Harm Reduction—not a new concept in integrated health care

Daniel A. Nauts, MD, FASAM

dnauts@msn.com

406-868-7515

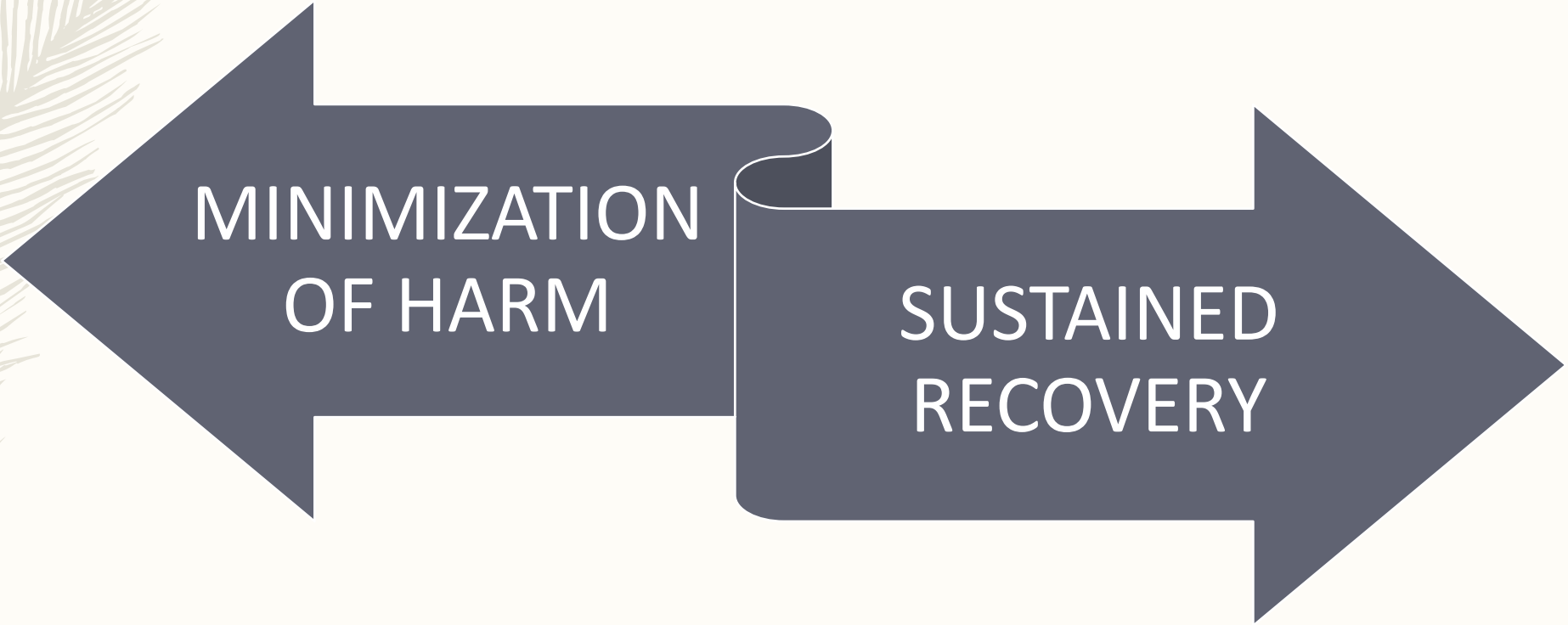
Harm Reduction

- The best should never be allowed to be the enemy of the good!
- Approach is person-centered, meet people where they are at.
- Reduce harms of SUDs to individuals and communities.
- Improved health and functioning of the individual is primary goal or outcome.
- Harm reduction interventions should be integrated into the continuum of SUD prevention and treatment.

TREATMENT GOALS

- Variable based on degree of ambivalence.
- Stage of change not the same for each identified problem.
- A harm reduction approach will apply to some problems and a comprehensive therapeutic approach to others.
- Engagement long term develops trust and an opportunity to facilitate change e.g., resolve ambivalence and facilitate determination.

TREATMENT GOALS—a Continuum



MINIMIZATION OF HARM

- Accept less engagement
- Accept less compliance
- Accept less adherence
- Accept the use of other substances
- Define the minimum, realizing the challenge for team buy-in.

SUSTAINED RECOVERY

- More engagement and broadening of social supports
- Compliant/committed/motivated/self actualizing
- Abstinence
- Growth and stability across multiple domains and determinants of health
- Lapses/relapses are the results of mistakes, not failures, and create learning opportunities and potential enhanced recovery.

What can you and your team tolerate???

- Think about the care provided other chronic diseases, like diabetes and the continuum of harm minimization to comprehensive care management
- What happens in AA? **“Keep coming back”**--regardless of abstinence—harm reduction through continued engagement
- What constitutes abandonment especially when relapse can be **LETHAL**?
- UDTs: are positives deal breakers? Therapeutic opportunities or requirement for punitive action?
- Functional status, is always the benchmark for potential intervention, especially with co-occurring patients