Chapter 22

HARM REDUCTION TOOLS AND PROGRAMS

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WHERE AND WHY DID HARM REDUCTION ORIGINATE?

The history of harm reduction is a lesson in the important principles of public health. During the late 1970's and early 1980's, Hepatitis B was killing thousands of injection drug users throughout Europe. The Netherlands began the first coalition of health care providers and consumers to develop life-saving strategies. In Rotterdam and Amsterdam, IV drug users formed "junkie unions" to meet with public health officials to insure that whatever the public health department decided to do to curb the epidemic would actually benefit them, not just society at large. It became obvious very quickly to the public health workers that sharing dirty syringes was the most likely cause of the epidemic.

When HIV hit in 1982-3, these same drug users began to die from a mysterious disease that also appeared to be blood borne. Once again, the Dutch public health system turned to the people who were dying and asked a simple question: "What is it that you need to stay alive?" The response was very specific: "We need clean syringes and an ample supply of them. We need easy access to medical care for other deadly non-IV-related problems (abscesses, vein care, tuberculosis, etc.). And we need more drug treatment. But some of us want to get totally clean and some of us don't. Some of us want to quit shooting dope, by we aren't about to stop smoking pot."

The Dutch government and its people made a crucial decision that everyone deserved to live, no matter what their behaviors, even if those behaviors created some societal harm. In 1986, the Dutch enacted Harm Reduction as its public health policy. Since that time, the HIV infection rate has plummeted, drug use has not increased, and costs of medical services have remained steady.

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During this time, the United Kingdom and Australia were also responding to the new AIDS crises in their IV drug-using communities. Government sponsored programs experimented with a number of radical strategies, including providing free syringes and offering drug substitution therapies in addition to methadone (this allowed the addict to decide to go on "maintenance" with his or her drug of choice, if this is what it would take to keep them

healthy and keep the community at large safer from co-infection, burglary, etc.). By 1989, in Liverpool, England syringe exchange alone was responsible for a new HIV infection rate of less than 1% of active IV drug users, while, during the same years in London and New York, the infection rates were closer to 60%.

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Needle exchange programs have sprung up all over the world and in many major American cities since the late 1980's. New York was the first state to issue waivers so that 5 community groups could legally operate a syringe exchange. Since then, only a few states and some local communities have either legalized syringe exchange, or given public health emergency waivers to groups. The North American Syringe Exchange Network (NASEN) was born and continues to advocate for a do research about, the benefits of syringe exchange.

Despite such success in reducing HIV and other harms, syringe exchange networks in the United States continue to operate illegally in most states and with constant police threats and raids.

Up until about 1988, the major focus of drug policy activists was syringe exchange. But that changed when a disheartened social worker, Edith Springer, went to Amsterdam and England to learn more about their drug treatment models. She transformed the large agency in her charge in New York into a Harm Reduction agency (which to her meant welcoming people into treatment even if they were still using). While many staff revolted at this notion, many became persuaded by her arguments. "Dead Addicts Don't Recover," Edith said to her staff, and to anyone else who would listen. This is the first principle that drove the development of harm reduction from a political and needle-exchange-only movement, to the creation of alternative treatment strategies.

At it's heart, harm reduction is a public health philosophy which uses a multitude of strategies to reduce drug-related harm, ranging from syringe exchange to drug substitution therapies, to abstinence, to controlled use. These methods have proven effective in helping people make lasting changes in a variety of health related behaviors: nutrition, exercise, smoking cessation, weight control, and preventative medical care.

PEER-BASED HARM REDUCTION

Syringe exchange is probably the most well known harm reduction strategy (other then condoms) to prevent the spread of HIV and other sexually transmitted diseases. These programs taught us that even people with serious drug addictions are interested in protecting themselves and others and that addicts can make rational choices and significant behavior changes, despite continuing to still use or drink. Most of these programs began as, and continue to be, grass roots and peer-based.

Many needle exchange programs now offer, in addition to clean syringes, instruction in proper injection techniques and vein care, warnings about bad drugs that are in circulation, wound care, and social services that connect IV drug users with treatment, housing, and employment. Workers in these programs, often current and past IV drug users, are especially suited to be knowledgeable and empathic.

The Harm Reduction Coalition (HRC), with offices in New York and Oakland, California, is the largest peer-based, consumer led harm reduction group in the world. It has nurtured the development of three major areas in the harm reduction movement: 1) policy and advocacy, 2) street outreach, and 3) treatment revision. HRC publishes newsletters and drug information brochures, and holds conferences to disseminate the latest ideas. **Visit www.harmreduction.org**

Several other local and national harm reduction groups provide services ranging from education to research. DanceSafe, **(dancesafe.org)** one such group, provides excellent information through their website about the recent flow of "rave drugs". They also offer technical assistance in the dance clubs by testing samples of the drug Ecstasy to determine if it's safe. They also offer instructions in safe use while dancing and have been successful in forcing club owners to offer free water and a "cool down" room to prevent deaths from overheating.

Another peer-based harm reduction strategy is the formation of new self-help groups such as Moderation Management and Drink Link **(www.moderation.org)** both of which hold meetings in which people develop plans to control and monitor their alcohol in order to reduce problems they might have had in the past. Many of these groups use the Internet in order to facilitate people meeting and sharing their ideas.

PROFESSIONALLY DEVELOPED HARM REDUCTION

Many psychologists have been researching and developing harm reduction clinical techniques long before the phrase "harm reduction" became used. Because most of these clinicians come from a Cognitive/Behavioral model, they are comfortable examining the components of complex behaviors and planning specific strategies to help people make changes. One of the leaders in the field, G. Alan Marlatt (The Addictive Behaviors Research Center at the University of Washington in Seattle), is best known for his groundbreaking research (with Judith Gordon) on relapse prevention. (Marlatt and Gordon. 1985.)

Many other professional chemical dependency specialists in this country are developing effective treatment strategies: William Miller and Stephen Rollnick (Miller and Rollnick. 1987) who developed Motivational Interviewing, continue to research and train clinicians in this method. Fred Rotgers (Rotgers, Keller, Morgenstern, 1996) is known for his research on evidence-based practices in substance abuse treatment and for his clinical practice with moderation techniques. Reid Hester is developing web-based software applications that can be used as self-help modules. The Drinkers Check Up is one such program. Download from: rhester@behviortherapy.com

Marc Kern has been instrumental in developing SMART Recovery as an abstinence-based alternative to 12 Step.
http://www.addictionalternatives.com
habitdoc@msn.com http://smartrecovery.org/

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In addition to these behavioral oriented professionals, many psychodynamically trained clinicians have contributed to what is now called Harm Reduction Psychotherapy (HRP). Andrew Tatarsky in New York, for example, has edited a book that contains moving cases from experts treating people with significant substance abuse problems (Tatarsky, 2002). I have also written a book on harm reduction psychotherapy that outlines a formal assessment and treatment program that is especially useful for dually diagnosed clients (Denning, 2000) A new book, written with Jeannie Little and Adina Glickman, addresses the drug using person directly and can be used as a self-help guide for change (Denning, Little, Glickman, in press. Guilford Press. 2003) The Harm Reduction Therapy Center in San Francisco has recently opened to provide both direct clinical services, as well as training for substance

abuse counselors and psychotherapists in this new model. (www.harmreductiontherapy.org)

PRINCIPLES AND TECHNIQUES OF HARM REDUCTION PSYCHOTHERAPY

WHY SHOULD WE USE HARM REDUCTION IN TREATMENT?

HRP refers to several clinical models for treating addictions based in the international public health movement termed harm reduction. The very mention of "harm reduction" often causes more heat than light, with people taking sides for or against. But when you think about it, it is almost impossible to be against harm reduction. It's what we do every day. We all find ways to reduce the risks of life. When I drive to work each day, for example, I reduce my risk by wearing a seat belt. Abstaining behavior may sometimes be the best harm reduction strategy, and yet most of us choose, for a multitude of reasons, to practice other harm reduction methods.

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On the other hand, it is sometimes difficult to be <u>for</u> harm reduction, to allow your client the freedom to make choices that may lead to his personal disaster, or watch her struggle with impulses that we suspect will cause pain to others. We sometimes feel right in many of these circumstances to weigh in with strict rules for our clients' behaviors, hoping to forestall disaster to them and reduce our own sense of personal discomfort or failure. If only they would listen to us.

Drug treatment in the U.S. is currently based on the "American Disease Model" which asserts that addiction is a primary disease, not caused by any other condition, and is characterized by loss of control and denial, and is only treatable by abstinence. Requiring abstinence as a condition of entering treatment and terminating clients who relapse are two examples of setting the threshold for treatment too high. By doing so, we dramatically limit the range of people who can and will come to treatment. Substance abuse is the only mental health problem where the client is required to give up his symptom (drug use) before entering treatment.

Harm Reduction Psychotherapy, by contrast, founded on the basic principle of the harm reduction movement, respects peoples' choices. A basic HRP principle is to meet clients "where they're at"; and offer "low threshold" treatment. This means removing

barriers (such as lack of childcare) or eliminating the traditional "hoops" (requiring abstinence prior to entry) that people have to "jump through" in order to access services.

WHAT ARE THE BASIC PRINCIPLES OF HARM REDUCTION PSYCHOTHERAPY?

Harm reduction efforts respect the client's autonomy and develop a relationship of mutual collaboration with the goal of reducing drug and alcohol related harm. In addition, harm reduction psychotherapy suggests that the concept of denial be replaced by the more accurate idea of ambivalence regarding drug use. This allows the person to fully explore the adaptive reasons for his drug use as well as the harms that are accruing as a result of it. Additional principles stress the need to develop a hierarchy of client needs, a list that includes all other services, with the importance for each set by the client.

PRINCIPLES

1. *Harm Reduction is any action that attempts to reduce the harm of drug abuse and drug prohibition.* Reducing harm can take on many different strategies. Some of the more common strategies include syringe exchange, which reduces the spread of blood-borne diseases such as HIV and hepatitis. Other strategies include managing one's use by reducing the amount of frequency of use, switching to a different drug, or stopping one of several drugs that one uses. These techniques are referred to as substance use management (SUM) and will be described in detail later in this chapter.
2. *There can be no punitive sanctions for what a person puts in their body or refuses to put in their body.* Punishing people for doing drugs is not just a matter of the criminal justice system, but is a problem within our treatment system. When we punish people for drug use while in treatment, we set up a dynamic of dishonesty that undermines any effort to get better. We can only hope to foster honesty and self-examination if we encourage a client to talk openly about all of their experiences with alcohol and drugs in order to develop appropriate treatment plans.

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3. *People use drugs for many reasons and not all drug use is abuse.* People are drawn to different drugs for different reasons. There is no disease process that results in a person's "drug of choice". People tend to experiment with different substances until they find one that gives them the results they are looking

for; relief from emotional suffering, improved social or sexual performance, etc. This is known as Khantzian's self-medication hypothesis **[ref]**. While economics and one's peer culture certainly influence the drug of choice, most people develop relationships with specific drugs.

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4. *People can, and do, make rational decisions about important life issues while still using.* We tend to think of people with substance abuse problems as being out of control and unable to think about their use. The fact is, most people who decide to quit using have done so when either intoxicated or in a state of withdrawal. These altered states of consciousness do not prevent a person from rationally assessing her situation and decide to change it. We, as counselors, should not give the message that a person cannot take steps towards changing their use while still using.
5. *Denial is not actually denial. It is a product of shame and punitive sanctions and is usually quite conscious.* Most people know if they have a drug problem; they are not in denial. Admitting this is difficult mostly because of the punishments that can be levied against the person who admits to having a problem. When we demand immediate and total abstinence, and if the person cannot maintain it, we accuse them of not trying or of being in denial. In fact, the person is hiding or minimizing, or outright lying to us because they are trying to avoid suffering more harm at the hands of drug treatment rules.

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6. *Ambivalence and resistance to change are "human" qualities. It is our job to work with someone's ambivalence, explore it, not confront it.* Hitting bottom is not necessary for change. In fact, most people do not get motivated by hitting bottom, they adjust to the bottom, leading to increased harm in their lives. People are always ambivalent about making changes because it is about leaving the relative comfort of how they're used to doing things for the unknown fears of what will happen if they change. Ambivalence and resistance are not barriers to our work with clients. These psychological factors are an integral part of our work and to be welcomed and respectfully discussed.
7. *Addiction is a relationship, an attachment that offers significant support to the person. Treatment must offer that support, as well as respect that maybe we can't do it as well or*

with such reliability. Addiction is not a disease. People who are addicted to drugs have developed a relationship to the drug, a relationship that, like those with people, may have more or less healthy and harmful aspects. We as counselors need to acknowledge the benefits that a client might get from this relationship to alcohol or drugs as well as notice the harms that are occurring. We need to examine the biological roots, but not forget the psychological and social roots of drug abuse.

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8. *Change is typically slow, incremental, with many setbacks. Relapse is the rule, not the exception. Plan for it. Help people stay alive and healthy and connected to treatment during their relapses.* People generally do not make lasting changes in large leaps, but by small steps. Each person goes through a predictable process that takes place in stages until stable change is achieved. The Stages of Change Model is explained later in this chapter Expecting abstinence immediately means that the important work that needs to be accomplished in the earlier stages has been missed. Relapse, while a typical part of the change process, can be made worse by not paying attention to the work of stages prior to the Action stage. Recovery does not begin with abstinence. It begins the moment that a person becomes worried about their use, or begins to think about making a change.

8. *Success is any positive change- any step in the right direction.* Harm reduction redefines success. Instead of success only being recognized when a person quits using and doesn't relapse, success is seen as any step in the right direction. Any reduction in harm, any improvement in health and well-being is seen as a step towards permanent change. This new definition of success allows you and your clients to celebrate improvements rather than feel discouraged by a lack of perfection.

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WHAT ARE THE PRIMARY TECHNIQUES OF HARM REDUCTION PSYCHOTHERAPY?

- The use of Motivational Interviewing to establish an honest therapeutic relationship, with the goal of influencing the client toward change;
- An assessment of the client's place in the Stage Model of Change;
- Active encouragement of the expression of ambivalence and resistance to change;

- Developing a Decisional Balance that shows the pros and cons of changing or not changing;
- Developing a Hierarchy of Needs in which the client and therapists together decide on the relative importance of different problems and agree on the order in which they are addressed;
- Psychiatric evaluation and medications to reduce psychiatric symptoms and to promote and maintain abstinence from drugs of abuse;
- Psychological treatment of emotional disorders such as depression, anxiety, trauma, or psychosis that interact with substance abuse problems.

Harm Reduction Psychotherapy defines addictions as bio-psychosocial phenomena. The general framework comes from Norman Zinberg's Drug, Set, and Setting model (1984), described in this chapter. The primary point is that the relative importance of a drug, biology, psychology, culture, and environment varies in each person. In treatment, each person needs to be individually assessed and her unique circumstances understood.

Knowledge about how people make behavioral changes is essential to any treatment process. Prochaska and DiClemente's (1992) Stage Model of Change provides this. They describe the stages through which a person passes on their road to behavior change, the lessons that must be learned, and suggest the techniques that can be used in working with people relative to which stage they are in.

These concepts and strategies are central to HRP and are especially useful when engaging a person whose drug abuse is intertwined with significant emotional problems. All of the methods follow from a particular style of talking -- a style that decreases resistance in the client.

MOTIVATIONAL INTERVIEWING

Motivational interviewing is both a treatment strategy and a technique for interviewing clients (Miller & Rollnick, 1991). The word "interviewing" should be thought of in the same way that Sullivan (1954) used the term "the psychiatric interview," that is, a prolonged conversation which both gathers information and builds the therapeutic relationship. Information gathering per se is only a small part of the "interview." The development of a therapeutic relationship is of primary importance.

Much chemical dependency literature relies on the concepts of denial and lack of motivation for treatment to explain the difficulties of working with people with substance use disorders. In contrast, motivational interviewing is based on several assumptions that contrast with those traditionally used in chemical dependency work. Miller and Rollnick (1991) suggest that motivation is not a stable trait residing within the individual, but rather, a flexible state existing within an interpersonal matrix. If motivation is viewed this way, it suggests (as research asserts) that the counselor has a unique ability and responsibility to enhance a client's motivation for change. This is an inherently hopeful stance that requires clinicians to develop strategies for enhancing motivation.

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- Miller and Rollnick (1987) elaborate these strategies in two phases: first, building motivation to change, and second, strengthening the client's commitment to change. The following techniques are involved in the first stage of motivational interviewing (See Chapter 19).

These techniques reflect genuine respect for the client and a belief that the client can, with help, arrive at a responsible decision about addictive behaviors. No time line is suggested for developing motivation that leads to change. For some people the process will be relatively quick, taking only a few sessions. Others may need a year or more before significant motivation is built. Clinicians trained in providing psychotherapy should not be surprised that chemical dependency treatment, even the first phase of such treatment, may be a long-term effort.

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THE STAGES OF CHANGE

Any time a person wishes to make a change in her life, whether it involves a complex series of decisions (like switching jobs), or a relatively straightforward choice (like quitting smoking), she goes through several stages of change. Addictive behaviors are often the target of such decisions and attempts to change. Changing drug use is essentially an internal and external process despite the fact that we tend to see it as only as an overt behavior. Researchers have focused specifically on how behavior change takes place within a person. Not surprisingly, they found that a person tends to go through the same process and stages when trying to change drug or alcohol use as he does when

deciding to change jobs or start an exercise program (Prochaska, DiClemente, & Norcross, 1992).

Important concepts in this theory include the fluidity of change and the importance of self-efficacy in both the initiation and maintenance of change. Clinical assessment of the client's place along the continuum of change provides a broader view of the person and creates possibilities for the development of interventions specific to the individual at a particular point in her treatment process. Thus, clinical interventions can be designed to match the client's current stage of change and assist her in the natural process of changing.

DRUG, SET, AND SETTING

This model helps explain how some people get into trouble with drugs and others don't. Problems with drugs result from an interaction - an interaction between three phenomena - the drug one uses, the set (meaning the person using) and the setting, or the environment influencing that person. Not only do problems with drugs emerge from this interaction, often the drug experience itself is a product of this interaction. It's not that any one of these things is the truth. It's that if you try to simplify a drug or alcohol problem, you are likely to miss the interaction and the relative importance of several different factors. Most of the clinical interventions used in Harm Reduction Psychotherapy target either the drug, the set, or the setting.

The "Drug, Set, Setting" model was developed in the early 1980's by psychiatrist, Norman Zinberg who studied the phenomenon of recreational heroin use to understand why some people did not become "addicted" to this assumed-to-be "addictive" drug. He developed the idea that addiction is not solely dependent on an "addictive" drug nor is it entirely dependent on a person being "diseased."

The DRUG itself influences the relationship. Each drug has its own unique chemistry and produces widely varied effects: A drug's action is the first important element, the second dosage. How a drug is taken - the route of administration – also affects the experience. The rate of onset is different when a drug is smoked, injected, absorbed through mucous membranes, or eaten (in order of rapidity.) The faster the drug comes on, the more compelling it is, which is why smoking cocaine has become a larger problem than snorting it was. Finally, a drug's legality

influences our relationship as illegal drugs have poor to non-existent quality control.

SET refers to the influence of the characteristics of each individual user on their drug experience: One's unique personality, motivation for using, and hopes for a good effect. Is the client a risk taker? Do she love a challenge? This personality trait may make it easier for people to experiment with different drugs than it would be for someone who is more cautious in their life. Does the person want a new experience of life? A search for meaning may motivate people to try LSD or some other hallucinogen.

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SETTING refers to the environment in which one drinks or uses drugs. Who is she usually with and where does she use? Alone? With friends or family? Outside under a freeway overpass or inside an apartment? The setting will determine not only what drug a person might use, but the effect it will have on him or her (shooting heroin in a back alley is not as safe as shooting it at home).

The "setting" also refers to the larger context of a person's life - the attitudes and beliefs of their community and the dominant culture around them. Community is a term that has come to describe everything from one's religious affiliation to one's local political and social climate. Many people define their community primarily by their personal relationships with their families and friends.

DECISIONAL BALANCE

Another HRT technique, decisional balance, is a conceptual, behavioral, and affective "display" of the ambivalence a person feels about her substance use. Many clinicians view this ambivalence as either a source of potent resistance or a denial of problems, either of which foretells treatment failure. A more productive way of understanding this is to acknowledge that drugs are used for adaptive reasons, for example, a client began to use psychoactive agents to prevent feelings of sadness or anger, or to enhance social interactions. Despite the fact that considerable negative consequences may have accrued over time, these original (positive) adaptive reasons for substance use persist in the unconscious life of even the most "motivated" client. What this means in terms of treatment is that most people retain significant conscious or unconscious ambivalence about their drug or alcohol

use, no matter what stage of change she's in when she first presents.

While the client's ambivalence is most obvious during the contemplation stage, it is operative in all stages. The systematic use of the decisional balance communicates the counselor's acceptance of the client's ambivalence while reminding the counselor of the need to work on many different levels at once.

There are several ways to construct a decisional balance worksheet but it is preferable to begin with a worksheet that is not too conceptually complex. People who are using drugs, or who have recently stopped, may have hidden cognitive problems even when they are not obviously impaired. Abstract reasoning is often diminished in a client whose drug use includes heavy alcohol intake or excessive use of tranquilizers. Paranoid thinking may be evident in the long-term stimulant user. For these reasons it is best to avoid complex cognitive tasks until you know the client better and have assessed cognitive functions.

To begin, take a sheet of blank paper and divide it into two halves. Typical questions include:

- "You've said you want to quit drinking. What do you think will be good for you if you do quit?"
- "What positive things do you expect to gain?"
- "On the other hand, can you imagine what might be the down side of quitting? What might not be so good for you?"

On a totally different note, one might ask these questions:

- "What have you noticed about your drug use that you like?"
- "How do you think the amount of speed you're using may affect your sleep problems?"

Record your client’s responses or use what information you already have from their chart to fill in the worksheet. Then ask if your statements fit her beliefs and feelings. It is interesting to note that if you "misquote" the client while attempting to help articulate pros and cons of drug use, she will probably revert to a previous stage of change.

This method of conceptualizing the decisional balance process places responsibility on you to conduct the interview in a way that builds rapport and elicits cooperation. Although the client has a concurrent responsibility, he may be incapable of full participation in the process because of the very problems that

brought her into treatment or because of the stigma attached to using drugs.

THE HIERARCHY OF NEEDS

Each person comes to treatment with their own agenda regarding what problems they view as most important. Even when a person comes specifically to a drug treatment program, we cannot assume that drug issues are at the top of their list. Each person has created, or needs to create their own rank ordering of concerns, their "hierarchy of needs". For one person it might look like this: get housing, find child care, quit smoking crack and go back to school. If we jump in with quit smoking crack, we may lose the client, or cause a "false compliance" with our version of their treatment plan. It is important to help the client articulate what is most important to them and then to negotiate which of those needs can actually be addressed in your particular setting. Attending to the problems that the person lists on the top end of their hierarchy, even if it only means giving them a referral to another program for that specific purpose, will improve trust and solidify the therapeutic relationship.

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ATTENTION TO THERAPIST PITFALLS

Therapist pitfalls fall into the category of countertransference (those reactions to the client that come from our own biases, lack of knowledge, or unresolved emotional problems The most common reactions to watch for:

- Bringing a moralizing tone to therapy;
- Being overeager to capitalize on a client's wishes to change without giving due attention to his attachment to drugs and resistance to change;
- Not eliciting enough detailed information about drug use for fear of producing craving or of appearing to support pathological drug use (i.e., enabling);
- Colluding with the client's resistance to change. In an effort to develop or protect the therapeutic alliance, being afraid to be challenging enough;
- Underestimating the negative aspects of a client and his life. In an effort to support the client's strengths and self-efficacy, not acknowledging and giving space for the depth and extent of his hopelessness and despair.

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SPECIFIC SUBSTANCE USE MANAGEMENT TECHNIQUES

You have many different clinical interventions available to form an ongoing treatment plan for your client, many methods which are already used in both psychotherapy and drug treatment settings (psychoeducation, coping skills training, stress reduction, nutrition, relapse prevention training, family therapy). At least three other major interventions are standard in harm reduction oriented treatment that are sometimes not utilized in more traditional treatments.

PSYCHIATRIC MEDICATIONS

Routinely used in mental health settings, medications are often controversial in drug treatment settings. Some outpatient and most residential programs will not allow a person to be on psychotropic medications, claiming that it undermines the "drug free" lifestyle that is at the heart of most recovery programs. Increasingly, programs that focus on the dually diagnosed do allow medications, but even then there may be restrictions placed on the type of medication (programs usually allow antipsychotic and antidepressant medications, but often ban the antianxiety drugs because of a fear of cross addiction).

The field of addiction medicine is not unanimous on the timing of the use of medications, nor on the appropriate medications to use. For example, despite research that has shown that anti-anxiety medications can be safely used with alcohol or drug abuse clients if they are accurately diagnosed and monitored, most addiction physicians will not prescribe benzodiazepines (i.e., Valium, Klonopin, etc.).

Many physicians require that a client be at least 30 days "clean and sober" before they will prescribe antidepressants. There is a belief that most depressive symptoms will clear up once the person stops using (especially alcohol). Some also believe that it is dangerous to combine these medications with alcohol or street drugs. In fact, many of the newer antidepressant medications (SSRI's such as Prozac, Celexa, Paxil, etc.) can be safely prescribed if the person is drinking, or using sedatives or marijuana, or some club drugs. It is the stimulants that usually cause drug interaction problems with the SSRI's. Antipsychotic medications can be safely given even when the person is still using.

A third rationale for limiting the use of medications with people who are not abstinent is the belief that they will not

work. Again, many patients receive significant relief, if not complete remission, when they take appropriate psychiatric medications prior to a period of abstinence. In fact, such psychological relief may help the person get off drugs if one of their primary reasons for using is relief from emotional pain.

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DRUG SUBSTITUTION THERAPIES

Methadone, LAAM, buprenorphine, marijuana, etc. are increasingly being used as drug substitutes as the field of addiction medicine gains acceptance. However, these therapies are still a controversial part of many traditional drug treatment programs. The fear of relapse and the belief that real recovery means being absolutely "drug free" makes staff reluctant to recommend these interventions, even to people who relapse frequently. The message that clients often receive is that these treatments are second best, with abstinence still being the gold standard of success. Most drug substitution strategies are for opiate dependence. These are legal and stringently controlled by federal law. Marijuana, however, is still illegal for any medical purpose, including drug substitution therapy.

The history of methadone in this country shows shifting opinions; from hailing it as a lifesaver to seeing it as a racist ploy to keep African Americans enslaved by drugs. The fact is that the majority of clients who use methadone dramatically reduce their use of opiates and of other drugs as well. Methadone is used either as a short-term intervention with the aim of eventual detoxification, or as a long-term treatment in order to prevent relapse to heroin use. For short-term treatment, termed "brief maintenance" federal regulations allow up to 180 days of methadone, with gradual reductions to a drug free state. In the past 5 years, even briefer protocols of methadone maintenance have been developed, some as short as 1 week. The long term efficacy of these strategies have not been adequately studies, but many clinicians feel that such rapid detoxification does not contribute to stable abstinence.

In addition, it is thought that those who continue to use methadone have a better long-term outcome in other areas of life than do those who are heavily addicted and use it for detoxification only. People on methadone are able to work, take care of their families, and contribute to society in more

consistent ways than are those who continually relapse after short-term methadone detoxification. LAAM has similar actions, but is longer acting (up to 72 hours) and similar success rates.

Buprehorphine has just been approved by the Food and Drug Administration for office-based use by private physicians who undergo specialized training. It is a partial opiate agonist, which means that it mimics the action of opiates such as heroin without causing euphoria. Because it is only a partial agonist, though, it can only be used for people who would need 30 mg. or less of methadone. It can also be mixed with an antagonist such as Narcan to prevent diversion to the street or the use of increasing doses in an attempt to get high. This new treatment should dramatically increase the numbers of people willing to use this opiate replacement therapy, since it allows for private practice visits rather than clinic attendance.

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A PSYCHOEDUCATIONAL PROCESS**

**Note: This section is written directly to a drug using client to give information to the reader, and to directly teach the psychoeducational model that has been developed by those of us who work in the field. I owe a special thanks to Dan Bigg of the Chicago Recovery Alliance.

Substance Use Management (SUM) is a term widely used in the harm reduction movement to describe any steps taken to control the use of, and the harms associated with, alcohol or other drugs. SUM relies on a your ability to be honest with yourself and on your willingness to observe yourself. It also assumes that you and only you are responsible for what you put into your body. The suggestions offered here are culled from interviews with physicians and pharmacologists, web sites, public health pamphlets, harm reduction videos, professional books and lectures, my clients and their families and friends, and my general experience as a therapist. If you have decided to quit, but want to take it slow, you can use these suggestions as steps toward abstinence.

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Substance Use Management (SUM) is based on three principles: being honest with yourself about your drug use and the impact of drugs in your life: being willing to make some changes: and,

finally, learning the skills to help you make concrete, beneficial changes in your alcohol or other drug use.

Specific SUM techniques include helping clients change the amounts of alcohol or drug use, the numbers/types of drugs used together, the frequency that they drink or use, the route of administration (how they put it in their bodies), the situation (alone vs. with others). It also entails helping clients plan their use.

Changing the Amount

Less is more. You are more likely to actually enjoy your drug experience if you don't do it all the time or in large quantities. This is because of tolerance. If you've been drinking or using for a while, chances are that you're using a lot more now than when you started. Your body has gotten used to some of the effects and made changes to keep the drug from having too dramatic an effect on you. So you continue to need more to get high as your body tries to balance you out. This is tolerance.

In order for you to decrease the amount, you'll have to deal with the fact of tolerance. Your goal is to decrease your tolerance so that you can actually control your use without suffering. If you're not totally physically dependent, the best and easiest way to decrease tolerance is to quit using for a while. Even a few days can make a difference, but a few weeks are much better. If you are physically dependent (you get sick or shaky when you try to quit), lowering your tolerance will be harder, and may actually be dangerous. If you try to "tough it out," your chances of succeeding go down, and your risk of medical problems goes up. If you are dependent on alcohol, benzodiazepines (like Valium(r), Xanax(r), Ativan(r), Klonopin(r)), or barbiturates, you run the risk of serious medical problems - convulsions or death - if you quit abruptly or drastically cut down. Going "cold turkey" or "kicking" is a very stressful thing to do. You might be better off going the traditional medical detoxification route until your tolerance is safely lowered, especially if you have HIV, diabetes, a heart condition, or other problems that are made worse by stress.

Once you know how much you are drinking or using, you can begin a reduction plan. You might want to start by writing the details of your current use in a journal or notebook- how much, how often, etc. Keep track for a week or two. That way you will know how much you typically use and then can really keep track of

your progress. The general rule of thumb is: "Start low and slow until you know". This means cutting down a little at a time in order to reduce the stress on your body. Stay at each new level until it feels comfortable or normal to you. (You might notice that as you cut down more and more, you won't be able to do it as quickly as you could in the beginning.)

Changing the Number/Types of Drugs Mixed Together

Many of the short-term adverse effects of alcohol or drug use are related to interactions when you take more than one drug at a time. Some drugs cancel out the action of another. Other drugs may actually slow down the metabolism of another drug, so you are in more danger of overdose even if you haven't taken much. Still other drugs speed up the metabolism and get rid of the drug effect much faster. The biology can get really complicated. The *Physician's Desk Reference* (PDR) has a companion volume that describes all of the possible drug interactions of prescribed medications, and usually of alcohol as well.

If you use one drug (like cocaine) for recreation, but then add alcohol on top of it to take the edge off or to help you sleep, you're more likely to run into problems. Some drugs that are relatively safe even in large quantities (benzodiazepines like Valium) can turn deadly when mixed with another drug (like alcohol). Some HIV antiviral medications and protease inhibitors (Norvil (is one example) are notorious for not mixing well with street drugs, alcohol, and some other legal drugs. Medications that help control blood pressure can be made less effective with excessive use of stimulants (like coffee, too, not just things like speed). Or, you could experience a dangerous lowering of blood pressure with some of the sedatives.

You can reduce the harm of mixing drugs if you do one at a time. If you pay attention to your first drug and control it, you might not feel the need to counteract one with another.

Changing the Frequency

If you've tried to cut down on the amount that you use and haven't had consistently good results, changing how often you use might be more satisfying. The fact is, the less often you use, the less chance that you will have to experience harm over the long run. Daily use causes a number of problems, but perhaps the most insidious is that you get used to the behavior of using, so that it becomes an automatic habit, and you stop paying attention to whether it's doing what you want (bringing pleasure, numbing pain,

etc.). Think about drinking coffee in the morning. If you do it every day, you probably could prepare it in your sleep, right? **Paying attention is the fundamental rule of harm reduction. If your drug use is automatic (a habit), you're not thinking.**

Some drugs lend themselves better to changing frequency than others. If you are a maintenance heroin or other opiate user, this is a ridiculous suggestion. You can't change your frequency - you dose whenever the last dose is running out. You should go back to reducing the amount gradually. If you are a daily heavy drinker, depending on the level of your physical dependence, it may be impossible to stop for a day. You, too might have to either reduce the amount or be medically detoxed.

Drugs should be used in moderation. But some cause brain changes that lead us to be concerned about frequency of use. Ecstasy's effect on serotonin cells is becoming a concern. Ketamine and other dissociatives (dextromethorphan, nitrous, and PCP) have been discovered to cause brain lesions (holes in the brain like Swiss cheese). The less you do these drugs, the better. However, they provide many users with wonderful experiences, either of closeness to others, hallucinatory visions, lessening of self-consciousness, or insights into self or the world. If you don't want to give up those experiences, try treasuring them more and doing them less.

Changing the Route of Administration

There are as many ways to get a drug into your body as there are creative people to think about it! Some are considerably more risky than others. You can swallow a drug, smoke it, snort it, put it in other mucous membranes, inhale the fumes, rub it on your skin, or use a needle to put it in a vein, a muscle or under your skin. Some drugs are "naturally" taken only in certain forms. Most drugs, however, can be prepared in several different ways and used by various routes of administration. In general, eating a drug is the safest route and shooting up into a vein is the most dangerous. But any way you use can be made more or less safe.

If you use needles, you probably realize that smoking is not a very efficient use of your drug, since, well, a lot of it goes up in smoke. But it is the fastest. Some ways of shooting are always dangerous. For example, does your drug of choice come in a pill form? Opiates often do. Eat pills if you can, but don't crush pills to inject - the particles are often too big and abscesses in your veins or in the smaller vessels in your lungs. Ocycontin(, an

oral opiate, is time released. Shooting that one will give you a much stronger dose than swallowing it and can easily cause you to overdose Cocaine can only be injected into a vein- you can't "skin pop" it or put it into a muscle without risking a toxic skin infection. Can you do your drug by some other route and save the IV for special occasions?

If comes down to your liking to shoot because it gets you off better, then safe injection is the harm reduction practice for you. There are numerous pamphlets and a good video that teaches how to make your injections safer (for example, The Straight Dope Education Series, put out by the Harm Reduction Coalition in New York). The first thing to put into practice is using a clean needle for each shot. Not only the needle, but the cooker and cotton and tie must be absolutely clean to prevent the spread of diseases like HIV and hepatitis and also to prevent nasty skin and heart infections. It is always risky to share any of your equipment with others. If you don't have a choice, remember that sharing needles requires scrupulous hygiene to prevent problems. If you're using an unknown potency of drug, test a little of it before you give yourself the whole shot. It'll act like an early warning signal if it's too strong or mixed with junk. The bottom line: Shoot safe. The Chicago Recovery Alliance, one of the oldest syringe exchange networks, has produced a 30-minute video that teaches safe injection techniques. (www.anypositivechange.org)

If you smoke, be aware that for short acting drugs like cocaine (and, of course, nicotine), smoking is the fastest way for it to get to your brain, but the drug doesn't last long. That will make you want to do more and more, faster and faster. This is where overdose becomes a problem. Try slowing down your use. Set a schedule. Distract yourself. The point is to stay high, not to have muscle spasms and heart attacks.

If you snort, take care of your poor nose. Heroin is not abrasive, but cocaine is, and so is speed. Mix the powder with a little water and spray it in. Or rub the inside of your nose with vitamin E oil before using. Crushed pills won't pass into the blood vessels in your nose very well, so you might as well just swallow them, or mix in water and drink.

If you drink or eat, what you have in your stomach can make a lot of difference. If you drink alcohol on a full stomach, it will take longer to be absorbed. This is a good thing because your

judgment isn't as impaired so you can make better decisions about the next drink.

If you are eating marijuana, figuring out how much is enough will take a bit of experimenting. When in doubt, eat just a little (1/4 of a small brownie, for example) and wait an hour to see how you feel.

If you are taking pills, the important thing is to know whether or not they are standard legal drugs or if they have been manufactured in someone's home chemistry lab. You can look up standard drugs in textbooks and online to see what you've got and how strong they are. You can also research how a particular drug interacts with others. For homemade pills, like ecstasy or LSD, you'll have to ask around. Does anyone know what it is and how strong? Has anyone taken this particular pill before? Take only 1 if you're not sure. You can always do more later.

If you feel weird or sick after taking something, don't go off by yourself. Find someone fast. Sometimes just talking to someone will calm you down and help you assess if you're really in danger. Don't worry about your pride or the cops or anyone's opinion. Take care of yourself. If you don't want anyone to know, call 911. Call poison control. And next time, try to use unknown drugs only when you are with people who can take care of each other if things go bad. Never leave a person who is clearly overly intoxicated or sick.. They might not sleep it off. They might just die.

Changing the Situation

If you're in a bar, the drug that's available is alcohol! If you are at a certain street corner, whatever the person is selling is what you can have. Sometimes changing the situation will automatically change your drug use. Decide what you want and don't want to use. Decide what effect you want to have. Make sure that you have what you want and so are less tempted by whatever else is offered. Most people have a drug of choice. Don't settle for second choice!

This is all about the environmental factors surrounding your drug use. Where you use and with whom can either increase or decrease the risk of using the very same drug. For example, shooting drugs under the freeway or in a bathroom makes it harder to take your time and use good hygiene. Try to arrange places and times when you can have some privacy, light, access to water, etc. Make sure that you can see what you're taking. Get to know

yourself in different situations. You'll find it easier to manage your drug or alcohol use if you are in charge of where you use.

--Insert M-C #18 here--

Planning Your Use

There are some simple rules you could make for yourself that will certainly reduce harm and might even save your life. Planning when and where and with whom to use is actually something that you can learn to do pretty easily. Most people think that people who use alcohol and drugs, especially people who have problems, or abuse these substances, can't possibly think rationally or control themselves in any way. You might even think this about yourself. But we have learned that people can, and do, plan how to use in order to maximize the benefits and minimize the harms. Some simple guidelines that you might make for yourself include:

- Designated driver - either literally have someone to drive you and others who are using, or someone to guide the experience and make sure no one gets hurt (and to call 911 if they do);
- Clean equipment- pack up your stuff ahead of time if you're going out, or get extra syringes at the exchange when you go. Make sure you have enough cotton, cookers, pipes, etc. before people come over so no one has to share;
- Who you're with and where (especially for psychedelic use) -being with friends or being alone in a place that feels good to you can make an enormous difference, and save you from a traumatic trip;
- Have enough water and food- start you fun out with some food and water, and keep more handy;
- NOT eating too much if you're using psychedelics that can make you vomit - it's pretty uncomfortable;
- Alternate alcohol with something else- if you start by drinking a glass of water or juice, then an alcoholic beverage, you can space things out a bit. Then have a glass of water in between each drink. You'll feel better the next day for sure.

You can probably come up with a lot more ideas that are particular to you situation. Be creative about your health and your fun!

CONCLUSION

The field of harm reduction psychotherapy, while new, has already developed specific guiding principles and techniques that are evidence-based practices. Client retention and satisfaction are high in these types of programs, and improvement in functioning is impressive even for those who do not achieve or maintain abstinence. The practice of harm reduction psychotherapy challenges us to radically redesign not only our treatment programs, but our attitudes as well.

Hopefully I have been able to challenge some old beliefs and offer ways of working with clients that are engaging and keep them in treatment. As mentioned, Dead Addicts Don't Recover!

Resources [added 4/1/03]