HALEY HARTLE:
We will get started promptly at 3:00 PM.

Alright, everyone. Welcome to today’s webinar, Harm Reduction for Skeptics, presented by Cyndi Turner and Craig James.

We are so happy to have you join us today, the Association for addiction professionals, will be the facilitator for this training experience, and with me today behind the scenes will be Allyson white will be addressing the issues or questions you may have that are not specifically for our presenters. In other words, you have a lot of support here today.

The permanent homepage for NAADAC webinars is W WW.NAADAC.org, so please update this to stay up-to-date. Closed captioning will be provided by Caption Access and keep an eye out in the Q&A and chatbox for the link to use close captioning once we get that up and running.

We are using Zoom for today’s live event and you will notice the control panel that looks like the one on my slide at the bottom of your screen. There are two main features to be aware of, the first is the chat box which allows you to send chat messages to the host, panelists, and each other as attendees, the second is the Q&A box and if you open that you can ask to panelists that will reply to you via text and we will answer them live when we got to the Q&A portion at the end with presenters.

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In the chat box we will post any handouts including a PDF from today’s webinar and a user-friendly instructional guide on how to access our online CE Quiz and immediately earn your CE certificate, please let us know when you are ready.

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If this is your first time going through the CE process, please go to the guide to guide you through the process. You can always email us at ce@naadac.org.

Please note if you need your certificate to say 'live' on it please complete the CE Quiz in the next 24 hours and download it and be sure to do those things if you need it to stay alive, for any social workers with us today, please stay on on the presentation for a brief two minute video on how to add your license number to your certificates.

Now I can introduce us to today's presenters. Cyndi Turner is the cofounder and see Insight Into Action Therapy, and Insight Recovery Centers. She has been a harm reduction therapist in the addiction field for three decades, and she codeveloped and facilitates the Dual Diagnosis Recovery Program and is a clinical supervisor for licensure and expert witness, a therapist for players involved in the NFL program for substance abuse, and a nationally recognized trainer.

She designed the Alcohol Moderation Assessment which predicts who might be a successful candidate for alcohol moderation and wrote, 'Can I Keep Drinking?' the commission's guide to alcohol moderation, alternative methods and management techniques and practising alcohol moderation, a conference of workbook.

Our second presenter is Craig James who has been in the addiction field for two years and is the cofounder and director of operations of Insight Into Action Therapy and Insight Recovery Centers and codeveloped and implements the Dual Diagnosis Recovery Program and is nationally recognized trainer on alcohol moderation and harm reduction. James serves on the board of Dandelion Meadow, the Virginia Association of Addiction Professionals, and the Loudon County community services Board.

Without further ado I will turn it over to our presenters.

CYNDI TURNER:

Thank you for the great introduction. Craig and I are excited to reach such a large audience on a very controversial topic. We hope by the end of this, you will have much more information and practical skills and potentially experience a paradigm shift in the way we treat substance use disorders, specifically alcohol use disorders.
Craig and I start very official where I do a few slides, he does one of them, by the end we will talk over each other. Hopefully that will keep your attention. We look forward to questions.

In order to think about harm reduction, I like to ask these questions: do you? Oops, I went too far. Do you use a seatbelt, put on sunscreen, wear a life jacket, use a helmet, or wear that stupid mask for the last two years? (laughs)

Each of these things are harm reduction techniques. These are potentially dangerous and harmful situations, driving a vehicle, being in the sun, riding a bike or motorcycle, being out in public for a long time here was dangerous.

These things we do all mitigate the consequences and that's what harm reduction is: reducing the consequences of potentially harmful behaviour.

As providers, I want you to think about – I know clinically, or radically that the weird thing -- we meet clients where they are at. Do you deal with mental health and substance use in your program? Do you use motivational interviewing, provide psychoeducation, use a strengths-based perspective, celebrate your client success rather than being punitive? Most modern programs do these things. These are all harm reduction techniques, a lot of people are doing this and they are not even aware of it yet.

I talk about what harm reduction is not because there's a lot of misnomers out there. A lot of times people think we are teaching people how to use drugs and alcohol. That is not the case. The people who are coming to us are already using these substances. We are not teaching them how to do it. We are not ignoring addiction, we will share with you how we treat addiction versus how we treat substance use, they are two very different things that occur on a spectrum. We do not support substance use, we support the person who has the individual right to make choices.

They may be unhealthy choices and we are trying to give them education and resources to be healthier and more balanced. A lot of times, people accuse us of being unethical. I will share with you over the next couple of slides why not knowing about harm reduction is actually more unethical.

So, we also talk about the definition of recovery. I think that is really, really important. You will see the most current ones here from SAMHSA, the Surgeon General’s report, and ASAM, all of these if you look at them and talk about change, self-directed lives, ultimate paths to recovery, prevention, does anyone notice what word, or what idea is missing here?
The word addiction.

CRAIG JAMES:
Abstinence.

CYNDI TURNER:
Sorry, abstinence. You do not need abstinence to be in recovery. Somebody can be in recovery and is still using substances. It is likely in a less dangerous, less frequent, less impactful way, but you do not have to be completely abstinent from substances to be in recovery.

I shared with you a minute ago it is unethical to not know about harm reduction and alcohol moderation. That's a lot of what we will focus on today.

Craig and I are both social workers and members of NAADAC, changed into thousand five, we have a new TSM, the DSM-V TR that came out in the middle of March, I do not believe substance use... They specifically state the harm reduction approach is consistent with the social work value of self-determination and meeting the client where the client is.

The board of counselling. Most boards are very similar, I picked Virginia because that is where we are. People who are licensed by the Board shall stay abreast of new counselling information, when they are providing services. Boards of counselling are stating, "You need to know what is was most current and the new services that are provided for clients."

NAADAC says addiction professionals need to engage in continuing education and need to know new procedures relevant to clients that we serve and we had to remain informed. The fact you are here you are learning about something that may be new to you. It is ethical, all of our codes are ethics date we need to know the relevant treatment protocols for our clients.

I will let Craig jump in.

CRAIG JAMES:
When we talk about harm reduction we are looking at three branches, we are talking about policy, talk about treatments and good Samaritan laws, and we also look at programs such as needle exchanges and safer sex programs, these are the things when we talk about harm reduction.
I call these silos. We have MAT, and motivational interviewing available, and harm reduction as we are talking about today, alcohol moderation.

CYNDI TURNER:

I told you we would jump in and talk over each other. (Laughs) He is not feeling good today. The ideas about practices, people do not know about needle exchanges and safer sex practices but not how to do it in our clinical study. That is what our focus is.

CRAIG JAMES:

Thank you. This will happen a lot more, folks. We are in the third wave. We can remember based on education and history, the moral model which was a temperance movement which gave rise to come "alcohol is an issue, we are not locking people up, we had to rise above AA," and we came into the second wave which is a disease model.

We understood the defect and symptoms and gave rise to treatment. Right now in terms of alcohol moderation and harm reduction, we are in the third wave. We have heard of mindfulness and motivation interviewing, DBT and CBT. We are in the third wave. This is where the paradigm shift is happening. We will talk in a moment about how there is 50 years of research behind harm reduction.

The question that gets posted is often: "why isn't it taught?" Simply put, it is difficult and messy. We often identify as commissions and providers, it requires us to sit and tolerate what could be considered "Risky behaviour" for our clients.

Harm reduction requires tolerance from our part. We often talk about the idea with clients, they are experts because it is their lives and we are experts because we bring our expertise is together. It is not taught because you see the third point has said that it challenges AA which is like challenging God.

Ultimately, it is messy and requires us to sit with clients and follow, but also to lead. The other piece is why it is not taught. This slide really speaks to what the treatment industry has had more of an impact on treatment than the providers have.

To do harm reduction, challenges residential programming process, if you look at that slide it says, "Heads in beds." It is $1000 a day. It is not that the programming does not work, because it does, we are
talking harm reduction and different levels of care and looking at ASAM, what is the appropriate level of care for that client?

It does affect profits and does not require an abstinence only approach.

About 40 years ago, we like to point out we are doing this presentation a month and 1/2 ago. And we know in the US, treatment is about four years behind Europe. What we find is that treatment in America starts once a gift to America, it goes from the West Coast to the East Coast, and we were in Alabama a month ago, and the lady says, "then it goes from the North to the South."

The idea is we are looking at change. Back in the 90s, 93% of programs were total abstinence, they were 12-step based, which helps some, but it does not help all. We will talk in a moment about why harm reduction and alcohol moderation makes sense.

About four or five years ago we found that percentage of 93% dropped to 77%. A lot of what we are talking about with harm reduction is we are not focusing on do not drink, we are looking at the why, right? We are removing the idea of abstinence from the conversation, we are trying to get clients to engage with us, we are talking about education and information, going back to the statement – you are using clients expertise truly expand what they know, and help them understand what they may need or give them options to facilitate the changes necessary.

The history of harm reduction, Cyndi will go into this later, but it is 50 years of research. A lot of what we know today we attribute to Edith Springer who was a social worker in New York City and realized how they were treating clients, and what they were doing was different. She is accredited with being the first person to write an article about prevention techniques. Which really helps facilitate what we are talking about today.

Alan Marlatt - I do this every time! They talked about looking at harm reduction, not requiring abstinence, but looking at how do we reduce risk and collaborate with our clients to give them other options to reduce the harm that is happening, that could happen if we did not get to them?

What are the core values? We will talk about this a lot. A lot of what I talk about with clients is that process. I want to know why you do what you do.
We did not look at the idea of acceptance that embracing choices to many consequences, if you have a client, excuse me, that is drinking 12 years a day, and we get it down to six or eight and whatever may be reducing harm, the other value is compassion, helping clients have some success, but having some forgiveness and compassion and letting them understand this is a healing process and we want to promote change.

We do that together in a compassionate way and we are removing stigma, removing shame, and guilt. Kindness, connection, what's his name? I forget it every time. Johan. He talks about the opposite of recovery, "The opposite of addiction isn't recovery, it is connection." We want to make that connection with clients and understand clients have the right to choose. We are not teaching clients how to use, they are doing it, as Cyndi said, when they come to us. We want to give them options so they can make the best decisions.

I'm still going, OK. The therapeutic approach. Harm reduction – you've heard dual diagnosis, we are looking at both mental health and substance use disorders which is about that 'why' foundation and what we talk about with harm reduction is looking behind the behaviour and going beyond the surface.

Our job as clinicians is to work with clients and focus on the tenants: what are the goals? What are we ultimately trying to do? Is it to be absent? That may be the case, is that to reduce the harm? However we get to that, we want to celebrate those successes.

If a client is able to – this is an example I like to give. If they drink five days out of the week and they get down to three, I will not focus on the days they drink, I will focus on the days they did not. How did you do it? What did you notice? We want to focus on the success a person has because that is through that confidence, the core values that allows us to really continue that process of recovery.

You will hear us say alcohol and harm reduction interchangeably. For the purpose of this presentation, they are one and the same. But what are we looking at? We are looking at addressing any positive change. We will take a motivational approach, meeting the client where they are. We want to get them in the room, and we want to start education. Education can lead to prevention, we are encouraging change by talking and conversations, and the fifth bullet, this is not the Nancy Reagan, "Just say no" campaign, this is 'know', we want to understand why.

That is what we are looking at when we talked about harm reduction. That point there is a statement that a client of Cyndi's made a few years ago which is really impactful to meet which is, "if I knew in my 20s and 30s, I would not be the alcoholic I am today in my 50s." Very powerful. A lot of what Cyndi and I do over the years, prior to doing the research, with take a harm reduction approach and understanding,
with clients, what is it you are doing? What is the benefit to why you are making the choices you are making?

A lot of this is treat the why. I use the metaphor of an iceberg. What we know about an iceberg as much of the mass is below the surface. While we will see what is above the surface, we will see a person drinking, making bad choices, we want to treat the why and go below the surface. We want to ask those questions.

I often point out and like to encourage clients and as clinicians, to ask tough questions. The answer: clients have the answer. Do they feel comfortable, do they feel safe and talking about why they do what they do? I want to provide that environment where they are safe to discuss what is going on, and often times, we find there is more mental health going on.

Guess what? Alcohol solves that problem temporarily.

74%.

CYNDI TURNER:
This number is significant. This is why Craig and I focus so much on alcohol moderation. SAMHSA found 74% of people who percent into treatment use alcohol.

Three out of four people coming into your program are dealing with alcohol abuse. If you are specifically in an alcohol treatment agency, or specifically giving methadone out, that's not necessarily the case. Across all levels of care, the majority of people are in there for alcohol.

This is why we focus so much on alcohol moderation.

I want you to ask yourself this question: are you an addiction treatment provider? I want you to hold onto that for just a moment as we go through a couple more slides, and I will ask you a second question for so, are you an addiction treatment provider?

I educate people on the different types of drinkers. These are not things I made up, this is across various organizations, and all the major agencies who look at alcohol use in the United States. And we find there
is really four different categories: the first category is what I call water, 35% of the population are called water because they do not drink at all.

These are not people who have a problem with alcohol or in active recovery, these are people that do not want the calories, they do not like the taste, they do not like losing control, maybe they had a family member who was an alcoholic.

Most of the clients, I asked them, how many people do you think not drink? They think majority of the people have a problem, that not everybody drinks.

(Away from mic) the next group is what I call donuts. They drink within normal limits. The reason I called them donuts is because having one or two doughnuts occasionally is not going to hurt you. Having multiple doughnuts every single day will eventually lead to serious consequences.

Again, this group does not mean they over drink sometimes and have a bench and a consequence, but normally if they have had a binge or problem with alcohol use is a night or a period and they have the night home, and it's not on a work night and does not cause problems, if there is a fight or over drinking, if there is a fight these people are not needing to drink.

The next group is what I call cucumbers and it's 22% of the population who are starting to experience mild to moderate alcohol use disorder. They are not yet addicted, they do not yet have tolerance or withdrawal, they could progress to that, but their amount is going up. Their frequency, the impact, they are starting to have problems.

The idea for those who are familiar with AA and 12-step models, the old saying used to be: "once you go from a cucumber into a pickle, you cannot go back."

I will give you data that challenges that. That was a huge paradigm shift for me three years and during that treatment. To 2%, mild-to-moderate, 6% meets criteria for severe alcohol use disorder. Many people self identify as alcoholic. They've got tolerance, they've got withdrawal, this group of people, devastating consequences for them as well as the people who love them.
So, this number is significant, but it is a relatively small number.

The first, 16%? It is 19 million people in the United States. That is everybody who fills the state of Florida. This is significant because most treatment is geared towards this group of people, however, 90 million people experience mild to moderate alcohol use disorders. This is in the yellow. This is the amount of people who fill the central time zone. 19 million, huge number, all treatment is geared towards them, 90 million, people who have mild to moderate. This is why we need harm and action and alcohol moderation, this is a much larger group of people who does not need residential or detox, who is better served with education prevention. Therapy, more than outpatient basis.

So, moderation management. It is a wonderful program. A lot of education, resources, groups that are free to the public. I would say it is the AA of moderation. It is available online. Moderation.org.

They also found 22% of people avoid health, and 90% of drinkers experience and problems are going to avoid getting help. The 22%, I cannot do the math. You have to help me. (Laughs) 90% of 90 million is 80 million people. 80 million people are not getting help. Because they do not like that alcoholic label. They do not like the stigma, or understand the twelve-step model. And higher power.

They are often given inappropriate level of treatment. I know when I was in school, the small class we have about addiction was, "You have a drinking problem? You have to stop taking forever and admit you are an alcoholic and go to AA."

A lot of people have said to me, "Your approach is the reason I got help." If you told me I had to quit drinking or do twelve-step to get your program, I would not have come. People tell me that on a weekly basis. I had the opportunity to engage people and help them prevent their disease from regressing.

I asked a question a couple of slides ago that said, are you an addiction treatment provider? I will ask this question now. Or do you treat substance use disorder? I treat substance use disorders. I treat addiction, but more of what I treat our alcohol use disorders. There is a bit of a shift, and again, if you are in detox or residential, you are treating addiction, likely, but most of us are treating substance use disorders.

(Multiple speakers)

CRAIG JAMES:
Here’s what we know. This is a model looking at what alcohol use looks like.

The idea is we can increase, these are the people who do not increase at all, we can have clients that have alcohol misuse and dependence, we want to have it reduced in seriousness, what alcohol production want to do, we want to move it from heavy use to more safer controlled moderate use.

They may consider as we address the why they might find themselves abstinent and we will talk about that later but we found the numbers we see with our clients that are trying moderation choose abstinence long term because the why has been addressed.

CYNDI TURNER:
This is me. I will jump in.

(Multiple speakers)

CYNDI TURNER:
People ask me how I got into this, I have worked in inpatient and outpatient, but I worked in an outpatient setting, Craig and I worked together, we were treating people who had DUls and they were in the alcohol safety action program, court mandated treatment.

Because I was taking this harm reduction approach and celebrated successes and dealing with mental health, once people completed their court ordered treatment they would voluntarily stay on and continue working with me. At the end they would ask me, "Can I keep drinking?" And I thought, I know some of you probably should not, but some can. What does this look like?

I wrote the first book, ‘Can I Keep Drinking?’ and Craig and I presented at conferences and training other colleagues, and wrote another book with updated information, the clinician's guide, but what kept happening was people would say, "There is no research for this. This does not fit what we do." I went and found there is 50 years of data that shows that harm reduction and alcohol moderation is a viable treatment. That blew my mind! How is it that only 10 years ago I learned there is actually data?

So, this is a lot of the research. These are the main ones. We skipped over a slide. Here we go. Somehow that skipped. The 50 years of research – I want to go to the highlights. I will not go into all of them. The research started in the 1970s.
They were in California and moved into Toronto. They found that drinkers with tools can control their alcohol use. I was like, "What?" They did not once, but repeated the study twice. Because this went into the mainstream media and people were like, "this is not possible, this is not true." And the word control is scary when you talk about addiction because it is a loss of control.

Later on in the 70s, the RAND report found it was possible for nondependent people to return to drinking, the mild and moderate substance use disorder, people said, "This is not possible" so they did not once, but twice and found the same data.

Alan in the 80s talked about moderation, and everyone knows who Alan is in relapse prevention in the work he did. The Institute of medicine in the 90s, the treatment alternatives to abstinence – that is not the only way to do it.

The NLAES (Reads) I always get it wrong. (Laughs) They found more than 50% of the dependent drinkers, people who are alcoholic or have a severe alcohol use disorder, more than half of those could change their patterns. At the time they would not be DSM for criteria. Huge paradigm shift!

We are saying people who have a problem with alcohol can actually go back and potentially safely drink. The World Health Organization found with interventions people can reduce the consumption by one thirds, and that is reducing to a potentially safer amount and frequency.

NESARC (Reads) I looked it up before we presented again. They found 30% met criteria, but 70% can return to safe levels. Throughout the decades, we are finding that we used to believe, want to go from cucumber into a pickle you can never safely go back? The data is showing that is not the case.

For me, I have to wrap my head around that. Again, these are the main research studies that I found, a whole first chapter of the commission's guide. It goes over and a lot more depth than other people like Stanton Peel and other people who have done research. They have bumped the system and shifted the paradigm.

But I will say, what my client said a few years ago, "It is like petting the Dragon." Having to make the decision, is tonight a drinking night? What will this look like?

My client said petting the Dragon was too hard.
Paradoxically, when you tell someone they can do it, they can actually then say, "This is not working for me." over months of therapy, structure, tools, and meeting with their family, half the people decided to stop drinking completely and become water.

HALEY HARTLE:
We are giving a bit of feedback it is hard to hear you. I do not know if you are just further away from the microphone or what, but just wanted to give you a heads up.

CYNDI TURNER:
OK.

(Multiple speakers)

CYNDI TURNER:
Thank you guys.

CRAIG JAMES:
Moderation defined. Part of the research is getting back and looking at, well, what does a drink look like? The American heart Association dietary guidelines for Americans and sensible drinking guidelines.

A lot of this is looking at what people are told is OK and acceptable, for the first three agencies, one drink per day for women and older adults, two drinks per day for men.

If we take a step back and look at the numbers here, you are saying that men can have two drink per day, for a week? That is 14 drinks a week. We will eventually develop tolerance, what will eventually happen?

NIAA’s definition was different but similar. We are talking about falling. They are looking at it and their position was for women, three, and women and older adults were three, four for men in a single day. About the amount you are junking.
Cindy and I talked about this and provided some context.

What counts as a drink? A lot of this is — when we talk about assessing clients and understanding what’s really going on, look at the can of beer on the left for a second. A lot of times when we assess and train our clinicians and team, if a client says they had a beer, was this a 12 ounce beer or 22 ounce beer? Was this 5%, less than 5%, or IPA?

Try to understand what our clients define as a drink to give us context as we work with them on alcohol moderation, I’m a big fan because in Northern Virginia and we have a lot of wineries and breweries in the area, excuse me, if you have a bottle of wine, you should get four glasses out of that. We have clients that said, I had a bottle of wine into glasses. Are they drinking out of a traditional glass or a goblet? Asking you all to take a step back and think what counts as a drink.

With all the research and taking a step back and working with our clientele, this is what the insight definition is about drinking. We are not encouraging clients to drink daily. We are also suggesting you have no more than three things any given time. For the moderation program, we say, “family members, how does your family member feel about alcohol use?”

Are you drinking for the mood, or the enhanced flavor of a meal?

The reason we say two to three drinks is try to keep that BAC below .055. This is why. A few years ago, the Department of Transportation contemplated changing blood alcohol content, legal — it is currently 0.08, they talked about making it 0.06, and if you look at it when BAC increases we go from slight euphoria and loss of shyness. Maybe a glass of wine reduces the anxiety if you are at a party, or at home relaxing, you can relax a bit more, maybe you can enjoy the moment and that time.

The more you drink, you will have that warm tingling sensation, and you will lose inhibition, and see loss in reaction time and memory and judgement will be affected.

The reason we encourage clients to stay below that point 0.005, is to stay in an area where you reduce potential consequences.

Practising alcohol moderation, what does it look like? That is what we are here to talk about today. The first thing we do, this is always to shock the clients because we want to get them in the room, we recommend four months of abstinence. Why? There is a method to the madness. If you think about a
calendar year, we are looking at four months. In any quarter of the year, you will have some type of celebration whether it is a national holiday, some type of event, and we want to help clients work through those events.

We will have people who say, "I cannot do four months. I will do 30 days." We will start with 30 but we recognize the longer we can keep or ask the client to sustain, the more likely we are to work on the things that are going on below the surface. In focusing on the why.

For four months they can develop refusal skills and role-play ideas about, "What will I say in these situations?" What's interesting is when we talk about a client, reducing risk and talking about the one-liners, many clients get nervous, what will I say if they ask if I want to drink? Many do not consider, no, I am fine, I will have water. Many will go into situations and say, "I thought it would be this and it was this."

If we get 30 days or 60 days we will take it. How do we manage risky situations and deal with problems, and identify coping skills and work through things they did not think they could work through, were not given opportunities to work through, that is really what this is about.

(Multiple speakers)

OK. Go for it.

CYNDI TURNER:

The Alcohol Moderation Assessment. The first one I developed was the can I keep drinking quiz? That was for my clients. We began training, and other people started. I realized it had to be done with the clinician in the room.

One of the ideas of harm reduction is it is accessible to everybody, Alcohol Moderation Assessment, what it does is it gives productions for person's ability to moderate. I updated in 2019 and it looks at the last four months.

Some of the questions have to do with their entire life, most of them is there drinking over the last four months. What I imagine is this is used like the audit. In a primary care setting, or probation office, or clinician, or even the person at home wondering, "Am I having a problem?" Or they had a fight with a loved one and said, "I am worried about your drinking." In the privacy of their own home they can take
this evaluation and it's available on these two websites, it is currently free for people, you are able to use it and have people come and take it as well.

This is the actual Alcohol Moderation Assessment. They are yes or no questions. A lot of this is based on the DSM. The first 13 questions, I will go to the next one – we will go through each of these questions.

For questions one through 13, you give yourself one point, –

CRAIG JAMES:

For every yes.

CYNDI TURNER:

A lot of these have to do with tolerance and withdrawal and it's not all gloom and doom questions, 18 to 20, they are actually – thank you. (Laughs) Protective factors with it gives you a total point. And it matches you, you will find good is someone who does not have alcohol use disorder, fair, poor, and unlikely as a mild, moderate, and severe, and if you notice, it is water, donut, cucumber, pickle. There is a whole methodology to why the assessment is the way it is.

CRAIG JAMES:

A lot of the assessments is based on the DSM, as Cyndi.

They talk about abuse versus dependence, it felt like a yes or no, light switch on or off. Five speaks to that moderate or severe because it looks at it on a continuum. The Alcohol Moderation Assessment looks at, and takes into account, the DSM-V and we highlight these five points here because if a person is experiencing any of these factors, they may not be a candidate for alcohol moderation.

We are not saying they should not, but these are things that we need to be aware of as providers, somebody working with clients. "You can try it, but the fact you are having cravings does not indicate you are a good candidate. But we can give it a try." If a person is experiencing issues with tolerance or having withdrawals, really not good indicators.
It is something we can really look at and consider with clients, as we said earlier we are talking about education, information, to figure out and help them self assess, "Should I do this, or should I not?"

CYNDI TURNER:
What you can do with your assessments, a lot of clients will take it ahead of time and realize, "I came out as a poor candidate" and come in and get therapy. We do a pre-and a post. They come in and engage with services, we do treatment, at the end of that for months or period of abstinence, they take it again and are likely, if they have managed those areas, they are likely a better candidate at that point.

CRAIG JAMES:
Based on those questions, if we go back here to this, good, fair, poor, unlikely, it corresponds here as well. If the client takes it and they identify two to three symptoms, it is mild. Four to five is moderate alcohol use disorder, and more than six is severe.

CYNDI TURNER:
Just so you know – the presentation was submitted prior to March before the new DSM came out. We have a new DSM up there.

CRAIG JAMES:
We will go right now to the questions so you can understand exactly what those questions look like that you may take, or a client has taken. Do I have more than two or three drinks, more than two drinks a day for men, one for women, or older adults?

If they are managing and staying in what's acceptable drinking, they are good candidates. Here it is talking about frequency and impact. If you are drinking daily, not a good idea – well, we do not want you drinking daily. Does not mean you are a good candidate but it's a high concern for us.

We are talking about moderation guidelines and we are not saying alcohol is bad, but the frequency of what somebody is using is a concern for us to talk about.

Has it increased? Has my alcohol use increased over time? We are talking about tolerance. If you remember back to the DSM, tolerance is a big concern. It may mean mild-to-moderate, or moderate to severe potential issue, we do not know, but we want to talk about why.
These questions are pre and post-, early on, may not be a good candidate, but as we do the clinical work and meeting with them whether it is once, every other week, and they are working to this program they make become a candidate.

We talk about alcohol in terms of tolerance and we are hoping they are staying within what is inappropriate serving size and considered appropriate serving size.

When I drink, do I have a hard time stopping, or is it like flipping a switch, is there a Jekyll and Hyde component to that? When I drink, am I more gregarious, do I become more aggressive? What is going on here?

(Reads) We are looking to have that conversation with clients. This question speaks to criteria, number two, a person's inability to cut back or cut down on their use. Medical conditions.

I had a brain fart. Go for it.

CYNDI TURNER:
This goes to DSM criteria, despite physical prompts exacerbated by alcohol was interesting, last month I had a physician in my office, a flight surgeon in the military. She studies internal medicine and was reading an old book in 2002 that said, "One or two chinks is good for you." At the same time, I was like, oh.

the 2002 study study to thousands of data and found there is no safe level of alcohol.

It does not mean nobody should drink. It means there is not a safe level because we still consume sugar, is there a safe level of sugar, or hydrogenated fat? There are lots of behaviours we engage in that are not good for us.

But the data that was put out about one drink of white wine a day is good for you for step do you know how that was funded by? it was funded by the wineries, those kinds of things. Alcohol does affect every organ in the body and weaken the immune system. Our goal is to find a safe level for the individual.

CRAIG JAMES:
Are you taking medications? If you have a medication box and people who are taking something for anxiety, depression, or attention deficit, what is happening when you take the medication? The bottle says do not take with alcohol, we asked the check with your prescriber because you can have this synergistic effect.

Para... CHES

CYNDI TURNER:
You take alcohol and caffeine and (Static) (Static) again, one may not have a harmful consequence but 10 will.

Our moderation plan is a bit different than it is for a woman who is 52. This is individualized treatment. People have asked us, "Can you do this individually or in a group?" Yes to both. Clients can get a lot of data on moderation management and go through the workbook and do this individually, we can do this on an individual basis and we run a harm reduction group, and my goal with the workgroup is – what is everything I do with a client in session, and I put that into a workgroup to be used with everybody.

We know we can only practice in the state when we are licensed and they get people calling me from all over the country saying they read my first book, can I work with you? I did not want to say no I can't, and I wanted to offer some services, and then also train others to do it. Next one. I will do it. (Laughs)

(Reads) Have there been repeated consequences from my use? This is DSM criteallrion five, six, and seven, use resulting in failure, continued use despite interpersonal... I will first connect with the client who is struggling and potentially bring in that other person and ask those questions, how does this affect your husband or kids? Have they said this or that? That can be tough, because they do not want to admit there is a problem.

Often there is some type of motivating event that brings them into treatment. A lot of our clients might be court ordered or spouse ordered into treatment.

CRAIG JAMES:
Have I experienced trauma? My father said this when I was younger, if you take care of your body, your body takes care of you. The thing that is interesting about this slide which I want to share is 60% of people with PTSD developed SUDs.
Your body will protect itself from a traumatic situation. When we start to bring alcohol into deal with the trauma, alcohol might give short-term relief and long-term it prolongs a distress the person is going through which affects emotional connection and withdrawal, which eventually calls a problem because the person will say, "I drink yesterday," and they drink more, and more, and build tolerance.

I'm saying while alcohol might provide temporary relief, it affects the body's ability to take care of itself. It is a self-sufficient system. Our job is to provide nutrients.

Do I drink? Am I looking to change my mood? Going back to that idea earlier of why, we are looking to understand the why - is this to change your mood? Is this to relax? Are you having a beer for the end of the day? Are you having wine, or a cocktail? What is the Association you are having with your alcohol usage? Champagne is for celebration, a cocktail is a party, wine is relaxation, and maybe it is a beer.

We want to see the associations with their alcohol use because it can be easily subconscious. A lot of what we are doing is making people aware and making it overt. We were at a conference last year and a therapist made the statement and said, "I went into therapy to help people get better. What I found it early on is folks can make themselves better, my job is to get the barriers out of the way so they can come to those conclusions on their own."

What I'm looking and talking about is – what is that they need, or not getting? Once they treat that, they might be good candidates for alcohol moderation, they will have a better relationship with alcohol.

The impact on loved ones. What you all probably are aware of and notice is one person has been drinking, the family system is affected. There are issues of trust, and it is very, very disruptive. The spouse has a problem. The children has a problem, and we want to incorporate the loved ones in this process to understand and get their sense of what is happening.

If you are doing this you will have the spouse say, "Did she tell you this? Did he tell you this?" Yes, they did, but we want to get the family involved in that process, not as an accountability partner because that affects the dynamic of the relationship, and we will talk about that here in a moment.

CYNDI TURNER:

That last bullet here – the person who is struggling with the alcohol use, they are the identified client.
if there is a power dynamic, or the trust dynamic in the relationship, it changes, that person is in the
doghouse. It is lower.

But when they take alcohol off as a focus, then the other person can be addressed. Maybe the person
was downstairs drinking because there was not intimacy in the relationship, or hurts that wasn't
managed. Those are the things that, when we stop making alcohol the focus, and be go through that
period of abstinence we can start doing more of the therapy.

It is really amazing as a therapist for clients to come in and assume I am going to tell them and berate
them, "Don't you know how bad alcohol is? You've got to do this!"

But most of our focus is not about the alcohol. A lot of people say, "We haven't really talked about my
drinking, but it's gotten better. I didn't realize I had a drinking problem, I had an anxiety problem, a
relationship from, work problem, etc."

You get to do a lot of really amazing work. It's about the alkyl, but it's not about the alcohol.

CRAIG JAMES:

That's what we mean when we say we work on substance abuse disorders.

At the bottom there, over 60% of people are occurring. We note drinking has an impact on medication. I
often share with spouses, parents... "What is this person keep using?" Because it works with the that's
that fourth bullet.

Most of our job is to give patients alternatives for what's going on for stop I know if I'm anxious,
overworked, if I go home and have a cocktail, I will relax.

Also just go home and go for a walk, right? There are other alternatives that we want to make sure that
clients are aware of.

Sometimes substance use robs you of the chance to let you know you have the capacity to work through
things. We turn to the thing that is quick and easy.
Using other substances. We may call this a lifestyle, transfer of addiction.

We've had clients say in the past that they've stopped drinking, "How did you do it?", "Well, my marijuana use went up." We want to understand are they using other substances in addition to just alcohol? We want to understand and watch with happening there.

CYNDI TURNER:
So hopefully you see that this is a therapeutic process, and hopefully you help them not use other drugs, their dependency on alcohol is less.

CRAIG JAMES:
This is the 22% that we did fight earlier. These folks, this is who we are shaping a lot of this too. Not that the 6% can get a lot to this, but this is how we get that 22% from becoming that 6%.

CYNDI TURNER:
Because also a harm reduction technique is, maybe you have someone who is drinking every day, who is addicted, but if I can help that person reduce it a little bit, or stop drinking and driving, that is harm reduction. Those are harm reduction techniques, that's not necessarily alcohol moderation techniques.

CRAIG JAMES:
Question 12. We do not encourage alcohol moderation if you have legal situation. Let us satisfy that first before we participate and try this. It's just smart and wise because your freedom is at risk there, potentially.

Environmental factors. This is question 13. The nature, nurture question. There is no one gene, as it says here. However, we do know that you are four times more likely to meet criteria or if there is a family history of substance use disorder.

CYNDI TURNER:
Direct.

CRAIG JAMES:
Thank you! A little different...

Withdrawal symptoms. If you are experiencing withdrawal symptoms, you are probably not a good candidate for alcohol moderation. With all symptoms, or probably not looking at this, were looking at detox, medical stability to even consider this. What we know is, with withdrawal symptoms, as well as... those are the blackouts we will get to in a minute. The physiology of the brain is changing. So we really want to be careful here.

CYNDI TURNER:

However, again, the data is showing about half of those people who met criteria for severe alcohol use disorder, some of them come and go back. Do not refuse treatment and say you can never go back because people are still going to make choices. I would rather them make a healthier, less risky choice.

In the few that Craig will go over here, the 14, 15, 16, 17... these are two points. These are more risky and more dangerous.

CRAIG JAMES:

With interesting is, we had a client the other day, yesterday as a matter of fact, coming in or program and she was talking about her drinking and it's increasing to the point... "My perfect drink is about six. I like really high IPAs, alcohol content beers. I'm going to the doctor next Monday to have my liver enzymes tract." and I said it was interesting because having those enzymes checked, shows that a problem is likely. But you may have good liver enzymes in the you still might have a problem.

A lot of clients, there liver enzymes look normal, but their binge drinking constantly.

CYNDI TURNER:

Starting stopping?

CRAIG JAMES:

Did I miss that? Thank you!

So, we have had clients, and the research speaks to the fact that when clients drink, it is affecting the liver, it is hardening deliver, they start, they stop, it actually causes... this is the impact in terms of
cirrhosis, and the fattening and the Harding and the scarring of the liver. It's actually not a really good idea to start and stop, started stop. It affects the body's process of taking care of itself, of losing...

CYNDI TURNER:

Basically, the liver is the only organ that regenerates. So when you start drinking, the liver actually starts to repair, this is heavier drinkers, people drinking multiple drink today. It's basically this baby fresh cells, that then you are putting the neurotoxin back into it. So people say, "You told me to not stop drinking!" This is the heavy drinkers. This is why we like to know about those liver enzymes will stop if somebody has a damaged enzymes, they are really not a good candidate to do this.

But, we still want to help them be healthier and more balanced.

CRAIG JAMES:

Blackouts. Not passing out, but blacking out, making that distinction. Blacking out is when the night continues and you have no recollection. The body has gone to preservation mode. It is taking care of the vital organs, which is why the memory is gone. We also say that blackouts are brain-damaged because the brain is not getting oxygen. To remember. To encode.

So if a person is securing thing blackouts, not a good candidate. Again, were talking in the last four months. If they had blackouts in college, that's different, were looking at the last four months.

The last piece here, another to pointer. If the person were to answer yes to this. We know through neuroplasticity and nuero biology, the brain doesn't stop developing until 27. The picture that you see is not an actual client, but a clients experience which was that they had their first drink at age 10.

Again, we we are really hoping the clients, and adults teaching their children, if we can delay drinking, we can delay a person meeting criteria. We really want the brain to develop. We don't want what is called cell adaptation, that the body becomes used to that foreign substance and needs that substance to function.

CYNDI TURNER:

Number 18, 19, 20, those are the protective factors. These, again subtract the point out.
While I review my alcohol use with my support system? This could be a spouse, someone in, say, moderation management, this could be a therapist.

This person should be able to offer perspective and accountability. So, the client or the person who is trying to change their alcohol use, they have got to train that person, how do I confront you what I’m worried about you? They will have typically developed on alcohol moderation plan by this point, and we will go over that in just a couple more slides here.

For example, this person may have a great moderation plan, Saturday's the data go out and drink, so they may let their accountability partner know that on Saturday or going out of a couple drinks that there committing to do, and then that person will call them after and asked him how it went. How it worked.

Another protective factor, do I have alcohol outlets or hobbies? Craig to alcohol free.

CYNDI TURNER:
What did I say? Alcohol free! (Laughs)

It is always so sad to me to know when I'm sitting with a buddy in their 30s, 40s, 50s, and I asked him what they do for fun, and they look at me blankly. And they're like, "I drink. I go out and I party. That's how I relax, that's how I do things."

I talked with my clients that it is much easier to add activities than to take them away. If you're going to sit home and not talk to anyone, not talk to your friends, you are going to be miserable, and you are going to relapse and have a problem.

I talked with them about, "What did you enjoy as a kid? Why did you stop doing that? Can you still do those things?" Look at what will you gain when you either remove or reduce your alcohol?

A mom that I work with, she was not drinking terrible amounts, she would have maybe two to three glasses of wine a night, but she was not able to drive her kids full stops or kids would ask her to go over ice cream, and she would say, "I probably should not drive. In quote so she was preventing herself from having fun with her kids, and she went through a period of abstinence and was really like, "Well! I can go out or even let my kid go out and have fun because then I can pick them up and do the carpool. I don't have to worry inhabit anxiety."
Again, as Craig talk to but a few slides ago, that Association. What role has alcohol been playing in your life? Can you change that pattern in some way?

Another client I worked with, a business owner, really overwhelmed, phone was ringing all the time, and what he would do is he would go to a restaurant in the middle of the day, turn his phone off, sit down, take a break for 20 minutes, and have a drink. I said, "Did you feel any intoxication from the one drink?" And he said no. "Did you feel relaxed?" Yes. "Why do you think you fought relaxed? He turned his cell phone off, he told his office manager he was taking a break, he sat down and relaxed. I said, "I wonder if you just had a salad or sandwich, went for a walk... with that work?" Those are the moments when our clients look at us like we are a genius, which I just love, when it something so simple, that they are in their one track perspective in their life, and we can look and explore what else could they do?

CRAIG JAMES:

I have to talk with clients about the idea that cigarette smokers have the best coping skills except they smoke. And they say what you mean? And all cigarette smokers do the same thing, not baking, but cigarette smokers.

Number one, they change their focus because they have to find their cigarettes and their matches were there later.

Number two, they change their access or proximity to their stressor. They usually go outside.

Number three, they breathe.

That is something that I work with clients about, teaching them those three steps. Focus. Proximity. Breathing. Basic skills that we think about, just don't smoke the cigarette. It's about providing clients with perspectives that they don't often see.

CYNDI TURNER:

Number 20, am I willing to go through a period of abstinence? So, if the person says "Nope! I can't do it! I won't do it!" There probably addicted. There may be a withdrawal, so they will need a different treatment. During the period of abstinence, hopefully they will have some insights. A lot of my clients say that they didn't realize they were the ones who was like, "Let's drink! Let's have some wine!" And they find when they explore other activities, they are enjoying those things or those relationships.
Keep in mind, again, this is a paradoxical intervention. When you tell somebody that they can keep drinking, that you're not going to take it away from you, but let's try some other alternatives, about half of those clients continue with abstinence.

Now, this doesn't mean that some clients don't struggle. We may have some clients to... they were drinking on a daily basis, having consequences, problem other job in relationships, their kids... they had their period of absence, they went back and implemented a moderation plan, but it might not work. So, they come back. They rework it.

Again, I don't look at it like the plan failed. I look at it like... "You had eight months of doing well! Let's look at what happens..."

CRAIG JAMES:

What did we miss?

CYNDI TURNER:

... Exactly, what wasn't working? I look at a problem or relapse as what can we do differently? Because life circumstances change the topic we do and alcohol moderation plan with someone in their 30s, then they get married and have a child, that is going to look very different than someone who is single.

So, we have to take into account what is their lifestyle look like?

Before implementing an alcohol moderation plan we want them to know what are the biopsychosocial consequences that they experienced? Have they manage those? Are they likely to continue if they drink in moderation?

They should not have a physical dependence on alcohol, they should not be using other drugs. When they drink, hopefully they are not acting destructive. If they are, there is a problem.

Again, with that BAC, below a .05, we are not seeing much physiological and emotional and dopamine changes, and all of that.
Before implement in the plan, they should all, hopefully, have had a period of abstinence. That four months that we talk about, that is also to help the brain and body repair and reset, and see what their baseline is.

Many times, people are getting all sorts of treatments for their insomnia, for their anxiety, for their stomach issues... and it was all alcohol-related. So, were letting a brain and body heal, and the other, again, is postacute withdrawal syndromes. So not those acute withdrawals that are managed in a detox setting, but these are, again, those neurotransmitters are resetting.

We describe the mood changes where, the taking your shirt is driving you nuts! We usually find that that takes about three months to reset from most people. That is why we recommend a four months not just 30 days.

We want clients to have experienced a range of positive and negative emotions. We've had people who, let's say, manage their depression, but then they get a promotion. Or something great happens! What did they do at this point? So, helping them look at other ways to manage the positive.

Again, managing the legal, probationary, work... again, it if you work as, say, a pilot or a nurse, a Department of Transportation... you have got to follow your job recommendations. You can't say, "I have a moderation plan and it's OK!" You have to satisfy those, and build that trust that family and friends.

Craig is gonna go over the actual alcohol moderation plan. Again, it's available in the workbook as well as in the clinicians guide.

CRAIG JAMES:
First question is, why does a person want to have a moderation plan?

This is a lot of fill in the blank. This is their answers. Is it, I wanted because I want to enjoy a cocktail after dinner? Do I want to celebrate an accomplishment or a child's wedding? Or, do I want to get intoxicated? Am I looking to do it to change my mood? So those are questions we are asking clients to come up with. A lot of this, their answers will tell you where they are and if the ready for this.

I will not drink in these situations. So, I'm not going to drink and drive. I'm not going to have a drink at happy hour with my colleagues because it's problematic. A lot of these answers come from, not just the
assessment that we do, but also the work, and their ability to identify there been problems, and where things have worked and did not work.

Question three, I will not drink until... this was interesting because it's whether were going to go to a sporting event, I am not going to pregame. I'm only going to drink once I get inside the game. If I'm going out for an event with my spouse, I am not going to have the preparation cocktail...

CYNDI TURNER:

The dressing cocktail.

CRAIG JAMES:

The dressing cocktail! So it is determining when you will and when you will not drink.

I will not drink after what? So if we are at a sporting event, I'm not going to drink after halftime. Or, I'm not gonna drink after two drinks. Really helping clients decide.

CYNDI TURNER:

I had a client recently who determined his plan, having a nonalcoholic drink after his alcoholic drink. He did well, he was the designated driver, he stuck to his limit. But then they would go home and they kept drinking. That's when he lost count and it ended up being an awful night. So I asked him what he learned from that and he said, "I learned if I come home, the night is over. I don't need to keep drinking." He also realized doing shots was not a good idea. Drinking when he doesn't know the amount...

So, again, I don't look at that as failure, look at that as success because he had a plan and then didn't plan for all of the contingencies. He learned something new.

CRAIG JAMES:

It's also interesting with this plan, with our retirees. When will you drink? So, if I'm retired, I have all day! We've had clients where "I can drink all day! I will drink until after 2 o'clock. In quote or the person who had daylight savings time...

CYNDI TURNER:
(Laughs) Yeah, he said I'm going to drink at nightfall." Well, we can do plan this in the summer when it's dark later on, what about winter minute circuit five?

CRAIG JAMES:

Said he talked about the type of drinks, it's easy when it's beer, or wine or a glass of water, sometimes clients don't always think about it, and that's OK because reteaching them a healthy relationship with alcohol. In quote what's the nonalcoholic drink that they have? We have a client of Cindy's, Jim, we can say his name, came up with the Jim Bellini which is...

CYNDI TURNER:

Again, he was someone who had doubled with moderation, and ultimately decided it didn't work for him, he was going to choose abstinence. He worked in the hospitality industry, so he had been catering, bartending, and he said, "You know, I have been clean now for over two years, but my birthday, I just want a drink. I feel like I'm missing something." And I looked at him and I said, "Jim, you are a bartender. Plan a drink for yourself. Make a cocktail." And he did. And we named it the Jim Bellini, and he is given me permission to share. It is a combination of lemonade, peach nectar, and sparkling white grape. It is absolutely delicious, it's vested with bubbles. We have had it at our open houses. I have added for baby showers.

Each year he is been abstinent, on his right knee date, he comes in and we have Jim Bellini's here. So, I encourage... there is a lot of the sober movement happening. There are so many mock tales that are just fun and tasty that people can have. So I encourage people to explore. I will even ask, "What drink did you like?" They love to Jim and tonic. Can't you still have the tonic with the line? And people didn't think about that. A piña colada is a vacation. You can still have one, just don't put the rum in it.

CRAIG JAMES:

Or coming up with new drinks because that might recall a negative association.

That next question, I will have no more than X number of drinks per something, for a total of this. So I will have no more than one drink per hour for a total of... Three? Per day. So it's really helping them understand what the limits they need to set are.

Who will they review their plan with? It can be a therapist, a friends. We often suggest that if you are going to use someone, and know those different types of drinkers, the water. What they may not understand the challenges. We also say that maybe a cucumber is not the best, pickle! Speckle, sorry, a
pickle may not be the best because they have a different approach. So it's probably trying a donut or cucumber may be more appropriate if you're looking for the type of person to review this plan with.

The last two questions, if I noticed something I will do what? This is where the person you are reviewing it with can really help you understand, "Hey, if I noticed that you are... if you say early can have drinks during a social setting, and you're doing more social events, if I notice that headway approach you?" And if you are approached, and we need to make some changes, what we do?

Maybe you create another period of abstinence. Maybe go back into therapy and address a few things.

Then you have the person who is doing the plan, they signed and dated, and their support persons does the same.

Alcohol moderation tools. Again, we are looking to keep that BAC below .055

Number one? Not doing shots. Doing shots has one intent. We know that is a mood changer. So let's avoid shots.

Let's only drink in social situations but we don't drinking alone. If you can delay drinking until the event, and that alcohol is a part of the event, not the main event.

We often say, listen, something you can do for O'Toole's offer to be the designated driver. It's amazing that when people start to do that they realize, "Was I that person as well?"

In the thing that can be scary for a lot of people is that their friends know them is that person. So this is part of that, it's having them understand that may be the case. We are not single getting friends, but how do you limit the risky situations will stopped sometimes you have to step away, and that's something where understanding and therapy.

Having a mock tail. Alternate beverages. And maybe having something to eat will help maintain a BAC below a .055.
Played through 24. So, this is really helping individuals and clients really stop and think. So, you can have a drink right now. What we you feel like in the next 24 seconds? What about in the next 24 minutes? What about in 24 days? Excuse me, 24 days.

You may have a drink and in the next 24 seconds you may feel nothing. But, in 24 names have you had one? Or two or three? And will you remember 24 hours from now? What's going to look in about a month?

So really helping client to stop and think and look at making the best possible decisions.

CYNDI TURNER:

I call this the glassed jar. And this can help somebody working in moderation or abstinence. Whether permanent or one term. So I asked clients how often they were drinking in a total week. Will get a total. So let's say I have a wine drinker, they're having a 10 $15 of wine each day. So I have them go out and I have them to get some fives and tens. I actually want you to physically get the cash. I actually want you to have a clear container. I want you to put that in a public place. In the kitchen. Where, let's say, your spouse, your family, your roommates, whomever can see it. And what they do is, if their commitment is, let's say, abstinence for a period of time, and they choose to drink, they need to put... other way around. If they don't drink, they put in that $15. If they do drink, they take it out. At the end of a set period of time, one, if that jar is filling up, that's motivation for them. It's a tangible reminder of the lifestyle changes they're making. And it builds trust with the family members and the people they live with because they can see that that jar is growing.

At the end of that, with the amount that is there, I encourage them to get something tangible. A female could do something that they wouldn't normally spend money on. A manicure, new purse, whatever. A man can get upgraded seats to a game, by a putter. The nice thing is, having a tangible reminder of how much money were spinning on alcohol, and now you have this thing, or this experience.

This works of people who are lower income, and even our upper income people who are able to afford it, but when they see, "Holy cow! I didn't realize my credit card bill was so high when I had a bar tab in that bottle of wine at the restaurant, and everything. Or my grocery bill is a much smaller." So this is a multiple layer exercise that hits them to look at how much were they spending, building trust, providing tangible motivation.

So, preparing to drink again. This is still weird for me working on the past 10 to 15 years with clients. This is an odd thing to do but we have to prepare them to drink again. We want them to know what this is going to look like.
So, one of the things they have to be aware of is what is the impact of losing their clean date? Most of the people did the daily counter, they been clean for 42 days... three months... what does it mean when you lose that clean date? For a lot of people, this is how they were getting trust back, this is how they were overcoming some of their guilt or shame.

Then, also, we have to prepare friends and family. He may have known this person is the party or the drinker, then they start drinking. Then we had the nonalcoholic beverages for them. If they start drinking again, what’s that mean? So, it is important to have them prepared, to let them know what this will look like the person that they associate with, and what does it do to our trust?

We want them to pick a person to have a drink with. I don't recommend doing it alone. I don't recommend doing it at home because it's too easy of an association. So, pick the person, the place, and a specific drink. If you’re just gonna go out for cocktails. That's not a good idea. You want to say specifically, "I am going to have two..." specific beverage.

Then process it. Do not make alcohol the made event. Don't pick a bachelor party to be the first time you have a drink again! Don't pick an all day sporting event. Have it be something where it is not the main event. Then evaluated. Did this work? What do I need to do different?

Because the first couple times a may not work. Again, those are data points.

But if they find that every time they have a drink there's a problem, there's a problem! (Laughs) So we need to do something differently.

So, we talked about the alcohol moderation plan once someone does go back to drinking. I created the quick check which really monitors how is this working? What is the frequency in which I’m drinking? Did I say I would do it only once a week and now it's creeping up and it's twice a week? Three times a week?

A physician I'm working with, actually a dentist, she did her... four months abstinence, then went back and she was only going to drink in social situations outside of the home, she did well the first couple times, but then they went on vacation, and she had something every night. Again, she only had one or two glasses, it wasn't that much, but then she got home, and her husband said "You want another glass of wine?" And she figured it was snowing, it was pretty, why not. And then she realized she slipped into drinking more than she wanted to and she needed to evaluate.
So what's the frequency, watch if you stopped counting the pours. It's not really 1 ounce shot to my drink, it's... I don't care how big it is! I keep pouring! So how much am I drinking?

What's the impact? How is this affecting me? How is this affecting. If I used to work out in the morning, but I don't because I'm hung over. If I find them having fights with my loved ones. If I'm not doing my responsibilities the next day. What impact is that having? Am I happy with that impact? Finally what is the intent. Is it to enjoy the taste of something?

People ask is how often we work with someone. Often it's a couple months and then we come back into a maintenance phase. Often I will see them once a month or so, or, like I said, I have a lot of people that I check in with every three months or so. Whether that is a therapist or that can be an accountability partner or something like moderation management. Hello Sunday morning is another website that offers support groups and quizzes, podcasts, etc.

So the steps of how to do moderation. The client takes the assessment for topic and do that on their own or with you.

I've a client who we will sit down next week. She took it on her own, and we will sit down next week and go through it. Look at her predictors of what we can manage, and what really rules are out and makes are not a good candidate.

We are going to treat the 'Why'. Hopefully during the period you're having a period of abstinence, learning new life skills, getting more balance.

We identify and meet with support people. Ideally, you are going to see them at least twice. Once the beginning, and then once as we implement the plan, and then if you're doing some maintenance work with them you are seeing them periodically. If the plan is not working.

You put the plan in place. Check those data points. You practice quick check.

So, to start to wrap up here, again, (Reads) "Drinking alcohol is like eating donuts..."
Some of my favorite books that I have read and actually had the chance to meet with several of these clinicians, they are all still around, (unknown name) Sanchez Schragis not practicing anymore, but these are great books on alcohol moderation.

Of course, the best ones are the ones I've written! (Laughs) 'The clinicians guide' take the clinician through everything from the research to how do you do this with the clients from the stages of change, to the assessment... to engaging family members, to actually how you... a deeper interpretation of the Alcohol Moderation Assessment. Really the how-to for clinicians for stopped in the workbook is for clients.

It is written without psychobabble that you don't need a therapist to do it with you. It can be done, and in fact we use it in our harm reduction groups here.

So, I see there is... gosh! 22 questions. 23 questions. We are happy to answer some questions.

HALEY HARTLE:

Yes! We have lots of questions to go through, so I’m glad we have a good amount of time. Thank you guys so much! Thank you both that was wonderful.

The main question I want to ask because we have a lot of people asking about it is, do attendees have permission to print out and use the alcohol moderation plan?

CYNDI TURNER:

Yes.

HALEY HARTLE:

OK. So, all of the attendees, you have permission to print that out and use it.

CYNDI TURNER:

My goal is really to reach as many people as possible. To help as many people as possible.
Wonderful. Thank you guys very much for that.

We will bump up here to the top, and we will work our way down.

First question was about the statistic in the beginning. The 35, 37, 22 and 6% stats. Are those lifetime stats? Or any given year?

CYNDI TURNER:
That is a compilation of numerous studies. Some of them looked at a short period of time, like a year. Some of them, like the (unknown term), that is over a lifetime and there are some longitudinal studies. So, basically what I did was, I looked at all of those, and this is the compilation of the data. The interesting piece is this is pretty consistent over many countries as well. This is not just the US although I did focus on the data.

HALEY HARTLE:
Thank you. The next one is, do you utilize the same harm reduction with other substance issues. HR in general seems to follow your approach and research.

CYNDI TURNER:
What I typically recommend is I do harm reduction with other substances, and alcohol moderation with alcohol. What I mean there is, I still work with people who use opiates, benzos, marijuana... I don't like to say legally, "Keep doing this substance," but I'm not going to not help somebody.

So the goal there is to reduce the consequences. So there are different substances, whereas alcohol over 21 is illegal substance. So, if that helps? The goal is really to reach as many people as possible, and reduce consequences.

I will also say this. The half-life of alcohol is different than the half-life of marijuana, which is different than cocaine, which is different than an opiate.

So, you have to know the substance you're working with.

HALEY HARTLE:
Thank you.

Our next one, have you seen any difference in ability to moderate in relation to a source?

CYNDI TURNER:
Yes. Absolutely. I can't remember what number the trauma question was --

CRAIG JAMES:
60%.

CYNDI TURNER:
Over 60% of people who have experienced trauma, which--

CRAIG JAMES:
I can't remember, but--

CYNDI TURNER:
The higher your ace score, the lower your probability of being able to successfully manage it. That is why treatment is important, and coping skills to manage the trauma.

HALEY HARTLE:
Thank you!

CYNDI TURNER:
Adverse childhood experiences will stop sorry! (Laughs)

HALEY HARTLE:
That's OK! I was trying to remember to!
(Multiple speakers)

HALEY HARTLE:

I couldn't remember what it was standing for before, my mind was blinking.

Next one. 12 step program are still considered abstinence for clean-up time the folk who are receiving mats, often lose connection with the group. Are there support groups emerging that are more supportive of Matt or harm reduction?

CYNDI TURNER:

Absolutely. Some of my favorites are moderation management. Again, go to moderation.org, support groups all over the world. HAMS, which is literally harm reduction alcohol moderation support for stopped are not as prevalent. (unknown name) was an offshoot of moderation management. And the other is hello Sunday morning, that is an Australian group that runs groups, and will also run... sobriety months where, for example, moderation management does January. Dry January.

Other people will go sober for October... so there are a lot of movements that support that 30 day reset.

HALEY HARTLE:

Thank you!

Our next one, do you recommend a period of abstinence before attempting to moderate or gradually cutting back. Or, I assume, client -- starting where the client is?

CRAIG JAMES:

All of the above! Yes! Ideally it's abstinence. If we can't, we start where they are, and we figure out what's the objective? Then we go from there for stopped so, yes. All of the above. Wherever the client is will meet them.

CYNDI TURNER:

My research is found... Martha Sanchez Craig was the first person to recommend 30 days. I have found more success with that four months, again, because the body is resetting and they have more chance to learn those coping skills and talents.
HALEY HARTLE:
Ellen says this remind me of DBT work I did with self-harm clients. Teaching them a nonlife threatening acts to replace the dangerous act of self-harm. Is this the same philosophy? For example, instead of cutting on a self, rubbing your wrist with an ice cube? Etc.

CYNDI TURNER:
Yes. That's exactly it! Less harmful behavior.

CRAIG JAMES:
Yes.

HALEY HARTLE:
Awesome, thank you.

Our next one... Why not use is it (unknown term)

CYNDI TURNER:
Some of our clients utilize that. There is something called the Sinclair method. Doctor Sinclair started, I think in Sweden, I'm not sure... Switzerland or Sweden, some were not here. Basically what naltroxone (?) does is reduces the cravings for alcohol, and it can be done for (indiscernible). A somebody practicing alcohol moderation with the Sinclair method, the idea is if you're going to drink, you take naltroxone (?) and it blunts the pleasurable effects of your less likely to drink as much was the Bible say the US hasn't utilize this very much for alcohol moderation, more for the person who is choosing abstinence.

HALEY HARTLE:
Awesome, thank you.

Next one. Do you think there are limitations to using substances as far as health problems, levels of care, and Matt services when it comes to harm reduction or abstinence?

CYNDI TURNER:
Read that again?

HALEY HARTLE:
Do you think there are limitations to using substances as far as health problems, levels of care, and MAT services when it comes to harm reduction?

So I think talking about health problems, do those because of limitations in being able to successfully walk through the harm reduction process?

CYNDI TURNER:
If I am understanding that right, yes. Because again, if you have a medical issue, if you are taking medication those are all going to be not good predictors for successfully doing it.

Yes, of course, we all have all sorts of other issues. The age of a person makes a difference. Again, the trauma, people in the LGBTQ community. Transgender. There are all kinds of other factors that, hopefully, good assessment by a clinician can look at those, and again, treats that Why, and what they're looking for.

CRAIG JAMES:
I also want to say, it's gonna take this approach for everyone. It's really individualized, which is why you can do some of this in a group setting. You've got to know what is specific to that person you're working with? Because if they have health implications, one drink may do one thing to one person, and another to another.

We have a longer presentation where we point out that men and women, men connection have more drinks than women for two reasons. One, men have more water in their bodies. We dilute alcohol faster and dehydrogenase. The enzyme to break down alcohol. There are a lot of factors individually that allow for, or do not allow for, people to apply harm reduction across the board.

CYNDI TURNER:
And the part about levels of care, I don't know quite... for example, if you're in a detox setting, the focus is not moderation. The focus is keeping a person alive, and protecting them from the withdrawals. Now, that person may say, "I don't care going back to drinking." At that point, I will help them practice harm reduction is the power we help protect your body, your liver, your legal, your relationships... all of that.
More and more, we are seeing more, even in residential settings, the people are embracing more harm reduction, alcohol moderation because the science is that some people can. They can. Don't make that be a barrier to someone getting help.

CRAIG JAMES:
Right.

HALEY HARTLE:
Our next one from Kara (?), for many years I worked with court ordered science where abstinence is mandatory where they are on probation or under court supervision. You've any recommendations to use this approach will focus on a temporary abstinence to avoid jail time? Or do you feel it is an either or approach.

CRAIG JAMES:
It's tough because courts are not necessarily looking into this from a treatment standpoint for stopped they actually have a blanket approach to it.

I would say that a person has to comply with the court requirements, the mandate... They acknowledge the gonna follow court rules. It doesn't preclude you from doing education and the foundation while remaining abstinence, that's how we work for sub that we've approached it which is, let's satisfy that, while you're here, let's look at what got you here, right? Not just the behavior... It's very rare this is the first time you've done this was probably the first time you been caught. Let's do the work behind that.

CYNDI TURNER:
Helps reduce recidivism for future charges. It's like, when you're done with this... it's like preparing for it, what will this look like?

The other thing that is really neat is, over the presentations we've done over the years, we have had a lot of probationary offices, and they are embracing her reduction, and I know a person recently who said she was gonna teach this to regroup, and she was a probation officer.

More programs are starting these types of things because they're realizing that the service works. This is a prevention model. And not everybody is addicted.
HALEY HARTLE:
Thank you very much.

Our next one... what about TH IQ, the substance that is found in opiate addicts and severe AuDs brain. So alcohol use disorder brains, I believe. Wouldn't ongoing drinking cause additional TH IQ to form in persons who are genetically predisposed?

CYNDI TURNER:
Again, they would be ruled out by... do you have any medical issues?

CRAIG JAMES:
The historical aspect. Again, we are looking at this, were talking about... there certain clientele were knocking to be appropriate for this. That's that 6% for different reasons. So this doesn't apply for everybody.

We are talking about... this is really that 22%, that 90 million that are struggling. So, this isn't appropriate for everyone stop if we know that there are going to be lasting applications, we wouldn't suggest it.

CYNDI TURNER:
Also, we have an obesity crisis in our country. In many parts of the world. It is a better to eat a whole cake? Or a piece of cake? That's really what were trying to teach people. Would be better to have an OK? Probably! Hey, if I can get you to exercise a little more, and have a little more vegetables, and only have one piece of cake, that's better.

This is not black or white, it's what's less harmful.

CRAIG JAMES:
And I think the challenge that we have both indicated is the paradigm shift. This is the only disease where you have to have remission to get treatment. If you think about, right? If I have heart disease... "Will until your heart disease is managed we will help you full stop" our position is, we want to help
everyone whether it's appropriate or not, how do we provide you information, data, so you can make a new formed decision.

Because the reality is people are gonna make decisions. Why not inform them and give them something that can sit with them, where they can grow where they're ready to, and he will come back at some point and want to talk about it.

HALEY HARTLE:
I think we have time for probably two more, I will try to get to two more questions.

Who initiates discussion? Client or therapist of alcohol moderation management?

CYNDI TURNER:
I would say we usually... the client leads that. They are usually coming in because there is an alcohol related problem. Or, they are coming in for mental health issue, and because I have assessed them for alcohol, I find out that they are drinking a little bit more that is healthy. So, I will still address that. I won't necessarily estimate they want to keep drinking. Most people come to us because they want to keep drinking or they know their alcohol use is a problem.

It's really: what does the client need?

HALEY HARTLE:
Thank you.

The next one: have you seen someone use harm reduction in your practice and then move onto an abstinence-based program?

And then... there was a second part of this question... let's go ahead and answer that first. Then they asked about DUI programs who teach harm reduction for stopped we will answer that first one.

CRAIG JAMES:
Actually, a lot of times that's what we created a harm reduction tracking IOP because we knew we would get more people and harm reduction and IOP. They will come into our a harm reduction program, though do the program, and because like a better they decided not to drinking more full stop "Are you sure?" "Yeah!" "Because you can" "no, life is better, I'm sleeping better, relationships are better..." so 50% of what were seeing, that comes through us, folks are doing harm reduction and remaining abstinence.

CYNDI TURNER:
That's what were seeing, and also the research was up I can't remember where I got that, but the research also shows about 42 to 60% going into abstinence.

CRAIG JAMES:
And what was the DUI question?

HALEY HARTLE:
Yeah, so the second part of Leslie's question was: what do you think of DUI programs in various states who teach harm reduction?

CYNDI TURNER:
I think it's brilliant! (Laughs) Only 6% of the people in the program have an addiction, and a percentage of those people who have severe alcohol use disorders, they can potentially safely go back. So, yes, I would much rather teach tools then scared straight because scared straight doesn't work.

CRAIG JAMES:
Because you're looking beyond the drinking, right? Ultimately, that's what were saying. Were not looking at the use of the alcohol. Were looking at why that's happening, and folks will let you know when you ask.

CYNDI TURNER:
Even in her IOP where most people have a significant alcohol use disorder, and the treatment is abstinence. Most of our groups are not just about drinking. They're mostly about mental health and coping strategies will stop
HALEY HARTLE:
Thank you both so much, that was a beautifully, perfectly timed ending!

Looks like we still have about 12 or so questions that we did not get you, so we will pass those along to you both, and we will make that available on the webpage so that attendees can see those answers!

Thank you both very very much.

I will go back to sharing my screen, and we will go over just a few logistics. Before we wrap up. Just a reminder, on the webpage that you used to sign up for this webinar, that is the same webpage you used to access the CE Quiz. The instructions for that as well.

That website is www.naadac.org/harm-reduction-for-skeptics-webinar

If this is your first time going through our CE process, be sure to use that instructions guide. You can also email us.

A final reminder that if you need your certificate to say 'Live' on it, be sure to complete that CE Quiz in the next 24 hours and download that certificate. Both of those pieces are very important.

For any social workers who are with us today, please stay on for that brief two minute video on how to add your license number to your certificates.

And this is a look at some of our upcoming webinars. We are continuing our women in recovery specialty online training series this Friday. With Lisa (unknown name). A few others coming here over the next couple weeks.

A reminder about our current specialty online training series, women in recovery, that we are continuing this Friday. The specialty series for women in recovery is designed for helping professionals who are dedicated to learning about the evolution of addiction treatment for women. This series is discussing current issues that affect all women in recovery, and we will discuss tools and best practices so that addiction professionals can feel confident in their ability and knowledge when treating women in the field of addiction.
If you complete all six of the trainings, by either live or on-demand attendance, and a pass at the CE Quiz, you are eligible to apply for the women in recovery certificates.

Registration for each training cost $25 for both NAADAC to members and nonmembers. So both will need to pay.

And we continue that this Friday on the 22nd.

By joining NAADAC, you have a lot of benefits. There's so many reasons to join, and to see more you can read more in a website or email us.

Thank you so much again it to both represent hers, thank you all for attending. A short survey will pop up at the end, so please take the time and give us feedback, sharing the notes for the present hers, and it tell us how we can continue to improve your learning experience.

Thank you again for participating in this webinar, and thank you for all of your valuable expertise, leadership, and support in the field to both of our presenters.

We encourage you to take some time to browse our website and learn how NAADAC helps its members, have a great everyone, and social workers I have that video for you here now.

(Video plays)

**Audio lost**

>>... Association management software, and two-year NAADAC member account for stop you only need to do this one time. After that the system will be set up to pull your license number into your certificate of completion that you earn after attending a NAADAC training or webinar. Let's get started, you can see the first step is to log into your member account.
Once you are logged in, you want to go to 'My profile', in the lower left-hand corner.

Ensure that you have selected a 'Account' in the account tab, and then Aero down and ensure you have selected 'Additional information' as you can see in my screen.

Next go to the right, select the look 'Licenses' tab, it's all set up as you can see. Then click title to add a new license'.

Here is where you really want to pay attention. He wants to under listens type that you select 'Social work license' in this field. This is what will tell the system to pull your license number into the certificate. You want to make sure you get that right.

It is required that you enter the states, as I am doing here. As well as your license number, that will go in the certificate, the rest is optional, but feel free to put that in so that the system has that recorded for you.

Once you have all of the information in there, go ahead and hit 'Save'.

If you have another credential or certification that you want to add into the system, you can go ahead and do that. You just want to ensure that, at the top under 'License a tight', you select 'State certification license or accreditation'. Then, fill out the rest of the information.

You only want to have one license type with 'Social work license'. That's it! You guys are all set up! Your CE Certificate will now include your license number as is required in many states and jurisdictions.

Thanks for watching! Get to learning!

HALEY HARTLE:
Thank you, everyone! See you at the next one!

(End)