Questions Asked During Live Webinar Broadcast on 10/23/19

Harm Reduction: 1 May Be Enough, and 1,000 IS Too Many

Presenter: Ami Crowley, EdD, NCC, ACS, ICADC, MCAP, LPC, LMHC

Please talk more about the "limits" and boundaries you mentioned when helping clients make better choices?

A: I may not be fully understanding this question so feel free to reach out for further details. When guiding the client towards goal setting, you base the goals on the areas of harm that have been identified and discussed by the client and therapist. The goals are directly related to ways to reduce harm. However, there are instances in which a desired goal of the client’s may fall outside of the realm of possibilities/boundaries available to the client. If I am working with a client to reduce the harm caused by their compulsive shopping behavior (identified harm is maxed out credit card and bank account in the negative) and their goal is to engage in their addictive behavior (compulsive shopping) on only 5 out of 7 days in the week, it would be important for the therapist to guide the client towards identifying and understanding that there are external boundaries preventing their specific goal from being successful.

Why is Tobacco Harm Reduction (vaping, swedish snus, etc.) not embraced by harm reductionists, given that it is 95-99% less harmful than smoking, and is actually an evidence-based tool for adult smoking cessation?

A: I do not believe Harm Reductionists are dismissing vaping as an alternative to smoking. In fact, research from the recent years is showing that alternatives such as vaping are acceptable harm reduction techniques (Notley, Ward, Dawkins, & Holland, 2018). Certainly there are some studies showing that vaping itself carries its own set of problems. However, the majority of concerns about vaping are related to younger users who likely are vaping for reasons other than smoking cessation.


What do you think about contracting with a client "If you aren't able to meet the goals you set up, can you commit to going into an abstinence-based program?"

A: A great question. I believe that this would depend on the client’s goals. Part of treatment planning with any client is establishing what they most want out of treatment. A client may desire for “controlled use” yet struggle to attain that. Harm Reduction would encourage revision of the goals to a more manageable expectation. However, it will not impress abstinence upon the client if the client has not chosen abstinence themselves.

How are health insurance companies adapting to this concept, because they set time limits, i.e set number of sessions, on client care?

A: While some insurance companies are setting limits, these tend to apply to higher levels of care such as IOP and PHP. Many insurance companies do not place restrictions on OP LOC and often do not even require a pre-requisite. That being said, there are some insurance companies who are more “hands on” with the client’s treatment and will set limits. Regardless of the situation, it is important to have a conversation with the client from the beginning that this approach is not a short-term type of treatment. It will take time and if insurance does not cover all of the sessions, exploring with the client additional options for payment for services would be needed.

I work in MAT - I try to work from a harm reduction standpoint, but is there a time when we say that outpatient MAT is not a high enough LOC? Do you believe there is a time to refer to a higher level of care?

A: Referrals for any level of care is based upon the client’s goals for treatment. If an individual comes to outpatient reporting that they drink 18 beers per day and their goal is to stop their use immediately to prevent further damage to their health, then I would recommend inpatient LOC as outpatient is not equipped to handle the variety of risks associated with such a
goal. If a client sets goals that should be manageable at an outpatient LOC, yet continue to fall short of achieving their goal each week, then the goal needs to be revised. An element of revision can be utilization of a higher LOC.

How do you track progress?
A: Progress is tracked by the client. They may be assigned the task of keeping notes or a journal on their use between sessions. Such a journal can include specific behaviors that are being addressed such as frequency and duration. The data the client gathers (self-report) is reviewed in session and based upon the results, the next steps are determined. The next steps can include sticking with the goal, revising part or all of the goal, or choosing a new goal. I prefer to assign my clients specific behaviors to track between sessions. I request they write down the information to reduce misreporting. This data can be kept in a notebook and reviewed as needed to assist in establishing goals and determining progress.

Do you have any advice for talking about harm reduction with legal authorities when they want the client to abstain right now?
A: When I have had these tough conversations, I bring with me data to support what I am promoting. Harm reduction is not debating why an individual uses, rather we accept that it happens. Relapse rates for abstinence-based programs vary between 40-80% depending on the addiction and level of care. Harm reduction doesn’t believe in relapse, rather, we support reduction of harm. When a client is involved in the legal system, an element of your work with the client is identifying and understanding legal troubles as harm. If a client’s use or continued use will result in legal issues, then that should be framed as harmful behaviors that need to be reduced. Having a strong alliance with your local legal authorities is helpful in “selling the concept” of harm reduction. I remind them that abstinence is a component of harm reduction and that any client actively working to reduce the harm caused in their lives due to their addiction will also be working to reduce the addictive behaviors. Now, I cannot say that I have personally had success in getting local legal authorities to support continued use as a final goal, however, I have had them support a process of reducing harm/reducing addictive behaviors towards a final goal of abstinence.

Do clinicians translate these philosophies and strategies to those that are underage? such as teens? and if so, how do you reconcile the differences in harms between teen use and adult use?
A: The motivating factor for me to become a harm reductionist was my work with adolescents and college students. They were not successful in abstinence-based programs. They were rebuffing the statements such as “once an addict, always an addict” and teachings of cross addiction. Many of these individual saw their use as a “normal” part of their development and difficulty at a young age should not determine the remainder of their lives. Helping these populations see the harm can be challenging, as often the harm is not immediate, and with a prefrontal cortex that is not fully developed, foresight is lacking. Harm reduction principles seem to fit better with teens and young adults as it does not sound like a permanent restriction. Rather, we work on identifying the immediate harm and provide them examples/data on future harms to consider. Teens are often more open to abstinence-based goals “for now” as they do not feel forced into abstinence forever. As the teens and young adults clear their body and mind from their addictive behaviors, they are better able to “see” the harm and establish goals to reduce it. It is not uncommon to work with teens and young adults to develop plans for moderate/controlled use to be implemented later in life.

Is it not illegal to have illegal substances in your body only to have them on your person?
A: No, it is not illegal to be under the influence as long as you are not also doing something like driving. It is illegal to be in possession of actual drugs and paraphernalia used/associated with drugs. However, once the substance is consumed, you are no longer in possession of it.

How might these best practices change when working with marginalized groups such as foster youth and/or young people of color?
A: Any therapeutic approach should address cultural norms, values, and the intersectionality of identities. The fact that harm reduction is an individualized approach to treatment encourages the client to identify and address these cultural influences from the onset and allows the therapist to tailor goal setting with the information provided by the client on their unique cultural identification.