The Learning Curve Institute

bespoke training in mental health, addiction and best practice in the workplace

Solution Focused Harm Reduction

A Compassionate Approach to Treating Adults with Substance Use Disorders

Dr. Seán Foy

The Learning Curve Institute.

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What I hope to do in this workshop

- Provide some background information on my work
- Provide an overview of SFBT and Harm Reduction
- Describe how they can work together
- Provide case studies to explain how we can use SFBT and Harm Reduction

A Little Introduction

- I have worked in the caring profession for over 30 years
- I initially qualified in addiction work, then I qualified as a Social Worker and I now work as a Clinical psychologist
- I have worked in Direct access hostels, detox's , rehabs and outreach work
- I worked as a manager in one of the first "wet" services in London
- I was first introduced to Solution Focused work in 1992

Exercise

I would be grateful if you could create a scenario or scenarios in the chat

Feel free to make it as complicated as you like, I just need the age, gender, what the issue is etc.

And please include:

- how the person feels about the issue
- do they want to change
- Are they unsure of what to do

Thanks

Exercise

- Please imagine we are about to put an advertisement in a local paper for someone to live the life of the scenario you have created.

- Please write the strengths someone would need to have in order to live this life for 6 months. The person's situation does not change over the 6 months, it stays the same.

- The only "Rule" is that whatever you write down must be positive.

People are doing the best that they can, given the circumstances they are in.

What do you think Harm Reduction is ?

What is Harm Reduction

In it’s simplest form Harm Reduction is the process of reducing the harms that exist with drug and/or alcohol use.

Harm Reduction… Continued

- It is aimed at working with clients “where they are at”.
- Abstinence is not the primary goal.
- Any reduction or stabilisation in drug use is determined by the person.

Principles of Harm Reduction

- **Pragmatism**
- **Human Rights**
- **Focus on Harms**
- **Maximise Intervention Options**
- **Priority of Immediate Goals**
- **Drug User Involvement**

(British Columbia Ministry of Health, 2005)

Principles of Harm Reduction Therapy/Treatment

- Engagement in treatment is a primary goal
- Many users are unwilling or unable to stop
- Abandon the abstinence requirement
- Use a lower threshold for treatment

Principles of Harm Reduction

- Drug use can be seen along a continuum of risk i.e. ways in which drugs are used may increase risk
- As a result any reduction in drug use or safer use practices can be viewed as success
- By reducing drug use or using in a safer way, the client is beginning a process of positive change

Principles of Harm Reduction

- Client provides the goals and the change strategy
- Worker and client working together to identify and resolve issues as they arise
- De-stigmatising drug use

What Harm Reduction is not…

- Harm Reduction does not advocate or condone alcohol or drug use.
- It is not coercive.
- It does not ignore or minimize the many "down-sides" of drug use (such as death, arrest or illness).

Common arguments for and against…

- **<u>Against Harm Reduction:</u>**
- Condones drug use
- Encourages use
- We accept defeat in the “War on Drugs”
- Sends “the wrong message”…

- **<u>For Harm Reduction:</u>**
- Works with people where they are at
- Provides options for those unwilling or unable to aim for abstinence
- Lessens the pressure on Emergency Departments
- Saves lives

How do you think a Solution focused Approach may work with Harm Reduction ?

A Solution Focused (SFBT) Approach

- A helpful conversation
- A collaborative approach
- Person's wishes and hopes are respected
- Person's abilities and resources are acknowledged and valued, e.g. a client who is reducing or stabilising their drug use
- The steps that the person has taken to address their drug use is acknowledged and a discussion about preferred futures may be started

Change Exercise

- Please think about a change you have made in your life, I won't ask what it is.
- Think about this change and the people who helped you make that change.
- What characteristics did they have that meant they helped you make that change? For example were they optimistic, did they believe in you etc. Also please discuss the characteristics of the people who did not help you make that change.

The SFBT principles

The approach is based on three things:

1) If it ain't broke, don't fix it

2) Once you know what works, do more of it

3) If it doesn't work, do something different

Key beliefs

- Maintaining a future focus
- Reframing problems and problem talk
- Amplifying positive change and exceptions
- Believing that the client is the expert on their life
- Finding client-led solutions, based on the client's strengths, skills and resources

Focused not forced

The worker and the client are focused upon a future where the“problem” does not exist, or is less of a problem, and on the times in the past, and present, when the “problematic” events have not occurred.

Note: There will be times when the client wishes to speak about the “problem” and at these times the therapist should acknowledge the difficulties and look out for, and comment on, the client’s ability in coping with the “problem”.

Solution Talk v's Problem Talk

- Best outcomes correlated to interviews where interviewer mainly focused on resource activation.

- Poorest outcomes correlated to interviews where interviewer mainly focused on problem activation.

(Gassmann & Grawe, 2006)

What we think about our service users

- When practitioners thought about their clients' strengths for ten minutes before they saw them, there were better outcomes when compared to a control group of practitioners who didn't.

(Flückiger & Grosse Holtforth, 2008)

In this next piece we will focus on two areas:

- Exceptions
- Scaling questions

Two Types of Exceptions

Berg & Miller (1992) define exceptions as falling into one of the following categories; deliberate or random.

- **Deliberate exceptions** are the times when the client has managed to change the problem, deal with it in a deliberate way

- **Random exceptions** by contrast are the times when the client manages to deal with the problem better because of circumstances which seem to be beyond their control. A genuine interest and a supportive approach can assist in working out what the client did, which meant they managed the issue better. That respectful inquisitiveness can lead to the client working out how and possibly why things were different

Exercise Chat or Roleplay

- Please think back to our scenarios , what exceptions might exist for this person ?
- Lets take our time and be curious about how the exceptions happened.
- Some Questions which may be helpful when working with people around exceptions are …
- When are times that you have used less or not at all?

- What were the circumstances surrounding these exceptions?

- What strengths or coping skills did you use during these times?

Working with clients

- What is happening here? How have you managed to use less on that day? How are you doing this?
- Any movement in reduction is recognised and positively enforced.
- The client's ability to maintain and not increase their current drug use is positively commented on; How have you done that?
- If there is an increase in use, how have you coped?

Working with clients continued…

- Was there a time where you felt like using and managed to postpone this, even for a short time?
- Essentially, look at client's strengths and coping mechanisms.
- Pragmatic information on actual harm reduction strategies is important.
- Client provides the goals and the change plan

Relapse prevention

- Practical strategies that can be used to reduce the possibility of relapse

- **Relapse does not solely signify a return to substance use after a period of abstinence**. It also encompasses instances when a person exceeds their pre-determined "maximum" level of substance use. For example, if someone aims to limit themselves to four beers but ends up drinking six, this can also be considered a relapse

High Risk Situations

These are specific circumstances that increase a person's likelihood of substance use. Imagine a person who typically uses cocaine every weekend; their high-risk situation is Friday night at the club with friends who also use cocaine. The therapist can help clients develop coping mechanisms to navigate these situations, such as:

Avoiding the high-risk environment: For example, choosing not to go to the club on Friday nights.

Developing self-awareness: Recognizing the emotions and triggers that lead to substance use. The acronym HALT (Hungry, Angry, Lonely, Tired) is a helpful reminder to pause and assess one's emotional state before engaging in potentially risky behaviors.

Setting clear boundaries: Communicating to friends about leaving the club at closing time to avoid extended exposure to the high-risk environment.

High Risk situations continued

Practicing drink/drug refusal skills: Developing assertive communication techniques to decline offers of drugs or alcohol.

Modifying behaviors: Arriving at the club later than friends and leaving earlier to limit the time spent in the high-risk situation.

Pacing consumption: Alternating alcoholic beverages with non-alcoholic drinks or choosing lower-strength options to reduce overall intake.

Exercise (Chat or Roleplay)

- Lets try to identify the High Risk situations that the scenario may encounter. The times when they may increase their drug use or relapse from abstinence

- Lets be curious about the times they have thought about relapsing but did not (the exceptions)

Rule Violation Effect (RVE)

- This psychological phenomenon occurs when someone sets a strict rule for themselves (e.g., "I will never drink alcohol again"). If they break the rule, they may feel a sense of failure and justify excessive substance use as a consequence. Relapse prevention plans should address RVE by:

- **Encouraging flexible goals**: Instead of absolute abstinence, clients can work towards harm reduction by setting achievable limits.

- **Normalizing setbacks**: Framing relapses as opportunities for learning and growth rather than catastrophic events.

- **Developing coping mechanisms**: Equipping clients with tools to manage urges and cravings in challenging situations.
- By incorporating these strategies into their treatment plans, therapists can support clients in developing the self-awareness, coping skills, and resilience necessary to navigate high-risk situations, manage cravings, and prevent future relapses.

Behaviour Chain

- This technique guides the client to retrace the steps leading up to their relapse. The therapist can then assist the client in identifying alternative choices they could have made at each step to prevent the relapse. By exploring these decision points, clients gain a deeper understanding of the factors that contributed to their relapse and develop strategies for making different choices in the future

Behaviour Chain Example

- **Paul, a 25-year-old man, relapses back into cocaine use after six months of abstinence.** He feels guilty and distressed, especially since he had outstanding drug debts. During his therapy session, the focus is on reconstructing the chain of events that led to his cocaine use.

- **Identifying the Trigger:** The therapist asks Paul when he first decided to use cocaine. Paul recalls that he was at home on a Friday night, feeling bored while waiting for his friends to call. He then watched a TV report about a cocaine seizure, which sparked thoughts about the drug.

Paul Continued…

- **Tracing the Steps:** The therapist guides Paul backward through each step, uncovering the sequence of events:
- 1.**Initial State:** Boredom at home.
- 2.**First Action:** Watching TV.
- 3.**External Trigger:** TV report about cocaine seizure.
- 4.**Internal Trigger:** Thoughts about cocaine are activated.
- 5.**Second Action:** Goes out to the pub with friends.
- 6.**Social Pressure:** Friends decide to buy cocaine.
- 7.**Relapse:** Paul uses cocaine.

- **Highlighting Exceptions and Coping Skills:** The therapist further inquires if Paul experienced any urges to use cocaine before the TV report. Paul admits to feeling bored, highlighting that boredom might be a vulnerability factor for him. The therapist can then explore how Paul managed to resist those urges previously, identifying his coping mechanisms and strengths.

Developing a Relapse Prevention Plan: By understanding Paul's behaviour chain, the therapist can help him develop strategies for managing boredom, such as engaging in enjoyable activities, connecting with supportive friends, or practicing mindfulness techniques. Additionally, they can discuss alternative choices Paul could have made at each step, such as calling a friend instead of watching TV or leaving the pub when his friends decided to buy cocaine.

This behaviour chain analysis helps Paul and his therapist pinpoint vulnerability factors and develop a personalized relapse prevention plan. The emphasis on identifying exceptions to drug use reinforces Paul's agency and highlights his existing coping skills, empowering him to make different choices in the future.

Basic Assumptions of SFBT

- Clients have resources and strengths to resolve complaints
- Change is constant
- Small changes can make a big difference
- It is usually unnecessary to know much about the complaint in order to resolve it.

Workers' Behaviours

de Shazer (1985) identified three types of behaviours which would result in clients being more inclined to discuss solutions, change and resources:

1. **Eliciting questions**: What is better? "What's been better since we last met?"

2. **Questions about details:** These can include, please can you tell me a little more about how that happened? How exactly did you manage to make that happen? What did you do that was different?

3. **Verbal rewards**: Here the worker is trying to affirm much of the work the client has already done in dealing with the problem. Always be aware of culture and context when providing a compliment or an affirmation with someone. The important part is that the person hears that you have been genuine and have shared an observation on how they have managed to do something.

Leading From Behind

Here we are neither pushing nor pulling but rather we are offering our collaboration to the client and are being directed by them. We are metaphorically one step behind client and looking in the same direction. We may notice something that the client has done well, an exception possibly or a situation where things went better for the client.

Miracle Question

- "Suppose that tonight while you were asleep, there was a miracle and this problem that brought you here today disappeared. The miracle occurs when you are asleep, so you do not know immediately that it has happened".

- "When you wake up, what is the first thing you will notice that will let you know that there has been a miracle"?

- Then, "what else?", "what will others notice?'

I ask this question in the following way…

"Imagine I meet you in 5 years time, outside on the street and everything has worked out for you….

What would you be doing?

Where would you be living?

How did you manage to make all of this happen?"

Exercise Chat or Roleplay

- Please imagine if we asked the miracle question from one of our scenarios

- We can ask it the traditional way or “if I met you in 5 years time and things were better …”
- I wonder what their response would be ?

Case Study about Bob

- Bob is a 26 year old man with learning difficulties. He smokes approx. an ounce of cannabis per week and drinks approx. 80 cans of cider @ 6%. He refuses to visit his GP.

- I worked with Bob a few years ago.

- Bob had tried a number of abstinence -based programmes but had always “failed” (his own words).

Bob continued…

- I asked Bob what he hoped for, how he felt he was doing and how he has managed to hold his consumption of both cannabis and alcohol at this level?

- This led onto a natural discussion about Bob's strengths and his hopes for the future. He was clear that he did not want to be sick from his drug use.

Bob continued…

- **Bob was keen to engage but clear that he would not “stop drinking”.**
- **We took a baseline of Bobs alcohol use (empty cans).**
- **We discussed his successes in the past where he managed to remain abstinent or had successfully reduced his alcohol and cannabis use.**

Bob continued…

- Bob had many exceptions to his alcohol use…for instance he drank less on Sundays, when he was occupied doing other things.

- He moved from 6% alcohol to 4.5% and eventually to occasionally .5%.

- Over the course of the work Bob reduced his alcohol intake by approx. 60%.

Bob continued…

- Bob has stopped smoking cannabis.
- Part of the work was sharing the information of Harm Reduction with Bob as he had never been offered this service and building on his unique strengths.
- He continues to drink cider, normally at 4.5% and when he disengaged from our service, he was re-engaging with some services in the area and trying to sort out his accommodation.
- He has re-engaged with his GP

Case Example: Mark

Background: Mark was a client who drank 9 cans of high-alcohol beer daily. He had a history of homelessness and strained relationships.

SFBT intervention: The therapist asked Mark the miracle question and helped him identify exceptions to his drinking.

HR intervention: Mark received information about the effects of alcohol and strategies for reducing harm.

Outcome: Mark reduced his alcohol intake, reconnected with his son and ex-partner, and felt happier

Case Example: Mary

Background: Mary was a heroin user ambivalent about stopping. She had children in care and was in an abusive relationship.

SFBT intervention: The therapist explored Mary's preferred future and identified times when she used less heroin.

HR intervention: Mary received information about methadone treatment and safer injecting practices.

Outcome: Mary entered methadone treatment and was working towards reducing her use with a goal of abstinence

Mark a Case Study

"Mark," a man in his 60s with a long history of alcohol dependence, to illustrate the combined application of SFBT and HR principles. Mark resided in a "wet service," a residential facility allowing alcohol consumption on the premises. I was Mark's key worker, and worked with him for approximately two years, during which time Mark progressively reduced his alcohol intake from nine cans of high-content alcohol per day to around three cans per day.

Mark Continued

- **Meeting Mark Where He Was At:** I recognized that immediate abstinence might not be feasible or desirable for Mark and focused on supporting his efforts to reduce harm. This approach aligns with the HR principle of accepting and responding to any improvement, however small.
- **Building Rapport and Trust:** Despite Mark's initial resistance and disrespectful behavior, I persisted in building a relationship based on respect and non-judgement. This supportive foundation facilitated open communication and collaboration.
- **Identifying Exceptions and Strengths:** I consistently searched for and highlighted exceptions to Mark's problem drinking, such as the times he managed to abstain or reduce his intake. For example, Mark successfully abstained on St. Patrick's Day to save money. I celebrated these successes, reinforcing Mark's self-efficacy and motivation to continue making positive changes.

Mark Continued…

Utilizing Scaling Questions: I used scaling questions to gauge Mark's motivation and confidence in his ability to change. This technique helped track progress and identify areas where Mark felt more or less confident.

Co-Constructing Experiments: Mark and I collaboratively developed experiments or homework tasks tailored to his specific goals and circumstances. For instance, recognizing Mark's desire to drink "properly" with his son, they visited a supermarket to explore lower-alcohol content options. This experiment facilitated a reduction in Mark's alcohol consumption while enabling him to achieve his social goal.

Respecting Client Autonomy: I consistently emphasized Mark's right to make his own choices, respecting his decisions even when they seemed counterintuitive. When Mark expressed a desire to reduce his alcohol intake by a seemingly impractical amount, the author collaborated with him to find a solution that worked for him.

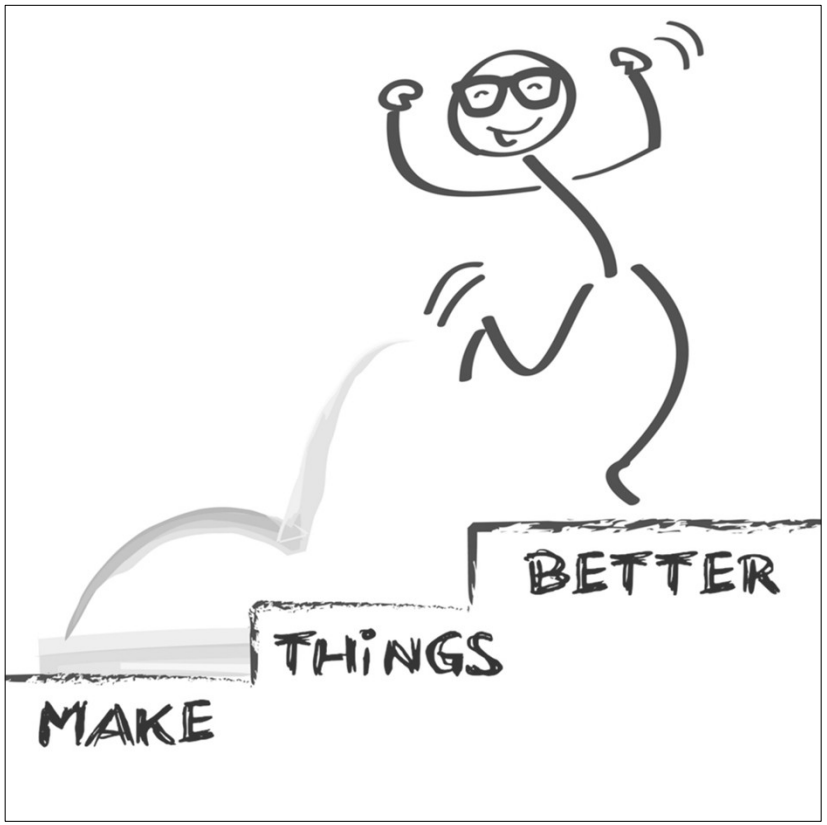
Focusing on the Miracle Question: I used variations of the miracle question to help Mark envision a future where alcohol was less problematic. This technique helped Mark identify his values and aspirations, motivating him to make changes aligned with his desired future.

Integrating Expert Knowledge: I recognized that sharing relevant information could accelerate client progress. While maintaining a "not-knowing" stance, the author provided Mark with information about the effects of alcohol on his health and supported his efforts to make informed decisions.

Similarities between SFBT and Harm Reduction

- They both respect the persons autonomy.
- They are both strengths based.
- They are both humanistic.
- Both view the person as being the expert in their own lives.
- Both evolved from practice.

How to become more of an SFBT and Harm Reduction Worker



- Awareness
- Practice
- Look for your own strengths and nourish these
- Get Quality Supervision
- Learn from the people you work with
- Humility
- Reflect

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SOLUTION FOCUSED HARM REDUCTION

Working effectively with people who misuse substances

Dr. Seán Foy