NAADAC
Ethics in Practice Part 6
April 9, 2021

>> JESSICA O'BRIEN: Hello everyone, welcome to the final series on Ethics in Practice: Part 6 today is Modern Ethics in Addiction Treatment and Panel Discussion and we will start off with the presentation by Aaron Weiner Angela Maxwell and Thomas Durham in the second hour and Mita Johnson. I am the training and professional development content manager for NAADAC the Association for addiction professionals. This online training is produced by NAADAC, closed captioning is provided by so check your most recent confirmation email or look at the Q&A in the chat box to see the link to the closed captioning. If you want to know more about this epic series check out the webpage, the at series, and the addresses at the bottom of the slide. This will show you how to take a quiz on demand or watch any sessions you have missed period or Attain the chip certificate of achievement if you have watched all parts of this series. Your payment that you includes the CE at the end. You can apply if you have done all sick, you can apply for the certificate for achievement of ethics in practice so congratulations if you have done that. Today's training is hosted by Goto Webinar. Again, if you're main button I think is the orange arrow at the top and you can click that to minimize the menu and move it out of the way if you need to. You can also re-open it and there is a questions box that you can see on the screen if you have any questions for the panel and this is like questions rich so send them in. Just write them there and we will collect them and post them to the panel, pose them to the panel at the end of the presentation.

Lastly, under the questions tab is the handouts so you can download PowerPoint slides for today's presentation, a user-friendly instructional guide on how to access the online CE quiz and immediately earn your CE certificate so make sure you use those instructions when you do take the quiz and get your certificate.

Okay, so Aaron turn on your camera, Dr. Aaron Weiner is a board-certified psychologist in a private practice consulting organization and earn the doctorate from the Illinois University of Illinois. Prior to forming he has served to the Director of addiction services at Linden Oaks behavioral health in Illinois and an adjunct faculty at the University of Illinois at Bana champagne and served on the board of the Society of addiction psychology and one regional awards for commitment to turning best practice ideas into programs. We will be joined later by these panelists so stay stand tuned until then, Aaron you can take it away.

>> AARON WEINER: All right. I think we've got it. It is up. So good morning everyone. Or slightly afternoon depending on your time zone and thank you for joining us today. I'm looking forward to the presentation. My name is Ahmed edition psychologist and I'm in practice private practice located outside of Chicago right now and I'm really excited about the presentation today because I think that ethics are fascinating but ethics can also be really dry

and so when I set out to make an ethics presentation or wanted to do something that I thought would actually be interesting and something that I would appreciate sitting through and would actually be useful in daily practice and daily life.

The goals for today, we will try to learn about core concepts, ideas and situations and then look at the ethical angles that surround the because addiction and addiction treatment in particular is really nuanced in this way. We will think about these ideas and situations in new ways and get broad. I don't just like to get at the person-person clinical I like to think about systems and think about society because I think for addiction and some of the dynamics in play we will discuss today you'll see there's a lot of interlocking parts.

All that said, any recommendations are my own unless this explicitly cited. The thing about ethics, they are great and it's part of the reason why there are principles and dilemmas it if it was super clear what you need to do it wouldn't be a dilemma. You would just do it. There would be a right answer but that is not how ethics are. And so disagreement is fantastic. I encourage you to put questions out there and put them in, we will be able to talk about them at the end. During some of the palm wax and we will have a few today I will try to highlight some of your responses if you put them in the chat so we can simulate that we are all in the same room even though I know we are not right now.

First, let's look at the 30,000 foot view, why do we talk about ethics? Because we have to renew our licenses. I'm just joking. That might be why you are here today and part of the series but there is important reasons. And ethical decisions are everywhere. There's a lot of conflict between different ethical principles, it is really meant to be our NorthStar as practitioners for how we go about conducting business. The tools of the trade and then there is how we use them and how we choose to use them and that is where ethics stepped in. Forms of floor for our integrity as practitioners and this is critical in terms of how people view us as a discipline both in terms of behavioral health providers but addiction provider specifically. So us individually and then as I said us as a field.

These are super great, it is a really, these are tough, these are not clear answers but if you understand the principles that should be underlying our practice, it guides us through the situation and also helps explain our reasoning to others. And thinking about it ahead of time allows us to plan. So if we have thought about these things before and been through them before if we know what our principles are and how we are going about the decision-making practice it means we are less likely to do something that we would regret later.

Specifically what are ethics? It is a set of standards that represent the values of an individual or profession and these issues involve conflict. And there can be a lot of different conflicts that come in ethical dilemmas or issues, conflict between different ethical principles within a cove and we will go through the NAADAC principles in a moment. There can be conflicts between

your personal and professional ethics or in the organization you are in. There can be ethical conflicts between your legal or even economic responsibility in terms of trying to keep a practice for clinic running versus discharging people, another aspect we will talk about today read you might find those in conflict read and then between different stakeholders with the same problem. You can see conflicts between both individual and public interests something that might be good for one person might not actually be useful as a general rule. So you have to think about where is my primary responsibility so who is to say what is the right thing? The quick answer is not me. I know that on the person giving the presentation today but I don't think any of us should be presumptive that we know the right thing to do but I am hopeful I can be a humble guide through these ideas today and through these discussions today and provide you with some ideas that you may not have thought about as closely before.

These principles were just streamlined if you haven't read the code that was released this year here are the principles that underlined the NAADAC code of ethics.

Autonomy, respecting the right for each person to make informed choices. That one actually is probably the most, one of the most important ones for me as a practitioner. That is critical. Obedience to legal and ethical directives. But then also conscientious refusal so not carrying out directives that are illegal or unethical. Beneficence.[Silence] Supply maximizing benefits to our clients. And gratitude, pass along the good we receive to others. To be competent in no what the scope of practices and maintain necessary skills within that period to make sure we practice with justice in mind to provide fair and equal treatment and accessible treatment to everybody.

Stewardship. Using available resources in a conscientious and judicious manner and then honesty and counter to tell the truth and all our work and dealings.

As we cut through some ethical scenarios the first of which is on the next slide and we talk about the topics for today, this is what to keep in mind in terms of how we are making decisions and are they aligned with the NAADAC code of ethics or the other CODA six code of ethics that might be part of your discipline. We are using the NAADAC code as our anchor point today but I'm a psychologist so I have the American psychological Association ethics but you might also be a professional counselor or social worker to keep that in mind as well.

Let's get to our first dilemma of the day to kick things off and start thinking of it. Here is the scenario. Revenue mail client who reaches out to you on a Friday. [Reading Slide]

Jesse, if you throw up that poll I would appreciate that.

>> JESSICA O'BRIEN: Here we go.

>> AARON WEINER: Go to detox if the symptoms become too severe. Ration his bills. Go to detox and decline to offer him any alternatives. Or other. So please pick one of those and also what principles apply? So if you would like to enter that into the chat I don't think you guys can see the check but I can push that out as well. But take a second and let us know what you think.

>> JESSICA O'BRIEN: I don't know if they can see the chat but they can definitely put it into questions box. We will give it two more seconds and I will share the results here.

>> AARON WEINER: Marvelous. So we have a lot of different responses. Marvelous we have a lot of different responses. Cope at home and go to detox. Ration his bills. Feel free if you feel free to put it in the chat.

Ration his pills go to detox be feel free to enter your answer in the questions box. Some principles we have to think about our beneficence, what is best for this person? Will they find more on the street are they at risk of overdose? Are we allowed to say ration your pills because technically speaking is that within our scope of practice? Should we just say go to detox and leave it at that and don't give more guidance? There are many ways to go with this and it's not necessarily one right answer and it gets trickier if someone is using heroin because it can be laced with fentanyl and is a higher chance they will accidentally overdose. But at the same time can you really say well, you have this much heroin left ration it for the rest of the week. It definitely steps into the gray area.

Again thinking about, here is how we encounter these issues, just random issues, this is something of course that I have seen in my own work over seeing treatment centers in my private practice but all these areas we talk about today are real. But it is something to get you started and to think as we move into our first major topic for today which is ethics and how they apply to Drug testing which is ubiquitous in our field. Trip working in the drug and alcohol field, it is complicated. Ethics around it is tricky. So we will take a little bit of time and break down the issues and talk about how we should ideally be looking at using drug tests.

Before we get into the ethical side let's talk about the basics which is, what is Drug testing and what do we need to know about it definitely? This is a test for a substance or metabolite in some sort of substrate, and it provides a generally reliable indicator for recent use although there are certain ways to have false positives and negatives but there's a number of different sample types that it can come in so urine is the most common part of the reason is it has the highest concentration of substances and you get a much longer detection window for urine than for other bodily fluids or materials that you might draw. So it means you have a longer detection window which is helpful in terms of how often you test people.

Sample tampering is possible and it happens all of the time, you can just say go online and buy and warmers to heat up the name of the product is but it is for research and novelty you to use only. The there's a rate great journal article that talked about the different contaminants you can use in urine drug tests and whether they work or don't work in different combinations. To obscure different drugs. But part of the reason for this is that urine particularly if you are using an enzyme immunoassay, it just looks at essentially, tries to have a chemical reaction with the Metabolites in the urine sub Q. put some adultery and in their it can and if you put some adultery and in their it can change the results.

Blood. It is less concentrated and shorter detection window, sometimes hours or one or two days. Instead of what can be weeks in the case of THC. They tend to be much less concentrated but gathering them is a lot less invasive, you do not have to draw someone's blood with some of these other methods such as saliva, sweat or hair. They can be easily contaminated particularly with hair, you can have THC contamination in hair from being around someone using marijuana whereas that would not show up in any reasonable amount or detectable amount in urine or blood. Analyses are less available and not everyone actually ends up doing those. So in terms of the types of detection window, many drug treatment programs we test people at least once a week if not more for substances we try to monitor and the two primary methods we use for drug tests are enzyme immunoassay's and liquid chromatography and mass spectrometry. You have very fast results, low resource utilization and they do not cost much so it is something where you can even by these for five dollars and they are easy to do. They do not cause too much to do compared to LC/MS. But the cons you cannot beat entirely precise and they are not comprehensive. Most screening test for example, EIA's test benzodiazepine but you cannot tell the difference between the positive between a Valium and Xanax and Ativan, it will show up as a benzodiazepine and you will have to get more detailed any way to tell what is in there.

They are much more susceptible to tampering. Because LC/MS looks at the sample at a molecular level. And so even if you have a contaminant the molecules of the metabolite will be present. So the EIA is subsynaptic well to tampering because of the chemical reaction and you can get false positives or negatives.

LC/MS really is in terms of detection the gold standard and is sensitive, very difficult to tamper with and literally breaks down the sample at the molecular level to look for whatever substance it is you are looking for. The downside was there more expensive and potentially have a longer turnaround time if it is not a local lab. And potentially limited access as well.

Is the utility and why should we use these quick and has treatment utility in the main utility is biomarkers versus self-report. If someone tells you they have been using but they've a test that comes back positive just gained information, multiple pieces of information that can be useful for the they may be lying about it which is helpful in determining if they need to change their

behavior to something that's more adaptive for function because perhaps that behavior is part of the problem to this point, they felt like it has been keeping them safe in some way. It also, this is really the key, it should be therapeutic for supporting recovery versus exacting some sort of punishment.

I talk about this in the slide, sort of like catching someone aspect. I think it is easy for treatment programs to fall into almost the role of a probation officer where you need to catch people and a lot of but that is not our job we always need to have that hat on our job is to give people an opportunity to hold out a hand that someone can take to make change in her life and improve their life in some way, we are not responsible for being a police or monitors. There is growth potential with a positive test and you can talk with someone about it but it should be an opportunity for growth and encouragement because as therapists and counselors that is what we are here to do.

Is easy to fall into the trap of the only sign of progress is consecutive days of abstinence. Which is helpful in great undersigned of progress but when you have someone for example, using substances every day and they have one positive screen into no weeks that still assigned progress. Even if they have one positive screen. So there's still growth and if they want a month before having a positive test again that would also still be treatment progress. Even if there is a lapse bridge can help in assisting in treatment planning and discover potential contaminants. I have worked with clients who thought they were using cocaine and ended up having at least with an opioid or something of that that nature but it helps to understand what biologically is going on with the person you are serving.

Monitoring. This is actually very helpful in the long run not necessarily in a short-term treatment context review only for-six weeks with someone, and it can be useful, someone with an accountability structure around them and say amount or, that can be incredibly effective about eight years ago or so I was practicing in Michigan and they had a professional rehabilitation program for dentists and physicians and psychologists, health professionals who are struggling with addiction at work, to save their license. There was a lot of monitoring that went on but they found that program which I think went on for two years after the violation, I believe it might've even been a daily or multiple time per week monitoring and 95% pass rate with people staying completely sober through that monitoring program. So there's definitely a lot of evidence that can be helpful and provide additional motivation and incentive to lock in the behavioral change but I have mixed feelings on a short-term care provision setting. So what are the downsides of drug screening?

You can have this gotcha mentality where you have drug screen police on your staff and it seems like that's the most important part of the treatment and all its underpinnings, addiction is a biopsychosocial problem and the actual use of the drug or alcohol is just the biological part, the psychological part of the social part or equally if not more so important. In terms of

maintaining sobriety or reaching substance related goals. So having the strong got to catch someone in the at 5 catching people is not our job. And people with accountability can absolutely be there job at catching people not so much.

This is something we struggled with, days those options equals success? The idea where one does someone get successful, when they're being discharged at the end of treatment was it a successful treatment or not? And what's the criteria for that? How does it relate to drug screens in their time in the program. Someone has any number of positive screens but they are engaged and trying, does that mean they have their graduation claimed to be not recognize that even if there's been improvement? Cost is also big. You might actually be racking up large bills for patients if your drug screening often or in a bought broad spectrum ways you have to think of clinical utility versus are we causing financial harm to the people we are serving by overusing this tool? False positives also create contentious situations for someone. They weren't positive and may be confirmation would show that but in the short term there could be a positive test and that could build mistrust and resentment between them and their treatment team. Also screens can be embarrassing for clients which you can look at that as a consequence of someone has been contaminating their samples or providing false urine etc. that can be seen as a consequence for action which can change behavior, the cause-and-effect of direct drug-related actions but it's also embarrassing. And can communicate a lack of trust. Making sure we are always viewing our clients or patients as people, as humans, it is important and sometimes drug screens can get in the way of that. But the focus on the screen rather than the processor person on the other side. So specifically, touching on a couple different ethical considerations here what is your responsibility as a treatment to find out the truth? I don't think there is a right or wrong answer to this. I don't think anyone's better than any others but there's a pivot point of beneficence and respect for autonomy. If you find out someone was using and lying but gives you the ability to have a therapeutic interaction with them that might help them versus at the same time can be respect that maybe someone is not ready for change we may be someone is hiding for their own reasons or they are at a point in their disease where this is part of what is going on and how do we balance those two principles?

Does it change if the client is justice involved? If someone is on probation or going through some sort of legal process, does a change in terms of what our responsibility is to verify with biological markers whether the ferocity at the veracity of their claims ethical versus financial responsibilities and presumptive versus definitive testing. Those LC/MS cost more than most EIA tests. So sometimes the clinic has automatic screening and confirmations that may not be necessary and if that cost is passed to the client I have to be aware of that.

For independent practitioners are you drug screening at all or do you have a partnership for this? A lot of people in independent practice or group practice or not connected directly to treatment centers do not drug screen. Now in the pandemic this gets a little more I've met tougher. Tough but if you're an independent practitioner part of your duty to your clients is to

have this relationship so if the drug screens would be helpful to your clients that you can have them go for one if that is something they are open to.

Think about that if you are not already doing it.

May be the best practices according to the American Society of addiction medicine, they published my guide to this in 2017. This helps navigate and make some decisions around vegetables we talk about in the last slide it, think of these selective schedule tests specifically for a purpose. It should not be a one-size-fits-all. We should really be thinking about each patient when making decisions and you may have a standard practice which is okay. It would be cumbersome not to. But we should also be thoughtful as someone goes through that center process about whether it affects them in terms of the frequency and frequent treatment context.

There are sometimes, again in the clinics I oversaw someone would disclose they had a relapse and say I use marijuana or cocaine and weeds tilt test them for that sometimes even specifically even though we knew what would be there and just thinking about doing really need to do that? Think critically about that. Avoid over testing so you can start with a screening for specific substances rather than doing it all the time and this is where abuse from drug screen has come from in the past you might've heard that urine has been called liquid gold because this is for a long time these abuses are even more prevalent but there's been a lot of over testing and billed to insurance and people have exploited it as recently as 2015, here is a bill someone got that was part of the article that I had a picture of in the last slide, this meant that a $208,000 bill for drug screen's aftertreatment program because of how much they had been testing and how they had been billing it and just as recently as 2019 there was a massive suit showing that in Tennessee pain clinics were doing $25 million in needless urine trucks drug and genetic testing. So think about this we do not want to over test.

Schedule randomly because otherwise it is easy to manipulate it if you are not testing as often as you need to. And make sure to use it as a tool to promote growth and change because that's our ultimate goal.

Testing brady- may not be aware of this but this is a metabolite of alcohol and this allows you to see whether someone has been drinking I think it's up to three days is the detection for EtG. You can see three days after drinking which is a lot longer than a breathalyzer would detect it and more on par with Drug test. The issue with EtG testing and something to think about with the principles we have spoken about is that it tends to be expensive and only and LC/MS test so it costs quite a bit. And think critically about the timing because a lot of times this is something you have to send off unless you have a local lab and if it takes a week to get back and LC/MS EtG test, that can be 1/ of the persons treatments help make sure it is relevant and it is susceptible to false positives because you do get UDS EtG from having a dish with alcohol

cooked off in it or hand sanitizer or mouthwash, that would awls all show up on and EtG so it is a tool that has its place but make sure to be thoughtful about it.

The next is closely related to UDS's. This has a lot of debate, this is a discharge initiated by a treatment center or housing environments and you can no longer receive treatment. It's either for repeated positive urine drug screens or infractions against a center policy. Certainly the second one is a little more clear, if someone is bringing a weapon to treatment or bringing drug paraphernalia etc., that is Marcotte and dry but where things get a little hazy throughout how ethically should we handle repeated positive urine drug screens? Usually it is viewed as positive -- necessary for patient, the treatment center or both. But what you have to think about because sometimes it is easy to say whether they are not engaging or trying and we will just discharge them or make them go to a higher level of care but you are actually doing at you are separating a vulnerable party because this is a symptom of their illness. Someone is still struggling with her addiction and separating a vulnerable party from treatment which is something if you think about it if someone had cancer getting worse, you are stopping treating them. That is pretty intense if someone says they will not necessarily go to residential or take a recommendation. So it's really how do you make this decision and what are your guidelines? At its core I would always recommend to make sure you have guidelines and make sure you know how you make decisions to be even write them out because otherwise it can be incredibly subjective without necessarily these guidelines and bumpers to keep you on track.

This is a model I came up with them and I was directing the Addiction Treatment Centers in Naperville five questions to consider about whether it is time to do an administrative discharge greater way to think about this. The first is, is the client benefiting from treatment? This has to do with the principles of beneficence and competence so even if someone is showing positive urine drug screens, they may still be benefiting. They also, if they say, have underlying anxiety, depression and trauma they may be doing a lot of good work on that side of the treatment. Even they still struggle to maintain sobriety if that is their goal. So it is important to think is the client benefiting from their time? Even if the ultimate outcome has not been reached. As the client attempting to adhere to treatment center guidelines? Are they really making an effort or do they not care and doing whatever they want and not engage in treatment? If it is the latter, that would be a stronger argument for the administration administrative discharge. If we put on that hat which I think is accurate, that this is a medical condition, addiction is a medical condition, they are using a substance is a symptom, having a symptom of a disease is a normal thing. Not necessarily a reason to let somebody go.

We have to think about in treatment environments what is the impact of the patient on the rest of the mill you? This has to do with the responsibility of one person versus everyone and this is where it can get tricky particularly on how they are being perceived by other people, you have a responsibility to care for everyone in your facility. Everyone under your care equally. So if one

person is making it so that others cannot properly engage in their caravan that is deftly something we have to factor in or figure out a way around.

Cannot just be about that one person even if they are benefiting, if they are destabilizing others that is a problem.

Also think about what would be the psychological impact on the patient of the discharge, this has to do with the question would this be a destabilizing factor and is it something you should take into account? Not necessarily, right? At the end of the day, making sure there are appropriate consequences for actions or isolating policies, that is an important part of eventually changing a substance use disorder as well that cause and effect but at the same time someone might actually end up being better off if they stayed versus whether they were discharge. And lastly, do they have a follow-up plan after discharge? Making sure it is solidly in place. This is something where they get a higher level of care and they say they are not going to go, well, as a treatment facility I would say that you have the responsibility and the obligation to come up with alternative options and so they are not just left not knowing where to turn and have this active addiction they haven't been able to control.

Those were my five points process of evaluating whether someone should or should not be discharged and there are situations where someone should be discharged administratively for repeated positive urine drug screens but not something that should be taken lightly and should be thought of pragmatically.

That said, we will use this as a segue to our next topic which is checking our assumptions as clinicians because again, if we are not thoughtful about how we do administrative discharge the assumptions can swoop in and make decisions for us we might not be seeing each person as an individual and as we go through training, as a health professionals we are explicitly made aware of the need to see our own lens and to see our own filters and know that we are interpreting other people in the world through those filters need to be mindful of that as we treat and make recommendations etc.

Specifically for addiction, do we have biases about individuals in addiction and recovery? There can be a lot of reasons why we have this and there's a significant portion of our field of people who have lived experience or a lot of clinical expense where you feel like you know the right way to do this or you know what people should be doing or this action is right or this area of risk is wrong and it is easy sometimes to fall into what they call a motivational interview, the reflex where you try to say this is the way to go. But making sure we see our own biases about this pre-

Something I did a pilot program I was trying to get approval to hire a new position and spend 20 hours a week for three months in the emergency department of one of the hospitals in our

system trying to guide people into treatment down there. What I found was a tremendous amount of bias that people were not even entirely aware with of. Nurse had an alcoholic father and said all of these alcoholics come in here just, they are using this as a place to crash and they don't really want help anyway. I heard multiple times the idea that we have to discharge this person from the ER before their bac gets too low otherwise they go into withdrawal and we have to admit them so let's get them out of there before then when they are safe enough to leave so we don't have to get them into our bed and clog up the bed. But you also hear the term frequent flyer, somebody keeps coming back and back again. That is a crass way of saying someone who's really been struggling but it's also a way to say they are never going to change.

They are a frequent flyer and come back over and over again. If you have that mentality it means you less likely in that moment when there is clarity and leverage to move in a different direction you will be ready because you will not be making a full effort and have an expectancy that they will not be open to it. Thinking about those classic studies were teachers thought the kids wouldn't achieve and then they didn't achieve as much because the teachers treated them differently. We can talk more about that study if you are interested but if you

So have biases not just about people but about our treatment. I think about this a lot. A place where if I am just being blonde the field of addiction struggles because of our roots is the best way to put it in what I mean is there's a tremendous amount of research supporting the 12 step recovery works. It does work but just like everything else it does not work for everybody and we also have a tremendous amount of support showing cognitive-behavioral therapy works in mindfulness -based recovery works and smart recovery works. In dialectical behavior therapy -- we have all these different tools that are out there.

Not only are there a bunch of tools that some people can be resistant to learning or using, but sometimes it is tough to say there is a new method, do I need to go learn it or even potentially as something become obsolete and I should be doing it lasts and something else more? That is tough I spent six years getting my doctorate, it would be tough to give up some of the things I feel like I have mastery over and some of the particles but if it came down to it that is my obligation as a clinician to do that. I need to be open to all different types of evidence-based treatments regardless of whether it's worked for me in the past, I've lived through it myself, that is the way medicine works. As we try to move addiction more towards being healthcare.

Medicine is a slightly wrong word to use, about more towards healthcare. We need to have that hat on in terms of the treatment we provide but also our willingness to change. And to realize all knowledge has a half-life that includes the treatments that we are doing and we need to be nimble and open to learning new things. Another topic is capacity. There's a lot of gray areas your here. But here's the question. If edition is a disease of the brain, what are the invocations for addiction related behavior because neurological factors do exist in addiction. So when I say this is part of what I mean is that there are certain elements of addictive decisions

that are conscious but also others that feel unconscious or compulsory. Were you actually have changes in the reward circuitry in your brain that makes it so that the addictive behavior is more pleasurable than other things in your life. You are not necessarily seeing that cause and effect clearly or minimizing addiction related consequences and magnifying problems with going different roots. So what does that mean for your capacity to make changes decisions? An example about this is grocery stores use tactics to get you to buy different things and one of them is undeniably verified and true, they put products at level that they want you to buy because you are more likely to see them than the ones closer to the floor or towards the ceiling. That is actually on purpose. And it shows up in their stock and inventory and what they are selling and what they keep on the shelf. So this may be the reason why milk is always in the back of the store. One part is because it needs to be kept cold and is closer to the loading dock but also have to walk past everything else in the store to get milk which is a commonly bought item.

So they do these unconscious factors that go into our a lot of our decisions that we might not even understand that this is what we bought more at the grocery store and while we bought a certain product that I level versus another down the versus another that was down near the floor and there are pathways in the brain that are changing and it gets to the questions of competency to make a decisions which is interesting. There is a group I was running in my detox unit at the time about three years ago, 28-year-old guy, 29 maybe, in his 20s but in their detoxing off methamphetamine. We were in group and it was a group therapy session I was leaving. I will always remember this because it totally blew my mind. But he was sitting there saying that he felt like he could manage a methamphetamine addiction and continue to go to school and hold a job and live a normal life despite the fact that before the age of 30, he had already had a stroke and a heart attack. And everybody else in the group, all the other patients on the unit were also flabbergasted, they could not believe what they were hearing. But to me that really underscored how skewed your perspective can be when you are in the midst of addiction. And that is because this truly is or at least partially a brain disease there are biological components to addiction that we have to be mindful of.

But what does that mean in terms of people's ability to make decisions? This comes -- this intersects with the idea of involuntary commitment for addiction which is something they do not do everywhere. For example in Illinois, do not have that but they might wear you all are but just as if someone was suicidal or homicidal, sending someone to involuntary treatment because of a substance use disorder because they are at risk of killing themselves, can someone make reasonable decisions about this? And I think there could be arguments either way that directly get at this idea of autonomy, beneficence, protecting people from harm, but that is where those -- those principles come in direct opposition. On one hand you want to keep somebody safe but on the other hand, can they have autonomy? Like, if this was a medical decision, they probably would be, they would have autonomy so yes they have the capacity to make decisions.

To involuntarily commit someone for a SUD there saying you don't because of your addiction your brain is not working properly which I don't think know if there's a right or wrong answer but it is something that is very hazy and gray.

Lastly, guiding patients in the right direction. This is something that I see a lot in treatment programs particularly with a newer treatment provider, particularly with people who have had lived experience. Because this is something that is 100% more prevalent and appropriate in pure support groups but sometimes less appropriate and treatment, the straight up advice giving as opposed to helping people come to their own decisions and reflect things out to them and go through more therapeutic process but it is easy when you're looking at someone is clearly making decisions that are not logically reasoned in traditional ways.

Let's put it that way. To try to step in and guide them toward something we think is right because objectively you might be able to say this is clearly healthier or clearly their judgment is clouded. And this is the addiction talking. But at the same time, is that always appropriate? And how much respect do we have to show for people's autonomy even if it seems like they are making poor decisions.?

I like to pose a second question, read back you are treating a patient in an.[Reading: "You Are treating a patient she is at greater risk of overdose if she resumes use peer ." So do you call in a safety check and why or why not. Please respond to the poll. Take a second and we would love to hear what you think. [Poll]

>> JESSICA O'BRIEN: Mature questions in the questions box. And you can also risk put your questions and the questions box and you can post questions in that question box as well. Five more seconds….

>> AARON WEINER: I feel like we need the Jeopardy music right now. I guess I could sing it.

>> JESSICA O'BRIEN: I will launch the results.

>> AARON WEINER: Thank you. Interesting so we have 68% yes, 32% no. This is one of the issues where I see both sides. Personally, I would be part of the minority. I would not do it because as I mentioned, I have a tremendous respect for autonomy. Autonomy which I think is incredibly important that the pivotal consideration is the question of if we were breaking confidentiality and calling a safety check, is there a credible concern here just in her non-presence in the program, that she has relapsed and also if she has relapsed that she is overdosed. There's multiple steps there in terms of assumptions for risk because you can relapsed without overdosing and you cannot be in session without using.

However, there is definitely more than small chance that she did it. When we think about principles this is the question about autonomy versus beneficence, what is our role to step in? There's not a right answer. And I recognize that I would be in the minority opinion on the answer their freedom not saying I am right. But it is something that thinking through ahead of time and knowing where you stand and where your team stands on things like this to be very helpful.

Next topic I want to touch on is enabling. This is something I want to get a little bit more nuanced in this and just the standard because as addiction professionals and I am assuming we are on the webinar today we know the basics that you are actively encouraging our behavior to persist or grow. Or allowing a behavior to persist through your intervention by preventing natural consequences. So this is something where, this is a line where -- this is less so for the practitioners but more for the family members because what is tough for them is distinguishing the difference between helping and enabling. And this is on the line of autonomy versus competence. Do they know what they are doing? A lot of times behaviors that feel like helping is enabling because you are protecting someone from natural consequences and sometimes it is difficult for example, for parents to understand that continuing to provide money for someone to make their car payments or post bail or whatever it is, to financially bail someone out when they are spending their money on drugs or alcohol where they're getting in trouble because of drugs or alcohol, that is actually stopping them from linking their behavior to the consequence which ultimately is what creates the motivation for change.

It is almost backwards where you normally want to help your children through these situations and you want to make sure they do not experience pain but in this situation pain that is earned is actually allowing them to experience that is -- otherwise you are prolonging can help them create a motivation for change. With enabling we minimize the role of substance use or as a dynamic, someone coming into offer to bail them out is always going to be accepted but there is always going to be, they will take it and they will look at the easy way out. You always have a choice. And this has to do with the question of dignity and autonomy but if someone is aware of and enabling dynamic they have a choice about whether they accept it. They do not have to do it.

But my mind goes to if we think about spoiler alert after the next 30 seconds of talking about the end of the movie Flight, if you don't want to hear this, mute this for 30 seconds. But if in the movie, he accepts the consequences of his actions. And ultimately that is what gives them the ability to move forward. But that is an incredibly important element -- when he could've potentially gotten out of it, he had a way out and await that would enable his behavior to continue but he chose not to. And he did not take that -- take what was offered. Even if someone is doing this behavior to perpetuate substance use disorder and addiction you do not need to actually take them up on that and that is a hard thing to do. But sometimes it might be the right thing to do.

Next topic. We have about 10 minutes and I just think all of these are useful to talk about. So I appreciate you coming with me on this potpourri of different ideas. Tough love and shaming. This is something that gets mixed up sometimes in treatment centers. And I think the research about this is important.

Tough love is generally seen, defined as being verbally harsh and aggressive with the intent to motivate behavioral change. Telling it to someone straight but often being pretty tense and the issue with this is often, this is confused with honesty, directness and offering candid feedback which are good things. But the problem is that you are engaging in traditional tough love behavior it can be humiliating and generate shame. And we have to be careful with shame. Because there is a mixed literature on this.

Shame for some people and this is oftentimes -- it is unhelpful because it makes people feel like there is something wrong with them but it can be motivating but also disempowering so it is really helpful -- it is definitely okay to be honest and okay to be direct and okay to give candid feedback but make sure you are doing it in the ugly appropriate way and if you are intending to generate shame or guilt, just be very judicious and thoughtful if you are doing that. Again, it is not literature entirely in one direction and I thought that was interesting when I researched this topic, it is not just shame equals bad in terms of substance use outcomes. But it is definitely something that can be very bad. And you might have better tools in your belt than eliciting shame in most situations.

Also remember it is not a consistent model with therapeutic intervention. When we think about how we are changes practitioners to approach a patient or client they are seen as an expert having integrity and respect for their dignity. Beneficence. So it is something that is definitely going off the standard model a little bit so if you do this he thoughtful about it.

Are ethical third question of the day regarding ethics. This happened back in January. What happened in New Jersey is that they actually gave smokers, cigarette smoker's priority access to COVID vaccines because of the risk of severe disease was higher. Because ICU was at a premium and if you were smoking you are at greater risk of ending up in the ICU for dying, they put active cigarette smokers in the same category as people with autoimmune disease, diabetes, and these other conditions that predispose you to have a highly negative COVID response and put them in the top people who could get the vaccine most soonest, so should smokers jump to the front of the line, yes, sir no? And think about why. And again I haven't seen any responses but feel free if you have an opinion about this to put that in there. But yes, sir no? Go to the front of the line. Arguments of four that someone is front of the line for or against going to the front of the line. Smoking is of course theoretically of voluntary behavior. But again if we say that addiction is a disease, is it really? That is a question. So -- what are your thoughts?

>> JESSICA O'BRIEN: I have launched the pole and there were some comments that came in and the questions box. So let's see. If they are vaccinated they are helping others. People with diabetes are the same. Their behaviors tend to --

>> AARON WEINER: Thank you for reading these. I cannot see the questions.

>> JESSICA O'BRIEN: Despite the fact that smokers harm everyone including themselves their lives are at risk with compromise lungs.

>> AARON WEINER: How did the poll go?

>> JESSICA O'BRIEN: There we go.

>> AARON WEINER: 50-50. So to put this poll out in my LinkedIn community, my LinkedIn profile and it was roughly the same I think it was, I think there it was 60-40, no, is what people said on LinkedIn but it was right around the middle. And I think you can see arguments either way. I think that there is a question there, I totally make it keeps people, smokers lives matter too. So they are at risk and we should help save their lives and keep them out of the ICU. But I also see the other side of the equation which is COVID has been active since March 2019 and we have known it puts people at greater risk, had they tried to station methods is it something they have not been able to stop. Someone once a vaccine they just pick up a pack of cigarettes and start smoking so they get a vaccine sooner? It is a really interesting question but again it gets at these principles of -- it also goes to the question of how seriously do we take a nicotine addiction as an addiction? As opposed to an opioid addiction or alcohol addiction or marijuana addiction? And do we view them as different? Or do we view cigarettes is more of a choice than heroin?

Interestingly, as a quick aside, I did not realize that rates were so low, the number of people who tried to quit every gear is very high but the percentage of people each year who successfully quit who try, is an average of 7%. 7% of people are successful in total. These are national level statistics and you can look them up. 2/5 smokers will never stop smoking for any significant period of time. And 2/they will die from smoking. That was shocking and I had no idea that quidding statistically success rates were so low but it does not impair you in the same way cognitively as some of these other drugs so sometimes we look at it a little differently. But looking at things differently is the name of the game so for the last topic now I want to talk about what this picture leads us into.

You have probably seen this these were two caregivers I believe grandparents of the child and the backward overdosed on heroin in the front seat. And I want you to ask about the reaction to this picture because a lot of times when people see this they feel a lot of things. They feel

scared for the kid in the back, maybe they feel angry at the caregivers in the front. But what oftentimes people are not seeing they feel is sad or empathizing with the adults in the front seat. Because what we are looking at here is the end stage or advanced stage of the disease where probably these people love the child in the back. They probably really care and love them but they are deep in addiction. And there have been systems that have clearly failed them to this point where they both passed out in the front seat with her child in the back. It also strikes me that I really struggle to find a version of this picture they did not have the child's face blurred out but you can see that the adults face are not. Why did he get that privilege? So what this gets us to is the question of stigma and addiction because this is a huge problem.

Both in the general public and also in clinical environments. It's highly stigmatized even more so than other behavioral health conditions. There's really no reason why it should be factually, like why should we stigmatize this but one. But I have for this is that others take that behavior personally.

If you had someone in your life with an addiction and you were very angry at them for having the addiction like your mother or father or something like that, the pain it causes you it is easy sometimes to generalize that to others suffering from the same condition. I think also there is an idea that it is a choice. Which of course is not true. When someone is actively addicted to a substance. It is really not anymore. At that point but maybe at one point it was. But when someone is in an addiction it is not just okay we will go ahead and stop but stigmatize it and treat it as something that is not actually a medical condition. We have pejorative words we use for the people in that population, like addicts, junkie, dirty versus clean.

We might actually say this on the next slide or an upcoming slide but if you are having a PSA test for prostate cancer and you've got a high PSA level, reduction would never come in and say well, you've got dirty blood. It was high. But you hear dirty drop all the time. And lien- is reference to dirty in this population you will never hear me say these words by the way you will need you'll hear me say the silver but not clean and sober.

That but you'll hear me say sober but not clean and sober.

This is a complex medical problem and what we should be moving towards. So, stigma matters for number of reasons. It harms the psychological well-being of users more so than for other behavioral health problems. There are so many examples of this. But I think I'm at the end of my time when this impacts our legal and medical system and legislation, individuals with addiction can oftentimes advocate cannot advocate for themselves. So they have something things issue stacked against him them like disease itself addiction itself. This may increase overdosed risk because stigma decreases the chance someone asks for help. If people could talk openly about addiction then opioid overdose rates would drop significantly because we could help people early in the progression of the disorder rather than letting it grow and grow.

You can actually catch it early. So it is on us as addiction professionals to redefine the narrative of addiction. This is the last point that I want to make for you guys today. What we can do with our language and I want to push hard to use person first language so that means if someone has an addiction that they are not an addict, if they have an alcohol problem they are not an alcoholic. Because we do not define people by a disease that they have. And this has been true for behavioral health for a long time and true in other parts of behavioral healthcare. This can be a challenging shift because clients may identify, self-identify as their disease. They identify themselves as an addict or alcoholic but that's not a reclaimed term. If you do a word association and you put the word addict on the board and say what you think of when you think of an attic and write up all the adjectives and behaviors and erase it and put a person in recovery what you think of when you think of a person in recovery, you see a very different set of adjectives and charts. So internalizing that as your identity I can have negative consequences for people.

We are not going to talk to someone out of it. As practitioners I would say strongly it is incumbent on us not to reinforce that and not to use those terms because it has a negative impact on a lot of people and we have alternatives associated with healing that we can use. So things to think about, eliminating the word abuse has been shown through research to increase stigmatizing attitudes even with clinicians. Makes us view people of as personally culpable and a punitive action because it's a violent idea and we tend to not like abusers. And remove clean and dirty from your enact vernacular. There are positive and negative screens and this is something that can be challenging in treatment teams to help with this change but encourage you to give it a try because when we talk differently we start to think differently and we start to think differently and it goes along with us. Society at large is where we need to think about changing perspectives and changing perspectives in language because that is ultimately what feeds into the stigma so thank you so much for your time and attention today and for my file you fellow panelists for going over five minutes. If you have questions feel free to ask them and reach out to me. Thank you again.

>> JESSICA O'BRIEN: Thank you Dr. I will briefly introduce our panelists who are going to join Aaron for some questions and good conversation so hopefully you have that in your head and are sending those in. Many of you are familiar with Dr. Mita Johnson who's been with us through the series and will join us again. Practicing in the world of mental health, marriage and addiction counselor for 30 years and an active member of NAADAC for over 15 years and served as the ethics chair and then she began her term as NAADAC's president in October 2020.

Dr. Thomas Durham has been involved in the field of addiction treatment since 1974 as a counselor and clinical supervisor program director and clinical educator. Sunlight retired and provides count support to the Phoenix House and is the NAADAC director of training from 2014. From 20 and taught graduate courses in psychology at north-central University. And Dr. Angela Maxwell overseas services in 10 counties across central, North Carolina. She works in

substance true abuse SU D and has been a certified substance use specialist and serves on many boards. I'm glad you are here for the final installment.

What I would like to start with first I know Aaron you answer this in your presentation, but what and why -- this is an important topic for us to discuss -- why is ethics an important topic to discuss? We can go alphabetically and I think Aaron that is you.

>> AARON WEINER: I touched on this in the beginning of the presentation. But I think that the integrity of us as practitioners and the integrity of our field lies on these ethics. Maybe many on the call have had this experience that you have a new patient and new client coming in and they talk about other last therapist was doing, talking about sports or they just weren't doing a very good job or they had a bad experience in a treatment center. And I hate that, he came out because you never want that to be the extremes people have. Because that just means they are less likely to follow up with someone else and ideally we are all competent and ethical and practicing to the top of our licenses and I think ethics provides that floor to make sure that is what we are doing and how the public perceives us. I've talked a lot. I've been talking for an hour so I will set back.

>> JESSICA O'BRIEN: Angela?

>> ANGELA MAXWELL: Good afternoon everyone. For me I would say the discussion of ethics is important. Aaron alluded to what I was going to say toward the end of the presentation which is the use of common language. Having a set of ethics gives us as professionals common language as it relates to conduct and how we actually engage our stakeholders. So it becomes a standardized way of understanding how it engage with our stakeholders whether the clients or coworkers or the general community or general public so it makes it clear. When we talk about integrity we understand how it is laid out. There are five of us on the panel at this moment so we will have five different definitions of integrity. The ethics lays that out for us and so he grounds us also in the space to do no harm in general. To promote wellness and ensure our clients and our community and is safe in the code of ethics helps work towards and go in a professional way. And lastly, I would say that it helps to clarify our values as a professional. So it not only conducts our or guides our conduct but it also lays out the values that we espouse as addiction professionals.

>> JESSICA O'BRIEN: ,Mita?

>> MITA JOHNSON: Good afternoon everyone. I look at do no harm and the boundaries around that so when I think about professionals coming into the field or being in the field for a while I do think that having a foundation or boundaries around which to provide services and to think about not only our intended effects but also the unintended consequences of some of the work we do is really important and we been hearing about a lot of the unintended

consequences of things we do and say and in Aaron presentation and that was at the forefront for me how do we do no harm and what does that encompass in all of the facets of the work that we do?

>> JESSICA O'BRIEN: Tom?

>> THOMAS DURHAM: I will share my perspective from the viewpoint of an area of expertise of mind which happens to be clinical supervision. From the standpoint, I feel it is important to stress the significant obligation that supervisors have in helping clinicians develop really an ability to think forward. Think forward of the consequences of professional behavior. Including maintaining boundaries, confidentiality, calm confidence etc. But getting into something that Aaron brought up is the issue of bias, as clinicians we have biases too. And those biases, to be the biases can become an example of countertransference which can often be harmful to the client. So as a supervisor I want to be able to be aware of when my supervisees might be regarding their biases and may actually be experiencing countertransference for the client which would be an attitude that could decline harmful to the client and their treatment. And I think it is important that the supervisor and clinicians are fully aware of the concept of vicarious liability.

Of course, that is something that extends beyond the clinician and may include the supervisor and ultimately the agency. As a supervisor, one can avoid negligence for instance by providing closed supervision and remaining actively involved in the treatment process. Of the counselors they supervise.

And be able to ensure those counselors reach that ability to think forward which I talked about earlier or that sometimes is put, think ethically. I'm not talking about micromanagement. In fact I would go the opposite of that I think good supervision means valving collaboration, trust, collegiality, and promoting independence on the part of the supervisee and that is part of the ethical behavior part of the supervisor to make sure that happens and make sure they develop that kind of relationship, I should say pit so it is monitoring the work of our supervisees but also working with them side-by-side in the trenches and helping them develop that ability to think ethically.

>> JESSICA O'BRIEN: Great. For me, this is simplistic but just that foundational tenet of beneficence and doing no harm, it is like life, it is really sticky and we do not often have a clear path and sometimes it is choosing between two ideal situations and knowing that the codes are there not as roles but as supports and guidance and sometimes people fear ethics, oh my gosh, there is so much that I have to avoid doing, but they are not there to scare people, they are there to help and provide this consistent practice for all professionals and Angela you refer to that.

Thank you guys, my next question for each of you is can you tell us about one of the hardest ethical cases that you have had to deal with in your practice and in this field and why do we go, we did alphabetical forward, my first name let us to alphabetical acris by first name so that would be Tom starting off period.

>> THOMAS DURHAM: Okay well actually I have two -- one is something that -- that I had as a clinician, the other is a dilemma that I had as a consultant to a supervisor. About something they experience. We will start with my first. This was years ago when I was working as a clinician. And I had a relationship with a client such that it was assessment referral so we didn't develop an ongoing relationship and one day I decided I was going to buy new tires for my car and I walked into the tire store unbeknownst to me the manager is the client.

He knew that I was familiar but he wasn't sure why or how. And in front of all the customers he said how do I know you? And so my dilemma is what do I say. Fortunately I was able to pull him aside and remind him of the relationship that we had had. This is maybe six months after I had seen him and it was maybe a three session assessment referral type of situation but it certainly presents a dilemma especially for many clinicians who may be in a smalltime or rural environment where they are likely to run into clients or former clients in public. And maybe with other people around. And what do you say and how do you react? You say hi, do you acknowledge them. So that, I think that's an expense many of us have had but that was my own experience prisoner want to mention another and that is as a consultant to supervisors, one common dilemma that many supervisors have is when they become promoted and they are now supervising a former colleague or someone they even socialized with. We are not talking about a clinical relationship, but we're talking about a different kind of boundary.

One of the problems with that is the possible appearance of favorability among other staff members. So what do you do? A lot of things can be done if it is a large agency maybe even change supervisors but that cannot always happen. Especially in a small agency or small community. And so the two individuals have to come to grips with the fact that their relationship has changed especially at work.

They need to be clear to their coworkers what that means and what changes they have made. So it is not another ethical dilemma not necessarily with the client but in our field, nonetheless.

>> MITA JOHNSON: As far as two ethical cases, really have been impactful on me, one of the cases that struck me was a situation where we had a family member, we had a family therapy going on, addictions involved, the clinician took sides against one of the family members, took the side of the other family members against this particular individual. This passed through supervision and was not getting adequate supervision to Tom's point, I cannot stress that enough. Because what ended up happening is that person ended up committing suicide after leaving. The details exactly what happened in the sessions where the sessions had cited against

this individual and the point was investigated and that documentation was the same for a year and there had not been, even though they had been meeting every week the documentation every week when we opened it up was identical. That just really impacted my heart in ways that I cannot even explain.

The other big one that happened is something most of you are familiar with is if you have had, in Colorado we had a situation where a counselor was had a six-year-old and the 6-year-old died inside of a blanket and that counselor has been released from prison over that particular situation but that impressed upon me abusing techniques that are not necessarily evidence-based. So when we are using evidence-based techniques and how do we are in a field and looking at addictions or profession where every day we are trying new things and we want to be progressive and do things that are helpful to the client and doing things in the 60s and 70s that are no longer viable today so working with supervisees and what evidence-based practices and if there's something we would like to try what do we do to put safeguards around that so those are big but when you ask what are ethics claims that are close to our heart.

>> ANGELA MAXWELL: Several years ago I had, the way my department is structured, this is dealing with when it look at the NAADAC code of ethics it's dealing with professional responsibility in the workplace and I had a team leader who I supervised and was with the organization for 18 years who at some point towards the end of her career with the organization that had biases towards people all of color and she had challenges with a co-team leader was African-American, the staff member was Caucasian and she started having challenges with her and when she would talk with me about it she would refer to this coworker as "that" like she would not even say her name. So every time I would bring it to her attention she would look at me as if, what am I saying wrong?

Part of her anxiety was dealing with individuals who were black and other persons of color started to stem from her graduate-level work and HPC Q historically black college university and she would talk with me about how uncomfortable she was is the only white person in a classroom full of black individuals or black students. And so it started to spill over into the workplace. She would not accept programs as a reminder to everyone I work in prevention so we do a lot of education in the community, community-based groups and schools etc. And in talking with her team they would highlight the fact that she would pass on all of the programs related that had audiences that were predominantly people of color, she would not serve that population. And so I ended up starting addressing the issue within our supervision 101 meetings. And try to have very open, engaging conversations around diversity and multicultural services and things of that nature.

And she was very resistant to that process. To the point that in one of our conversations I distinctly recall her saying, well, I tell you all this because you are different. That is you are different as a black woman. And for me that became a dilemma as an African-American female,

how do I now support this team leader in providing the best services that not just to the community that is a coworker understanding that she was resistant to the process and I ended up having to take this to my supervisor to figure out what was the best course of action. Through her coaching and through her supervision with myself as well as with my supervision, my supervisor, we eventually took it to HR and discovered she had other challenges related to integrity. Destroying customer satisfaction surveys that were unfavorable to her. And so we ended up transitioning her to a different position which increased her resistance. And ultimately we ended up offering her a new career direction outside of the organization but it was difficult for me working with someone who had been there for 18 years, dynamic, who seemingly made this pivot in her perceptions of those she served. And now that I know more, I understand that those biases were already there. And she just felt comfortable expressing them in the setting she was in.

The other one was presented to me by a colleague who is dealing with this now and she is looking to hire and diversify her team and her organization's process requires that interns and part-time staff get priority and open full-time positions and she wants to diversify with a person of color interpret part-time person is a white female who has been with them for two years but she's challenged with, do I hire outside of the organization to diversify or do I follow the practices of the agency and promote this individual from part-time to full-time and when we looked at gauging ethically in a culturally diverse society, I believe both of these scenarios highlight many things that supervisors as well as coworkers are probably facing today. So those two stick out to me.

>> JESSICA O'BRIEN: Thank you, Angela. Those are all good cases. Aaron?

>> AARON WEINER: Wow, those are really intense cases. I was not entirely sure of the case I wanted to talk about but then something happened in the news that really made me feel like there is a really useful examination to be had around the concept and the application of principles of harm reduction.

What you may have heard because it just came out recently was that a person said she was California sober as she says just using alcohol and marijuana and nothing else. And of course this person has been opened about the fact that she is owed overdosed in the past and is on a recovery track and this term of California sober has been popularized being acquainted with harm reduction and I think -- to me what I struggle with the most about this is that that is not actually really what harm reduction is about. And I want to talk a little bit of what harm reduction is in the now you can see it manifested in other areas. Specifically what I did. Harm reduction, the idea there is that you are basically trying to say if someone is going to keep using, how can they keep using in a way that does the least amount of harm? So if someone is injecting drugs, can we have them injecting using clean needle so they do not get HIV or hepatitis? Can we give them Fentanyl testers. If someone is going to drink out of a stop them

from drinking so much that they blackout and pass out commit crimes etc.? Keep it at a minimum? And I think sometimes that's confused with the idea of moderation although sometimes they do come hand-in-hand.

Whether someone can or cannot moderate, I think that is more of an individual question. But the struggle that I have with this phrase of California sober almost makes it sound like one is trendy or glamorized but also this person Angela, it's probably a structure to keep drinking and getting intoxicated with marijuana and particularly when they are a public figure that rolls down to youth, they will look about unsafe drinking and marijuana are not that bad. It's important it's not meth and cocaine and pills which ultimately end the treatment realm is not what we talk about harm reduction meaning, it can be, it can be kind of but the evidence that we have people stay on alcohol or marijuana and not backslide into opioids or pills when they are high or drunk is wiggly.

That said, this principle the idea of harm reduction and how do we do that in a way that's closer to evidence, it is something that was front and center when we were creating a medication assisted therapy clinic in my hospital system a few years back. In particular we had this plan for how we are going to treat positive drug screens and we were -- of someone initially people came into the clinic and they would come in once a week for therapy and their medication. And if they had negative screens for a month and they would go down to every other week and if they had negative screens for another month, they would go down to just coming once a month but if they had a positive screen they would essentially go back one so if they came in every other week they would come back to every week and that would provide some incentive essentially to have a negative screen. But we found that there were quite a few people who were very successful and not using illicit open opioids or heroin or street dogs but smoking marijuana all the time. And honestly were not actually making any attempt to stop doing that. While not using open wheel weights which create the question, okay, what do we do about this, do we want to do anything about this because temp technically speaking the primary thrust of the clinic is making sure people do not use heroin were used opioids is being achieved even if they are not actually meeting a stated clinic goal of abstinence which is what the clinical was shooting for clinic was shooting for. And we ultimately landed on those folk coming every week because that was the choice they were making and we felt that medically they were better off continuing to work with us bound to be discharged and potentially usable other substances.

The other complicating factor with that clinic is that in many clinics if you are dispensing the medication yourself you are making money by giving out that medication and so the financial incentives in clinics are often backwards where you make more money the higher the dose of the medication someone is on and you make more money the longer you retain them in the clinic. And so in a broader sense when we think about the affixes ethics of MAT we need to be clear about ethically gravure coming from and make sure we do not cross those lines between

the financial benefit of the clinic and the medical benefit and behavioral benefit of the patient. I will get off my soapbox but those are some thoughts on harm reduction.

>> JESSICA O'BRIEN: Each one of these we could spend a whole hour just discussing the nuances and ethical dilemmas. What I think ethics are so fascinating and a great topic.

I do want to get to some of the questions that we have from the audience. The first one is a combination of two questions -- Mita you spoke about this in a previous presentation about clients being mandated. And that they are not able to revoke their mandate, like -- their releases, their authorizations once they have entered treatment. And people couldn't find that in the code of ethics and wanted more direction or elaboration on that. If you don't mind.

>> MITA JOHNSON: They are asking about how much can a counselor release for a mandated client that's been sent to them for treatment?

>> JESSICA O'BRIEN: And whether they can revoke that?

>> MITA JOHNSON: Unfortunately the client is in the court system and the court determines that so we need to go back to the probation officer the PO and talk to them and find out what the options are for the client. And you want copies of all those releases obviously. So they have those releases most of the clients have actually signed all those fired to being referred to treatment, so the.

>> JESSICA O'BRIEN: Okay PIT someone asks if they could be a muted but that is not a feature that we have. So next question, have you been in a situation where you made what you thought was the right decision and it backfired you got in trouble I will open that to the group and whoever is first to respond...tough question.

>> ANGELA MAXWELL: Yes, as I said, in the world of prevention, this has to do with the implementation of evidence-based programs, of course modalities, we see it in treatment ensuring that you are utilizing as practice strategies that meets the need the audience you are serving. Based on the research attached to the developers work. So the scenario was again, many years ago, about 10 or 15 years ago, at the opportunities to provide educational program for young people in what are called our middle colleges here which is a hybrid between high school and college students.

We were waiting for the official training, it was a high school group and waiting for the official training for the evidence-based model, specific to high school students. In the interim, because the school wanted to start on a specific date, we decided to slightly modify a middle school evidence-based program that we had to meet those initial sessions for that group.

Although information wise, it seemed to be a match, it turned out to backfire on us in the sense that the students in the program knew instantly that it was not appropriate for them and felt that the information was dumbed down for them. And in follow-up conversations with the principal of that particular middle college, we disclosed what we had done as far as modifying the middle school curriculum and it wasn't targeted for high schools. Long story short, we ended up having to end that relationship. Because of that action we took. Even though it did not cause any long-term harm it did shatter the trust that my organization and this particular school hadn't so we were unable to continue the relationship but we were able -- fortunately, to rebuild that relationship. So the following year we were able to go back in but it took a lot of work to build that trust again. And it stands out in the back of my mind. And if we think about it professionally we may do that often. Oh, we will make tweaks here and there and adaptations here and there and if it does not align with the research then we should not be making the tweets. I ask them about the adaptations they would accept to maintain the fidelity of the program so we were out of bounds would be made that decision. There we go.

>> JESSICA O'BRIEN: That is good to think about how that can backfire. Because that is common oftentimes programs are under resourced and you don't have a lot of options. It is close enough, this could work. But it doesn't always and it is important to keep in mind -- like Mita talked about, the unthought about consequences that you do not really foresee playing out with someone and thinking about what could happen is really important.

>> ANGELA MAXWELL: From treatment perspective if we are implementing evidence-based best practices or models that do not through research meet the person need of the person we are serving, we can cause more harm than good in the long term. We are going to meet or reach the outcomes that we have laid out in the individual treatment plans or from our perspective our outcome plans.

>> JESSICA O'BRIEN: Absolutely. Anyone else have anything they want to add? Before I move on? Okay.

Thank you, Angela. This is in the lines of stigmatizing language someone asks, I heard of the word "accommodating" lately over the word "enabling" is that word more practical and help family members better understand the role or participation in a dynamic?

>> AARON WEINER: I can ship and on that one. My first thought I think it is one thing to accommodate or make room for behavior that is, that you may not agree with and that is uncomfortable to you or might cause minor annoyance but enabling is saying the person would not be able to sustain the behavior without your help. They would not have the money, they would not have a house to live in, they would not have, there are reasons without using you supporting them, life would collapse in on itself. I think that they are getting at two different concepts.

>> JESSICA O'BRIEN: I see everyone nodding. Next question, boundary issues, these are definitely something I experienced as well and my own work at different agencies, the boundary issues were always a recurring issue. And you would think that you've done trainings and gotten a handle and then something would come up again. And so I can echo this question, what needs to be standard practice for agencies to help support employees in the field? And then what do individuals need to do to continue to exercise their ethics muscle and keeping boundaries appropriate?

>> MITA JOHNSON: Tom I think of supervision right away I think of you.

>> THOMAS DURHAM: I was just on muting.[Laughter]. Two things come to mind. Number one, what we are doing now you are attending an ethics workshop. But also if you are in a position at your agency to make sure that the staff members get the training on an ongoing basis I would encourage that as well. You may even want to be on regulated regular administrative staff meetings on occasion on the topic of training and make ethics one of them. Maybe the most frequent maybe once a month or every other month. That is the first thing that comes to mind. But also as the clinical supervisor and I am reiterating what I said earlier but for any of you that are clinical supervisors or will soon be clinical supervisors that is something I think all supervisors should be aware of. Be aware of the ethical behavior not in an ethical way. You want to have collegiality with your supervisor supervisee but you want to observe their work without micromanaging end, proponent of observing the work of the clinician on the part of the supervisor. And it can be done in a way that is nonthreatening, the best way is to be there co-therapist for exit instance and I feel like it can be a relationship builder if you are working like that.

Be aware that what you're supervisee's are doing and what their needs are and promote the ethical thinking that I talked about earlier but be aware when they might be verging towards crossing the boundary and pull them back by having a discussion, an open discussion, where this might be heading and why it might be heading in some unethical territory so information, training, observation, develop a good solid trusting relationship with the supervisee, to be able to discuss issues like this openly, without them feeling like they are being criticized and I think all those factors play into developing good ethical behavior on the part of the clinicians.

>> MITA JOHNSON: I love what you just said. I think about safety. You are creating a safe space for a supervisee to come and ensure the things that they want to share but let's just talk about what happened, we all make mistakes in treatment, that is part of the process but need a place to process and determine what should have happened, the last thing that I need to know is something has gone wrong when I get a complaint and I have to, let's talk about that but I love getting them involved in conferences and case studies and anything you can do like that to

keep them always thinking. Having a better -- I think we have to have more conversations about the slippery slope but I love what you said, Tom, I would agree with that wholeheartedly.

>> THOMAS DURHAM: Dimension case studies and that is a great learning tool. I'm reminded of a textbook that was published probably 20 years ago that many of you are familiar with, Critical Incidents.

>> MITA JOHNSON: I love that.

>> THOMAS DURHAM: Is full of case studies, that is what it is and in my training have contacted William White before or once before and said, I use these in my training. He said absolutely that is what they are for. I'm not pushing that book but I'm giving it as an example. There are other publications out there that can be helpful. But providing a case study whether fictitious or real, and have a group of clinicians discuss what they would do, what would you do if you were faced with this?

>> JESSICA O'BRIEN: That is why I love hearing your cases today as professionals you've been in the field for a long time and exactly for that reason -- everyone has not faced an ethical issue. And mentors it is great to hear what can share about this and for being vulnerable in this space to do that. We are winding down. It went by so fast. But I want to give everybody, the panelists to give a closing, what do you want people to take away from this and Mita you had something you wanted to discuss a will go back to the alphabetical from the top and that would be Aaron.

>> AARON WEINER: All right well I will close by saying that I really appreciated the perspectives on the panel and appreciated the questions. I know we were probably not able to get to them all but I think the ethics side of what we do is fascinating and it is essential and it is going to lead us as a profession and society to interact with addiction in different ways. And so from supervision to prevention to clinical work to residential treatment centers, I think this really needs to be the heart of what we do and am so appreciated appreciative of everyone who came on today to think about this and to try to do better which is what ultimately we are trying to do. So thank you to everybody and I appreciate it.

>> ANGELA MAXWELL: To what Aaron says to what Aaron says. But it's been an honor to be on the panel and facilitate these sessions. Ethics is important to what we do and I encourage everyone if you have not done so to take the time to read the NAADAC code of ethics. It is a wonderful resource, it you do not necessarily want to find yourself in an ethical dilemma trying to figure out what to do. Really just brush up on it and increase her awareness. Around the code of ethics. So that we can engage in the work that we do at a high standard or a higher standard based on the guidelines set before us.

As Aaron says, thank you for joining us and we help I hope you have a great weekend.

>> THOMAS DURHAM: I want to read a quote and first of all want to state that we haven't mentioned much about law but there's a symbiotic relationship between ethics and the law and this quote comes from a textbook ETHICAL, LEGAL AND PROFESSIONAL ISSUES IN COUNSELING, ethical Laws dictate the minimum standards of behavior that society will tolerate whereas ethics represent the ideal standards expected by the profession." In some ways the bar is lower with the law and much higher with affix. They are symbiotic and they do interplay. But I think it is important that we as clinicians especially if we are in a position of training or supervision that we do work with the people that we are supervising or working with to help them gain an understanding about ethics so they can get to the point where they are thinking forward and thinking ethically and thinking with the consequences of professional behavior. Most of the time it is quite incident innocent and if people keep on top of what the boundaries are and as Angela said, read the NAADAC code of ethics. As is lengthy but there appeared understand the code and you will have it is lengthy but it is very good and understand that we have an ability as clinicians to gain an ability to think and act in an appropriate and ethical way when faced with a variety of apical dilemmas that we are faced with on a daily basis. And thank you so much for attending and thank you to my fellow panelists. This was a great discussion.

>> MITA JOHNSON: Thank you Tom, Aaron and Angela. NAADAC is by far the top of my list of professional organizations because they really do care about you as providers and allied providers and the resources available to you through NAADAC both in people and in tools like the code of ethics, are very important. We now have made our magazine free so anyone whether you are a member or not and look at the magazine could be always have current articles in there about evidence-based practices, and ethics corner and we have a way to at least keep you up-to-date on what is going on in the field. We also have an ethics committee, I have the pleasure of chairing that for four years before becoming president in October and we saw a lot of cases during that period of time in one of the things I would say is that we are a valuable resource to you as an ethics committee. If you've a question you can call and get one of us on that committee to respond to that call and actually walk through this scenario with you. You do not have to break confidentiality you just present you have a 40-year-old dealing with X in your agencies doing XYZ and you are curious about what to do in that situation. We would love to be able to help you work your way through that. We are also looking at a way to provide supervision to supervisors and Tom and Cynthia and others have been involved in the project to see what we can do to bring that to NAADAC.

So that is a future project for right now be aware that you do have an ethics committee, we get questions on a regular basis and are happy to answer them. You might have to give us a day or two but we will get back to you with the answers. In the code of affix, we totally overhauled it back in 2016 and made Ryan minor revisions to it in 2020. So you have that as a standard of

practice becomes grateful that NAADAC sponsored this six part series. I cannot thank Jesse enough and for putting this together and making sure it ran smoothly and putting up with all of us as speakers. And so I am grateful for that. I'm grateful to the esteemed members of this panel, you have the best of the best sitting here today talking to you. So we look forward to serving you in any way that we can and I want to thank you for participating in this seminar today.

>> JESSICA O'BRIEN: Thank you, because I feel like I am basking in reflected glory. Guys are amazing and this is one of my favorite panels to be a part of and I really, really appreciate all of the great sessions you have brought discussion to the table, your expertise and knowledge and what a resource, I hope you took notes but if you didn't, it was recorded, as always. But we do have to wrap up but I will make my part short. Just reminding that you get two continuous education hours, you already paid for it so just take your test and do not forget to use the guided is in the handouts. To guide you when you go to get your certificate. It will help you do that smoothly.

Some upcoming webinars to look forward to. April 21 we have Using is one of our free webinars. This is a deeper dive to what is coming up in April, we have baby boomers and substance use, how holistic care can help. Don't have a lot of stuff on older adult so this is really great if you guys can make it.

Next week, next week already I cannot believe it, there's so much work being done behind the scenes and it will be really good. But NAADAC 2021 Advocacy and Action Conference and Virtual Hill Day the 13th-15th and I hope you have signed up. Make it a point to do so if you have not for the conference will provide you with the opportunity to attend briefings on current legislation and learn about important advocacy issues in the virtual Hill Day will allow attendees to speak with law makers directly on a Capitol Hill and you can earn up to 11.5 we have Wellness Wednesdays the next is May 5 and it is a specialty series, you guys are all your today's so hopefully you are aware of the epic series but if you missed any go back and check out the page here, the address is at the bottom of the screen.

The benefits of membership, if you like Mita did a good job of summing up but my favorite is the youth free CE's now everyone gets free access to the magazine but we hope you if you are not a member you will join us but lastly, a survey will pop up at the end and we want to know your thoughts, but I want to hear from you guys and I want to think say thank you to all of you guys and have a wonderful weekend. You guys are awesome and I want to have y'all back in attendees, be well. That is it.

>> MITA JOHNSON: Thank you.

>> THOMAS DURHAM: Thank you.