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Meta-Competency 7-f Part 2: Applying Counseling Strategies from Harm Reduction Treatment for Substance Use

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Meta-Competency 7-f Part 2: Applying Counseling Strategies from Harm Reduction Treatment for Substance Use

Competency

- 7-f part 2: Apply harm reduction strategies for substance use concerns.

How to Use This Unit

This unit provides guidance for instructors on how to teach BHSSs evidence-based harm reduction strategies to effectively engage patients along a spectrum of use (i.e., substance, quantity-frequency, route of administration) and readiness for change (e.g., goals ranging from reducing substance-related harm, reducing use, achieving abstinence). These strategies are derived from the primary components of brief, evidence-based harm reduction treatment (HaRT).

This unit contains didactic information, example activities and assessments, and resources for further learning. The didactic information provides basic definitions of harm reduction, strategies for engaging patients in conversation around substance use, means of eliciting harm reduction and quality-of-life (QoL) goals, and safer use strategies. Example activities and assessments demonstrate how to engage students and reinforce learning. The additional resources contain suggested external websites, books, articles, and other resources to deepen learning and provide the scientific evidence base for the strategies in this unit.

The evidence base for HaRT is established for substance use behaviors, but it is reasonable that many of these principles could be applied to other health-related behaviors. Instructors might also consider tailoring the material to cover the application of harm reduction in specific service settings (e.g., primary care, emergency departments, syringe service programs) or within specific patient populations (e.g., people with co-occurring psychiatric disorders, people experiencing homelessness).

An important caveat: In some more medicalized settings or in places where it is more likely to encounter patients who are interested in achieving abstinence, then screening, brief intervention, and referral to treatment (SBIRT) may also be a helpful approach. For example, a BHSS may use SBIRT when abstinence is the patient's goal and the patient is eligible for and may be easily connected with treatment services. SBIRT is discussed in MC7-f Part I.

Separating education and training for both HaRT and SBIRT is consistent with current literature and practice in the field. The author of this unit recommends revised language in future iterations of the BHSS competencies. For example, MC7-f may be changed to "apply counseling strategies from evidence-based harm reduction approaches to help patients reduce substance-related harm and improve quality of life." For this unit and the Educator's Guide, the following definition from the World Health Organization is used for QoL: "an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns" (Orley & Kuyaken, 1994). It is important to note that there are many definitions of QoL and health-related QoL in the literature (Karimi & Brazier, 2016) that are distinct from or overlap with this definition.

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Competency Assessment Example for MC7-f Part 2: Applying Counseling Strategies from Harm Reduction Treatment for Substance Use

Sample Readings for MC7-f Part 2: Applying Counseling Strategies from Harm Reduction Treatment for Substance Use

Collins, S. E., & Clifasefi, S. L. (2023). *Harm reduction treatment for substance use.* Hogrefe Publishing. DOI 10.1027/00507-000

Pre-BHSS

Instructors should ensure students are exposed to the Psychoeducation (MC7-b), Motivational Interviewing (MC7-a), and Inclusive Language (Health Equity MC1) chapters before introducing MC7-f materials.

Sample Learning Sequence

FOUNDATIONS	ADVANCED	PRACTICUM
LO-1 Describe the harm reduction mindset.	LO-4 Apply harm reduction assessment skills to start a conversation about substance use.	LO-7 Assess substance-related harm.
LO-2 Define the harm reduction heartset.	LO-5 Differentiate harm reduction from use reduction goal setting.	LO-8 Elicit harm reduction and health-related QoL goals.
LO-3 Characterize HaRT components.	LO-6 Analyze a constellation of substance use to identify optimal safer use strategies.	LO-9 Codesign a comprehensive plan for safer use with patients.

BHSS Foundations

LO-1 Describe the harm reduction mindset.

Key Terms and Concepts for LO-1

- **harm reduction**: a grassroots and user-driven set of approaches to reducing substance-related harm and improving QoL without requiring abstinence or even use reduction (Marlatt et al., 2011). Harm reduction strategies or interventions can be administered at the individual, community, population, and policy levels to help people who use substances, their families, and their communities reduce substance-related harm and improve QoL.

- **harm reduction treatment (HaRT)**: a community-co-created, evidence-based way of interacting with patients, clients, and community members to guide them in reducing substance-related harm and improving QoL without requiring abstinence or use reduction.
  - Figure 1 HaRT Counseling Components
- **HaRT mindset:** a set of underlying philosophical beliefs around the topics of substance use, people who use substances, and the role of service providers in engaging with people who use substances.

Key Teaching Points for LO-1

What is Harm Reduction?

- Harm reduction encompasses a diverse set of strategies to reduce substance-related harm and improve QoL for people who use substances, their families, and their communities.
- Drawing on ecological systems theory (Bronfenbrenner, 1979), harm reduction strategies may be applied at various levels, for example (Collins et al., 2012b):
  - At the **macrosystem level**, harm reduction approaches are applied to a larger population through broad-based prevention strategies (e.g., public service announcements discouraging drinking and driving) and policy and legislative efforts (e.g., decriminalizing substance use, government regulations requiring warning labels on cigarette packages) (Marlatt & Witkiewitz, 2010).
  - At the **mesosystem level**, harm reduction approaches are applied in communities already disproportionately impacted by substance-related harm (e.g., people experiencing homelessness who use substances). Such interventions can include low-barrier housing programs, syringe services programs, and safer consumption sites. These interventions serve a specific community but have the added benefit of reducing harm to the surrounding community. For example, if people experiencing homelessness can inject in a safer consumption site, there are fewer syringes on the street in the surrounding neighborhood.
  - At the **microsystem level**, harm reduction translates into individual-level treatments, including medications, like buprenorphine and methadone (Ma et al., 2018); pharmacological adjuncts, like vapes and e-cigarettes (Hajek et al., 2019); and/or behavioral health and counseling approaches (e.g., harm reduction psychotherapy (Denning & Little, 2012; Tartarsky, 2007), HaRT (Collins & Clifasefi, 2023)).

What is HaRT?

- HaRT entails counseling to meet people "where they're at," both in their motivation for change and in their communities. HaRT provides an effective, structured way for BHSSs to talk to patients about substance use across diverse service settings, patient populations, and levels of motivation for change.
- In HaRT sessions, BHSSs will deliver three specific components: a) assessment and collaborative tracking of substance use and substance-related harm, b) elicitation of patient-driven harm reduction and QoL goals, and c) discussion of safer use strategies (Collins & Clifasefi, 2023). (See **Figure 1** for a visual representation of the HaRT model.)
- Research indicates that HaRT significantly improves substance use outcomes, including reduc quantity and frequency of substance use and substance-related harm (Collins et al., 2019; Collins et al., 2021; Mostofi & Collins, 2023).

    - HaRT is an additional evidence-based approach to others used in the substance use treatment field, including various means of assessment, brief intervention (e.g., SBIRT, contingency management), and treatment (e.g., cognitive behavioral treatment, 12-step facilitation, Motivational Interviewing).
- HaRT is not intended to diminish the value of the above approaches, many of which are evidence based and highly effective for patients. However, because it does not require abstinence or use reduction, HaRT can accommodate a broader spectrum of patients, ranging from those who want to achieve abstinence to those who want to reduce use to those who want simply to start reducing harm and improving QoL.

HaRT Mindset

- In using a pragmatic HaRT mindset, BHSSs share with patients scientifically informed strategies to reduce substance-related harm. BHSSs also support patients in defining and pursuing their own realistic and sustainable goals.
    - Figure 2 Use Reduction vs Harm Reduction

Key Tenets of the HaRT Mindset

- **Substance use and harm do not correlate 1:1**: The abstinence-based treatment system was based on the notion that reducing use means reducing harm. However, research has shown that substance-related harm does not always correspond directly to the amount of use (Collins, 2016). Factors like housing status, systemic inequities, and law enforcement interactions significantly impact one's experience of substance-related harm. For example, an unhoused person who drinks alcohol on the street is at higher risk of experiencing substance-related harm (e.g., arrest for public consumption, experience of assault)—even when drinking the exact same amount—compared to a housed person drinking in their own apartment.
- **The focus is on harm reduction**: In contrast to abstinence-based approaches, HaRT does not require people to stop using to start recovery. Because abstinence is neither required nor precluded, BHSSs can meet patients where they are at across the spectrum of use (i.e., substance type, quantity/frequency, route of administration) and motivation for change (i.e., motivation for harm reduction, use reduction, or abstinence). Research has shown this approach is thus more broadly appealing and applicable than abstinence-only or use reduction approaches that have a preset, provider-driven goal.
- **HaRT is predictive, not prescriptive**: Instead of mandating a certain goal, like abstinence, HaRT helps patients create their own goals. BHSSs help guide discussions about the relative risks of patients' substance use choices based on the patients' own perception of potential harm. By curiously and nonjudgmentally inviting patients to explore their choices, BHSSs empower patients to make scientifically informed decisions, reinforcing their autonomy and self-determination.
- **HaRT encourages full transparency about systemic harms**: HaRT acknowledges that health and social service systems, despite good intentions, can cause harm. In mandated treatment, it became commonplace for treatment providers to send reports on substance use and toxicology results to the criminal justice system (e.g., judges, probation officers). In this way, systems of care have, often through monetized contracts, contributed to the mass incarceration of minoritized and marginalized communities. HaRT encourages transparency and advocacy with patients. The chapter MC1 Health Equity provides information to a) help BHSSs recognize the impact of systems inequities on patient engagement and b) use inclusive engagement approaches to promote equity in behavioral healthcare.

Sample Activities/Assessments for LO-1

Activity: Explaining Differences Between Abstinence-Based/Use Reduction Treatment and HaRT
Students write a paragraph explaining the difference between abstinence-based/use reduction treatment and HaRT.

Activity: Panel on Coexistence of HaRT and Abstinence-Based and Use Reduction Approaches
Students volunteer to serve on a panel to discuss ways that HaRT (and harm reduction approaches more broadly) can coexist with abstinence-based and use reduction approaches. In planning this panel, it is important to remember that abstinence-based and use reduction providers and harm reduction providers have sometimes been pitted against one another in a false dichotomy. When all these various approaches are available to patients, there is a broader, more inclusive spectrum of substance use treatment and counseling options available.

Activity: The Rationale for HaRT
Students work in pairs to discuss and tailor the instructor-provided script to settings they hope to work in. For example, if a student wants to work in job placement settings or housing settings, they can tailor the script to address that topic appropriately. What might be some of the challenges or barriers to creating such a rationale in different types of settings? What might be some of the benefits?

- LO-1 Script for Introducing the Rationale for HaRT

Specific Resources for LO-1

Resource: Harm Reduction Treatment Text
Harm Reduction Treatment for Substance Use: An empirically informed guide to harm reduction treatment intended for practitioners and educators.

- Collins, S. E., & Clifasefi, S. L. (2023). *Harm reduction treatment for substance use*. Hogrefe Publishing. https://doi.org/10.1027/00507-000

Resource: Community-Based Harm Reduction
Meeting People Where They're At: A presentation on the research, background, and community co-development process undergirding HaRT.

- UW PBSCI. (2018, June 8). *Meeting people where they're at: Community-based harm reduction treatment* [Video]. YouTube. https://youtu.be/TC2niy7CVls?si=_FcS1zKIA6g77y0a

Resource: Coalition for Harm Reduction
National Harm Reduction Coalition: This website provides free information and training about harm reduction's grassroots origins, principles, and concrete strategies.

- National Harm Reduction Coalition. (n.d.). *Home page.* https://harmreduction.org

LO-2 Define the harm reduction treatment heartset.

Key Terms and Concepts for LO-2

- **heartset**: a way of being with patients. A heartset is how providers feel about their patients and how they convey that through words and actions in ways that contribute to healing.

- **compassion:** feeling with the patient, coupled with an unconflicted desire to remove suffering and to support patient-defined and -led treatment goals, intentions, prayers, or hopes.
- **"cultural competemility":** balancing the need for cultural competence and cultural humility in interactions with patients (Campinha-Bacote, 2018).

Key Teaching Points for LO-2

HaRT Heartset

- If the HaRT mindset (see **Figure 3**) conceptualizes harm reduction and its impacts, the HaRT heartset is a *way of being* with patients that entails a culturally humble, compassionate, advocacy-oriented stance and accepting patients wherever they fall on the spectrum of change.
  - Figure 3 HaRT Heartset

Key Aspects of the HaRT Heartset

- **The HaRT heartset is compassionate.** The Latin root of "compassion" translates to "feeling with." In practicing HaRT, BHSSs will pair this compassion with an unconflicted desire to remove suffering and to support patient-defined and -led treatment goals, intentions, prayers, or hopes.
- **The HaRT heartset requires embracing cultural humility, emphasizing openness and advocacy for patients' values and priorities.** Drawing from cultural "competemility" (Campinha-Bacote, 2018), BHSSs balance a) learning about communities they work with to build cultural *competence* and b) not assuming all patients from a certain population share the same characteristics, values, and goals, which is having *cultural humility*. In practicing HaRT, BHSSs invite and uplift patients' own narratives about their resilience and recovery.
- **The HaRT heartset supports patients' recovery and even transformative change.** BHSSs celebrate with patients the power of any positive movement towards harm reduction and QoL enhancement. In doing so, BHSSs help patients steadily rebuild their self-efficacy and generate more and more positive and even transformative changes in their lives (e.g., returning to work after years of unemployment, reconnecting with estranged family, attaining housing after experiencing homelessness).
- **The HaRT heartset emphasizes advocacy for patients as well as their empowerment.** BHSSs facilitate connections to essential harm reduction and social services, accompany patients to provider appointments, gently correct stigmatizing language used in our systems of care, and connect patients with community-based organizations to help them sustainably advocate for themselves (e.g., National Urban Survivors Union, People's Harm Reduction Alliance, Never Use Alone, VOCAL).

Sample Activities/Assessments for LO-2

Activity: Learning HaRT Heartset Features
Students match the bolded sentences above with their defining features.

Activity: HaRT Skill Observation and Affirmation
Provide short examples of BHSS/patient exchanges that demonstrate each of the above Key Teaching Points. Students use clickers, polls, or raise-hand functions to "buzz in" with the correct construct being demonstrated.

Activity: Compassion and Self-Compassion Meditations
Students build their compassion "muscle" by trying compassion and self-compassion meditations. See examples of activities below. These practices have been scientifically tested and shown to build compassion. They also help with self-care.

- **Greater Good in Action Compassion Meditations**
  Compassion Meditation**:** This exercise draws on a guided meditation created by researcher Helen Weng and her colleagues.
    - Greater Good in Action. (n.d.). *Compassion meditation*. https://ggia.berkeley.edu/practice/compassion_meditation
- **Self-Compassion Exercises and Workbooks**
  Self-Compassion Practices**:** Self-compassion exercises and workbooks from Kristin Neff are highly recommended resources to help BHSSs build self-compassion and compassion for others.
    - Self-Compassion LLC. (2024). *Self-compassion practices*. https://self-compassion.org/self-compassion-practices/

Specific Resources for LO-2

Resource: Journey to a More Meaningful Life
Pathway to Happiness Program: Four-week program featuring science-based practices and compassion meditations from the University of California–Berkeley's Greater Good in Action.

- Greater Good in Action. (n.d.). *Welcome to your 4 weeks Pathway to Happiness!* https://ggia.berkeley.edu/onboarding/start

For a full list of websites speaking to the above constructs, see: LO-2 Resources – List of Websites

LO-3 Characterize HaRT components.

Key Terms and Concepts for LO-3

- **HaRT components:** concrete actions and activities undertaken with patients in HaRT encounters. They include patient-led tracking of harm reduction metrics, harm reduction goal setting, and discussing safer use strategies.
- **patient-led tracking of harm reduction metrics**: BHSSs have ongoing conversations with patients about their constellation of use and experience of substance-related harm. These can be tracked over time to show patients their incremental steps towards harm reduction.
- **Short Inventory of Problems for Alcohol and Other Drugs (SIP-AD):** 15-item Likert-type scale that can be summed to create an overall reflection of patients' substance-related harm.
- **harm reduction goal setting:** planning, implementing, and assessing progress towards what patients want for themselves. These goals aim to reduce substance-related harm and/or improve QoL.
- **discussion of safer use strategies:** conversations around ways patients can stay safer and healthier, even if they are using alcohol or drugs.

Key Teaching Points for LO-3

HaRT Counseling Components

- HaRT includes three counseling components: assessment and collaborative tracking of substance-related harm, eliciting and tracking patient-defined goals, and discussion of safer use strategies. These components can be combined with medications (e.g., buprenorphine, naloxone) and safer use supports (e.g., syringe programs, vape pens) to reduce harm and enhance QoL.
    - See also Figure 1 and **Figure 4 Introduction to HaRT Components**

Collaborative Assessment and Tracking of Substance Use Outcomes

- Collaborative assessment involves casual, approachable conversations about patients' substance use and its impacts. A simple opener like, "People use substances for different reasons—tell me about their role in your life," helps build rapport and gather useful information.
- While eliciting this narrative about a patient's substance use, it is key for BHSSs to track:
    - Type of drug currently used
    - Quantity of use in a sitting or per day
    - Frequency of use in a recent timeframe (e.g., past week, past 30 days)
    - Substance-related harm (e.g., as evaluated by the SIP-AD)
- As relevant, BHSSs can assess and track other outcomes like QoL, psychiatric symptoms, biomarkers, and other notable outcomes specific to the setting.
- Outcomes are tracked over time, and positive changes are reinforced with affirmations. Even when progress stalls, BHSSs affirm what is going right (e.g., "Even though you didn't make the change you wanted to this week, you made it here to today to keep trying. Nice work!") and collaboratively explore ways to leverage goals and safer use strategies (see key teaching point on this below) to help the patient make those changes come through in the metrics.

Elicitation of Patients' Harm Reduction and QoL Goals

- The second HaRT component involves eliciting and discussing patients' own harm reduction and QoL goals. BHSSs can begin simply with, "What do you want to see happen for yourself?"
- Goals that patients identify may be goals around substance use (e.g., reducing substance use, avoiding triggers, getting sober) or increasing QoL (e.g., starting an art project, going to the library, going to the gym). Prior studies have indicated that patients do volunteer substance-related goals, but only a small minority of those goals entail abstinence achievement (Fentress et al., 2021; Collins et al., 2015), so getting people excited about what *they* want to see happen versus pushing abstinence-based goals is a great way to engage people who are not ready, willing, or able to quit.
- Providers track goal progress weekly, offering affirmations, encouragement, and reflections regardless of outcomes. They also help patients break larger goals into smaller, manageable steps and address barriers together.

Discussion of Safer Use Strategies

- The third component entails discussing the relative risks and benefits of patients' current substance use and strategies that can help them:
    - Stay healthier when using (e.g., drinking water to stay hydrated, taking B-complex vitamins to avoid thiamine deficiency in the context of heavy alcohol use).
    - Alter the manner in which they use (e.g., not mixing drugs and alcohol, not using alone in case of opioid overdose).

    - Change the amount they use (e.g., drinking reduction, abstinence). If reduction or abstinence is a goal, and a patient is physiologically dependent on alcohol or benzodiazepines, BHSSs can review information on the risks of withdrawal, self-tapering schedules, or the possibility of a medically supervised withdrawal (Anderson, 2010). In the case of opioids, this discussion should also involve referrals for medication for opioid use disorder to manage withdrawal and overdose risk.
- This discussion is facilitated by safer use handouts (see MC6 on Care Planning and Care Coordination for examples) with information to help patients make more scientifically informed decisions about their use.

Sample Activities/Assessments for LO-3

Activity: Becoming Familiar with HaRT Counseling Components
Students match the HaRT counseling components with their corresponding definitions, purposes, and one-line intro scripts based on what they learned from **Figure 4.**

- Figure 4 Introduction to HART Components

Activity: Summarizing HaRT Counseling Components
Students summarize the three HaRT counseling components in their own words in a short-essay format. For each component, they should be able to define it, describe its goals, and write examples of open-ended questions they would ask to start a conversation.

Specific Resources for LO-3

Resource: Introduction to HaRT Mindset, Heartset, and Components
Partner Learning Webinar on Harm Reduction: Hour-long presentation by Susan Collins on harm reduction, substance use, and the value of meeting people in the present moment.

- HealthierHere. (2019, April 25). *HealthierHere partner learning webinar on harm reduction* [Video]. YouTube. https://youtu.be/qwzIP3jKatY?feature=shared

BHSS Advanced

LO-4 Apply harm reduction assessment skills to start a conversation about substance use.

Key Terms and Concepts for LO-4

- **substance use**: an individual's intake of drugs or alcohol.
- **constellation of use:** patterns of substance use.
- **frequency**: how often an individual uses substances within a specific timeframe (e.g., the last week or month).
- **quantity**: how much of a substance an individual uses within a specific timeframe (i.e., per day, sitting, or episode)
- **route of administration:** how an individual gets the substances into their body (e.g., oral administration, snorting, smoking, injecting/slamming, rubbing anally/hooping, anal dosing/booty bumping).

Key Teaching Points for LO-4

Starting the Assessment: Eliciting the Patient's Narrative with Open-Ended Questions

- BHSSs should be encouraged to start an assessment by eliciting patients' narratives about their substance use using open-ended questions and prompts. For example:
    - "A lot of people use substances to celebrate the good times or feel better in the bad times. How about you?"
    - "Some people use alcohol or other drugs to celebrate with friends or family. Some people use to de-stress after a long day. Some people use to delay withdrawal. Tell me a little bit about the role substance use plays in your life."
- The first part of this process normalizes substance use so patients do not feel interrogated or judged. The second part uses open-ended questions to elicit a narrative around substance use.

Continuing the Conversation: Use Follow-Up Questions to Fill Gaps in the Patient's Narrative

- The BHSS should ask follow-up questions for assessment accuracy and completeness. This ensures they have the four crucial pieces of information about people's use before the conversation is done: types of substances used, quantity, frequency, and route of administration. Here is an example of how to assess these different aspects of use or their constellation of use:
    - LO-4 Example Assessment of Constellation of Use
- During the substance use assessment, the BHSS should keep asking "What else?" after the patient tells a story about each substance, so that nothing is inadvertently missed.
- The BHSS should set a time frame that is recent, easy to remember, and most relevant to the setting and specific work they are doing. Timeframes like "past week" or "past 30 days" are helpful to understand current use (which is the most relevant typically). "Last year" is typically required for International Classification of Diseases-11 (ICD-11) or Diagnostic and Statistical Manual of Mental Disorders-5, Text Revision (DSM-5-TR) diagnosis.

Using Metrics to Track Substance Amounts

- Assessing alcohol use:
    - It is important to translate alcohol use into "standard drinks" because alcoholic beverages have different concentrations, typically referred to as alcohol by volume (ABV):
        - A standard drink is the equivalent of one 12 oz beer (5% ABV), one 5 oz glass of wine (12% ABV), or a 1.5 oz shot of hard liquor (40% ABV/80 proof).
        - In practice, however, it is often difficult for patients to accurately convert their drinking into standard drinks on their own. If you ask a patient how much they drank on a typical day in the past week, and they say, "I had three drinks on a typical day in the past week…"
    - For Patient A, "three drinks" might mean *three 12 oz Truly Hard Seltzers, which is indeed three standard drinks.*
    - For Patient B, "three drinks" might mean *three Long Island Iced Teas, which would actually be 5.072 standard drinks.*
    - For Patient C, "three drinks" might mean *three 24 oz cans of Steel Reserve 211 High Gravity malt liquor,* which is really *9.72 standard drinks.*
        - Therefore, it is critical to measure the number of drinks correctly. Otherwise, you might not understand how much a patient is really drinking at any given

point. Moreover, if they are changing their use over time, it might appear that they are drinking a different amount when it is just different alcohol concentrations, or vice versa. (See Blood Alcohol Content Estimator in LO-4 Resources for a handy and free standard drinks calculator to remove the guesswork.)

- Assessing drug use:
    - For drug use, especially when patients purchase on the illicit and thus unregulated market (e.g., purchasing from a drug supplier or dealer), it can be even harder to track exact amounts. Even when it's a regulated market, like cannabis, patients might use inexact increments like "a joint."
    - Although not perfect, BHSSs can use whatever metric the person feels comfortable measuring their use in (e.g., number of dollars spent each day, grams/ounces used each day, number of pills or joints smoked each day). If possible, the same metrics should be used from week to week for consistency.

Sample Activities/Assessments for LO-4

Activity: Four Categories of Information on Substance Use
Students write down the four categories of information they need to collect to understand patients' substance use and define these categories.

Activity: Using the Blood Alcohol Content (BAC) Estimator/BACCUS Tool
Students use the BACCUS computer program tool described in the Resources section below to calculate the number of standard drinks in the above example (Markham et al., 1993).

Activity: Role Playing Open-Ended Prompts
Students engage in role plays in which they try out the open-ended prompts above to focus the assessment.

- For example: *"Some people use alcohol or other drugs to celebrate with friends or family. Some people use to destress after a long day. Some people use to stave off withdrawal. Tell me a little bit about the role substance use plays in your life."*

Then, the role play continues for at least five minutes to help students learn how to fully assess the substances used, quantity, frequency, and routes of administration. After role plays, students summarize all the information they have gathered and write up or discuss verbally with the class how this assessment informs their understanding of the patient's constellation of use. How could this understanding give them clues about possible relevant harm reduction goals and safer use strategies to discuss later in the encounter?

Specific Resources for LO-4

Resource: Calculating "Standard Drinks"
Blood Alcohol Content (BAC) Estimator: A free tool to calculate "standard drinks" from various types of beverages consumed. It can also help estimate blood alcohol levels.

- Center on Alcohol, Substance use, And Addictions. (n.d.). *BAC estimator*. https://casaa.unm.edu/tools/baccalc.html

Resource: Assessment Tools to Measure Different Aspects of Substance Use and Related Constructs
Assessment Instruments: The Center on Alcohol, Substance use, And Addictions (CASAA) assessment library is intended to be a resource for substance use researchers and providers. All the instruments in this library are not copyrighted and may be used without permission.

- Center on Alcohol, Substance use, And Addictions. (n.d.). *Assessment instruments*. The University of New Mexico. https://casaa.unm.edu/tools/assessment-instruments.html

Resource: Substance Use Screening
Screening and Assessment Instruments: This resource is to help providers and researchers find instruments used for screening and assessing substance use and substance use disorders (SUDs). Some instruments are in the public domain and can be freely downloaded from the web; others can only be obtained from the copyright holder.

- Addictions, Drug & Alcohol Institute. (n.d.). *Substance use screening & assessment instruments*. University of Washington. http://lib.adai.washington.edu/instruments/

LO-5 Differentiate goal setting in harm reduction and use reduction contexts.

Key Terms and Concepts for LO-5

- **use reduction or abstinence-based treatment:** often based in the stepped-care model, treatment becomes more intensive and abstinence focused as substance-related harm increases. This approach assumes that reducing or stopping use will lead to reduced harm.
- **HaRT recovery:** supports the realization of patient-driven goals and recognizes any patient-led movement toward reducing harm and improving QoL as positive steps. In HaRT, "recovery" is defined by the patient and not by abstinence, moderation, use reduction, or compliance with providers' conceptualization of recovery. Abstinence is only a valid form of harm reduction if it aligns with the patient's *own* goals and resources.

Key Teaching Points for LO-5

Differentiating Goal Setting in Harm Reduction and Use Reduction Contexts

- **Why use fully patient-driven goal setting in HaRT?**
    - An important preface: In sharing where harm reduction and use reduction differ, we are not pitting them against each other or minimizing the value of other evidence-based approaches (e.g., cognitive behavioral therapy, relapse prevention, Motivational Interviewing, 12-step facilitation, mindfulness-based relapse prevention, contingency management). These approaches can be very helpful when aligned with patients' own motivation for change, and the field needs all kinds of approaches to help all kinds of patients.
    - That said, in our current system, provider-driven use reduction approaches are a mismatch for most people we work with.
        - Use reduction approaches are founded in traditional abstinence-based treatment programs. These approaches often assume that providers "know best," and providers are charged with guiding patients toward provider-driven goals (e.g., abstinence or "moderate drinking").

- Research from SAMHSA (2024) has shown that most Americans (95%) with SUDs don't want "treatment." Even among those who acknowledged their need for treatment, the top three reasons for not attending were: a) wanting to handle alcohol and other drug use on their own (70%), b) not feeling ready to start treatment (62%), and c) not wanting to stop using alcohol and other drugs (56%).
    - These findings about the general population are evident in research with more marginalized people, too. In nontreatment-based, community settings with people experiencing homelessness, only about 5% reported wanting to achieve abstinence (Fentress et al., 2021).
        - That means that many of these provider-driven methods will not be a good fit with patients' current motivation for change. This is where BHSSs might notice patients resisting, dropping out, or quietly going along with the procedures until the program is over, rebounding soon thereafter.
- **Why and how does HaRT goal setting work?**
    - HaRT can be helpful for people no matter their motivation for change because it flexibly supports *any* patient-driven goals that can reduce substance-related harm (e.g., fewer blackouts, avoiding withdrawal, abstinence) or improve QoL (e.g., reconnecting with family, meaningful activities, volunteering, creative pursuits).
    - HaRT was codeveloped with community members severely impacted by SUD. It prioritizes patient perspectives and does not pressure patients toward provider-defined goals.
    - The main point of HaRT goal setting is not achieving a specific outcome but helping patients develop self-efficacy in regularly setting and achieving meaningful goals. Goals are broken down into clearly defined, manageable steps within realistic timeframes. BHSSs help patients see progress and build their confidence around setting and achieving harm reduction and QoL goals.
    - HaRT goal-setting discussions are conversational and inviting rather than checklist oriented. BHSSs elicit patients' narratives about goal setting and experiences. BHSSs offer affirmation, reflection, and ongoing support, regardless of the outcome.
        - Here are examples of less helpful and more helpful goal-setting conversations: LO-5 Example Script of Eliciting Goals

Sample Activities/Assessments for LO-5

Activity: Comparing and Contrasting HaRT and Provider-Driven Goal Setting
Students compare and contrast how goal setting works in abstinence-only and harm reduction counseling scenarios.

Activity: Role Playing Provider-Driven and HaRT Goal Setting
Using the LO-5 Example Script of Eliciting Goals as a template for structure and timing, students role play a counseling scenario in which the student who plays the BHSS uses a HaRT approach to elicit from their patient at least two goals they will strive for over the next week.

Specific Resources for LO-5

Resource: HaRT with Substance-Using Patients

Harm Reduction Treatment for Substance Use: This e-book includes handouts to use to facilitate goal setting.

- Collins, S. E., & Clifasefi, S. L. (2023). *Harm reduction treatment for substance use*. Hogrefe Publishing. https://doi.org/10.1027/00507-000

Resource: Analysis of Harm Reduction Goal Setting

Patient-Driven Goal Setting Among People Experiencing Homelessness and Alcohol Use Disorder: This journal article includes the kinds of goals that more marginalized populations have shared using both quantitative and qualitative analyses.

- Fentress, T. S. P., Wald, S., Brah, A., Leemon, G., Reyes, R., Alkhamees, F., Kramer, M., Taylor, E. M., Wildhood, M., Frohe, T., Duncan, M. H., Clifasefi, S. L., & Collins, S. E. (2021). Dual study describing patient-driven harm reduction goal-setting among people experiencing homelessness and alcohol use disorder. *Experimental and Clinical Psychopharmacology*, *29*(3), 261–271. https://doi.org/10.1037/pha0000470

Resource: Participant-Generated Treatment Goals

Evaluating Harm Reduction: The findings of this study confirmed that people experiencing long-term homelessness with alcohol use disorder can independently generate and achieve treatment goals toward alcohol harm reduction and QoL improvement.

- Collins, S. E., Grazioli, V. S., Torres, N. I., Taylor, E. M., Jones, C. B., Hoffman, G. E., Haelsig, L., Zhu, M. D., Hatsukami, A. S., Koker, M. J., Herndon, P., Greenleaf, S. M., & Dean, P. E. (2015). Qualitatively and quantitatively evaluating harm-reduction goal setting among chronically homeless individuals with alcohol dependence. *Addictive Behaviors, 45*, 184–190. https://doi.org/10.1016/j.addbeh.2015.02.001

LO-6 Analyze a constellation of substance use to identify relevant safer use strategies.

Key Terms and Concepts for LO-6

- **relative risks:** likelihood of experiencing harm or negative consequences associated with substance use under varying circumstances.
- **relative risk hierarchies**: structured frameworks that rank substance use behaviors based on their likelihood of causing harm.
- **colearning**: collaborative process in which individuals or groups engage in shared learning, recognizing and valuing each participant's knowledge, experiences, and perspectives. Rather than a unidirectional transfer of information, colearning emphasizes mutual exchange, active participation, and collective discovery.

Key Teaching Points for LO-6

Understanding Relative Risks

- In HaRT, BHSSs should be informed about different types of substances and understand the relative risks of patients' own constellation of use. These risks can differ based on the type of substance, route of administration (e.g., smoking, injecting, or snorting), and the frequency and

quantity of use. Context also matters: Are patients using alone at home where overdose might go undetected? Are they using with others who might increase their relative risks? Are they using while performing potentially dangerous activities like driving? Additionally, individual factors, including age, socioeconomic factors, physical health, and co-occurring psychiatric disorders, can further shape the degree of harm.

Discussing Relative Risks with Patients

- The BHSS will start a conversation with the patient as discussed in LO-4. When this conversation is led with open-ended and nonjudgmental questions, patients often share more openly about what and how they use. The BHSS does not need to angle themselves as an expert but must listen with curiosity. It is important to a) affirm what they are already doing to stay safer and healthier and b) provide psychoeducation, sharing *why* that behavior is safer.
- During these casual discussions, the BHSS should avoid monologues on relative risks. Instead, they can make the discussion of relative risks more conversational, dropping small bits of psychoeducation throughout the encounter when and where it is relevant. For example, if a patient indicates they have gone from injecting to smoking methamphetamine, the BHSS can offer an affirmation and add psychoeducation to clarify why this change is safer (e.g., less injection injury risk, less likely to spread blood-borne illnesses if sharing needles). This is especially effective when paired with strengths-based reflections and open-ended questions to elicit and reinforce stories about safer use.
    - LO-6 Example of Affirmation and Psychoeducation

Consulting Authoritative Sources

- When a BHSS is unfamiliar with certain substances or routes of administration mentioned, it is crucial to listen to the patient, take their reporting at face value, and then double-check with authoritative sources. This step cannot be overlooked. Patients often intend to engage in safer use, but due to the lack of mainstream and accessible information sources, they may not have the most accurate or up-to-date information. (See Resources for LO-6 for sources of information on safer use strategies.)
- If the BHSS learns that their patient is engaging in riskier use, they should ask the patient's permission before sharing information.
    - LO-6 Example of Asking Permission

Building Relative Risk Hierarchies

- As the BHSS learns foundational information about relative risks and safer use, they can build relative risk hierarchies that are most relevant to the patient base they serve. Typically, these are not shown to patients, but they can help the BHSS remember what behaviors are safer or less safe when assessing substance use. Below are some examples of relative risk hierarchies to provide an idea of what these can look like. It is helpful to tailor these to the substance use, behaviors, and patient populations that BHSSs are working with.
    - **Relative risk hierarchy for alcohol:** A relative risk hierarchy was set up for people experiencing homelessness and severe alcohol use disorder with physiological dependence (see **Figure 5**). This relative risk hierarchy considers factors that contribute to worsening alcohol withdrawal symptoms (e.g., after reducing to lower ABV beer, a patient returns to higher ABV malt liquor) or blackouts (e.g., consuming hand sanitizer "cocktails" where mixers mask the flavor and thus perceived concentration of this high-ABV product).
        - Figure 5 Relative Risk Hierarchy of Alcoholic Beverages

- **Relative risk hierarchy for injection drug use:** The next relative risk hierarchy was inspired by the excellent guide from the National Harm Reduction Coalition (n.d.) called "Getting Off Right," which covers relative risks at each turn of the complex set of medical procedures that is injection drug use (see **Figure 6**).
  - Figure 6 Relative Risk Hierarchy of Injection Sites
- **Relative risk hierarchy for nicotine**: As shown in **Figure 7**, the relative risk hierarchy for nicotine is relatively simple. As typically used by adults, nicotine itself is a highly addictive, yet relatively harmless, stimulant; thus, a focus on less risky routes of administration is the most reliable way to reduce the risks associated with tobacco use *and* the risk of relapse. Anything that is not smoking is about 85% safer than smoking, but even reducing smoking can reduce cancer and cardiovascular risks (Chang et al., 2021). A complete switchover to chew tobacco is approximately 85% safer, vaping is 95% safer, and nicotine replacement therapy (i.e., patches, gum, lozenges) is 99% safer than smoking (Nutt et al., 2014).
  - Figure 7 Relative Risk Hierarchy of Nicotine Products

Walking with Patients on the Recovery Pathway

- The BHSS will need to remember that it is the patient who invites the BHSS to walk with them on their recovery pathway. The patient reaches a fork in the road where they can make different decisions about their use moving forward. The BHSS asks permission to provide information to help the patient make a scientifically informed decision about their use. Then, the BHSS steps back and defers to the patient and their own decision-making process.

Sample Activities/Assessments for LO-6

Activity: Counseling Scenario Script
Students explain a counseling scenario in which they engage in colearning around relative risks. They write the script of what the BHSS says to elicit and engage in the conversation, and plausible patient responses.

Activity: Constructing a Relative Risk Hierarchy
Students construct a relative risk hierarchy for a certain substance use behavior as shown in **Figures 5–7.**

Activity: Relative Risk Hierarchy Role Play
Students complete a 10-minute role play during which they co-learn with the patient about the patient's constellation of use. They draw on their understanding of relative risk hierarchies to share a piece of advice, asking permission and using the affirmation-psychoeducation-affirmation approach in the section above, "Discussing Relative Risks with Patients."

Specific Resources for LO-6

Resource: Materials to Help Explain Relative Risks of Substances and Routes of Administration
Harm Reduction Issues: The National Harm Reduction Coalition has a content library of resources to promote the health and dignity of people affected by drug use.

- National Harm Reduction Coalition. (n.d.). *Harm reduction issues*. https://harmreduction.org/issues/

Resource: Peer Support
Harm Reduction for Alcohol (HAMS): HAMS is a peer-led and free-of-charge support and informational group for anyone who wants to change their drinking habits for the better.

- Harm Reduction for Alcohol. (n.d.). *Home page.* https://hams.cc/

Resource: Safer Drug Use
Resources for Safer Drug Use: The Harm Reduction Research & Treatment Center has compiled safer use strategies and general information for alcohol, stimulants, depressants, cannabis, and nicotine.

- Harm Reduction Research & Treatment Center. (n.d.). *Resources for safer drug use*. https://depts.washington.edu/harrtlab/resources/

Resource: Multimedia Library
Drug Policy Alliance Library: This resource library has multimedia materials, including fact sheets, podcasts, reports, and videos.

- Drug Policy Alliance. (n.d.). *Search all resources*. https://drugpolicy.org/resources/?issue_years=1984-2025&resource_years=1984-2025

BHSS Practicum

LO-7 Assess substance-related harm among other relevant metrics.

Key Terms and Concepts for LO-7

- **substance-related harm:** Negative consequences that occur for the patient in the context of their own alcohol or other drug use. Such consequences may be experienced acutely or chronically and include physical, psychological, financial, legal, spiritual, social, or interpersonal problems.
    - Note: substance-related harm can be conceptualized in various ways. For this unit, it is defined at the individual level of harm because this is the primary focus of case management or counseling.
- **Short Inventory of Problems (SIP):** easy-to-administer, psychometrically sound, and universally applicable measure that can provide a 30-day snapshot of patients' substance-related harm.

Key Teaching Points for LO-7

Introduction to the Short Inventory of Problems

- In more substance use treatment, counseling, or clinical case management settings, using a universal measure of substance-related harm, the Short Inventory of Problems (SIP), is essential (see **Figure 8**). By using the SIP to measure patients' level of substance-related harm at the start of a working relationship and over time, the BHSS can affirm patients' progress and better understand where there are still key points to address.
    - Figure 8 Short Inventory of Problems (SIP)

Recommended Steps for the Introduction and Use of the SIP

- Introducing the SIP: The BHSS introduces the SIP by saying something like:

  - "As we have discussed, this is harm reduction treatment, and my job is to support you in reducing your substance-related harm. One way we will check in to see if we are on track is to measure your experience of substance-related harm once a month using this questionnaire. What questions do you have?" *The BHSS then answers any questions or concerns a patient may have.*
- Administering the SIP: For the initial instructions, the BHSS can say:
  - "I am going to read to you some events people sometimes experience related to their substance use. Please indicate how much each has happened to you in the past thirty days by telling me the appropriate number, where 0 = never, 1 = once or a few times, 2 = once or twice a week, and 3 = daily or almost daily."
  - When reading the prompts, the BHSS should ensure the patient can see the questionnaire and answer choices. As the BHSS reads off the prompts, they should repeat the timeframe and scale anchors every time. If these prompts are not repeated, the patient might draw on events that happened more than 30 days ago, or they may rush to the "worst" response (e.g., "All threes!") without thinking about how often they have actually experienced each. That said, if a patient continues to experience harm from events further in the past, some items are worded such that it is ok to record this observation.
- Providing feedback: The BHSS should provide feedback about patients' responses in a compassionate and affirming way. The BHSS may say:
  - "Thank you for sharing your experience of problems when you have been using substances. When we look at the scale from 0 to 45, where 0 means you have experienced no problems, and 45 means you have experienced all 15 problems nearly every day, your score is at 30. That's about two-thirds of the way up the scale. Some problems you experience most frequently include [*the BHSS reads off the ones they endorse with a "3"].* How does that sound to you?" *This helps the BHSS gauge if they are correct in their summary and what patients do with that information.*

Assessing Other Relevant Metrics

- The BHSS may then elicit other metrics from the patient if they can be quantified or dichotomized, and that can be tracked together. For example, the BHSS might say:
  - "In harm reduction, we also really care about how you are doing overall—not just about substance use. What other things would you like to measure that could help us determine how things are going?" *For example, patients might say they want to track alcohol-related seizures, blackouts, or overdoses. They may want to track other symptoms, like depressive or anxiety symptoms, biological metrics, or health-related QoL.*

Tracking Metrics Over Time

- As shown in **Figure 9**, the BHSS can use a blank progress tracking grid to help patients record substance-related harm over time, as measured by the SIP.
  - Figure 9 Simple Chart to Create a Trajectory to Record Patient Progress
- To introduce this process, the BHSS says:
  - "Because my job is to help you reduce the harms you experience when you use substances, we will track your scores on the SIP, which is a measure of substance-related harm, on this graph. That way, we can see how I'm doing in supporting you. If we need to, we can change things to get you closer to where you want to be."

    - "Often, people find it helpful to track other outcomes—other measures of harm, substance use, mental health, or quality of life—over time to see how these things change and connect with each other. Which of these would you like to track over time?"
    - "Great! Each *[name timeframe here],* we will track these outcomes to check in and see how things are going. How does that sound?"
- Depending on the patient's treatment trajectory, the BHSS can repeat the process of assessment, feedback, and tracking at each encounter or regular intervals. The SIP is tracked at monthly intervals given its time frame; however, if needed, the BHSS can reduce the time frame of the SIP to two weeks without changing the original measure.

Sample Activities/Assessments for LO-7

Activity: Selecting Metrics to Track
Small groups brainstorm what metrics might be most relevant to collect in the setting they are working in (e.g., psychiatric symptoms, housing readiness, QoL) to track alongside substance-related harm. Groups then share insights about their choices. Groups may explore how tracking various metrics could provide insights into patients' experiences, impact patients' perspectives on their own substance use, and influence the BHSSs' understanding of involving patients in tracking their progress over time.

Activity: Role Play Assessment Practice
In pairs, students practice administering the Short Inventory of Problems (SIP), alternating roles as the BHSS and patient. Students learn to deliver prompts, clarify instructions, and provide affirming feedback on patient responses based on the scripts above and using **Figures 8 and 9**. Instructors should walk around the classroom observing and providing overall feedback to the class.

Specific Resources for LO-7

Resource: BACCUS Standard Ethanol Content Calculator and Other Tools
Software, Instruments, and Manuals: The University of New Mexico's CASAA website includes tools that can facilitate assessment, including the BACCUS standard ethanol content calculator and various assessment instruments (including versions of the SIP-AD, a modified SIP tool to assess alcohol and drug use).

- Center on Alcohol, Substance use, And Addictions. (n.d.). *Software, instruments, and manuals.* https://casaa.unm.edu/tools/index.html

Resource: Harm Reduction Resources & Assessments
Professional Tools: The Addictions, Drug & Alcohol Institute at the University of Washington has extensive information on harm reduction topics and a comprehensive collection of assessment instruments.

- Addictions, Drug & Alcohol Institute. (n.d.). *Professional tools*. https://adai.uw.edu/information/professional-tools/

LO-8 Elicit harm reduction and health-related QoL goals.

Key Terms and Concepts for LO-8

- **harm reduction goal setting**: a process that entails asking about what patients want to see happen for themselves. The resulting goals can encompass substance-related goals and/or QoL goals. The former serves to capture what people want to move away from, and the latter captures what people want to move towards.

Key Teaching Points for LO-8

Using Open-Ended Questions to Elicit Goals

- Some patients have goals in mind when they talk to a treatment professional. Others may have given this topic less thought. Still others are convinced that professionals believe the only legitimate goal is abstinence and thus might feel compelled to say they are abstinent. This is why the BHSS needs to use simple, open-ended questions to elicit goals that patients believe are reachable and desirable. This should be a fluid conversation in which the BHSS gets to know the goals closest to their patient's heart. They should elicit and listen carefully to patients' own narratives and stories about what they want to see happen for themselves and why, then reinforce these goals.
    - LO-8 Examples of Eliciting Goals

Identifying Achievable Goals that Can Be Broken Down into Weekly Tasks

- It is important that patients' goals, particularly those in the earlier encounters, can be achieved within the next week (or until the next scheduled encounter) to ensure the goal setting process builds patients' self-efficacy and autonomy in reaching the goals patients set for themselves. So, if patients mention larger goals that may be difficult to achieve right away (e.g., "getting back to work")—even if patients are enthusiastic about this goal—the BHSS should help them to break these goals down into more achievable pieces: *"That's a great goal [affirmation]! It's also a big goal. What do you think is the first step in achieving that goal?"*
- The BHSS may help patients visualize the stepwise nature of goal setting using the visual aid in **Figure 10.** The BHSS can record the larger goal (e.g., "getting back to work") in the top step. Then, they return to the bottom step and ask the patient to name the first step toward that larger goal, something that the patient can do in the next week. This stair-step model can be used from week to week to guide patients' incremental progress towards a larger goal.
    - Figure 10 Stair-Step Approach to Honing Harm Reduction Goals

Keeping a Record of Goals

- When documenting in electronic health records, the BHSS may create a numbered list of goals in notes with a header (e.g., "current week's goals"), as noted in **Figure 11**. If larger goals are broken down into smaller goals for the following week, the BHSS can write in the smaller goal first at the numbered line. Then, in parentheses, they write down the larger goal on the same line.
    - Figure 11 Example Way of Recording Goals and Progress Towards Them
- As the BHSS records goals for their records, they should also make a copy for patients to take with them. **Figure 12** shows a harm reduction goals form that patients can take with them. On the reverse side, the relevant safer use strategies can be printed.
    - Figure 12 Harm Reduction Goals

Reviewing Goals

- The BHSS should affirm patients for goal setting and remind them that these will be reviewed the following week. Goal setting and follow-up should be an ongoing, routine process that drives

encounters. For example: *"Thank you for sharing with me what you want to see happen! I have written it down in my records, and we have it here for you to take with you as well. That way, you can remind yourself what you want to make happen for yourself this week. I look forward to checking in with you next week to see how things went!"*

- The next week (or whatever time interval your meetings take), the BHSS should check in with the patient: "*Last week you said you would [repeat goals]. How did that go?*"
    - The BHSS should elicit the patient's experience with their work towards the goal and affirm what went well.
    - Even if the goal was not yet accomplished, the BHSS should affirm the patient for working towards it or even showing back up today to share. Those are important steps!
    - If goals seem too big, the BHSS can help the patient using the stairstep model to break the goal down even more.
- BHSSs should keep setting goals with patients and check in each time they meet. This helps the patient hone their abilities to set and achieve goals over time.

Sample Activities/Assessments for LO-8

Activity: Brief Goal Planning
Students engage in a 10-minute role play during which they inquire about patients' goals using the following script: "We will be meeting over the next [xx amount of time]. What would you like to see happen for yourself? Some people call this a goal, a vision, or an intention." Students follow up on the patients' responses using reflections, affirmations, and additional open-ended questions until at least one goal (and its smaller, concrete steps) is clearly articulated.

Activity: Stair-Step Approach to Honing Harm Reduction Goals
Students are provided a bigger goal patients might have that would be relevant to the settings they could be placed in (e.g., "I want to get housing," "I want to reconnect with family," "I want to stop injecting meth," "I want to get back to work"). Then, as shown in **Figure 10**, students construct a "stair step" to break down that larger goal into bite-sized goals that can be pursued weekly.

Specific Resources for LO-8

Resource: Harm Reduction Goal Setting and Marginalized Populations
Serving Chronically Homeless Individuals with Alcohol Dependence: The findings of this study confirmed that people experiencing long-term homelessness with alcohol dependence can independently generate and achieve treatment goals toward alcohol harm reduction and QoL improvement.

- Collins, S. E., Grazioli, V. S., Torres, N. I., Taylor, E. M., Jones, C. B., Hoffman, G. E., Haelsig, L., Zhu, M. D., Hatsukami, A. S., Koker, M. J., Herndon, P., Greenleaf, S. M., & Dean, P. E. (2015). Qualitatively and quantitatively evaluating harm-reduction goal setting among chronically homeless individuals with alcohol dependence. *Addictive Behaviors, 45*, 184–190. https://doi.org/10.1016/j.addbeh.2015.02.001

Resource: Harm Reduction and Goal Setting
Patient-Driven Goal Setting Among People Experiencing Homelessness and Alcohol Use Disorder: This study illustrates how harm reduction goal setting works as well as typically encountered goals in marginalized populations (i.e., people experiencing homelessness).

- Fentress, T. S. P., Wald, S., Brah, A., Leemon, G., Reyes, R., Alkhamees, F., Kramer, M., Taylor, E. M., Wildhood, M., Frohe, T., Duncan, M. H., Clifasefi, S. L., & Collins, S. E. (2021). Dual study

describing patient-driven harm reduction goal-setting among people experiencing homelessness and alcohol use disorder. *Experimental and Clinical Psychopharmacology*, *29*(3), 261–271. https://doi.org/10.1037/pha0000470

Resource: Harm Reduction Approaches
Harm Reduction Treatment for Substance Use: Concrete guidance on HaRT with substance-using patients. For forms used in **Figures 10, 11, and 12**, see the appendices.

- Collins, S. E., & Clifasefi, S. L. (2023). *Harm reduction treatment for substance use*. Hogrefe Publishing. https://doi.org/10.1027/00507-000

LO-9 Codesign a comprehensive plan for safer use with patients.

Key Terms and Concepts for LO-9

- **safer use**: underscores, as one community advisory board member, Will Williams, put it, "Progress not perfection." The harm reduction approach does not aim to eliminate harm or make use completely safe, but it prioritizes identifying ways to decrease the risk of harm where possible.

Key Teaching Points for LO-9

Introducing Safer Use Strategies to Patients

- Even if patients are not interested in reducing use or achieving abstinence, there are still things they can do to decrease the risk of harm they experience due to substance use. To introduce this discussion, the BHSS can show patients safer use strategies. **Figure 13** shows an example of safer use strategies for cannabis.
    - Figure 13 Safer Use Strategies for Cannabis

Using a Step-by-Step Script

- The BHSS can ensure positive uptake and avoid discord by following a step-by-step script with the patient. See LO-9 Step-by-Step Script for a detailed example. After the BHSS introduces the safer use strategies page(s), they should elicit which strategies patients have tried before and the patients' narrative around them. This will ensure patients commit to safer use on their terms and with greater intrinsic motivation.
    - LO-9 Safer Use Strategies Example Script

Safer Use Strategies Do Not Enable Patients

- A BHSS might worry they are enabling patients by talking about safer use strategies. However, research shows that quite the opposite is true, and the BHSS is providing strategies that may even save their lives (Alawadhi et al., 2024).

Sample Activities/Assessments for LO-9

Activity: Role Play with Safer Use Strategies Example Script
In pairs, students engage in a role play using the Safer Use Strategies Example Script to move their partner through the safer use strategies pages. Instructors should have students follow up on the patients' responses using reflections, affirmations, and additional open-ended questions to drive home

what they are already doing "right" and invite further commitment to safer use strategies to build on their successes.

Specific Resources for LO-9

Resource: Safer Use Strategies Pages
Resources for Safer Drug Use: The Harm Reduction Research & Treatment Center has compiled safer use strategies and general information for alcohol, stimulants, depressants, cannabis, and nicotine.

- Harm Reduction Research & Treatment Center. (n.d.). *Resources for safer drug use*. https://depts.washington.edu/harrtlab/resources/

Resource: Safer Drinking Strategies
Brief Counseling at Drop-In Center: This paper describes how people with alcohol use disorder identified personal harm reduction goals and practical ways to drink more safely through a brief counseling approach.

- Grazioli, V. S., Collins, S. E., Paroz, S., Graap, C., & Daeppen, J.-B. (2015). Harm-reduction goals and safer-drinking strategies among individuals attending a new drop-in center. *Addiction Science & Clinical Practice*, *10*, Article O19. https://doi.org/10.1186/1940-0640-10-S2-O19

Resource: Safer Use for Unhoused
Safer Use and Homelessness: This study replicated prior findings that people experiencing homelessness and alcohol use disorder regularly adopt strategies to reduce alcohol-related harm.

- Alawadhi, Y. T., Shinagawa, E., Taylor, E. M., Jackson, C., Fragasso, A., Howard, M., Fan, L., Kolpikova, E., Karra, S., Frohe, T., Clifasefi, S. L., Duncan, M. H., & Collins, S. E. (2024). Safer-use strategies in the context of harm-reduction treatment for people experiencing homelessness and alcohol use disorder. *The International Journal on Drug Policy, 129*, 104448. https://doi.org/10.1016/j.drugpo.2024.104448

Unit Summary

Harm reduction refers to a set of approaches that aim to reduce substance-related harm and improve quality of life. It encompasses strategies that may be implemented at the individual, community, population, and policy levels. This unit focused on an evidence-based, individual-level approach to harm reduction, known as harm reduction treatment (HaRT), which can be used across clinical, counseling, social work, and case management settings. HaRT was developed through 15 years of community-based participatory research with people who use substances and the community-based agencies that serve them (Collins et al., 2018). It builds off the foundational work of substance use researchers and grassroots harm reduction movements. The aim is to destigmatize substance use, support social justice efforts, and empower communities' visions of healing and recovery.

HaRT meets people "where they're at" in their motivation for change and in their communities, without requiring abstinence-based goals or settings. Using HaRT, BHSSs embody a pragmatic mindset and compassionate heart-set, using three core components: patient-led harm reduction tracking, elicitation of patient goals, and discussion of safer use strategies. These tools are adaptable across settings and levels of patient readiness. Research indicates that HaRT effectively reduces substance use and harm among marginalized populations (Collins et al., 2019; Collins et al., 2021; Mostofi et al., 2023).

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Annotated Bibliography

Collins, S. E., & Clifasefi, S. L. (2023). *Harm reduction treatment for substance use*. Hogrefe Publishing. https://doi.org/10.1027/00507-000

- This book presents a comprehensive, evidence-based framework for delivering harm reduction treatment to individuals who use substances. Grounded in principles of compassion, autonomy, and pragmatism, it outlines practical strategies for engaging patients without requiring abstinence. The authors detail goal setting, relationship building, and clinical and counseling techniques tailored to real-world service settings. Case examples and session tools illustrate how providers can support patients in reducing substance-related harm and improving overall QoL. The book is intended for professionals in clinical and counseling roles seeking alternatives to abstinence-only treatment models.

Collins, S. E., Clifasefi, S. L., Nelson, L. A., Stanton, J., Goldstein, S. C., Taylor, E. M., Hoffmann, G., King, V. L., Hatsukami, A. S., Cunningham, Z. L., Taylor, E., Mayberry, N., Malone, D. K., & Jackson, T. R. (2019). Randomized controlled trial of harm reduction treatment for alcohol (HaRT-A) for people experiencing homelessness and alcohol use disorder. *The International Journal on Drug Policy*, *67*, 24–33. https://doi.org/10.1016/j.drugpo.2019.01.002

- This study aimed to examine the impact of a patient-driven harm reduction approach with a sample of persons (N=168) experiencing homelessness and alcohol use disorder who were recruited via community-based service centers (i.e., shelters, drop-in centers, health-care clinics). Specific treatment components included a) collaborative tracking of participant-preferred alcohol metrics, b) elicitation of harm reduction and QoL goals, and c) discussion of safer-drinking strategies. Compared to participants in an assessment-only control group, those randomized to the HaRT group showed more confidence they could engage in harm reduction, lower peak alcohol use, decreased alcohol-related harm, fewer AUD symptoms, and less positive urinary ethyl glucuronide tests.

Fentress, T. S. P., Wald, S., Brah, A., Leemon, G., Reyes, R., Alkhamees, F., Kramer, M., Taylor, E. M., Wildhood, M., Frohe, T., Duncan, M. H., Clifasefi, S. L., & Collins, S. E. (2021). Dual study describing patient-driven harm reduction goal-setting among people experiencing homelessness and alcohol use disorder. *Experimental and Clinical Psychopharmacology*, *29*(3), 261–271. https://doi.org/10.1037/pha0000470

- This dual study focused on patients' harm reduction goal setting. Across both trials, qualitative findings indicated improving QoL, meeting basic needs, improving physical and mental health, and changing drinking behavior were participants' top four goals.

Witt, L. B., Greenberg, J., & Cantone, R. E. (2024). Harm reduction and substance use in adolescents. *Primary Care*, *51*(4), 629–643. https://doi.org/10.1016/j.pop.2024.05.005

- This article presents HaRT as an essential component of primary care and behavioral health intervention related to adolescent substance use. The article cites numerous studies and discusses strategies to reduce overdose deaths, decrease infectious disease burden, and strategies to improve systems of care. While HaRT was primarily studied in the adult population, there is significant evidence that harm reduction strategies are effective in the adolescent population as well.

References for this Unit

Addiction Technology Transfer Center. (n.d.). *Northwest ATTC.* https://attcnetwork.org/center/northwest-attc/

Alawadhi, Y. T., Shinagawa, E., Taylor, E. M., Jackson, C., Fragasso, A., Howard, M., Fan, L., Kolpikova, E., Karra, S., Frohe, T., Clifasefi, S. L., Duncan, M. H., & Collins, S. E. (2024). Safer-use strategies in the context of harm-reduction treatment for people experiencing homelessness and alcohol use disorder. *The International Journal on Drug Policy, 129*, 104448. https://doi.org/10.1016/j.drugpo.2024.104448

Anderson, K. (2010). *How to change your drinking: A harm reduction guide to alcohol* (2nd ed.). CreateSpace.

Bigg, D. (n.d.). *Dan Bigg, Director of Chicago Recovery Alliance* [Interview]. Chicago Students for Criminal Justice Reform. https://www.chicagocjr.com/dan-bigg-director-of-chicago-recovery-allianc

Bronfenbrenner, U. (1979). *The ecology of human development*. Harvard University Press.

Campinha-Bacote, J. (2018). Cultural competemility: A paradigm shift in the cultural competence versus cultural humility debate – Part I. *The online journal of issues in nursing, 24*(1). https://doi.org/10.3912/OJIN.Vol24No01PPT20

Chang, J. T., Anic, G. M., Rostron, B. L., Tanwar, M., & Chang, C. M. (2021). Cigarette smoking reduction and health risks: A systematic review and meta-analysis. *Nicotine & tobacco research: official journal of the Society for Research on Nicotine and Tobacco*, *23*(4), 635–642. https://doi.org/10.1093/ntr/ntaa156

Collins, S. E., & Clifasefi, S. L. (2023). *Harm reduction treatment for substance use*. Hogrefe Publishing. https://doi.org/10.1027/00507-000

Collins, S. E., Clifasefi, S. L., Dana, E. A., Andrasik, M. P., Stahl, N., Kirouac, M., Welbaum, C., King, M., & Malone, D. K. (2012a). Where harm reduction meets housing first: Exploring alcohol's role in a project-based housing first setting. *The International Journal of Drug Policy, 23*(2), 111–119. https://doi.org/10.1016/j.drugpo.2011.07.010

Collins, S. E., Clifasefi, S. L., Logan, D. E., Samples, L., Somers, J., Marlatt, G. A. (2012b). Current status, historical highlights and basic principles of harm reduction. In G. A. Marlatt, K. Witkiewitz, & M. E. Larimer (Eds.). *Harm reduction: Pragmatic strategies for managing high-risk behaviors* (2nd ed., pp. 3–35). Guilford Press. http://www.guilford.com/excerpts/marlatt2.pdf

Collins, S. E., Clifasefi, S. L., Nelson, L. A., Stanton, J., Goldstein, S. C., Taylor, E. M., Hoffmann, G., King, V. L., Hatsukami, A. S., Cunningham, Z. L., Taylor, E., Mayberry, N., Malone, D. K., & Jackson, T. R. (2019). Randomized controlled trial of harm reduction treatment for alcohol (HaRT-A) for people experiencing homelessness and alcohol use disorder. *The International Journal on Drug Policy*, *67*, 24–33. https://doi.org/10.1016/j.drugpo.2019.01.002

Collins, S. E., Duncan, M. H., Saxon, A. J., Taylor, E. M., Mayberry, N., Merrill, J. O., Hoffmann, G. E., Clifasefi, S. L., & Ries, R. K. (2021). Combining behavioral harm-reduction treatment and extended-release naltrexone for people experiencing homelessness and alcohol use disorder in the USA: A randomised clinical trial. *Lancet Psychiatry*, *8*(4), 287–300. https://doi.org/10.1016/S2215-0366(20)30489-2

Collins, S. E., Grazioli, V. S., Torres, N. I., Taylor, E. M., Jones, C. B., Hoffman, G. E., Haelsig, L., Zhu, M. D., Hatsukami, A. S., Koker, M. J., Herndon, P., Greenleaf, S. M., & Dean, P. E. (2015). Qualitatively and quantitatively evaluating harm-reduction goal setting among chronically homeless individuals with alcohol dependence. *Addictive Behaviors, 45*, 184–190. https://doi.org/10.1016/j.addbeh.2015.02.001

Denning, P., & Little, J. (2012). *Practicing harm reduction psychotherapy: An alternative approach to addictions* (2nd ed.). Guilford Press.

Fentress, T. S. P., Wald, S., Brah, A., Leemon, G., Reyes, R., Alkhamees, F., Kramer, M., Taylor, E. M., Wildhood, M., Frohe, T., Duncan, M. H., Clifasefi, S. L., & Collins, S. E. (2021). Dual study describing patient-driven harm reduction goal-setting among people experiencing homelessness and alcohol use disorder. *Experimental and Clinical Psychopharmacology*, *29*(3), 261–271. https://doi.org/10.1037/pha0000470

Hajek, P., Phillips-Waller, A., Przulj, D., Pesola, F., Smith, K. M., Bisal, N., Li, J., Parrott, S., Sasieni, P., Dawkins, L., Ross, L., Goniewicz, M., Wu, Q., & McRobbie, H. J. (2019). A randomized trial of e-cigarettes versus nicotine-replacement therapy. *New England Journal of Medicine, 380*(7), 629–637. https://www.nejm.org/doi/full/10.1056/NEJMoa1808779

Karimi, M., & Brazier, J. (2016). Health, health-related quality of life, and quality of life: What is the difference? *PharmacoEconomics*, *34*(7), 645–649. https://doi.org/10.1007/s40273-016-0389-9

Ma, J., Bao, Y., Wang RJ., Su, MF., Liu, MX., Li, JQ., Degenhardt, L., Farrell, M., Blow, F. C., Ilgen, M., Shi, J., & Lu, L. (2018). Effects of medication-assisted treatment on mortality among opioids users: A systematic review and meta-analysis. *Molecular Psychiatry, 24,* 1868–1883. https://doi.org/10.1038/s41380-018-0094-5

Markham, M. R., Miller, W. R., & Arciniega, L. (1993). BACCuS 2.01: Computer software for quantifying alcohol consumption. *Behavior, Research Methods, Instruments, and Computers, 25,* 420-421. https://casaa.unm.edu/assets/docs/baccus.pdf

Marlatt, G. A. (1998). Basic principles and strategies of harm reduction. In G. A. Marlatt (Ed.), *Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviors* (pp. 49–66). Guilford Press.

Marlatt, G. A., & Witkiewitz, K. (2010). Update on harm-reduction policy and intervention research. *Annual Review of Clinical Psychology*, *6*, 591–606. https://doi.org/10.1146/annurev.clinpsy.121208.131438

Marlatt, G. A., Witkiewitz, K., & Larimer, M. E. (Eds.). (2011). *Harm reduction: Pragmatic strategies for managing high-risk behaviors* (2nd ed). Guilford Press.

Miller, W.R., & Rollnick, S. (2023). *Motivational interviewing: Helping people change and grow* (4th ed.). Guilford Press.

Mostofi, N., & Collins, S. E. (2023). Impact of harm reduction treatment with or without pharmacotherapy on concurrent substance use among people experiencing homelessness and alcohol use disorder. *Journal of Addiction Medicine*, *17*(5), 574–579. https://doi.org/10.1097/ADM.0000000000001182

National Harm Reduction Coalition. (n.d.). *Getting off right: A safety manual for injection drug users*. https://harmreduction.org/issues/safer-drug-use/injection-safety-manual/

Northwest Addiction Technology Transfer Setting. (n.d.). *Screening, brief intervention, and referral to treatment (SBIRT).* https://attcnetwork.org/northwest-sbirt/

Nutt, D. J., Phillips, L. D., Balfour, D., Curran, H. V., Dockrell, M., Foulds, J., Fagerstrom, K., Letlape, K., Milton, A., Polosa, R., Ramsey, J., & Sweanor, D. (2014). Estimating the harms of nicotine-containing products using the MCDA approach. *European addiction research*, *20*(5), 218–225. https://doi.org/10.1159/000360220

Orley, J. H., Kuyken, W., World Health Organization. Division of Mental Health, Fondation IPSEN pour la recherche thérapeutique, & International Quality of Life Assessment in Health Care Settings Meeting (1993, Paris, France). (1994). *Quality of life assessment: International perspectives: Proceedings of the joint meeting organized by the World Health Organization and the Foundation IPSEN in Paris, July 2–3, 1993* (J. Orley & W. Kuyken, Eds.). Springer-Verlag. https://iris.who.int/handle/10665/41833

Substance Abuse and Mental Health Services Administration. (2024, July). *Key substance use and mental health indicators in the United States: Results from the 2023 National Survey on Drug Use and Health* (HHS Publication No. PEP24-07-021, NSDUH Series H-59). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://library.samhsa.gov/product/2023-nsduh-report/pep24-07-021

Tartarsky, A. (2007). *Harm reduction psychotherapy: A new treatment for drug and alcohol Problems*. Jason Aronson, Inc.

Tervalon, M., & Murray-García, J. (1998). Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved, 9*(2), 117–125. https://doi.org/10.1353/hpu.2010.0233