Clin Soc Work J
DOI 10.1007/s10615-016-0584-3

ORIGINAL PAPER

Starting Where the Client Is: Harm Reduction Guidelines for Clinical Social Work Practice

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Abstract Harm reduction has gradually entered social work discourse and is now seen as a promising approach for treating individuals with drug and alcohol problems. However, beyond statements and data supporting the utility of a harm reduction approach, few guidelines for clinical practice have been detailed in the social work literature. This lack of concrete detail regarding how harm reduction is actually practiced limits the potential implementation of the model into day-to-day clinical work. This article reiterates that harm reduction is a viable approach to clinical social work practice with individuals who have drug- and alcohol-related problems and for whom traditional approaches may be inappropriate. It focuses on harm reduction therapy as an emerging treatment model that can be implemented by clinical social workers and mental-health and substance use treatment providers. The article identifies and elaborates several basic tenets that can be incorporated into clinical social work. It is hoped that social workers who learn how harm reduction is implemented in clinical practice will be more apt to incorporate its principles into their work.

Keywords Harm reduction · Clinical social work · Harm reduction therapy · Addiction · Addiction treatment · Drug and alcohol treatment

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Introduction

The term "harm reduction" was coined in Europe in the 1980s to describe public health approaches to working with active injection drug users (IDU; Marlatt 1998). Sterile syringes were distributed among IDU in an attempt to reduce their risk of transmitting blood-borne diseases. This was a novel approach that ran counter to the criminal model at the time—rather than mandating treatment or arresting these IDU, the focus was simply to help them keep safe and to encourage them to seek treatment when they were ready. Fast forward to today and decades of international empirical data now confirm that these types of syringe exchange programs are one of the most effective ways to curb the spread of HIV among IDU. Harm reduction, as a movement, grew out of these sorts of humane, compassionate, and pragmatic interventions. Its aim is to engage people who use drugs to work towards safety and health (Denning 1998). The premise of harm reduction is that by welcoming people as they are, and by offering help that meets people's basic needs, we can increase client engagement and lower their reluctance to change.

The spirit of harm reduction has been integrated into clinical settings in the form of individual and group psychotherapy known as harm reduction therapy (HRT). It was developed in the 1990s by several psychologists, social workers, and researchers, and has grown into a robust paradigm of treatment that has been used with clients who engage in a wide variety of risk behaviors relating to substance use (Denning 1998, 2000; Little 2001; Marlatt 1998; Springer 1991; Tatarsky 1998, 2002). HRT offers a unifying approach based on the values of self-determination (Ryan and Deci 2000), inclusion, freedom from harm, and the promotion of public health. It supports work with

Published online: 16 April 2016

clients towards self-selected treatment goals including, but not limited to safer use or abstinence. In a recent online article, Rothschild (2015), a psychoanalyst, referred to HRT as the "third wave of addiction treatment." She posited that HRT provides an alternative to the moral and disease models that have dominated substance-use treatment settings over the past century through punishment or the imposition of abstinence on people presumed to have the disease of addiction. Meanwhile, Little (2015), a clinical social worker, proposed HRT as an "umbrella" for treatment of substance use and co-occurring disorders by providing a framework to effectively treat substance use and related problems in an integrated biopsychosocial model. She points to the client-centered and trauma-informed focus of HRT, which does not require the client to address their substance use before mental-health needs can be treated.

Harm Reduction and Social Work: Natural Partners

Harm reduction and social work share many values. Chief among them are respect for client autonomy and self-determination. In harm reduction practice, as in social work, practitioners start where the client is. Both fields are strengths-based: both regard the client as an expert and work to create a collaborative working alliance. Like social workers, harm reductionists understand that their job is to facilitate the client's growth, self-discovery, and decision-making process. They seek out and highlight their clients' competencies and support the development of self-efficacy. Given these like-minded values, it is only a matter of integrating the specific framework and treatment interventions for social workers to be leaders in harm reduction practice.

Over the past two decades, a growing number of social work clinicians and researchers have written articles related to harm reduction in peer-reviewed social work journals. These articles range from position pieces promoting harm reduction philosophy as something aligned with our values (Bigler 2005; Brocato and Wagner 2003; Lushin and Anastas 2011; Macmaster 2004; Reid 2002; Seiger 2003; Straussner 2012; van Wormer 2004) to empirical outcome studies of the approach in various settings (Davis et al. 2014; Karoll 2010; Mancini et al. 2008; Witkiewitz 2005). In addition, social workers have published articles relating to harm reduction in other professional journals (Henwood et al. 2014; Lee et al. 2011; Little 2006, Little and Franskoviak 2010; Little et al. 2008).

The National Association of Social Workers (NASW) has also begun to mention harm reduction in some of its recent publications, most notably in (1) *Standards for Social Work Practice with Clients with Substance Use Disorders* (NASW 2013a), (2) the current edition of *Social Work Speaks* (NASW 2012) in the sections on HIV/AIDS and on alcohol, tobacco, and other drugs, and (3) in *A Social Work Perspective on Drug Policy Reform* (NASW 2013b). Manuals and books have detailed public health and/or clinical guidelines for the practice of harm reduction or HRT (see, e.g., Denning and Little 2012; Harm Reduction Coalition 2011; Tatarsky 2002).

This article will fill a gap in the social work literature by detailing clinical interventions of HRT and discussing how they can be integrated into social work practice. Forging a therapeutic alliance, creating a therapeutic environment, and conducting a client-centered substance-use assessment can help to set the stage for the harm reduction approach to substance-use treatment. The authors will also highlight key evidence-based interventions that have already been incorporated into both social work practice and HRT, such as motivational interviewing and cognitive behavioral therapy (CBT). Finally, the considerations for outcome measures of HRT will be discussed.

Creating a Therapeutic Alliance

The first weeks of substance-use treatment are critical. It is estimated that approximately 15–28 % of individuals do not return for the second session of treatment (Coulson et al. 2009) and 30 % drop out within the first month (Palmer et al. 2009). Factors that are known to contribute to nonattendance and dropout rates include perceived shortcomings of the agency and its approach, motivational ambivalence about treatment goals, and lack of connection to staff members. In summarizing research on treatment retention, Miller (2006) says that "therapist effects" (p. 137) such as empathy and client-centeredness account for the largest impact on motivation, as measured by retention, adherence, and behavior change. A HRT practitioner can do several things to create a safe and welcoming environment where a therapeutic alliance can form, such as: lowering thresholds for treatment entry, conveying a neutral stance towards substance use, taking an exploratory approach, and ensuring that the client feels like a collaborative partner in her or his treatment.

Lowering the Threshold for Treatment

One of the top reasons that many people with substance-use disorders don't seek treatment is that they are not yet ready to practice abstinence (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). HRT practitioners make explicit from the first contact that the client can come to treatment whether they have decided to

commit to abstinence or not. In HRT, everyone is welcome, regardless of their stage of change, their relationship with drugs, or their goals for future use. An HRT practitioner's willingness to work with clients who are still using exemplifies the belief that clients can always be engaged in working to improve themselves and their circumstances. The client's decision to walk in the door is interpreted as a sign that they are motivated for help. As Miller (2006) writes: "No one is unmotivated. The question is what a person is motivated *for*…. A person's level of motivation (e.g., desire, self-efficacy, readiness, problem-recognition) is action-specific" (p. 136). A HRT practitioner works with clients to take the actions they are most motivated to take first, then continue to work with them towards new goals that may present themselves later on.

Conveying a Neutral Stance Towards Substance Use

Known as the "righting reflex," well-intentioned clinicians can consciously or unconsciously convey that they know what is best for their client, which can place the client in a defensive position (Miller and Rollnick 2013). It is natural for providers to feel anxious about the harm experienced by some of their clients who use illicit substances. It is also understandable if they succumb to the inclination to be directive. However, acceptance of people's capacity to make choices for themselves is the first step in building a therapeutic alliance grounded in respect rather than paternalism. An HRT practitioner should maintain a neutral stance towards substance use, neither condemning nor condoning it. It ought to be clear that the practitioner does not believe the use of alcohol or illicit drugs means that a person is "bad" or diseased, or even that the person necessarily has a problem.

The first principle of HRT is "people use drugs for reasons." Tatarsky (2003) speaks to the multiple meanings of substance use and many theorists have discussed the self-medicating aspects of drugs (see, e.g., Khantzian et al. 1990). It bears repeating in the early stages of treatment that the HRT practitioner understands that people use drugs for reasons, reasons that need to be understood, not judged. Another principle of HRT is that "not all substance use is abuse" (Denning and Little 2012). Substance use occurs on a continuum from benign to chaotic, and people may move back and forth between those poles throughout their drug-using lifespan, with most lifetime users never meeting criteria for dependence (Anthony et al. 1994).

Exploring the Client's Relationship with Drugs

HRT practitioners view individuals as having a *relationship with drugs* rather than an *addiction* to them (Denning et al. 2004; Marlatt 1998; Tatarsky 2002). A *relationship with drugs* is nonpathologizing and recognizes that one's relationship with any drug can range from helpful to harmful. It also affirms client autonomy and choice—someone who has developed a relationship with a substance can change or end that relationship. It also captures the complexity of a person's use, which the concept of addiction currently does not. "Addiction," as a social construct, creates a dichotomy between those who have a problem and those who do not. The reality is that "non-addictive" use (e.g., experimental use of heroin with a nonsterile syringe, college drinking games) can also be harmful and have lasting effects, such as contracting a bloodborne disease impaired driving, or alcohol poisoning.

In addition, people can have a different relationship with *each* substance that they use (Denning and Little 2012). HRT practitioners do not ignore the fact that there are individuals who use all substances in harmful ways, but they also see that there are many who are capable of moderating their use of one or more substances while struggling with the negative effects of others. For instance, a client may admit to having a problem with alcohol, while saying that they can use marijuana on occasion and do not like to use cocaine at all. Sometimes it is one substance that has meaning and gives a desired effect, and not necessarily any or all of the substances that the client uses. In other words, substance users are capable of being discriminating. HRT practitioners are open to treatment goals that may focus on only one mood-altering substance, and they are willing to help clients pursue different goals for different substances.

The effect of this approach is to demonstrate respect for the client's self-assessment, and to put the client in the driver's seat in the prioritization of problems. It also conveys to the client that the clinician is open and curious about her or his unique experience with substances. HRT is not a "one-size-fits-all" approach to treatment and encourages a multifaceted and nuanced way of thinking about how and why people use drugs.

Collaboration

HRT practitioners join their clients in a partnership in which both have expertise and the client is the undisputed expert of her or his life, problems, relationship with drugs, and needs. The burden on the HRT practitioner is to let go of any preconceived expectations so that she is not perceived as someone with an agenda but rather as a partner in change. Such a partnership can lead to honest and authentic discussion about the meaning of the client's substance use and what he wants for himself.

This collaborative stance should be reflected in the language used during assessment and treatment. Although there are models that require clients to self-identify as "addicts" or "alcoholics," HRT practitioners avoid using

these defining labels. Instead, one can use more neutral terms such as "substance use" and/or "substance misuse," which give clients room to identify the way in which they are being harmed. Although there are individuals who find meaning in self-identifying as an "addict," the HRT practitioner is not the one to decide. In fact, research suggests that allowing clients to construct nonaddict identities can help facilitate the recovery process and a more positive sense of self (Howard 2008; McIntosh and McKeganey 2000).

Creating a Therapeutic Treatment Environment

Program structure, rules, and clinician comfort and competencies must adapt to accommodate a wide range of substance-using clients in HRT settings (Harm Reduction Coalition 2011). Denning (2001) has written about practicing HRT in communal settings. Facilities that are licensed and bound by local, state, and federal laws are encouraged to use punitive sanctions judiciously. Community safety should be prioritized. However, the behaviors that are discouraged need to be truly harmful, not just uncomfortable to staff. If, on the other hand, the behavior in question involves actual threats, violence, or other harms, then it must be addressed in accordance with policies and procedures. The difference in a harm reduction setting is that these behaviors are not automatically assumed to arise from drug use, and drug users are trusted to manage themselves just as anyone else. In order to facilitate engagement and change within an atmosphere of safety and trust, we recommend the following policies: regular training and supervision of all staff, judicious use of drug testing, and the understanding that intoxication does not necessarily preclude a client from accessing services.

Supervision and Training

HRT practitioners are advised to receive regular individual and/or group clinical supervision in order to manage the complexities of working with clients who actively use drugs. Supervision provides practitioners with opportunities for reflection and feedback on how they are working with high-risk clients, as well managing their own countertransference reactions and burnout (Harm Reduction Coalition 2011). In addition, ongoing training opportunities should be provided so that clinicians are current in their knowledge and methods. HRT practitioners should stay up-to-date on the pharmacology of alcohol and other drugs, especially those that are "new" to the streets. Many HRT practitioners also enhance their skills by developing clinical specialties and strategies that can be integrated into their harm reduction practice.

The Use of Drug Testing

Drug testing (usually urinalysis or breathalyzer) is a monitoring practice used by many programs to track abstinence in between sessions. In general, HRT does not use, and does not advocate the use of, drug testing. Practitioners who have developed a therapeutic alliance are encouraged to rely on clients' openness about their use and research suggests that clients who feel a stronger working relationship are less likely to keep relevant secrets in treatment (Kelly and Yuan 2009). This might seem risky, but riskier still is the client who drops out of treatment because of a lack of trust from the clinician. In circumstances where drug testing is required by a referral source, HRT practitioners should engage clients early on to discuss the best ways to manage this requirement in an honest and ethical manner. Some clients request drug testing as a strategy to maintain personal accountability or to remain in compliance with referral source requirements. Others are not amenable, and need to weigh the pros and cons of complying with drug testing.

Services for Intoxicated Clients

HRT in communal settings holds clients to certain behavioral standards, regardless of the client's substance use (Harm Reduction Coalition 2011). Given that clients are working towards self-selected goals that may not include abstinence, they sometimes come to treatment under the influence. Most HRT practitioners do not necessarily see this as a violation of policy or of the therapeutic relationship. As long as clients do not endanger themselves or others, and they behave respectfully toward peers and service providers, they should be made welcome (Denning and Little 2012). Just as sobriety does not necessarily guarantee appropriate conduct, intoxication does not necessarily guarantee inappropriate behavior. A common concern in communal environments is about the "triggering" effects of clients who are intoxicated on those who are not using, or attempting not to (Denning 2000). Staff must work hard to resolve these conflicts and to reinforce the resolve and resilience of people who are moderating or abstinent. The authors are, however, uncompromising about impaired driving. If someone has driven to a session under the influence, we call a cab and, if needed, ask for their keys. When immediate safety is concerned, HRT practitioners become more directive.

Conducting a Comprehensive Client-Centered Assessment

Substance use (whether problematic or not) is drug specific, individual specific, and context specific. Research on controlled substance use by Zinberg (1984) resulted in the

conceptualization of a model called "Drug, Set, Setting." In his studies of nonaddictive heroin use, Zinberg found that controlled heroin users used the same decision-making processes as social drinkers. His research found that both positive and negative drug experiences emerge out of an interaction among the drug (the type of drug, how it is consumed, how much, and how often), the set (the mindset of the person using), and the setting in which the drug is consumed (where, with whom, and the social context). For instance, a glass of wine with dinner is different from sharing a bottle of wine with a friend at happy hour, which is different again from drinking at home alone on an empty stomach after a divorce. It also leads to different consequences. It is important to recognize that users can have different experiences, even with the same drug, on different occasions of use. Much of this can be attributed to the fact that every drug has its own pharmacology, can be used for different reasons, and can be used while in different mental states and in different environments.

HRT was developed, in part, for people with co-occurring disorders because it understands and accepts the self-medicating possibilities of drugs. Denning and Little (2012) have expanded the Drug, Set, Setting matrix to include co-occurring mental-health issues and ongoing life stressors and adapted the model as a framework to conduct a full biopsychosocial assessment. An important goal of the assessment process is to identify what the client may have to give up or adjust in order to reach their substance-related goals—whether safer use, moderation, drug substitution, or abstinence.

Assessing Drug Factors

The HRT approach to assessment can be quite different from most substance-use assessments conducted in both treatment and research settings, where the focus is largely upon the negative consequences associated with the client's substance use (usually in attempt to determine whether the client has met diagnostic criteria for a substance-use disorder). Although determining whether a client meets diagnostic criteria can be important for billing and reimbursement purposes, the purpose of a HRT assessment is for both the clinician and the client to understand the client's relationship with drugs (see Table 1). Salient areas to highlight are safety concerns (especially needle sharing, overdose potential, and dangerous withdrawal); drug classification (e.g., stimulant, opioid, sedative); route of administration (oral, smoking, snorting, injecting); and drug combination (drugs that potentiate or mask each other's effects).

Assessing Set Factors

Questions relating to set factors are designed to uncover the unique dynamics and functionality of each client's use as well as their personal history (see Table 1). Motivation and expectation are the key areas of focus. *Motivation* can range from a desire to medicate physical or emotional pain, enhance pleasure, alter consciousness, or some combination of these. Self-medication of co-occurring mental-health symptoms is a commonly identified motivation for use. Motivation can also include the identification of the client's stage of change, readiness to address their substance-use goals, and self-efficacy. *Expectation* requires exploring what the client anticipates their use to be like (i.e., their intended effects). Substance-related expectancies can be quite powerful and have a strong impact on how people experience intoxication (Patel and Fromme 2014).

Far from encouraging further use, these questions can deepen social workers' understanding of the client. For many clients, substance use continues to be adaptive, despite coexisting harms. People use drugs for reasons, and those reasons are real, meaningful, and often have worked well for the purpose for which they were intended—alcohol as a social lubricant, stimulants to party, opiates to soothe depression or the pain of loss, ecstasy to connect with others, or marijuana to quell the symptoms of posttraumatic stress disorder (PTSD). In order to truly assess a client's substance use and make a clear treatment plan, a clinician must understand the adaptive and functional role of drugs for their client (Magidson et al. 2014). Such questions also give the client and clinician ideas about alternative opportunities to achieve the same ends. It can help to keep this saying in mind: you cannot take away what you cannot replace. It is only *after* understanding the function of substances in a client's life is it appropriate to explore their harms. The following case example from an author's work illustrates set factors:

> A 26-year-old man was in counseling for depression. Over the course of the work, it was revealed that he was also ambivalent about changing his pattern of marijuana use. He liked getting high, but he could see that it was a costly habit which could also affect his job prospects when looking for work. He frequently appeared tense and anxious in sessions and also spoke of his struggles with managing his temper. One day, in passing, he approached the author on the street. He seemed quite relaxed. They exchanged pleasantries and agreed to see one another at their session the following week. At the next session, the client confessed that he had smoked marijuana moments before they met on the street. They used the remainder of the session to discuss how marijuana appeared to serve a useful function—it made him feel relaxed. This was a turning point for the client, who had believed that he just liked to get high—not that it served any function beyond recreation. When he saw this connection himself, he became interested in exploring other

Table 1 Multi-disciplinary assessment profile using drug, set, setting as the organizing structure (reprinted with the permission of Denning and Little (2012))

Drug
Type of drug(s) used: including frequency, amounts, methods and patterns of use
Level of abuse or dependence, including the continuum of use, abuse (including negative consequences, dependence and user's level of control
Prescribed medications: Current and past prescribed medicines, including patterns of compliance
Set
Motivation and expectation: what the client hopes and expects to get out of the use of a drug
Client's stated goal(s): Including type(s) of treatment desired as well as types of treatment rejected. Goals may not be related to substance use at all
Stage of change: Where the client fits in a motivational schema
Self-efficacy: The client's degree of confidence in his ability to control or to make changes in his life, including drug use
Treatment history: A history of the client's attempts to stop or reduce substance use, with and without help
Psychiatric and medical problems: Psychosocial history, medical history, DSM diagnosis, observation, and client's subjective statement about how drug use impacts emotional problems, medical or mental disorders
Developmental grid: Outline of key events and personality traits that will be used to guide treatment
Setting
Setting of use: Where and with whom a person uses
Therapist's concerns: these may be goals that the therapist wishes the client would express, or dangers that the client isn't acknowledging
Support system: including quality of ambient environment and culture, presence or absence of friends and family

stress management techniques that he had not been interested in prior to this.

Assessing Setting Factors

Understanding the context of a client's relationship with substances is essential in identifying the factors that promote potentially harmful substance use as well as those that protect against it (see Table 1). Substance use does not occur within a bubble; rather, it is strongly affected by mezzo- and macro-factors, such as family and social group circumstances as well as larger societal and cultural norms. A clinician can ask a number of open-ended questions to understand the impact of the setting and environmental factors that are unique to their client. It is important to identify environmental risks: whether the client may be triggered by them or whether their ongoing use in particular settings may place her or him in harm's way. In getting a sense of the macro factors that may affect how the client views her- or himself and her or his substance use, a clinician may explore how the client's family and cultural group look upon substance use. These setting factors are best identified early and explored on an ongoing basis.

Establishing a Hierarchy of Needs

In HRT, the movement between assessment and treatment planning is seamless. The therapist helps the client choose the most manageable issues on which to focus, but *not necessarily the most urgent*. Practitioners include clients in the treatment planning process so that they are working towards self-selected goals, whether they are abstinence, moderation, reduced use, or safer use (Denning and Little 2012; Tatarsky 2002). A treatment plan is called a "hierarchy of needs" (see Table 2). This hierarchy has to be arrived at by constructing a matrix of the problems and risks, combined with the client's level of concern and motivation to change (as indicated by how soon the client feels the issue should be addressed). This is especially helpful for people with multiple co-occurring stressors, challenges, and risk behaviors who are experiencing a variety of harms in their day-to-day lives. An important consideration is also to recognize that what is harmful for one person may not be for the next. This is illustrated in the case of a former client of one of the authors below whose sample hierarchy of needs are translated in Table 2.

A street-based homeless veteran living with AIDS referred to vodka as his "antifreeze" because he felt it helped him get through cold nights on the street. Despite the fact that he lived on the streets and spent most of his days and nights in various degrees of intoxication, this client religiously attended his weekly HRT sessions as well as sessions with his psychiatrist to discuss his ambivalence about drinking and his difficulty coping with distressing flashbacks. Although troubled by his drinking, the most pressing concern to him was his homelessness and fears about dying from AIDS-related illness. He was eager to work with a case manager to get a voucher for his own apartment, and he increased his attendance to medical appointments. After several months, he requested a referral to detox.

Table 2 Client hierarchy of needs—sample based on client case study (reprinted and adapted with the permission of Denning and Little (2012))

What needs to be done	What I'm going to do	When	What help do I need?
Identified problems, tasks, and areas of concern can be listed here	Client determines a related course of action tied to this issue	The client determines the best timeline for each task and can be specific (dates, number of days, weeks or months) or can be more general- examples: "now," "6 weeks," "when I get out of detox," etc.	Here the client decides which pieces of information they must gain, which service providers or agencies could be necessary, which logistical and financial supports may be required, etc.
Get back on HIV medications and find out current viral load and CD4 levels	*Go to doctor's appointment and get up-to-date bloodwork*	*Now*	*Case manager to set up appointment and accompany me to my first appointment*
Get into a single resident occupancy (SRO) room	*Find out what needs to be done to apply*	*Next week*	*Case manager to help me navigate the process*
Reconnect with adult daughter	*Find a current address or phone number*	*When I'm ready*	*Need to ask her mother for her current contact information*
I need to stop drinking	*Go to detox because I had really bad DTs the last time I tried to stop cold turkey*	*After I get housed and off the streets*	*I will need the support of my case manager, social worker, and psychiatrist*
I need to talk about my feelings and learn how to manage my triggers	*Go to counseling appointments, keep going to my psychiatrist appointments, and keep taking my medications*	*Now and I need to keep going*	*I need to keep track of my appointments*

We find it useful in clinical practice to introduce clients to the stages of change from the transtheoretical model (Prochaska et al. 1992). It provides a cognitive framework for understanding what often seems like stubborn progress toward changing drug use. The hierarchy of needs places great emphasis on enhancing clients' feeling of self-efficacy. The easiest way to accomplish this is to consider the stages of change and how ready the client is to pursue different change goals. Once each area of concern has been viewed in light of the stages of change, the treatment plan becomes evident. If the team begins at the top—in other words, tackles issues that are in the most advanced stage of change first—success can occur quickly. As a result, self-efficacy will build and the issues about which the client is more ambivalent can be explored, with the client perhaps entering that process with greater confidence and enthusiasm. It is not a sequential treatment model, where one typically resolves substance misuse before moving on to psychotherapy for other life issues. Rather, the HRT addresses any or all of a client's issues simultaneously, in order of the client's needs and preferences. As in the case of social work practice, taking care of socioeconomic needs has often been part of early stabilization work in HRT.

Key Components of Treatment

HRT combines the wisdom of various treatment approaches into how it addresses substance-related problems. It is simultaneously trauma-informed, while acknowledging psychodynamic factors, motivational influences, cognitive considerations, and medical needs. Clinicians will approach the work differently based on their training and theoretical orientation, but many may find themselves incorporating multiple components into their work.

Trauma-Informed Care

HRT is trauma-informed therapy. Many people, particularly women, who reach the level of chaotic substance use have histories of trauma (Najavits 2004). The first ethic of HRT is to *do no harm*. This means that we should make great efforts to do nothing that could be retraumatizing, such as exercising authority and/or control, asking intrusive questions, being unpredictable, or using shaming language/techniques. An HRT practitioner needs to remain mindful of trauma and its varied effects on client behaviors, particularly adverse childhood experiences, which are strongly correlated with a number of negative health outcomes among adults (Felitti 2003). It can be helpful when practitioners use trauma stabilization techniques when a client is overwhelmed (Fisher 1999) and refer to trauma specialists when we assess that symptoms of trauma are dominating the client's experience.

Psychodynamic Considerations

The psychodynamic roots of HRT involve exploration of the conscious or unconscious role and meaning of substance

use in a person's life (Tatarsky 2003). People develop attachment styles based on their interactions with early caregivers; these attachment styles persist in adulthood (Bowlby 1988) and can be seen in their relationships with people as well as their choice of drugs and pattern of use. For example, people who have an anxious and insecure style of attachment, rooted in experiences of unreliable caregivers, tend to be highly ambivalent about their drug use. Harm reduction therapists conceptualize people's relationships with drugs in part through the lens of attachment theory (Denning and Little 2012). On the one hand, a client may unabashedly love the feeling of heroin, the relief from pain and the comfort it offers, but they are also painfully aware of the problems it is causing. The clinician, understanding this as an expression of anxious attachment, provides a secure attachment by being absolutely reliable and by providing steady nonreactive responses to anything the client says. She joins equally with both sides of the ambivalence and avoids challenging either one. If the therapist were to take sides, this would have the effect of making the client anxious rather than mobilizing their motivation for change. An even-handed and reassuring response can have the desired effect of neutralizing and soothing the client's internal torment, freeing them up to think more dispassionately about the options at hand.

Whether or not one is a psychodynamic therapist, it is important to have a working understanding of the psychodynamic concepts of transference and countertransference. For example, people who have been through numerous treatment programs and "failed" (to complete programs or to maintain the predetermined goal of abstinence), will come into treatment guarded against the possibility of being told to do the very things that have not worked in the past. The therapist will understand this transference, even if it is not verbalized, and will be explicit about the open-ended enquiry and client-driven goals that make HRT different. The therapist will also seek to understand how some of her own feelings about the client can deepen her understanding of the client's internal experience.

Motivational Interviewing

Motivational interviewing (MI; Miller and Rollnick 2013) is well-aligned with HRT. In addition to its basic principles and techniques, all of which are essential to the practice of HRT, of particular interest are the tools for working with people who are ambivalent or undecided about change. MI assesses client readiness to change as indicated by the presence of "sustain talk" and "change talk" so that the therapist can target interventions to the appropriate stage of change and level of readiness.

Embrace Ambivalence

Ambivalence is at the heart of change. Most people pass through some phase of ambivalence when contemplating changing something that didn't start off as a problem. We can recognize ambivalence from "yes, but" statements. People go back and forth between enthusiastic "change talk" (I must, I can, I will) to "sustain talk" (I love drinking, I can't, I'm not sure; Miller and Rollnick 2013). Respect for ambivalence is critical to maintaining the therapeutic alliance and to facilitating its resolution. First, we highlight it and make it conscious by reflecting back what we have heard: "What I hear is that you really enjoy drinking, it gives you warm feelings toward other people, *and at the same time* you worry that you have damaged your health, especially your liver." In HRT, we like to stay away from the word "but" in favor of "and." "And" communicates a true embracing of both sides of ambivalence. By normalizing clients' attachment to drugs, the clinician opens mental and emotional space to explore the important role that drugs play in their lives, to contemplate what will be lost if they change or give them up, and to begin the mourning process.

Ask Permission to Give Information

People listen better when they are open to new information. Simply asking permission to offer information can create that openness. Asking permission is part of a good therapeutic alliance, a true partnership. Most clients already know the harm associated with their use, but sometimes they are open to learning more about pharmacology, infectious disease risk, and other pieces of information. Rather than using information to try and scare a client into quitting, HRT practitioners are willing to educate and inform clients about risk and how to mitigate it.

Cognitive-Behavioral Interventions

HRT has many cognitive-behavioral components, which involve the identification and changing of thoughts and behaviors that sustain potentially harmful substance use. Two cognitive-behavioral strategies key to HRT are relapse prevention (RP; Marlatt and Gordon 1985) and substance-use management (SUM).

RP is characterized by its focus on identifying high-risk situations and strategizing how to cope with these type of situations, so that the individual can avoid falling back into old patterns. A relapse is understood to be the result of a number of factors, so that it can be avoided through planning. Rather than viewing it as a "failure," a relapse can be viewed as a broken promise to oneself. Whether it involves a return to drinking after quitting or snorting four

lines of cocaine when one committed to have only two, the emotional response is the same—disappointment and shame. RP frames a relapse as a learning opportunity. HRT practitioners call this "blaming the plan." In order to help people save face so that they can think about new options rather than focus on self-judgment, HRT encourages formulating a plan A, B, and C for every situation. When one or another doesn't work out, perhaps it's the plan.

SUM is a unique contribution from harm reduction to substance-use treatment (Bigg 2001; Denning and Little 2012). SUM involves a combination of accurate education about drug effects, exploration of safety considerations, and the active teaching of skills to manage, reduce, or eliminate the use of alcohol and other drugs. The techniques focus the client's attention on details of their drug use that they might be unaware of or might have never talked about with another person. SUM works by changing the amount, frequency, route of administration, and/or combination of drugs used.

Psychiatric Treatment and Medication-Assisted Treatment

HRT supports the inclusion of both psychiatric medications and medication-assisted treatment (MAT) alongside psychosocial counseling. There is ample international data supporting the use of MAT for physiological dependence on opioids (methadone, Suboxone) and alcohol (naltrexone), so these options should be discussed with clients. MAT is not viewed as a violation of abstinence-based recovery. It is seen as a tool to help avoid relapse while also improving quality of life for people whose physiological dependence may place them at risk for uncomfortable withdrawal and/or relapse. These medications are FDA-approved and should be considered in any evidence-based work with clients who are dependent upon opioids and/or depressants.

Outcomes of HRT

Addressing Harms, Not Ignoring Them

HRT does not ignore harm, especially harm to others. It requires practitioners to confront dangerous behaviors and set clear limits on harmful activities such as impaired driving or assaultive behavior. "Our core principle of sovereignty over mind and body [is] that no one should be punished for what they put in their body, absent harm to others" (Nadelmann as quoted in Jewish Currents 2011). HRT practitioners need to be clear with clients about the limits of their confidentiality and the circumstances when they are mandated to report client behavior to the authorities, just as in any other clinical setting. HRT practitioners ought to be proactive about challenging risky drug use, unsafe sex, and any substance use in the presence of children. For circumstances that fall short of mandated reporting requirements, the practitioner should challenge risky and harmful behaviors within the limits of the therapeutic relationship.

Redefining Success

Although harm reduction values abstinence as one harm-reducing outcome, it is not the only one. Harm reduction is often accused of being anti-abstinence. This is not correct (Little 2015). Abstinence *is* a goal of harm reduction; it just isn't the only one. The treatment remains client-centered insofar as abstinence is the goal chosen by the client, not predetermined by the clinician or program. Harm reduction expands the standard of success from abstinence *to any positive change*. The resulting treatment is entirely individualized, with a different course of treatment and different outcomes for each person. How it is this defined or operationalized varies from person to person. Goals can be substance-related (e.g., amount, frequency), risk-related (e.g., route of administration, safety planning, environmental), health related (e.g., mental or physical, medication compliance), or relating to other lifestyle factors (Denning et al. 2004). Abstinence, substitution, moderation, gradualism (i.e., reduced use), or risk reduction/safer use are all valid goals for clients to pursue.

Incremental and demonstrable changes are successes worthy of acknowledgement and recognition by practitioners, researchers, and the clients themselves. Lifestyle changes do not occur overnight for everyone and many clients find a path to healthier life by taking small steps towards change, particularly as they attempt to build up feelings of self-efficacy after prior unsuccessful attempts towards change. Unfortunately, reductions in amounts, frequency, and associated negative consequences of use are not necessarily acknowledged as treatment success in traditional settings. They are not considered recovery in mainstream substance-use treatment contexts either, as evidenced by SAMHSA's (2013) most recently released working definition of recovery, which clearly states, "Abstinence from the use of alcohol, illicit drugs, and non-prescribed medications is the goal for those with addictions." In harm reduction, recovery is not about *whether* one uses or does not use substances, but *how* use affects a person's life. Instead, recovery can be characterized by a sense of well-being, autonomy, resiliency, relatedness, competence, and empowerment. Anderson (2010) promotes the idea that "absence of problematic substance use" should be the standard of "recovery."

Safety First

Safety means reducing harm to oneself and others. Not drinking and driving, using sterile syringes and equipment, having naloxone on hand, and not using alone are but a few of the harm reducing possibilities that HRT practitioners keep foremost in our minds (Harm Reduction Coalition 2011). Beyond our obligations as mandated reporters, there are a number of circumstances in which we take action in our moral duty to reduce harm. We might encourage family members to make sure that drugs (including legal drugs like alcohol, tobacco products, and prescription medications) are out of the reach of children, and that they plan their drug use around obligations and responsibilities.

Challenges and Limitations of HRT

At present, the National Institute of Drug Abuse (2014) describes addiction as "a chronic relapsing brain disease" (p. 5). According to this definition, it is a lifelong affliction that will become more severe over time without treatment or assistance, and it will likely be marked by frequent relapses. This definition guides most abstinence-based treatment today, which views potentially harmful use as a medical condition that must be constantly managed but that can never be cured.

In light of this dominant conceptualization, implementing a harm reduction approach would require a significant paradigm shift for practitioners and treatment agencies alike. Many find that HRT's willingness to work with actively using clients is fundamentally unethical due to the fact that practitioners willingly treat clients engaging in high-risk substance use rather than imposing the safest alternative: abstinence (Davis and Rosenberg 2013). Meanwhile, a HRT practitioner may argue the ethical merits of their approach by stating that the imposition of abstinence may dissuade a potential client from accessing treatment altogether. Instead, this approach may be the best way to get these otherwise underserved populations to at least access care and be treated by professionals. Although it may feel unnatural to "allow" a client to access services while using drugs, HRT practitioners would rather have a client know that they had support available to them in case they wanted a referral to detox, a primary care physician, or the local housing authority.

HRT practitioners also truly hold true to measuring outcomes as *any positive change* so that a client's simple act of showing up for groups for 5 days in a week is seen as a success, considering that he may not have set foot in a treatment agency in the past 5 years. This radical readjustment of expectations and willingness to celebrate these small victories is foreign for treatment providers in traditional settings who may still feel like this isn't real "treatment" or that real "changes" must be measured in terms of number of days abstinent. This makes HRT otherwise uncharted territory for most practitioners who may be uncomfortable or troubled by this radically different way of marking daily successes.

Another area where HRT may have challenges is in its legitimacy to outside organizations. Referral agencies that mandate abstinence-only treatment (e.g., criminal justice, child protective services, employers) may disapprove of the flexibility of acceptable treatment outcomes in HRT settings. Insurance providers could possibly have concerns with paying for treatment that may not explicitly aim for complete abstinence from all mood-altering substances. Licensing and credentialing of treatment agencies varies from state-to-state, so that there are also states where an explicitly harm reduction-oriented treatment facility may not be an approved treatment provider.

In spite of these challenges, there continues to be a contingent of HRT practitioners in private practice and employed in agency settings where HRT is the predominant model. These practitioners and settings frequently manage external referrals and funder concerns by demonstrating that a harm reduction approach can help clients to work gradually towards an ultimate goal of abstinence. Harm reduction settings are also commonly funded by private and federal monies allocated to HIV prevention, as well as through other innovative fundraising efforts (e.g., donations, social enterprise, consultation, and training revenues), and by creating sliding fee scales so clients can pay for services out-of-pocket (see Center for Harm Reduction Therapy 2016; Lower East Side Harm Reduction Center 2014). Referrals and funding issues remain a concern.

Few individuals who meet diagnostic criteria for substance-use disorders (SUDs) actually pursue and/or receive specialty substance-use treatment. According to findings from the annual *National Survey on Drug Use and Health*, almost one in eleven Americans over 12 years of age (22.7 million people) needed substance-use treatment in 2013 due to meeting diagnostic criteria for SUDs or engaging in risky substance use; however, it is estimated that only 2.5 million of those individuals actually received treatment that year (SAMHSA 2014). This 90 % discrepancy has been described by experts (e.g., researchers, practitioners, and other health-care providers) in the field of substance use as the "gap between need and service utilization" (Tucker and Simpson 2011, p. 371).

Social workers and substance-use treatment providers can do one of two things with this information: they can either choose to maintain the status quo so that only those willing to pursue abstinence are admitted for treatment *or* they can choose to meet these individuals "where they're at." HRT equips and encourages providers to do the latter. As indicated by its name, it is an approach to working with people that aims to reduce substance-related harm to

individuals, their families, and communities. HRT promotes the tenet that people who use substances have the ability to decide what they need and, when supported in making treatment choices for themselves, can harness their own intrinsic motivation for positive change (Denning and Little 2012; Rothschild 2010; Tatarsky 2002).

Conclusion

Social work must return to its roots to "start where the client is" by promoting lower thresholds for substance-use treatment entry and to support client self-determination in treatment decisions such as the selection of treatment goals, which may include harm reduction, controlled use, or abstinence. We strongly believe that such a shift will open the doors to treatment and increase the accessing of services for a greater number of substance users who have otherwise been deterred from seeking or staying in treatment by the abstinence-only mandate. We also believe that the fixation upon complete abstinence as a measure of success diminishes the substantial gains that can often be made through reduced use, safer use, and other steps to improve one's quality of life and health. Engaging these currently untreated substance users would help to bring about greater stability and improved health in the lives of this vulnerable and otherwise ignored population.

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