Interview with Andrew Tatarsky, PhD on Harm Reduction

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What are the principles of harm reduction?

Harm reduction is considered to be both a philosophy as well as a set of practices. You might think of harm reduction as based on compassionate pragmatism; being driven by compassion, grounded in scientific evidence to relieve peoples suffering. It's a core shift away from the abstinence only requirement in treatment that has dominated the field, where anything short of that is considered active disease. Abstinence only programs require that people buy into abstinence as a goal in order to enter and be maintained in treatment. I would suggest that this is a setup for failure and limits access to treatment to the overwhelming majority of people struggling with substance use issues, because the majority are not ready for abstinence or to move into the action stages of change.

A first principle of harm reduction is that any reduction in drug related harm or any movement in a positive direction is an acceptable goal and starting point of treatment. A second, with the catchphrase "meet people where they are" places primary emphasis on treatment alliance, engagement, creating safety. Harm reduction clinicians need to work hard to keep their own values and agendas out of the treatment relationship, and start with empathic listening, which is supported by psychotherapy research. A third principle is that focusing on small, incremental changes can be a useful way to engage people where they're ready to begin making any positive change, to then support them through a journey which may begin with safer using practices, reducing use, and in many cases ultimately helping people embrace abstinence as the most meaningful, realistic goal. The final principle is collaboration, where we invite our patients into the treatment relationship. This is also a fundamental shift, as traditional addiction treatment has been authoritarian and prescriptive.

How can harm reduction treatment providers collaborate with other providers?

Harm reduction centers can collaborate with traditional abstinence based treatment settings. It's a misunderstanding that it's either abstinence or harm reduction. Addiction, however you understand it, is problematic or harmful behavior. We might think of harm reduction as an "umbrella concept" that includes abstinence as a viable goal and starting point for treatment for those patients for whom it is appropriate. Addiction treatment, per se, falls under that "umbrella," and abstinence-based treatments fall under that umbrella, too.

I think of harm reduction as framing treatment in a way that engages people across the entire spectrum of goals, including around abstinence. I'm always encouraging traditional abstinence-oriented treatment centers to extend their reach to all of those folks who are not ready for abstinence. Why not develop a recovery readiness program? Or a contemplation phase in treatment? A way of opening the door to people who want help but don't know what their goals are yet.

What's been the biggest challenge in advocating for the harm reduction model?

It's been educating the public that there is this alternative treatment. Many people come to us looking for an alternative, often reporting they wish they had been told about this [harm reduction] years ago. On the other hand, I think there is something in the zeitgeist happening in the last couple years, and maybe it's because of this opioid and overdose crisis that is kind of shaking people up all over the country. Shaking people out of their acceptance of a treatment model that isn't helping people and encouraging people to become curious about alternatives. People are starting to look around and discover this work.

Any types of patients where harm reduction might not be best approach?

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One of the challenges is the mandated patient, particularly if the clinician has some responsibility to report to an agency. It can be a challenge to create a sense of safety in the therapeutic relationship, such that the person feels safe and able to really talk about these vulnerable issues that can create legal trouble. Also, if we think about problematic substance use on a spectrum, then on the more severe end, where there is really a clear and present danger to oneself or others, we are not going to be supportive of an outpatient psychotherapy. Having said that, it's often difficult to determine that and so if we can create a safe relationship in which we can do a deep kind of assessment, we may actually help determine early on that somebody needs to be in a higher level of care and can play an important role in helping them get there rather than just say, "you're engaging in risky behaviors, I won't work with you." Hopefully if somebody feels that way they will refer that patient to somebody who will treat them.

What is the biggest misconception about harm reduction?

It's that people think harm reduction means giving people "permission to use drugs." We are not interested in "enabling" people to continue to do harm to themselves. Our interest is in supporting people in reducing harm to the greatest extent. And if the person is truly addicted, it means putting their addiction into remission. Some people think of harm reduction as a bad word, but I think it's an entire misconception of what it is. I think we all have the same goals for people who are engaging in problematic use: the greatest reduction in risk and the greatest improvement in quality of like and health. The important question is, how do we most effectively help people achieve their positive change goals.

For a clinician new to harm reduction, any practical piece of advice?

I love to ask this question to large groups of people. At the point that a drug user becomes concerned about their use, what percentage of people do you think are ready to stop? At this last opioid summit somebody said, "0%, 2%"...but what does that tell us? That an overwhelming majority of folks need harm reduction. So, if you're starting out in practice, this is one of that largest undertreated, underserved population of patients I think we have. And, lots of these people are in the mild-moderate range of severity, still working, and functioning quite well. They are motivated and want help. They can be great patients and really need a compassionate, knowledgeable provider who can meet them on their own terms. ■

References

1. Tatarsky, Andrew, and G. Alan Marlatt. State of the Art in Harm Reduction Psychotherapy: an Emerging Treatment for Substance Misuse. Journal of Clinical Psychology. 2010; 66(2): 117–122.

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