HIV and hepatitis crisis that was happening amongst IV drug users.

Harm reduction is a set of practical strategies and ideas aimed at reducing the negative consequences associated

with drug use. So rather than the focus solely being on eliminating or minimizing the drug use, the initial focus is really on the consequences or the risks. I think most of us in working with this population understand that this tends to be a population that's often marginalized, really stigmatized. They don't always have a voice in their treatment. They don't always have a way to advocate for themselves.

>> It's done amazing things in terms of saving people's lives. It's still not incredibly widely accepted. There's still some things about it that feel a little controversial. Some things about it make people feel a little squishy, which I can certainly understand. Something I think a lot of us don't realize is that we actually all of us live with examples of harm reduction every day. Let's look at some of those. One of the things I talk about is the designated drivers. The designated driving campaign is really unique. It doesn't assume that people won't drink. Have someone drive you home after you do your thing. The target is not on the active drinking. It's on the act of driving after drinking.. Another example that is really important in saving lives is nicotine replacement therapy. This would talk about nicotine gum, the nicotine patch or lozenges. For people who are addicted to cigarettes or tobacco or snuff it's the nicotine they're addicted to, but it's the delivery method that poses such great health risks. Nicotine replacement therapy gives people the drug, nick team, that they want, but eliminating that delivery mechanism, like the actual cigarette or the actual tobacco. So many diet books and nutrition box, you know, have this much protein every day and this many carbs and that really ideal

eating that I don't know, maybe we aspire to, but isn't always realistic. Despite our best intentions, we will still find ourselves sitting in the drive-through lane. We will find ourselves sitting at the cheesecake factory with one of those book size menus, and when we do, we can make better choices. If that's where we're at, there's a better choice within that we can make. Naturally, we should stop and talk about meat. I am in Texas, after all. My dad was in a hospital. He had a heart thing. He was fine. It's not a sad story. As he was kind of getting ready for discharge, gearing up for that, the doctor came in, and he said, sir, we should talk about meat. He knew meat was a conversation he needed have. What he told my dad when it came to meat, you can have meat that comes from animals with four legs rarely. You can have meat that comes from animals with two legs sometimes. You can have meat that comes from animals with no legs as often as you want. It's short and easy to remember, and kind of funny. Really importantly, it doesn't have the word no. It doesn't have the word never. My dad /PRAEBL E probably wasn't going to respond terribly well to being told he can never have beef again. My dad has a 7 foot barbecue pit in his backyard. Sufficed to say, meat is a big deal. A lot of that I credit to the approach that doctor took. The way that he kind of found a way to meet him where he was. How do we take kind of this -- these big ideas of harm reduction and start applying them to the clinical setting. There were some wonderful clinicians back in the late 1980s and early 1990s who were, you know, starting to ask themselves that question. There are some people who have written beautifully about it and certainly inspires the work that I do. One of the primary ones that I

always turn to as Pat Denning. She's written a wonderful book. A couple of them, actually. Of critical importance is that we meet people where they are. That means accepting where people are. That means they may be continuing to use. They may not have any immediate goal of stopping their use. They may be looking at stopping one substance, but not necessarily another. Wherever they are is where we meet them. We feel like it's really crucial to get to know each person and their relationship with drugs. We have to see each person as a complex individual who may have needs that extend far beyond just substance use. At its heart, harm reduction is about compassion. It's about pragmatism. It's about collaboration. It's not something we do to people or for people. Harm reduction is something that you do with them, long time them. It's really tangible, and it fills a much needed gap in our service delivery system. It's about supporting people's options. For some people they find harm reduction as kind of their beginning point of recognizing that they need help some people find it when other modalities haven't helped them. It's meeting wherever somebody is in their trajectory and recovery. In working with people with substance use issues we certainly are familiar with a lot of kind of themes that I'm sure you all see over and over again. A lot of those are depression, anxiety, trauma, anger. Often beneath that and within that are some of the themes that I see over and over. A big one is really just a complete lack of self-compassion. Not only not having it, but not understanding it. Not understanding it as a concept not understanding what it would even look like. Not how to go about self-compassion. I highly recommend a wonderful book by Christian Neff. She writes really beautifully approximate about

self-compassion.

Lack of self-worth. That's another one where people do not feel that they have value. I cannot tell you how many people who despite their circumstances, they may be financially successful and have wonderful families and be struggling with substance use. They feel that they are a piece of shit, and that's heart breaking, and that is a very difficult space from which to launch positive life change. And managing shame. There tends to be so much shame with this population. With we are in a shame space we are feeling unworthy. Being in a shame state is actually a really great way to induce wanting to use. Even now in 2020 there is so much stigma around substance use, and that stigma contributes to that shame and that shame, again, is inducing people to want to continue to use. In harm reduction we talk about this stamp of objective curiosity. Just being cure justice and try to understand, and helping our clients learn that they don't make themselves better by beating themselves up. That helps to get outside of that guilt cycle because so often people experience so much guilt. Guilt about their life. Guilt about their choices. Sometimes just guilt way back about this initial choices to use. And boundaries.

I could talk forever about boundaries. So often people's boundaries are unhealthy or, frankly, nonexistent. When we work with people, you know, we talk a lot about the importance of self-care. Everything we usually talk about whether it's exercising and participating in activities that we like and having a good support system. All of those things are critically important. Sometimes we forget that we need sort of these kind of intrinsic things, these boundaries that help us really

navigate our life and our interpersonal relationships. When I think about boundaries, I always -- I think of the way that they build skyscrapers. Modern day skyscrapers are actually built -- they are designed to sway in the wind. If they have not enough moment, they snap in the wind, and if they have too much, you no longer have a building. How much they need to move is, of course, dependent on geographic wind conditions and how high the building is and, I don't know, Frankly just a lot of factors that are beyond the reach of my therapist brain.

Ideally, our boundaries function in this same way. Strong and able to withstand difficult conditions, but with enough flexibility to adapt to different and changing circumstances. I am often working with cues for what kind of boundaries they have in place, and people who are oftentimes having a lot of interpersonal issues or a lot of issues with work or having section /WAL encounters they're not feeling great about that after the fact. Oftentimes these are the result of kind of boundaries that aren't really functioning very well. Unfortunately, if you don't have self-compassion and you don't have self-worth, and a lot of times people feel like they actually aren't worthy of having boundaries or taking care of themselves in this way.

Care gives often come to see us because they are just sort of at a loss. I don't know what to do. I don't know how to help this person. Sometimes it works, but for many people it doesn't, and there's a lot of different reasons, but one of the main reasons is that tough love is about trying to change someone else. We know it's really hard, but not impossible, to change another person. When I'm working with a person, I talk

about their boundaries and what kind of boundaries are they putting up. Boundaries are about what we need and not what will change another person. It's a key distinction. I also did a lot with care gives and kind of rethinking Anne enabling and co-dependency. These are words that get used a lot, and care gives are oftentimes really afraid of doing anything that's going to be considered enabling or co-dependent. I think we need to take a broader view of that. Let's say you have -- you're working with someone and they're in a relationship with someone and that keeps calling them several times a week in the middle of the night to come pick them up because they've been drinking and they're too drunk to drive.

Early in her career Pat Denning talks about this kind of idea of needing to sort of rethink these things and the example she gives is a young woman. She's, like, 27, married to a man who has alcohol use disorder. They have three young children. On a regular basis she calls her husband's boss to make excuses about why he is going to be late for work or not be able to come in. At some point a clinician tells her that's really co-dependent behavior. Your husband is not going to get better if you keep doing this. So she stops. Very quickly her husband loses his job. This plunges the family into poverty. Not surprising, this worsens the husband's drinking, and, therefore, it worsens the circumstances for the family as a whole. This really shifted things for Pat Denning and her approach and realize the importance of looking at things from a systems view for those of you who do family work, you know, of course, we're familiar with the importance of taking that system view of the family and how each function affects the family as a whole. If

we are looking at enabling or independent. If you are looking as a broader view, really have an adaptive purpose that just to remove quickly could cause damage to the system as a whole. I also help care gives kind of understand what role are they taking on. Oftentimes care gives for one reason or another are in that role of cop or gate keeper. That doesn't tend to be very effective. It creates a dynamic rife with rebellion, resentment, mutual resentment and it's exhausting. It puts the accountability of someone else's use in someone else's hands which doesn't tend to be very effective. I also encourage care gives not to seek out promises. It's tempting, I think, especially when we are fearful and angry and worried about someone. We need these reassurances. The problem, as we all know, recovery and making life changes when it comes to substance use when there is a setback, it often feels personal, especially if promises had been made around that. Also encouraging care gives what they can realistically take on, and this brings it back to the boundaries thing. It's important that we help care gives to figure out based on their own abilities and resources and their own value system, you know, how can they best support the person they care about while still taking care of themselves. If our care gives burn out, then other people who are struggling lose a key support system.

Continuum of use. There is this idea that use is on a continuum. Use has been looked at historically as a binary thing. You either use or you don't use. We've always been a little more flexibility about this when it comes to alcohol. You know, people refer to themselves as a social drinker or I drink

a few glasses of wine every night with dinner. When it comes to drugs, we're always, like, you either use or you don't.

In harm reduction we don't consider all elicit drug use to be abuse, and so we see use as being on a continuum. It's important to note that the continuum is not this inherent linear progression. Just because someone begins to use socially doesn't mean it becomes habitual and so on. If you notice, the arrows go both ways. Many people do move back to smaller numbers on the continuum without any treatment. I like to keep a version of this in my office, and when I'm working with clients I'll sometimes pull this out and ask them, you know, to identify where do you see yourself on this continuum? Beyond that, asking them where they want to go. I don't assume that the answer is always going to be zero abstinence, no use. The thing is if we treat people as if they are only on the ends of the continuum, then we end upping inning a whole host of experiences and what's happening in the middle. If we're working with someone who is starting off at a place of abuse or dependence and over time they get back to habitual or social use, well, they may not be at abstinence, but they may be at a better and safer place.

And this kind of piggybacks on to the continuum. The idea that the progression from use to dependence is not inevitable. I know -- I think objectively we know this, but it can feel a little uncomfortable to talk about sometimes. I think we worry that by acknowledging this, we're saying there is not risk or that addiction doesn't happen, and certainly it does. But not for the majority of people who use. Many people do -- we don't need to look a lot further than the example of college kids or high school kids. We look at their drinking rates, and

their drinking patterns, and we see that so much of that kind of drops off over time, but for some people the progression from use to dependence does happen, and when it does, we are now, of course, looking at addiction. We see addiction as a bio psycho-social phenomenon. The full picture of how addiction culminates for an individual is really complex, and so it's so key as we're working with people and we're getting to know them, we're kind of pulling through all of this kind of bio psycho-social history and information to piece that picture together. While we're going through it, it's so important that we don't use that information only as like a deficit-based approach. Our strengths are also a bio psycho-social phenomenon, right? Our strengths are how any of us do better, how any of us make positive changes in our lives.

When that's the case, very often supportive counseling and support around that underlying issue are enough to return a person back to non-problematic substance use. I think this makes intuitive sense, but I think when we work in substance use, we forget that sometimes. We tend to see everything kind of through that addiction lens. I know I fall into it.

Let's take a different example. So let's say we're working with a client, and they're going through a really complicated grief process, and during this time it's a stressful time and they're grieving and they're partly dealing with that by overeating, and they've gained 15, 20 pounds in a relatively short period of time.

We wouldn't naturally look at that overeating as indicative of an eating disorder that's going to lead to obesity or heart disease. We would see that as a mal-adaptive strategy,

and the ultimate issue is being the grief. Sometimes it can be the same thing for substance use.

So as we're working with our client that's really key that we establish the client's goal. A great way to do this is to ask such a simple question, like what would you like to see changed? Most of us if we went to school for any kind, we're taught some version of this question. Sometimes we forget to ask this of our clients with substance use issues. We think we know it needs to change, but, yeah, you need to stop shooting heroin. You need to stop smoking meth. That's what needs to change.

It can be so tempting to just kind of start from that place, but it really helps to kind of slow it down and see if the client has a different goal. Very often the client will have some really strong ambivalence about their goal, and it's so helpful for us to embrace that ambivalence.

We do our best work as therapists when we really help them explore and understand that ambivalence ask come to a deeper understanding of their feelings and their relationship with their substances. Maybe a goal -- maybe a client has a goal of stopping one substance, but not necessarily another. Ultimately their goals need to come from them, and ambivalence is a really normal part of that process. I think we can relate to it. Maybe we eat too much. Maybe we're in not so great of a relationship. Maybe we're in a job that makes us unhappy. There's always a reason to stay. There's always a reason to go. There's always a reason to change, and there's always a reason not to. We often need time and ideally support to make those decisions and then make plans around those decisions. Same as our clients. As we are working with them to establish their

goals, we're then working on kind of putting together in this hierarchy, again, from a client perspective. Certainly if there's something major going on, like suicidal ideation, those things take clinical precedence. If the client comes in, and they're having problems at work and substance use, and they want to work on the work issue, that's where I start. I might look for connections and links between their substance use and what's happening at work, but how and when I bring that up, I'm going to kind of somewhat determine by how much trust and rapport will be established and how ready I think they are. Very often the resistance goes down, and I see my role as providing guidance and expertise that helps them develop their own goals and their own priorities. I was doing a call with someone, and he had expressed, you know, issues with alcohol and some other kind of secondary things he wanted to talk about and talked about how alcohol has been affecting his life and all of that. I asked him, you know, is alcohol kind of where you want our initial focus to be or do you have other things that you would like to address? He thanked me for asking that. He said I don't just want to be seen as someone with a drinking problem or someone in recovery. He said I'm more than that, and I have had a hard life and a complicated life, and, you know, I appreciate you asking that. He didn't have an answer prepared. I started our first session with that question, and he liked the question, and that got us off on a good foot together.

You want to dance at night. You want to have better sex. You want to minimize physical and emotional pain. You want to feel more like yourself. You want to feel less like yourself. There's a cure for what ails you, right? We know that oftentimes

the drugs end up causing substantially more problems than they could have ever solved, but for many people the initial -- there's actually self-care. Not self-destruction. Given that chronic isolation that you were living with, you know, I get why you felt like you needed an escape from that. It's not that we're validating their drug use, but we can validate the feelings that led to the drug use. There's guilt that's connected to the earlier decisions to use.

I'm sure most of you are familiar with the studies that they've done where they put a rat in a cage with drugs, and over time the rat will just take more and more of the drugs until the rat becomes addicted and oftentimes overdose. These studies have been used to highlight and illustrate this idea that drugs are so all-powerful that they will take over and they will hijack our brain. I'm sure there's a lot of you that are a bit younger than I am watching, so if any of you are not around in the 1980s to see a lot of the anti-drug commercial, I highly recommend a little diverse trip down YouTube sometime and checking them out because we got real dramatic in the '80s and '90s in some of our commercials. Dow want to play our commercial?

>> Nine out of ten laboratory rats will use it, and use it, and use it until dead. It's called cocaine, and it can do the same thing to you.

>> KIMBERLY: I always wonder how the rats turn out. I apologize for not having an exact date here, but Bruce Alexander was very familiar with these studies, and he started to realize that in these studies the rats were not in an environment that replicated nature. Rats do not normally live in isolation with no still lie or no friends with nothing to do but

consume drugs. He still had his isolation rats, and then he set out to build a rat paradise, so he called it -- rat park. Rat park was amazing. It had all things rats like. Wheels to run on, tunnels to crawl through, things to scratch, places to hide. Food was plentiful. There were other rats that you could hang out with and have sex with. Just a wonderful happy little rat life. They also put drugs in rat park. What they found was that the rats in rat park consumed significantly -- significantly -- less of the drugs than the rats in isolation. In isolation the rats were consuming about 25 milligrams of morphine a day, and then rat park, it was less than five milligrams. They were, like, hmm, this is interesting. They end up taking some of those rats that had been in isolation, and already addicted. They moved them into rat park. They've been isolated. We're going to put them in rat park and see what happens. Why is this relevant? In all that time of just looking at drugs and the affect on our brain, what we didn't really fully look at was context and environment. Dr. Bruce Alexander talks about the fact that maybe addiction is not really a disease, but rather, an adaptation. An adaptation to a particular kind of environment. For people who feel isolated and they feel alone, and addictive lifestyle can be a substitute for a full and meaningful life. In "Chasing the Scream" Johann talks about this war on drugs in order to punish people who are addicted to drugs, we have built the very conditions that are most likely to produce and deepen addiction, which are these kind of confines of punishment and isolation.

As we are working with our clients and we are trying to understand what it is that continues to maintain their addiction beyond just, you know, the physiological components of it. We

need to assume that there are cages that we can't see. I have worked with people with some forms of substance use that don't express some amount of loneliness. There's innate loneliness that impacts the feelings about themselves and their ability to make changes.

People who are actively using can and do participate in treatment. It's true, I tell you. Especially when they're granted the freedom to address their issues from their perspective of importance. Now, of course, this September to say that every single person is appropriate at any given time for every single kind of treatment. Certainly not. But simply because someone is continuing to use drugs or alcohol doesn't need to preclude them from participating in any kind of treatment, and ideally, the interactions between the client and the therapist that create an environment in which change is possible. Especially when we're doing that with that objective curiosity. When we're avoiding that confrontation, because confrontation doesn't tend to be terribly effective with this. Harms like denial, lack of motivation, are not very often accurate, and they're almost never helpful. It is natural to hide certain traits about ourselves when we think they're going to be judged or criticized or we're going to be punished for it. When we engage with collaboration and curiosity, a lot of times we can minimize that.

Increasing motivation for change is the work. That is the therapeutic work. Not a condition for beginning the work. I don't expect anybody that comes to see me to have already gone through, you know, sort of that gut wrenching soul searching process of trying to decide how they want to change and if they

want to change and what they want to change. I'm always prepared to do that work along side them. In their brilliant book on motivational interviewing Miller and Rolnik, they talk about how motivation is fluid and exquisitely sensitive to the interactions between two people. I like that quote.

So in harm reduction, we believe that any reduction in harm is a step in the right direction. Even those little teeny tiny baby changes. Those little tiny shifts. We've gotten to acknowledge them and validate them and celebrate them.

For many years I worked at a methadone clinic, which I loved, and a not uncommon scenario would be, you know, somebody presents at intake. They've been using IV heroin for, I don't know, two, five, ten years, whatever. They're kind of a mess. They're not very healthy. Their life is not very stable. In that moment you have a choice if they're down to a Graham a day. I can focus on the fact that they are enrolled in treatment and continuing to use or I can focus on the fact that they have decreased their use from a gram a day to a quarter gram a day, and what that represents. That represents fewer needles, less risk of overdose, less illegal transactions, less financial resources, being diverted away from other things. I can choose to acknowledge that progress. When I do, people tended to feel better about themselves and better about their treatment and see the progress that they had already made. They tended to feel energized and feel good about themselves, and it's much easier.

My doctor look at my blood work and said, girl, you need to make some changes. You're going to have to start exercising. That doctor is not going to prescribe me five hours a week of tennis, and if he does, I'm not going to do it. Tennis is really

hard, and I'm wildly uncoordinated. It's never going to happen. It's an embarrassment for everybody if I try to play tennis. I won't do it. What's right for me and given any previous injuries I've had, given my logistical or financial constraints, my interests or my talents. Successful is absolutely related to self-advocacy. People have to feel like they can do it. It's part of our job to help empower people to feel like you're capable of making changes. Big changes, small changes. We have to feel like we can do it. Our sense of power and our sense of confidence and control are essential to our self-east I'm and the ability to make life changes. I was working with this woman, and she had some issues with drinking. Nothing terribly severe. She said that child saved my life. I was, like, hmm, I think you saved your life. She was, like, no, it was the baby. I said, well, I think that your baby I object Spider-you, but I think you did it. She was, like, no, it was the baby. Now, I'm no baby expert, but what I do know about them is they are not terribly helpful. Never known a baby to, like, pitch a hand in any kind of way. And they seem to cause people quite a lot of stress when they have them.

I told her -- I said I think that you and your love for your child inspired you, but you made those changes. You did it at an incredibly stressful and overwhelming time in your life. It took us a while of kind of going back and forth for it to click to her that she was responsible for those changes that she had made, and she kind of always had this habit of feeling powerless, of feeling like she wasn't capable of doing anything, and kind of giving credit to other people for changes that she had made. Make time for yourself, and anticipating things you

enjoy and sleeping and exercising and having a good support system. Solution, those things matter. A lot of times is our approach to our work, the way that we do our work. A piece of that is redefine and reframing success. If only abstinence is success, then by extension any use is failure, and that can be a really stressful thing for our clients, and it can be really stressful for us too.

I'm sure you have heard the term how do you know an addict is lying? Their lips are moving. I have only heard that from people in our profession. That profoundly bums me out. I always assume that I am being told the truth, always. I don't look for the lie. I assume I'm being told the truth. Should I find out later that I wasn't, that I was being lied to, I choose to see lying as a protective device rather than a manipulation. I don't take the lie personally. The lies aren't about me. It's nothing to do with me. Whether they lie to me or whether they tell me the truth, doesn't really change much in my personal date to day life. I work to create an atmosphere of understanding. Like anybody, I have a tendency to be a little judgy. It's not a good color on me. It's something I need to work on. Tends to happen the most when I'm tired, when I'm stressed, when I'm not taking good care of myself. When I eliminate judgment from this space, it really improves the experience for both of us, where and, finally, focusing on the process and letting go of the outcome because no matter what sometimes there's not going to be a good outcome. The question is did you do the best that you could do. Did you do everything within your scope of practice to support this person? Did you provide them with referrals and resources? Did you seek

consultation? Did you show up for them? Did you do those things. If you did, you have to let go of the outcome. The truth is we never have any control over it any way.

For many years I worked in a methadone clinic. Somebody that I went to grad school with was working, and he said it's like doing therapy on a pirate ship. I was, like, sold. Where do I sign up? I loved it immediately, but I learned pretty quickly there was a lot of yelling sometimes and screaming and cussing. I would just say something that was a rule or a policy, and then I would get told to go F myself. I was, like, I really don't know what to do with this. We didn't cover this in grad school. We talked about transference, but nobody told me this was going to happen. It was confuse, and I didn't have place to put. I don't know what to do with this. I was pretty sure it wasn't personal, but I also didn't really understand it. Then one day a month in it occurred to me that for many of these people they were having the worst day of their life. Their children were being taken away from them. They were losing their dogs, they were being diagnosed with HIV and hepatitis C. They weren't going to have money to pay for their treatment. They were facing criminal charges and having to go to jail or prison. I won't having the worst day of my life. Not that every day was great. Not that everything was fine in my life, but those weren't the kinds of problems that I was dealing with. This is a time that helped me do a couple of things. It helped me understand. It helped me to have a deep are more sincere compassion. It was a reminder that it wasn't personal, and it helped me kind of have the energy to keep coming back and doing that every day. It became the most fun favorite job I ever had. I highly recommend

it. It was an amazing experience.

Switching gears it was developed, and he kind of developed it at the counter to that idea that it's always the drug itself that has the greatest impact on creating addiction. He understood there's more to it than a rat in a cage. There's more things that are happening.

And so he realized that set and setting often are what help determine the unique effects that a particular person gets from a drug. You know, it's why one person can drink tequila and have a lovely evening and another person drinks tequila and rips the toilet paper dispenser off a bathroom stall. It's individual differences.

The three interrelated factors of drugs set and setting are what combine to create unique experiences for people. Certainly you could do this as an assessment. I tend to do it as a conversation. I do recommend going through it kind of each one for each particular substance that people use. If they identify alcohol as their only substance, if they have pretty different experiences when they drink beer versus liquor, then I would recommend, you know, going through it twice. Once for beer. Once for liquor. What are he this taking? How strong is it? A term like Opioids, such a strong category. There's a difference between Vicodin and Fentanyl, right? How strong is the drug they are taking? Are they swallowing it, snorting it, injecting it? How is it getting into their system?

They describe morphine as a chemical scalpel. It has a precise effect on the brain. They describe alcohol as a chemical hand grenade. It's all over the place.

And amount. How much is someone taking?

>> What's going on? What kind of coping deficits does a person have? What's their mental health, physical health? I skipped through this one, but expectation. Expectation is something I really like to explore. A while back I was doing a consultation with a colleague. She contacted me because she was working with a client. There were issues with alcohol, and he didn't want to stop drinking. She was describing someone that wanted to date but had social anxiety. Dating makes all of us a little nervous. The person was drinking before the date. Get ready. A little liquid courage. Fired up. Has a drink or two and goes out to the bar, restaurant, wherever they're going. This person gets nervous all over again. Drinks a little more. Before he know what's happening, he is an hour into the date, and four or five drinks deep. Not always remembering the dates.

This was making it weird, not just making him relaxed. What people expect to happen is what happens, and that's good information too. There's a big difference between getting high in a back alley and getting high in a landscaped backyard. Difference between getting high in a hotel room and getting high, you know, in your car. Where is it happening? Are they using alone or other people in? If it's other people, who are they? Is it friends or random people they met at a party moments ago? Who are the people? How at ease or how rushed do they feel? Is this kind of a thing where you have your ritual and you lay out your implements, and you have a whole evening planned around your abuse, or are you trying to chug three beers in the driveway when you get home before you walk in the house? And trying to shoot up in a bathroom stall before someone comes in. It matters in terms of their experience. Also, it matters in

terms of safety in certain regards as well. Culture matters a lot. It matters all throughout treating someone's substance use. Is their use a part of their culture? Is it frowned on by their culture? Do they perhaps belong to a particular subculture when we are working with our care gives and talking about things like enabling and co-dependency, taking culture into context is really, really critical because -- absolutely just being normal and appropriate and to be expected in another culture. There's a quick diversion there. I really like this activity. I like it for a lot of reasons.

One, it's a little less intense than like a full scale really long assessment. In my experience people seem to like going through this process, partly because it operates on this idea of objective curiosity, and it asks questions that a lot of people haven't really considered about their own use before. A lot of times they just think it's interesting.

Need to address a myth. There is a myth that harm reduction is against abstinence. Not true. Doesn't even really make sense. We don't get kickbacks from drug dealers or alcohol lobbyists. The fact is regardless of what any of us say or any of us do, there will be people who continue to use both licit and elicit substance that is are harmful to them. Abstinence might be the only course of action that's really going to work for them for some people, but they may not be in a place to pursue that, and they may only be able to manage small change at any given time.

>> It was a person that was going to walk around and all that.

Decisional balance exercise, this one is really great.

At the top you have change my drinking and change my drunk use, and beneath it continue using the way I am now and then we have the pros and cons of each. It's so important to talk about the pros of someone's substance use or the benefits of it.

What would be good or not so good if you changed your drinking? In this example there's a couple of things that would stand out to me. They have going to bars on here twice. I want to know a little bit about that.

In bars there's an opportunity for social connection. Are bars a big part of their, like, work culture where everybody goes? Does somebody in their family own a bar where a lot of family gatherings take place. What's the significance of the bar.

Another thing on here. Troubleshooting. Was that the impetus for their substance use. To what degree does it help maintain their substance use? What is their sleep hygiene like? What kind of improvements can we start by trying to make towards their sleep. We don't have to wait for people to be sober or completely abstinent before we start making some positive changes.

Another one I see on here a con for changing the drinking. Fear of the unknown. This is a big one for a lot of people. For people who have been using for a long time or who started when they were quite young, I've heard people say things like I don't know who I am if I stop. It's helpful for people to be able to explore. One of the great things about this tool is it kind of gives you different areas to look at to do the clinical work through, to figure out what sorts of shifts or improvements someone could start making in their life now.

Here we are. Substance specific harm reduction strategies.

>> We're never neglecting the very tangible pieces of harm reduction. Those life-saving action items that people can do. If we had all day long, we could go through every single drug and every single substance and all the tons and tons of really specific harm reduction strategies for each one, but Alas, we don't have that much time.

>> Usually we'll do a couple at a time, and really hand select them.

>> A person's transportation plan needs to be a fit for their logistical and financial circumstances school working with people with the way that -- when it comes to alcohol in moderation -- here's a part of people moving in the right direction while getting information about themselves and trying to change their drinking. It's a greet tool. Talking about different moderation strategies. Abstinence days. These can be a great thing to be incorporate. We want to make sure that it is safe for somebody just to abruptly stop drinking. If it is abstinence days can be a great way to peek behind that curtain of what might it be like to not drink. Is it decreasing later down the line. It would be dangerous for me to just abruptly stop drinking. For people who are interested in medication as an option it is outside, I believe, the scope of my practice to say I am for or against or that any particular person should try it or not true try it. There are options that always have referrals and information for medication assisted treatment options, and I'm always going to stop short of someone I think that it's not a fit for them. They really see that --

sometimes location is disrupting the automatic processes they've had. Increasing the mindset and increasing an awareness of what we're doing. Many of you that have ever been a smoker, I'm sure you have the experience of at some point looking down and realizing you have half a cigarette in your hand, that you have no recollection of lighting or smoking at all. As if my magic it appeared. Same thing happens with alcohol sometimes. Especially nowadays. It's easy to get in a habit of a particular place in a particular chair and just pouring and pouring and pouring. I'll recommend something as basic as, you know, just try mixing it up. Try sitting in a different room. Try using a different cup. Just changing these little basic things sometimes. Just see what happens.

>> She came to me, and she was having black-outs. She had concerns about her drinking. She didn't really know how much she was drinking. I was, like, well, lease find out. I encouraged her to just pour what she would normally drink into a measuring cup and add it up over the course of the evening. The next time I saw her, she came back and told me she was drinking a pint of vodka every night. That shifted something for her, and she kind of reframed it for herself. Like, what if I went to a bar and ordered a pint of vodka? What is that?

Avoid mixing alcohol with other drugs. Alcohol doesn't mix well with a lot of over-the-counter medications. It's very dangerous with other central nervous system depressants. Weirdly dangerous with cocaine. Sometimes if someone will stop mixing at the same time, that's a hugely important decision.

Sometimes there's a little bit less can be a really big step in the right direction. Opioids.

Opioids and harm reduction. So certainly medication assisted treatment is an option. While there's always new medications hitting the market, as of now methadone and morphine are evidence-based treatment for opioid dependents. My soapbox is the same. I will always make sure people understand all of their options but I stay out of this is this medication right for you or not. It's not a doctor, so it's not for me to say. Things like a needle exchange. I have a hard time understanding the perspective of not giving out this kind of information and access.

>> It can be devastating to families and to our community as well. I will always make sure people have access and information about where to get needles, how to shoot more safely. The health risk of HIV, hepatitis C, not to mention just bacterial infection, skin infections, sepsis, it's so huge and dire, and usually things like clean needles and safe shoot practices are cheap and they are easy ways to keep our community safe and to save people's lives. So many overdoses occurring now. Not always just because people are choosing to take Fentanyl. Fentanyl is oftentimes being added to drug supplies. In some regions of the country being added to powder heroin and other regions it's more common to be added to counterfeit opioid pills. There are actually Fentanyl testing kits that people can purchase where they can test their supplies to see if it's positive for Fentanyl. In a lot of states, you go to a pharmacy and buy it outright. There's organizations that will give it to you for free. It's easy to use, safe to have. It's saved thousands and thousands of people's lives.

If you are just, you know, half a bottle of Vicodin left

over from a root canal, have Narcan in your house. Using less after periods of abstinence. This is really important in terms of overdose prevention. It's not that we want to help people plan their relapse. We don't want to be so focused on abstinence. People are more likely to overdose after they have come out of treatment, after they've come out of jail, or a hospital. In talking to them about safely using less and doing something like tester or tester doses because their tolerance will have decreased.

>> I will always make sure that they know that to be safe they should try using a little less than they're used to. I know not everything in these recommendations feels like a fit, and I know we're back to some of you having that sort of, like, eh squishy feeling, and, again go /ET it. I can appreciate it. Some of the best things to do to keep people alive today so that later they can be well.

I want to leave you with my favorite quote. The opposite of addiction is not sobriety. It's connection." I like this quote for a lot of reasons, but primarily as a clinician it helps remind me that my job is not just to help people remove problems and bad things from their life. Ultimately, my job is to help people build or rebuild a life, and a life where they feel connected and connected to themselves, connected to mean, connected to people that care about them, connected to their community. When we value people, when we show them kindness and acceptance and we empower them and we share together the belief and their ability to make positive changes, we do a lot.

I'm really grateful to have been able to present this today. Grateful. Guys gave me a reason to wear my favorite red

Blazer. I know it makes me look like a fancy theater usher, but I like it anyway. Really grateful to have the opportunity not just to present, but specifically to present on harm reduction, because I do feel it's an important thing, and it's a life-saving topic. I wanted to briefly go over some resources.

This is certainly not all harm reduction resources, but it's a good view, a good starter pack, if you will. The harm reduction coalition is the national organization. They have recently redesigned their website. It's beautiful. It's easy to navigate. So much information. They are primarily geared towards opioids and IV drug issues. Not entirely, but that's going to be kind of their primary focus. They have also recently launched their Nyloxone finder. This is an easy to use map tool. You can put your location in across the country and it will show you where the places that are closest to you that you can access Naloxone. Harm reduction international, another great site. Dance safe.org. Dance safe is a trusted, reliable place to purchase Fentanyl testing kits. They are primarily geared towards NDMA, but they have great information on other types of drugs and harm reduction practices.

These are references. I highly recommend checking out any of these. I am going to give control back Samson, and I will see you a bit later. I believe for our Q & A.

>> SAMSON: Yes. Thank you so much, Kim, and, yes, we are going to have a live Q & A in just a moment. Have I a list of nuggets that I am taking away. Just the moment you said -- I had a wow moment. Perceive their lie as a protective device. I don't know why that set off an left arm for me because I worked so closely with teens and adolescents, and you almost

get bitter. After a while you think, oh, come on. One of the examples you shared was almost exactly what a client would say to me, and I feel like what is it they're protecting, and just, you know, such a powerful presentation, Kim. Kim being feel free to take a quick break. Right now I'm going to go ahead and get us ready to hear from Halcyon health. This webinar is scheduled by Halcyon Health. It provides support that adapts to your life. Matt, I will hand this over to you, and you can take it from here.

>> MATT: Hi, everyone. Thanks for having us. We're really excited to be able to sponsor this webinar. Harm reduction is very meaningful to us in our work as well, so this is very fitting. I wanted take a few minutes just to give you an overview of Halcyon. We'll share a video, and then talk a little bit more about what we offer. Our specialty is substance use disorder and addiction recovery support solutions. We have created our only HIPPA compliant care platform that has certified peer recovery services. Our services are available to anyone in the U.S. Our mission is to fill gaps in care to make sure that people truly do not fall through the cracks and we support everyone in enhancing their overall well-being and improve health outcomes.

We're able to support people to make positive change in their lives because, as Kim talked about today, we understand that recovery looks different to everyone, and our coaches who have lived experience of recovery can help support our members to explore what the best route to recovery looks like.

Now we'll give you a short video to show you more information about what our support looks like.

>> Are you or someone you love struggling with the substance use disorder? If so, you're not alone. The good news /STP Halcyon Health is here to help. It's an integrated evidence-based substance use disorder designed for long-term recovery. Unlike other one size fits all treatment programs, we understand that everyone's journey to recovery is unique and that different things work for different people. Whether your goal is total abstinence or you would like to reduce your drinking or use of a particular substance, we're here to help you put your thoughts and ideas into action. We'll provide the support you need to build your personalized recovery plan and serve as a helpful guide along the way to achieving your goals. You can think of us as a pocket-sized support team available whenever you need us, because you are the center of everything we do. How does it work? Well, each day when you open the Halcyon health app, you will see new cards in your daily health plan. These are personalized for you by your recovery coach and care team. We strive to ensure that the coaching environment is always comfortable, safe, and positive. Our experienced coaches are here to actively listen and help you achieve your goals. Simply click on each card to open it and complete the action item. There are three types of cards. Lesson cards, which provide you with content your recovery coach thinks would be helpful at different points. Survey cards. Which help track your progress over time and tell us what we need to know so we can better meet your needs and visit cards, which remind you about upcoming appointments. Ready to get started? Take the next step with Halcyon Health.

>> SAMSON: I hope you enjoyed that short video.

I just want to take you through our member journey very quickly. What you are seeing on this slide is that when you sign up for Halcyon it's a quick process because we know that moment of motivation can be very fleeting for some people who are looking for these services. We just want to capitalize on that opportunity to quickly get them connected to our care. You as a provider can talk to your prospective client and make a referral. That member then enrolls with us and completes an intake with their dedicated care coordinator, who then helps match them to their certified peer recovery coach. Then with member input, the Halcyon health care team designs a personalized recovery plan and handles all referrals, plus the care coordination. The member then works with their coach to build recovery capital and improve their overall well-being, and additionally, the care team works with the member to assess progress using ongoing surveys and member communication further refining the plan as needed.

We take the partnering process very seriously because the experience really begins with our partner providers. We make sure -- we make it a point to insure that our partners are fully comfortable describing Halcyon to their clients. Then we have a referral who makes sense. We'll see the information that we can give to our partners, all of which can make this the best process and best relationship that we can have with you. Lastly, I just wanted to touch on a nugget, as Samson said, that struck a cord with me and Kim's presentation. I, too, believe that sometimes people think they aren't worthy of support. When they have an addiction disease or substance use issue. We don't believe that at Halcyon. Everyone deserves support. What they

deserve more is support that's unconditional and puts them at the center.

If you are interested in thinking through how we can become a part of each other's recovery villages, please reach out to us. We would love to hear from you. In the chat you'll see a link to schedule time to speak further with Emily, our business development partner, and I just want to thank you again for your time, for having us here at NAADAC. It's a huge opportunity, and we're happy to be able to support your efforts. It's a wonderful organization. I wish you and all of your loved ones a happy holiday season.

>> SAMSON: Matt and Halcyon Health, thank you. We'll do a Q & A. We'll try to get -- we will try to get as much many these done as we can. Everyone just like Matt said, in your chat box you can click a link to learn more about Halcyon health, right now on your screen is the contact information for Kim and for organization substance use therapy. I'll let her speak to that link as an additional resource. Kim was so kind to share her email address here. Hopefully it's an email address that goes to somewhere, but, no, I'm joking.

>> KIMBERLY: It does.

>> SAMSON: She would love to connect with you all. We have some great questions. Like Matt said and I'm going to share with you all, says this topic is so important to NAADAC because we firmly believe that it is our number one job as care providers to expand a person in recovery's perspective of help. Expand their ability to receive help. Not restrict it. Not say that you can only get help this way, right? But we want to make sure if they are in that worst place one day, that they know the

variety of places and models and people they can go to for help. That simple philosophy is what guides a lot of the decisions we make as an association that represents this profession and helps to treat this incredibly challenging disease with you. The first question from Kim is Jake from Colorado. Jake asks, what are some ways for those of us working in clinic settings to back harm reduction strategies as evidence-based, when we're being questioned by other partners or colleagues or even other providers in our program.

>> KIMBERLY: Certainly -- depending where you work, you may be limited to what degree you can implement different components of harm reduction. It is, for better or worse, not a fit for every environment and every modality. When it can be, I think that, you know, there are some wonderful articles and papers out there that point to the components of harm reduction that are absolutely evidence-based. Methadone. They are evidence-based. It is evidence-based that naloxone has saved thousands of people's lives. There's wonderful research about the efficacy of things like needle exchange, and there's no evidence that shows that things like needle exchange and safe shoot practices in any way kind of enable use. All it does is enable cleaner, safer use. At its heart, harm reduction is about practice and pragmatism and offering solutions that work, and it's about collaboration and so I think it's somewhat dependent on individuals and to make it fit with their setting what pieces of it can work showing people kindness and listening to their story and helping them find solution that fits and regardless not everybody is on board with harm reduction. I think that will change more and more over time, but, you know, kind of to each

their own. I hope I have answered that.

>> SAMSON: Yes, definitely. Great answer there. I was trying to turn my web cam off so I didn't distract you as I was trying to organize these questions. Now I've got them here. Janice from Kentucky asks the next question. I was just wondering if you could elaborate on what is the Sinclair Method?

>> KIMBERLY: So traditional Naltrexone, you take it every day just as you would a regular medication. Under the Sinclair Method, which was developed by Dr. Sinclair, you take it only on days in which you're planning to drink, and the timing is very specific. People believe taking it that way is more effective than just an everyday medication.

>> SAMSON: NAADAC released an article earlier this year in advance of the recovery magazine. You can go to our website and learn more about the Sinclair Method from, I believe, the spring or summer edition of the advances in addiction recovery magazine. An article by Dr. John Eunhau further explaining what Kim just explained here. Our next question is from Vanessa in Wisconsin. Vanessa asks, is there a continuum of use that aligns more with the DSM five? The DSM five takes out the variations of dependence and abuse, but places on a continuum of mild, moderate, severe. Should this be updated?

>> KIMBERLY: Yeah. There are actually several different versions of the continuum of use that I have seen out there. I took that version and adapted it from Pat Denning's book on practicing psychotherapy. I like that one because it has a really broad range and because I use that version a lot with clients I want them to be able to give me the subtly within

there. In fact, a lot of times they'll be, like, I'm a 3.8 is. Yes, there are ear versions. That's just one that I'm partial to.

>> SAMSON: Wonderful. Thank you so much. And a lot of people are asking about this Norman model you mentioned earlier. How can we learn more about the Norman Zinburg model? Is there a resource you can recommend?

>> KIMBERLY: He wrote a book. There is a book about it. I don't have the title with me. It's referenced a lot in harm reduction literature books.

>> There's a lot that affects it.

>> SAMSON: So a lot of questions. I'm going reword some of these because they're asking some of the same questions. I hope I do this justice. We had about three or four people ask about the earlier statement about abstinence only can be stressful. A lot of people are saying I agree. Abstinence only is stressful for the counselor and client, but how do you help counseling not focus on abstinence only goal if the referral, parole officer, court, or program itself is abstinence only?

>> KIMBERLY: Yes. And that's kind of going back to not always having the freedom and the flexibility depending on the environment in which you work in. I get that. There is also a difference between how you're playing out your work role and how you are internalizing it, right? The way that you internalize it, you always have -- that's always up to you. If you see someone making steps and getting better slowly over time, then you can feel good about that even if knowing that that's not enough or not compatible with the court mandating or

what your environment says has to happen. In a perfect world people would get to always select their treatment just like they do with medical treatment. It's hard whether people are not aligned properly with what they want in the treatment on their end. I think that's going to be an issue we continue to have until the court system either steps out a little bit of overseeing substance use or they're willing to get a little bit more flexible and what treatment can look like.

>> SAMSON: I wish I could write up what you just said. Now deeper and deeper on this topic. Larry, shout out to you. Tell us where you are from. I didn't get your location, but great follow-up question on what you just said. Larry is bringing up a topic that we are not just their treatment provider or counselor, but also sometimes they're advocates on topics like this, and so he asked when working with courts and court mandated clients, how do we convince the court that punishment and demanding abstinence is actually less effective for that specific case? Do you have any reference sources or citations or things that we can represent to the court when we're advocating.

>> KIMBERLY: I wish -- I wish I had a great answer to your question, Larry. I'm mad that I don't. What does it have to do when what is the specific issue. We know that things are very different based on where you live. Understanding basic rules sometimes can employ a really long way in being able to advocate. For example, I used to work at a methadone clinic, and very often I would be working with people who were on probation. Their probation officer would call, and they would say they would demand that they get off methadone. I would say,

cool, where do you have your license to practice medicine? They would get very angry. I would remind them that methadone was a medication that was prescribed by a doctor. Unless they were going to have a judge contact us, then they were operating outside their scope of practice and further, they were encroaching on practicing medicine without a license.

That was just a way that I was able to advocate because as a probation officer, you do not have the authority to tell someone to get off the medication that's prescribed by a doctor. It will make them /AEUPBG but it's also correct. Sometimes figuring out what are the common issues that are coming up with that you are most frequently working in and then just doing a little bit of digging kind of around that can be a good start.

>> SAMSON: I'm just -- oh, go ahead.

>> KIMBERLY: It's okay. I also want to know, as an aside, I also had the opportunity to work with officers, so I don't want to paint a picture that it was always unpleasant. I had an incredible experience both the negative and the positive.

>> I love the advocacy spin and as you see, Kim's email is here. I know you asked to follow up about NAADAC. You can send me an email or CE at NAADAC.org if you have questions about partnering with you on advocacy efforts. We have a lot of resources in each state. Always connect your state affiliate or state board there to see if there are advocacy resources. Great questions there. Our next question is from Geraldine from Ireland. Geraldine from Ireland asks, when working with young people, the challenge here is often not as much what is clinically determined but what the young person is dealing with in their environment. How do we deal with harm

reduction if it's a child protection issue?

>> Some of that will depend on the laws and the statutes in your area and how legal proceedings and Child Protective Services work. I don't want to speak to that. I do believe in harm reduction for adolescents.

We have enough time has gone by since the days of just say no and DARE to see that they weren't effective. Part of the reason that they weren't effective was because they didn't give enough information, and it was pretty easy to feel like, oh, there's 100 examples of times where people used drugs, and it was fine. I'm just going to discredit all of that. When adolescents get it really wrong, really wrong with drugs and alcohol, in the worst case scenario, they die. Harm reduction is about giving people the information to keep them alive and well and to make better choices. Ideally over time the adolescent's choice may involve not continuing to use and figuring out, you know, what's going on in this person's life that drugs are kind of acting as a substitute for, but in the meantime, absolutely. If they're going to be using and they're going to be experimenting, by not offering information, we tend to do that kind of just say no approach, which then they don't come to us anymore. They either rebel or don't ask us questions or let us know what's going on. If we can create that environment where we can provide support and we can listen and give them potentially life-saving information, then, you know, we've done a good thing.

>> SAMSON: Throughout your whole presentation you were talking about harm reduction under the umbrella of safety. Promoting safety. A lot of these -- I'm seeing a lot of

these, and we'll send some of these questions to Kim. A lot of these questions are very case by case, and so, you know, if you are working with your client, you're promoting safety, you know, that's your main goal and the techniques that you go to achieve that, it's about how to get there. Great question. Thanks for connecting with us again. The next question comes from Mc/KEPBZ where I. McKenzie asks, what are your thoughts on peer support groups for harm reduction.

>> I had the opportunity when I worked at a methadone clinic to work along side people who were, you know, patients on methadone as well, and I learned compassion and book learning, frankly, only gets you so far. I love that more and more peer support specialists are being added. So many of the people that are leaders of the harm reduction movement are in and of themselves peers. That does a lot for advocacy and giving people a voice. I love the movement towards more and more peer support across substance use as well as mental health.

>> SAMSON: Last one. I'm going to try to squeeze this one in. Thank you so much for your time and after you answers this question, if you have any final thoughts, please feel free to throw them out to the audience here. This last question comes from Margaret from New Zealand. Margaret asks our government has recently given permission to accompany to test illegal drugs that concert goers are using to make sure they are safe. What do you think about this strategy?

>> TIM KIMBERLY: Hello. I have always wanted to go to New Zealand. You are doing super cool stuff with harm reduction. The website that I mentioned in my resource dance safe.org, for a period of time dance safe was going to big

outdoor concerts and raves and things, and they were setting up and testing people's drugs on site. Again, things like Fentanyl and dangerous additives and -- are sometimes added. They were shut down from doing that. They're not able to do that in the United States. They are able to sell some of their testing kits online. I had heard that they were doing this in New Zealand, and for me it comes down to we cannot be so focused on the morality of people's choices that we neglect to protect their mortality. That's really what it comes down to. People dying because drugs are contaminated, buzz they don't know thousand use them properly or safely, it's -- it's a loss of a life. Loss of life devastates families. It devastates communities. I would be hard-pressed to find someone who has not lost a partner or child to substance use who probably would not be more of an advocate for harm reduction because the loss of a life is irreversible. For me personally it's inconsolable that we would not do these things that are relatively inexpensive and really kind of pragmatic to just take care of people who need to be taken care of right now.

Is I'm excited to see how these things progress in New Zealand, and I like reading about how other countries are doing things with harm reduction it's interesting to see how things might move forward for us. I don't think anything moves forward unless we have conversations and unless amazing people, like all of you who support this population, we all kind of work together to get creative to figure out, you know, how to make things better for people. I want for thank NAADAC for the opportunity to meet all of you today.

>> SAMSON: We all learned so much. Hopefully

one day once I build back up if I do build back up in practice, you'll have to be my harm reduction coach. You know a consultant to get me back up-to-date on things. Is everyone, here is the information on how to get your CEs. Every NAADAC webinar has its own home page that houses everything you need to know about that webinar. Immediately following the live event you will find the online CE quiz link on the exact same website you used to register for this webinar. That means everything you need to know will be permanently hosted at www.NAADAC.org. Here is the schedule for our upcoming webinars. Please tune in if you can as there are some interesting topics with great presenters just like today. You can join us later this week Friday, December 4th, with Dr. Ilene McCabe teaching on engaging learners in online supervision, or Wednesday, December 9th, 12:00 noon eastern to learn from Jeff Wilson on substance use disorders and suicide. We also have a really dynamic panel of experts holding a virtual town hall event on opioid use disorder in the black community on Friday, December 11th, 2020. Please make sure to join us. We'll see you there. If you haven't already, please make sure to bookmark this web page, www.NAADAC.org/cultura-humility-resources. You'll have access to our new eight-part cultural humility webinar series. Also, our highest viewed webinar this year, substance use disorder in the African-American community and the virtual town hall event that was connected to that. Over 3,000 total views, climbing. We are also going to have many more resources we'll add it that web page in 2021. As an additional resource, NAADAC the association for addiction professionals has provided a COVID-19 resources page that includes six excellent free webinars covering top egg

concerns in the addiction profession and presented by leading experts. As a member, here's a quick review of the benefits of becoming a member with us. By joining, you'll have immediate access to well over 145 free CEs. All NAADAC members receive free access to our advances in addiction recovery magazine. As you heard earlier, there's a really detailed article in there by Dr. John detailing the Sinclair Method and what it means in terms of alcohol recovery and addiction treatment.

You'll also become a part of our national initiative for advocacy for the addiction profession and those we serve. Many more benefits. A short survey will pop up at the end. Please take some time to give us feedback. Share any notes you have for us or the presenter so we can continue making your learning experience awesome. Thank you, again, for participating in this webinar. Kim, thank you for your valuable expertise, leadership, and support in the field. Also, many thanks to our webinar sponsor Halcyon Health for sharing their innovative solution to support long-term recovery. I encourage you all to take some time, browse our website and learn how NAADAC helps others. Stay connected with us on LinkedIn, Facebook, and Twitter. Have a great day. Be well.

(Session concluded 4:00 p.m. CST)