Integrating harm reduction and abstinence-based substance abuse treatment in the public sector.

by Futterman, R., Lorente, M. & Silverman, S. (2004). Substance Abuse, 25 (1), 3-7.

Abstract
Harm reduction and abstinence-based substance abuse treatment can not only be integrated, but their integration is more powerful than either separately. This integration has more positive effects than either model separately on the large problem of patient retention in substance abuse treatment. This integration is particularly relevant for its utility and acceptance in the public sector. Examples from a clinic currently utilizing this model in a public hospital are presented.

The theory of harm reduction (1) as it relates to substance abuse treatment has been one of the most fruitful developments in the theory and technique of substance abuse treatment, emerging from the integration of the formerly disconnected world of psychology along with the related techniques of relapse prevention (2) and motivational interviewing (3). Harm reduction, however, has often been described as being technically the antithesis of abstinence-based substance abuse treatment (4, 5) despite the fact that there is a great deal technically in common within these theoretical contexts. It appears that it would be productive to explore the commonalities as well as the differences in these two theories. If the two theories could be integrated, a broader spectrum of patients could be served in a coherent and individualized fashion.

In fact, harm reduction and abstinence-based substance abuse treatment can not only be integrated, but their integration is more powerful than either theoretical framework separately, particularly in terms of patient engagement and retention. A case will thus be made for the benefits of this integration using the example of a clinic that is currently employing this model (6, 7). Implications for its acceptance and utility in the public sector will be explored.

The harm reduction philosophy means, among other things, that patients are accepted into treatment at various levels of substance use and that continued usage is not the criterion for termination of treatment. Some patients at intake declare their use to be problematic, and some complain that they are only coming in to please a judge. Either way, the patient can be treated in a harm reduction program. The harm reduction practitioner seeks to reduce the negative effects on a patient's life of his or her misuse of substances, i.e.

effects on the patient's medical health, mental health, relationships, without abstinence necessarily being the goal of treatment. This model which stems from a psychological outlook is similar to an outpatient psychiatric clinic model in which patients are treated in an individualized manner depending on their symptomatology. In such a clinic, work continues whether small or large gains are made. If the patient does not respond to treatment, the treatment will be changed or an appropriate referral will be made to a different level of care or to different services. One way or another, however, work continues. This contrasts with how treatment is done in traditional abstinence-based substance abuse treatment in which declaring oneself an addict is seen as evidence of a patient's readiness for treatment (8) and can thus be a requirement to get services (9). Complete abstinence from the use of all addictive substances is a requirement to be in treatment (9) and is the goal of treatment. If someone is not deemed ready for the work at intake, they may be referred to a different level of care such as an inpatient detoxification unit or they may be told that they are not ready to commit to abstinence yet, and thus should return when they are ready to do the hard work required to achieve sobriety.

Can substance abuse clinicians tolerate continued substance use while also being focused on abstinence as a goal? An integrative approach combining these two seemingly contradictory models is currently being used at the Growth and Recovery Program, an adult outpatient substance abuse program at North Central Bronx Hospital and Jacobi Medical Center in the Bronx in New York City. Despite concerns by some harm reductionists about its potential acceptance in the public sector (10), this integration of models has been accomplished in a public hospital in a program licensed and audited by state and federal substance abuse (New York State Office of Administration of Substance Abuse Services), mental health (Department of Mental Health) and hospital (Joint Commission for the Accreditation of Hospitals Organization) regulatory agencies. It is our belief that regulatory agencies provide freedom to experiment within reason particularly if the abstinence goal is clearly stated. The abstinence goal is thus the key to a wide range of potential empirically-validated envelope pushing.

In this program, patients are accepted at various levels of substance abuse as long as the outpatient level of care seems appropriate, but they are told clearly that the long term goal is abstinence from all addictive substances, thus assimilating abstinence-based treatment techniques into a harm reduction theory. Theories related to harm reduction are also used in concert with this integration. Relapse prevention theory (2), which is based on cognitive-behavioral techniques, assumes that relapse is a natural and predictable part of the recovery process. Motivational interviewing (3) is a set of techniques in which rather than clearly choosing sides in the patient's ambivalent debate about whether to use drugs, the therapist encourages the patient to continuously weigh the argument in his or her own head. This contrasts with traditional abstinence-based substance abuse treatment in which the therapist clearly states that the patient is in denial of the problem partly due to the drug's ill effects on the patient's judgment (5) and needs to see the reality of the problem immediately in order for the work to begin (9).

Used together, these more psychologically oriented modes of working ease a great deal of the countertransferential anger that often arises in traditional substance abuse treatment

(11). This facilitates a generally more laid-back atmosphere than is found in traditional abstinence-based substance abuse treatment (5) despite the aggressive treatment being administered. In addition, patients often report that they feel that they are treated more respectfully and that the treatment feels more individualized, which has profound effects on patients' engagement in the treatment and long term retention, one of the most persistent problems in substance abuse treatment (12).

What, then, is the purpose of the abstinence goal in this treatment, and why is this harm reduction? This approach utilizes the strengths of each model. From the harm reduction side, it provides the cooler arena that promotes patient engagement and retention, a safe base that a patient can use to explore more difficult psychiatric and recovery issues. It provides a sense of community in which patients can experiment with the often new experience of speaking openly about things they might feel shame about, a place to safely work through issues. The abstinence goal provides a clarity of purpose and more structured frame in which to work. The clear goal helps patients concretize boundaries in which more abstract work can be done.

Harm reduction, however, has often been described as being technically antithetical to abstinence-based treatment (4, 5). This may be due less to the issues of when clinicians continue working with a patient and more to do with the theories of treatment or even atheorectical nature (4) of much of what has occurred in abstinence-based treatment. Abstinence-based practitioners have often been wary of harm reduction as well, seeing it as a soft, enabling strategy (9) that is not rigorous enough to confront the fortitude of an addiction. Harm reduction, however, does not mean that the treatment is soft. This philosophy can be the context in which aggressive work is done. In this program, for example, there is a sense of urgency in which clinicians are vigilant for and comment quickly on any behavior changes in order to intervene early if a relapse appears to be approaching. Referrals to detoxes and 28-day rehabs with plans for patients to be returned to continue outpatient treatment in this program are used early on if the patient is unable to rise to the difficult task of outpatient treatment initially. Patients have consistently reported a clear understanding of the goals of treatment without any confusion about the harm reduction/relapse prevention context. No one yet in this treatment has equated it with a laissez-faire, anything goes attitude among staff. The abstinence goal is particularly clarifying for patients.

A harm reduction philosophy creates a comfortable, respectful atmosphere in which patients can connect to the program as a whole which goes a long way toward solving one of the most consistent problems of substance abuse treatment: patient retention (12). In this model, aggressive efforts are made to engage and retain patients in treatment. Toward this end, there are as few rules as possible in the program, but a firm external structure is set. The idea behind this is that it was found that patients often seemed to be attempting to pick fights partly in order to easily angrily leave treatment and continue using drugs. Some amount of this behavior is of course unavoidable, and no amount of clarity and reasonableness from staff is going to eliminate all effrontery toward authority, but a large amount of early treatment drop-out was found to be avoidable by staff paying close attention to bypassing some of the more common reasons for premature

termination. In traditional abstinence-based treatment the atmosphere is more confrontative (13), and early drop-out is a considerable problem (12).
A byproduct of this model's attention to treatment engagement in the context of the harm reduction message that patients should keep attending the program whether they have recently relapsed or not, is that patients feel a strong sense of community in the program. Patients develop a trusting treatment alliance with the program as a whole which becomes a fundament for their being able to tolerate harder to swallow interventions such as process oriented interpretation. The abstinence goal has a profound effect on this sense of community and on patient engagement. Patients find the clarity of purpose comfortingly clear. Patients are often unsettled by having others doing poorly around them if staff is perceived to be blasé about it, and patients have been known to plead with staff or get angry when perceiving this accurately or otherwise. Patients who are doing well have been known to become quite anxious when others do poorly amongst them. The clarity of goal provides room for all to work on other more abstract issues.

Harm reduction, being a psychologically based theory, is conducive to a better integration of psychiatric care. Patients in this population often have a particular discomfort with their own emotions (14). In this program, psychoeducation is combined with therapy groups to help patients to gradually expose themselves to their emotional lives in a safe, controlled way (6).
Harm reductionists have often had a somewhat wary attitude toward the 12-step model (4), seeing it as simplistic or dogmatic, particularly as it relates to some history of anti-psychiatric admonishments (8), and practitioners have at times been uncomfortable with patients and clinicians who rigidly adhere to the 12-step theory (4). Rather than being technically antithetical (4), the harm reduction philosophy is highly compatible with a 12-step treatment model by way of their coherence in psychological principles, and patients can be quick to bridge the gap. One of the essential slogans of 12-step programs, for example, is "keep coming back" which means that no matter how well or badly someone is doing, they should attend meetings, which is the same big tent starting point of harm reduction and relapse prevention. Many of the slogans and ideas behind 12-step concepts can be easily related to psychological principles which may otherwise be hard to grasp. The serenity prayer, which is a prominent part of most 12-step meetings, is strikingly similar to the idea of radical acceptance in dialectical behavior therapy (15). Some clinicians have been concerned about polarizing groups in which 12-step adherents separate from non-12-steppers (4, 8). In this program, however, 12-step oriented patients have often been asked to explain their ideas to others who are unfamiliar with them. Patients have often achieved great understanding of each others' points of view and have elaborated on each others' ideas.

Given that many patients in substance abuse treatment are mandated in one way or another, is harm reduction possible? In this program, it has been found that a harm reduction context with a long term goal of abstinence is not only possible, but more productive with mandated patients. Mandated patients who arrive initially with predominantly external reasons to be in treatment respond well to the relaxed but structured attitude of harm reduction treatment. Using motivational interviewing

techniques and a harm reduction orientation helps to bring out internal motivation without patients becoming sidetracked on authority issues.

Parole officers, rather than being concerned about potential softness of harm reduction, are inherently harm reductionist in practice. It has been routinely found in this program that parole officers are fine with a certain amount of positive urine toxicology reports if the patient is seen as being engaged in treatment, and staff is clear on the abstinence goal. If the program reports that the patient is attending and participating, parole officers are generally happy to have the treatment continue rather than violating the patient's parole and remanding the patient to prison. When mandated patients fail to respond to treatment and rehab is seen by the clinicians as being necessary, reluctant patients are often told honestly that rehab is not only clinically the right thing to do, but that it is a way out of returning to jail, and in fact parole officers see it that way. Clinically, rather than give it to the patient raw in traditional terms, the clinician sides with the patient, and thus gives him or her the message more on the medium-rare side.

The harm reduction philosophy being a broader psychological theory tends toward patients working on various areas of functioning in addition to sobriety. In this program, it has been consistently found that patients are able to begin having stretches of sobriety within their first 90 days of treatment, thus the majority of the work is expended on the maintenance of sobriety. That is done by working directly on standard relapse prevention techniques, but also by working on other areas of functioning, particularly work on characterological issues (6), but also on stabilizing a person's medical issues, housing issues, and on vocational attainment. Full integration of vocational rehabilitation services with the other clinical aspects of the program (7) promotes broader functional improvement, and the abstinence goal becomes a crucial part of this. Patients understand that they must work on maintaining a period of sobriety, and become generally stable in order to be referred to desired vocational services outside of the program.

In conclusion, the integration of harm reduction and abstinence-based substance abuse treatment is more powerful than either model separately. The abstinence goal provides more room for the more abstract harm reduction work to occur. The accepting atmosphere of harm reduction with the addition of the clarity of the goal of abstinence promote patient retention better than either separately. The implications of this integration is that harm reduction can be more accepted and powerful in the public sector.

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