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The Strategy of Harm Reduction in Working with Drug Addicts and Alcoholics

Abstract: The policy of EU Member States, the United States, South America and Australia is heading towards the restructuring of the support system for addicts by implementing actions meant to limit the health and social damages resulting from the use of psychoactive substances. Many countries offer access to low-threshold programmes whereby the participant is not forced to maintain abstinence or submit to the excessive rules and obligations of a rehabilitation center. Harm reduction is a philosophy based on pragmatic and realistic goals of working with addicts and users. It assumes that each change, even the smallest, is important and should be supported. Harm reduction programmes usually function in several sectors of social assistance – therapy, social rehabilitation, dangerous behavior prevention and social services. In Poland, the widening of the scope of the treatment offer by harm reduction programmes is still marginal, and the changes in the system of treating addiction do not keep up with the dynamic changes in the pattern of using psychoactive substances. The monolithic system of assistance, based on abstinence, is not sufficient and does not respond to the changing needs in terms of helping those people who require it.
Key words: harm reduction, addiction, treatment programmes, addiction prevention.

Introduction

We know a lot about the life consequences of psychoactive substance use, especially alcohol and drugs. Research in the field of medicine, psychiatry, psychology, pedagogy or sociology provide data indicating a serious health, psychological and

social losses resulting from the excessive use of psychoactive substances. A person using drugs or alcohol to a detrimental extent or who is an addict[1] has limited possibilities in proper social functioning, and the damages that arise as a result of this use, cause individual suffering and serious social losses. There is a group of addicts referred to in medical rehab as "high functioning" alcoholics or drug addicts, who, despite meeting the diagnostic criteria, can perform tasks for years which require to perform various social roles, mainly in the professional area. However, most of them experience enough serious emotional and social difficulties that they too seek help for themselves by taking advantage of the diverse treatment or rehabilitation offer.

Increasingly, the distorted image of treating addiction is indicated, which was created mainly based on research conducted among patients of rehab centers, where people with the most severe courses of the disease go. For this group of patients the only effective help strategy was the paradigm of total abstinence from psychoactive substances, which was started in the 1950s. As indicated by John Cunningham and Jim McCambridge, the image of addiction as a chronic and incurable disease changes when extensive population studies are taken into account, which show that there are many individuals who meet the criteria for alcohol addiction, however, their symptoms disappear without the use of specialized therapy treatments, and changing the pattern of using to a more adaptable one is maintained in the longer, three-year term (Cunningham, McCambridge 2012, p. 6–12; Klingemann 2013, p. 5–8).

It is also worth mentioning the concept of self-medication by Edward Khantziana, which assumes that addiction arises as a result of a mechanism for coping with internal problems, so it is a secondary phenomenon to the primary problems of the individual. This trend is more common among women than men, who are looking for a panacea for symptoms of affective and anxiety disorders (Bukowska 2012, p. 133). For this group of patients, the dichotomous model of therapy based on total abstinence, as a condition of participation in the later stages of support, turns out to be difficult or even impossible to realize. In practice, this means that patients from this group forgo attempts to reach for professional help or experience failure from the start, confirming the belief that the use of alcohol or drugs is expensive, but the only possibility to deal with individual problems.

The results confirm that there is a group of people addicted to psychoactive substances, in whom the use of short, sometimes one-off interventions, cause substantial, long-term changes (Cebulska 2015, p. 11–13).

[1] "Harmful use" is a medical term reserved for how psychoactive substance are taken, which causes physical or mental damage, "addiction" is a complex of physiological, behavioral and cognitive phenomena, among which the use of substances dominates other behaviors which previously had higher value. More: Pużyński, Wciórka 2007, p. 73.

Such factors as the highly individualized clinical picture and course of addiction, study results confirming, in some cases, the possibility of using methods of working on returning to a satisfying life other than long-term therapy and abstinence, and above all, the philosophy of helping to focus on improving the quality of life, not completely eliminating the symptoms, have become prerequisites to enrich the support system for maladjusted people, struggling with addiction to alcohol and/or drugs. The fifteen-year period of broadening the treatment offer in Poland with actions in the area of harm reduction in Poland makes it possible to summarize the results.

Harm reduction associated with taking psychoactive substances in the Polish legislation and methods of realization in therapeutic practice

The first half of the 1980s was a period in which drug use ceased to be just a disturbing social problem. The pandemic of HIV growing among intravenous drug users has forced legislators of the United States, followed by Australia, Canada and most Western European countries for rapid interventions to control the outbreak. The purpose of these actions was not focused on the treatment of drug addiction, nor even alcohol, but to reduce harm resulting from intravenous injection (HIV, HBV, HCV). These countries used the needle and syringe replacement programme and the methadone programme associated with the idea of preventing overdoses among opiate addicts (Sempruch-Malinowska, Zygadło 2012, p. 253). These programmes were previously realized in the US Over the last thirty years, harm reduction programmes have developed into a powerful aid system, providing a rich offer addressed not only to intravenous drug users, but also for other addicts, including alcoholics.

In Central and Eastern Europe harm reduction programmes were introduced a little later, in the 90s, but to a much smaller scale than in other European countries. Poland, as one of the first countries in Western Europe, began operations in the field of harm reduction, but now the pace of these changes is so slow that only Belarus executes fewer programmes. It is surprising that in Poland the term "harm reduction" was first used nearly twenty years ago in the National Health Programme for the years 1996–2005 for the operational objective no. 5[2]. It is surprising, because harm reduction continues to causes a lot of controversy, even though so many years have passed, among specialists in addiction therapy

[2] In one of the points of operational objective no. 5 of the National Health Programme for the years 1996–2005 on the postulated effects, the following provision appeared, guaranteeing "the introduction of generally available programmes to reduce health harm in people taking psychoactive substances casually and in addicts". More: *National Health Programme 1996–2005*.

and psychotherapy[3], specialists in psychiatry, public health and prevention of risky behavior. Sometimes it is treated like support for addiction and not the addict. As indicated by Katarzyna Malinowska-Sempruch and Marek Zygadło, the disadvantage of the record contained in the National Health Programme is the high level of generality of the term "harm reduction". This results in confusion in the environment, whose task is to provide help and support to addicts, and not use this term as an empty slogan without practical implementation, based on the principles of harm reduction policy.

Harm reduction is any action taken to reduce harm caused by the use of psychoactive substances. It is addressed at people who use these substances, their families and communities. Harm reduction programmes involve stopping the process of deepening dependency, increasing the quality of life, security, often the most basic necessities of life. Programmes of this type are carried out under the conditions of treatment, social welfare, activities of NGOs. Typically, the recipients are people who are deeply addicted, marginalized, socially excluded (Klingemann 2015, p. 3).

Poland's Harm Reduction Network, which is based on the interpretation developed by the *Harm Reduction Coalition,* in defining the harm reduction model, has formulated the following principles (Sempruch-Malinowska, Zygadło 2012, p. 253):

— *It is assumed that aid is granted in any situation in which a person currently functions.* This principle is of cardinal importance because it means that the task of the helper to resign from one's own course of actions. The most common starting point is to assist in solving urgent current problems, often of a social nature, i.e. homelessness, poverty, physical illness. As noted by Justyna Klingemann "it is recognized that there are no hopeless cases, it is never too late for change, harm reduction programmes are a safe place to talk about problems, possibilities of obtaining help and support, a place where you can take a shower, wash your clothes, find information about casual work, or make use of the kitchen"(Klingemann 2015, p. 4).

— *It is assumed that people who currently take psychoactive substances are able to make decisions, manage their own behavior, and also to change them.* This assumption undermines the commonly occurring stereotype, also present among some therapists, that a person addicted to drugs or alcohol cannot responsibly affect their own lives. In many places around the world there are hostels and night shelters, where it is allowed to consume alcohol. The sco-

[3] In Polish rehabilitation medicine, there is a formal division into a sector of outreach activities addressed at drug addicts and alcoholics. Specialists in the field of working with people addicted to alcohol have the title of addictions psychotherapist, while specialists working with drug addicts have the title of addictions therapist. Both titles are equivalent and they are obtained in separate certification proceedings.

pe of consumption is determined individually, which gives the possibility of institutional control, does not rule out partnership relationships between staff and residents, and restricts uncontrolled drinking or drug use. This example also justifies another principle described below.

— *It is assumed that to achieve total abstinence is not always the most important and the most preferred aim when helping people who take psychoactive substances.* According to the State Agency for Solving Alcohol Problems, the number of persons addicted to alcohol is 2% of the population, of which only about one sixth takes advantage of rehabilitation treatment. The effectiveness of therapy programmes is limited, which means that only a small proportion of this group will achieve any benefits (Jakubczyk, Wojnar 2012, p. 374). The main reason for resigning from therapy and other outreach activities is the requirement of abstinence. Research in the United States organized by SAMHSA, also confirmed in Europe, indicated that due to the requirement of abstinence, nearly 90% of people seeking this type of aid did not surrender to therapy activities. Knowledge of the course of addiction suggests that breaking abstinence is a symptom of the disease, so the expectation of immediate and absolute sobriety is illogical and inconsistent with the knowledge about it (Sempruch-Malinowska, Zygadło 2012, p. 256).

— *It is assumed that some ways of taking psychoactive substances are safer than others.* Recognition of addiction diseases often leads to comparing them to other diseases with a similar chronic course. Good examples are diabetes and obesity. Treating the mentioned diseases does not intend to completely eliminate hazardous foods from a diet. Diets are developed in a highly individualized way, and the patient alone decides what to give up and what to try to reduce. In the case of people using drugs, the most dangerous situation arises during intravenous injection with reusable equipment. In response to the needs of this group of clients, changes are sought in the way drugs are taken to a much less threatening way or to replace substances potentially more harmful for ones that causes less damage. As noted by Sempruch-Malinowska and Zygadło, "if a patient takes opiates by injection, then let us consider how and in what we can support him – in reducing the frequency, changing the way the substance is used, changing the substance itself, undertaking substitution treatment, and perhaps sometime in the future – pursue the goal of abstinence" (Sempruch-Malinowska, Zygadło 2012, p. 258).

— *It is assumed to include persons who take psychoactive substances in the creation of their own strategies and help methods.* Probably no other principle mentioned here aroused such discussion in the community of rehabilitation treatment. The medical treatment model is based on clear procedures for dealing with situations of specific symptoms. The task of the physician is the knowledge and implementation of a therapeutic procedure, and the patient's compliance with these directives. In such a model, helping authorizes the

helper to control and impose his own rules. The harm reduction model takes into account the willingness of the patient to make changes to the extent that he deems possible. This idea takes into account knowledge in the area of human motivational processes. The best solutions will not bring the expected results if the person having to implement them does not understand them, if he is not interested in them or if he sees them in terms of a painful loss or challenge which he is not able to meet.

— *It is assumed that in order to ensure the effectiveness of actions, the environment and conditions of the person taking psychoactive substances should be taken into account.* This point emphasizes the cardinal importance that the conditions of the dysfunction and current factors in the addicted person's environment have for introducing the desired changes. In efforts to provide aid, it is sought to diagnose the threatening factors and then eliminate them from the environment in which the addict functions. Such a factor may be codependence of the partner or staying in an environment in which the addict experiences violence or is its source. One strategy that has been used in rehab treatment for a long time is the temporary or permanent strive to isolate the addict from the threatening environment.

The idea of a total elimination of psychoactive drugs from social life seems impossible to achieve. The pragmatic approach described is oriented to prioritize short-term, feasible objectives. Emphasis is also placed on promoting humanistic values in which respect for human rights and dignity is superior. This pragmatism gives priority to measures which, after assessing the benefits and losses, seem possible to realize. Hence the tendency to prefer short-term actions, with clearly defined objectives.

The effectiveness of harm reduction programmes largely depends on the policy of a particular country against drug addiction and drug abuse. Countries promoting a restrictive and repressive system policy for people who use psychoactive substances introduce such programmes in a very limited extent. A permissive drug policy and system that takes into account the possibility of using treatment substances instead of absolute punishment gives ample space to carry out activities in the area of harm reduction.

In the policy of EU countries, including Poland, there is a tendency to withdraw from repressive measures against drug users, while developing the area of preventive and curative measures. The EU anti-drug strategy for 2013–2020 in the field of drug prevention recommends the diversification of efforts to reduce the demand for drugs, considering such action to be much more effective than reducing supply which was promoted in the 1990s. This resolution is the foundation on which modern addiction prevention programmes are built. It should be underlined that the Member States, in accordance with the principle of subsidiarity, decide themselves what regulatory mechanisms they will use in the field of drug demand and supply (Sobeyko 2008, p. 119–131).

Harm reduction programmes are implemented in four main areas: education, work in the environment, substitution therapy and harm reduction psychotherapy (Sempruch-Malinowska, Zygadło 2012, p. 253–264). Here is a brief overview of them.

Drug education

Educational activities aim to transfer tangible, specific and current information that is useful in the situation of drug use and other psychoactive substances. As part of *harm reduction*, we are moving away from the method of scaring with the consequences of drug use due to the low effectiveness of these strategies. The transfer of information based on facts, not myths, is being promoted; such that in the event of contact with drugs will help avoid the risks associated with contamination of drugs present on the market, the actual strength of their effect, the possibility of overdose. The characteristics of these activities are presented in Table 1.

Table 1. Educational activities carried out in the harm reduction model

Drug education	Recipients	Implementers	Activities carried out under the programme
Programmes within the scope of selective prevention and indicating	people experimenting with drugs or using them in a detrimental manner	Trained educators and psychologists, specialists in addiction therapy	Early intervention programmes, e.g. FredsGoNet, short-term therapy programmes, social skills training
Street education	addicts, excluded, marginalized, seeking professional help	Trained volunteers, street therapists, addiction treatment specialists, social workers	Directly reaching people who use drugs in their environment, distributing information leaflets
Chat-rooms, online clinics	all interested	Addiction treatment specialists, psychiatrists, general practitioners, lawyers	A rich Internet offer that provides information in the field of knowledge about drugs, the mechanisms of addiction, the health consequences of drug use, possibilities for anonymous help

Source: own study.

Outreach work

Programmes in the field of harm reduction can be divided into low- and high -threshold. Low-threshold programmes have minimum requirements of recipients, usually concerning specific rules of social conduct, i.e. the prohibition to use violence or bring weapons. High-threshold programmes formulate for the participants

a number of clearly defined requirements at the stage of recruitment, as well as over the duration of the programme. Examples of low-threshold programmes (Table 2) are: needle and syringe replacement and daily community centers for active drug users *(drop-in center)*. Substitution therapy in Poland, in most cases, is part of the rules of high-threshold programmes.

Table 2. Outreach work in the lives of addicts in the harm reduction model

Outreach work	Recipients	Implementers	Activities carried out under the programme
Points for needle and syringe replacement	persons using drugs in the form of intravenous injection	party- and street-workers, community centers for active drug users (drop-in center), clinics and health units authorized for this	during set, usually permanent shifts, street therapists inform how to secure used needles and syringes by collecting them into special containers, they distribute sterile equipment
Information on safe injections	persons using drugs in the form of intravenous injection	party- and street-workers, community centers for active drug users (drop-in center), clinics and health units authorized for this, addiction treatment specialists, doctors and medical personnel	providing information on the rules of safe injections (e.g. the rule "leave one vein for the doctor"); the first educational project of this kind in Poland was conducted by an employee of Krakow's Monar, G. Wodowski
Injection rooms	persons using drugs in the form of intravenous injection	in Poland this is an illegal procedure	intravenous drug use in safe and hygienic conditions in cooperation with medical staff; these places often offer the opportunity to test the composition of the drug, in order to detect anomalies and pollution. Denmark, the Netherlands, Germany, Switzerland, Spain and Norway have special facilities for the use of safe injection, operated by medical personnel, and taking drugs in them are a legal procedure
Overdoses prevention	mainly persons using drugs in the form of intravenous injection, but also by other users	party- and street-workers, community centers for active drug users (drop-in center), clinics and health units authorized for this, addiction treatment specialists, doctors and medical personnel	providing information on the rules of safe use of intravenous drugs and others (e.g. do not use alone, start with small doses, watch your body after taking the substance, remember about first aid rules, call an ambulance)

Source: own study.

In many countries, in the environment of drug users, low-threshold programmes are implemented. The task of street therapists or so-called party-workers is to reach active drug addicts in places where they reside – in the streets, railway stations, clubs, discos. These types of actions are best developed in Warsaw and Kraków. In Kraków, street therapists move around on bicycles, they also have a special bus that reaches other cities (Malczewski et al. 2009, p. 7). The purpose of these activities is the exchange of used injecting equipment, providing advice, information, support, and if it is possible, to motivate to participate in other forms of assistance to improve quality of life, e.g. in substitution programmes. Research conducted by the Information Center for Drugs and Drug Addiction and the National Bureau for Drug Prevention, monitoring the operation of low-threshold programmes showed a gradual decrease in the number of needle and syringe exchange programmes in recent years. In 2002, there were 21 such programmes, and in 2008 only 13. Low-threshold programmes is the least developed area in Poland. In the United States and many Western European countries, activities such as: replacement of needles and syringes, distilling water and filters for purifying drugs, distributing disinfectants and training on safe injection, prevention of overdoses and pre-medical aid are among the basic environmental measures initiated already in the 1980s (Sempruch-Malinowska, Zygadło 2012, p. 260).

Substitution therapy

Substitution therapy (Tab. 3), the third of these areas of harm reduction, is addressed to people addicted to opiates and involves the use of a medical substance with properties and effects that are similar to those taken by the drug addict. This substance is called an agonist, which has no euphoric effect, it is administered orally, prevents withdrawal symptoms, reduces mental hunger and limits the health and social consequences associated with addiction (http://www.kbpn.gov.pl/portal?id=106992; access: 3.01.2016).

Table 3. Substitution therapy performed in the harm reduction model

Substitution therapy	Recipients	Implementers	Activities carried out under the programme
Low- and high--threshold programmes	people addicted to opioids who are 18 years of age and consent to the treatment	public and private health care institutions and penitentiary institutions	a form of medical care using a substance similar in effect to the drug in order to prevent the occurrence of the withdrawal syndrome and to reduce the health and social consequences associated with addiction

Substitution therapy	Recipients	Implementers	Activities carried out under the programme
Heroin-assisted therapy	not implemented in Poland; in many Western European countries aimed at people who unsuccessfully try to keep with other therapy programmes, including substitution	substitution therapy points, health centers	administration of heroin to addicts under strict medical supervision or the possibility of taking medicinal heroin independently purchased in a pharmacy on medical prescription

Source: own study.

According to data posted on the website of the National Bureau for Drug Prevention in 2013, the number of problem opioid users was in the range of 10,444–19,794. Approximately 2,200 people took advantage of substitution therapy, representing about 15% of addicts. There is a particularly unfavorable situation in Podkarpackie and Podlaskie Voivodeships, where there are no substitution programmes conducted, and in the Silesian Voivodeship where access to them is very limited. Substitution, as a method of working with people addicted to opiates, is now available in all European Union countries, the United States and Australia; it is recommended by the European Commission, the World Health Organization and UN agencies. The aim of substitution therapy is to reduce the possibility of the spread of HIV, HCV, HCB and other blood-borne infections, improve the somatic and mental health of the addict, reduce risky and criminal behavior. In psychosocial terms, the aim is to improve the functioning of the patient and their social reintegration by relieving withdrawal syndromes, overdose prevention and abandonment of the use of illegal substances.

Each patient participating in the programme is subject to an individual treatment plan, in which the physician and the addict together determine the dose appropriate for the metabolic needs of the patient. In substitution therapy, the principle is adopted that the addict can be in the programme for many years or even a lifetime, because the conditions of the treatment are similar to those of cardiovascular diseases or diabetes.

Considering the fact that few opiate addicts who reach out for aid remains in long-term abstinence, substitution therapy is a proposal for expanding the available treatment offer. The objective pursued is not idealistic but pragmatic and focused on reducing the most serious damage to the individual and society.

It is also worth mentioning that in some countries (Belgium, Denmark, Germany, Netherlands, Spain, Luxembourg, the United Kingdom and Switzerland), there are centers that administer purified heroin to addicts who are resistant to all other forms of treatment, including substitution therapy. The goals of treatment

with medicinal heroin are limited to reducing the risk of HIV infection and risk of fatal overdose (Sempruch-Malinowska, Zygadło 2012, p. 263).

Harm reduction psychotherapy

The fourth area of work, consistent with the principles of harm reduction, relates to the therapeutic approach not focused on the goal of abstinence from drugs or alcohol. It is, in fact, a philosophy of working with other people, taking into account the holistic approach to it and the socio-cultural context (Tatarsky, Kellogg 2012, p. 239).

The harm reduction model best fits the image of integration psychotherapy, i.e. one that is not only rooted in a tradition of psychotherapy but draws solutions from many, individually matching the strategy to meet the client's needs. As the objectives it assumes holistic diagnostic activities aimed at identifying the psychological, biological and social factors that contribute to the process of addiction. This approach involves the cooperation of specialists in various fields and combining, if necessary, other harm reduction techniques, e.g. substitution therapy. Essential to the practice of teaching and social rehabilitation process is the ability to adapt activities to the skills of personnel with different levels of education, professional qualifications and executed actions. The assisting person can be a security guard, receptionist, street therapist, nurse or youth coach (Tatarsky, Kellogg 2012, p. 239). This philosophy opens up a space for dialogue between the various specialists who are engaged in the process of working with socially maladjusted people. From my observations, as a specialist in addiction therapy, it seems that coordination between the therapist, teacher, school counselor and probation officer brings very good results on condition that all the aforementioned people adopt a similar, pragmatic vision of assistance.

Table 4. The tasks of a therapist performed in the psychotherapy of addicts based on the harm reduction model of Andrew Tatarsky

The tasks performed in the process of therapy with a drug addict and/or alcoholic in Integrative Harm Reduction Psychotherapy (IHRP)
Management of therapeutic alliance
The therapeutic role of the therapy relationship
Enhancing the skills of self-control in the process of change
Identification of needs as a form of treatment
Understanding ambivalence
Setting goals within the framework of harm reduction
Strategies to actively promote positive change

Source: own study based on Tatarsky, Kellogg 2012, p. 239.

The paradigm of harm reduction assumes that working with an addict starts with the thing, with which the client comes to get help and not with what the person assisting regards most important. This simple but very significant change of attitude causes that the therapist and the patient are equal partners cooperating in the process of change. Andrew Tatarsky, recognized as a pioneer in the field of harm reduction and addiction therapy, explains that the strategy is to take small steps in the direction of the greatest possible reduction of damage resulting from problem behavior (Tatarsky, 2007, p. 2). The author has formulated seven basic tasks (Tab. 4) that the specialist helping the addicted person has to implement[4]:

- **Management of therapeutic alliance**

Therapeutic alliance is understood as the skill of consistent cooperation implemented on the basis of the adopted objectives and tasks under the directive *start where the patient is and work on his objectives.* Therapeutic alliance is not a fixed construct but is subject to dynamic transformations, which means that in response to the changing attitudes of the patient, the therapist is also obligated to change his own attitudes in such a way as to meet the needs of the patient. The basic disposition here should be a readiness to immediately respond to emerging conflicts in the relationship and desire to understand them in order to repair the alliance.

To strengthen the alliance, the therapist bases on skills such as: active listening, shared exploration of the topic, empathy, reflection and controlling countertransference[5].

- **The therapeutic role of the therapy relationship**

This factor is mentioned as a priority by representatives of all therapies (Czabała 2010, p. 213). Difficulties in relationships with other people underlie non-adaptive behaviors, including those related to the use of drugs or alcohol. The therapy relationship is the space in which these problems are likely to emerge. Strong therapeutic alliance enables to discuss the difficulties and experiment with other, more adaptive behaviors. Such an experience is a healing factor, because it provides the patient with information that difficulties in relationships can be overcome and that for others – in this case, the therapist – the patient is important and it is worthwhile for him to make the effort to maintain a relationship with him.

- **Enhancing the skills of self-control in the process of change**

Addicts, like most socially maladjusted people, have deficits in terms of self-control of own behavior. Tatarsky notes that one should make contact with

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[4] Description of the principles of harm reduction in psychotherapy based on: Jabłoński et al. (eds.) 2012, p. 239–252.

[5] Countertransference is understood by the author as any personal reaction of the therapist in relation to the patient. The task of the helper is to make himself aware of the basis of own reactions and not to take action under their influence.

the "part" of the patient that wants to make changes and seeks to improve well-being. Therefore, during the process of change, it is important to strengthen curiosity, self-reflection and tolerance for unpleasant feelings. Curiosity in the nature of one's own suffering increases self-awareness and insight, through which the patient discovers the relationships between events, thoughts, feelings, impulses and choices. Thanks to launching these dispositions, it is possible to increase the tolerance of unpleasant feelings and their acceptance. Self-awareness training allowing an internal dialogue and relaxation training allowing to control bodily reactions are helpful in this.

- **Identification of problems as a form of treatment**

For impact on the maladjusted person to be effective, his cognitive characteristics should change – this conclusion is formulated by all schools of psychotherapy (Czabała 2010, p. 227).

The aid provided to an addict consists in, among others, understanding the patient's experiences, the manner in which they influenced life decisions. The process of identifying the problems of the patient stimulate him to look into his own situation. Deeper self-diagnosis of one's own problems is the starting point for formulating strategies to reduce suffering and harm arising in connection with taking risky behaviors, including addictive ones. As emphasized by Tatarsky, the ability to identify problem behaviors helps to get a clear picture of one's behavior and of how it affects other spheres of life, how it prevents the execution of values and life goals that are important to the patient. Identifying one's own problems is therefore a factor that strengthens the sense of control of one's own life, which is so often impaired in relation to the developing addiction.

- **Understanding ambivalence**

Using psychoactive substances carries consequences of two kinds: negative, which are the cause of suffering, but also positive as the temporary lifting of emotional discomfort or functioning in a way that is not possible in a state without the use of drugs or alcohol. Ambivalence is therefore a consequence of experiencing losses, but also gains. Developing the belief that there are other alternative ways to deal with difficulties takes a lot of time, so when working with an addict, the topic of appearing ambivalence should be developed so that the patient has the opportunity to consider possible solutions. In the classical addiction therapy based on the principal goal of abstinence, there is a tendency to minimize the time spent on analyzing the profits resulting from the use of drugs or alcohol. The harm reduction model underlines the crucial importance for building a therapeutic alliance; it has empathy towards both attitudes of the patient. Tatarsky stresses that "if the therapist is set on only one part of the patient, and strengthens only this side (usually the one that wants to stop taking or doing so in a safer way), there is a risk that he will ally with only this *side,* which may be directed against the other side. As a result, the *side* that one wants to change can commit to many things and plan many activities, while the *side* of the patient who wants to

continue to take drugs [...] continues using without any changes. The expression of empathy for both aspects of ambivalence makes the conflict remain in the patient. Both parties are involved in therapy and both are also taken into account in planning new goals" (Tatarsky, Kellogg 2012, p. 244).

- **Setting goals within the framework of harm reduction**

The harm reduction approach in psychotherapy is based on the gradual change of risky behavior of the patient to the least harmful by using a variety of methods, both in the field of harm reduction, as well as those based on abstinence. A measurable effect of undertaken treatments is constructing, together with the patient, the Ideal Use Plan, through which the patient is able to: assess the problem areas of psychoactive substance use, enhance motivation for positive changes, set goals in terms of harm reduction, plan strategies for achieving new goals. The described plan is to contain information about the type of substance, ways of use, doses, frequency and circumstances of use. Such a constructed plan is treated as an experiment, which means that everything that happens in the course of its implementation shall be subject to effectiveness assessment. With this approach, the patient has the opportunity to actively create solutions and modify the plan in a way that suits his needs.

- **Strategies to actively promote positive change**

The last element, which can be carried out after developing the Ideal Use Plan, is choosing the strategy for its implementation. The authors of this model have decided to adapt the cognitive-behavioral strategy with proven scientific effectiveness. In this strategy actions in the following areas are realized: education, analyses of desires, identification of thoughts, feelings and beliefs, balance of decision-making and internal dialogue, identification of triggers, controlling or counteracting these factors, alternative actions[6].

The seven of the said recommendations for working with addicts in the harm reduction model is a proposal of actions involving the patient, supporting the building of a solid alliance with the helper and through small, gradual changes leading to the addict's better functioning in the personal and social area.

When reviewing harm reduction strategies, it is clear that it is traditionally dedicated to drug users. A network of support has been developed for them, which in relation to the assumed objectives is adapted to the needs of the individual but also to social needs. Changes in the drug policy in Poland have been resounding, to promote the strategic objectives of the National Programme for the Prevention of Drug Addiction for 2011–2016, reducing drug use and related health and social problems[7].

[6] More on this topic: Beck et al. 2007; Tatarsky, Kellogg 2012; Tatarsky 2007.

[7] More on this topic: Ordinance of the Council of Ministers dated 22 March 2011 on the National Programme for the Prevention of Drug Addiction for the years 2011–2016, Journal of Laws No. 78, item. 428.

The case is slightly different in rehabilitation treatment offered to alcoholics. Although in this environment there is no need to replace injecting equipment, considerations about legalizing different types of alcohol, because the procedure of drinking alcohol is legal, or to create special points where an addict can safely consume it, in this sector of alcohol addiction therapy there are changes appearing which fit within the harm reduction model. What is new is implementing programmes to reduce drinking (POP)[8], and their aim is to develop a disciplined pattern of alcohol consumption, according to a predetermined plan. It is addressed to people who do not accept the model of total abstinence, and their addiction is in the initial phase, in which experienced consequences are not as severe. The results of an American study (Fudała 2014, p. 9–15), confirmed by Polish teams implementing the POP programme indicate that the recipients of these measures are younger people with high social support, professionally well-functioning, having a family, and those that are not able to maintain abstinence and despite attempts, they experience multiple relapses.

In 2015, a team of treatment advisors of the Director of The State Agency for the Prevention of Alcohol-Related Problems (PARPA), which consists of, among others, Bohdan Woronowicz, Marcin Wojnar, Jadwiga Fudała, Barbara Bętkowska-Korpała, Tomasz Głowik, Justyna Klingemann developed recommendations for institutions expanding their offer of limited drinking programmes. The recommendations are a collection of practical tips and guidelines including indications and contraindications for their use, possible objectives for implementation, a plan of the introduced changes, a schedule monitoring the situation of drinking and preventing returns to disruptive models, draft diagnostic questionnaires, educational materials and for the patient's own work. The recommendations shall also provide an interpretation of the philosophy of helping and a list of scientific studies confirming the effectiveness of both types of programs in rehabilitation treatment – based on abstinence and harm reduction[9].

Summary

The basic strategy of working with addicts, with proven effectiveness among drug addicts and alcoholics, it is still the abstinence model. However, the introduction of harm reduction programmes opens up the possibility of helping a greater number of people suffering from addiction, who due to the requirement of abstinence

[8] Description of the implementation of the example programme is located in: Cebulska 2015, p. 11–13.

[9] All recommendations and the full text of attachments are available at: http://www.parpa.pl/index.php/lecznictwo-odwykowe and in: *Zalecenia do tworzenia i realizacji programów ograniczania picia alkoholu w placówkach leczenia uzależnień*, "Terapia Uzależnienia i Współuzależnienia", no. 5/2015, p. 32–34.

do not benefit from the basic treatment offer. Harm reduction programmes also meet social expectations associated with reducing crime and social marginalization.

One of the characteristics of addiction is the impaired ability to make real decisions based on cause-and-effect reasoning. An addicted person, when starting treatment, often chooses to participate in it without actual readiness to realize the goal, which is abstinence. The lack of conviction and motivation to assume responsibility for making the change often results in the return to the destructive use of psychoactive substances. The harm reduction model takes into account this aspect and makes it possible to take real action to help people who have come to therapy as a result of succumbing to the pressure of the family, employer or fulfilling the conditions laid down by a court. Work experience in this model indicates that there is a large group of people who in the initial phase of treatment aim to restrict the use of the substance, after several unsuccessful attempts to implement it, decide on abstinence on their own (Ligus 2006, p. 321–326).

The discussion concerning the effectiveness of introducing measures from the scope of harm reduction is underway in the field of the drug and alcohol policy adopted in the given country. Poland, as a member of the European Union, is required to comply with the EU Minimum Standards in Treatment and Harm Reduction[10], and these involve the necessity to introduce intervention for all in need, using the available current achievements and the latest scientific evidence. A big obstacle in introducing the latest developments in the field of working with addicts is the law, which treats drug users as criminals. This approach greatly reduces activities in the field of harm reduction, without removing the problem of drug use in society. The repressive drug policy causes that the procedure for drug production and consumption is done through the "black market" or within the framework of the law, like in the case of so-called "designer drugs" – substances that are legal in many cases, which does not mean safe, mild and harmless. Recent changes in drug policy toward the permissive approach, in New Zealand, Uruguay and the United States as well as the Czech Republic, draw attention to the need for systemic changes in Poland. The direction of these changes is an extended prevention of risky behavior, a real therapy offer for various types of recipients and activities in the environment in order to reduce social harm resulting from the use of different legal and illegal psychoactive substances.

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