The Wisdom to Know the Difference: Harm Reduction Assessment, Interventions in combination with Motivational Interviewing Strategies

Why Consider Harm Reduction with Addictions?
Guiding Principles :

People get into trouble with 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 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.

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 client and the treatment provider work together to identify the problems and to plan solutions. A combination of Drug or Behavior, 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.

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.

Fundamental to harm reduction is to start where the client is and treat clients with respect. People have the right to make their own choices, including the "bad" ones.

- **Self-medication hypothesis was developed by Edward Khantzian in the early 1980s.** Khantzian found among the people he and his associates worked with that pre-existing emotional problems prevented successful adaptation to adult life. Alcohol and drug use becomes a strategy to attain greater functionality.

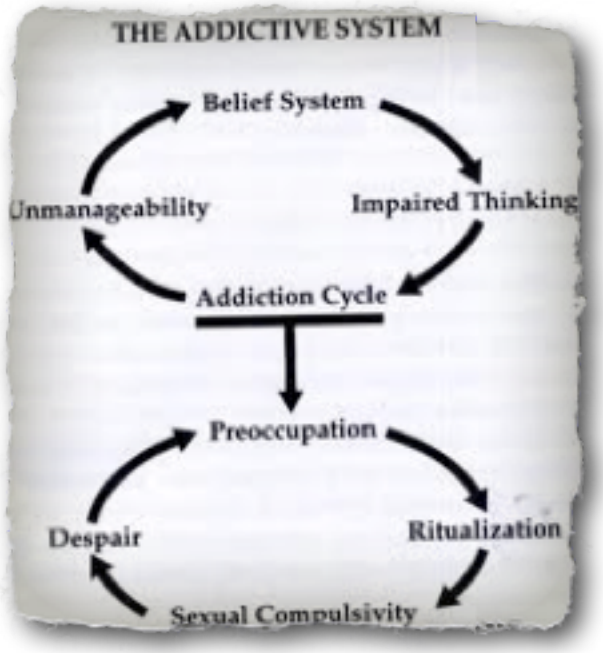
What does this theory leave out?

(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; this outcome is not only real; it is desirable!

Behavior on a Continuum
Defining Harms and Risks

Culturally~~~~Societally~~~Community~~~~Family~~~~Relationship~~~~Individual



Process Addictions or Process Pattern Problems) Often operate in conjunction with other behaviors: Substances + Risky Sex + Gambling
They usually involve poor impulse control and risk taking.
Some Behavior maybe interchangeable and can be seen as a problem behavior syndrome rather than a distinct addiction.

High Risk Behaviors are Social Constructions and can be Adaptive & Maladaptive depending on social context.
Example- A Model who learns to purge and restrict food before a big photo shoot

Many Process Patterns do not fit comfortably into a disease model but are often seen as : **Right Time + Right Situation + Right Place Phenomenon**

Clients will often identify themselves as addicted and recognize the addictive or loss of control element to their behavior

Gambling	Work	Sex	Video Games	Exercise	Foods
Poor Impulse Control Risk taking	Poor Impulse Control??	Poor Impulse Control /Risk taking	Poor Impulse Control/Risk Taking	Poor Impulse Control??	Poor Impulse Control?
May Need Higher Than Normal Arousal to elevate excitement	May Have Higher than Normal Arousal to elevate excitement	May Need Higher than Normal Arousal to elevate excitement	May Need Higher than Normal Arousal to elevate excitement	May have Higher than normal arousal state	May need Higher Arousal State or may Have
2.6% of Canadians	31% Canadians	3-6% of Adults in US	10.3 % of Ontario Students grade 7-12		

Process Pattern Problems differ from pure Obsession/Compulsions because they are directed toward a goal and are expected to yeild pleasure.

In Contrast OCD is rigid, stereotyped and repetitive and not performed for any result.

Harm Reduction is a paradigm shifting idea that has the potential to significantly improve the treatment of Problem Substance Use (*andProcess Pattern Problems and Addictions*). The essence of Harm Reduction is that all change reduces the harms associated with the *behavior* and can be regarded as valuable. Andrew Tatrsky

Start Where the Client Is!

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

Is Moderation Possible?

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,
destigmatizing the behavior and developing a power sharing collaboration

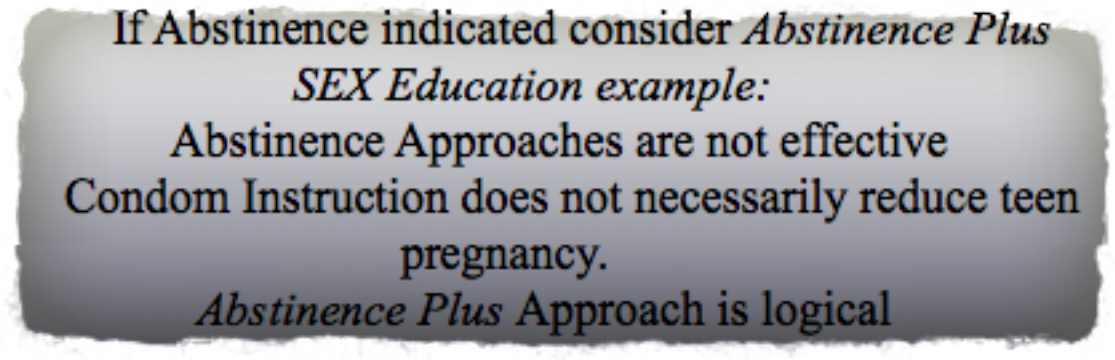
Creating a Harm Reduction Plan with a Client

- **Engagement as a therapeutic task and focus**
- **Clinician Attitude management**
- **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**

Managing Engagement - create healthy rapport, assess counselor responses and biases and manage, use all assessments as treatment facilitating clients strengths to change, embracing ambivalence and solving ethical dilemmas, Provide education about Harm reduction and rationale for experimental trial and error client centered approach, Contract around harms

"HARM REDUCTION TREATMENT=COMPASSIONATE PRAGMATISM"
Alan Marlatt

Managing Engagement - Creating a working rapport, assessing negative beliefs and patterns from other treatments and internalized negative experiences with

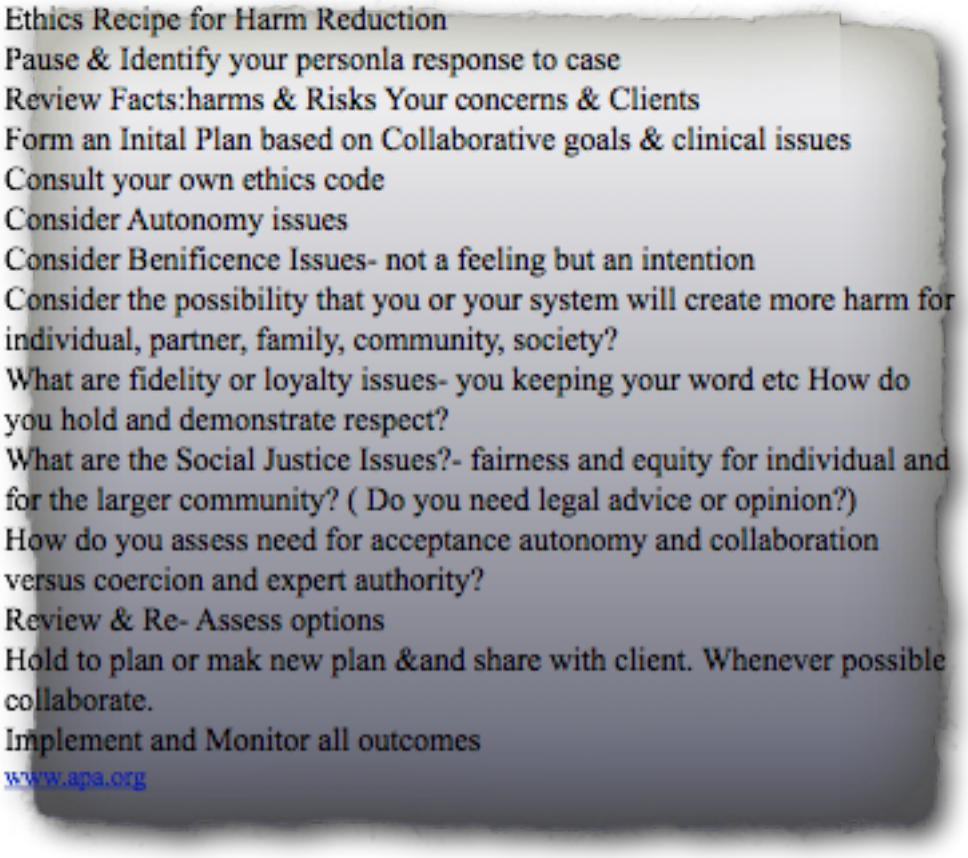


relationships and in other treatment; Strengthening self management skills for change; Using Assessment as Treatment, embracing Ambivalence; Normalizing feelings and behaviors by acknowledging the functional aspect of behavior; Educate and prevent the relapse violation effect by normalizing relapse as a part of change; Repairing engagement problems; Provide education and informed consent about Harm reduction Therapies; Negotiate around high risks and harms; Fostering a collaborative experimental attitude about treatment (trial and error with frequent observation and evaluation

Interventions-

Urge Surfing-reflecting on Urges not acting on them- Id urges as a set of sensations and thoughts; cultivating uncritical observations slows down urge+ action with space +time; interupts habitual self defeating pattern and makes alternatives possible
ID event---thought---urge----choice---action sequences
Teach thinking thorough urge skills
Use Dialogue with aspects of self desire to use versus desire to change and others (Stone & Winkleman Voice Dialogue Method) or cost benefit analysis
Reflect on reasons for change
Id triggers
Teach management skills to resolve triggers: CBT,relaxation,Assertiveness, 18 Alternatives list

Create the Game Plan


Ethics Recipe for Harm Reduction
Pause & Identify your personla response to case
Review Facts:harms & Risks Your concerns & Clients
Form an Inital Plan based on Collaborative goals & clinical issues
Consult your own ethics code
Consider Autonomy issues
Consider Benificence 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 mak new plan &and share with client. Whenever possible collaborate.
Implement and Monitor all outcomes
www.apa.org

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

DRUG Or Behavior	Current Use	Planned Use	Desired Effect	Route of Use	Setting	Start date
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 masturbation	Great Sex		alone	After Halloween
Tobacco	Pack/day	quit	None	smoke		No sure Yet

Relapse Prevention

Brief Situational Confidence Questionnaire

Right now I would be able to resist using drugs or drinking heavily in situations involving

Alcohol_____ Pot_____Opiates_____Stimulants_____

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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