Michelle Day: [00:00:00] Good afternoon everyone, and welcome to the Fletcher Group Rural Center of Excellence's Webinar series. Today's session is scheduled to run from 2 p. m. to 3 p. m. Eastern Standard Time. My name is Michelle Day and I am your moderator for the session, along with Janice Fulkerson and Erica Walker. A couple of brief housekeeping items and then we'll begin.

You entered today's session on mute and your video was off and will remain so for the entirety of the webinar. Your chat feature is located at the bottom right of your screen. Use the drop down feature to communicate with either the panelists only or panelists and attendees. Please direct all questions regarding the webinar content to the Q&A section. Be advised that this meeting is being recorded and will be available to you on our website once it has been transcribed. You can access our website at www.fletchergroup.org. Also, at the conclusion of today's session, [00:01:00] there will be a short survey regarding the webinar content. Your participation in that survey is greatly appreciated and will only take a few moments to complete.

Joining us today for a second month in a row. is Dr. Alex Elswick. Dr. Elswick is a tireless advocate for people who use drugs and people with substance use disorders. He currently serves at the University of Kentucky as an Assistant Extension Professor for Substance Use Prevention and Recovery. Alex is the co founder of Voices of Hope, a non profit recovery community organization, and the co founder of the UK Collegiate Recovery Community. He is a trained researcher and therapist. But most importantly, Alex is himself a person in long term recovery from the chronic disease of addiction. Alex, the floor is yours.

Dr. Alex Elswick: Almost played it again. All right. Good afternoon, everybody. And, uh, thanks [00:02:00] so much for joining. Um, hopefully you were able to join last month, the 1st week of May for, um, Addiction as a Chronic Disorder, because in many ways, I kind of designed today to pick up where that 1 left off. So, if you didn't get the opportunity to watch that um, feel free to go back and check that out. And one more bit of my own housekeeping before I jump in. I want to say thanks to all the folks at The Fletcher Group, um, to, uh, to Michelle and Erica and their whole team. I know it's a, it's a big undertaking organizing these things. And, uh, we were just talking before we got on. It's really the nature of my job to, to disseminate information about addiction and recovery. And so I'm so grateful for, for opportunities like this that are provided by the Fletcher Group. So really glad to be here with you all. Um, I'll give you a brief introduction for the benefit of those, uh, of you who didn't join us last month.

So my name's Alex. Um, what's most important to know about me is that I'm a person in recovery. And, um, addiction and recovery is not [00:03:00] something that I ever anticipated entering my life, but once it did, it really changed my view of everything in the world. Um, it, it changed my spirituality. It changed my politics. It changed my understanding of everything. And, um, and so it, it, it led me to go into clinical work as a marriage and family therapist, to, to found organizations like Voices of Hope, which serve people who use drugs and people with substance use disorders. And it's given me this healthy, well rounded perspective.

And, um, and I want to share a little more personal experience today. I'm not going to tell you the same story. I told you last time as we really focused on addiction as a chronic disorder, but, um, in order to kind of frame recovery capital and the importance of asset based recovery, which is what we're going to focus on today. I want to use some personal experience so that it doesn't all feel so scientific and so academic. Um, so my name's Alex and I was born here in Lexington, Kentucky. Um, born to really privileged circumstances. Dad's a doctor, mom's [00:04:00] an accountant, really a suburban kid through and through. I, um, have some risk factors for addiction, um, genetic predisposition, um, multiple mental disorders, um, anxiety disorders.

Um, and, uh, and as a, as a consequence, you know, when I was 18 years old, I had, um, my wisdom teeth removed and I was prescribed oxycodone. Um, I think I encourage you all last time, last time to laugh alone at your monitors as you look at these pictures. But, um, I, uh, I got addicted to opioids and I'm going to speed through the addiction part because we focused on addiction last time and our focus today is recovery. Um, but, you know, addiction took me to jail. It took me in and out of treatment centers, and in and out of treatment centers, and onto the street and eventually to a final treatment center at the Salvation Army, which is, um, homeless shelter in Dayton that had a treatment component. And I think I shared with you last time that I ended up spending 6 months at the Salvation Army, and those [00:05:00] were.

Um, really difficult six months and a grueling six months to get my brain back and my body back. And I wish that that was it. I wish for the sake of everyone who struggles with addictions of any kind that that level of effort was enough to just be cured, to just be finished. But unfortunately, that's not the case. As we learned last time, vis a vis addiction as a chronic disease. And so here's what I learned from my own experience. When I left the Salvation Army, I left with all these barriers that are really characteristic barriers that people face when they leave treatment or they leave incarceration. Because I had bad credit and I had lots of debt and I had a criminal record and I had no college degree and I had no marketable skills and I was disqualified from most forms of supportive housing because I had a drug trafficking charge.

I had no idea what I was going to do. Like so many people in my position, I had no idea what I was going to do. How I was going to try to restore all the things that I'd lost at the same time that I maintain my recovery. But [00:06:00] it turns out, you know, I talked about my privileged background. It turns out that I had a lot of help. And in order to kind of highlight the difference in experience, I want to, I want to compare my experience to my buddy, Jason, who graduated the Salvation Army with me. But he didn't have the same family support that I had, and he didn't have the same financial backing that I had, and so he couldn't afford a halfway house or any type of supportive recovery residence.

And so instead, he had to continue his recovery at the Gateway Shelter in Dayton, which is the shelter where, you know, folks are more likely to be injecting drugs, not, not the shelter that has a treatment component. And, you know, that's an advantage that I had over Jason. Number 1, that I was spared the indignity of, of trying to continue my recovery from a homeless shelter. But more important than that, I was spared the stress. The bio psycho social stress associated with trying to recover from a homeless shelter. My, um, my buddy Jason had his, he had to wake up, you know, two [00:07:00] hours early before a job interview in

order to catch two buses in order to get there because he's facing all the transportation barriers that you can think of.

And the day that he woke up for his job interview, he realized someone had stolen his underwear and his socks. And that would almost be funny if it weren't such a devastating reality of the sorts of things that you and I might take for granted. That there's going to be underwear and socks in our drawer. Um, that's the kind of bio psycho social stress that's really hard to appreciate for some of us, especially those of us who have a privileged frame. And I didn't have to do that. And, um, and it's not because I'm better than Jason and it's not because I'm smarter than Jason and it's not because I was more honest or more open minded or more willing or whatever kind of moralistic narrative you want to spin.

The difference between me and Jason is that I had lots of help. Um, my, uh, my dad had a relationship at a church and the pastor at the church, let me sleep at the parsonage for free. And it's really hard for me to, um, [00:08:00] overstate what a significant resource that is for me to access. Because now I don't have to worry about making rent. I don't have to worry about getting evicted. I can take all that energy and all that effort and all those resources and I can marshal them towards focusing on my recovery. And Jason can't do that because Jason's got to try to make ends meet at the same time that he's got to face the same recovery that I do.

That's it. That's an advantage that I had over Jason. And we love to say that addiction doesn't discriminate. And I know what we mean when we say that, we mean it can even afflict people like me in the suburbs, but it's really not entirely true. Addiction does discriminate. Those things are called risk factors, and they're often most apparent when it comes to recovery, when we see that the playing field really isn't level. And I'll give you one more example, and then I'll hop off of this soapbox and, and move on. Um, you know, most people leaving treatment, leaving incarceration, they go pound the pavement and submit job applications to jobs that, you know, frankly, many of them are humiliating. And it's not a knock on service industry work, but, you [00:09:00] know, people who use drugs are capable, competent, aspirational people.

But we've so instilled this idea, this, this stigmatized notion that they're unreliable and they're lazy. And so they got to go flip burgers. Right? And I didn't have to do that. Um, and I, and I, and it's not because I'm better than Jason. It's not because I'm smarter than Jason. Like, you get the whole shtick. It's not because of how much I willed it or how much I sacrificed or how much I love my mother. I mean, it has nothing to do with any of those things. It's simply because my dad's a doctor and I'm a nepo baby. You know, my, my dad had a patient who had a mental health experience, kind of like mine. And he said, I want to give Alex a job.

And when he gave me a job, I had health insurance. And when I had health insurance, uh, I could go meet with a therapist and then I could address my anxiety. And so this was my experience in recovery, is as in the, in the blink of an eye, I started accruing all of these resources that were like, built on each other, like, [00:10:00] scaffolding that were really critical to my recovery. And so, when I got into graduate school. Um, in the research world, sometimes we say we don't do research. We say we do "me search" because it's really just this selfish pursuit of exercising your own demons, you know, and for me, the demon that I'm

always trying to exercise is this kind of survivor's guilt. Is the explanation when I ask the question, how come I'm here?

And my friends are in cemeteries and my friends are in state prisons and detention centers. And the answer that I get from. Much of the scientific community and much of the general public is that I wanted it more, that I worked harder, that I sac, I mean, it's, it's not true. It's just absolutely not true. There's nothing special about me. I'm not particularly resilient. I gave up a half a dozen times. Um, the difference was I had help. And, um, and I had access to the things that I needed. And, and so I got into graduate school and I'm asking this question, how can it be that I'm in recovery and my friends aren't [00:11:00] when I made all the same decisions?

And it became painstakingly obvious that I had access to so many of the things that better positioned me for recovery. And that stuff is called Recovery Capital. And so we'll do a deeper dive on that in a second. I skipped over these pictures last time, um, but since I showed you all my shameful stuff, give me three minutes to show you a little bit of pride. Um, I did a ton of damage in my relationship with my family, as you can imagine, in addiction, and so a big part of my recovery was restoring those relationships. And the first time that I went to my parents house for dinner after I left the Salvation Army, um, I went to enter the, they have a garage keypad, and I went to enter the code and the garage wouldn't open.

And so I went to enter it again, and it wouldn't open, and it took me a while to figure out that they changed the code because they couldn't trust their adult son to have access to their home. And that's, um, that hurts. You know, that's not an indictment of them. That was a really healthy, fair boundary, but it just, it was indicative for me of, of, you know, [00:12:00] how much trust had been eroded. And so anyways, all of that to say, uh, every Wednesday I met my mom and dad at the Waffle House at the Awful Waffle. And it, it was like neutral ground on which we could reconnect and Restore those relationships at our own pace. It was really cool. Um, a really important part of my recovery. And then. This is Voices of Hope circa, our staff circa like 2017.

And today we have more than 100 staff all in recovery. So really exponential growth there, which is pretty cool. And then the last thing I want to share with you just to double down on the importance of Recovery Capital is, um, I've been telling people lately, I've told people for a long time that this is the highlight of my life, but I got married last year. So you cannot tell my wife that I say this. But, um, a couple of years ago at the Rx Drug Abuse and Heroin Summit, I got to do a speaking engagement with the President, which was pretty cool, but far more exciting for me was to talk about some of my research on recovery capital with Nora Volkow, the [00:13:00] Director of the National Institute of Drug Abuse. Dr. Volkow, and Dr. Francis Collins, the Director of NIH. So, I think I say all of that, if it's not just as a straight up humblebrag, I think I say it to say NIH and NIDA find Recovery Capital to be rather important as well. So we're not going to do a whole bunch of brain science. That was entirely the subject of last time.

So I'm going to do like a two minute review just to give us that context. And then we're going to focus on what we want to focus on today. You all remember that's not actually your brain

on drugs, right? Egg in a frying pan. So we saw this slide last time where we were looking at what are called PET scans, Positron Emission Tomographies, and it's just a fancy technology to allow us to look at dopamine activity in the brain. And so we said the brain on the left, the far left is the brain, a normal, healthy control brain. The brain in the middle looks identical to an addicted brain because this is where this process has taken place of using and coming down and using and coming down. And even though you get a short term spike in dopamine, which causes you to experience euphoria, [00:14:00] causes you to experience a high, or at the very least, relief for people who are addicted.

Um, in the net, your dopamine levels are down regulating. They're trending downward until you have a brain that looks a lot like the brain in the middle. And we, we, we talked last time about this term anhedonia, which means no pleasure. It means, really, to have an addicted brain is to be unable to derive pleasure from the world around you naturally. The only thing that's going to really precipitate pleasure in that brain is going to be methamphetamine. But here's the big catch that we talked about. We said that brain in the middle is not actually the brain of someone who's addicted. That's the brain of someone who was addicted. Now they're 30 days abstinent and yet functionally that brain still looks disordered.

In terms of its utility, in terms of the way that brain is actually going to function, it's going to function like an addicted brain. It may be the case that they're 30 days abstinent and that they've gained some weight and that they're stating all their best intentions and that they sound clear cognitively, but that brain is still very much disordered as a consequence of [00:15:00] drug use. And so we say all of this to say, if we know that addiction is this chronic disease that impacts somebody's brain for three to five years, what are the implications of that for recovery? Well, the primary implication of that is that recovery is not going to be an event, right? It's a process. If, if these changes are long term changes. You know, in recovery, people told me you can't walk three miles into the forest and try to walk one mile out, right?

Um, and, and so the same thing sort of applies here. And so what does it look like, um, to sort of, um, address addiction over the long term as a chronic disease? That's what's called Recovery Capital. And before we get there, I want to show you a diagram. This is borrowed from the Kentucky Opioid Response Effort and their Cascade of Care. And what you see at the top are like this, these six hexagons kind of represent what you and I probably would think of as kind of the conventional continuum of care. And if you wanted to simplify it even further, you might just say it's like treatment. [00:16:00] It's like prevention, treatment, and recovery. Right.

When we think about the big buckets, um, sometimes we include law enforcement too, but here's your big, uh, continuum of care. And so often when our focus is on prevention, treatment, and recovery, what we're neglecting is these two things that are happening at the bottom, which is harm reduction and building assets. Building Recovery Capital. And that's really the two things that I want to focus our time on today. So what is Recovery Capital? We said that maybe last time, if we got to it, I can't quite recall. Think about any other time you've heard the term capital. Social capital, financial capital, it doesn't matter. Capital always means resources.

So Recovery Capital means recovery resources. It's just a fancy way of zooming out and thinking of what are the totality of things? What are all of the resources outside of a person? Things like employment, education, mental health services, relationships, living in a community free from stigma, having job opportunities, all that, but also things within a person. A person's [00:17:00] intelligence, maybe a person's, um, problem solving ability, maybe someone's mental health. It's right. It's this big bucket of all the things that make us a unique person that make our substance use disorder unique. And if you're not familiar with recovery capital, I like to put it next to Maslow's Hierarchy of Needs, because many people in our field are familiar.

And you'll remember that Maslow, first of all, Maslow, if you look at the top of his hierarchy of needs, he talks about reaching your full potential. And I think this is an interesting connection because I'll show you a little bit later, that's actually verbatim part of the definition of recovery. So in a lot of ways, I like to think of Maslow's Hierarchy of Needs as a Hierarchy of Recovery. And my favorite thing about that is that it suggests or it would suggest that people who use drugs and people with substance use disorders actually need the same things as other human beings in order to recover. Um, and sometimes I think we, we think of people who use drugs as some kind of alien who needs some type of really high tech treatment in order to, to [00:18:00] recover from a substance use disorder.

And the reality is, so often, uh, the work that needs to be done is the meeting of basic needs that aren't being met. Vis a vis things like, um, mental health, safety and security, addressing trauma. And remember that Maslow said you have to meet your needs in order. And, and, and that sounds maybe fancy, but if you think about it, it's super intuitive. For any of you who have kids, you know that you wouldn't send your kids to school in the morning with an expectation that they're going to behave well in school and they're going to perform well in school when they didn't get a good night's sleep and you didn't get breakfast in their belly, right? I mean, I don't even think you need to read the parenting magazine to come up with that.

That's really 101 intuitive stuff. And the same thing applies to people who use drugs, okay? The way that Recovery Capital works The reason why improving your housing or addressing your mental health or developing a new relationship, the reason why each of these things promote recovery is because they reduce stress. So remission or [00:19:00] recovery from substance use disorder is more likely for people who have Recovery Capital because they're able to reduce stress. You know, when I was living in halfway house at one point, um, it was a really stressful environment. And I was surrounded by people whose recovery wasn't super strong and maybe weren't great influences on me.

My biopsychosocial stress was pretty high and it was a pretty big threat to my recovery. When later in my recovery experience, when I moved into that church parsonage by myself, my, my biopsychosocial stress was reduced. And it was reduced as a consequence of my Recovery Capital. And so, so far, I hope all that makes sense. I don't think I've said anything that's super revelatory. You may not have heard the phrase Recovery Capital, but once you look at it, you recognize those things as the resources that we have to build for people. But here's the big question that I want us to explore today. And that is, when do we start to build Recovery Capital?

So we agree that addressing mental health, or someone's housing, or their relationships, or whatever it is, is important. But do we do [00:20:00] it right now, today? Or should we get them sober first, so that they can be a good steward of those resources? It's kind of a chicken and an egg problem. And I want to suggest to you all that in my community, and I'm guessing in your community, that we've answered this question. And that we've answered this question by deciding that folks need to become abstinent first. In other words, folks sort of earn access to these resources. As a consequence of their abstinence. And are denied access to these resources as a consequence of their inability to achieve or maintain abstinence.

And so let me give you some kind of concrete examples to help drive this home. Because at first, when I give you this question, I think some people look at it and think that's a super oddly specific question. But as we work through some of these, I think you're going to see this is a tension that plays out at every level of our field. So housing to me is the preeminent example. We don't have housing for people who use drugs in our communities in the United States. It doesn't exist. Um, you know, the closest thing we have might be [00:21:00] emergency shelters, but most emergency shelters have drug and alcohol free policies. They'll deny people who are intoxicated and in some cases, even ban people um, who bring drugs and alcohol onto property. We know this because it's happened to many of our participants at Voices of Hope. It means they virtually have nowhere to go. Um, you, you're, you're probably aware we have sober living, but sober living is not a place you go to become sober. Sober living is a place you go if you're sober and abstinent the day that you walk through the door, right?

And so let's just, let's just think of an example. Let me go back to my brain for a second. And let's say I, um, am graduating my sixth treatment center and I've relapsed type, five times previously, despite my genuine efforts towards abstinence. And so I recognize, Hey, maybe this 30, 30 day treatment center is insufficient. Maybe I need more time. And so I opt into a halfway house. I need to be in a secure environment. So I check into this halfway house and the day I check in, I'm abstinent. Cause I just walked out of that 30 day treatment center. Right? But [00:22:00] let's say two or three days later, as often does happen, this brain that I have, that's utterly compromised and disordered, does what a disordered brain does and makes a disordered decision.

And I decide to use a substance. Somebody in the house, um, you know, tells the house manager and they drug test me and I test positive. Probably what's going to happen to me. I mean, I'm going to get kicked out, right? I'm going to get kicked out because I present a threat to the other, whatever it is, what we're doing then is we're depriving somebody of one of the foundational aspects of Recovery Capital. One of the foundational aspects of Maslow's Hierarchy of, of Need, of health and wellness, and we're doing it by the way, at a time that people need help the most. At a time that people are experiencing duress, biopsychosocial stress in the midst of a relapse, right? Um, whenever I talk about families, I always want to give the caveat that I really am not being critical of family members.

That's not on my heart. That's not my intention. What I'm being critical of is [00:23:00] the really bad advice that scientists like me and others have given to family members, because I'm sure you've heard us tell you or your loved ones or someone, you know, that your loved one needs to hit rock bottom. This really kind of ill defined idea that rock bottom is this fertile, spiritual ground on which people recover.

And the idea is, um, that any attempt to support somebody through their recovery in the midst of a relapse, for instance, is, is conceived as enabling and it conceived as withholding their rock bottom or preventing them from hit rock bottom. I'm sure this is a narrative all of you have heard. And the problem with that is, while enabling is a phenomenon, I'm a, I'm a family therapist by training, so it's obviously a phenomenon I'm aware of.

There's also this massive, robust, growing body of research that suggests that family involvement is positive in every way. When your family is, is supportive of your recovery, you're more likely to access treatment. You're more likely to complete treatment. You're more likely [00:24:00] to, uh, to engage with aftercare services following treatment. I mean, all of these outcomes are better when your family supports you. And this belaboring rock bottom, and don't enable, don't enable, effectively pathologizes family support. And it makes family members, who otherwise would be very supportive family members, afraid to support their loved ones. Um, you know, and my mom would testify to this.

She had a family therapist tell her, you know, Shelly, Enabling is only bad when you're enabling addiction. If you're enabling recovery, it's a good thing. And she describes that as an epiphany for herself. Um, and, and I think for many parents, this, this, this really concrete fear that, um, even if I send a text message to express love, that I need to withhold love until they hit rock bottom or whatever it is. So all of these are just examples of us obsessing with abstinence first, saying people need to get abstinent and then we'll help, right? Let me give you another example. And this is directly from my personal experience. The clinic where I was [00:25:00] trained, um, had a policy that said if someone was, um, if, if drug use was mentioned as a part of the intake call, even if it wasn't the primary presenting problem, if drug use was mentioned at all at intake, we had a policy that said that that individual would have to show evidence of treatment completion prior to coming to us for therapy..

And if you, if you think about the real world impact of that policy, I'm sure we meant well. I'm sure the logic is, hey, we can't have a bunch of drunken intoxicated people in therapy. That's going to, uh, that's going to, you know, disrupt therapy. It's going to make it less effective. So instead, what we did was we said, we're not going to work with you until you're abstinent. And you know, that the real world impact of that was not that a bunch of people in my community ran off to treatment to get sober so they could come hang out with me in therapy. No, what, what happened was they never came to therapy at all. They effectively didn't get access to any help because we were demanding abstinence first.

If we had been more honest providers, we [00:26:00] might have hung up a sign out front that said, We don't serve families who use drugs. Get abstinent or go somewhere else. And then kind of the most absurd example of this, I guess, over prioritization of abstinence comes from one of my favorite addiction thinkers, a guy named William White. And he wrote this paper back in 2005, and verbatim, the title of the paper is, It's Time to Stop Kicking People out of Addiction Treatment. And this is what he argued. He said, look, substance use disorder is the only disorder for which the patient is blamed for the failure of the treatment, right? If we give you a medication and you don't react well, we don't blame you or your body for the way that you reacted.

We blame the medication. We blame the treatment. We might even blame the decision of the treatment provider. But when you experience a return to use following an episode of treatment for substance use disorder. We don't question the efficacy of the treatment. The first thing that we do is look at you and say you relapsed and you chose drugs over your kids.[00:27:00] And that totally belies this story we've been telling about addiction as a disorder, let alone addiction as a chronic disorder, right? Another way of thinking about this is when I go to treatment, what I'm acknowledging to you all is I can't control my drug use. Right? I mean, can we agree on that? If I could control my drug use, by definition, I wouldn't need treatment in the first place.

So here I have this problem where I can't control my drug use, and I come to you and say, Hey, treatment provider, I need help. And you go, okay, I'm going to help you control your drug use. And then let's say two days later, because I have this chronic brain disease and it acts up and I use drugs. What are you going to do to me? Well, you're probably gonna kick me out of treatment. So think about the logic of that. I came to you and I said, I can't control my drug use. And you said to me, I'm going to help you with that. And then two days later, indeed, I couldn't control my drug use. And you said, get the hell out of here until you can control your drug use.

It's, it's really wild. It's really, um, it takes a lot of zooming out to see it, I think. But once it hits you, you see it as a real putting the cart before the horse. [00:28:00] And one other way of thinking about this is if you're a person who believes in rock bottom, if that's kind of been your frame for understanding recovery, then I would submit to you that you don't agree with Abraham Maslow, because you got Maslow all the way upside down. Because effectively what you're asking people to do is to reach that potential, to recover from their addictions without the benefit of all of the resources that research says would help them recover from their addictions. You follow what I'm saying? We're withholding the types of resources that would make abstinence more likely because people aren't abstinent yet. And to me, that's a really, really kind of wild, um, uh, Catch 22. And so here's what some of the experts have to say about Rock Bottom. Keith Humphreys was a former advisor to the National Office of Drug Control Policy.

He said, "It's remarkable that people believe what's needed is more punishment. If punishment worked, nobody would be addicted. It's a pretty punishing experience." That's so well said. If you remember [00:29:00] back to the webinar in May, when we talked about the brain, and we talked about anhedonia, that no pleasure, that inability to experience pleasure when you're in that addicted disordered state. That's the most punishment I ever experienced in my addiction. The criminal legal system couldn't do worse to me. My family couldn't do worse to me. Society and stigma couldn't do worse to me. None of it was as bad as what my brain did to me. That was abject suffering. If suffering and pain were enough to end somebody's addiction trajectory, I would have stopped right then and there.

I promise you, everyone would. But it wasn't enough. In fact, what characterizes an addiction is continuing to engage in a behavior despite the consequences. So what on earth makes us think that more and more consequences are going to change the behavior? That belies the very definition of addiction in the first place, right? And then this is the moment that William White's colleague grabbed him by the shoulders and shook him awake and said, Bill, you're not getting it. My clients don't, don't hit bottom. My clients live on the bottom. Their

capacities for physical and emotional pain are beyond [00:30:00] your comprehension. If we wait for them to hit bottom, they die. The issue of engaging them is not an absence of pain. It's an absence of hope. And every time I read this, um, I'm reminded of a guy who we've, we've We've had the chance to interact with a little bit at Voices of Hope and his name's Caleb. And he's been, um, he's experienced homelessness in a few different cities, including Lexington for a long time, I'm going to guess 25 years, and he has an alcohol use disorder.

And I just imagined that if I really believed that Caleb needed more pain, if I really believed in rock bottom, then I would go under the bridge and with a straight face, I would look Caleb in the eye and I'd say, look, I know you don't have any, any family left, but I And I don't, I know you don't have any significant social relationships and certainly no job prospects or leisure time activities, but you know, the reason you continue to drink is because you haven't suffered enough. And I would just like. That violates something in me. I don't know how you experience that. I guess I [00:31:00] hope for many of you it violates something in you and you go, there's no way that what Caleb needs is more pain. His life is filled and filled to the brim with pain. There's no way that that's what he needs more of. Maybe he needs a little bit more hope instead.

For the sake of time, I'm going to skip these examples and go to our definition. So here's SAMHSA's definition of recovery. Many of you have probably seen this before, but I don't know how critical of an eye you've given it. Um, because this is the, you know, definitions are boring and they're dry and they're the kind of thing you breeze over when you're in school. Even those first four words, a process of change, that's the kind of thing I would have breezed past in school, but it turns out that's part, that's a really operative part of this definition. Process of change. It means recovery is not an event. It means it's not linear. It means people don't wake up one day and spontaneously say, I think I won't do heroin anymore.

If they do, then by definition, what they're experiencing is not addiction, is not, not substance use disorder, right? Um, it's a process of change. It's fits and starts. It [00:32:00] means relapse is a part of recovery. And I know some people in the field who bristle when we say that because they say, Hey, we don't want to normalize relapse. And my response to that now and forever is relapse is normal. Like it or not, addiction is a chronic disorder. And so substance use disorder, uh, people who have substance use disorders, experience symptoms of recurrence, um, or rates of recurrence at similar rates of other chronic diseases. So if you look at rates of, of recurrence for COPD or asthma or, uh, diabetes or hypertension, chronic diseases almost always relapse about 40 to 60%.

And substance use disorder roughly falls within that window. So relapse is a part of the process for many, many people. And instead of being punished, it's something that needs to be supported. Because when you first got addicted, we all said out of one side of our mouths that you had a brain disease. And then as soon as you experienced your first relapse, it's like, we all forgot that you had a brain disease. And we started talking about choice. When you still have [00:33:00] that very addicted brain that's inhibiting your ability to make choices. So it's a process of change through which individuals do three things. They improve their health and wellness. They live a self directed life and they strive to reach their full potential.

And so what you notice there is for the experts at SAMHSA, recovery is not about abstinence. There's no mention of abstinence. There's no mention of drugs because for the, for the experts at SAMHSA, recovery is not defined by the results of your 12 panel drug screen. You know. You can be perfectly sober and you can be leading a horrible, horrible life.

That doesn't mean that that's recovery. And you can be a person who continues to use some sort of a substance and be experiencing all of the merits of recovery. Because what recovery is really about is health and wellness, autonomy, and reaching your potential. So now when you look back at this graphic, I know it seems kind of simplistic, but when you look back at the graphic, you might notice something that you didn't notice before. And that is that the harm reduction and the capital building is not something that we start doing after people graduate treatment. You notice that it's not [00:34:00] starting way over here at treatment. It's starting as soon as we encounter somebody. Right? Because we don't, we don't get people sober and then provide the resources they need.

We have to provide the resources they need in service of them becoming, uh, in, in recovery. Right? So I know this is a little annoying. I think people roll their eyes when I put up pictures of old professors, but this is a really helpful way to understand Recovery , a little better. Because sometimes when I, when I present on this, my fear is that people walk away going this guy said people need resources. Great. Thanks for the hour webinar on that, you know, and it's more nuanced than that. Um, and I think this is helpful. So William Cloud was working on his doctoral dissertation in the 1960s, and he's studying college students who have addictions. And he noticed two things that I think are really interesting about these college students.

The first thing he noticed is that they were recovering from their substance use disorders at a higher rate than what was being reported in the general public. And he didn't have any type of explanation for this, [00:35:00] but he made note of it. And he said, well, that's just odd. And then secondly, as they followed these kids over the long term longitudinally, They found that many, if not most, of these college students, even many of those who had severe substance use disorder in college, were recovering from their addictions without formal help. They weren't going to treatment, inpatient or outpatient. They weren't going to therapy. They weren't meeting with a clinician. They weren't even going to AA, NA, uh, 12 step support groups of, of any kind. They were just sort of organically recovering. And he, he thought, well, this is wild. This is not something I've ever seen anybody talk about or write about.

And he met Robert Granfield and they wrote a paper called The Elephant No One Sees. And they argue there's an elephant in the room every time we're discussing addiction and recovery. And the elephant we're ignoring is called natural recovery. And natural recovery refers to recovery without formal intervention. So that means you didn't go to treatment. You didn't go to a mutual aid organization. You didn't go to a therapist. You had a severe addiction [00:36:00] without a doubt, a veritable addiction, but you recovered without formal help. And if you're like me, the first time I heard about natural recovery, I remember thinking, first of all, that must be so uncommon because everyone I know who tells their story, who you hear about, had this severe addiction, they went to rehab. And then they went to AA or whatever it is, right? That's the Pathway that I knew, just that one strict pathway. And here's the shocker. Not only is natural recovery a phenomenon, it is the phenomenon in recovery. It is the single primary pathway of recovery. If you take all the like 23, 25 million

people in the United States who are in recovery today, the majority of them got there without formal intervention.

46 percent of people with drug use disorders and three quarters of people with alcohol use disorders. And so, if you're thinking ahead, this begs a really important question. How, right? Like, how the heck is it possible that these folks can have addictions, even [00:37:00] severe substance use disorders, and recover without formal intervention? And the answer is, Recovery Capital. The answer is Recovery Capital. When we're talking about these resources, you know, we're not just saying that that Recovery Capital is important. We're saying this is the stuff of recovery. The reason that these college students that that William Cloud was studying, the reason they were recovering at a higher clip and without formal intervention is because they were a privileged subset of the population in the 1960s. So they were, they were kids who really, um, were going to go back to families of origin and hometowns, and they were going to get set up with a job connection from dad, and they were going to buy a house from a friend and, and they were going to have all the things that they needed.

And as a consequence of reducing all that biopsychosocial stress, they had sufficient recovery capital. They didn't even need to go to treatment. So when I harp on Recovery Capital, what I'm saying is this is, this is vastly more important than treatment. Sometimes treatment's necessary to have a period of crisis stabilization, often necessary, especially for people with severe SUD, but it's [00:38:00] never sufficient. Recovery capital is always necessary for recovery. And sometimes if you have enough of it, it can preclude the need for treatment. So in order to just incorporate this a little bit more, let's take a step back and think about how we've tried to address addiction in this country over the last like 75 years.

So starting in 1971, Nixon declares war, really it starts in 1914 with the Harrison Narcotics Act, but we've been waging a war on people who use drugs for a long, long time. Big propaganda war, but really 1971, Nixon declares war on drugs. And so we start waging a war on people who use drugs and we see mass incarceration and prison industrial complexes and blah, blah, blah. The biggest indictment of the War on Drugs comes in the form of two graphs. That I wish I included here, back to back. The first is a graph of incarceration, which has this huge, huge inflection point, um, and and then, you know, the only way that all of that incarceration would be acceptable to us and our communities is if it led [00:39:00] to a commensurate decrease in, in drug use, right? So like, okay, we're doing a lot of damage because we're locking up our communities, but Hey, at least we're reducing drug use and drug related harm. And you know what the reality is that line of drug use looks like a horizontal line, like no effect for the most part. And then it's actually increased in the last few decades.

So all that to say War on Drugs approach didn't work. And so starting about 2000 to 2010, we started getting a little wiser and we were like, it was really when we started to learn some of the brain research that I got the chance to share with you all last month. And we got some of this neuroimaging and we said, Oh, these aren't bad people trying to be good. These are sick people trying to be well. And so we saw the advent of all the specialty courts and the progressive alternatives to incarceration. And this is a step in the right direction. Like, make no mistake about it. This is a step in the right direction. We're trying to provide people with the things that they need.

But here's the problem. Remember the brain scan? Go back to that slide of the three brains in your mind. And remember that when I'm graduating a treatment center, [00:40:00] I'm graduating with a brain that's still very much functionally addicted. So during the 30 days that I'm in treatment, I have access to all the recovery capital in the world. When you think about what a treatment center is, you know, um, we used to keep all the gold in Fort Knox. So I like to think of treatment centers as Fort Knox for Recovery Capital. This is treatment centers. You have all the recovery capital in the world. You have educated counselors, you have peer support, you have 12 step meetings, you have structure to your day, you have nutritious meals, right?

Like all of the ingredients that we talked about that we described for recovery capital are present. And so it's no wonder that most people tend to be successful and even tend to be abstinent while they're in treatment, that biopsychosocial stress is reduced for them. They're able to marshal their energy and effort and focus on recovery. That's why it's effective. But here's the big problem. Here's the big tension. When they leave treatment, their brain, as we established, is still very much functionally addicted. And yet, they have to leave [00:41:00] all that recovery capital behind in the treatment center. They graduate from treatment and go back home, probably to the same environment where they got sick, and they leave behind all that good stuff, all the stuff that predicts recovery.

The educated counselors are still in the treatment center, and the 12 step meeting is still in the treatment center, and the peer support is still in the treatment center, you know, on down the line. And so this is the primary problem that we have, the big challenge. We've made a good move moving from a War on Drugs approach to a treatment centered approach. But the problem is acute treatment is never going to be sufficient to address a chronic brain disease like addiction. And so one step further where we want to go is what's called ROSCs. You all may have heard of these before, Recovery Oriented Systems of Care. The most important thing to understand here is just simply that our first approach, we were going to address addiction in a jail cell.

And it didn't work. The second approach, kind of the approach we're using today, the treatment centric approach is, we're going to address addiction in treatment centers. And I want to suggest to you all that it's not working. And I think there's a lot [00:42:00] of different ways to assert that, but part of the best evidence is we're losing 100,000 people per year. Something, something is not working. And so the focus of a ROSC is, instead of packing the resources in a jail or in a treatment center, we're packing the resources at home where people live, right in their communities. And you notice that treatment is still a really important part of a ROSC. It's, it's, if you're a treatment provider on the call, Please don't walk off saying, you know, that I was poo-pooing treatment.

Nothing could be further from the truth. I think treatment helped save my life. It was a necessary period of crisis stabilization, but acute treatment was no match for my chronic brain disease. I still had to get out even after six months and figure out how I was going to live in recovery while my brain was still healing. And so what you notice on the periphery there of a ROSC is Recovery Capital. It's just saying, let's take all the capital. Let's pull it out of treatment centers and let's, let's put it in communities where people live, where they can put it into good effect, you know? And so here's my really quick analogy for

the difference between treatment and recovery. [00:43:00] Um, my first job in recovery was working in a, I told people that I was doing tobacco research, but that was a bold faced lie. I was actually just digging holes. And there was a team of researchers who was actually doing the research, but, um, I'm a suburban kid.

I'd never been in a greenhouse before. And it was amazing the way that the conditions were so perfect. That the plants had access to all the nutrients that they need. They just shoot up and grow. And when they reached enough, um, sort of level of maturation, we would load the trays in a trailer and go out and set the tobacco, which I'm guessing many of you all have done. It's hard work. And, um, and we would set the tobacco in good soil that had all of those nutrients that the plants needed, and they would, they would transplant pretty effortlessly and they would thrive. And so here's my analogy for the difference between treatment and recovery, because treatment centers are like greenhouses for people who use drugs, right? They're, they're, they're climate controlled environments where people have access to all the nutrients that [00:44:00] they need, all the sunlight, the water, the air quality control, it's Recovery Capital, right? Except unlike the plants, which are getting trans, transplanted into good soil, that resembles the good environment in the greenhouse.

We're taking people out of treatment and we're, we're, we're considering their, um, their long term recovery, their recovery environment, their, um, their Recovery Capital as an afterthought and giving them none of the resource, the resources or nutrients that they need for recovery. And then we shame them when they can't recover because they have this chronic disease that we continue to treat acutely. Right? So Recovery Capital is vitally important and part of one of the the fundamental bases one time. Um, I had someone ask me So there's so much that falls under Recovery Capital How do we know what's most important and obviously you can look to the literature for that But for my part one of the most important aspects of Recovery Capital is social connection in all of its forms And part of the reason for that that I think is really interesting is remember that I told you, [00:45:00] um, that effectively what addiction is in the brain is dopamine down regulation. Dopamine going down, down, down, down, down.

That's oversimplified, but that's effectively what it is. So an oversimplified kind of reductive explanation of recovery is dopamine up regulating in your brain. Dopamine going up, up, up, up, up, right? And it turns out there are a number of things that we can do to expedite dopamine up regulation. In other words, a lot of things we can do to help the, the addicted brain heal even faster. Or, or restore to normal levels even faster. And that includes things like exercise, things like meditation. Um, what's so cool about those things is not only do they give you a short term spike in dopamine, sort of like a drug would, which is, which feels good and is motivating, but also they raise your dopamine baseline, which is really what we want to, uh, for, for dopamine upregulation. And I say all of this to say, this is an article that was published about 15 years ago. And the arctic, [00:46:00] the authors show how social interaction actually upregulates dopamine. So if you wanted to get out of all the fancy brain speak and you wanted to say it in a straightforward way, social interaction is organic medicine to the addicted brain.

One of the most ubiquitous, freely available things that we can do for our neighbors who use drugs and who have substance use disorders is connect them at every level of their lives to every level of their communities as much as possible. And if you think about it, the shame of

it is, we do a really good job of doing the opposite, um, of disenfranchising people who use drugs, of marginalizing them, ostracizing them, just shoving them to the, to the periphery, right? That's why at Voices of Hope we value all pathways of recovery. It's actually kind of a part of our core ethos that we're not obsessed with abstinence. And, and let me say at least once before the end of, I've got 12 minutes left, before the end of the webinar, I have nothing against abstinence and no one [00:47:00] should.

Abstinence is the ultimate form of harm reduction. It's the safest form of recovery. If I could choose for people who have a problematic relationship with drugs, I would choose abstinence. But that's a big if, because the reality is, as I'm going to show you in a moment, I can't choose. I can't make that choice for folks, and you can't either. And that's a reality that we have to address. So what we do at Voices of Hope is we try to be like a ROSC. We try to be that transplant where we take all those ingredients that made people really successful in treatment centers and we transplant it to our community, to where people live. So instead of just accessing support for 30 days, people can access it for life.

People can keep coming and keep coming and keep getting the things that they need. That's, that's one feature of a ROSC. And so with my last 10 minutes, I want to connect this whole discussion of recovery capital to harm reduction. And part of the reason for this is because sometimes in my travels across the state, I hear harm reduction used pejoratively, like, [00:48:00] um, negatively in a derogatory sense, like, like harm reduction is a bad thing. And so I really want to make the assertion today. First of all, simply put that reducing harm is a good thing, but that's me being a little bit cheeky. I want to give you a well reasoned understanding of why harm reduction is so important. And so some of you all may have seen this if you're clinicians.

If you're not, let me explain this super briefly because it's really helpful to make this point. So these are the Stages of Change. When you want to change any behavior, you go through kind of these characteristic stages. So you're like, I want to lose weight or, um, I want to quit drinking. You know, maybe you got a DUI and you're in pre contemplation, which is kind of like denial or ambivalence. And you're like, okay, I got a DUI, but everybody gets a DUI. I don't think I have a problem. You know. And then contemplation, maybe you got a second DUI and you're like, well, not everybody gets two DUIs, but I'm still not sure that I have a problem. And then preparation, you're pretty well convinced you have a problem. And then action, you take action. Maintenance, you [00:49:00] maintain the behavior change.

The reason I bring this up. It's because I want you to imagine that we can locate all the people in our community who use drugs and all the people with substance use disorders somewhere on this spectrum, right? They're all in various stages. They're all in their own stages. You know, some people who are in long term recovery, you know, some people who are in the, the treatment process, you know, some people who are in utter pre contemplation, and they clearly have a substance use disorder, but they're not convinced of it. The problem with the system that we have that's so abstinence focused, that's so over prioritized as abstinence, is that we can only be effective with people who are in that stage of behavior change where they're ready, able, and willing for abstinence right now, today. And that's these folks right here.

It means all of the folks in our communities who are in pre contemplation, in contemplation, in preparation, aren't fit for our treatment system, because they aren't ready to take action right now, today. And so, so often what we say to them is, come back when you're ready to get sober, [00:50:00] right? They're just not ready yet, we say. They just haven't had enough pain yet. They gotta go do more research, we like to say, right? Um, and in the interim, my friends go away, and they hit their bottom, and they die. And we bury them and they never get another chance. And they never get another chance because all we cared about was abstinence and we didn't care about connecting them with the things that they needed.

And the real value of harm reduction is that it allows us to engage with people no matter what stage of change they're in. It doesn't matter if you are in complete and utter pre contemplation, total denial, the worst case of denial we've ever seen. You have this atrocious addiction that's impacting all the people around you and you're convinced it's not you and it's not an addiction. And yet we can still be effective with you. We can reduce the harm of your drug use, not only for you, but also for your family, for your community, for the people around you. And more importantly, we can start to, to build the ingredients that you need to give you a foundation for recovery. Most people don't get abstinent [00:51:00] cold.

They get abstinent when they have the things that they need. And so here's another way of making this point, because I know it gets a little, a little complex. There, there's a treatment gap. You all may have heard of the treatment gap before. Um, year after year, our big epidemiological survey, um, the National Survey on Drug Use and Health shows a 90 percent treatment gap. In other words, 90 percent of people who need treatment don't get it. And this is one of the most horrifying stats in our field. And most often when we receive that information, we think it means people don't have access to treatment. And so if people don't have access, we say we must need to build more treatment centers and we need more treatment beds.

But what's interesting is if you do a deeper dive on those data and you ask those 90 percent who stand in the treatment gap, why they didn't receive treatment this year, do you know what the majority of them tell you? The majority of them report it has nothing to do with treatment barriers. It has to do with the fact that they didn't think they needed treatment or they didn't want to be abstinent. And that's, look, that's an [00:52:00] uncomfortable reality, especially for a lot of us who've worked in abstinence based addiction recovery for a long time. A lot of us have that inclination to say, fine, send them away and they'll come back when they've had enough pain. And that's not been my experience. My experience is my friends are dying.

And so instead what we're advocating for, while abstinence is a wonderful outcome, and while I wish that for everyone, it clearly isn't the desire of everyone. And research shows that people are much more likely to achieve their goal when they're given goal choice between moderation and abstinence. And so to just kind of wrap up, I want to, I want to make this connection between harm reduction and recovery because sometimes I hear harm reduction talked about like it's a dirty word. Sometimes I hear people talk about harm reduction as though it's a last ditch effort. Like it's a last resort. It's just something we do for people who went to treatment 15 times and just won't get abstinent. Right? And nothing could be further from the truth. Harm reduction is a pathway of recovery. And I want to make that case with my last four minutes.

All right. [00:53:00] Um, we had a participant who came to Voices of Hope. Well, she's experiencing homelessness. She's, this sounds like a stereotype, but she's, she's pushing her shopping cart out in front of Voices of Hope every single day. And she has a substance use disorder. And our sign out in front of our center says Recovery Community Center. And as I've told you throughout our presentation today, to most people in my community, the word recovery means abstinence. And so every day that this woman pushed her shopping cart by our center, she saw the sign that said Recovery Community Center, but in her mind, what she heard was Abstinence Center. And she is one of those 90 percent who stand in the treatment gap, who doesn't have the necessary resources. She's homeless. She has no desire to be abstinent today. Abstinence is not going to improve her quality of life overnight, right? In fact, it's probably going to make it worse in the short term. And so, day after day, she pushes her cart by, pushes her cart by.

And then one day, she heard through word of mouth that she could get her laundry done for free at Voices of Hope. Um, it's really low barrier. We just ask that people meet with a [00:54:00] Recovery Coach. They don't have to commit to any kind of behavior change. They don't have to go to treatment or anything like that. Just chat with a Recovery Coach for five minutes. You can do your laundry for free. And so she starts bringing her laundry in. And of course, it's not like she puts her laundry in the washer and leaves the center. No, no. She puts her laundry in the washer and now she's spending an hour, two hours, three hours hanging out at a Recovery Community Center.A Recovery Community Center, which by the way, was designed with people like her in mind to create a place of belongingness for people like you. Not people who are sober or in recovery, but even those who are seeking recovery and even those who are unsure where they stand. And so she did this for about three weeks. And on the third week, um, she's got her laundry in and she's, this is a true story you all. She's got her laundry in. She goes out on the back, um, smoking pad behind Voices to smoke a cigarette. And she turns to our Recovery Coach and out of the sheer blue, she says, [00:55:00] Hey, if I wanted to get into treatment, could you get me into treatment? And our Coach is like, girl, if you want to get into treatment, we'll have you there in an hour, you know? And that's exactly what they did. And today that woman is more than 18 months in recovery. And to be more specific with you, more than 18 months abstinent. And I want to tell you why that's one of, of all the great success stories that exist, one of my very favorites, because it's the clearest example had we only focused on abstinence in the beginning, she wouldn't be abstinent today. I'm wondering if that makes sense for you all. If our only focus had been to prioritize abstinence, and we didn't think about Harm Reduction, and we didn't think about Recovery Capital, and we didn't think about connecting with her as a human being before we corrected her, she would have never come through our doors.

So what Harm Reduction is, not only is it directly a practice that reduces harm, it's also a philosophy that allows us to better engage with people. And so it's a philosophy that you can use in your work. Even in abstinence based [00:56:00] context in some cases, um, recognizing that, um, when, when instead of punishing non abstinence, instead of chasing people away and telling them they're bad because they're using drugs, when you connect with people first, you create that fertile environment in which people want to recover, in which they're motivated to move through these stages of change.

Um, so I know we went through a lot. Let me give you my recap here. Recovery Capital is vitally important. Treatment may, I mean, what, what natural recovery shows us is that

treatment may or may not be essential for someone to recover from an addiction, but Recovery Capital certainly is. You can't do it without sufficiently reducing your biopsychosocial stress. Until Caleb can sufficiently reduce his biopsychosocial stress, I gather he's going to continue to drink. Um, Harm Reduction and Recovery Capital, just like Harm Reduction and recovery, are not at odds. They're not opposites. Harm Reduction is not something we do for somebody who We think recovery is not working for harm.

Reduction is recovery. And it's one of the most robust [00:57:00] pathways of recovery. There was a paper published just a couple of months ago that showed that people can slowly reduce their meth use over time into abstinence. And it makes me chuckle, not because it's a bad study. It was a perfectly good study, but it makes me chuckle because there's a part of me that wants to say, isn't that obvious? That's, that's how most people change every other kind of behavior. So why is substance use the only behavior under the sun where we would expect people to have complete and sudden and perfect behavior change? It just doesn't make sense. I know from my own experience, there was such an extensive period of time where I was trying and failing, trying and failing. And I didn't need people to punish me for my failures.

I needed support through those opportunities. So what we're advocating for is, is not that abstinence is bad. Abstinence is a wonderful outcome, but to shift our focus a little bit towards making sure that we're building the appropriate resources and appropriately reducing harm for those who need it. So thank you all again for joining. I think I have email here as always. Happy to correspond with you that way. [00:58:00] Or if we have a couple minutes, um, I'll be happy to take questions too.

Janice Fulkerson: We do, Dr. Alex, have several questions from people and I'll try to work in a few in the last few minutes that we have. Um, when you were talking about housing, um, and talking about, you know, options, someone asked, what about the scenarios where we have people in early recovery and then those that, uh, still, um, haven't reached that early recovery in the same environment, like a peer recovery center or others? What about the risk to the population. That's one question. Then there are others, but let's see if we can get through this one, and then we'll present the other ones.

Dr. Alex Elswick: I love that question. And it's a, it's a good question because sometimes Harm Reduction gets myopic and it gets so focused on reducing harm for one individual that it forgets that it has to reduce harm for society writ large or for a recovery community writ large or whatever it is. And so I think what you're bringing up is a really, really good [00:59:00] point. That it's not, it's not as simple as I'm making it. I'm just trying to establish the other side, right? It's not as clear cut as I'm making it. And obviously these are some things that we need to understand more about. We need research to help us understand what kind of mixtures of abstinence and non abstinence can contend, can still lead to good outcomes and what kinds actually threaten people's recovery.

Um, I think that's a perfectly reasonable thing to ask. And, um, and so, you know, when I work with, for instance, um, I did a training not long ago for, um. a social service provider that works with victims of sexual assault. And we were having this conversation about the relationship between sexual sexual assault and drug use, and that we know that so many victims of sexual assault also develop substance use disorders. And so if you follow that

logic, that means if you're, if you're a sexual assault provider has a policy that said you can't have drugs here. Then any of the women who have substance use disorders are going to have a barrier to accessing the care that they need. And so I just say that to reflect your point.

It's a, it's a difficult [01:00:00] conversation. It's not black and white. It's not as simple as it's certainly not saying, let people use drugs. That's, that's not at all what Harm Reduction is. In fact, that's harm production. Right? Um, so all of that to say, without giving you a concrete, tangible answer, because I don't have it. I think your question is a good one and leads us, to points to the research that needs to be done. What does this look like? How do we better integrate Harm Reduction into more traditional models of treatment and care?

Janice Fulkerson: Lovely. Thank you. We have a couple of other questions that have come in. We will capture those, we will send them to you, and then encourage you to correspond with the folks and individuals that put those questions in the Q&A. We want to thank you, Alex, for being here today. We're getting a lot of positive comments, like Paul says, hands down the best presentation I've seen in a while. So thank you for being here.

For everyone else, we want to say these webinars are on the Fletcher Group website. They are posted within a couple weeks after [01:01:00] we have them live here. We encourage anyone who wants follow up to submit a technical assistance question on our website, and we will follow up with you and help connect all of the resources that you may be looking for that we have access to. Thanks for being here. Have a great day, everybody.

Dr. Alex Elswick: Thanks, everybody.