Questions Asked During Live Webinar Broadcast on 4/20/2022

Harm Reduction for Skeptics: Practical Applications for Alcohol Use Disorders
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Do you think that there are limitations to using substances as far as health problems, levels of care, and MAT services when it comes to harm reduction or abstinence?
A: Absolutely! The Alcohol Moderation Assessment is a tool that is designed to help individuals identify if they are a good candidate for alcohol moderation. Things like having health problems and taking medication lower a person's chance of success for practicing alcohol moderation.

12 step programs still consider abstinence for "clean time" folks who are receiving MAT often lose the feeling of connection with the group. Are there supports groups emerging that are more supportive of MAT or Harm Reduction?
A: More and more programs are becoming treatment-based rather than 12-step based (93% were 12-step in the 90s, it dropped to 74% in 2017) so MAT is becoming more accepted. Moderation Management and HAMS are two programs that welcome anyone who wants help with their substance use.

I also describe “clean” as: not using any non-prescribed, mood-altering substances. I believe that individuals who have stopped using heroin with the aid of Suboxone or stopped using alcohol with Naltrexone are “clean.” If we say that addiction is a disease, why wouldn’t we use medicine to stop its progression?

Do you recommend a period of abstinence before attempting to moderate or gradually cutting back or (I assume) starting where the client is?
A: We have found that four months of abstinence prior to attempting moderation yields the best results. However, we meet the client where they are and view any progress as positive. We never kick anyone out of treatment for using the very substance that brought them in for help (we may recommend detox if it is medically warranted). Many clients state that they avoid programs because they are not willing or able to stop using substances at the time they call. I find that once I form a relationship with them, they are more open to education and weighing the pros and cons of their lifestyle.

Can you clarify the 35/37/22/6% stats, are they lifetime? Or in a given year?
A: These numbers are the compilation of numerous data studies over decades of time. We know that substance use fluctuates over a lifetime, thus the best way to interpret them is in a given year.

For many years, I have worked with court ordered clients and abstinence is mandatory while they are on probation or under court supervision. Do you have recommendations to use this approach while focused on temporary abstinence (to avoid jail time)? Or do you feel it is an either-or approach?
A: This is addressed on question #12 on the Alcohol Moderation Assessment: Do I have any legal, probationary, or work issues? These issues need to be satisfied first. We don’t encourage anyone to put their freedom or jobs at risk. However, we present around the country and have heard of several jurisdictions that are utilizing harm reduction methods, realizing that not everyone who uses a substance has an addiction and needs abstinence.

Do you utilize these same harm reduction principles with other substance use disorders?
A: We utilize harm reduction principles for all substances. Moderation for is only appropriate for alcohol as it has a clear set of guidelines, is a legal substance, and has research of how it impacts people at different doses.
Have you seen someone in your practice use Harm Reduction, and then move on to an abstinence-based program? What do you think of DUI programs in various states who teach Harm reduction?
A: Harm Reduction is a great way to engage people who are in a Pre-Contemplative or Contemplative Stage of Change who would otherwise not get any kind of help because they do not need/want abstinence. About half of those who attempt moderation chose abstinence. I am in full support of programs who teach Harm Reduction as only 6% of the population needs total abstinence while 22% will benefit from brief interventions focused on treating their “why.”

This kind of reminding me of DBT work I did with self-harm clients, teaching them non-life-threatening acts to replace the dangerous self-harm- so is this the same philosophy? Example instead of cutting on self, rub wrist with an ice cube?
A: Yes! The idea is that better is better. The all-or-nothing approach of complete abstinence keeps some people from getting any kind of help. We encourage less dangerous choices/behaviors. Recovery is a process that changes during the course of treatment. The goals at intake often look very different than the outcomes several months later.

Have you seen any difference in ability to moderate in relation to ACES scores?
A: Yes—this is addressed on Question #7 on the Alcohol Moderation Assessment (Have I experienced trauma or have a PTSD diagnosis?) Having an Adverse Childhood Experience is a negative predictor for being able to practice alcohol moderation. It does not rule them out, but points to an area where work needs to be done prior to trying it successfully. It is important not to take away a coping skill prior to a client learning new ones.

How could I use this model for the clients I work with on Methadone? Why not use Naltrexone for cravings?
A: Harm Reduction methods are absolutely appropriate for clients on Methadone as well as Naltrexone. Check out the Sinclair Method for Alcohol Use Disorders.

Do you think Churches help or hurt those looking for alcohol recovery?
A: That is too broad of a question to answer—it depends upon the church and their messaging. Many 12-step meetings are held in churches. Religious leaders are often the first person that people go to for guidance. Our goal is to educate as many people as possible about the different kinds of help available for those who struggle with substances.

Can you address why there are differences in the amounts of alcohol for each sex? And the differences in ethnicities?
A: Alcohol is dispersed through the body in water. Women tend to have less water in their bodies and women tend to weigh less than men. Therefore, women have a greater concentration of alcohol in their bodies, thus women become intoxicated faster than men, experiencing the effects quicker. The same is true for older adults. Another factor is a stomach enzyme called dehydrogenase which helps to breaks down alcohol. Women and certain cultures tend to have less of this enzyme and are thus not able to process alcohol as well.

Any information on "starting/stopping" and the kindling effect?
A: The liver is an amazing organ that has the capacity to regenerate. This sounds like a good thing, but is not when a person has heavy alcohol consumption. If the liver is damaged and someone stops drinking, it begins to repair itself. This is good. However, if someone begins drinking again, they are doing so on new tissue that gets damaged easier.

The “kindling effect” refers to repeated withdrawal episodes from alcohol where each episode gets progressively worse. Please keep in mind questions #14 and #15 on the Alcohol Moderation Assessment: Have I had withdrawals from drinking? and Do I have elevated liver enzymes? Both of these questions are two of four questions that if someone answers in the affirmative, they score two points which almost always rules them out as a good candidate for alcohol moderation. Having withdrawal symptoms and a damaged liver typically meets criteria for Severe Alcohol Use Disorder.
What about THIQ (the substance that is found in opiate addicts AND severe AUD's brains? Wouldn't ongoing drinking cause additional THIQ to form in persons who are genetically predisposed?

A: As noted above, once a person’s body has undergone physiological changes, they are likely dealing with a Severe Alcohol Use Disorder—the 6% who are “pickles.” It is unlikely that they are able to practice moderation. We can help them practice Harm Reduction and slow down the damage that their alcohol use is doing with support and education if they are unwilling or unable to practice abstinence.

Can you recommend online harm reduction support groups or client-friendly websites/worksheets/programs?

A: My favorite support group is Moderation Management. They are a non-profit and offer on-line and in person support groups as well as education tools. HAMS is another on-line program. These are both free. Please be aware that there are many apps that are popping up that charge a fee for help. Some are people with a great marketing team while some have scientific backing. Always do research and look for clinical/medical training before you or a client hands over a credit card.

In Practicing Alcohol Moderation: A Comprehensive Workbook, I provide user-friendly tools that take a client through the moderation process.

Can supported employment act as a leverage technique with harm reduction and if so, how?

A: Supported Employment is the idea that individuals of all abilities can be paid for their work when given reasonable accommodations. Harm reduction meets the client where they are and celebrates successes. It seems as if the two are symbiotic?

Do the 74% of people who present seeking help with alcohol NOT use other substances, such a marijuana? Do you use HR with individuals who use other substances, such as marijuana?

A: The National Survey on Drug Use and Health found that: 74% of adults who struggled with a substance use disorder had an alcohol use disorder and that one in eight struggled with both alcohol and drug disorders simultaneously. About 12% use alcohol and another substance. Thus, alcohol is the #1 substance of use.

As noted above, we practice Harm Reduction with other drugs. Moderation is only for alcohol.

Any supplements that can decrease the effects of initial withdrawal.... most clients who wish to quit, seem to "cave" because of the anxiety. Even though they may not qualify for actual medical withdrawal at a facility.

A: I am not a medical doctor and always consult with our psychiatrists about the physical body. I believe education on what to expect when stopping alcohol is important. We can be their cheerleader through the initial discomfort and Post Acute Withdrawal Symptoms (and get them medical care if they are displaying withdrawal symptoms that warrant it). I have found that when people treat their “why” with therapy that focuses on tangible coping skills and increase their supports that they have better outcomes. Medication can be beneficial if there is an underlying mental health issue and activities of daily living are impaired. Anti-cravings medications also can be beneficial in the early days of recovery to manage PAWS and prevent a return to substance use while learning what their recovery will look like.

The 35% of nondrinkers -does that include people in recovery?

A: As noted above, the numbers are a compilation of data and people change over a lifetime. The best way to look at the data is over a year’s period. Thus, if someone has been in abstinence-based recovery for over a year, they would fit into the non-drinker “water” category.

Who initiates discussion (client or therapist) of alcohol moderation management?

A: We typically take the lead from our clients. Your assessment should help figure out their goals, but it is our job to know what types of treatment are available. For example, if someone comes in to me for relationship issues and I learn that alcohol is a contributing problem, I would explore the role that alcohol is playing in their life and ask what they would like to do about it. Another example which is very common in outpatient settings, is that people are having issues with overdrinking but do not have tolerance or withdrawal and have tried AA meetings and not felt like they fit there. I might introduce the topic of moderation if they are not ready to quit drinking permanently.
When I mention the Sinclair method to others or doctors, I am told that naltrexone cannot be mixed with alcohol and that its dangerous, how can I encourage more open mindedness to explore this approach?

A: Our job as clinicians it to educate our clients and their providers as well as have a referral network of prescribers who are trained in MAT. If I went to a cardiologist and they were not familiar with my type of heart murmur, I would find a new doctor!

I work in supportive housing practicing the housing 1st model- harm reduction is a huge part of the self-sustainability process. Do you have any stats or additional Intel/knowledge on this approach and treatment in supportive housing?

A: I don’t have any information on this. I turn to Google and look for the scientific journals.

Could you speak to how you would work with clients who are not good candidates for moderation due to medical concerns, multiple failed moderation attempts, etc., but who are completely disinterested in abstinence?

A: Practice Harm Reduction! Focus more on when your client makes a positive change than an unhealthy behavior. For example, let’s say they are still drinking every day, but one day they do not black out. I would ask things like: How did you do that? What did it feel like? Could you try to do that again? What might get in the way? Give suggestions without shaming. For those who might need abstinence but are unwilling to work towards it, explore what you can add, not just what to take away. Can you help them eat a little better, meet with their doctor, exercise, and/or take their medications if they are unwilling to give up alcohol? Stay focused on the process and building a relationship with your client and their support system. I can list many clients where it took months, if not years, of supporting, challenging, educating, and negotiating before they found a balance that worked for them!