Susan E. Collins
Seema L. Clifasefi

Advances in Psychotherapy –
Evidence-Based Practice

Harm Reduction Treatment for Substance Use

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About the Authors

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co-learning moment. Many community members – research participants, clients, community advisory board members – have told us over the years that they simply hoped their own experiences could help someone else in need and could help their communities heal. We believe they have.

Finally, we dedicate this book to our families, who have their own long and complicated histories with substances, substance use and SUD, and for whose future we are fighting.

Contents

Preface

We are writing this preface over 2 years into the global COVID-19 pandemic, which hit the US with force in early 2020. The past 2 years have been both a harrowing and a heady time in our nation's history, full of seismic shifts toward healing and justice, as well as heartbreaking losses and setbacks. The field of substance use treatment and research has been a part of this picture. The pandemic ushered in record-breaking rates of morbidity and mortality, disproportionately impacting communities of color, people with disabilities, and older people. For many, however, the toll went beyond the infection and its proximal sequelae. As the psychological impacts of the pandemic took hold, overdose deaths and alcohol-related deaths due to accidents and liver disease spiked in unprecedented ways.

Fortunately, just in time to meet this challenge, high-ranking government officials in the US have warmed to harm reduction as national policy. For the first time in history, the White House has formally embraced harm reduction: The Biden–Harris administration's inaugural National Drug Control Strategy centers harm reduction as essential to "keep people alive" and "engage and build trust with people who use drugs" (White House et al., 2022). The definition of "recovery" from the National Institute on Alcohol Abuse and Alcoholism was recently expanded beyond abstinence to include remission from symptoms of alcohol use disorder, cessation of "heavy drinking," and improvements in biopsychosocial functioning and quality of life (Hagman et al., 2022). National leaders in substance use treatment, policy, and research funding recently defined the concept of *preaddiction* to introduce more nuance into the diagnosis of substance use disorder and more approachable pathways for primary and secondary prevention (McLellan et al., 2022). As harm reduction researchers and clinicians, we appreciate these steps.

Of course, people who use substances, and their families and their communities, have been engaging in ways to reduce harm long before these recent steps, often in the face of government inaction and even persecution. The specific term "harm reduction" has, over the past 4 decades, come to be most closely associated with grassroots activism and public health efforts to reduce harm associated with substance use and sexual behaviors, particularly in response to the HIV/AIDS crisis of the 80s and 90s. We acknowledge the importance of the vast and diverse harm reduction work done in communities, across professional disciplines, and around the world. For this reason, we want to be clear that this book will address just one narrow aspect of the larger field of harm reduction. Namely, we are US-based and Western-trained substance use treatment clinicians who are writing a psychotherapeutic manual on an evidence-based harm reduction treatment practice developed with and for people who use substances.

With this focus in mind, harm reduction for substance use is a set of compassionate and pragmatic approaches to reduce substance-related harm and improve quality of life for people who use substances, their families,

and their communities. The modern harm reduction movement has been underpinned by strong grassroots efforts that have often been led by people who use substances and have been marginalized within the system. In our roles as researchers and clinicians, we have sought to positively contribute to harm reduction, while being mindful of the concerns about governmental, public health, and academic appropriation of the work. We have engaged in long-term collaborations with community members and community-based agencies to share resources, co-learn, cocreate, implement, evaluate, and disseminate the work you are reading about here.

This book, *Harm Reduction Treatment for Substance Use,* is laid out similarly to others in the *Advances in Psychotherapy – Evidence-Based Practice* series. In Chapter 1, we provide definitions, scientific rationale, and historically relevant models that informed the development of HaRT, and in Chapter 2, we detail its underpinning theoretical tenets. In Chapter 3, we review treatment indications and practice preparation for HaRT. We also review psychometrically sound assessment tools we have used in research trials and clinical practice to inform, guide, and evaluate our application of HaRT. Early in Chapter 4, we describe the implementation of HaRT in outpatient psychotherapy and community-based settings. Then we share HaRT's evidence base, challenges in its application, and its placement in cultural context. We close with two case vignettes in Chapter 5 and provide further readings that expand on harm reduction treatment in Chapter 6. In the Appendices, we have provided measures and worksheets to facilitate application of HaRT in clinical practice.

As we share information about HaRT for your consideration, we want to acknowledge and thank the grassroots activists and thought leaders who have spent decades fighting for harm reduction treatment, programming, and policy, often at great risk to themselves, to help their communities survive and thrive. We are thus donating any royalties we receive from this book to community-based harm reduction agencies, from whom we have learned so much.

1.1 Terminology and Definitions

Harm reduction approaches do not require abstinence but aim to reduce harm and improve quality of life

As applied to substance use intervention, the umbrella term "harm reduction" refers to a compassionate stance and a set of pragmatic strategies that minimize substance-related harm and enhance QoL for people who use substances, their families, and their communities (Collins et al., 2011). As its name implies, harm reduction breaks with traditional abstinence-based approaches in that its focus is on minimizing harm, and it does not require or even particularly elevate abstinence or use reduction as ultimate goals (Heather, 2006). While we appreciate the contributions of abstinence-based approaches as important and effective recovery pathways for some, we believe harm reduction approaches are necessary additions to the spectrum of care to ensure greater treatment reach, engagement, and effectiveness.

1.1.1 Harm Reduction Heartset Is Foundational

The harm reduction heartset is culturally humble and compassionate

As defined above, harm reduction can be described as a set of strategies; however, it is the culturally humble and compassionate spirit or *harm reduction heartset* with which strategies are applied that is essential. In fact, this heartset should drive the nature of more concrete interventions and the way they are implemented and thereby received by the community. Of course, we are not the first ones to say this. Dave Purchase, the late and great founding director of the North America Syringe Exchange Network (NASEN) and the Tacoma Needle Exchange noted that harm reduction is more "an attitude" than a fixed set of approaches (Marlatt, 1998b, p. 6). Handing out clean syringes constitutes a fairly concrete harm reduction intervention, but Purchase knew the most important part was *how* he set up his program to center people who use substances, *how* he handed out syringes with nonjudgment, and *how* he was in community with love, humility, and compassion in this work.

1.1.2 Harm Reduction Mindset Is Pragmatic

Pragmatism means meeting clients where they are at in their communities and in their motivation for change

Adopting a *harm reduction mindset* is pragmatic for those of us seeking to work with the entire spectrum of people who use substances. After all, it is substance-related harm that drives the diagnosis of substance use disorder in the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5). Pragmatism also drives harm reduction clinicians' additional focus on QoL. Our research has shown that people who use substances are striving to meet their basic needs and engage in meaningful activities, just as much if not more than changing their substance use (Fentress et al., 2021). This same research has shown that a clinical focus that prioritizes both what people want to leave behind (i.e., substance-related harm) *and* what they want to move toward (e.g., engaging in meaningful activities, fulfilling basic needs) is associated with positive treatment outcomes (Fentress et al., 2021).

Abuse, 2008). The corollary is that, by not prohibiting substance use and by supporting clients' choice about their substance use goals, non-abstinence-based approaches may "enable" or facilitate continued, harmful drinking (Denning & Little, 2012).

At the bottom of that sign in the breakroom, however, someone had scrawled in pen, "And sometimes they tell the truth." That act of defiance shows a move away from the absolute nature of the messaging that preceded it. It is the kind of nuanced understanding that we must embrace to support our clients in incremental change toward harm reduction.

Clinical Vignette 1
Susan E. Collins's Personal Experience With Tough Love

If you come from a place of privilege wherein you have been able to maintain some control over the flow of your life, we would ask you: Have you ever lied to your doctor or an employer about smoking, or how much you are drinking or have used drugs?

Susan shares: "I did until I had health problems related to my substance use that were undeniable to the doctors from whom I sought help. I was sat down for 'the talk' and was told I was an 'alcoholic.' I felt the shame flood my body, and I argued back: 'No, I am not. 'Alcoholic' has not been a diagnostic category since the DSM-II.' The physician looked at me with pity and responded that I was 'in denial' before he told me I needed to stop drinking for the sake of my family and my health and go to abstinence-based treatment. Despite my extreme privilege in that situation, I felt shame, anger, resentment, and entrapment, likely similar to what my clients had always felt in the treatment systems I was working in. Unlike for other medical diagnoses, substance use disorder is not managed collaboratively such that clients can contemplate a clinician's diagnosis, ask questions, get a second opinion, or consider multiple options for recovery goals and pathways. At worst, there is dire punishment (e.g., denied liver transplant, threat of imprisonment, loss of child custody). At best, there is this disconnected emergency department doctor's 'tough love,' which, when one is on the receiving end, does not really feel like love at all."

Yet, as harm reduction clinicians we must take this nuanced stance a step further. Considering our interlocking systems of oppression, of which the treatment system is a key component, it impossible for our clients to *not* lie to us (see Clinical Vignette 1 for one of our perspectives). This assertion might sound shocking, so let us take a moment to look at a routine aspect of our substance use treatment system. We clinicians feel compelled, and often are compelled through our systems' policies and financial contracts with other entities, to be informants on our clients. We routinely conduct complex, intrusive, and humiliating toxicology assay procedures (e.g., observing clients as they provide urine samples, cutting clients' hair) and send toxicology reports and letters to nonclinicians – employers, child protective services, courts, and probation and parole officers – detailing our clients' substance use as well as treatment attendance, plans, and progress. Somewhere along the way we were converted from well-intentioned healers charged with protecting privacy and confidentiality, to proxy judge, jury, and jailer. We do not talk about this as clinicians, but perhaps some of us appreciated the sense of

harm reduction field have developed psychotherapeutic practices, clinician manuals, and self-help guides (e.g., Anderson, 2010; Denning & Little, 2012, 2017; Tartarsky, 2002). Thus, the tradition of individual-level harm reduction approaches and the acknowledgment of the need for individual-level harm reduction approaches for SUD is not new.

HaRT builds on this growing interest in harm reduction and client-led approaches. In Section 1.4 we outline the HaRT model (see Figure 1) and its theoretical underpinnings in more detail.

2.2.1 HaRT Mindset

The HaRT mindset is transparent, pragmatic and focuses on a mutual understanding of clients' relative risks and safety

The *HaRT mindset* supports the realization of client-driven goals and recognizes any client-led movement toward reducing harm and improving QoL as positive steps in recovery (Marlatt, 1998a). It is important to reiterate that "recovery" in harm reduction does not automatically imply abstinence, moderation, or use reduction, or compliance with clinicians' conceptualization of recovery. In Table 1 and in the following section, we delineate the assumptions that are inherent in the use reduction mindset (wherein the "doctor knows best") and the harm reduction mindset, wherein we support client-driven goal setting because the "client knows better."

Table 1
Illustrating the Differences Between the Use Reduction and Harm Reduction Mindsets

Use reduction	Harm reduction
• Ultimate goal is abstinence. • Use and harm correlate 1:1. • Role is prescriptive: Clinician "prescribes" treatment goal and pathway. • **Doctor knows best!**	• Ultimate goal is harm reduction. • Use and harm do not correlate 1:1. • Role is predictive: Clinician helps client assess their risk for harm and develop ways to reduce risk. • **Client knows better!**

Harm Reduction Is the Ultimate Goal

HaRT expands our reach to clients who are not ready, willing, or able to attend abstinence-based treatment

There are important reasons for the prioritization of client-driven, harm reduction goals over provider-driven, use reduction goals. First, the focus on harm reduction versus use reduction is pragmatic. We acknowledge that life-long abstinence is one viable means of reducing substance-related harm, and abstinence-based treatment presents one viable pathway to that end. However, the vast majority of people who use substances – even those with SUD – are not ready, willing, or able to stop using or attend abstinence-based treatment (SAMHSA, 2022). Thus, client-driven and harm reduction pathways are more intrinsically appealing, lower barrier, and more inclusive of the broader spectrum of people with SUD. This positions harm reduction goals as more engaging and harm reduction treatment as having greater reach than the de facto narrower focus on abstinence-based goals via abstinence-based

Pharmacological Support

A fourth component – pharmacological adjuncts and medication-assisted treatment, such as those discussed earlier in this chapter, in Section 2.1 – can be added to further bolster clients' harm reduction outcomes, goals, and safer-use strategies. Evidence-based pharmacological adjuncts that support harm reduction include naloxone to reverse opioid overdose; buprenorphine and methadone to stave off withdrawal, decrease overdose risk, and as relevant, prevent relapse to illicit opioids; naltrexone and acamprosate for AUD, and safer nicotine products (ranging from smokeless tobacco, to electronic nicotine delivery systems, to nicotine replacement therapy).

The behavioral aspects of HaRT can be combined with pharmacological support to boost treatment effectiveness

2.3 What HaRT Is *Not*

We deeply appreciate the assertion made in other practices that defining what a construct *is not* is just as important as defining what it *is* (Miller & Rollnick, 2009). In this case, defining what HaRT *is not* serves a specific purpose. We do not wish to minimize the importance of other evidence-based approaches to substance use intervention and treatment (e.g., cognitive behavior treatment, relapse prevention, 12-step facilitation, motivational interviewing, mindfulness-based relapse prevention, and contingency management), but rather to circumscribe what is unique to HaRT so providers can more confidently engage in the practice and be transparent with clients about their treatment rationale and planning.

Because this question often comes up in trainings and in conversation with other researchers and clinicians, we created the slide featured in Figure 4.

HaRT was codeveloped with community members and prioritizes their perspectives and goals

In fact, what all the evidence-based treatment modalities listed in Figure 4 share is the underlying assumption that the clinician (or researcher) knows best and that, when there is disagreement – even subtle, unspoken, or unknown to one of the parties – about appropriate goals (i.e., abstinence or

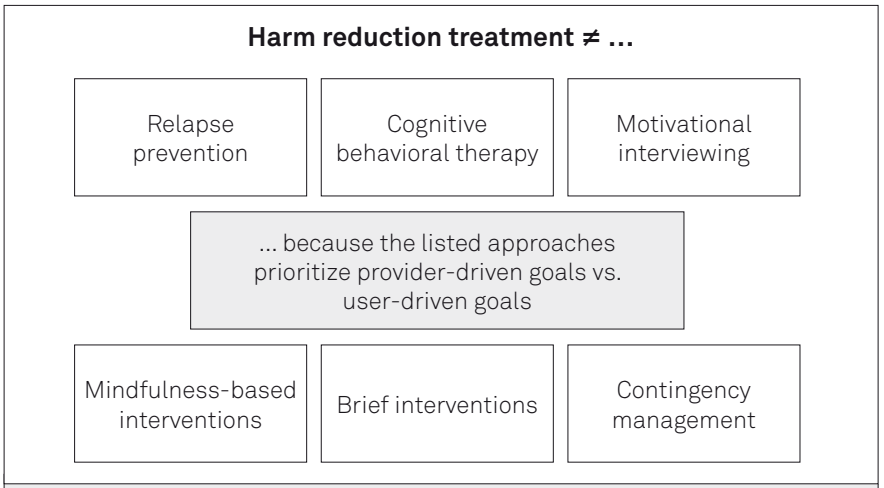

Figure 4
Differentiating harm reduction treatment from other treatment and intervention modalities.

3.2 Preparation for HaRT

In harm reduction, we acknowledge larger systems influences on our clients and our work; thus, this section serves as a continuation of the prior section's coverage of treatment indication. Specifically, this section will help you assess whether your practice *setting and system* are indicated for HaRT implementation, and if so, how to prepare yourself to navigate the system on your clients' behalf to ensure strong application of HaRT, which will be discussed in Chapter 4.

3.2.1 Reflecting On and Readying Your Practice Setting

Depending on the level of minoritization and marginalization of your client base, you might already be aware of your clients' experience of the systems in which we work. Here are a few examples of how we and our colleagues (too slowly) awakened to our role and complicity as clinicians and researchers in the interlocking systems of oppression. We noticed that people experiencing greater marginalization in our system (e.g., People of Color, LGBTQIA2+, womxn, people experiencing homelessness or houselessness, rural clients, clients experiencing more severe levels of substance-related harm, clients with co-occurring disorders) were often and variously subject to greater monitoring, offered fewer services, exposed to harsher treatment and service conditions, and/or experienced less flexibility and compassion from us and our settings. We realized a large proportion of substance use treatment serves *mandated clients* and often entails reporting to courts, probation or parole officers, or child protective services about clients' treatment attendance, self-reported substance use, and urine toxicology reports. We became increasingly concerned that our clients might be reincarcerated or lose custody of children based on reports we crafted. We noticed our own discomfort in our staffing meetings or in consultations in which clients and their lives were reduced to reporting on their level of use or experience of substance-related harm. Worse, we regretted conversations about our clients that dehumanized or belittled them (e.g., laughing, scoffing or rolling our eyes at their histories, experiences of relapse, behavior exhibited while intoxicated, or feeling they "had it coming" when they experienced substance-related harm).

Once we realized the harmful nature of our systems and our actions within them, we tried to find new ways forward by asking community members what *their* experience of our systems and our services had been. We learned across several studies that community members who had been marginalized in the system appreciated talking to counselors and clinicians about their physical and mental health and even about their substance use. However, they did not appreciate and reported shutting down when those conversations ended with overtures about abstinence, resulted in clinician-driven treatment plans and goals, and were shared – sometimes perceived as surreptitiously – with other entities (Collins, Clifasefi, Dana, et al., 2012; Collins, Jones, et al., 2016; Nelson et al., 2022).

When we asked people how they would redesign treatment in their own vision, they told us that intrinsically derived motivation and recovery path-

people responding more compassionately and pragmatically to people who use substances.

Aside from these more extreme examples, we believe there are ways to practice HaRT responsibly, even given systems limitations. Key to fidelity to the model is understanding and defining your own positionality within the system, conveying your positionality to clients transparently and regularly, and advocating for harm reduction, more generally, and your clients, more specifically, within your system and other systems as well. We expound on how to enact these processes in the following sections.

3.2.2 Preparing to Navigate Systems For and With Clients

Once you have taken stock of the HaRT readiness of your setting and whether HaRT is a viable approach within it, you can make decisions about how you will navigate the system to better work for your clients as you implement HaRT in your practice. Here are some important steps.

Understanding and Defining Your Own Positionality in the System

It is important to understand what your setting can do for clients and what it cannot (e.g., treatment and other social service offerings), what its rules and norms are and how they are shaped (e.g., policies and procedures), and how you might be interfacing with other systems and entities (e.g., connection to funders and internal and external collaborators and agencies). Understand where *you are* in the larger organizational chart. How much referent, expert, and/or institutional power do you have to shape systems? How much can you define your own practice within the existing system? Consider these questions and your answers carefully. In section 4.1.1, we will discuss how to translate those to your clients through your treatment rationale and informed consent process.

Engaging in Systems-Level Advocacy

Build and listen to community advisory boards; advocate to meet their stated needs; push back on dehumanizing practices

Even if you do not have a lot of institutional power, you can take steps to remedy problematic omissions or commissions in your own work and in your setting. First, consider where current practices do not align with the harm reduction principles discussed earlier in this book. Then, you may engage in the following numbered actions, as relevant for your setting and practice. Please note that these are suggested starting points and not an exhaustive list.

1. *Ensure that client and community voices are heard:* If possible, we recommend assembling a community advisory board of people with lived experience – the key stakeholders in, and individuals who represent end users of, your services – to inform the services you provide (for a research-based example of this process, see Collins, Clifasefi, et al., 2018). Be sure to compensate people for their time, provide refreshments, listen attentively, and include their suggestions liberally. If their suggestions do not align with existing services, rules or norms, or connections to other agencies, work on reshaping your services and systems to come into alignment with the community's expressed interests.

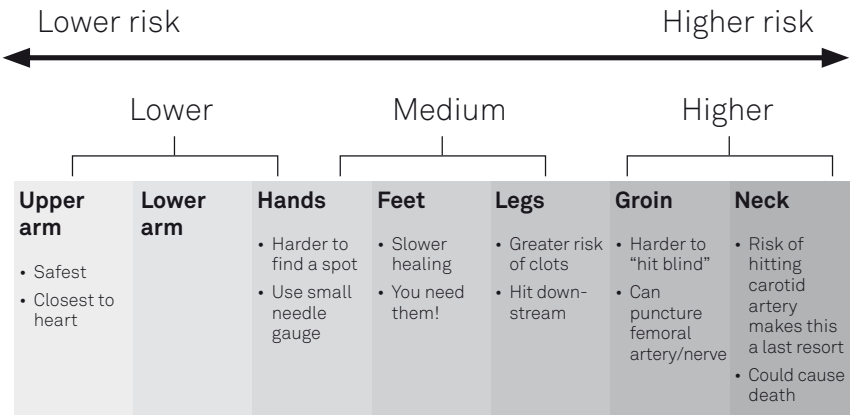

Figure 8
Relative risk hierarchy of injection sites. Based on National Harm Reduction Coalition, 2020.

We were inspired to create the next relative risk hierarchy (see Figure 8) when we read the excellent guide from the National Harm Reduction Coalition called "Getting Off Right" that covers relative risks at each turn of the complex set of medical procedures that is injection drug use (National Harm Reduction Coalition, 2020).

Create relative risk hierarchies to be prepared for ongoing discussions of relative risks

As shown in Figure 9, the relative risk hierarchy for nicotine is relatively simple. As typically used by adults, nicotine itself is a highly addictive and complex, yet relatively harmless stimulant; thus, a focus on less risky means of obtaining nicotine is the most reliable way to reduce risk. Some researchers have estimated that anything that is *not* smoking is about 85% safer than smoking, but even reducing smoking can reduce cardiovascular risks. A complete switchover to chew tobacco is approximately 85% safer, vaping is 95% safer, and nicotine replacement therapy (i.e., patches, gum, lozenges) is 99% safer than smoking (Nutt et al., 2014).

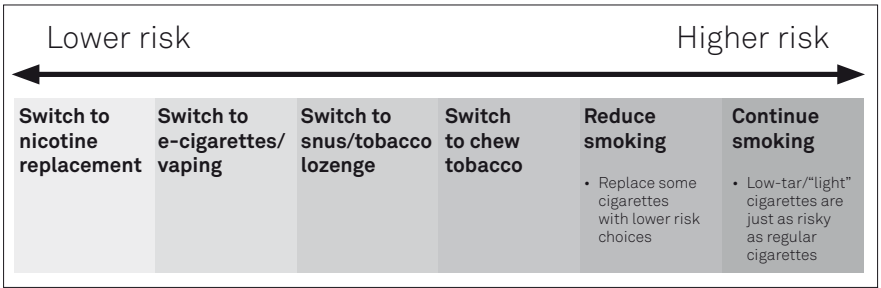

Figure 9
Relative risk hierarchy of nicotine products.

4.1.2 HaRT Heartset

In this section, we will discuss the HaRT heartset, or our *way of being with* ourselves and our clients, as well as ways to embody the heartset through words and actions.

Values

The HaRT heartset entails cultural humility, acceptance, compassion, flexibility, advocacy

The HaRT heartset both aligns with values common to client-centered care and expands them to become more transformative and advocacy-oriented. We review the heartset values briefly before we show how they are integrated into clinical practice. First, there is sense of *acceptance* and support of the client, or from a humanistic or motivational interviewing standpoint, unconditional positive regard (Miller & Rollnick, 2013; Rogers, 1957). Harm reduction clinicians have a sense of *compassion* – or "feeling with" the client, which, depending on the clinician's spiritual or clinical practice, is well-paired with lovingkindness (*Mettā* or *Matrī* in the Buddhist and Vedic traditions), or a desire to remove clients' suffering (Bibeau et al., 2016). This sense inspires *flexibility* and *responsiveness* to the client and their state, including their level of intoxication in session, cognitive functioning, and disabilities (see Clinical Vignette 3 for a clinical example).

Clinical Vignette 3
Flexibility in HaRT

Due to his medical history including multiple traumatic brain injuries, regular seizures, and alcohol-related cognitive impairment, one of our clients could not remember his alcohol consumption from week to week to complete our regular substance use assessments. At his suggestion, we provided him with a number for texting his daily use. By accommodating his disability on his own terms, we were making his treatment more accessible and engaging.

HaRT values are grounded in *cultural humility* – a lifelong-learner approach entailing openness to, curiosity about, and commitment to uplifting clients' values, ways, and priorities in the face of clients' systems-level oppression (Tervalon & Murray-Garcia, 1998). We also appreciate the cultural *competemility* model (Campinha-Bacote, 2019), in which there is a balance between cultural competence and cultural humility. Within this framework, we learn as much as we can about the communities we work with – population-level demographics; health inequities; cultural beliefs, values, and practices; preferred and effective treatments – *and* we do not assume this general cultural knowledge will hold true for every individual we encounter. Instead, we carefully pay attention to what is said and unsaid, learning from our clients on their own terms and as they craft strengths-based narratives for their own benefit instead of our own. We recognize our own identities and values and consciously set them aside so we may be open to clients' ways, values, knowledge, and strengths, and we commit to elevating them in our work. We recognize our power and privilege and the inequities our clients face, and we push back in our systems of care on their behalf.

On this note, the HaRT heartset requires we engage in systems-level *advocacy* for our clients and help clients engage in self-advocacy as well.

Managing Discord and De-Escalation

Discord in the therapeutic relationship is jointly generated by the clinician and larger systemic pressures

In substance use treatment, we have often referred to clients' pushback as "resistant" or "in denial" of the harm they experience due to substance use. There has, however, been growing acknowledgment that discord is not generated solely by the client but is jointly created in the therapeutic relationship (Miller & Rollnick, 2013). As harm reduction clinicians, we need to avoid blaming the client for discord (e.g., describing them as "argumentative," "treatment resistant," or "in denial"). In fact, we even go beyond the therapeutic relationship as the generative source of discord: We recognize the role of our systems and our own positionality in them, which can foster distrust, oppression, and barriers to healing.

We also need to recognize the heightened risk for discord and escalation in HaRT, because we are more likely to be working with clients who are actively experiencing intoxication and withdrawal cycles, which can engender greater impulsivity, lower inhibitions, and, depending on the substance (e.g., alcohol, stimulants), may be associated with greater levels of restlessness, anxiety, or agitation. Keeping that in mind, harm reduction clinicians must pay even more attention to early signs of discord (see Box 14; Miller & Rollnick, 2013).

Box 14
Pay Attention to Early Signs of Discord

Defending: "It's not my fault"; "It's not that bad."

Squaring off: "Who are you to tell me what to do?"; "You have no idea what it's like for me"; "You're wrong about that."

Interrupting: The client may talk over you and say things like "You don't understand"; "You're not hearing me"; "I don't agree."

Disengaging: The person seems to be inattentive, distracted, or ignoring you. Perhaps the client changes the subject and goes off on a tangent. Their eyes glaze over or glance at a clock.

Working with clients who are intoxicated is a key and important aspect of HaRT. We are modeling compassion to our clients and colleagues and demonstrating session-by-session that working with intoxicated clients is not enabling but can serve as a corrective emotional experience for clients who have been turned away in their times of greatest need (see Box 15). In meeting people where they are at, especially when they show symptoms of SUD, we are demonstrating compassion and acceptance in a substantive way and providing support when clients' need it the most.

Managing Discord

If discord arises, stop, check your nonverbals, downshift to simple reflections, apologize for misunderstanding

When you sense discord in the therapeutic relationship, pause and ensure you are engaging in active, reflective listening (Box 14). In particular, you should downshift to simple reflections, hewing closely to the client's words. As relevant, whole-heartedly apologize for misunderstandings on your part or your own or your system's contributions to the situation. It is important for harm reduction clinicians to take responsibility for our role

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Appendix: Tools and Resources

The following materials for your book can be downloaded free of charge once you register on the Hogrefe website:

Appendix 1: Safer-Use Strategies for Alcohol, Downers/Depressants, and Uppers/Stimulants
Appendix 2: Sample Letter for Mandated Treatment
Appendix 3: Short Inventory of Problems for Alcohol and Drugs – SIP-AD
Appendix 4: Progress Tracking Form
Appendix 5: Harm Reduction Goals Form
Appendix 6: SHaRE Form

Appendix 6: SHaRE Form

SHaRE Form		Week __ assessment of week __ goal	
Client's Stated Goals (week __)		Progress y/n	Achieved y/n
1			
2			
3			
4			
5			
6			
Week __ notes on progress towards goals since week __:			
		Week __ assessment of week __ plan	
Client's Safer-Use Plan (week __)		Achieved y/n	
1			
2			
3			
4			
5			
6			
Week __ notes on safer-use tips used since week __:			
Other notes/comments:			

See p. 108 for instructions on how to obtain the full-sized, printable PDF.