Audio Transcript for Episode 510: "Reframing Addiction From Problems to People" with Dr. Nzinga Harrison

Please note: This transcript has been lightly edited to remove filler words or sounds.

Opening Quote: “I would like to completely and utterly undermine the widely held belief that people with substance use disorders don't get better. 75% of people with substance use disorder recover to a meaning of life and purpose and substance use that supports their functioning.”

[music playing]

CHAD MOSES: You’re listening to the To Write Love on Her Arms podcast, a show about mental health and the things that make us human. I’m your host Chad Moses, and in each episode, we’ll be talking about the things that can often feel hard to talk about, like depression, addiction, self-injury, and suicide. We’ll be sharing stories and exploring big themes like hope, healing, and recovery. If any of the topics we discuss or the stories we share feel too heavy for you, know that it’s OK to pause, to restart, or to stop altogether. As we discover new stories, we hope to remind you that your story is important.

[music playing]

CHAD:

Just say no.
There’s no hope in drugs.
Drugs are whack.
Recognize, Resist, Report.

These phrases stem from programs and campaigns and political agendas that ultimately failed the United States and its people. The Drug Abuse Resistance Education Program or DARE filled schools in the 90s and while overall being deemed severely ineffective, continues today by asking youth to take pledges to stay away from drugs and gangs. This program came on the heels of the failed and heavily criticized War on Drugs that began in the 70s but really took off in the 80s. With it came laws that criminalized drugs and racially targeted specific groups and communities of people—especially people of color. Its focus weighed heavily on deterring use rather than emphasizing treatment and recovery.

So today, with all of this in mind, we have the immense honor of talking with and learning from Dr. Nzinga Harrison about addiction and the on-going and growing opioid epidemic. Dr. Harrison is a physician, educator, and the Chief Medical Officer and Co-Founder of Eleanor Health, a value-based provider of comprehensive, outpatient addiction treatment. Above all else, this conversation is about reframing the way we as individuals and as a society view and address addiction and the people who are dealing with substance use disorders.

All that being said, I am your host Chad Moses. Let’s get started.

[music playing]

CHAD
Here we are. This is the tenth episode of our fifth season of the podcast, and this is the first time this season that we're talking about this specific subject, which is the opioid epidemic. You as someone working, co-founding and working, as Chief Medical Officer at Eleanor Health, this is something that you see daily, even beyond your nine to five. But let's just start with the basic definition. When we say, “opioid epidemic,” what are we talking about, that's definitely a buzzword in the media, but what is it that we're referring to when we use those words?

NZINGA
So yeah, you're exactly right. Opioid epidemic has become a bit of a buzzword. So to pin down what we're talking about, opioids are painkillers. They are substances that bind a specific receptor in our brains and bodies, which is the opioid receptor. And the opioid receptors message is an absence of pain, physical and emotional. And so when we talk about specifically what those substances are, it's like heroin. It's like fentanyl. It's like the narcotic pain medications that people get prescribed after injuries, those are kind of the big three buckets that you can think about. And so the opioid epidemic is referring to just a wild number and dramatically increasing rate at which people are developing addiction to those opioid substances. And it's been going on for way longer than it's been on the front page of media. So I've been practicing Addiction Medicine and serving people with addiction for almost 20 years now. And I've been taking care of opioid addiction, that long, and it predates my career.

CHAD
So with the admission that it predates your career, and you've been in the field for, you can measure by the decades now, when do you recall first hearing, “opioid epidemic,” and did that hit you as a shock of like, “Wait, now we're talking about this?”

NZINGA
I probably first recall hearing, “opioid epidemic” maybe seven or eight years ago. And it did not come to me as a shock, because it was on the heels of kind of a number of rapid-fire stories of celebrities unexpectedly dying of overdoses, of young white suburban kids, teenagers, young adults dying of overdoses. And so it didn't surprise me that the concept of epidemic came because it was now affecting a community that was not quote, unquote, who you expect to be a drug addict. And I put that in quotes, because that's not the way that I talk about people. But that's what the sentiment was. And so that was one of the biggest stigmas that we had been fighting in addiction and psychiatry treatment for my whole career. Definitely, all of the generations before us, was like being able to get people to see that addiction doesn't happen to other people, it happens to all of the people. And so once, you know, it started hitting home for all of the people, that was the fuel that was needed to kind of drive this recognition of an epidemic that had been at play for a long time.

CHAD
Yeah, so because it's been at play for a long time, we kind of discussed a little bit about how we got here, where we are now. But are there specific markers, through policy, through just how the medical practice has evolved? What did get us here? Can we kind of reverse engineer where we landed?

NZINGA
So, I want to introduce a concept as the first part of answering your question here. In medicine, we have this concept, bio, psychological, and social concept of health. And it says that every illness develops for biological reasons. Every illness develops for psychological reasons. Every illness develops with social inputs. And to make the biggest impact the most quickly for people, you have to be able to intervene in all three of those buckets. I have started teaching about what I think is a term I made up to expand that

concept of bio, psycho, social, cultural, political, because we know there are cultural reasons that health thrives or illness develops. We certainly know there are political reasons. And so taking that bio, psycho social, cultural, political mindset, if we look back, let's start at cultural, political, the criminalization of drug use. The criminalization of drug use goes back to the 1800s. Before that, there were drugs; there were no illegal drugs. The entire intent of the first laws and each laws that came subsequently were directed at a specific racial or ethnic group. So laws were developed to criminalize opioids to target Chinese immigrants. Laws were developed to criminalize marijuana to target Mexican immigrants. Laws were developed to criminalize the crack form of cocaine to criminalize black men in the south, and always associated with a political agenda. And so when you criminalize an illness, you make it impossible for people to ask for help for that illness, you send people to jail instead of treatment for that illness. You create generational harm as a result of both of those. And so that socio-political environment of criminalizing drug use contributes to the epidemic we have today.

CHAD
That is, gosh, just so poignant that, yeah, you don't, culture and politics are always going to be hand in hand. Why? Because they both, you know, deal with people, and how we tend to people, and especially when we rebrand people as problems. Yes, as problematic. Demographics or problems that we believe are specific to one people group and perhaps not to another. Yeah. Thanks for introducing us to that.

NZINGA
Yeah. No, you just spoke to my heart when you said it starts with rebranding people as problems, that spoke to my whole soul. And I was like, yes, the movement we need is a re- rebranding back from problems to people. And that's kind of what I was describing. When you asked what did I think made us start to recognize the opioid epidemic on a mass level? It was because the problem of addicts was rebranded to people who need help. Yeah, which is the truth, that's truly what we're dealing with, right. And so that was kind of like cultural, political, if you look at social, social is all about those things that wrap around our lives that turn into health or illness. It's stability, housing, stability, financial stability, relationship stability, life, meaning, purpose. And so when we look socially across the world, in the United States, for sure, at the social construct that leaves so many people impoverished across all of those domains, that is driving the opioid epidemic.

CHAD
Going back to the history part of it started back in the 1800s and and totally like I'm even seeing in modern day pop culture of, you know, these historic dramas and historical fiction, like, you know, my brain immediately goes to Deadwood. And there's this whole story arc of a grieving widow who's addicted to laudanum to opium. And it just seemed like, yeah, like, this is a substance that is readily available, it's readily prescribed. drugs have always been part of the picture. And because of that, you know, addiction and substance use disorders have always been part of the picture. But let's fast forward a bit to to the 90s. What was it specific to the culture, the political the social sphere of thirty years ago, that has drawn us to this point that we now acknowledge opioid epidemics.

NZINGA
Um, I think if I had to point to the 90s, I'm going to bifurcate it into two arms. So one, I'll stay with the criminalization of substance use, but it was only for heroin. It was not applied to prescription opioids. And part of that is systemic, which I'm going to draw on the other arm, which is like the power of the pharma lobby, and back in the 90s. So I went to medical school, late 90s, early 2000s. And it was just starting to be a movement that did not allow pharmaceutical reps to be an integral part of our medical education. So when I was a medical student, pharmaceutical reps were an integral part of my medical education. That's when I am formulating, that's when I'm learning how to practice medicine. And I remember, in medical

school, that is when pain became the fourth vital sign, that is when it became pain needs to be zero out of 10. Treat aggressively with narcotic opioid pain pills until pain is zero. Because the literature at that time, which is still true was telling us that untreated pain leads to poor outcomes in all domains. That is true. What was irresponsible about that was that it presented those opioid medications as completely pain free. And we are a pill society. So from the time you're three years old, and you bump your toe, we give you a Tylenol, right, so we start training that reflex to pills very early, there is no stigma, there is no danger associated with taking pills. And so it was literally like, if a person had any pain at all, while they were in the hospital, they got discharged with a thirty day supply. And it was, did you put a thirty day supply of opioid pain medicine on their discharge medications? Because if not, you were not practicing standard of care. That was very much politically driven by pharmaceutical reps being able to be an integral part of our medical education. That has since changed. On the other side, it allowed the gap to widen between who will believe those people that have addiction, and who are people that are just taking the medication that is prescribed to them by their doctor. And that group that's taking the medication prescribed to them by their doctor just flew under the radar. Because it was hard to conceive that you could be addicted to something being prescribed to you by your doctor.

CHAD
There has been, fortunately a shift in that. But just to, you know, to recap that a little bit. We had pharmaceutical companies that were everywhere, including, effectively the classroom and the campus. They were reassuring medical professionals and medical students that patients were not at risk of having long term, adverse, addictive relationships with these substances. And what we're seeing there is this breakdown, you mentioned systemic, I think that totally applies here, this systemic breakdown of trust between patients who don't have all the letters behind their name. And the prescribing clinicians who are not developing the drugs, but receiving what is told would be a part of the treatment plan, a responsible part of the treatment plan. So this, this sense of false assurance has now led to the deaths of over a million people just in the United States of people, dying deaths of despair. That's not even touching the most recent wave of the opioid epidemic with, you know, fentanyl laced pills. And, I mean, it's at what point like, it's so easy to look back and say, Yes, this went wrong. Yes, this went wrong. Yes, this went wrong. But looking backwards, doesn't really solve the person that is currently in the grips of addiction, you know, they don't really care about the history so much they care about their present, they certainly care about their future is always going to be that way. I remember when this first kind of entered my consciousness, I went to the University of Virginia, and I'm a sports fan and one of our offensive linemen that actually went to school with a guy named Eugene Monroe. He retired from the National Football League, because he said, I don't want to be prescribed pain pills anymore. You're just going to give me this thirty day supply and pretend like this ain't going to be a problem down the road. Like, that was the first time it clicked for me. That like, this is wild, like this is someone whose job is to show up physically, in ways that I can't imagine day after day being told, yeah, you take this and it'll be better and he's saying, “I don't think so. I think there's there's something beyond just next week and something beyond just next season. Like I got a whole life I want to live and I don't want pills to be a part of that life” and I mean I dont even think there's a question there. I just wanted to. Yeah, just it occurred to me when you were talking about the history and you know, just about the most recent history that opioid epidemic is a phrase that is, you know, about a decade old and and, you know, really hoping that people can see conversations like this and, and people like you and people like Eugene, as kind of luminaries, too. Just because this has been normalized, doesn't mean that it's the best path forward.

NZINGA
You know, you made me think of a few things as you were sharing Eugene's story. And first, I want to say thank you for using the word luminary. So Eleanor in Greek means shining light. And it is one of the reasons we chose the name Eleanor for Eleanor health. Beautiful. Yeah. So I love that you use the word

luminary, when you're sharing Eugene's story of thought of a couple of things, which is, no, it's not normal, to normalize it. But even in a bigger sense, what we have normalized is the expectation to do whatever it takes to continue producing and delivering despite whatever physical or emotional pain you might be in. And so opioids for a lot of people represent that ability to meet what is an unacceptable standard that we have in this country to continue to produce despite what pain you're in, initially, opioids make that possible. And then the other thing that really kind of pinged in my brain, as you were sharing Eugene's story was this idea that I'm thinking beyond today's practice. I'm thinking beyond Sunday's game, I'm thinking beyond the end of the season to the rest of my life. This is an integral part of what was so dangerous when I was in medical school and for a decade after, with the pharmaceutical reps being such a part of our education, and then even after former reform came, and they were no longer part of education, it had already been ingrained. And so physicians of my generation, we're passing this down to the upcoming physicians. But it was not thinking beyond today. And this is a problem that we have as a larger society. It's a big problem that we have in health care is when you're in the hospital, my job is to think about you for today. When you're in my office, my job is to think about you for today. When do we start holding healthcare accountable for thinking about people in longitudinal ways that also consider their futures?

CHAD
And in that is the understanding that tomorrow is unpredictable, by definition. So let's talk about most recent history. So in 2019, nearly fifty-thousand people died due to opioid related overdoses, that number nearly doubled after the COVID 19 pandemic. Can you tell us more about where the opioid epidemic is today? And what role the pandemic, this unexpected tomorrow, played in in seeing that number increase?

NZINGA
Yeah, so the opioid epidemic continues to be completely out of control. We saw the highest number of overdose deaths last year, ever. And that's, I guess, kind of the sad news, the more encouraging news that I'll put that up against this, that our eyes are wide open, and there is a lot of energy and intention, throughout healthcare, throughout regulatory systems, throughout legal systems to try to be different, so that we can start getting a different outcome. In terms of why COVID knocked the opioid epidemic, even further off the rails, I'll go back to that bio psychosocial, cultural political framework. When we are under existential threat, our stress is at its highest. Our physiology and psychology is least prepared to protect us and reaches out by any means necessary for an immediate solution that resolves the fear around that excessive existential threat. And so you think about COVID. One day, things were fine. Three days later, the country is shut down. All of your routines are completely disrupted and routine represents stability to our brains, all of your routines are completely disrupted. Your support system is severed, which is what you need the most during times of distress. The, I'm going to call it low level, which is inaccurate, because we actually walk around with a significant level of distress just at baseline. So like the everyday level of distress, was magnified. If you were already using an opioid completely as prescribed, that put you at risk for using more of that opioid because it's going to, it's going to treat that distress in that moment. If you are already using an opioid a little bit outside of the way the prescription was designed, or using an illicit opioid that was going to increase the frequency and quantity of your use. If you are not using but you had depression, anxiety, stressed out, fewer, you know, connections then kind of needed to meet your needs. That created an opportunity for opioids to slip into your life as a coping mechanism. And so just from all angles COVID itself was perfectly designed to knock an opioid epidemic off the rails.

CHAD
It's been reported, and this kind of plays into that. That COVID theme as well. But it's been reported that nearly four out of five people who use heroin, roughly 80%, first misuse prescription opioids. Why is it

common for heroin to be preceded by opioids? I guess on some level, our pills, the new gateway drug, simply by virtue of their availability.

NZINGA
You answered your question. By virtue of their availability, one, two, ubiquitously available with zero stigma attached? I'm telling you just two days ago, my mother in law had dental surgery. And I had not to share all her business but like she has had dental surgery. She knows how to manage her pain afterwards. She said I typically just manage my pain with an extra strength Tylenol. They said, Well, let us give you this bottle of narcotics just in case. And she came home with a bottle of narcotics that she didn't want. She managed her dental pain with high dose Tylenol. Right. And so it's built into our systems the same thing. I had a root canal a few years ago, and they were like, opioids actually are super dangerous for me, like they slow my heart rate to almost stop. And so I put it on my list of allergies. I am allergic to opioids, they caused me a dangerously low heart rate. My dentist was bending over backwards trying to figure out how to give me an opioid for this root canal. I was like no, really, I think I will just like ibuprofen and Tylenol myself to the max, and I will probably be able to do it. Here's a prescription anyway, just in case and then the prescriptions for 15 days.

CHAD
How long is this supposed to hurt for doc?

NZINGA
Is there something you want to tell me about this root canal. right? And so it's not just so ubiquitously available, it's ubiquitously available from people that we trust with our health. And it's ubiquitously available without any stigma. And so that makes it like a gateway like no other gateway, right? Like if actually like the other gateway, which is alcohol. Alcohol is the primary gateway drug. But so at some point, it becomes nearly impossible to sustain a prescription pill addiction from access, so once the medical establishment recognizes an opioid addiction, prescriptions for the opioid stop. Now what should happen is a connection to treatment and a prescription for Suboxone. But what most often happens is just a cold cut off, right? So then the prescriptions are cold cut off. So then you go to the street for pills, but the cost of street pills is wildly high. So you sustain that for a while, at some point, you're not able to sustain the cost of those pills. And so heroin is a dramatically cheaper option. And it's a big stigma, bridge to jump. But once you try heroin the first time, a lot, a lot of times or pressed fentanyll. A lot of times people will snort it. And then it's just, it just grabs on to folks, and then you move to IV. And that's kind of the developmental process.

[music playing]

BECKY EBERT: Hey there, it’s Becky Ebert, TWLOHA’s editor and producer. I want to talk to you for a moment about something specific: T-shirts. To Write Love on Her Arms has always sold t-shirts as a way to help fund our mission—the mission of hope and help. But the products we sell in our store do so much more than help us financially. Each piece of merchandise is a conversation starter. It spreads the TWLOHA message to someone who may not have found out about us otherwise. So whether you wear our shirts, hats, hoodies, or rain jackets, we want to thank you for bringing a message of hope and help wherever you go. To see our latest designs, head to store.twloha.com now and use the promo code PODCAST20 to receive 20% off your entire order.

[music playing]

CHAD
So one more question, kind of as we're getting to the summit of the epidemic, before we start addressing, what can we do, we've also seen studies that have shown that recently, the biggest increase in opioid related deaths has been among the youth among 18 to 24 year olds specifically. Do we know why that particular age range is seeing such a substantial rise?

NZINGA
I have some hypotheses around why. One starts with the fact that in adolescence, it is normal to try drugs. That is a normal part of developmental risk taking and initiation of drug use most often happens between 15 and 18. When we were younger, that tried drugs was a cigarette or that tried drugs was alcohol. Now that pills are in everybody's cabinet that tried drugs is narcotic pills. Layering on top of that normal developmental phase to try drugs is the increased risk we have from biological, psychological, and social perspectives for our youth. So we have all time highs, depression, all time highs, anxiety, our LGBTQ youth are not being wrapped in love and support, rather discriminated and kicked out of packs left and right. And identity threat is a huge risk for the development of depression, anxiety, substance use disorders. And so when you have a young person, who may not even recognize how dense their depression, anxiety, self esteem difficulties are, take that first pill just as part of normal experimentation, the sense of relief, and hope, and belonging, and everything's going to be okay, that comes with that pill is extraordinarily dangerous. So then you layer on top of that, the natural lower impulse control, because we're not finished, you know, myelinating, our impulse control pathways in our brain until twenty-four, twenty-five, twenty-six. And so you put that natural trying of drug use, on top of a dramatic sense that things will be okay, for the first time in a long time. On top of that not fully matured brain, you have a recipe for the highest number of overdoses to be among our young people.

CHAD
I feel like it's so important to take a beat just to acknowledge that substance use disorders and addiction don't happen in a bubble like so often. It's trying to cope with something. It could be social anxiety, it could be a breakup, it could be traumatic environments at home, you name it, but it often is about kind of addressing the self in a world that is way bigger than yourself. You mentioned you know some of these kind of standard risk taking behaviors that us young-uns do. I say us, I'm no longer young and it's been a minute since I've been a young man but but when I first started using substances, it was totally trying to find a sense of self not even like in a peer pressure way but just in a I know how I feel now. Oh, and I don't like how I feel now once a way to feel different. And over time, I realized, hey, that different feels pretty good. And then after a while, I'm like, Hey, I think I might not exist, if different continues, like, bring me back to shore, what will it take to, to change it back? And we work as To Write Love on Her Arms, and me personally, so much in the music world. And our friends, especially in the dance music space have been on the front lines really trying to figure out how do we address this problem? How do we go about reframing conversations around substance use? How do we go about protecting our friends, our fans, our patrons, the people that make these events, even possible? You don't have to look too far to see that there's numbers that in music events that came back after the pandemic, you're seeing spikes and hospitalizations due to substances, people that were out of practice, as it were, what they used to use regularly at these events they no longer had access to, and now the doors are open. So let's get back in it and, and all of a sudden, being around people for the first time in two years, I'm used to just me and maybe my roommate, and now there's 50,000 people around me, this is actually kind of scary, maybe maybe the substance will help. So there have been a number of festivals that have come to us saying, How can we combat this? We give people the option to to freely dispose of their products, and in a safe way, we were not going to criminalize you if you walked in through the gates and you had something on you and you realize maybe this is a bad idea. We want to incentivize you making wise decisions. So at no point are the EMTs gonna arrest you. You have ways out, I say all this as a long, long wind up to talk

about this topic of harm reduction. When we say harm reduction, what does that mean? Particularly on the social, cultural, and dare I say maybe not so much in the States, but maybe we're getting there at the political level

NZINGA
100%, and even on the biological and psychological levels, also all five of the buckets. So I always like to start with this quote that I heard from Monique Tula, who is executive director of the Harm Reduction Coalition. And she said harm reduction is the practice of unconditional love for people who use drugs. Isn't it beautiful? Yes, period, period. So when you look at the principles of harm reduction, harm reduction is a social justice movement, grounded in the rights and respect for autonomy and humanity. If people who use drugs, we recognize the risks of drug use, we seek to reduce the harm that drug use causes. And so it's really going back to what you said earlier, which is reframing the problem. The people are not the problem. The drug use is not the problem. The problem are the harms that come from the drug use. So how do we direct our efforts at reducing those harms? And so I love the way you described the approach of the festivals, because part of it is like culturally, we're pack animals. So you said when you were a young person, and you started using drugs early on, it was to find a sense of self. In general, human sense of self is connected to the pack that you're currently a part of. And so how do we not, from a harm reduction perspective, culturally, set the expectation of drug use from the moment people are born? Right? And all of our media, just, It's wine o'clock somewhere, right? Xanax was initially marketed as a Mommy's Little Helper. It was marketed to stay at home moms as a way to be able to tolerate their kids. Wait until you turn 21 You're going to be able to get smashed, right? Like can't wait. And so we get that message very early on that to fit in, you have to be using. So from a wider cultural perspective at the Music Festival, how do you start another narrative, which is like you don't have to be using to fit in. And to fit in we want you to be using safely if you're using, right? Like that would be a beautiful harm reduction method. And then the next is equipping people to reduce their harm. So at Eleanor, we use our urine drug screens to drive harm reduction. We try to do everything to drive harm reduction and reduction of the impact of trauma that people have had. Those are like core things for Eleanor. But during drug screens are usually used punitively, right, like if this drug screen is positive, you're going to be kicked out of treatment because you're not ready for abstinence. A harm reduction way is like, let's use this urine drug screen to make sure that you're taking what you actually think you're taking. Because you know how many times someone thought they were taking cocaine and their drug screen popped for fentanyl. And somebody thought they were smoking marijuana and their drug screen popped for fentanyl. Right? And so we're like, okay, use these fentanyl strips, no matter not just opioid drugs, any drug that you're taking, use these fentanyl strips to test it first. So that you're not accidentally taking fentanyl as a way to try to reduce the harm of the drugs that you're taking as your decision whether you're going to take drugs or not. How do we support you in doing that and the way that is least harmful? And so from a political legal perspective, I'm just gonna stay on fentanyl for one more second. In an overwhelming number of states, it is a felony to have fentanyl strips. A felony. So whereas we're telling people and giving people fentanyl strips, please use these fentanyl strips, test the drugs before you use them to reduce the risk of overdose. If there's an overdose, this is what it looks like. Here's Narcan so that you or that person doesn't have to die. Make sure everybody in your life has Narcan. These are two harm reduction strategies. We're actually creating criminal risk by trying to help people keep themselves alive. So that's something we can do everybody listening on this podcast like, check in your state, our fentanyl strips, illegal misdemeanor felony doesn't matter. Start your advocacy right now today for fentanyl strips not to be criminalized in your state. That saves lives. That is a harm reduction strategy. Talk about it. Drug use doesn't have to be a secret. You're not a bad person. It's not going to smudge your family reputation. Talk about it. Talk about depression, anxiety. You're not weak. It will save somebody's life. Make it okay to feel emotions. Help people know where they can reach out to for help, right? Like these are all harm reduction strategies that basically I'm going to use your words a thousand times on this podcast and one thousand times in the

next week also, reframe the problem from the person. Reframe the problem from the drug, reframe the problem to the harm that the drug causes and spend our efforts on reducing that.

CHAD
Such an important message that this is. Stop moralizing substance use. That if we believe that you enter this world with immeasurable worth, that you're irreplaceable, a substance doesn't change that. You are still irreplaceable. And you know, certainly there's going to be all sorts of models and the buckets we've been talking about that, bring to you know different amounts of accountability to the table, but nothing about you has changed. Yeah, going back to music festivals, shout out to my buddy, Raquel. He, he's my buddy in recovery. And he is a music manager and he's a brilliant human and he invited me to a recovery meeting at a festival and it was interesting because it wasn't like a traditional 12 Step meeting. It was really just kind of shared time but most people already knew each other there it's a it was a it was a tight circle and hearing their stories was beautiful talking about how they first started using in order to feel a sense of connection to people around you like if I take substance x and then then I'm going to be on the same wavelength, we're going to have the same Good Vibrations all about and, and now that I'm sober, I realized that those connections haven't changed. That that same depth that I felt when I was when I was high, I can still feel that same amount of devil sober. And even more so. But yeah, like it's, oh, there's just so much more at risk then running out of jail cells, right? Like we're talking about people, people that are hoping to feel a sense of connection. People that ran out of options or weren't presented with enough options to begin with. I love what you said about what we can do. We don't have to wait on politicians, we don't have to wait for November for election cycles to make a difference. But you mentioned asking questions about legality about felony and misdemeanor status of certain substances. Do your research. You talked about Narcan what are some ways that people can acquire Narcan. Now let's maybe before we get there, what is Narcan very briefly, and what is it meant to do and how can we equip ourselves with ways to have this life saving remedy?

NZINGA
Narcan is the overdose reversal drugs. So Narcan is the brand name. Naloxone is the generic name. So that's kind of like a tissue and Kleenex. Alright, so you go buy a whole bunch of tissues that are not the brand Kleenex, they're still tissues, you can buy it in the lock zone that are not the brand Narcan. It's still naloxone. It's an overdose reversal drug. And what it does is knock opioids off the receptors. So the most deadly part of opioids is that when they bind the receptors in your brain and your body, they tell your brain to stop breathing, literally just remove your drive to breathe. And so when you start breathing, that - stop breathing, I'm sorry- that leads to overdose death. When a person literally appears to be dead from an overdose by opioids, you can give them this Narcan. Narcan knocks the opioids off the receptors, that drive to breathe comes back, the person wakes up. What is very important is that Narcan is shorter acting than most opioids that people are taking. And so you may have to give a second dose but most importantly, you call 911. And then you give that dose so that paramedics can hopefully be there, take care of the person and make sure they don't go back into an overdose state. So that's what Narcan is. Narcan is not as widely available as it needs to be. If Nzinga ran the world, you could walk into every Walgreens and Kroger and CVS and pick up Narcan off the shelf just like you can pick up Tylenol and ibuprofen. You have to get it from a pharmacy. There are some states that are very forward thinking Thank you very much. This was first started in the city of Baltimore, where there's a standing doctor's prescription for Narcan. Anybody can walk up to any pharmacy and just ask for some Narcan. Now you have to pay for it. If you have insurance, it will cover it if you don't pay out of pocket, you can get Narcan. In states where there is not that standing order, any doctor, your primary care doctor and urgent care doctor, anybody can give you a prescription. You take it to the pharmacy. There are tons of community organizations that will give you Narcan kits for free. And so I've mentioned the Harm Reduction Coalition. Earlier when I when I mentioned Monique Tula you can go to their website harm reduction.org. They have

an Naloxone locator. Put in your zip code. It will tell you where you can go get Naloxone. Last thing because you know, it'd be taking about 30 minutes to answer every question, who should have Narcan? Everybody. So back in the 80s and 90s, we went on that big initiative to get everybody to learn CPR, so that if you were a bystander on the road and a stranger collapsed, you could at least try to help keep them alive until the ambulance got there. Everybody should have Narcan. You should especially have it if you're prescribed or taking any opioids, or if you know anybody who's prescribed or taking any opioids, or if you're taking any opioids illicitly. Or if you know anybody who's taking any opioids illicitly. But the real answer is everybody.

CHAD
Thank you so much for for that information. I know at To Write Love on Her Arms we talked to people who are still on the planet because because of Narcan we know the value of it. I remember the first time I heard the term harm reduction. It was the first year I was working for To Write Love. That's 14 years ago. And I remember reading this article about a clinic in Vancouver that was there to do harm reduction for intravenous drugs, specifically for heroin. They were there to provide fresh needles so that there wasn't going to be cross contamination of any venereal diseases. They were there to safely administer. They were there to make sure that the product wasn't laced. They were there to make sure that someone didn't overdose. And I remember reading this saying, hey, this feels kind of fucked up. Like you're telling me that nurses are now giving drugs. And then I talked to a friend about he's like, Dude, you have this all twisted, like, these are people making sure that someone who decides to use drugs or someone that resorts to using drugs, doesn't die, like it's better for them to wake up tomorrow and have another stab at recovery, right? To that end, are you aware of resources that enable, kind of in the moment harm reduction work? Or how does even someone go about finding places that if they are in the grips of addiction and grips of substance use disorder? Where are some places to turn to to make sure that tomorrow is still possible?

NZINGA
Yeah, I definitely, I promise you the Harm Reduction Coalition does not pay me. But it is just such a beautiful resource, they have so much support and information for people. So harmreduction.org. I'm always especially sensitive to the other mental health needs that come along with substance use disorders. So we know 80% of people who meet diagnostic criteria for a substance use disorder also have another mental health condition. And so always point to the suicide Crisis Text Line, always point to the Trevor Project for my LGBTQ Rainbow Youth. There are so many resources, the internet, I know can be a not beautiful place. But for this, literally, if you Google, I need help with addiction. Google has a beautiful tool that will tee up local resources for you. And then for other folks, I just say listen, connection is the name of the game. Period. If there is only one cue, right, your friend that you've talked about earlier, that you can develop enough trust and sense of safety to truly let them see how much help you're wanting. Just find one person find who that is.

CHAD 55:06
Shifting gears into the super local, we're talking about in our own homes. You mentioned, you know, with your loved ones with your family members that just had some some dental surgery done. You know, they get fifteen, twenty, thirty days worth of pills to help with a toothache. Odds are these pills just kind of sit in a cabinet for a while waiting to perhaps be discovered, perhaps be sought out? What are some options if we're aware that we have substances that can be radically dangerous, what are the safe methods to go about disposing of these? Ie don't don't just go flushing the toilet. We don't we don't need all the other fishes getting stoned.

NZINGA

No, do not we don't want that don't put it in the toilet. So every pharmacy will take back old prescriptions. So you can just round up. And this is not just old opioid prescriptions, even though that is what we're talking about. Like, it is hard for us to part with half empty bottles, pills, antibiotics, steroids, allergy medicines, right? Like take them all, you can get another prescription. Take them all, the pharmacy will let you discard them. There are also periodically buyback days. So the DEA and I don't know why it's called buyback because they're not going to give you any money for it. But we'll have like drop spots where you can just come safely drop these things off. Usually, local fire departments and local police departments will also, no questions asked, take back vials of prescription medications. But what is incredibly important if you have a young person in your home at all, keep the house empty of pills as much as possible. If you have a person who is at risk for developing substance use disorders, so that's anyone with depression anxiety, stressed out, previous history of risky use, just keep the house empty of narcotic pills are two really good hyperlocal strategies.

CHAD
I'm going to tell them myself a little bit. I admitted to not be a young person anymore, but just to really hone in on the date range. I was a dare kid. Hey, there you go. glad it worked well for us. For the uninitiated, that was a government program in public schools that stood for Drug Abuse Resistance Education, you really don't have to do too much and dig in to find ways in which that program fell radically short of its goals. But that is how most of us in our generation first learned our language around substances. It strikes me that there has perhaps always been a conversational gap between what we're comfortable talking about, how we talk about it, and and how readily that information is about it. You mentioned like talk to your kids about substances don't have them find out about drugs through locker room chat, because that could be horrible information and very damaging in the long run. What are some ways that we can reform and and reframe conversations, proper conversations, appropriate conversations around substances?

NZINGA
So the underlying principles that are the most important language is excruciatingly impactful. And we under appreciate the unintentional stigma that we send with our words. For example, I'm ten years clean, means that while you are actively using drugs, you're considered dirty. Back to your point about the infinite value and worth of every human being the moment that they graced this earth. And so language is excruciatingly important and so just being explicit about your desire to not use stigmatizing language and explicitly correcting yourself when you make that mistake, because we all gonna do it. Number two, compassion. The drug use is not the problem, the person is not the problem, the harm that can result from drug use is the problem. That's what we're trying to equip you to be able to prevent and or mitigate. That leads me directly into, I put the emphasis on equip you, because we don't need to be patriarchal about this. This needs to be grounded in that person's self agency and autonomy and the absolute right to make decisions for themselves. And what we're here in a support role to do is to provide education and access to resources that can reduce harm, should they choose to use drugs. And so when I have that conversation, I've been having drug conversations with my kids since they were about three years old. And this is because my family history is biologically stacked for severe cocaine addiction, severe alcohol addiction, severe heroin addiction, as well as depressive disorders, anxiety disorders, and psychotic disorders. I'm bringing all of that to the table in my DNA, right. And so the conversation that we're having with our kids are, you have a higher biological risk for developing drug addiction than maybe your other friends. We don't know what their biological risk is. Because you know that you have a higher biological risk, here's how you recognize if drug use is getting risky for you. The red flags are, we've created an environment where you don't have to lie about using drugs. If you start to feel like you have to lie about using drugs, let that be a red flag. We want you to have self agency and the ability to connect to other people without feeling like you need a substance to do that. If you start feeling like you need a substance

to do that, let that be a red flag. You will set boundaries for yourself around how much drugs you want to use. If you start finding it hard to meet your own boundaries that you've set for yourself, let that be a red flag, right. And so we started having those conversations early, because like diabetes, high blood pressure, asthma, which also run in our family, and you also have higher risk for those than your other friends. And so we're watching our nutrition and our diet, and we're not going to hopefully start smoking because that makes asthma worse. And we're going to you know, change our carpets and our house to reduce pet dander. These are all the ways we empower our children to make the healthiest decisions they can make for themselves with information that is not, because bad people use drugs, so just say no. Which is what DARE was. At Eleanor, we do culture oppression, racism and Recovery Training for every new person that starts the company, whether they're in a direct community member facing role or not as part of our culture. One of the slides, a couple of the slides are about DARE and the importance of language and training out the stigma that we've all been trained in.

CHAD
I love how you modeled the conversations with your kids. The idea that, that we're hoping that all of us are always becoming better versions of ourselves, but that doesn't mean that we already have all of the equipment readily available that it is super empowering to to allow someone to make a decision. Yeah, this has been absolutely amazing. I could speak with you for another nineteen hours, but I would love to give you the last word anything that we didn't touch on that that you wish we did, or any parting wisdoms or mantras, or you have but this is the unscripted Nzinga moment.

NZINGA 1:06:15
An unscripted Nzinga moment, I would like to completely and utterly undermine the widely held belief that people with substance use disorders don't get better. 75% of people with substance use disorder recover to a meaning of life and purpose and substance use that supports their functioning whether that is abstinence or controlled, 75%. We have the ability to make that even higher by keeping people connected.

[music playing]

CHAD: Simply saying thank you to Dr. Harrison for her time, insight, energy, and expertise doesn't feel adequate, but we're going to do it anyway. We are better and more informed as both individuals and as an organization due in great part to your willingness to speak with us and our listeners. Thank you, thank you, thank you. And to you, the one who's listening right now, we imagine you're in a similar boat and we hope you know how incredibly grateful we are to have you growing in compassion and gaining knowledge and understanding along with our team. You showing up and tuning in means so very much to us. We're glad you're here.

[music playing]

CHAD: We hope this episode has been a reminder that your story is important, you matter, and you're not alone.

If you're struggling right now, know that it is OK to reach out and that there are people who want to help. Part of our mission is to connect people to the help they need and deserve. You can find local mental health resources on our website twloha.com. That's T-W-L-O-H-A.com. And click FIND HELP at the top of the page.

If you're in the US or Canada, and you need to talk to someone right now, you can always text our friends at Crisis Text Line. Simply text the word TWLOHA—that's T W L O H A—to 741741. You'll be connected to a crisis counselor. It's free, confidential, and available 24/7.

For a list of crisis support resources for listeners living outside of the United States, please visit twloha.com and click on the International Resources tab.

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A big thank you to our friends at Copeland for the original music on this episode. The To Write Love on Her Arms podcast is produced by Rebecca Ebert. Music assistance was provided by James Likeness and Ben Tichenor. And again, I'm Chad Moses, thank you so much for listening. We're glad you're here.