

Providing Mental Health Counseling Services at Harm Reduction Programs:
A Review of the Literature

Grace Bowe

Department of Counselor Education, State University of New York at Brockport

Master's Thesis

August 22, 2023

Abstract

This paper examines the need for mental health counseling services at harm reduction programs and seeks to answer the question of why mental health services may be beneficial to harm reduction programs and how best to implement and enact these services. It covers the rationale for providing these services, such as the lack of integrated substance use and mental health services and harm reduction programs' ability to engage hard-to-reach populations. The paper also summarizes the available research on existing counseling services at harm reduction sites and the broader field of harm reduction psychotherapy. From this literature, best practices for program design and therapeutic process for mental health counseling at these locations are identified.

Providing Mental Health Counseling Services at Harm Reduction Programs:

A Review of the Literature

Harm reduction programs, which are low-barrier service sites where individuals using drugs receive services to help reduce the risk of substance use and facilitate engagement in other services, are recognized for their ability to reach some of the most underserved and hard to engage populations of people using drugs (Allman et al., 2007; Lee & Zerai, 2010). The population served by these programs experience high rates of homelessness, isolation, financial insecurity and high rates of mental health concerns (Disney et al., 2006; Mackesy-Amiti et al., 2012). Simultaneously, a large body of research also suggests that the individuals served by harm reduction programs have limited interaction with traditional health care systems and have negative perceptions of the care they receive when they do engage, thus harm reduction programs can be an important point of entry into engaging with health and social services (Ahern et al., 2007; Biancarelli et al., 2019; Heimer, 1998). Despite this, very little research exists on integrating mental health counseling services into these programs when compared to similar services such as medication assisted treatment or medical care (Francia et al., 2022; Krawczyk et al., 2022). This paper thus seeks to answer the questions of why mental health counseling services may be beneficial and needed at the programs and how best to implement and enact these services.

Overview of Harm Reduction Programs

Harm reduction approaches to substance use were initially developed in the 1990s by people who used drugs and grassroots organizations to prevent the spreading of infectious disease such as HIV and to stop unintentional overdose (Marlatt, 1996). Over the three decades

since, harm reduction programs have become a widely established and evidence-based public health strategy to reduce the negative consequences of drug use and improve the wellbeing of people actively using drugs (Logan & Marlatt, 2010). As Allmann et al. (2007) write, these programs are valuable because “not only can sensitively delivered services help to reduce the harm associated with an individual’s drug use, they can lead also to broader improvements in health and employment outcomes and reduction in the risk of other harms, like crime and related violence” (Allman et al., 2007, p. 195). As harm reduction as an ideology and evidence-based practice has grown, so too have the programs and services offered by harm reduction organizations. These programs have grown from solely offering syringe exchange services, to also offering connection to on or off-site medical care and supportive services. (Allmann et al., 2007; Rogers & Reufli, 2004; Smye et al., 2011). In recognition that these programs have grown beyond their traditional provenance of seeking to reduce the infection diseases and overdose risk of injection drug use to holistic programs that seek to improve the general health and wellbeing of individuals who use drugs, Smye et al.’s (2011) definition of harm reduction is particularly useful. They write that harm reduction is:

An approach that represents a continuum of services that embody a philosophical, pragmatic and compassionate approach to providing care while minimizing the negative harms associated with substance use, understanding that not all people have the same ability to change, the same level of drug use, or even experience the same harms (Smye et al., 2011, p. 3).

Individual mental health counseling is one aspect of this continuum of services that can logically and beneficially be situated in harm reduction program’s menu of services.

Rationale for Offering Mental Health Counseling in Harm Reduction Programs

The best argument for why mental health counseling services are well suited to being offered at harm reduction program sites is that they could engage people in services who would not otherwise seek any sort of care (Little et al., 2008). Many treatment programs for either substance use or mental health require that a person either be abstinent from all substances prior to beginning treatment or have a desire to become fully abstinent as the goal of their treatment (Gallagher & Bremer, 2018; Logan & Marlatt, 2010). Thus, those who are actively using substances, or who do not have certainty that abstinence is their ultimate goal, may avoid or fear seeking treatment (Tatarsky & Kellogg, 2010). Individuals currently using drugs also may avoid seeking health services, including counseling or treatment, due to the stigma they experience at the locations where services are offered (Biancarelli et al., 2019). Research has shown that many providers hold stigmatizing beliefs about people who use drugs or who have mental health conditions, and these prejudiced beliefs impact the quality of health care received (Ahern et al., 2007; Biancarelli et al., 2019; Francia et al., 2022). Ahern et al. (2007) report that 'drug user' status can both hinder access to health care and affect the quality of care received. Concerningly, the same stigmatizing beliefs that dissuade people using drugs from seeking health care, including counseling and mental health care, can lead to an increase in mental health symptoms. Research shows that alienation (internalizing the idea that people who use drugs deserve marginalization) and discrimination due to drug use status and history are independent predictors of poorer mental health (Ahern et al., 2007).

Ability for Harm Reduction Programs to Engage Underserved Populations

While people using drugs frequently report having negative or stigmatizing experiences in the traditional health care system, harm reduction programs already serve successfully this population of individuals who may otherwise fall through the cracks of the existing treatment

infrastructure, and the programs and staff are usually experienced positively by program participants (Rogers & Ruefli, 2004). Multiple researchers have demonstrated that participants of needle exchange and harm reduction programs report feeling high levels of trust in the staff of the programs, greater than the trust they have in traditional medical or drug treatment programs (Treolar et al., 2016; MacNeil & Pauly, 2011; Lee & Zerai, 2010). Research by Treolar et al. (2016) found that participants in syringe exchange programs had high levels of trust in program staff and were willing to discuss sensitive and difficult subjects with program staff such as drug use or sexual health. The participants in the study reported that the trust they felt stemmed from the lack of stigma they experienced from staff, instead feeling like they were treated with respect and “like any other person” (Treolar et al., 2016, p. 138). Similarly, MacNeil and Pauly (2011) describe that needle exchange programs are experienced by participants as “safe havens in an unsafe world,” places where they will feel accepted and treated like human beings and where they will experience less of the stigma and marginalization they may encounter in most other health care or social services settings (p. 26). As a result of the intentional and successful cultivation of trust by harm reduction programs, these sites are logical and effective locations for mental health counseling services and are likely to produce positive results.

Need for Integration of Substance Use and Mental Health Services

The individuals who frequent harm reduction programs who may need mental health counseling services are further failed by the existing system by the lack of integrated services for both mental health and substance use concerns (Lawrence-Jones, 2010). While some programs exist that will admit and treat substance use and mental health interrelatedly and concurrently this is the exception rather than the rule - substance use treatment programs may be unwilling to work with individuals who have complex mental health comorbidities and mental health

programs unwilling to treat patients who are actively using substances, especially if these individuals are not currently willing to work toward sobriety (Krawczyk et al., 2022; Krejci et al., 2008; Tatarsky & Marlatt, 2010). The co-occurrence of substance use and mental health concern, often referred to as “dual diagnosis” or co-occurring disorders in the literature, is common (Mackesy-Amiti et al., 2012; Wang et al., 2016). Some research indicates that up to fifty percent of individuals with mental health conditions also meet diagnostic criteria for a substance use disorder (Mancini & Lindhorst, 2010). Individuals who are using drugs and suffering from mental health conditions however also have some of the poorest outcomes and retention in substance use treatment services, and the lowest rates receiving mental health treatment (Rhoades et al., 2014). Individuals with co-occurring disorders, rather than substance use or mental health concerns alone, are also at higher risk for adverse health and social outcomes such as homelessness, social isolation, and medical issues including infectious disease (Mancini & Lindhorst, 2010). In short, this population has some of the highest need for treatment and supportive services but is most likely to fall through the cracks of the existing system.

Substance use treatment and harm reduction services have traditionally been conceptualized as two separate pillars of the substance use service system, which is then itself conceptualized as a separate system from mental health services, with the exception of some specific services for individuals with “co-occurring disorders” (Krawczyk et al., 2022; Lawrence-Jones, 2010). This service ecosystem fails to acknowledge the reality that some degree of co-existing mental health concerns and substance use seems to be the rule not the exception, and that rather than being separate conditions and concerns these conditions are typically complexly interrelated and co-determined (Mancini & Lindhorst, 2010; Krejci et al., 2008) Service delivery for individuals with co-occurring disorders typically fall under one of three

service delivery models: serial (where one is treated for either substance use or mental health before beginning the other treatment), parallel (where treatment occurs at the same time in separate programs), or integrated (where treatment occurs simultaneously at the same program; Lawrence-Jones, 2010). Of the three models, integrated service typically has the best outcomes, though some research indicates this is also the rarest service delivery model (Lawrence-Jones, 2010; Jones and McCance-Katz, 2019). Even within an integrated program, different staff in the same program may treat someone for substance use or mental health rather than the same counselor addressing both issues. Lawrence-Jones (2010) notes that this separation of services can lead to individuals viewing and thinking about their substance use and mental health concerns as separate concerns, even when the etiology of both may be the same and considering them holistically leads to a more complete and useful conception of client needs.

Similarly, there is a systemic separation between harm reduction and substance use treatment services, which can obscure the fact that the clientele of these programs are also more similar than they are different (Krawczyk et al. 2022). Many individuals in traditional substance use treatment programs or mental health counseling still actively engage in drug use and many participants in harm reduction programs express a desire for some degree of treatment or help with substance use or mental health concerns (Krawczyk et al., 2022; Gallagher & Bremer, 2018). However, these services are rarely co-located or offered in an integrated manner, which may be the most beneficial model of offering services. As Krawczyk et al. (2022) write,

Creating a substance use service system that is truly person-centered and successful at improving health and dignity will necessitate moving away from the binary mentality of harm reduction vs. treatment to one which is better tailored to individual clients. This

includes offering a continuum of co-located treatment, harm reduction, and social services that can meet individuals where they are (Krawczyk et al., 2022, p.8).

In recent years, many strides have been made towards embracing greater unity between treatment and harm reduction services, particularly in regards to offering medication assisted treatment, such as buprenorphine, at syringe exchange programs or delivering treatment in a more harm reduction friendly manner, yet gaps in coverage are still wide particularly when it comes to offering counseling services at harm reduction programs (Krawczyk et al., 2022; Jakubowski & Fox, 2020).

Literature on Established Programs

There are very few research studies examining efficacy outcomes for offering mental health counseling at harm reduction programs, likely because these services are still in their infancy and historically most research on services for people actively using drugs have overwhelmingly focused on preventing infectious disease and overdose, or on facilitating entry to treatment (Wright & Tompkins, 2006; Wang et al., 2016). While there have been great strides in recent years to make medication assisted treatment available at harm reduction sites, and these services have been shown to be well received and efficacious for participants, research, and implementation of mental health counseling services in the same site lags behind (Krawczyk et al., 2022; Jakubowski & Fox, 2020). Some evidence shows that even in programs where harm reduction and medication assisted treatment services are offered at the same time, the percentage of individuals receiving either individual or group counseling services remains low. A study by Krawczyk et al. (2022) found that while “nearly all clients of MOUD [medication for opioid use disorder] only programs received individual counseling (93%), 27% of MOUD + SSP [syringe service program] clients and 30% of SSP only clients also indicated participating in this type of

service” (p.7). This may partially be due to harm reduction programs, in contrast to traditional treatment environments, being unlikely to mandate participation in counseling or psychosocial treatment as a prerequisite to receiving medication (Krawczyk et al., 2022; Smye et al; 2011). Harm reduction programs typically strive to make all service provision as low-barrier as possible, where individuals are allowed to self-determine their engagement in services, so participants may choose to engage with medication-based substance use treatment and not counseling, even when counseling is available (Jakubowski & Fox, 2020). Nonetheless, it's important to acknowledge that the limited engagement in counseling might stem from the reality that these initiatives are predominantly underfunded and positioned on the outskirts of the substance use service structure, with the same study finding that harm reduction programs simultaneously reach the highest risk populations but report the smallest numbers of staff and least available treatment services on site (Krawczyk et al., 2022, p. 8). While harm reduction approaches typically take the view that counseling should not be mandated to receive medication for opioid use disorders and research on, this does not negate that counseling is a need for this population or would benefit from services, only that these services should be offered on a voluntary basis (Jakubowski & Fox, 2020).

Research Showing Promising Potential for Counseling Services at Harm Reduction Sites

While harm reduction approaches to treatment don't support mandating participation in counseling, and research on counseling in harm reduction programs lagging perhaps as a result, there is still much evidence that suggest that mental health counseling is needed, beneficial, and well-situated within the milieu of harm reduction programming (Lee & Petersen, 2008; Krawczyk et al., 2022). This is seen in qualitative research which suggests that offering non-mandatory, low threshold counseling services makes these services more desirable and beneficial

to participants than traditional or mandated services. Snow et al.'s (2019) study of patient experiences in a low-threshold medication assisted treatment clinic, found that participants highly praised the voluntary nature of counseling services and wanted to participate in them, with one participant stating the following about the group counseling services:

I went to a lot of the groups after I had done detoxes or some sort of program so I already knew a lot about what they were saying. But I wasn't forced to do these groups. You are forced to do those [outside services] ones. There's a difference. This is participating on your own free will...their groups are helpful (p. 3).

The lack of a mandate made a significant impact on how this participant, and others in their research, experienced these counseling services and indicates there is potential that offering these low barrier services in harm reduction programs would result in people engaging in and benefiting from services they would otherwise avoid.

It is also worth considering the large body of research on the positive outcomes and connections to service experienced by participants in harm reduction services in general (Rogers & Ruefli, 2004). These programs have been shown to not only aid in reducing or controlling drug use, but also contribute to enhancing stability in terms of housing and economic well-being (Lee & Zerai, 2010). Furthermore, they play a role in strengthening family relationships, promoting engagement with healthcare services, and equipping participants with the skills to effectively cope with negative emotions (Rogers & Ruefli, 2004). Individuals who participate in syringe exchange service have also been shown to have significantly higher rates of entering and staying in substance use treatment (Krawczyk et al., 2022; Heimer, 1998). These impressive outcomes for greater health and wellbeing from participation in harm reduction services make it

easy to logically infer that counseling services offered in these programs may result in the similar engagement and positive outcomes. Making these services co-located at harm reduction programs increases the accessibility of the services for participants and the ability for program staff to easily connect participants to counseling and treatment when desired (Francia et al., 2022). Particularly relevant to considering the potential efficacy and outcomes of counseling and treatment services of harm reduction is qualitative research done by Lee and Peterson (2008) which found that participants of harm reduction programs experienced feelings of humanization and demarginalization when engaging in services and that this acceptance was crucial to their desire to engage and participate in treatment.

Strong evidence on the potential efficacy and benefit of offering counseling services at harm reduction programs also comes from a paper by Little and Franskoviak (2010), pioneers of the harm reduction therapy approach described later in this paper, where they summarize the work of the Harm Reduction Therapy Center in California which provides low-threshold harm reduction counseling at multiple community-based organizations, including needle exchange and harm reduction programs. While they did not conduct formal outcome research on the more than one thousand patients served by their programs, their client data gives evidence that suggests extremely positive outcomes. They write that of their total patient population:

approximately one-third attend regularly scheduled appointments, the rest see a therapist for at least brief encounters, and more than half attend drop-in groups regularly. At the time of writing, about 60% are successfully managing their substance use, 50% no longer present in crisis, 70% have more stable mental health, 60% are taking psychiatric medications, and 60% are more stable in housing (Little & Franskoviak, 2010, p.186).

They also note in the same paper that similar programs exist in New York and other parts of California and have demonstrated similar impressive ability to retain and engage clients in services and improve the health of this at-risk population.

Harm Reduction Psychotherapy

While offering counseling services in harm reduction programs is relatively new and understudied, there is an established literature on the theory and practice of harm reduction psychotherapy. Over the past twenty years, practitioners such as Tatarsky, Marlatt, Little, Denning and others have developed and published work on a model of therapy they call Harm Reduction Psychotherapy, intended to be the treatment wing of the harm reduction movement. (Denning, 2002; Little & Franskoviak, 2010; Logan & Marlatt, 2010; Tatarsky & Marlatt, 2010). While this work has not focused solely on offering harm reduction focused counseling services out of harm reduction programs, they have produced a body of research which lays a theoretical foundation for this work and show promising outcomes for this type of service (Little & Franskoviak, 2010; Logan & Marlatt, 2010; Vakharia & Little, 2017). Their work is rooted in established evidence-based models of psychotherapy as their own clinical practice and research (Tatarsky & Kellogg, 2010). In particular, Harm Reduction Psychotherapy stems from humanistic approach to counseling and psychotherapy and can be traced back to well-established and evidence-based theories in therapy and human behavior, such as Motivational Interviewing and Self Determination Theory (Ryan & Deci, 2000; Gallagher & Bremer, 2018; Vakharia & Little, 2017). These theories all emphasize the importance of intrinsic motivation over extrinsic motivation when it comes to effective behavior change. Additionally, they highlight the significance of self-efficacy, competence, and acceptance in facilitating meaningful transformations.

Harm Reduction Therapy is defined by its pioneers as a comprehensive method of working with individuals who use drugs, focusing on understanding drug use within a broader context (Logan & Marlatt, 2010; Tatarsky & Kellogg, 2010). This approach values and acknowledges the strengths of clients while respecting their autonomy. The therapy recognizes that people have various reasons for using substances, and their relationship with drugs, as well as their treatment requirements, are individualized (Vakharia & Little, 2017). It also aims to be an accessible therapeutic approach, meeting clients at their current stage and offering services aligned with their self-defined objectives (Denning, 2003). Just as the therapeutic philosophies it stems from highlight unconditional positive regard for clients and centering of clients' own goals, the broader field of harm reduction has always centered the need for services to accept all range of client goals and experience and allow them to determine how they engage with services (Marlatt, 1998). A common refrain in the harm reduction approach is to “meet clients where they are at”, accepting not only their current use of drugs but their own goals in regard to their substance use and overall health and wellbeing (Little & Franskoviak, 2010). In conventional substance use treatment, the counselor typically assumes an authoritative role and dictates the goals, interventions, and treatment outcomes (Krejci et al., 2008; Gallagher & Bremer, 2018). However, this approach often diminishes the client's sense of ownership and belief in their ability to make positive changes. In contrast, Harm Reduction Therapy emphasizes a cooperative and collaborative approach between the counselor and client, fostering a sense of ownership and empowerment for the client's progress in treatment.

Best Practices for Counseling Services at Harm Reduction Programs

From the research that exists regarding implementing both counseling and treatment services at harm reduction programs and the broader literature on the practice of harm reduction

psychotherapy, it is possible to identify several best practices for the design and implementation of counseling services at harm reduction locations. The literature on harm reduction programming has provided a well-defined set of principles and practices for services - principles that all medical, psychosocial or environmental interventions in these settings should adhere to (Mancini & Lindhorst, 2010; Logan & Marlatt, 2010). Services should be in line with the core ideals of harm reduction and should strive to be as accessible and low threshold as possible (Little & Franskoviak, 2010). Furthermore, the broad body of literature on harm reduction psychotherapy, even though not all is specific to practice in actual harm reduction programs, provides excellent insight into what the actual process of counseling in this setting should look like (Tatarsky & Kellogg, 2010; Vakharia & Little, 2017). In the following pages, specific best practices drawn from this literature will be described in more detail.

Fidelity to Harm Reduction Counseling Perspective

As mentioned earlier, while practicing counseling utilizing the theoretical perspective of Harm Reduction Therapy is not limited to harm reduction program settings, any counseling offered in the locations will be most effective if it retains fidelity to this established model, as well as the established tenets of the harm reduction movement (Vakharia & Little, 2017). As harm reduction has grown in popularity, availability, and acceptance, the definition of what this concept means in practice may become distorted (Allman et al., 2007; Mancini & Linhorst, 2010). Mancini and Linhorst (2010) give an example of how some practitioners may interpret the idea of harm reduction in different ways, resulting in enacting interventions that increase, rather than decrease, harm. They write of service providers who chose, under the guise of practicing harm reduction, to retain and slowly dole out money from clients benefit checks so clients would not spend too much of their income on drugs. While this intervention was well

intentioned and intended to reduce harm, for some individuals it ended up doing the opposite because “ clients are then forced to panhandle; exchange belongings, food, or sex for drugs; or purchase drugs ‘on credit’ from drug dealers” (Mancini & Linhorst, 2010, p.136). Similar missteps are possible in counseling services if therapists rely on what “feels” beneficial or harm reducing in a given situation, rather than falling back on what the established literature and history of what harm reduction should mean - supporting individual clients to reach whatever self-determined positive change they seek to make (Karoll, 2010; Marlatt, 1998; Vakharia & Little, 2017). It is not the practitioner’s job to determine what harm reduction and positive change look like for a client, rather they are there to help a client explore and achieve this for themselves (Little & Franskoviak, 2010). When considering best practices for counseling in harm reduction programs, it is essential that the service operate based on established concepts and models of harm reduction services, rather than resorting to doing the definitional work themselves.

Similarly, while some practitioners have recently re-conceptualized harm reduction as a step on the road to abstinence from substance use, this is not how most choose to view the goal of harm reduction programming and harm reduction therapy (Logan & Marlatt, 2010; Vakharia & Little, 2017). As Little and Franskoviak (2010) write, “the goal of harm reduction is harm reduction” - and this will mean something slightly different to every individual engaging with counseling services (Little & Franskoviak, 2010, p. 177). A counselor meeting a client should be prepared and willing to work with a client who has the desire to work towards total abstinence from substance, someone who may be considering making some changes, and an individual who has no desire to change their relationship or patterns of substance use whatsoever but still wants support and care to work on other goals they might have regarding their mental or

socioeconomic wellbeing (Logan & Marlatt, 2010). Harm reduction therapeutic approaches remove the focus on abstinence as an expected or even desired outcome of treatment. Instead, the goal of harm reduction therapy is “any positive change” (Little & Franskoviak, 2010). A harm reduction therapeutic mindset recognizes that some of the work they do with clients might be related to working on a client’s relationship to substance use and much may not (Tatarsky & Kellogg, 2010; Tatarsky & Marlatt, 2010). Following from this viewpoint, the field of harm reduction counseling does not make a distinction between the work of doing “substance use counseling” and “mental health counseling” (Tatarsky & Kellogg, 2010; Denning, 2002). Instead, Harm Reduction Therapy, and any counseling performed in harm reduction programs, should be based in an integrated biopsychosocial, rather than a sequential, model of treatment. In other words, clients are treated simultaneously for their substance use, emotional and psychiatric, and environmental concerns - as the field views all three as unextractable (Little, 2006).

Low-Threshold

A core component of the harm reduction programs, and a necessary factor in integrating counseling and psychotherapy into these programs is that these interventions have low barriers to entry and that few conditions on how people engage and participate in them. This model of engagement has become known as “low-threshold” services. (Edland-Gryt & Skatvedt, 2013) As Little and Franskoviak (2010) write, these programs are specifically designed for those individuals who cannot

Meet the high threshold requirements of other clinics, such as sitting quietly in a clinic waiting room, having the attention span or comprehension skills to fill out intake paperwork, or possessing the trust to enter an office with a staff person with the door closed (p.179)

Services are offered on an on-demand, walk-in basis and can take the form of whatever is needed for a particular client and a particular time, and clients are accepted as they are - without any expectation on them to change or engage in a certain manner (Denning, 2002; Vakharia & Little, 2017).

Many traditional treatment programs have high expectations for client behavior, and client deviations from these prescribed rules may result in them being labeled as difficult patients, or, at worst, unable to receive services from the program. (Edland-Gryt & Skatvedt, 2013; Wang et al., 2016). For instance, clients who come into programs high, loudly voice their displeasure with their circumstances or treatment, or who frequently miss appointments may be labeled as people who are unable or unwilling to benefit in service, rather than considering that the services offered are unable or unwilling to benefit the individual (Denning, 2002; Edland-Gryt & Skatvedt, 2013). As Little and Franskoviak (2010) write, “under the guise of creating “safety” for both clients and staff, programs frequently create rules and systems to prohibit these and many other “disruptive” behaviors. Often this is more about staff comfort than actual safety” (p. 181). It may take more staff work and effort to be able to manage and respond to complex or challenging client behaviors therapeutically, but by being unable to accommodate, conceptualize, and accept certain challenging clients’ actions, it perpetuates a system where those most in need of help and services are unable to receive them (Dodd et., 2016; Francia et al., 2016).

The literature illuminates how low-threshold service programs are not only easy to access for many individuals, but the services are also appealing and experienced positively by participants (Krawczyk et al., 2022; Snow et al., 2019; Treolar et al., 2016). A qualitative study of patient experiences and a low-threshold bridge clinic providing medication and treatment for

opioid use highlights that patients felt the lack of punitive or stringent requirements for participation and engagement made them more willing to enter and stay engaged in services (Snow et al., 2019). The authors found that:

Patients highlighted the benefits of universally reported that the lack of a “controlling environment” in this clinic helped them stay engaged, emphasizing that “many addicts feel out of control...and I think they need a little less control, just to decide something on their own. This clinic allows you to do that (Snow et al., 2019, p. 3).

Some arguments against low-threshold models are that it enables individuals to avoid needed treatment, however research seems to show the opposite - that participants want to engage more and get more benefit from services that are flexible enough to meet their needs (Edland-Gryt & Skatvedt, 2013; Snow et al., 2016; Little and Franskoviak, 2010).

Counseling Process

In addition to being structured on the programmatic level as low-threshold, integrated, and harm reducing, mental health counseling services should adhere to these same tenants during the actual practice of counseling. This means that assessment, treatment planning, and measuring outcomes should be carefully considered to ensure they are in line with a Harm Reduction Psychotherapy theoretical lens (Tatarsky & Marlatt, 2010). Additionally, in these settings it is of crucial importance to ensure services are trauma informed and attuned to the systemic injustices and barriers clients might face (Krejci et al., 2008).

Assessment and Treatment Planning

From the initial interaction, the practitioners’ goal must be to begin developing a collaborative helping relationship (Vakharia & Little, 2017). Assessment processes, in addition,

should be flexible in their duration and timeline of completion, should hold true to both harm reduction principles and humanistic, person-centered counseling approaches, focusing on client selected goals and aims. As Karoll (2010) writes “in the assessment process, practitioners need to focus upon the clients’ current situation, their wants, and information on what worked in the past so as to identify personal and environmental strengths applicable to resolving the present identifying problems” (p. 267). Regarding treatment planning, a similar process should occur where the goals selected come from the client and strengths are highlighted, even when that goal may include continuing to use substances, albeit more safely. While these tenants may seem commonplace and unremarkable for mental health counselors, whose professional training and code of ethics teach them to prioritize clients' voice and goals in the assessment and treatment planning process, it is worth highlighting how typical service provision and institutional requirements often prevent this from occurring in practice in traditional service settings (Krawczyk et al., 2022; Francia et al., 2022). As Lawrence-Jones (2010) writes, most mental health and substance use services and program “tend to have a specific remit which often results in interventions being narrowly defined rather than person centered and needs-led” (p. 117) This often is caused by requirements and processes well above the individual therapist’s control or domain, such as insurance or funding mandates. Regardless, the trickle-down effect creates therapeutic processes that is inconsistent with the tenets of a harm reduction approach such as high-barrier intake processes, where a large body of information must be disclosed before services even begin, or adherence in treatment plans to certain goals such as reduced substance use or engagement in pre-determined services (Edland-Gryt & Skatvedt, 2013; Lawrence-Jones, 2010). The individual therapist thus has an obligation to avoid or mitigate these requirements as much as possible in order to maintain a harm reduction approach, and program directors should

examine program structure to ensure therapists are able to truly practice in a harm reducing manner.

In contrast to these high barrier approaches to assessment and treatment planning, when practicing from a harm reduction therapy standpoint it is not important to find out about the clients' treatment objectives or even the precise details of their use during the initial visits (Little & Franskoviak, 2010; Little et al., 2008). It is normal for clients to be unsure of what changes, if any, they want to make, and therapy is meant to assist clients explore these possibilities rather than to accomplish a predetermined goal (Denning, 2003). By not anticipating any disclosure, the counselor is also demonstrating respect for the client's right to self-determination (Logan & Marlatt, 2010). The counselor also should not take an authoritative role and dictate the goals, interventions, and outcomes of therapy as this can diminish the client's sense of ownership and belief in their ability to make positive changes (Gallagher & Bremer, 2018). A harm reduction therapy approach instead emphasizes a cooperative and collaborative approach between the counselor and client, fostering a sense of ownership and empowerment for the client's progress in treatment (Little & Franskoviak, 2010).

Length of Treatment Time

Some research on harm reduction-based, low-threshold services takes the view that these programs should be transitional and a bridge to engage hard to reach populations in more traditional services (Snow et al., 2019). While “bridge” models of care demonstrate some effectiveness in engaging individuals in mental health services or medication immediately while waiting for other services to be able to admit them, the idea that low-threshold, harm reduction services should only be transitional or temporary leaves much to be desired (Taylor et al., 2023).

In Snow et al.'s (2019) study of patient experiences at a low-threshold "bridge" clinic, they report that most patients disliked the transitional nature of the service, finding that most participants wanted to stay in the low-threshold program indefinitely. They write,

While some said they worked with the resource specialist to transition out smoothly, others said they felt like they were "stepping on hot coals" when coming to clinic follow-up, wondering if this would be the week "that they'd - throw me out" (Snow et al., 2019, p. 5).

The positive experiences patients had with low-threshold services did not make higher threshold services thus more appealing and easier to access, they simply made the idea of leaving the low-threshold service anxiety-provoking. Little and Franskoviak (2010) report that they have experienced the same phenomenon in their harm reduction therapy programs in community-based settings, writing "our attempts to refer clients to other mental health or substance abuse programs, and the clients' previous attempts at treatment, have been largely unsuccessful" (p. 178). Most literature on harm reduction therapy thus emphasizes that the ideal is that services have no set duration or requirement on participation (Denning, 2002; Little et al., 2008). Services are best when they can be engaged with as frequently or infrequently as individuals choose, and for as long a time period as they choose. As Little and Franskoviak (2010) write, the ideal service model is one where "clients can move in and out or vary the intensity of treatment, depending upon their needs. In other words, they can regulate the "dosage" of treatment in the same way that they dose themselves with their drugs" (p. 180). Clients' ability to make self-determined decisions about the length of treatment is supported. The fact that there is no stated limit on involvement also acknowledges the complexity of the difficulties that participants face and the possibility that change may be a drawn-out or cyclical process (Denning, 2002). Giving

clients more control over treatment length improves their capacity for independent decision-making. It also respects the complexity of the difficulties participants experience and the possibility that the process of bringing about change may be prolonged or repetitious by refraining from a strict time limit on participation (Tatarsky & Logan, 2010).

Measuring Success

When it comes to measuring success and treatment outcomes, an important component of ensuring services are effective and positively benefit clients, some counselors and program managers may struggle with the circuitousness of change for this population and lack of ability to measure change in the same way a substance use treatment program might, such as reductions in symptoms or cessation of substance use (Logan & Marlatt, 2010; Mancini & Linhorst). Compared with these traditional markers of progress in counseling and treatment, Lee and Zerai (2010) offer a different conceptualization on how to measure outcomes for harm reduction programs. They introduce the concept of “demarginalization”, the feeling participants experience at these programs that they matter and are valued. Their research show that that this report feeling of demarginalization, which is fostered by the unconditional acceptance and non-judgment offered and subsequent relationship building found in harm reduction programs, is linked to outcomes such as the increased willingness to participate in treatment, being able to better articulate their goals, and overall increased quality of life (Lee and Zerai, 2010) . Using this framework in harm reduction counseling, rather than simply decreases in substance use or mental health symptoms, is a recommended approach. Little and Franskoviak (2010) also detail how engagement in services in itself is a positive and trackable way to measure success and client engagement for harm reduction psychotherapy in low-threshold programs.

Integrated and Systems Approach

In any counseling environment, it is essential to recognize the inherent power dynamics in the therapeutic relationship and strive to build relationships that empower and try to move clients out of marginalization rather than sustain existing power structures. This is particularly crucial when counseling in a harm reduction environment, where many participants are marginalized not just by their drug use, housing or mental health status, but other intersecting facets of identity such as race, gender, and socioeconomic status (Smye et al., 2011). The clients of harm reduction programs are people who use drugs, people who are frequently homeless or living in poverty, people who engage in transactional sex, or people who are HIV positive (Allman et al., 2007; Lee & Zerai; 2010). They are people who are typically on the margins of society, and who face stigma and discrimination in multiple areas of their lives and identities. As Freedman et al. (1996) elucidate, the therapist's words carry significant weight in therapy, whether desired or not, and despite efforts to mitigate this. To prevent the perpetuation of disempowering dialogues during counseling, counselors need to be conscious of their personal biases, perspectives, and presumptions.

Moreover, when interpreting a client's issues, counselors must take into account the cultural and social contexts in which these problems arise. As Smye et al. (2011) write, "harm reduction approaches that fail to address the multiple intersections that influence peoples' health and well-being and their experiences of and responses to mental health and addictions care may also fail to improve health in a meaningful way" (p. 2). Addressing the client's environment is essential in providing comprehensive solutions to their needs, as solely focusing on individual solutions is often insufficient to address the complex concerns individuals bring into counseling (Little & Franskoviak, 2010; Tatarsky & Kellogg, 2010). In order to truly understand and assist clients whose concerns stem partially or primarily from environmental issues, counselors must

adopt a person-centered approach and be open to taking on non-traditional roles (Carver et al., 2020; Francia et al., 2022). This may include helping clients' access resources for financial stability, housing, or other environmental challenges, and collaborating with other professionals who possess expertise in areas beyond the counselor's own knowledge (Killiam & Reppert, 2013).

While harm reduction therapists should be willing to take a holistic and inclusive approach to counseling work and spend time in sessions addressing social determinants of health such as assisting with linking to entitlements and basic living needs, it is important to not let the "case management" tasks and needs be the sole focus of their work (Little & Franskoviak, 2010). There may well be priority needs that must take precedence over any other work - ensuring basic living needs such as food are met, dealing with safety concerns, or addressing factors that prevent individuals from getting to the locations where therapy is offered or participate in sessions - and a therapist should take the lead in letting clients determine what issues or services are most important at any given time (Killiam & Reppert, 2013). However, therapists should not lose sight that just because the patient population has complex, overlapping needs that are at times relating to their very survival, they are also in need of the same thing from therapy as any other patient: a safe and trusting environment to explore their suffering, identity, and goals for the future (Tatarsky & Kellogg, 2010). As Little and Franskoviak (2010) write, case management alone does not "allow the time or space for people to sit with no other goal than to talk about the horrors of their pasts, the difficulties of day-to-day life, their dreams and hopes, and their relationship with drugs and alcohol" (p. 187) Counselors must balance working systemically and in tandem with other professions to address environmental forces that impact well-being without

losing sight of the intrapsychic and interpersonal concerns that are uniquely addressed in a therapeutic relationship.

Finally, counselors must be prepared to challenge structural inequities that prevent personal development both inside the mental health and substance use system and in society at large. It is critical for counselors to take part in advocacy on a larger scale, speaking out against laws, prejudice, and structural inequalities that limit their clients' capacity to improve their well-being, form good self-concepts, and live in safety and security. According to Killiam and Reppert (2013), "to ignore the need for systemic changes is paramount to blaming the client for her current situation and telling her how to fix herself" (p. 11). While therapy may assist clients in overcoming and coping with the consequences of marginalization and discrimination, it is the ethical responsibility of a harm reduction therapist to acknowledge and work against the societal injustices that have contributed to this individual's suffering, which include policies and procedures in the mental health and substance use treatment ecosystem which perpetuate marginalization (Smye et al., 2011).

Trauma-Informed

In addition to being systematic and integrated, counseling services in a harm reduction environment also must be trauma-informed - meaning the therapist must view the impact of trauma as central in understanding a client's experiences, behaviors, and symptoms (Krejci et al., 2008). Trauma is extraordinarily prevalent in the lives of individuals who use drugs and who suffer from mental health characteristics, and this trauma is often re-experienced by clients in traditional service settings (Krejci et al. 2008, Rogers & Ruefli, 2004; Killam & Reppert, 2013). The harm reduction model, which places an emphasis on client autonomy and relationship building, is thus already a more appropriate approach for individuals who have experienced

trauma than some older approaches to substance use treatment (Tatarsky & Kellogg, 2010). Because people are believed to be in denial about their use, confrontational or more authoritative tactics may frequently be used in traditional substance use approaches to address substance use. For trauma survivors who "may be especially prone to mistrust and vigilant for signs of interpersonal danger", this method is not therapeutic (Krejci et al., 2008, p. 265). Being trauma-informed also involves being consistent and predictable in the provision of services (Vakharia & Little, 2017). Programs that are constant and predictable, with little variation in the schedule or availability of services delivered unless there are urgent situations, are essential for ensuring that services are trauma-informed. A departure from the usual or a lack of consistency in services may discourage people from continued engagement who may find it difficult to trust in health care providers or other people as a result of past trauma (Krejci et al., 2008; Killam & Reppert, 2013).

Implementation and Barriers

As one may gather from reading about best practice for mental health counseling services at harm reduction programs, the ideal for service delivery may be incompatible with the existing systems for funding and monitoring mental health and substance use services. As mentioned earlier, the integrated and holistic nature of services, where mental health concerns and substance use are treated in a holistic and integrated frame rather than independent concerns to be addressed by separate individuals or even programs, may pose difficulties to a system where funding for mental health and substance use is often delivered through separate funding streams and grants (Lawrence-Jones, 2010). Funding for substance use programs has been traditionally limited in comparison with funding for health interventions, and harm reduction programs are

marginalized even within that small piece of the pie (Krawczyk et al., 2022). As Krawczyk et al. (2022) note,

Many harm reduction services operate independently from the medical system and are not eligible for insurance reimbursement. Additionally, programs have been historically banned from accessing federal and local funds for SSPs [syringe service programs]; programs have had to depend on scarce funds acquired through a combination of small grants, individual donations, and charitable foundations (p. 7).

While considering how to implement counseling services in harm reduction settings, it should be acknowledged that available funding streams may not allow for perfect fidelity to harm reduction principles and practices (Mancini & Linhorst, 2010). The best practice guidelines should form a theoretical foundation from which services are developed, but deviation to meet both funding requirements and to best suit unique locales may be required.

Conclusion

Harm reduction programs have grown from their beginnings as an intervention to reduce death and disease for people who use injection drugs to comprehensive programs seeking to increase overall health and wellbeing for all people who use substances. Integrating mental health counseling services into the programs that already successfully serve some of the most underserved individuals helps extend counseling and treatment services to those who may otherwise be failed by the existing substance use and mental health treatment system, which has historically prioritized abstinence-only substance use treatment and been comprised of fragmented and siloed mental health and substance use services. Research on offering counseling and psychotherapy at these sites is still somewhat limited and it is clear more research is needed,

particularly on outcomes and efficacy for these services. However what research exists does show great promise for the potential of these programs and from this literature one is able to identify core components necessary for the success of the program and the counseling process within them. Ensuring fidelity to a harm reduction viewpoint and ensuring that services are flexible, low-threshold, integrated and trauma-informed will lead to the best chance of success for counseling service at harm reduction programs.

References

- Ahern, J., Stuber, J., & Galea, S. (2007). Stigma, discrimination and the health of illicit drug users. *Drug and Alcohol Dependence*, 88(2–3), 188–196.
<https://doi.org/10.1016/j.drugalcdep.2006.10.014>
- Allman, D., Myers, T., Schellenberg, J., Strike, C., Cockerill, R., & Cavalieri, W. (2007). Improving health and social care relationships for harm reduction. *International Journal of Drug Policy*, 18(3), 194–203. <https://doi.org/10.1016/j.drugpo.2006.07.005>
- Biancarelli, D. L., Biello, K. B., Childs, E., Drainoni, M., Salhaney, P., Edeza, A., Mimiaga, M. J., Saitz, R., & Bazzi, A. R. (2019). Strategies used by people who inject drugs to avoid stigma in healthcare settings. *Drug and Alcohol Dependence*, 198, 80–86.
<https://doi.org/10.1016/j.drugalcdep.2019.01.037>
- Carver, H., Ring, N., Miler, J., & Parkes, T. (2020). What constitutes effective problematic substance use treatment from the perspective of people who are homeless? A systematic review and meta-ethnography. *Harm Reduction Journal*, 17(1), 10.
<https://doi.org/10.1186/s12954-020-0356-9>
- Denning, P. (2002). Harm Reduction Group Therapy. In A. Tatarsky, *Harm Reduction Psychotherapy: A New Treatment for Drug and Alcohol Problems* (pp. 310–346). Jason Aronson, Incorporated. <https://books.google.com/books?id=hu0pVjZhhD8C>
- Disney, E., Kidorf, M., Kolodner, K., King, V., Peirce, J., Beilenson, P., & Brooner, R. K. (2006). Psychiatric comorbidity is associated with drug use and HIV risk in syringe exchange participants. *Journal of Nervous & Mental Disease*, 194(8), 577–583.
<https://doi.org/10.1097/01.nmd.0000230396.17230.28>
- Dodd, Z., Banga, C. A., Mason, K., Meaney, C., Leszcz, M., & Sockalingam, S. (2016).

- Engagement in group psychotherapy among marginalized individuals with hepatitis C. *International Journal of Group Psychotherapy*, 66(3), 338–360.
<https://doi.org/10.1080/00207284.2016.1149410>
- Edland-Gryt, M., & Skatvedt, A. H. (2013). Thresholds in a low-threshold setting: An empirical study of barriers in a centre for people with drug problems and mental health disorders. *International Journal of Drug Policy*, 24(3), 257–264.
<https://doi.org/10.1016/j.drugpo.2012.08.002>
- Francia, L., Lam, T., Berg, A., Morgan, K., Savic, M., Lubman, D. I., & Nielsen, S. (2022). Putting out the welcome mat—A qualitative exploration of service delivery processes and procedures as barriers to treatment-seeking for people who use alcohol and other drugs. *Drug and Alcohol Review*, dar.13551. <https://doi.org/10.1111/dar.13551>
- Freedman, J., Jill, M. S. W. F., & Combs, G. (1996). *Narrative Therapy: The Social Construction of Preferred Realities*. Norton.
- Gallagher, J. R., & Bremer, T. (2018). A perspective from the field: The disconnect between abstinence-based programs and the use of motivational interviewing in treating substance use disorders. *Alcoholism Treatment Quarterly*, 36(1), 115–126.
<https://doi.org/10.1080/07347324.2017.1355223>
- Heimer, R. (1998). Can syringe exchange serve as a conduit to substance abuse treatment? *Journal of Substance Abuse Treatment*, 15(3), 183–191. <https://doi.org/10/djjhfx>
- Jakubowski, A., & Fox, A. (2020). Defining low-threshold buprenorphine treatment. *Journal of Addiction Medicine*, 14(2), 95.
- Jones, C. M., & McCance-Katz, E. F. (2019). Co-occurring substance use and mental disorders among adults with opioid use disorder. *Drug and Alcohol Dependence*, 197, 78-82.

- Karoll, B. R. (2010). Applying social work approaches, harm reduction, and practice wisdom to better serve those with alcohol and drug use disorders. *Journal of Social Work, 10*(3), 263–281. <https://doi.org/10.1177/1468017310363635>
- Killam, W., & Reppert, M. L. (2013). Interviews with formerly homeless African American women about the benefits of counseling and the process of change. *VISTAS Online, 1*–13.
- Krawczyk, N., Allen, S. T., Schneider, K. E., Solomon, K., Shah, H., Morris, M., Harris, S. J., Sherman, S. G., & Saloner, B. (2022). Intersecting substance use treatment and harm reduction services: Exploring the characteristics and service needs of a community-based sample of people who use drugs. *Harm Reduction Journal, 19*(1), 95. <https://doi.org/10.1186/s12954-022-00676-8>
- Krejci, J., Margolin, J., Rowland, M., & Wetzell, C. (2008). Integrated group treatment of women's substance abuse and trauma. *Journal of Groups in Addiction & Recovery, 3*(3–4), 263–283. <https://doi.org/10.1080/15560350802424886>
- Lawrence-Jones, J. (2010). Dual diagnosis (drug/alcohol and mental health): service user experiences. *Practice, 22*(2), 115–131. <https://doi.org/10.1080/09503151003686684>
- Little, J., & Franskoviak, P. (2010). So glad you came! Harm reduction therapy in community settings. *Journal of Clinical Psychology, 66*(2), 175–188. <https://doi.org/10.1002/jclp.20673>
- Little, J., Hodari, K., Lavender, J., & Berg, A. (2008). Come as you are: Harm reduction drop-in groups for multi-diagnosed drug users. *Journal of Groups in Addiction & Recovery, 3*(3–4), 161–192. <https://doi.org/10.1080/15560350802424845>
- Logan, D. E., & Marlatt, G. A. (2010). Harm reduction therapy: A practice-friendly review of

- research. *Journal of Clinical Psychology*, 66(2), 201–214.
<https://doi.org/10.1002/jclp.20669>
- Mackesy-Amiti, M. E., Donenberg, G. R., & Ouellet, L. J. (2012). Prevalence of psychiatric disorders among young injection drug users. *Drug and Alcohol Dependence*, 124(1–2), 70–78. <https://doi.org/10.1016/j.drugalcdep.2011.12.012>
- Macneil, J., & Pauly, B. (2011). Needle exchange as a safe haven in an unsafe world. *Drug and Alcohol Review*, 30(1), 26-32.
- Mancini, M. A., & Linhorst, D. M. (2010). Harm reduction in community mental health settings. *Journal of Social Work in Disability & Rehabilitation*, 9(2–3), 130–147.
<https://doi.org/10.1080/1536710X.2010.493481>
- Marlatt, G. A. (1996). Harm reduction: Come as you are. *Addictive Behaviors*, 21(6), 779–788.
[https://doi.org/10.1016/0306-4603\(96\)00042-1](https://doi.org/10.1016/0306-4603(96)00042-1)
- Rhoades, H., Wenzel, S. L., Golinelli, D., Tucker, J. S., Kennedy, D. P., & Ewing, B. (2014). Predisposing, enabling and need correlates of mental health treatment utilization among homeless men. *Community Mental Health Journal*, 50(8), 943–952.
<https://doi.org/10.1007/s10597-014-9718-7>
- Rogers, S. J., & Ruefli, T. (2004). Does harm reduction programming make a difference in the lives of highly marginalized, at-risk drug users? *Harm Reduction Journal*, 1(1), 7.
<https://doi.org/10.1186/1477-7517-1-7>
- Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *The American Psychologist*, 55(1),
- Smye, V., Browne, A. J., Varcoe, C., & Josewski, V. (2011). Harm reduction, methadone

- maintenance treatment and the root causes of health and social inequities: An intersectional lens in the Canadian context. *Harm Reduction Journal*, 8(1), 17.
<https://doi.org/10.1186/1477-7517-8-17>
- Snow, R. L., Simon, R. E., Jack, H. E., Oller, D., Kehoe, L., & Wakeman, S. E. (2019). Patient experiences with a transitional, low-threshold clinic for the treatment of substance use disorder: A qualitative study of a bridge clinic. *Journal of Substance Abuse Treatment*, 107, 1–7. <https://doi.org/10.1016/j.jsat.2019.09.003>
- Taylor, J. L., Wakeman, S. E., Walley, A. Y., & Kehoe, L. G. (2023). Substance use disorder bridge clinics: models, evidence, and future directions. *Addiction Science & Clinical Practice*, 18(1), 1-13.
- Tatarsky, A., & Kellogg, S. (2010). Integrative harm reduction psychotherapy: A case of substance use, multiple trauma, and suicidality. *Journal of Clinical Psychology*, 66(2), 123–135. <https://doi.org/10.1002/jclp.20666>
- Tatarsky, A., & Marlatt, G. A. (2010). State of the art in harm reduction psychotherapy: An emerging treatment for substance misuse. *Journal of Clinical Psychology*, 66(2), 117–122. <https://doi.org/10.1002/jclp.20672>
- Treloar, C., Rance, J., Yates, K., & Mao, L. (2016). Trust and people who inject drugs: The perspectives of clients and staff of Needle Syringe Programs. *International Journal of Drug Policy*, 27, 138–145. <https://doi.org/10.1016/j.drugpo.2015.08.018>
- Vakharia, S., & Little, J. (2017). Starting where the client is: Harm reduction guidelines for clinical social work practice. *Clinical Social Work Journal*, 45.
<https://doi.org/10.1007/s10615-016-0584-3>
- Wang, L., Panagiotoglou, D., Min, J. E., DeBeck, K., Milloy, M. J., Kerr, T., Hayashi, K., &

- Nosyk, B. (2016). Inability to access health and social services associated with mental health among people who inject drugs in a Canadian setting. *Drug and Alcohol Dependence*, 168, 22–29. <https://doi.org/10.1016/j.drugalcdep.2016.08.631>
- Wright, N., & Tompkins, C. (2006). How can health services effectively meet the health needs of homeless people? *British Journal of General Practice*, 8.