camh Centre for Addiction and Mental Health

Harm Reduction Approaches:
Working With Complexity

Facilitated by: Dale Kuehl

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WELCOME

Faculty/Presenter Disclosure

- ***Faculty:*** *Dale Kuehl*
- ***Relationships with Commercial Interests:***

  Not applicable

Disclosure of Commercial Support

- ***Faculty:*** *Dale Kuehl*
- ***No Commercial Support***

Mitigating Potential Bias

- ***Faculty:*** *Dale Kuehl*
- ***Not applicable***

Learning Objectives

1. Define the harm reduction philosophy and discuss its meaning and application for people with a Concurrent Disorders (CD).

2. Discuss the importance of goal-choice within the transtheoretical model of change.

3. Apply knowledge of harm reduction principles and strategies using interactive questions.

What is Harm Reduction?

- It is a public health alternative to the traditional disease, criminal and moral approaches to substance use.
- Recognition that not all people want to abstain from alcohol or drugs, and they still need to be served by community services and health care providers.
- It is consumer/user driven and emerged as a "bottom-up" rather than a "top-down" approach
- Promotes "low-threshold" accessibility to services

Harm Reduction in Canada

- Harm reduction emerged in response to the HIV epidemic and to a lesser extend Hepatitis C and TB among Intravenous Drug Users in Toronto, Vancouver and Montreal.

- Creation of safer drinking guidelines, methadone maintenance treatment, needle exchange services & supervised injection site

CD Harm Reduction: Defining Features

- Prevention of harm rather than of drug use
- Focus on people who continue to use rather than those who abstain from use.
- Reference to all psychoactive drugs, including controlled drugs, alcohol, tobacco and pharmaceutical drugs.
- Includes use of prescribed drugs (e.g. methadone, or suboxone).

It is not: *A dichotomy between continued use and abstinence.*

Harm Reduction Principles

Harm reduction principles serve to:

- enhance the therapeutic relationship
- allow for client self-determination
- and foster an open and honest dialogue between the client and clinician.

They promote:

- self-reflection
- goal setting
- acquisition of new skills and strategies to address substance use.

(Tatarsky & Kellogg, 2010)

Let's Discuss...

Even when clinicians or organizations are open to trying harm-reduction approaches, there can be challenges...

- What are the harm reduction implications for working with concurrent disorders?
- What are the ways that working with people with complex problems challenges harm reduction theory and practice?

Why is CD Important?

- High rates of co-prevalence
- Rates of help-seeking
- Rates of retention
- Rates of outcome
- Rates of relapse
- Systems of care and particular services have been set up to exclude, ignore, or be unable to identify complex problems

→ The most vulnerable in–need clients are either not getting care or are having trouble accessing it.

Why is Harm Reduction Important with CD?

- Working with the reality of their behaviours, particularly substance use
- Working with the reality of medication non-compliance
- Working with the likelihood of relapse
- Working with unsupportive environments
- Working with families and social supports
- Working with other service delivery systems

The Hierarchy of Stigma surrounding CD

Which disorder below is most stigmatized?

(a) Schizophrenia with marijuana use

(b) Bipolar Disorder & crack cocaine use

(c) Inhalant abuse and psychosis

(d) Borderline Personality Disorder with opiate use

(e) Anxiety Disorder with benzodiazepine overdose

(f) Psychosis with developmental delay & alcohol abuse

Substance Use Continuum

Casual/Non-problematic Use

- recreational or other use that has negligible health or social impact

Chronic Dependence

- use that has become habitual and compulsive despite negative health and social impacts

Beneficial Use

- use that has positive health or social impact
- e.g. medical psychopharmaceuticals; coffee to increase alertness; moderate consumption of red wine; sacramental use of ayahuasca or peyote

Problematic Use

- use that begins to have negative consequences for individual, friends/family, or society
- e.g. impaired driving; binge consumption; harmful routes of administration

Health Officers Council of British Columbia (2005) - http://www.cfdp.ca/bchoc.pdf

Harm Reduction & Abstinence

- Non-use is a viable choice – as long as it is a choice
- Can be described as overlapping elements within a continuum of care.
  - Drug holiday = short-term abstinence
  - Abstinence from one drug, but not ALL drugs
  - Long-term abstinence from all drugs
  - Abstinence as the goal, but harm reduction strategies if one relapses

One core principle of Harm Reduction is

Flexible Goal Choice

(1) Abstinence:

- Cold-turkey
- Tapering down
- Medically-assisted (e.g. Valium, Clonadine)
- Outpatient vs. inpatient

(2) Reduction goal (e.g. "Low-Risk Drinking Guidelines"):

- **Frequency:** -alternate drinking days with abstinent days
  -have one hour in between alcoholic drinks
- **Quantity: Men:** No more than 15 SD's/week + 3 SDs/day
  Women: No more than 10 SD's/week + 2 SDs/day

(3) The 'no-change' goal: Agreement to at least monitor and discuss substance use [engagement strategy].

Abstinence: Cold vs. Warm Turkey

Immediate and abrupt quitting known as the "cold turkey" approach can be an obstacle to some clients accepting a goal of abstinence, but there are 3 alternatives known as "warm turkey" routes:

(1) "Sobriety sampling" (trying abstinence for a defined period of time on an experimental basis);

(2) "Tapering down (a gradual reduction of consumption with a longer term view to achieving and maintaining abstinence); and

(3) "trial moderation" (a carefully planned and monitored period of reduced use) with evaluation.

Benefits of Goal Choice

- Goal choice allows clinicians to engage clients still using who may be contemplating abstinence.
- This means that if a client is not ready or interested in pursuing abstinence as a goal, other goals can be considered.
- The M.I. strategy of "working where the client is at" recognizes the importance of engagement, and knowing that goals are not static and can change over time.
- Harm reduction strategies can be used at *any* phase in the change process.

CD Harm Reduction

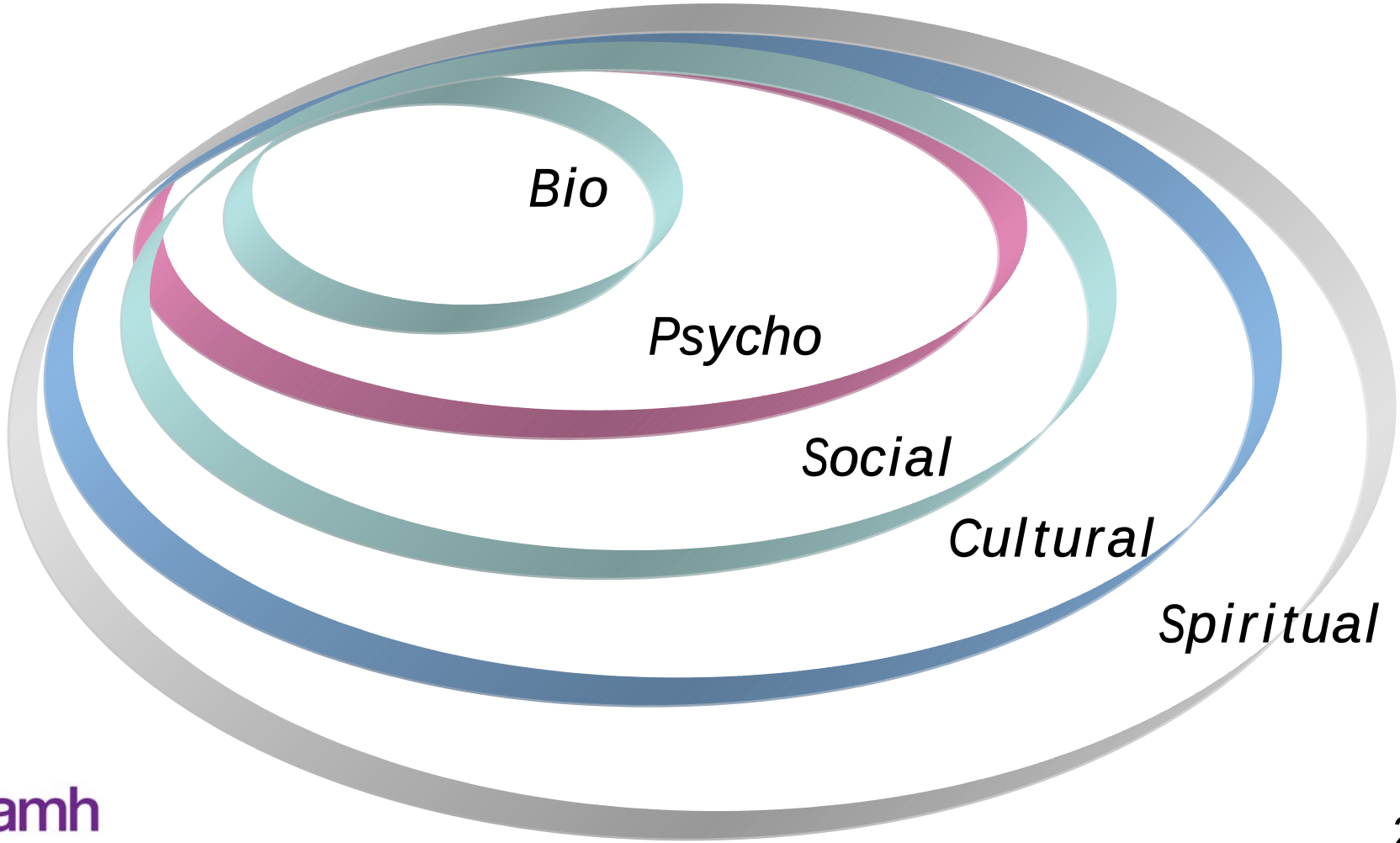
- People with concurrent disorders (especially those who have more severe forms of dependence), are not as successful at being able to limit their use;

- For many clients, having the opportunity to try moderation and reduction can be a useful avenue for then exploring motivation and ambivalence to re-think the value of an abstinence goal

What contributes to a positive rapport with clients and establishing a good therapeutic alliance?

A Holistic Approach

Bio-Psycho-Social-*Plus* Model



The Heart of Harm Reduction

- A set of ***values*** that is challenging the way we think about concurrent disorders issues and CD treatment
- A set of ***practices*** that (while still evolving) is already radically altering the ways we work with people (and communities) who are at increased risk.
- It's not just about the programs & practices, but an opportunity to **engage…**

Harm Reduction:
The ENGAGE Framework

- **E**stablishing supportive relationship
- **N**ot blaming
- **G**iving options
- **A**ccepting individual choices
- **G**aining awareness
- **E**ducating around potential harm

(Skinner, 2003)

Discussion

You are working with a client with schizophrenia who is using marijuana and crack and their housing is in jeopardy. He's ambivalent about making change...

What considerations might you and your client take into account in choosing a harm reduction or abstinent approach?

Harm Reduction Strategies

- Safer ways of taking substances
  (e.g., smoking heroin instead of injecting);
- Substituting the drug of choice with a safer one
  (e.g., prescribed methadone instead of heroin; a "light" beer instead of regular beer);
- Reducing quantity: Doing 1/3 of what would normally be used to reduce the risk of accidental overdose;
- Never sharing: injectable drugs or needles, cookers, spoons, cotton or other tools;
- Avoiding mixing different drugs;
- Never using alone
- Self-care: Getting a healthy amount of food, sleep and exercise; and drinking lots of water to avoid dehydration.

So What Constitutes Success?

RE: Substance use change:

- Reductions made (or abstinence achieved)
- If not abstinent from all substances: maybe the one associated with more harm has improved (e.g. crack), while another may remain (e.g. marijuana)
- Less use of withdrawal mgmt. (if that was the previous pattern); or less ER visits
- Less # of "use days" than at baseline
- Lesser "quantity" consumed (on use days) than at baseline.
- Other???

What Constitutes Success? (cont'd)

RE: Mental health issue(s):

E.g. Anxiety:

- Frequency and intensity of panic attacks is either reduced or eliminated
- For clients using anti-anxiety meds: no longer using medication once they learn psychological ways of coping

E.g. Depression:

- Ratings have improved (e.g. 5/10 instead of 10/10 depressed) -- No longer suicidal
- Increased tolerance for negative emotions (distress tolerance / emotional regulation)

What Constitutes Success? (cont'd)

RE: Other Indicators:

- Enhanced self-esteem
- Enhanced self-efficacy
- Enhanced self-care behavior
- Enhanced Relationships
- and enhanced overall level of functioning.

In the words of a client:
Improved self-worth

"I have changed my view from looking at myself as someone who doesn't have anything to contribute or isn't worth anything. I see myself as someone who can put back into the community and can contribute to the community. I can look for jobs, I can find a job and contribute; even with my drug use I can still do things. It has given me back my life."

-Anonymous

Take Away Messages

- Focus on **risks**, not the substances.
- Focus on ways to **reduce the risks**, which may/may not include stopping the substance use.
- Focuses on ***"any positive change".***
- Treat your client the way **YOU** would want to be treated.
- Support **client's right to choose** their goal(s) to reduce risks.


KEEP
CALM
AND
REDUCE
HARM

Dale Kuehl, MSW, RSW
(416) 535-8501 x32512
Dale.Kuehl@camh.ca

Resource Slides

Why Harm Reduction?

- Abstinence has its limitations
- “War on Drugs” has failed to eliminate use
- People will continue to use drugs
- People will continue to suffer as a result
- People continue to be arrested
- People continue to be stigmatized and not access healthcare services
- People who use drugs have knowledge the “experts” don’t have

Principles of Harm Reduction

1. Acceptance that licit and illicit drug use is part of our day-to-day world with a goal of minimizing the harmful effects;

2. Substance users and those with a history of drug use should be involved in the design, development and delivery of programs and policies;

3. Drug use is a complex, multi-faceted phenomenon, which encompasses a continuum of behaviours from abstention to severe abuse.

Principles of Harm Reduction

4. Acknowledge and educate ways of using that is less harmful and reducing spread of communicable infections and diseases

5. Focus is on improving the quality of life for the user and society not abstinence from all drugs

6. Non-judgmental, non-coercive services and programs

7. Acknowledgement of poverty, class, racism, societal isolation, past trauma, sex-based discrimination and their social inequalities impact on a person's ability to reduce drug-related harms

(Adapted from Harm Reduction Coalition, 1996)

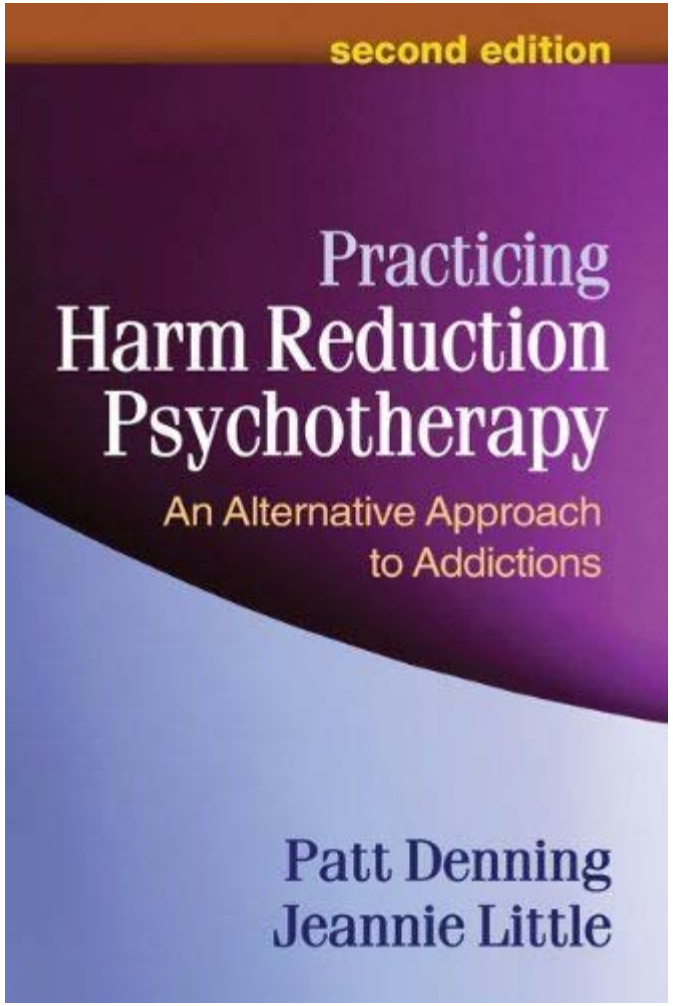
Homelessness & CD

Homeless adults who use crack face discrimination and poor treatment from service providers.

- 50% of homeless adults who use crack said they had been judged unfairly or treated with disrespect by a health care provider in the past year.
- The most common reasons people felt they were discriminated against were because of their use of alcohol or drugs or because the health care provider thought they were drug-seeking.
- 24% of homeless adults who use crack reported having had at least one negative experience with hospital security, including being told to go away, verbally assaulted, physically removed or beaten up.

The Street Health Report 2007 Research Bulletin #3: Homelessness & Crack Use. Street Health. Toronto: October 2008.

CD & Harm Reduction Psychotherapy



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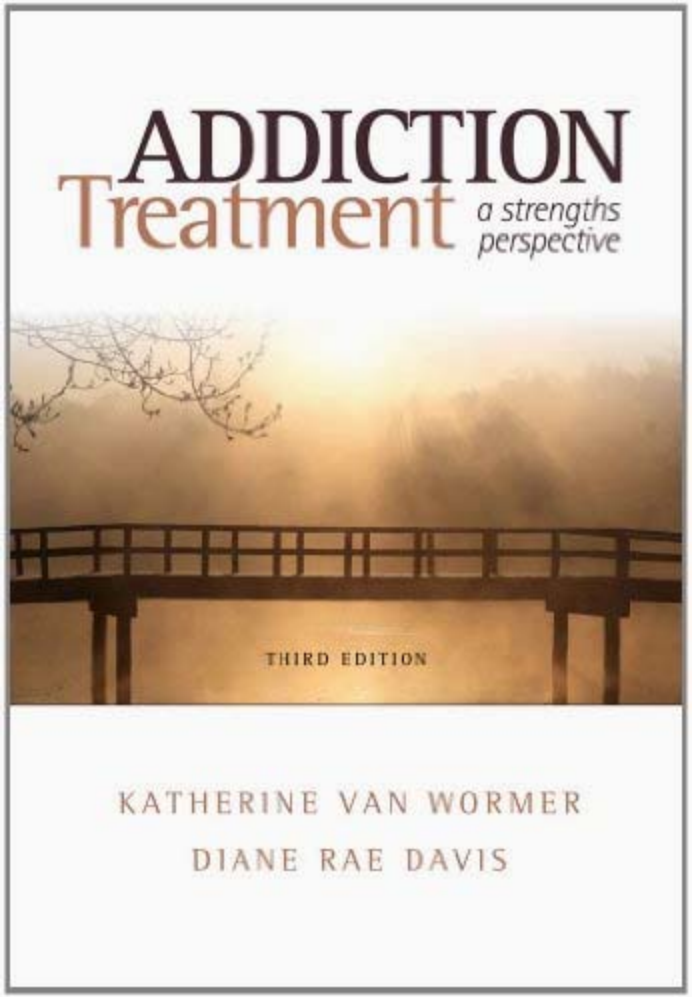
CD Bio-Psycho-Social Approaches



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