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ATTC
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HARM REDUCTION:

A Pragmatic, Clinical Model for the Treatment of Persons with Substance Use Disorders

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Module Objectives:

1. Know and understand Harm Reduction as a process of helping people with substance use disorders.
2. Establish the clinical aspects of Harm Reduction and how to implement them in the helping process.
3. Understand Harm Reduction from the standpoint of public health, and psychological and behavioral models of change.
4. Understand Harm Reduction as a process of directed change that is initiated and developed with a solid therapeutic alliance.

Introduction

Substance use disorder is currently one of the most challenging public health problems for society, as well as for many providers delivering physical and mental health services to people trying to manage the direct or indirect consequences of their substance use. Humans have been associated with psychoactive substances since the dawn of time. These substances have been used mystically, culturally, medicinally and in rituals. The plants from which psychoactive substances are obtained were used as part of cultural and regional expressions and were not considered harmful, but rather went hand in hand with survival and certain religious, spiritual or mystical factors (Tatarsky, 2002). In the past, the harmful effects of these substances on human beings were unknown. Their use in limited and unadulterated quantities could achieve beneficial functions for the body, but it has been proven that excessive and continuous consumption can generate addiction, as well as harmful effects in the short and long term.

Beginning in the 1960s, there was a growing interest in the study of the impact of drugs on individuals. The primary focus was on abstinence as a measure of success. In the 1970s, the Netherlands became interested in harm reduction in response to the limitations of the abstinence-only treatment approach. In the late 1980s and early 1990s, harm reduction began to be accepted in the United States as a framework for public health strategies to reduce the spread of HIV. The National Institute on Drug Abuse (NIDA) published the handbook Drugs, Brain, and Behavior: The Science of Addiction. It was updated in 2010 and 2014. NIDA (2014) defines addiction as a chronic disease of the brain with recurrences, characterized by the need, pursuit, and compulsive use of drugs that affect the individual in their bio-psycho-social environment, thus altering the expected functioning within the environment in which they function. The Diagnostic and Statistical Manual of Mental Disorders, in its fifth edition (DSM-5, 2013), conceptualizes addictions as a substance use disorder. Extensive research has led to an understanding of the neurophysiological impact of substance use. Furthermore, it is evident that substance use has a multifactorial origin that should not be ignored.

Drugs will continue to be a part of humanity. The development of new synthetic drugs represents another major public health challenge. Programs and policies with prohibitionist and punitive approaches have emerged in an effort to counteract the impact of drugs. Programs based on psychoeducation, motivation, awareness, craving management, relapse prevention and cognitive behavioral techniques have not been sufficient to reduce harm in the general population. This entails further evaluation, design, and research on helping strategies. Harm reduction is not in opposition to abstinence. Abstinence is included as a goal that can be achieved if that is the person’s aim. Individuals who use substances are very diverse, and their differences range from the amount and frequency of use, their personal goals, motivation, and readiness to change their emotional, psychological, cognitive, and other characteristics. Harm reduction has a public health focus, but it should also be evaluated from a clinical perspective to work with people seeking help to manage the harmful consequences of their drug use.

What is Harm Reduction?

In the 1970s, the Netherlands, Germany, England, Australia, and Canada began to search for options when working with people with a history of substance use, realizing that abstinence-only treatment was not succeeding. In addition, if people rejected abstinence, they were not considered for treatment. Tatarsky (2002) indicates that harm reduction was born as a social justice movement, promoting human rights as the guidance and another approach to therapeutic interventions for people who mostly come from backgrounds of marginalization, exclusion, and poverty. Their difficulties are rooted in complex histories where social deprivation and lack of opportunities are coupled with psychological conditions from a history of violence and isolation, in addition to substance use disorders. In the United States, harm reduction was accepted in the late 1980s and early 1990s as a set of pragmatic public health strategies to reduce the spread of the Human Immunodeficiency Virus (HIV) and other risks associated with substance use. These included strategies such as using clean needles, condom distribution and methadone-assisted treatment.

People with a history of substance use have been criminalized by laws, forced into unwanted treatment, stigmatized by society, and judged morally. Most of the treatments offered are based on the person achieving and maintaining abstinence. Relapse, expected within the recovery process, has been criticized and judged. People who reject abstinence or do not comply with treatment are seen as unmotivated. Prejudice toward people with substance use disorders has been evidenced through language, punitive approaches, and by viewing them as incapable of making decisions and being an active part of their change process. The moral model has fought drugs with a sinful approach that declares “war on drugs” and that people who use drugs are sinners who must be saved, even if they do not want or ask for it. For its part, the medical model conceptualizes substance use as a disease in which the physician diagnoses and establishes treatment unilaterally. Abstinence-based models are useful for individuals who seek services on their own or through their family’s request and whose goal is to stop substance use. Tatarsky (2002) indicates that in the early days of substance use treatment, the therapist had the mandate and goal of helping people despite themselves and against themselves, if necessary. Resistance was seen as a symptom and evidence of a need for help. A person’s failure to acknowledge that they were ill was seen as denial. Refusal to initiate treatment required the implementation of strategies considered punitive or rejected by the person but accepted among service providers. An example of this is the admission to treatment programs even if the person does not accept having a compulsive use of substances; or the use of confrontation as a strategy to get people to accept that they have a situation to address. The person’s individual perspective and opinion was not accepted or considered.

Although there are various treatment models, there is evidence that if the person's perspective, goals, and desires are not accepted and included, success is limited. Various research and models based on scientific evidence highlight the importance of integrating the person in the process of change. Marlatt (1998) in his book Harm Reduction defines it as "Compassionate Pragmatism". This author points out that harm reduction is a compassionate and pragmatic approach that helps people solve their drug problems. Denning and Little (2017) indicate that harm reduction means being free from punitive sanctions regarding what people chose to put into their body without fear, stigma, and shame.

Harm reduction is a pragmatic approach that accepts substance use as a fact of life. This allows people who use substances to enter treatment from where they are, not where the service provider thinks they should be. Substance use and its consequences unfold within a continuum of harm that can affect individuals and their community. Behavior related to substance use changes gradually. Harm reduction seeks to help move along the change continuum, approaching the point of least harm. Any harm reduction is a step in the right direction (Marlatt, 1998). Tatarsky (2002) indicates that the harm reduction approach takes into account people's difficulties and proposes changes and programs that arise from a humanistic view of the world, based on basic principles of public health, where the most important thing are the consumers and their needs.

The fundamental and survival processes of life are related to breathing, drinking, eating, and moving. Behaviors that threaten people's health are related to smoking, alcohol abuse, unhealthy diets, lack of activity, and stress (Prochaska, J.O. and Prochaska, J.M., 2016). Stress is the common determinant that drives people to breathe, drink, or eat at toxic levels. Strategies are needed to understand this determinant and help people recognize the variables that affect their stress level to promote change.

Risk and Harm Reduction Model

Becoña (2016) raises several questions regarding the impact of substance use on individuals, the community and society at large:

1. How to reduce the risk of drug users contracting infectious diseases such as HIV, Hepatitis B and C, Tuberculosis, experiencing overdoses or developing health-threatening abscesses?

2. How to reduce the likelihood of people who use drugs engaging in criminal activities that may cause harm to themselves or others?

3. How to increase the likelihood that substance users will act responsibly towards others and their families, complete their academic preparation, and obtain and maintain employment?

4. How to increase the social reintegration of substance users who have made life- changing decisions?

5. How to ensure that drug control policies do not cause more harm than good to both substance users and society?

The author of this paper defines harm reduction as a set of practical strategies aimed at meeting drug users where they are, with the aim of helping them decrease or eliminate the harms caused by drug use.

Harm reduction is defined as the set of policies, programs and interventions that aim to reduce the harmful consequences that the use of legal or illegal substances has on the health of the individual or society. The Harm Reduction Model is a set of strategies and practical strategies and ideas aimed at reducing the negative consequences associated with drug use. This initiative seeks social justice through respect for people's rights. It is a non-confrontational but directive style of intervention, based on the Transtheoretical Model of Change of James Prochaska and Carlo DiClemente (1984) and the concept of self-efficacy of Albert Bandura (1997).

Andrew Tatarsky (2002) published his book *Harm Reduction Psychotherapy: A new Treatment for Drug and Alcohol Problems, translated into Spanish as Psicoterapia de Reducción de Daños: Un nuevo tratamiento para problemas de drogas y alcohol*. Patt Denning and Jeannie Little (2017) published the second edition of Over the Influence: The Harm Reduction Guide to Controlling your Drug and Alcohol Use. These authors present several clinical strategies for treating people with substance use disorders.

Denning and Little (2017) state that recognizing the complexity of personal relationships with drugs and the role that drugs play in their lives is important. The author believes and respects the right of individuals to self-determination, that drugs are a normal part of the human experience, and people have a right to cope with life's experiences as best they can and should not be pressured to abandon their way of coping without offering them something to replace it. The author believes that people make informed decisions when they have realistic and unbiased information; furthermore, people are more likely to change when they have access to realistic options for change based on evidence, pragmatism, and compassion. In addition, people are free to decide whether to use drugs and to choose the solutions that work best for them. The author also states that the goal of harm reduction is to reduce the negative consequences related to substance use and to change the person's relationship with substances.

Theories of Addiction

Several theories have been developed over time to try to explain addiction:

1. Moral Model

This model conceptualized addiction as a moral and sinful failure in which people made poor and bad decisions. People who used substances were considered unable to resist temptation and were described as “immoral and vicious”. It is a reductionist model that starts from the premise of sin. Society in general accepted this premise, resulting in a stigmatized and prejudiced vision that is still generally maintained today.

2. Disease or Biological Model

This model emphasizes that addiction has a biological origin that causes changes in the brain. It refers to the fact that people continue to use drugs because of the changes caused in their brain. The probability of genetic or hereditary predisposition is considered. This model, which presents addiction as a disease, led to the establishment of treatment rather than punishment for people with addiction. Several research studies have made advances in understanding the structural changes in the brain and developing drugs for overdose management, therefore reducing drug-related deaths. In 2007, the National Institute on Drug Abuse (NIDA) published *Handbook on Drugs, Brains, and Behavior: The Science of Addiction* revised in 2010 and 2014. The World Health Organization describes addiction as a chronic disorder and *The Diagnostic and Statistical Manual of Mental Disorders* (2013), fifth edition, includes addiction as a mental health disorder. ICD-10 (International Classification of Diseases) includes drug addiction as a health diagnosis.

3. Learning Disorder

Fernandez (2018) points out that some experts on addictions describe it as a learning disorder. Addictive behavior is referred to as an interference with motivation and decision making. He states that once a behavior is repeated consistently for a certain amount of time it begins to be performed automatically. Such behavior begins to fulfill a psychological purpose. He mentions that like other developmental and learning disorders or problems, people may be neurologically more vulnerable to changes in the brain.

4. Self-Medication Hypothesis

Khantzian (1985, 1997) developed this hypothesis affirming that people use drugs to control physical and emotional pain. This hypothesis explains the compulsive use of certain drugs to manage depressive symptomatology, anxiety, chronic pain, trauma, or grief. In our culture, people discuss their life circumstances and recommend, even share, their medications as a way of seeking relief without going to the doctor. However, doing so may put other people at risk because the medication has not been prescribed for them.

5. Responsibility Without Guilt or Shame

Pickard (2017) outlines that addiction is an individual’s decision, which they can stop under certain circumstances. This approach asserts that people are responsible for their decisions without judging or stigmatizing behavior.

6. Biopsychosocial Model

This approach establishes that the biological component and the impact of drugs on the brain and body are a fact. It states the importance of understanding the psychological components: difficulty in managing emotional stress, low self-esteem and dissatisfaction caused by the consequences of a harmful or unhealthy lifestyle. The social component relates to sociocultural messages about substance use and peer influence, as well as to the lack of access or services to develop strategies for managing diverse life situations and circumstances. From this standpoint, addiction requires treatments and approaches that integrate three components: biological, psychological, and social.

Prejudice, Stigma and the Helping Process

Prejudice, stigmatization, and lack of sensitivity are aspects that keep people that use substances from seeking help. The societal belief that individuals who used substances did not want to change their “sinful behavior” has contributed to stigma and prejudice. Many medical and mental health professionals assumed that people who used drugs were reluctant and unwilling to change their lives, so they developed punitive methods that discouraged people from accepting help. At present, scholars and researchers are proposing new approaches aimed at understanding that people who use substances should be treated with a holistic and integrated approach, avoiding segmented and fragmented care. This implies treating people with respect, acceptance, and compassion, considering the totality of their experiences, the management of their stressors and their particular needs. In addition, it involves understanding and accepting people’s decision as to whether they wish to eliminate drugs from their lives. Harm reduction represents a comprehensive approach that addresses the negative effects of substance use and reduces substance abuse. Abstinence is not the ultimate goal, but rather understanding and respecting each person’s individual goal. From this perspective, the provider should recognize and show respect for the person’s wishes and, additionally,

understand that each person is different so that this can be integrated into treatment. It is therefore not about treatment for people who use drugs, but about what aspects of treatment can be acceptable and helpful from their personal perspective.

Harm Reduction, Public Policy, and Support Programs

Harm reduction interventions have focused on intravenous drug use, mainly opioids, because of the risk of infectious diseases transmission such as HIV, Hepatitis B and C, and Tuberculosis, as well as the risk of developing abscesses, which can lead to death. In 1984, the Netherlands initiated the first syringe exchange program in response to a Hepatitis B epidemic. In 1985, because of the HIV epidemic, the methods used for treating substance use were challenged. Within this context, harm reduction policies for people who use intravenous drugs began to be considered.

In this context, low-threshold treatment programs have emerged, which are health centers based on harm reduction with minimal demands on the participants. In these programs, no unsolicited interventions are performed and participation in other services is not required. These programs may include integrated services that are accessible to people whenever they wish to access them. Islam, M., Topp, L., Conigrave, K. and Day, C. (2013) define low-threshold services as those where abstinence from drugs is not imposed and no attempt is made to control the person's use as a condition for accessing services. Low-threshold treatment programs include basic health care and personalized services. They should not be confused with syringe exchange programs.

Some of the interventions aimed at minimizing the spread of HIV and other infections, preventing deaths and other health issues include:

1. Opioid Agonist Therapy

Opioids are synthetic substances created in laboratories, while opiates are natural substances found in the seed and flower of the Papaver somniferum plant. The dried and fermented juice is known as opium. NIDA (2014) states that opioids are endogenous or exogenous substances with a morphine-like effect. Chemicals derived from morphine are referred to as opioids. This class of drugs includes heroin, as well as a group of drugs known as synthetic opioids that are prescribed for pain management. Synthetic opioids include fentanyl, certain painkillers legally available by prescription such as oxycodone (Oxycontin), hydrocodone (Vicodin), codeine, morphine, buprenorphine, and others.

In 1965, it was noted that people undergoing methadone-assisted treatment experienced a decrease in withdrawal symptoms, as well as decreased cravings to return to opioid use. There are several clinics in Puerto Rico that offer methadone-assisted treatment for opioid users. Methadone is a synthetic opioid used for maintenance therapy for heroin users. It eliminates withdrawal symptoms for 24 to 36 hours.

There are other medications that have proven to be effective in the treatment of heroin withdrawal, such as buprenorphine and naltrexone. Naltrexone is a medication designed to rapidly reverse opioid overdose, so it can save lives by restoring a person's normal breathing. It is an antagonist that binds to opioid receptors, blocking their effects. It can be administered with a nasal vaporizer or as an intramuscular, subcutaneous, or intravenous injection. It is useful for people with less severe or incipient dependence, as well as with a strong motivation to maintain abstinence.

Buprenorphine is an agonist for use to treat opioid dependence. It is produced in two formulations: Suboxone (which contains buprenorphine and naloxone) and Subutex (which contains only buprenorphine). Naloxone may be included to prevent abuse, as it causes withdrawal symptoms in people who abuse buprenorphine.

2. Syringe Exchange Program

Syringe exchange programs reduce the risk of intravenous drug users contracting infections such as HIV and other blood-borne diseases. Syringe exchange consists of people who use intravenous drugs turning in their used syringes in exchange for new syringes. In the metropolitan area of Puerto Rico, the Program Punto Fijo of Iniciativa Comunitaria exchanges used syringes for new ones, it also provides other services for people who inject drugs. The Program Punto en la Montaña offers syringe exchange services in the central area of the country. The Program Intercambios Puerto Rico offers services in the eastern part of the country. There are other programs under non-profit or governmental organizations that rely on their funding to provide these services in Puerto Rico, the U.S. Virgin Islands, and the United States.

In addition to the distribution of sterile injection equipment, the exchange program includes filters, cookers, and distilled water. The goal is to educate on the proper use of paraphernalia, and how to safely inject and dispose of syringes.

3. Supervised Consumption Facilities

These rooms are supervised facilities located in accessible places and with hygienic measures so that people can use substances safely. They prevent people from reusing syringes and paraphernalia and prevent overdose deaths. In addition, they provide safe handling and disposal of syringes and paraphernalia. The first supervised consumption room was established in Bern, Switzerland, in 1986. Other European countries such as Germany, the Netherlands, Spain, Norway, Luxembourg, Denmark, Greece, and France have such facilities. The United States and Puerto Rico do not have supervised consumption rooms.

4. Peer Overdose Prevention

This strategy educates peers of injection drug users on the adverse effects of intravenous drug use and on the administration of Narcam (Naloxone) to manage and counteract the symptoms of opioid overdose and cardiopulmonary resuscitation (CPRI). It is a way for people close to injection drug users, such as family members or peers, to increase or develop their knowledge, as well as their confidence and skills in handling an overdose.

Risk and harm reduction includes the search for and implementation of strategies that contribute to preventing health conditions and even death in people with substance use disorders. In addition, it seeks to reduce community problems and avoid epidemics of infectious diseases. From this standpoint, it offers a collective approach to work with specific problems. However, the complexity of addictive processes requires seeking methods and interventions that work at the individual level, taking into consideration the wishes, objectives, and goals of each person.

Harm Reduction Psychotherapy

The World Health Organization defines substance use disorder as a pathological pattern of behavior in which people continue to use a substance despite experiencing significant problems related to its use. This organization defines addiction as a brain disease just like other recognized neurological or psychiatric disorders. NIDA (2014, 2020) states that addiction is a health disorder that affects the brain and modifies behavior. WHO recommends clinical interventions to stop or reduce drug use, control dependence-generating behavior, restore interpersonal relationships, and improve social and emotional skills. Harm reduction from the clinical perspective redefines the person-provider relationship; it establishes respect for the person's strengths and ability to change, and the person collaborates in the choice of strategies and goals.

Tatarsky (2002), and Denning and Little (2017) argue that harm reduction is a philosophy that guides how people are understood and professional self-awareness in a pragmatic and compassionate manner. They define it as a clinical theory that critiques and corrects the limitations of existing treatments. It is a movement composed of clinicians, researchers and policy makers seeking a progressive, effective, and helpful perspective for individuals. In addition, it is a framework for helping people with substance use disorders, who are unable or unwilling to stop using substances, to reduce the harmful consequences of their use.

There is consensus that addiction can affect individuals, the community and society. The scientific literature and research have established the importance and necessity of providing treatment for people with compulsive substance use. The medical model attempts to achieve a cure by offering treatment to people with addiction. Laws have been established in an attempt to persuade substance use and compel treatment as a punitive measure. These approaches did not initially consider the wishes and interests of the individual, asserting that because of their substance use they were incapable of making decisions for their well-being. If a participant resisted receiving the recommended treatment, it was addressed through confrontation. The emphasis was for the person to recognize the harmful consequences of their substance use and accept the diagnosis. Miller and Rollnick (2013) indicate that addiction is a sign, an indication, and a symptom of stress and of a situation that must be understood. Fernandez (2018) mentions that addiction is a biopsychosocial phenomenon that causes negative consequences including feelings of shame and guilt in the person. This paper argues that biological, psychological, and social factors culminate in dependence on one or several drugs or a compulsive behavior as a means of coping with emotional, psychological, and environmental stress.

Harm reduction accepts that people have the right to self-determination: being free to choose without being punished. The goal, then, is to reduce harm and change the person's relationship with drugs. It integrates public health, physical health through medical treatment, counseling and addressing the psychological aspects of drug use.

According to Denning and Little (2017), some of the options for people with compulsive substance use are:

1. **Safety:** Establish a safety plan with the person that involves, for example, using new syringes at each use and not sharing paraphernalia, as well as other strategies for the person to develop self-care, such as changing the route of administration; using nasal instead of intravenous; or mixing the drink with ice and water.

2. **Control:** Help the person develop rules that they can follow to help control the level of use, such as keeping drugs in a place that requires effort so that use is intentional and does not result in danger to others (e.g., children); or avoiding situations or people who have caused them harm in the past.

3. **Moderation:** Establish a moderation plan that initially establishes amount and frequency of use and that the person can consider decreasing to a level that helps them feel good while reducing harm, such as avoiding use before going to work; not drinking alcohol during the week or at night; using substances or alcohol when the kids are sleeping or when they are out of the house; eliminating the most dangerous drugs (e.g., cocaine because of the financial expense and heroin due to a hepatitis C diagnosis); and continuing the use of marijuana and occasionally pills.

4. **Abstinence:** When the person's goal is to stop using substances altogether or wants to stop using some drugs and continue using others, such as considering stopping the use of heroin, but continue using marijuana and pills. If the person is experiencing anxiety and the substance use is for managing it, then consider and suggest that the person consult a physician or psychiatrist for a prescription of anxiolytics.

1. Relationship Between the Person and the Service Provider

The person-provider relationship is the first step in making the individual feel comfortable and accepted. Unconditional acceptance, described in 1957 by the American psychologist Carl Rogers in his humanistic approach, establishes the importance of accepting people as they are without setting conditions. Empathy as part of this process involves trying to see the world through the eyes of the person without establishing opinions, judgments, or prejudices about it. Empathy is described as the degree of verbal and non-verbal communication achieved between the service provider and the person that suggests a bond in which trust, understanding and acceptance of the person is fostered, regardless of whether any level of sympathy exists. This involves the importance and need to allocate time to establish a relationship of trust and respect where the person feels welcomed, respected, and accepted without trying to press for change.

2. Change, Motivation, Resistance and Ambivalence

Prochaska, Norcross, and DiClemente (1994, 2018) define change as any activity initiated to help modify thoughts, feelings, and behaviors. This suggests that the person be viewed from a holistic perspective as an integral human situated in their usual context.

Demotivation is consistently referred to as an explanation for a person's failure to make the expected changes. Miller and Rollnick (1991, 2013) define motivation as the state of readiness to change. It is the sum of internal and external forces and other influences that move a person to be ready, willing, and able to achieve goals and begin a process of change. Motivation is multidimensional, encompassing all the inner urges and desires of individuals, external pressures and goals that influence the process, perceptions of risks and benefits, as well as cognitive appraisals. Motivation can fluctuate over time or depending on the situation; and it can be influenced by other people. It is interactive or influenced by social interactions (friends, family); by internal factors (emotions and perceptions); and by external factors (external pressures and goals). Motivation is dynamic, fluctuating and can be modified. This implies that people may begin the process of change highly motivated, but later, for various reasons, their motivation may decrease. It is important to note that the style of the service provider impacts, positively or negatively, the person's motivation.

A further aspect to consider in the process of change is resistance and ambivalence. Ambivalence is accepted as a normal part of the human experience and of change. It is the simultaneous presence of motives for and against change. It is the natural dilemma in which one can see that a behavior can bring negative consequences, but at the same time it plays an important role for the person. Resistance is the first response to the possibility of change. Attachment to the familiar may cause the person to remain in a harmful behavior, as a mechanism to avoid facing unfamiliar experiences. Ambivalence and resistance are not contradictory but are accepted as a natural and understandable part of change. If there is resistance and the person resists the process, it means that the situation is viewed differently from the way the service provider views it.

3. Goals and objectives

Once the person-provider relationship is established as a bilateral working alliance, the person's interests, goals, and objectives should be considered. This implies that people may want to change some aspects and needs that they understand are not related to substance use. The person may establish needs such as obtaining housing, employment, medical treatment, government assistance, assistance in legal proceedings, and others. It should be noted that these are concrete, external needs that most probably people do not associate as consequences of their substance use. It is imperative to offer support and make efforts to meet those needs. Once these needs are addressed, the person-provider relationship is established, and issues related to substance use should be discussed without exerting pressure.

4. Knowing a Person's Relationship with Drugs

The following tables are from the book Over the Influence, second edition, by Patt Denning and Jeanne Little (2017). These tables help to learn about aspects related to substance use and allow people to put into perspective their history and consequences of substance use. The recommendation is establishing the reasons why the person started using substances, and why that person continues to use them.

My choices:

Drug	Reasons to start using it	Reasons for its use at present

Once the past and present reasons for using drugs have been established, an exercise that determines the amount, frequency of use, factors leading to use, and level of use should follow. The level of use should be described as never used, experimental, occasional, regular, heavy, or chaotic.

Continuum of drug and alcohol use:

Drug	Amount	Frequency	Factors leading to use	Level of use

It is important to establish the harms and risks of drug use, including alcohol. Harm is established as the cost or consequences of using substances. Risks relate to the possible negative consequences or problems arising from substance use.

Harms and risks of drug use, including alcohol:

Drug	Amount	Frequency	Factors leading to use	Level of use	Harms/ Risks

Once the harms and risks associated with substance use have been established, the secondary benefits must be assessed. People must understand how drugs impact their life, both positively and negatively.

Benefits and risks of drug use, including alcohol:

Drug	Levev of use	Benefits	Harm/Risks

Denning and Little (2017) mention the importance of establishing with individuals their interaction with each of the drugs or alcohol they use (Over the Influence, 2nd ed., page 101). The type of drug, route of administration, frequency, and timing (when) of drug use; legal status; and combination with other drugs, including those prescribed by physicians; and discussing drug experiences, harms and benefits should be established. It is relevant to examine personal and general aspects related to their occupation, personality traits or style; motivation to use and expectation of what will happen; aspects of physical, mental, and emotional health; and the name and dosage of the drugs they use. In addition, other aspects should be considered, such as the place or environment where the person uses substances; an assessment of whether the community where the person is located accepts or rejects substance use; what stressors are evident; and the type and level of support the person receives. The information obtained should be discussed and analyzed with the person without judgment or opinion. No recommendations or suggestions for change should be offered. It is up to people to decide what they want to do with their substance use.

Transtheoretical Model of Change

The Transtheoretical Model of Change is evidence-based and recommended for the management of substance use disorders. The model has proven useful in changing unhealthy lifestyles and in helping to understand the reasons why individuals often fail, despite wanting to make changes in their lives. Prochaska and DiClemente's (1994) Transtheoretical Model of Change conceptualizes the change process as a sequence of stages through which people progress as they consider, initiate, and maintain new behaviors. This model considers motivation as an important factor in change, and assigns an active role to the subject, who is considered the main actor in their behavioral change. This model establishes the stages of change as one of four dimensions influencing behavioral change.

The stages of change reflect the process and progress in behavior change. People with a substance use disorder, even when they verbalize their intention to change, go through different stages that provide information about their own inner process. According to the Transtheoretical Model of Change, these stages represent a cyclical, non-linear process in which the person may move back and forth between stages for various reasons or motives. Change is an individual and distinctive process for each person. This implies that, even if two people express their intention to change with respect to substance use, according to the model, they may be at different stages and the intervention strategies should be different. Likewise, if a person has a substance use disorder involving several substances and expresses an intention to change, they may be at different stages for each of these substances. This implies that a person may set as a goal abstinence from one substance, moderation for another, but continue to use others. There is no specific time to move from one stage to another; some people may even remain indefinitely in one stage even when they express an intention to change. Furthermore, a person may be committed and motivated to change, move forward from one stage to another, and then, due to various variables, return to the initial stage. This may generate frustration in the service provider who may consider that the person is not committed or motivated to change. However, this is a normal and natural part of the process. Recurrence, defined as a return to the initial behavior or symptoms that have been addressed, is a latent possibility, regardless of the stage of change in which the person is at.

Stages of Change

Each stage of change is defined by particular and specific characteristics. Assertive and specific actions are required to make people maintain their intention to change and understand the process. The stages of change are: precontemplation, contemplation, preparation, action, and maintenance.

1. Precontemplation:

Precontemplation is a stage in which the person does not recognize the existence of a harmful behavior, and therefore does not express the need for change. This occurs regardless of the consequences of the behavior. If the negative impact of their substance use is discussed or analyzed with the person, people will resort to various arguments in order to justify or minimize it, presenting a defensive attitude. People often argue that they will be able to change, stop or reduce their substance use when they want to, so they reject any approach or intention to help. It is common to hear verbalizations such as: "I have no problems that I need to change", "I may have my faults, but who does not". The defense mechanism observed in precontemplation is denial and rationalization.

Table 1 outlines the different types of people in precontemplation and recommendations for working with them. At this stage, the relationship between the provider and the person should be developed in an attempt to solidify the relationship, gain trust and make the person understand and feel that they are accepted and respected.

Table 1: Types of precontemplators

Types of precontemplators	Metas
1. Revel: They enjoy their lifestyle, having fun and the joy they believe substance use brings them.	A. Increase awareness of lifestyle consequences. B. Increase knowledge about the effects and impact of substances at the neurophysiological, psycho-emotional, family, and social levels.
2. Reluctant: They show great sensitivity to the effect of substances on their lives but lack knowledge about the problem. They display reluctance to make changes in their lifestyle.	A. Establish advantages and disadvantages about substance use. B. Raise awareness of the scope of the problem. C. Increase knowledge about the effects and impact of substances at the neurophysiological, psycho-emotional, family, and social levels.
3. Rebellious: They invest a lot of energy and passion in maintaining their right to make their own decisions. They fear losing control of their lives and resent being told what to do by others.	A. Emphasize personal control. B. Increase awareness of personal freedom. C. Analyze the consequences of the harmful behavior.
4. Resigned: They are overwhelmed and hopeless about change and the energy it requires. They are overburdened by their problems, including their relationship with psychoactive substances. They have previously tried to change the harmful behavior, either by seeking help or on their own, and have not achieved the desired outcome. They firmly believe that nothing can work for them.	A. Develop or regain hope and optimism regarding the possibility of change. B. Explore barriers that prevent new beginnings.
5. Rationalizing: They offer compelling reasons for maintaining the harmful behavior, regardless of the consequences. They convincingly claim that their relationship with substances is not a problem. They debate and use excellent arguments to demonstrate that they do not have to change their harmful behavior. They tend to be confrontational and argue that substances are a problem for others, but not for them.	A. Reflecting, rather than arguing, about the impact of substance use. B. Focus on the person, rather than on their behavior. C. Acknowledge and validate the person's arguments; and reframe them to promote self-analysis.

2. Contemplation:

A stage of change in which the person shows awareness of the possibility of a substance use problem and is considering beginning to address it but does not verbalize a commitment to take action. The person may be considering solving the problem, understands it, sees the causes, and thinks about possible solutions, but is not ready to make the change. Ambivalence and insecurity are evident in relation to the problem and undertaking the change. The expressions of people in the contemplation stage are accompanied by the conjunction “but”; for example, “I think I should do something, but...”.

In the contemplation stage, people may listen to information about their harmful behavior, and begin to analyze and compare their behavior with their values and the impact it has on those around them. Although people may begin to evaluate the advantages and disadvantages of their substance use, they tend to favor the positive aspects of their behavior. People present an internal reflective process of the impact of their harmful behavior but are not considering initiating change. Ambivalence is defined as the simultaneous presence of motives for and against change. That is, feeling two different ways about something or someone. This is an expected part of change because behavior plays an important role for the person, regardless of its negative consequences. Therefore, although people recognize that substance use affects their family relationship and brings economic and health problems, it also represents their way of socializing and having friends, as well as an escape from family stress. The dilemma arises when they want to have a good family relationship, be able to meet financial commitments and maintain good health but do not want to lose social interaction and relationships with friends. Drugs serve a function and are part of the person’s life history. The service provider must understand this and help people resolve their dilemma so that they can develop skills that will help them manage their life circumstances and seek their well-being.

At this stage, the service provider should normalize ambivalence and assist the person in assessing the decisional balance by evaluating the advantages and disadvantages of substance use; promoting a shift from extrinsic to intrinsic motivation; assessing personal values; and emphasizing the person’s free will, responsibility, and self-efficacy. Likewise, harm reduction strategies involving safety and self-care should be discussed.

Service providers need to accept and understand that individuals have the best understanding of their pattern and history of substance use. They must accept that the person has the insight and knowledge necessary to generate the change plan (internal), if desired, or work on harm reduction (external) in partnership with the service provider. This requires the provider to maintain a collaborative, non-directive attitude; and to engage in reflective listening. As people work on harm reduction there is the possibility that their awareness of substances' impact on their lives will increase.

In the precontemplation and contemplation stages, the goal is to increase awareness and understanding of the harmful behavior and its risks. It is up to the service provider to establish a relationship of trust and empathy, as well as an environment of unconditional acceptance in which the person feels understood and supported, without being judged or criticized in a negative way. It is important to accept that people have the knowledge and experience to make their decisions. Simply put, they are adults who expect to be treated with respect, not as children who are told what to do because they lack the capacity to make decisions. In an environment where they are criticized or tried to be led in a particular direction, they will show resistance. The Transtheoretical Model of Change promotes respect for the individual and, therefore, it is not acceptable to push the person in a particular direction, offer unsolicited advice, or emphasize incorrect behaviors with the expectation that they will change or modify them as soon as possible. Behavior change is a lifelong process; therefore, it is a long-term process.

2. Preparation:

A stage of change in which there is awareness of the problem, and the person is committed to the possibility of changing the harmful behavior. The person is ready to change in the immediate future but is not yet sure of the decision to be made or the steps to be taken. At this stage, it is important to clarify the person's goals and strategies for changing their substance use; present possible harm reduction options; negotiate the plan; reduce possible barriers that may affect the change process and the alternatives chosen by the person; establish social/family/work/economic support and management alternatives; and assess treatment expectations and the person's role.

The goal is to establish an effective action plan in collaboration with the person, to be implemented in the immediate future, reduce harm, and increase commitment to change. However, having a plan that appears to be effective does not necessarily imply change. The person is engaged in an internal process of change. For the help provider, one of the challenges of this stage is to assist the person in managing impulsivity and low tolerance to the search for immediate gratification, and to manage cravings if the person chooses moderation or abstinence from one or several substances. At all stages, it is necessary to constantly evaluate the person's motivation to ensure alignment with the end goal. It is a mistake to believe that because people verbalize the intention to change and establish a plan to follow that there will not be a recurrence of substance use, risky behaviors, or that they will again question whether they really need to make a change in their substance use.

When the person voices a statement of change, even if it is only with the service provider, it increases the person's commitment to the goal. When others know about the person's decision, the expectation of the action increases. However, this verbalization should be confirmed with the person. To this end, it may be helpful to ask questions or make interventions such as: "Your decision to make changes to addictive behavior seems to be firm, tell me about that." "You say you are going to cut down on heroin use, use new syringes at each use, and not share paraphernalia. Tell me about that." "Where do you feel you are in the process?" "What would you like to do now?" Setting dates is extremely important because it implies commitment to action. If the person refuses to set a date or does not follow through, it is an indicator that they have shifted to the contemplation stage.

If the person is in the preparation stage, the variety of alternatives that are available should be presented, discussed, and analyzed. It is important to analyze with the person the advantages and disadvantages of each option, answer their doubts and questions, offer simple literature, discuss the recommendation of medical evaluation and other possible alternatives.

The agreed plan should be specific, individualized, and functional from the person's perspective. The person's specific needs should be considered and alternatives for the best management of these needs should be established. The action plan should include both a change and a treatment plan. The change plan refers to the changes people wish to make in their daily lives beyond treatment. These may relate to harm reduction options. The person should keep the change plan on hand and review it as often as necessary. The service provider should constantly discuss with the person the needs or situations of daily living and the skills that may be required to manage them. The treatment plan includes the person's use of treatment alternatives to support the change plan.

3. Action:

A stage of change in which the person shows willingness to modify the harmful behavior and implement the previously worked plan. At the beginning of this stage, people experience pain and distress and feel that they receive little positive reinforcement. If the person has opted for abstinence from some substances and moderation with others, they will probably have to manage the physiological, psychological, and social breakdown of those drugs. At the beginning of this stage, the support the person receives from the provider is extremely important to maintain the commitment to change. Important behavioral aspects can be observed at this stage of the process: making decisions regarding daily living; avoiding events that trigger substance use; learning new ways to respond to internal and external stimuli; developing new relationships that promote change; learning to manage relationships that promote substance use; and managing rules, control, and safety agreements such as syringe exchange, no sharing of paraphernalia, and use of prophylactics, among others.

In the action stage, people show awareness of the problem and are focused on implementing the necessary changes to be consistent with their decisions. The person perseveres in the acquired commitment and makes observable changes. Commitment to a healthy lifestyle is evident. The service provider should promote a realistic vision of change through small steps. It is necessary to help the person identify high-risk situations and develop appropriate management strategies. When people start to implement the established plan, it is normal for them to have doubts, to question whether what they are doing is correct; they may even reevaluate whether their substance use really warrants so much effort on their part. In these circumstances, it is important to explore with the person the aspects of the action and treatment plan that are functional, and those that are not and make the appropriate adjustments. The goal is to achieve problem solving, to make the person feel optimistic about the changes or decisions made, and to support self-efficacy.

The established action and treatment plan may collide with the reality of the person's daily life and reintegration into their social environment. It is important to suggest techniques such as acupuncture, meditation, relaxation strategies, mindfulness and others that may be of benefit to the person, as well as stress management. The use of positive reinforcement is necessary early in this stage. Addictive behaviors have been consistently reinforced and that is one of the reasons they are so difficult to eliminate. People in the action stage need their new behaviors to be reinforced. It is important to observe micro changes in the person, such as compliance with the schedule and frequency of meetings; improvement in physical appearance; increased verbalizations regarding topics of interest; and attendance at non-substance related activities with people with healthy lifestyles. Other changes can be observed in self-care, safety, and control of substance use, such as syringe exchange, use of prophylactics, not sharing paraphernalia, moderation and avoidance of substance use before work. The service provider must raise the person's awareness of ongoing changes and promote self-reinforcement.

4. Maintenance:

In this stage, the person consolidates the progress made during the previous stages. The person has reached the initial goals established in the work plan and is on track to maintain what has been achieved. The service provider should help to identify and evaluate sources of pleasure and healthy recreation in an appropriate environment according to the person's interests. By doing so, the person will be able to sustain the change over time and in a wide variety of situations. The goal is to sustain long-term change and continue to practice the new behavior pattern. At this stage people value the rewarding aspects of their new lifestyle; maintain awareness of the problem; decrease craving or desire to use the substances they decided to stop; increase attention to relapse prevention; show greater adherence to change; and maintain self-care and harm reduction decisions if they continue to use one or more substances.

As a result of the changes presented and the achievements obtained, the person may present a high level of confidence and neglect important aspects that have already worked on. Overconfidence may result in unnecessary exposure to people, places and situations that may induce relapse or neglect aspects of control and safety for those drugs that are still being used. The service provider should continue to offer positive reinforcement; follow up on solving problems currently impacting the person, assess any situations that threaten the person's stated commitments, and continue to review long-term goals.

At this stage it is important to examine and work with issues related to the person's life history. That is, unresolved issues such as relationship problems, childhood abuse, depression, anxiety, social skills and other family and environmental problems that may cause stress. Spirituality can be a significant factor at this stage. The service provider's recommendations should be subject to the person's principles and wishes. Therefore, the values, beliefs, and desires of the person must be explored. These may differ from the value and belief system of the service provider, but it is the person's belief system. No attempt should be made to chart a specific spiritual path for the individual. A spiritual path is decided by each person according to personal values and belief systems.

Helping the person develop or increase job or academic skills is extremely important. This may involve referring the person to other providers who can assist in the development of a variety of skills. In the maintenance stage, the person must be able to connect with other resources for service. The maintenance stage goes beyond the person exhibiting changes in substance use behavior. To sustain recovery and harm reduction it is essential that the person is healthy and maintains substance-related goals. The aim at this stage is for the person to be able to integrate change into the overall context of daily life, regardless of the decision made about the use of one or more substances.

Harm reduction is not opposed to abstinence. This option is for the person to evaluate and decide whether to accept or reject it. If the person decides to continue with the use of substances, to reduce the use, or to abstain from the use of any substance, harm reduction is a good option. It promotes safe use, and reduces the likelihood of disease transmission and death from overdose.

Motivational Interviewing

Motivational interviewing is an evidence-based approach that combined with the Transtheoretical Model of Change has been shown to be effective in managing harmful behaviors. Miller and Rollnick (1991, 2013) indicate that motivational interviewing is a strategy that can be used in the Transtheoretical Model of Change and it presupposes that the responsibility and capacity for change lies with the individual. They define it as a collaborative conversational style to strengthen internal motivation and bring the person closer to change. It is a directive, person-centered style of interaction intended to support, explore, and resolve a person's ambivalence towards substance use and to begin making positive behavioral changes.

The goals of motivational interviewing are:

1. Resolve ambivalence
2. Avoid generating or increasing resistance
3. Motivate the person to talk about the change
4. Increase motivation and commitment to change
5. Help move through the stages of change

Miller and Rollnick (2013) state that motivational interviewing has four interrelated elements:

1. **Partnership:** The process by which people work together to accomplish a common goal, without judgment and without imposing on each other.
2. **Evocation:** Each person possesses the motivation, resources, and ability to change, it is just a matter of activating these elements.
3. **Acceptance:** This involves honoring the value and potential of the person receiving help; it recognizes and supports the autonomy or decision-making power of the person; and it seeks through empathy to understand the perspective of the other and to affirm the person's efforts and strengths.
4. **Compassion:** It is actively promoting the welfare of the other person.

Motivational interviewing uses specific principles and strategies to promote motivation for change; it analyzes and reflects people's perceptions without criticizing or correcting them and promotes respect for the person's choice or decision. It is designed to explore and reduce ambivalence and resistance, and to foster self-motivation.

Conclusion

Harm reduction is a set of policies, programs and interventions that seek to minimize the harmful consequences of drug use, legal or illegal, on the health of a person or society. It is a movement made up of clinicians, researchers and public policy makers that seeks a progressive, effective, and supportive perspective for people who use substances. This framework provides service to people who cannot cope with or do not want abstinence. Harm reduction provides them with alternatives to manage their self-care and avoid health issues, such as the spread of disease through sharing paraphernalia and syringes; not having a hygienic environment; and death from possible overdose.

This approach considers the person's wishes and goals and does not impose conditions. It recognizes the importance of establishing a professional bond based on respect, empathy, compassion, and acceptance of the person regardless of their decisions. Goals are set by the person based on the understanding that they have the capacity to make them. Strategies for harm reduction, like the use of medications for heroin use, such as Methadone, Suboxone, Subutex and Naloxone are also discussed. The individual, family and friends are counseled on the use of Naltrexone to reverse overdose. In addition, it relates to syringe exchange programs, guidance on the hygiene of paraphernalia and on avoiding sharing it, and the use of prophylactics. These are measures to prevent the spread of diseases such as Hepatitis B and C, HIV and other sexually transmitted diseases, tuberculosis, abscesses, and death due to overdose.

Psychotherapy in harm reduction is viewed from a bio-psycho-social standpoint in which a holistic approach is used to engage with the person. It considers the person's life history, the role of substances in the management of stressors and possible self-medication. The stages of change of the Transtheoretical Model of Change, which is evidence-based, serve to understand where people are at in relation to their substance use. The Motivational Interviewing approach, also evidence-based, is used in combination with the Transtheoretical Model of Change. This approach presupposes that people have the capacity to change. Using a collaborative conversational approach, it strengthens intrinsic motivation and provides support for managing resistance and ambivalence.

People with substance use deserve to be treated with respect, care, and professionalism. Harm reduction at the pragmatic and clinical levels is an option that provides valuable strategies for people with substance use who are not considering abstinence. For those who are considering abstinence, but do not yet feel ready, harm reduction is an option to work on safety and well-being while increasing motivation for change.

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