Harm reduction takes different approach to addiction

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As counselors in the mental health profession we continuously look to advances in treatment approaches involving a variety of mental health-related issues including drug/alcohol abuse, stress, anxiety, depression, and other behavioral difficulties.

Looking for new approaches that can result in better outcomes is always our objective. One such approach is "harm reduction," a treatment intervention particularly useful for patients with high risk behaviors such as alcohol/drug use, gambling, and unprotected sexual activity.

Harm reduction represents a philosophy for engaging at-risk patients with the intent of empowering patients to make better choices and to understand consequences.

A key philosophical shift is the transition of abstinence to a harm reduction model of treatment. The critical piece here is the idea of "starting where the patient is." For example, persons doing cocaine may also be doing pot. The initial objective is to get patients past the cocaine abuse first and then at some point the process of confronting the pot use.

This approach also opens the door for developing a therapeutic alliance that anchors patients in the treatment process. Abstinence may be the best approach for many, but it should not be a pre-requisite or stipulation for treatment.

As "traditionalists" in the field of mental health treatment, we need to lower the threshold keeping in mind that abusers may not be ready for abstinence but may be able to tolerate moderation of risk-taking behaviors.

The old school way of thinking is that persons who are still engaged in risky behaviors are not yet committed to a plan of abstinence. The potential for reaching "non-conforming" persons is increased by staying away from stipulations written in treatment plans that essentially threaten curtailment of services if considered "non-compliant."

Recent evidence-based data within a harm reduction treatment environment shows much better retention rates than with a traditional psychotherapy model.

With alcohol/drug abuse, a harm reduction model of treatment looks at relapse as a stage of change regardless of the addiction. Making mistakes is ok but preferably not the same risky mistakes.

The harm reduction model of treatment can conflict with agency policy regarding abstinence as a condition of providing treatment.

Resilience is an attribute we all have, although at times, it can be severely tested and sometimes overpowered by the urge to engage in risky behaviors.

Harm reduction therapy allows for reinvigorating this attribute by way of emphasizing the ability to adapt; restructuring social outlets that are more healthy which has the potential for helping the patient to begin the process of redefining self; being able to "face the music" with laughter; and, developing new involvements.

Ambivalence, in which the part that wants to change is in conflict with the part that wants to stay high or intoxicated, can be a critical piece in the treatment process. However, this split must be healed. An "I don't care" attitude is the activation of the split.

In harm reduction counseling, ambivalence can be the key to reducing risky behaviors by way of making use of a systematic focus on the pros and cons of using and stopping; even making use of cost/benefit analysis with the patient can be eye-opening.

The core principles of Harm Reduction include:

- Embracing small incremental change.
- Seeking to decrease harmful consequences without requiring abstinence.
- Starting where the patient is.

There are implications however:

- Harm Reduction is an umbrella concept that must be linked with a full range of counseling interventions.
- The onus is on counselors to decide how to reach their patients.
- Treatment goals must be developed between counselor and patient that focus on decreasing risky behaviors.

Counselors must be willing to continually look at shifting long standing treatment paradigms in order to accommodate new attitudes, new styles of adaptation and different ways of making use of patient strengths and vulnerabilities.

Starting where the patient is (even if it means lowering the threshold) stands a better chance of getting the patient engaged in the journey of making changes.

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