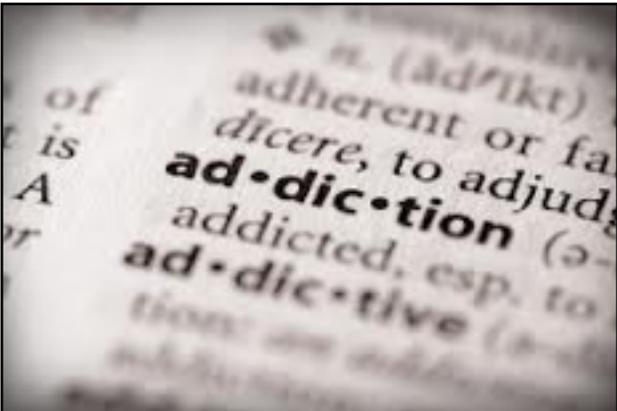
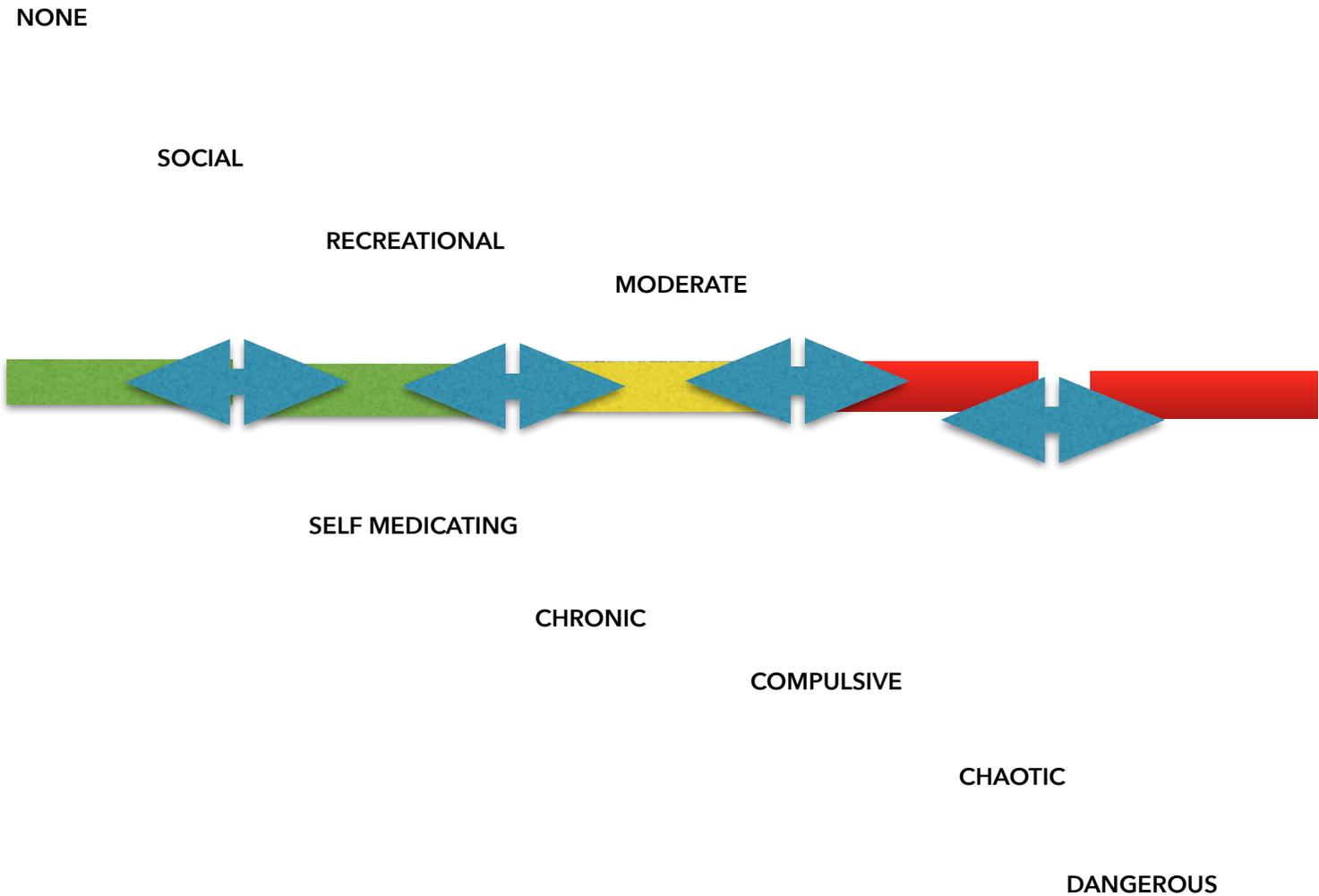


Simple but not easy: Harm Reduction Methods in a Case Consultation format



What are your values about substance use?

What are your clients values?

“HARM REDUCTION TREATMENT=COMPASSIONATE PRAGMATISM”

Alan Marlatt

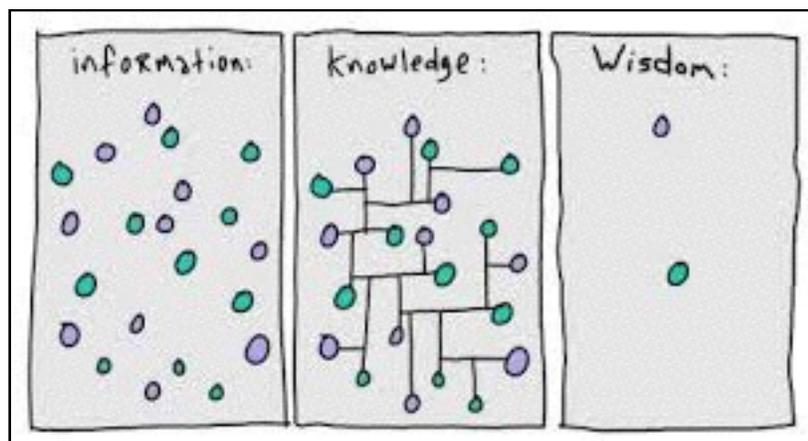
Guiding Principles

People get into trouble with substances & destructive behaviors for reasons

New learning in neurobiology supports the fact that people, especially those with physical, mental or emotional illness, get significant relief from behaviors such as substance use video gaming, thrill seeking in gambling and sex or in combinations of food.

The relationship with the behavior is the problem not necessarily the behavior Harm is relative. Depending on one’s reason for acting out the behavior may be preferable to one’s experience without it.

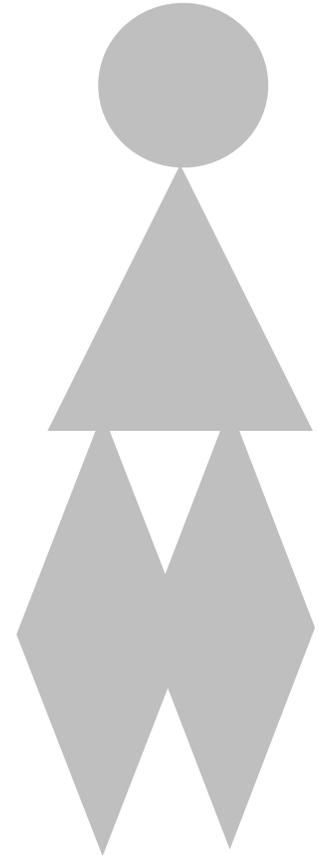
Harm Reduction is a collaborative process model, not an outcome model



What Theory? What Social Construction works for you ... your client?

Self Medication Hypothesis-Khantzian
Disease Concept of Addiction-Jellnick
Harm Reduction Psychotherapy-Denning
Client Centered Practices-Rogers & Others
Transtheoretical Model of Change-Prochaska & DiClementi
Motivational Interviewing Miller & Rollnick
Narrative & Solution Focused Therapy White and others
Magic & Wizardry-Dumbledore
The Force-Yoda

- Self-medication hypothesis was developed by Edward Khantzian in the early 1980s. Khantzian found among the people he and his associates worked with, pre-existing emotional problems prevented successful adaptation to adult life. Alcohol and drug use becomes a strategy to attain greater functionality. So their substance use serves a purpose and is a substitute for other coping skills that must be developed to acquired.
- Self-Determination Theory informs us that internal awarenesses have more value than externally driven, goals are most highly correlated with intrinsic motivation and therefore with successful change. Persons need healthy competence, attachments (relatedness) & Autonomy
- Harm Reduction Psychotherapy, Motivational Interviewing, Narrative Therapies synthesize client centered philosophies and ethics to make meaning of the behavior with the client. Substance use is a symptom or a behavior depending on several factors.



You will know (the good from bad) when you are calm and at peace. Passive. A Jedi uses The Force for knowledge and defense. Never attack.

What does theory leave out?

(Social and cultural aspects of drug and alcohol use and behavior including neighborhood, quality of immediate physical environment regarding where one lives (a senior on disability buying lottery tickets and going to the casino on a bus from her assisted living facility versus a trust fund thirty something who has taken up playing professional poker...) AND the neurobiological actions of the reward pleasure component of the behavior or behavior/substance combo themselves. (a middle age crystal meth user who has paired all his sex activity with drug use)

Outcomes are as varied as the people seeking change;
any harm reduction outcome is not only real; it is desirable!

RELATIONAL & HARM REDUCTION ASSESSMENTS (BIO PSYCHO SOCIAL)

Harm Reduction is any action that attempts to reduce the harm of substance or other behaviors.

Harm Reduction has a Top Down Public Health Component and a Grass Roots User Driven Approach

Harm Reduction keeps focus of attention is the damage done by the behavior and not the behavior itself.

Examples are the impact on health, mental health, loss of primary relationship, job, housing, etc.

Harm reduction offers a flexible client centered approach that is culturally competent.

Cultural~~~~Societal~~~Community~~~~Family~~~~Relationship~~~~Individual

RELATIONAL & HARM REDUCTION ASSESSMENTS

Managing Engagement : Create a working rapport, assessing negative beliefs and patterns from other treatments and internalized negative experiences with relationships and in other treatment.

Strengthening Self Management: Develop & enhance skills that decrease harms and risks.

Assessment as Intervention: Create and evoking new conversations about behaviors that promote and affirm autonomy, wisdom, values, culture and beliefs

Embracing Ambivalence-: Normalize feelings and behaviors by acknowledging the functional aspect of behavior

Educate and Prevent the Relapse Violation Effect : Raise awareness of and plan for relapse as a part of change;

Repair Micro and Macro aggressions & past engagement problems and false beliefs of both client, provider and system

Provide education and informed consent : Explain and test harm reduction & other theoretical frames; develop a shared language

Negotiate around high risks and harms : Foster a collaborative experimental attitude about treatment (trial and error with frequent observation and evaluation

High Risk Behaviors are Social Constructions and can be Adaptive & Maladaptive depending on social context.

A Model who learns to purge and restrict food before a big photo shoot.

A Nurse who is stressed out working with trauma all day and goes home to drink every night to shut it off

A Veteran who uses meth to feel alive and normal

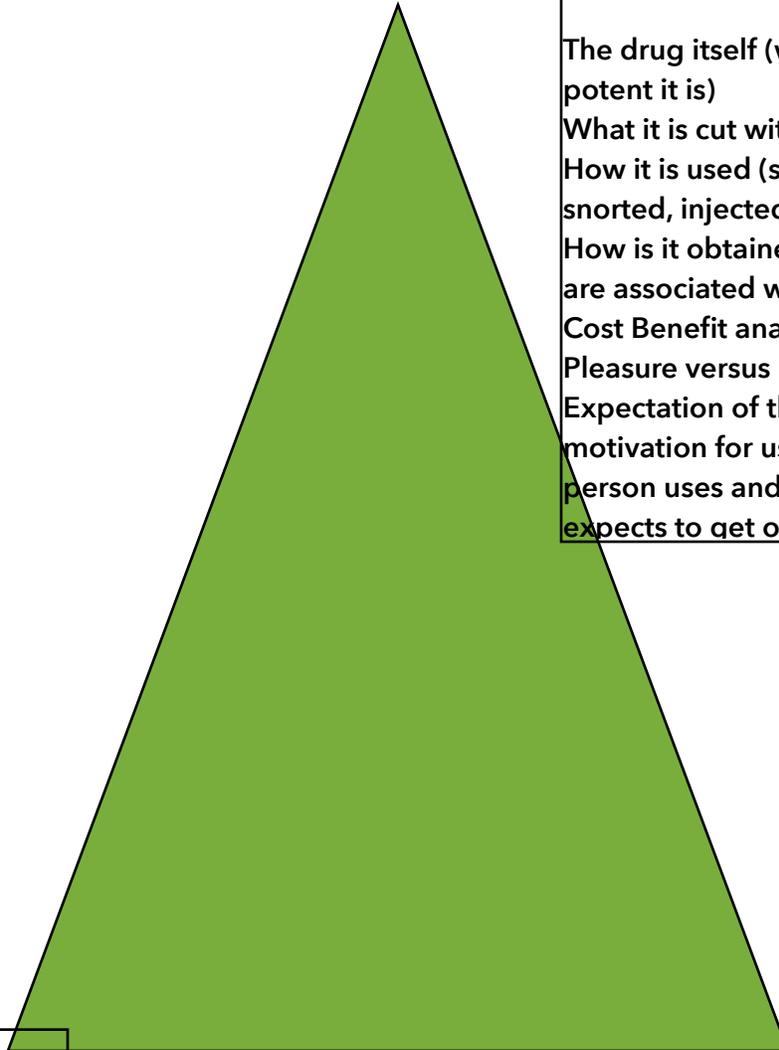
A Schizophrenic who uses nicotine and cocaine to have a social experience or calm down voices

Drug, Set, Setting

Adapted from :
Zinberg, N. (1984)

Drug, Set, Setting

New Haven:
Yale University



DRUG

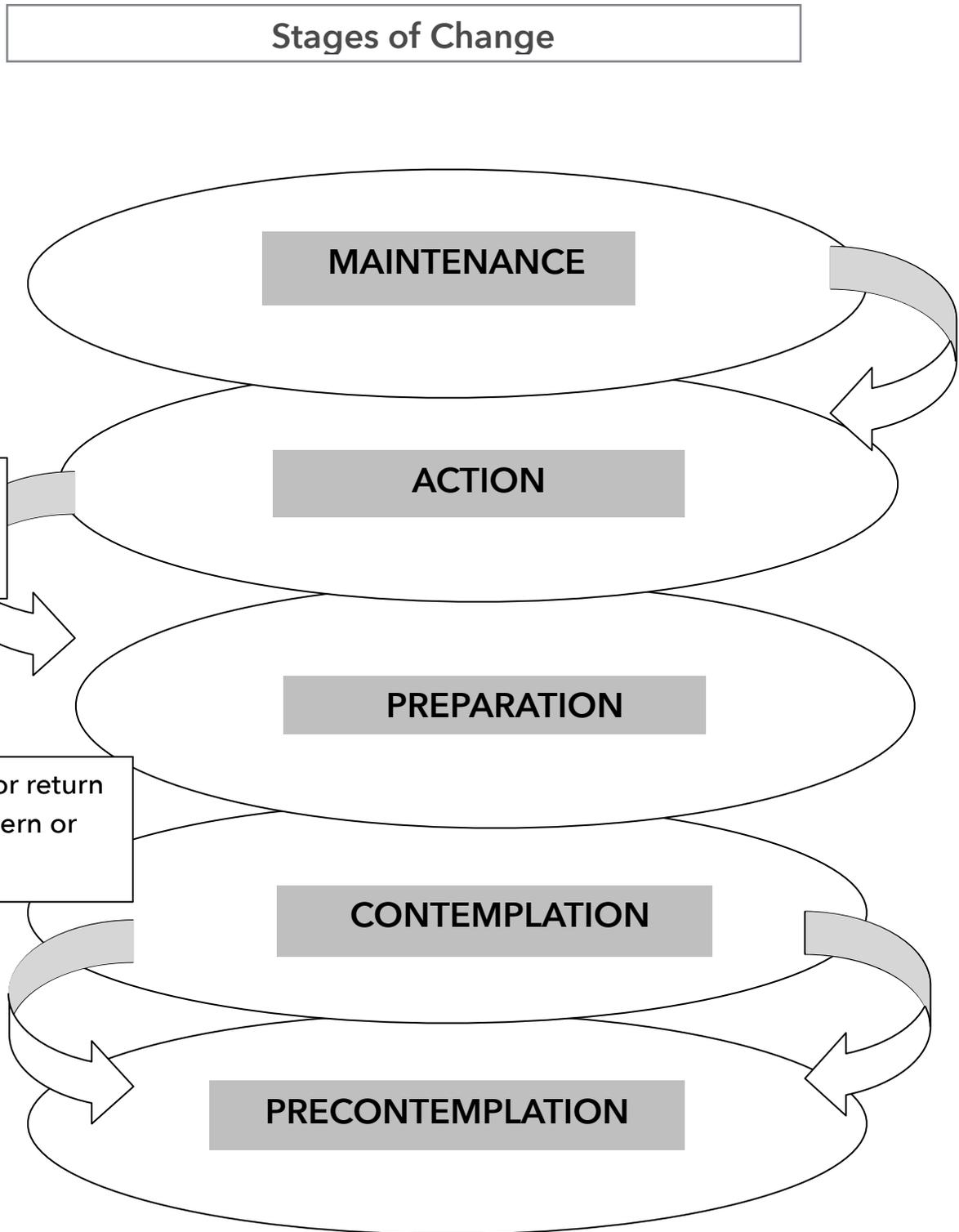
The drug itself (what it does and how potent it is)
What it is cut with
How it is used (swallowed, smoked, snorted, injected, absorbed)
How is it obtained what risks or harms are associated with it?...
Cost Benefit analysis
Pleasure versus punishment
Expectation of the drug and motivation for using the drug (why a person uses and what a person expects to get out of it)

SET (person)

Person's unique physiology
Person's physical health
Person's mental or emotional state
Person's cultural identity, culture of origin, and sense of belonging.
Person's relationship to pleasure, self soothing.values

SETTING environment (s)

The stress in a person's life: social, economic, or environmental
The support in someone's life
With whom and where someone uses
The social and cultural attitudes toward drug use - the meaning ascribed to drug use or to a particular drug by the person's community and surrounding culture



Incremental change is normal and motivation is fluid
The Stages of Change Model, based on research, explains the process that we go through to make major behavior change and asserts that change is most effective if we work through the stages one at a time, thoroughly, in order, and preferably with support.

Reasons for Use

1. Pleasure/Social Assess: desired effect (DE) amount and combination needed for DE, Ability to guarantee DE, intended and unintended outcomes, after effects if any, other coping skills

2. Self Medication

Assess Symptoms and DE, amounts needed, Ability to guarantee DE, intended and unintended outcomes, after effects if any, other coping skills

3. Maintenance

Assess triggering symptoms, DE Ability to guarantee DE, intended and unintended outcomes, after effects if any, other coping skills

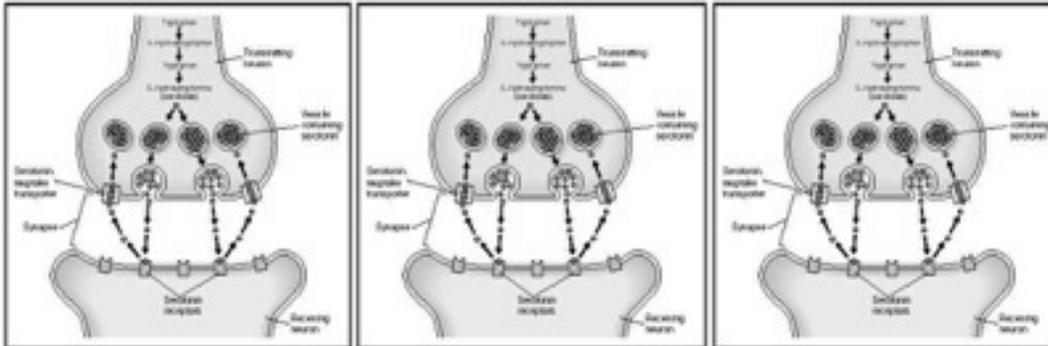
What goals and aspirations does this person have for change?

Do your Goals for change match the persons?

What stage of change are they in? Are they ready to make a plan for change?

What do they want the substance to do? Is it doing it?

NEUROTRANSMITTERS, DRUGS, AND MENTAL ILLNESS



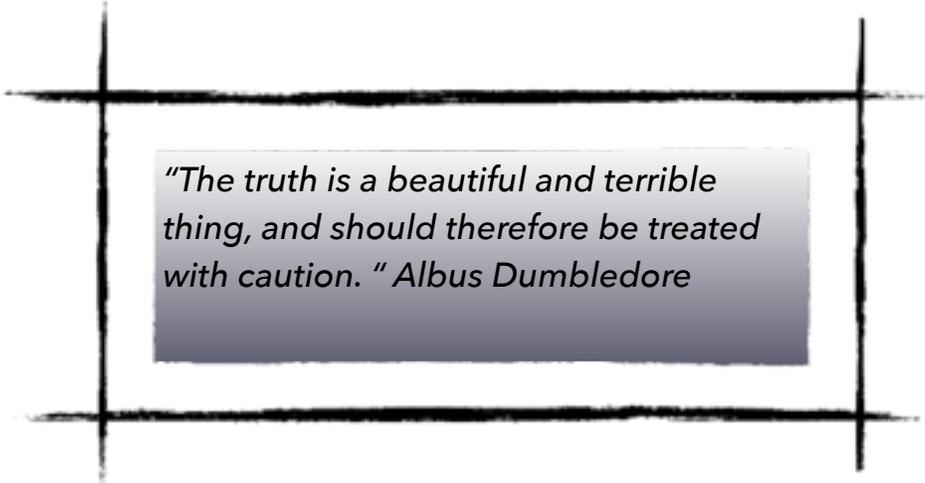
Neurotransmitter	Major Functions of Neurotransmitters	Drugs Affecting	Associated Mental Illnesses
Dopamine	Reward, muscle activity, energy, attention, pleasure , emotional stability	All, but some more than others!	Schizophrenia, other psychosis
Norepinephrine	Energy, motivation, eating, attention, pleasure, alertness, assertiveness, confidence - "fight or flight"	Stimulants, nicotine	Anxiety, depression
Serotonin	Mood stability, appetite, sleep, sexual activity, aggression, self-esteem	Stimulants, hallucinogens	Depression
Anandamide	Learning, memory, motor coordination, integration of sensory experience with emotion	Marijuana	
Endorphins	Pain control, reward, stress control	Opioids, alcohol, marijuana, PCP	Mood lability, emotional pain
GABA	Major inhibitory NT, muscle relaxant, controls aggression, arousal - brain's "valium"	Alcohol, benzodiazepines, barbituates, PCP	Anxiety, insomnia
Glutamate	Major excitatory NT, memory, learning, arousal, reward	Ketamine, PCP	Mania

What are the Harms of staying the same? Of trying moderation? Of making the change? of slow incremental change?

Initially a harm reduction approach involves Mobilizing client strengths for change, de-stigmatizing the behavior and developing a power sharing collaboration

Creating a Harm Reduction Plan with a Client

- Engagement as a therapeutic task and focus
- Clinician Attitude management
- Ongoing Assessment & Collaborative Goal Setting as a part of treatment
- Medical Assessment
- Facilitating Capacities for Change
- Ideal Behavior Management Plan including interventions for increasing strengths and motivations and relapse contingencies



"The truth is a beautiful and terrible thing, and should therefore be treated with caution." Albus Dumbledore

Harm Reduction Principles

- The focus of attention is the damage done by drug and alcohol use, and not the drug use itself. Examples are impact on health, mental health, loss of primary relationship, job, housing, etc.
- Harm reduction is exemplified in public health approaches such as needle exchange, methadone, and the distribution of Narcan. Policy and advocacy approaches include decriminalization of drug use, fair sentencing laws and medical marijuana to reduce the harm done by the War on Drugs. Harm reduction also means offering treatment on site with housing, and making sure that the treatment incorporates the stages of change and motivational interviewing to engage people.

Guiding Principles that inform harm reduction work:

Not all drug use is abuse

Most people in the U.S. use some type of drug, and most do not have problems. Moreover, most can and do make rational choices about, and while, using drugs.

Drug use occurs on a continuum from benign to chaotic, and people move back and forth between those poles throughout their drug-using lifespan, most never reaching the point of chaos.

Drug abuse is a health, not a legal or moral concern-There should be no punitive sanctions for what a person chooses to, or refuses to, put into her/his body.

People use drugs for reasons

New learning in neurobiology supports the fact that people, especially those with physical, mental or emotional illness, get significant relief from street drugs.

People don't usually have the disease of addiction; they have a relationship with drugs.

Harm is relative. Depending on one's reason for using, drugs may be preferable to one's experience without them.

Incremental change is normal and motivation is fluid

The Stages of Change Model, based on research, explains the process that we go through to make major behavior change and asserts that change is most effective if we work through the stages one at a time, thoroughly, in order, and preferably with support.

Harm Reduction is a collaborative process model, not an outcome model

Harm reduction requires that the drug user and the treatment provider work together to identify the problems and to plan solutions. A combination of Drug, Set, Setting and the Stages of Change Model help to establish each drug user's Hierarchy of Needs (treatment goals).

Self-Determination Theory informs us that client-driven, not externally-driven, goals are most highly correlated with intrinsic motivation and therefore with successful change.

Motivational Interviewing is the most useful model for facilitating motivation and change.

Fundamental to harm reduction is to start where the client is and treat drug users with respect.

People have the right to make their own choices, including the "bad" ones.

Outcomes are as varied as the people seeking change; this outcome is not only real; it is desirable!

Abstinence is one of many harm reduction goals; it just isn't the only one.

At any point in time, most people in the U.S. with drug problems are not abstinent.

To date, treatment has abysmal abstinence outcomes but much better harm reduction outcomes.

CASE STUDIES

Marcel is a 21-year-old African-American man, self-referred for inpatient treatment due to drug and alcohol abuse. He is currently unemployed, homeless, and has charges pending due to a number of "bounced" checks written over the past several months. Marcel reports that both of his parents were drug addicts and he experienced physical, sexual, and emotional abuse throughout childhood at their hands. His father died of liver disease at the age of 37.

Marcel also reports that at the age of 14, he was kicked out of his family's home because his father suspected that he was gay. Although they live in the same town, he has not had any contact with either parent for 7 years. Marcel describes his relationship with his older sister as "fair." Marcel is not presently involved in a steady relationship, but does have a network of friends in the local gay community with whom he has been staying off and on. At the time that he left home, Marcel survived by becoming involved in sexual relationships with older men, many of whom were also abusive. He has had numerous sexual partners (both male and female) over the past 7 years, has traded sex for drugs and money, has had sex under the influence of drugs and alcohol, and has been made to have sex against his will. Marcel identifies himself as bisexual, not gay.

Marcel first used alcohol at age 14, when he had his first sexual encounter with a man. He began using other drugs, including inhalants and marijuana by age 16 and amphetamines and cocaine by age 19.

At 21, four months prior to entering treatment, he began using crack. He has recently been kicked out of treatment for inappropriate sexual behavior and is couch surfing and has relapsed. He says he only went to treatment to get off the street and wants to work on getting disability.

Last week, Alexia came in to seek help for a recurrent SA issue. She reports current alcohol and cocaine (crack) use and says that she can't stop like she used to. Alexia is a 32-year-old, divorced woman who is employed as an administrative assistant at a local human services program. She lives with her 11-year-old daughter, Christine, in an apartment located near her job. Although she makes a relatively low salary, Alexia has managed to support herself and her daughter without financial support from Christine's father. Alexia was married briefly to Christine's father when she was 20, but she left him after he became physically and sexually abusive toward her. He also was an alcoholic. She had almost no contact with him for many years. Her mother, a widow, is a strong support for Alexia and Christine, as are two cousins, Denise and Moira. Alexia reports growing up in a "normal middle class family" and states that her childhood was "good" despite her father's occasional drinking binges, which she says were related to him celebrating a special account he had landed (he was in advertising), and her mother's "occasional bad depressions." She is the youngest of five children and the only girl. She says her mother nags at her about her drinking and tells her she must quit or will be like her father.

Up until a month ago, Alexia was regularly attending twice-weekly treatment sessions at an outpatient chemical dependency clinic, and she went to AA/NA regularly 3 times a week. She had a sponsor and they kept in touch several times a week-more, if needed. From the beginning of recovery, Alexia has experienced some mild depression. She describes having little pleasure in life and feeling tired and "dragging" all of the time. Alexia reports that her difficulty in standing up for herself with her boss at work is a constant stressor. She persisted with treatment and AA/NA, but has seen no major improvement in how she feels.

Alexia reports having had a lot of gynecological problems during her 20s, resulting in a hysterectomy at age 27. When asked if she was ever physically or sexually abused as a child, she says no; however, she confesses (with some difficulty) that when she was 11, she had an affair with her 35-year-old uncle (father's brother-in-law). Alexia reports feeling numb and tense. She talks, only when specifically asked a question. She feels hopeless about her ability to put her life together and says that she only sees herself failing again to achieve sobriety. Of her recent rape, she says that she "only got what she deserved" for being in the wrong place with the wrong people at the wrong time. Alexia reflects that she was unable to adequately protect her daughter from sexual assault, and she speculates that maybe she is an unfit mother and should give up custody of her daughter. While Christine is currently staying with Alexia's mother, Alexia is concerned that her ex-husband will try to get custody of Christine if he hears that she is getting help for alcohol and drug treatment. He has been in recovery himself for two years and began demanding to see Christine again about 2 months ago.

After Alexia had been sober for about 3 months, an older boy sexually assaulted Christine after school. Alexia supported Christine through the prosecution process; the case was tried in juvenile court and the boy returned to school 2 months later.

After Alexia celebrated her 6-month sobriety anniversary, she reports that she started having a harder time getting herself up each day. Around this same time, she returned to drinking daily. She says that she then started experiencing bouts of feeling worthless, sad, guilty, hopeless, and very anxious. Her sleep problems increased, she began having nightmares, and she lost her appetite. After a month of this, she started attending AA/NA and treatment less often, instead staying home and watching TV. She started her crack use again one night after her boss got very upset with her not finishing something on time. She went to a local bar after work that day and hooked up with a guy she met there to get crack. In accompanying him to a local dealer's house to get some crack, she was raped by several men. Alexia did not return home that night (Christine was at a friend's sleepover party) and did not show up for work the next day. She does not recall where she was the rest of that night. This event caused her to seek help.

What are the most significant Harms to Address First?

What behaviors would you target for work?

What makes sense about client's behavior?

What are possible reasons for substance use from the client's point of view?

How is his behavior adaptive?

What stage of change do you think he's in (for stable housing, for drug treatment, for case management, for counseling)?

What are client's strengths?

How long do you think it might take for client to reach your goals?

What are their goals?

What would be his most likely points of resistance?

What feelings and attitudes of your own get stirred up by the client?

Assessing Risk/ Engagement Potential/ Relationship Needs

Where would you start with this person?

Is engagement present? Possible?

What are the most concerning behaviors?

How regulated are they?

What issue would you target first?

What stage is he at in terms of drug use? Behaviors?

Assess need for autonomy, collaboration, compassion, relationship for new experience
(evoking)

What is Motivation? *To Change* *To Stop* *To Go back In Time?*

Is moderation possible?

If Use is a binge pattern, is delaying the start of the binge possible?

➤ Creating a Harm Reduction Plan with a Client

- Engagement as a therapeutic task and focus
- Clinician Attitude management
- Assessment & Collaborative Goal Setting as a part of treatment
- Medical Assessment
- Facilitating Capacities for Change
- Ideal Behavior Management Plan including interventions for increasing strengths and motivations and relapse contingencies

IS DRUG SET SETTING A USEFUL ASSESSMENT TOOL?

What Matters to YOU?	What Matters to your Client?

DRUG Or Behavior	Current Use	Planned Use	Desired Effect	Route of Use	Setting	Start date
Alcohol	5 Drinks	4 drinks 3x/week not while playing cards	FUN	oral	out with friends	NOW
Playing Poker	4 days a week	1 Night decrease amounts of game 25 cents to 10 cents	decompress from work	N/A	with friends in private club	Not sure
Internet porn	4 -5 x Weekend	1x a month No phone dates Just masturbat ion	Great Sex		alone	After Halloween
Tobacco	Pack/day	quit	None	smoke		No sure Yet

Ethics Recipe for Harm Reduction Plans

- Pause & Identify your personal response to case
- Review Facts: harms & Risks Your concerns & Clients
- Form an Initial Plan based on Collaborative goals & clinical issues
- Consult your own ethics code
- Consider Autonomy issues
- Consider Beneficence Issues-not a feeling but an intention
- Consider the possibility that you or your system will create more harm for individual, partner, family, community, society?
- What are fidelity or loyalty issues-you keeping your word etc How do you hold and demonstrate respect?
- What are the Social Justice Issues?-fairness and equity for individual and for the larger community? (Do you need legal advice or opinion?)
- How do you assess need for acceptance autonomy and collaboration versus coercion and expert authority?
- Review & Re-Assess options
- Hold to plan or make new plan &and share with client; whenever possible collaborate.
- Implement and Monitor all outcomes; Revise as needed

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MEDICATION & RELAPSE SELF ASSESSMENT

POT _____ OPIATES _____ STIMULANTS _____ ALCOHOL _____ OTHER: _____

1. 1.UNPLEASANT EMOTIONS (e.g., If I were depressed about things in general; if everything was going badly for me.)

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

not confident

totally confident

2. PHYSICAL DISCOMFORT (e.g.,If I were ill, jumpy, physically uncomfortable, tense.)

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

not confident

totally confident

3. PLEASANT EMOTION (e.g., If something good were happening, I wanted to celebrate, I was happy, things were going well.)

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

not confident

totally confident

4. TESTING CONTROL OVER MY ALCOHOL OR DRUGS (e.g., If I had the thought or belief that drugs were o longer a problem for me, if I felt that I can handle it again, if I am around people with worse problems than I or if i were around normal social users who didn't have problems.)

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

not confident

totally confident

5. URGES AND TEMPTATIONS (e.g., IF I had a sudden urge to use. If I were in a situation where I typically had used before, if I began to remember how good a rush or high felt, if I had a craving.)

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

not confident

totally confident

6. CONFLICT WITH OTHERS (e.g. If I had an argument with a friend; If I were having conflicts with significant others, at work or home.)

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

not confident

totally confident

7. SOCIAL PRESSURE (e.g., If someone would pressure me to " join in, be a good sport," use with them. If I was invited to someone's home and they offered me drinks or drugs.)

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

not confident

totally confident

8. PLEASANT TIMES WITH OTHERS (e.g., If I wanted to celebrate with friends, make friends, be at a social gathering and want to enhance the enjoyment.)

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

not confident

totally confident

(2003 Sobell & Sobel

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