

Questions Asked During Live Webinar Broadcast on 6/12/19



Changing Minds: Implementing Harm Reduction

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How would you implete Harm Reducation in a child welfare setting?

A: This is such a challenge, and one we're actively facing here in MA as a result of marijuana legalization, among other factors. My colleagues in child welfare have often said that they focus on impairment and impact on parenting, vs. the use itself. In the case of child welfare, the increasing safety aspect includes not only personal safety, but obviously safety of the child(ren) as the paramount concern. I think the tenants of attending to medical needs, using Housing First, and reducing frequency of use may all be helpful to individuals involved with CPS, along with education about safe storage and plans for alternate care on occasions where the parent may use.

How do you address clients coming into your center while using substances? What is the preferred harm reduction approach.

A: There's some variation here based on where the person is in the change process. Safety and security are paramount, and staff members should never feel forced into meeting with someone if the situation feels volatile or unsafe. If an individual is struggling to engage, we may provide practical support like getting them home safely. What we want to avoid is an individual who uses before a meeting as an avoidance strategy... we want to show caring concern and engagement vs. "kicking them out."

As a provider in a county human services department, many of our residential treatment programs are 12-step based abstinent only. How can someone in my role utilize harm reduction in their practice without stepping on the toes of the residential treatment facilities that we partner with?

A: That's a delicate balance! I would suggest a multiple pronged approach. Meet with the residential program and have an open dialogue about what informs both of your practices. I tend to focus on the health aspects of employing harm reduction: we're focused on keeping people alive and healthy. And then you can also have a frank conversation with the individuals you're serving and weigh the pros and cons of continuing to use in these programs. I'm not sure if your involvement with them is tied to being enrolled in a residential, but I would suggest having a "low threshold" for services and that they could remain engaged with outpatient supports even if the residential model isn't a good fit for their recovery journey.

This is good information as a clinical supervisor it provide various techniques to help the counselor. My agency utilize this model in MAT, and co- occurring disorder. Have you applied this approach in agencies that serve both population

A: My agency isn't an MAT provider, but we do work with adults who receive MAT services from other providers, and we have had success with helping keep those individuals consistent with attending MAT services by reducing the amount of shame and stigma associated. We only serve individuals with co-occurring disorders, so we've found it very helpful for that population! The biggest shift we observe is that staff members who are comfortable with mental health but unfamiliar with SUD have seen harm reduction as something they CAN do for an issue they're not inherently comfortable with.

Have clients in group therapy resisted harm reduction when personally operating from a self-help model?

A:

Would you suggest advising a client to use a less harmful substance, or would you just accept that idea if it's something that they bring it up themselves?

A: I haven't personally advocated someone to switch from cocaine to marijuana, as an example. If someone is using multiple substances, I may help them evaluate which ones are serving what purposes, and highlight the drawbacks to the more harmful substances (particularly with IV use).

Can you give us some examples of harm reduction interventions?

A: There are a few highlighted on the slides, but it's not an exhaustive list or fully placed in context there. I would check out the Harm Reduction Coalition website for a wealth of information on the the practice of harm reduction in order to see what interventions may fit for your practice.

<https://harmreduction.org/our-resources/>

You say "includes abstinence"... do you mean that it CAN include abstinence or that it always does?

A: That is can include abstinence. For nearly all of us, abstinence from drugs and alcohol (including nicotine and caffeine) would likely improve our health and wellness, even if our current use isn't problematic. So it should always be on the table as an option, but it may not be the option everyone decides to pursue.

Do you consider this more of a program or an intervention for folks with co-occurring disorder?

A: An intervention, in what is hopefully a broad array of interventions for individuals in various places in the change process.

Aren't their ethical concerns in promoting "reduction in amounts/frequency" with substance use? Example; If the person reduces their cocaine use from x5 per week to x2, then they would be validated correct? However, what if they get arrested/overdose/etc. during the targeted x2 usage? Isn't the practitioner/agency liable?

A: I can't speak to any specifics around case law with liability using harm reduction. The consistent message we've received from our state partners is that doing something is better than doing nothing, and keeping someone in treatment is the preferable outcome to discharging due to use. I think from my perspective, the key is to have the INDIVIDUAL set their targets, so I'm not the one saying "only using 2x a week is going to fix this" and be realistic in what those targets can achieve. Reduction of risk isn't total mitigation of risk, and I think that's important for us to communicate that using LESS won't take all the risk off the table, but it can reduce it.

Adverse Childhood Experiences. (ACEs). Anxiety, depression and post traumatic stress. Two separate streams, led to over four decades of addiction. Harm Reduction will not work for someone like me, but I am a huge fan of the process for others. Which segment needs to be addressed first - removing the substance, or finding a mental balance? Thank you for letting me share.

A: I know we were able to discuss this on the livestream, but I'd just like to reiterate that my personal approach is always both/and, not either/or. There are some wonderful co-occurring curricula out there, and I personally use Seeking Safety, developed by Lisa Najavits, for this particular co-occurring pattern. That program acknowledges that substance use has served a purpose, and therefore individuals must learn new skills and strategies before giving up the strategy they've relied on so far.

<https://www.treatment-innovations.org/seeking-safety.html>

Where was the case consultation form from?

A: It's adapted from a format in Integrated Dual Disorder Treatment (IDDT) published by SAMHSA. I've had the great good fortune to learn about that practice directly from Kim Mueser and Lindy Fox, and I would highly recommend checking out their materials.

<https://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based-Practices-EBP-KIT/SMA08-4367>

Is there a reimbursement differential for the co-occurring members in the program?

A: Unfortunately, not currently for us through our DMH contracts. Our state Medicaid program is actively encouraging the

development of co-occurring disorder programs, however, and I believe the reimbursement rates through their structures will be a bit higher to accommodate the additional training and skill needed to address both issues in tandem.

Do you find harm reduction sometimes is misunderstood as substitution? I am thinking in Tobacco Cessation circles.

A: Yes, it certainly is. I am personally biased, given that I am also trained as a Tobacco Treatment Specialist, that we give tobacco and nicotine short shrift in the overall landscape of substance use disorder, especially in the co-occurring disorders world, where a huge percentage of individuals smoke, and it's taking years off their lives. What I appreciate about how harm reduction works in my own practice is letting the individual set the priorities in treatment. We can place all substances on the same plane and acknowledge their impact on the person's life, and give them the decision making power to decide which makes the most sense. We're then not looking to nicotine as a "replacement," we're looking at it as one piece of the overall puzzle of this individual's recovery. I hope that's clear!

I have included links to resources where relevant. Please note I have no formal relationship with any of these entities and am not receiving any incentives to promote them to you, they are just resources I personally use and find helpful!