

Starting Where the Client Is: Harm Reduction Guidelines for Social Work Practice

Sheila P. Vakharia PhD LMSW

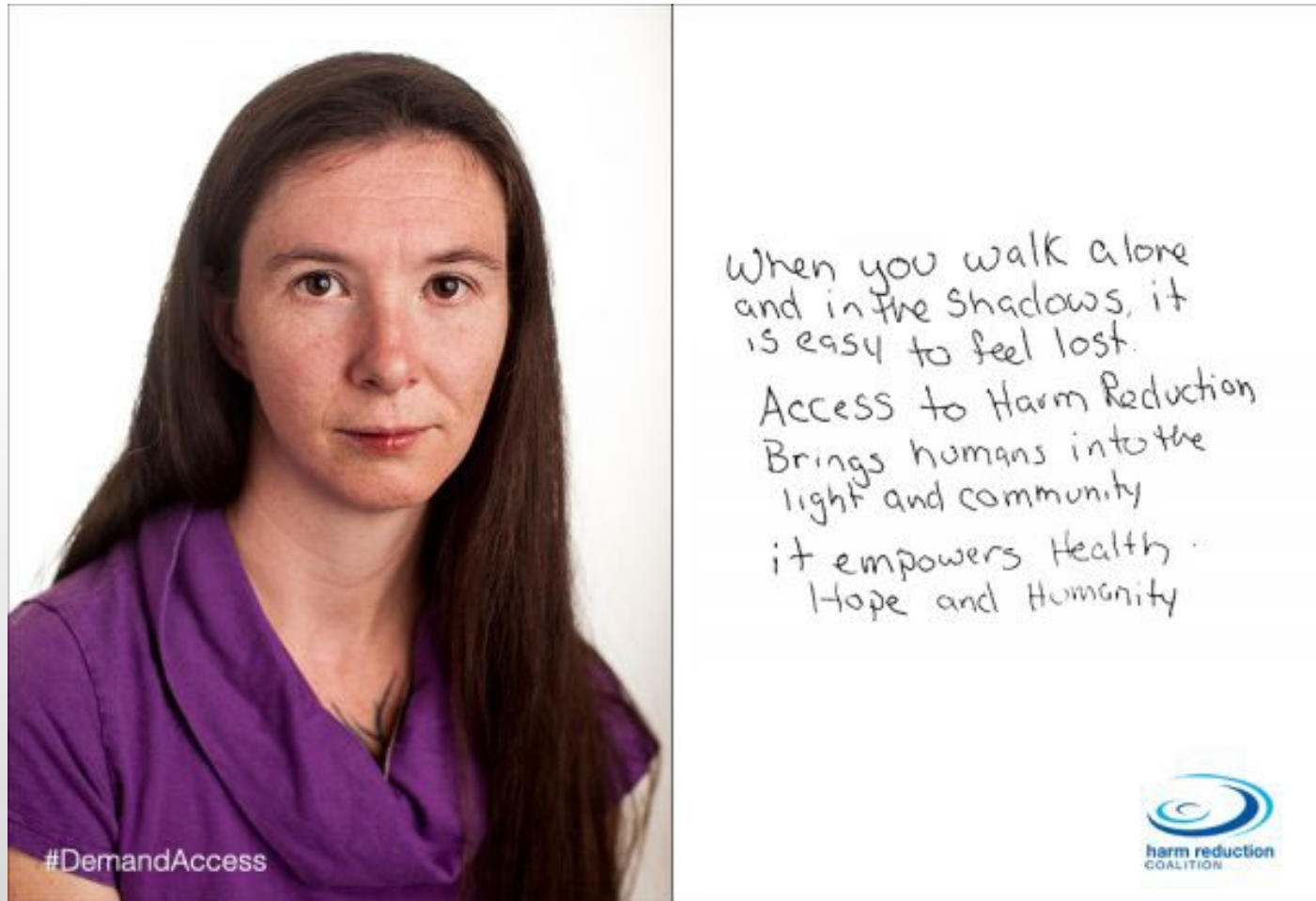
Deputy Director,

Department of Research and Academic Engagement

Drug Policy Alliance

**many thanks to National Harm Reduction Coalition for photos

So what is harm reduction?



“harm reduction is a set of compassionate and pragmatic approaches for reducing harm associated with high-risk behaviors and improving quality of life”

(Marlatt, Larimer, & Witkiewitz, 2012, p. 5)

Origins of Harm Reduction: Mutual Aid & HIV Prevention

- *Junkiebond* in Netherlands in 1980's*
 - Injection drug users (IDU) were then highest known risk group for HIV
 - 1st syringe exchange program (SEP) in Amsterdam in 1984
 - Response to HBV/HIV epidemic affecting them and their loved ones
 - By 1988 - 720,000 syringes exchanged
- Through word of mouth, has gradually spread internationally over the past 40+ years in various forms of treatments, programs, and public policies

*Read Maia Szalavitz's latest *Undoing Drugs* for more!

Harm Reduction Tenets and Principles

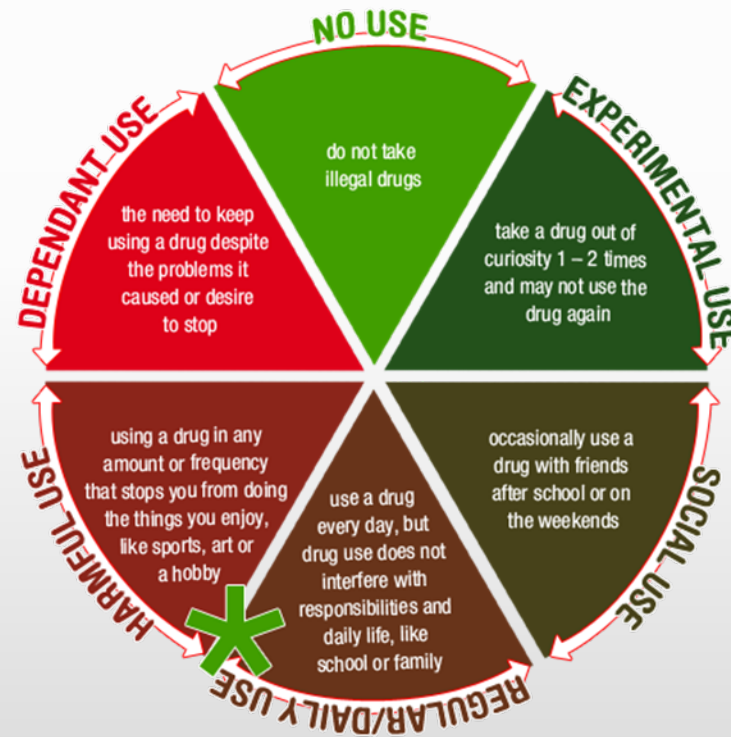
Drugs are Here to Stay

- All societies have used mood-altering substances over course of history
 - Cultural and social norms for moderation or occasional use
 - Often incorporated into religious/spiritual practices
 - Examples: coca leaf chewing in Bolivia, wine during Catholic communion, ayahuasca in the Amazon, marijuana among Rastafari, coffee/tea with breakfast
- Drugs are not going away and the aim of a drug-free world is unrealistic and unnecessary
- Drug use is NOT a moral issue, should not be a criminal issue either

Drug Use Occurs on a Continuum

Not all use is problematic!

Use is not necessarily 'abuse'



Use can vary from substance to substance!

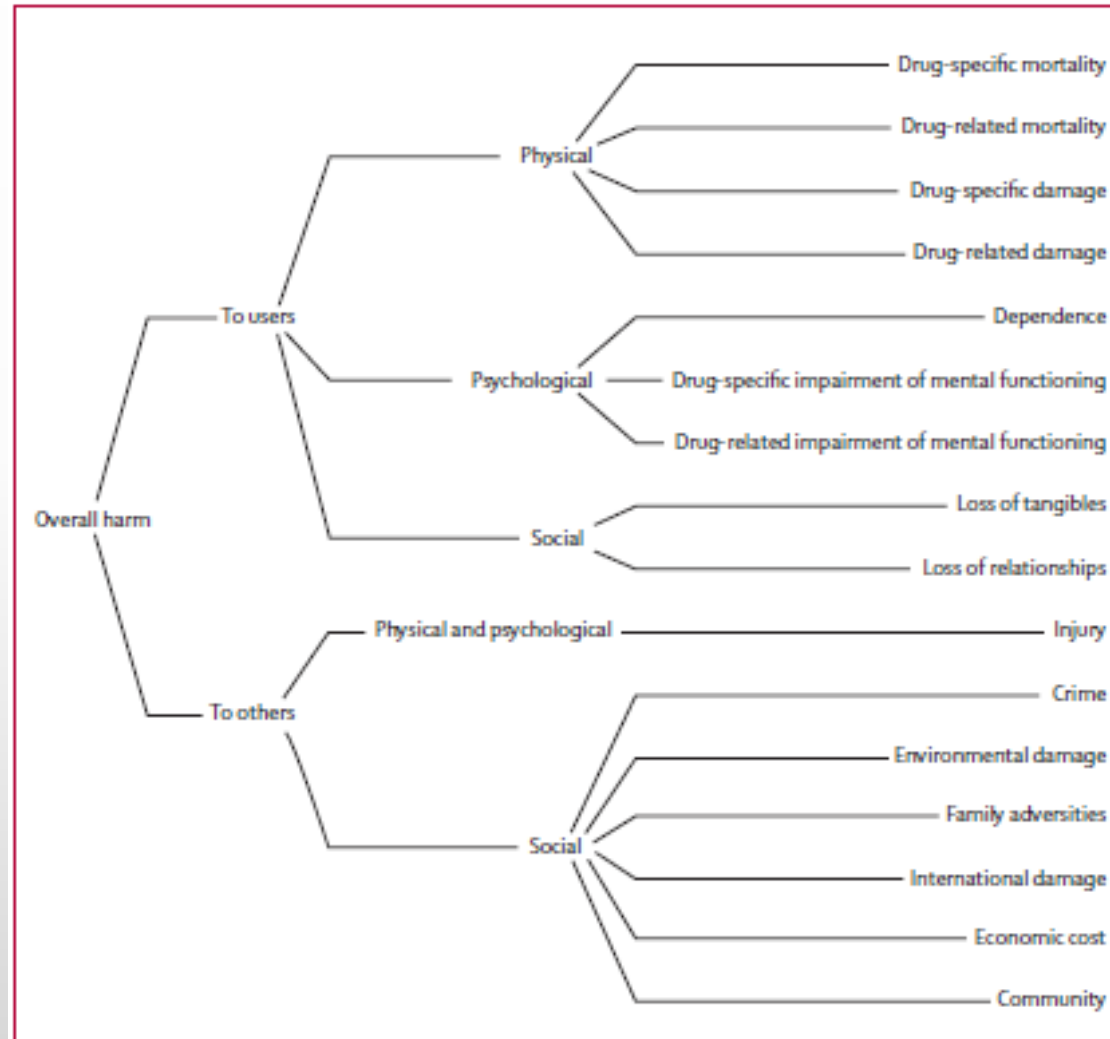
Harm is relative!

Drugs can be dangerous!

Many potential harms to use

Many potential areas where we can help

How can we help people be safer?



Even non-dependent users face harms sometimes

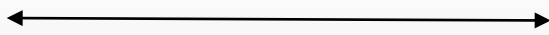
Figure 1: Evaluation criteria organised by harms to users and harms to others, and clustered under physical, psychological, and social effects

(Nutt, King, & Phillips, 2010)

People use drugs for reasons

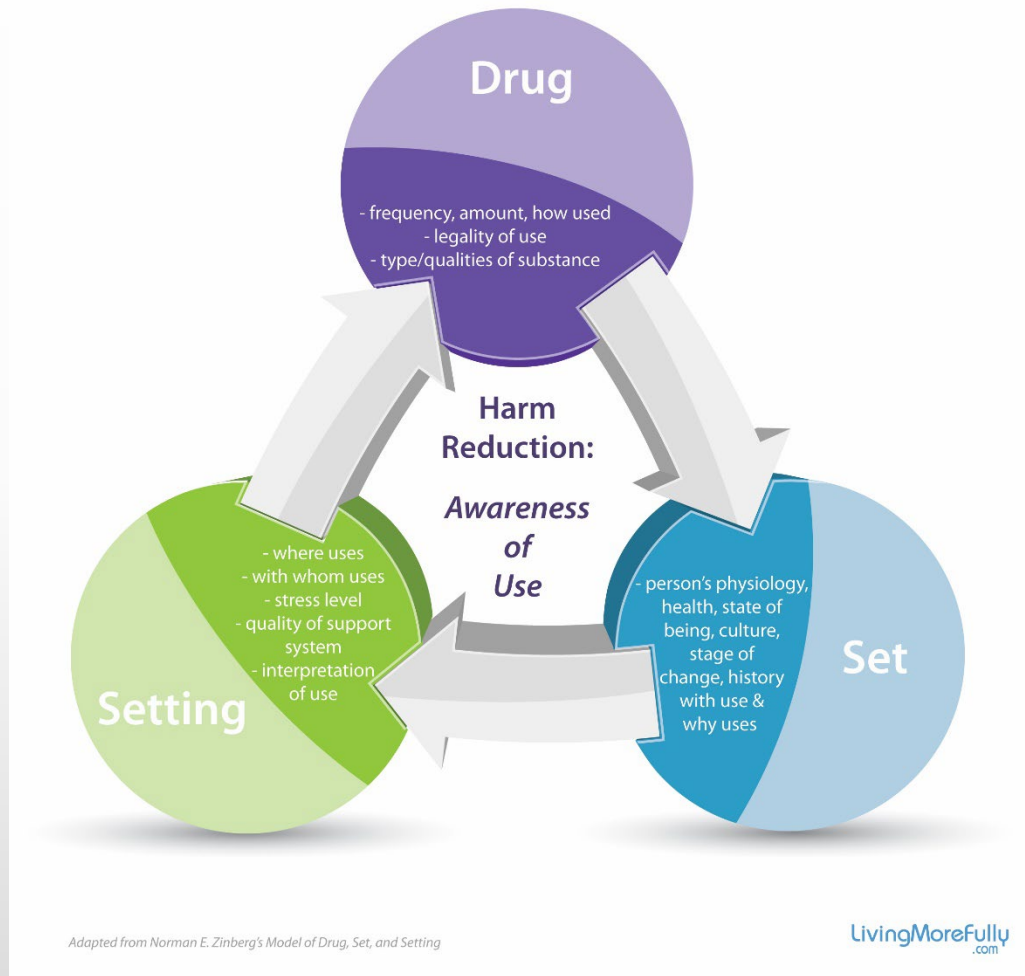
- Drug use is a meaningful activity with significance to the user
 - The use of a drug can serve one or many functions for the user
 - The importance of ritual in preparation, consumption, intoxication
 - Accessing or suppressing dissociated parts of themselves
 - Helping them get through challenging times, experiences
 - Serving social and interpersonal functions
- The role of trauma and other mental health concerns
- Drug users often DO do a cost/benefit analysis of their use
- “Don’t take away what you can’t replace”

People have relationships with drugs

- People have relationships with their drugs, rather than an addiction to them.
 - Non-pathologizing language
 - “Addiction” is a dichotomous concept
 - Relationships can range from helpful  harmful
 - Relationships can CHANGE
 - One can have different relationships with the different drugs they use
 - ~~“A drug is a drug is a drug”~~
- Every individual has a different relationship their drugs
 - ~~“Terminal uniqueness”~~

Drug, Set, & Setting Model (Zinberg, 1984)

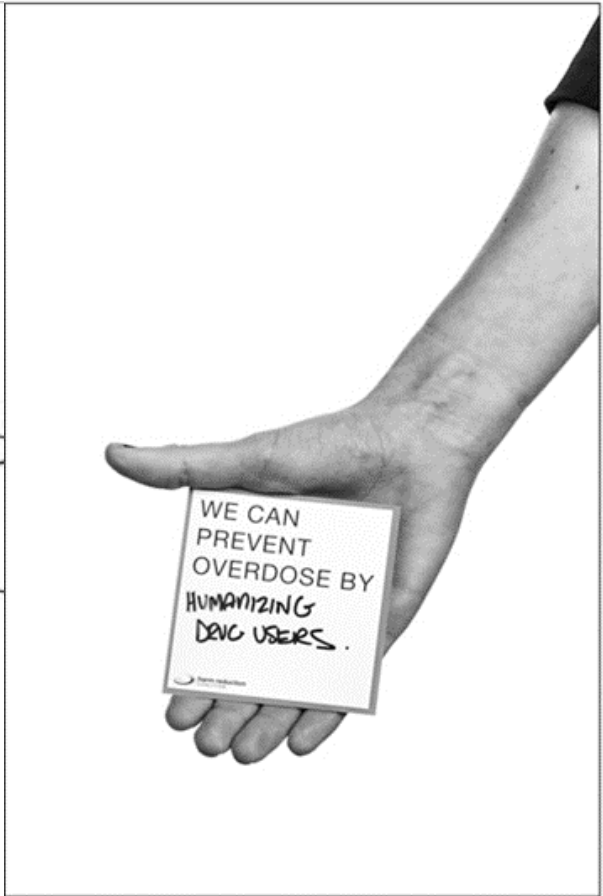

- Substance use does not occur within a bubble
- These factors which explain why some may use problematically and others don't
- Harm reductionists find this model more useful than disease models, criminal models, moralistic models of addiction



People who continue to use drugs matter



People who use
Drugs are valuable
and very important
always show them
Dignity and respect

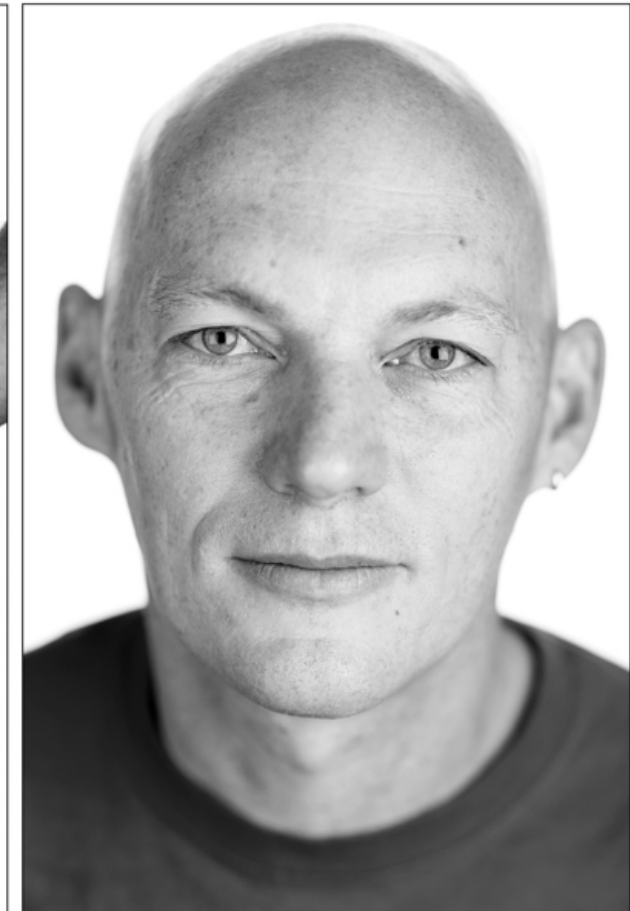


People who continue to use drugs matter

- An untapped population with potential unmet needs
- Everyone is motivated for something- it's important to find out what that is
 - May want access to other services or supports
 - May want to be a part of a community and give back
- More than just “addicts,” these are community members, friends, family members with something to contribute

Harm Reduction in Direct Practice

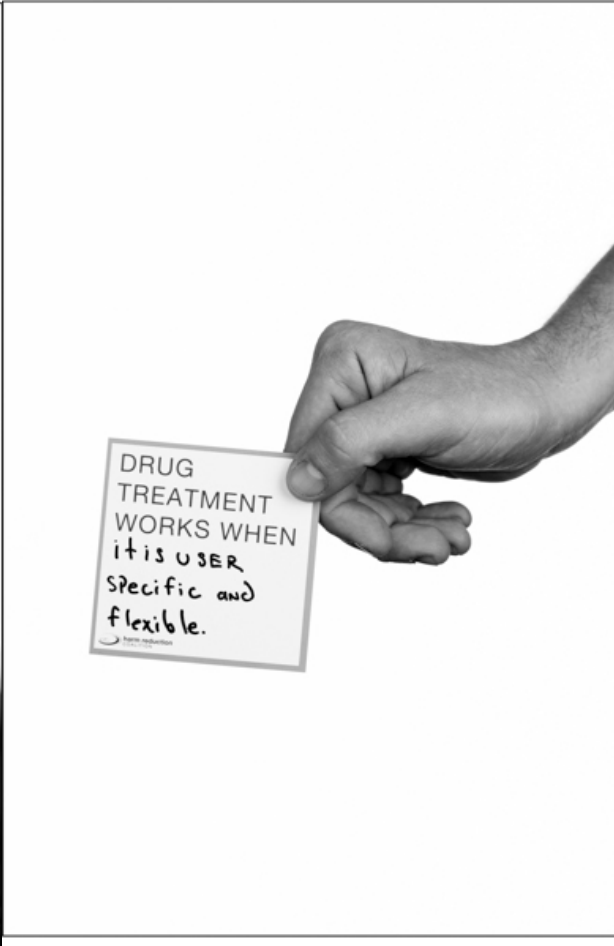
Low Threshold – “Come as you are”



Low Threshold Services

- Most people who have SUDs (90%) aren't in treatment because they are unready or unwilling to quit (SAMHSA, 2020)
 - How can we get THEM to come to US? (principle of attraction)
 - Better yet, how can WE get to THEM? (mobile services)
- Our systems of care should be on a continuum to have impact
Low Threshold ←————→ High Threshold
- For example: treatment readiness groups, harm reduction groups, recovery readiness groups, drop-in times

Client-Centered and Collaborative Treatment



Client-Centered and Collaborative Treatment

- Clinician conveys a neutral stance towards substance use
- Explore client priorities, values, concerns
 - What worries client most?
 - What would client like to change?
 - What does client need help with?
 - Where would you like to start?
- Individualized planning- no “one-size-fits-all” approach

Abstinence is great, but it's not for everyone

- Not everyone is ready, willing, able to abstain but EVERYONE deserves help and compassion
- A radical stance of “compassionate pragmatism rather than moralistic idealism” (Marlatt, 1998)
- If people are going to continue to use drugs, make sure they are safe and know how to reduce risk to self and others
- Successful outcomes of treatment should be improved health and quality of life rather than fixation upon whether a person has a chemical in their body
- Examples: seat belts, designated drivers, nicotine patches, methadone

Trauma-Informed Care

- Trauma survivors have history of being made to feel powerless
 - Substance use is often a way in which they take their power back to change how they feel/help them focus
 - Substance use is a proactive behavior
 - Can be adaptive for a while
 - Harm reduction respects their use of substances to cope
- Harm reduction does not involve exercising power, control, authority, shaming, blaming, stigmatizing
 - Treatment can be re-traumatizing and triggering, harm reduction approaches try to avoid these

What do Harm Reduction
Policies Look Like?


Some examples

- Supervised Consumption Spaces
- Sterile equipment
- Medication Treatments
- Drug-checking
- Drug Education
- Naloxone access
- Safe Supply
- Decriminalization
- Regulation


What we DON'T need

- ~~Supply side interventions~~
- ~~Criminalization and Incarceration~~
- ~~To further damage relationships between doctors and patients~~
- ~~Drug testing and surveillance~~
- ~~Stigma~~
- ~~Coercion in the name of “help”~~
- ~~Temporary funds~~

As you leave today...



Challenge your own thoughts on drug use & drug users. This is not about being comfortable. Access to humane, kind, loving, and compassionate treatment is a basic human right.



harm reduction
COALITION