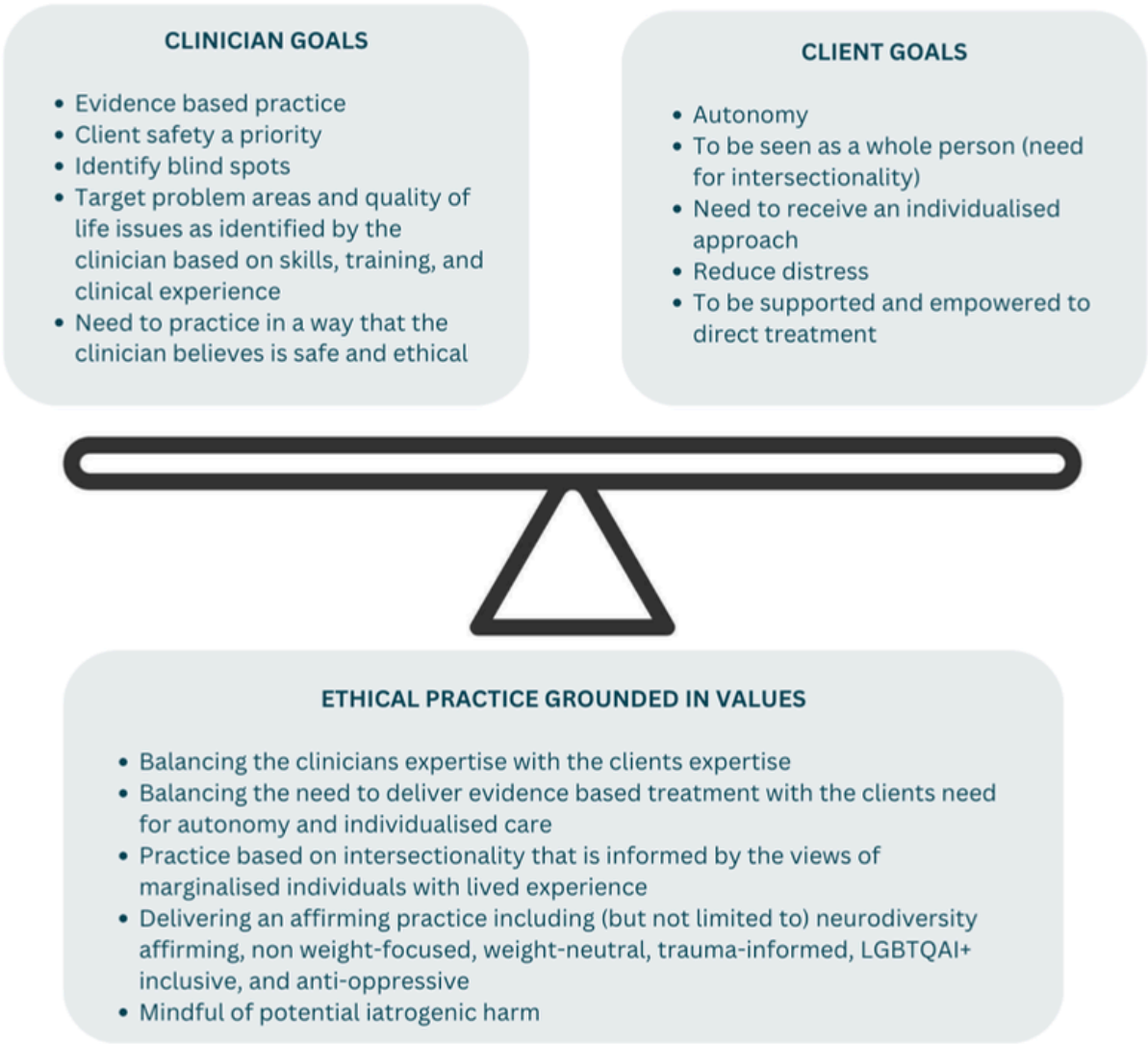
Build Sustainable Progress with Your Most Challenging Cases

A Harm Reduction Guide for Clinicians

This tool is for psychologists, dietitians, and other mental health clinicians wanting to use a harm reduction approach when working with clients who present with eating disorders, self-harm, suicidality, drug use, and other behaviours that put them at high risk.

Clinicians should strive to balance their own goals and expertise and the client's goals and expertise, with an ethical treatment approach that is firmly grounded in values.



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CLINICIAN GOALS

Evidence based practice

Where possible, interventions should always be grounded in unbiased evidence-based practice. Clinicians should present each client with a variety of evidence-based approaches and avoid misrepresenting or "overselling" the effectiveness of any one evidence-based approach, keeping in mind that the therapeutic relationship is one of the strongest predictors of outcome (Flückiger et al., 2018).

Client safety a priority

The client's safety is always the priority in treatment. This includes immediate safety (such as immediate risk to life) but should also include long-term safety (such as long-term risk to life). An intersectional view of safety should be considered, that is, not just physical safety, but also sexual safety, emotional safety, and psychological safety.

Identify blind spots

The clinician should aim to notice things the client may not have considered ("blind spots"), so the client can make fully informed decisions. Whether the blind spots are shared with the client will depend on the therapeutic goals and whether the potential benefits of sharing outweigh the potential risks.

Target problem areas and quality of life issues as identified by the clinician based on skills, training, and clinical experience

Clinicians should draw upon their skills, training, and clinical experience to identify problem areas and quality of life issues, and where possible communicate these potential target areas to the client. Clinicians should be careful to ensure that identified problem areas are not based in neuronormative, ableist, or privileged ideals. Clinicians should be willing to share the knowledge, differential diagnosis, and thought processes that led to their conclusions with the client, and be receptive to feedback.

Need to practice in a way that the clinician believes is safe and ethical

Clinicians each need to have a clear set of guidelines and boundaries in which they believe they can practice safely. When working with high risk clients, clinicians should (where possible) communicate to clients the boundaries and associated outcomes. For example, if the client has a specific plan to kill themselves soon, the practitioner will notify emergency services. Clients should be referred on when the clinician does not have the sufficient expertise to provide quality treatment, but clients should not be discharged for being "too complex." When referring on, clinicians should be honest that the client's needs are outside their area of expertise (so the client isn't left feeling they are the problem), and every attempt should be made to pair the client with a more suitably qualified provider.

CLIENT GOALS

Autonomy
Wherever possible, clients should be given the autonomy to make their own choices about medications, treatment, and health behaviours to the best of their abilities, beliefs, and priorities.

To be seen as a whole person (need for intersectionality)
Clinicians should see each client as unique, with unique strengths and challenges, and therefore requiring a tailored approach to treatment. Clinicians should work hard to avoid assumptions about the client based on their identity, diagnosis, or presenting issues. Clinicians should be mindful of their own privilege and take steps to improve their knowledge around the unique obstacles clients within marginalised communities face. Because each client's mix of identities and experiences is different, no clinician should present themselves as the expert on a client's experience, even if they too have lived experience or are part of a marginalised group.

Need to receive an individualised approach
Clinicians should not have a ‘one size fits all’ approach, but should instead be able to offer a range of treatment options to each client. Clinicians should be willing and ready to adapt treatment in a way that is affirming and meets the client's self-reported difficulties (rather than a pre-determined list of difficulties based on diagnosis).

Reduce distress
Clinicians should value reducing the client's self-reported distress, being mindful that the client is the determiner of what elements of their life result in the most distress, not the clinician.

To be supported and empowered to direct treatment
Clients should be empowered to determine their own goals for treatment. Funding body requirements (eg. Medicare, NDIS) and standard treatment goals shouldn't override the client's own goals.

ETHICAL PRACTICE GROUNDED IN VALUES

Balancing the clinician's expertise with the client's expertise

Clinicians should work collaboratively with their clients to pool the shared knowledge of the clinician's expertise from their training and clinical experience along with the client's expertise from their lived experience. Clinicians should work collaboratively with clients to identify shared treatment goals.

Balancing the need to deliver evidence based treatment with the client's need for autonomy and individualised care

Clinicians should strive to balance the need to provide clients with an effective evidence-based treatment, alongside the client's needs to receive individualised care, have autonomy over their treatment and their life, and to be seen as a whole person. Clinicians should not insist on delivering an intervention that a client has expressed is unhelpful for them.

Practice based on intersectionality that is informed by the views of marginalised individuals with lived experience

Clinicians should hold in mind that much of the research behind our treatments excludes people with co-occurring mental health difficulties and under-represents marginalised communities, so it is difficult to draw conclusions about the effectiveness of such treatments for individuals with complex co-occurring presentations or belonging to marginalised communities. Clinicians should aim to have a practice that is guided by the perspectives of marginalised individuals with lived experience.

Delivering an affirming practice including (but not limited to) neurodiversity affirming, weight-neutral, trauma-informed, LGBTQIA+ inclusive, and anti-oppressive

Clinicians should have a practice that incorporates the values and needs expressed by the clients themselves, as well as being guided by the lived experience community.

Mindful of potential iatrogenic harm

Clinicians should be aware that treatment itself can cause harm, and hold to the principle of “first, do no harm”.

Reference: Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. Psychotherapy, 55(4), 316–340.

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