HARM REDUCTION APPROACHES WITH ADOLESCENTS WHO USE SUBSTANCES

Amanda Reiman and Barry Lessin

"This is a book that will lower parental anxieties and help teens engage in honest conversations about drug use. Lessin and Reiman have taken science and clinical wisdom to develop their IDEA structure – a collaborative conversation that places the complexity of teen drug use in the context of normal adolescent development."

Patt Denning, *Ph.D., Director of Clinical Services and Training at the Harm Reduction Therapy Center, co-author of* Practicing Harm Reduction Psychotherapy: An Alternative Approach to Addictions

"In their new book, *Harm Reduction Approaches with Adolescents Who Use Substances*, Barry Lessin and Amanda Reiman are on the cutting edge of new thinking about working with adolescents. Called harm reduction, this approach has the following defining characteristics: 1) adolescents are treated with respect as collaborators in the change and healing process; 2) use of substances by young people is not entirely ruled out, nor taken as a sign of an irresolvable, lifelong disease. Rather, the entire child, their outlook and relationships with the people and the world around them, are the building blocks for the Lessin-Reiman adolescent helping approach. If their approach sounds like plain common sense, steeped in what readers understand to be the basics of sound parenting and youth development – so be it. For Lessin and Reiman there can be no better sign that they are tracking with the best practices for yielding healthy functioning at any age."

Stanton Peele, *Ph.D., founder, Life Process Program for Addiction Coaching, author of* A Scientific Life on the Edge: My Lonely Quest to Change How We See Addiction

"This book finally provides the much-needed response to the question that harm reductionists are asked every day: "But what about the kids?" In this comprehensive book, Reiman and Lessin provide families, providers, and communities with a framework with which to understand why young people use drugs and how to support them to make safer choices."

Sheila P. Vakharia, *Ph.D., MSW, author of* The Harm Reduction Gap

Harm Reduction Approaches with Adolescents Who Use Substances

Harm Reduction Approaches with Adolescents Who Use Substances details the concepts of harm reduction and how they can be implemented in work with adolescents on the topic of substance use behaviors.

This book reviews the concepts of harm reduction as they have traditionally been applied and in the context of working with adolescents around issues of substance use behaviors. Using both conceptual and real-world examples, this book guides students through case examples and exercises designed to not only better understand harm reduction as a concept, but to practice putting it to use in real world clinical scenarios. This book also aims to reduce the stigma associated with talking about substance-using behavior and to provide nuance around different types of use, from experimental to hazardous, using person-first language without resorting to shaming and blaming. Practical elements incorporate skills of Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT) into discussion.

Suitable for use in a variety of upper-level and graduate courses, this book educates students about the traditional concepts of harm reduction and how they can relate to adolescent substance use and family therapy.

Amanda Reiman, Ph.D., MSW, is a public health researcher who has been studying cannabis as a harm reduction tool for 20+ years. She is the founder of Personal Plants, an education platform focused on helping people develop healthy, balanced relationships with cannabis. In development is a 10-week online program called Cannabis in Balance which helps people identify and change unhealthy behaviors around cannabis use. Dr. Reiman earned her Ph.D. in Social Welfare from the University of California, Berkeley, and conducted one of the first research studies on medical cannabis patients and the use of cannabis as a substitute for alcohol and other drugs. She then taught courses on substance abuse, drug policy, and sexuality at Berkeley for 11 years. Dr. Reiman is an internationally recognized cannabis expert and public health researcher. Formerly the in-house cannabis expert for the Drug Policy Alliance, she has written for and has been quoted in numerous national and international publications as well as peer reviewed academic journals and several textbooks. Dr. Reiman currently lives just outside of Tacoma, Washington, with her partner, Sean, and their two cats and two dogs.

Barry Lessin, M.Ed., CAADC, is a harm reduction psychologist in private practice, specializing in working with individuals and families impacted by substance use. With a career spanning nearly 50 years, Barry has served as a clinician, drug policy advocate, educator, researcher, and administrator. He has experience providing services across the entire continuum of addiction treatment, and draws on an integrative approach informed by decades of work across

intersecting systems – mental health, substance use treatment, and grassroots policy reform. His work has been informed by program development and oversight roles at innovative addiction treatment centers, including serving as Director of the first substance use program integrated into a community mental health center in Philadelphia, and contributing to the development of the city's first intensive outpatient addiction treatment program. Over the past 15 years, his focus shifted to drug policy reform and family advocacy, where he collaborated with harm reduction pioneers and held clinical leadership and capacity-building roles in nonprofit organizations to expand access to harm reduction education and treatment for families facing systemic barriers to care. Barry played an important role in a grassroots coalition that advanced Pennsylvania's 911 Good Samaritan and naloxone access legislation – vital public health measures that provide legal protections during overdose emergencies and expand access to lifesaving naloxone. He currently lives in suburban Philadelphia with his wife, Jennifer, and two cats.

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Dr. Amanda Reiman would like to dedicate this book to the pioneers of harm reduction. The advocates, policy makers, and educators who have championed this approach in the face of backlash. And especially the population of people who use drugs, and their tireless fight for visibility, humanity, and safer lives.

Barry Lessin would like to dedicate this book to the families and parent advocates I've learned from – those who have supported adolescents through substance use, emotional challenges, and systems that have too often let them down. Your persistence and resilience has shaped the way I approach this work. I also want to acknowledge the professionals and educators who are working to expand access to care that is respectful, practical, and developmentally appropriate. Your efforts continue to move the field forward. This book is intended as a resource for all of you – and for the young people at the center of this work.

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Preface

This book is for anyone with a stake in adolescent well-being: current and aspiring therapists, school counselors, healthcare providers, educators, and caregivers. Whether you do or will sit with teens in clinics, classrooms, living rooms, or community programs, the work of supporting young people is complex – and often urgent. Substance use, emotional distress, school pushout, and system involvement don't show up in isolation. They are entangled with identity development, peer dynamics, intergenerational trauma, family stress, and structural inequities.

Mainstream models of adolescent substance use treatment have too often prioritized abstinence, compliance, and diagnosis over understanding, context, and relationship. These models frequently overlook the ways in which substance use can function – for regulation, connection, escape, identity formation – and fail to account for the developmental tasks adolescents are still navigating. And while families are essential to supporting youth, many have been left without clear guidance, appropriate support, or access to evidence-based care.

Harm reduction offers another path forward. It is not a soft alternative to "real" treatment – it is a rigorous, ethical, and relational approach that begins with respect: respect for autonomy, for ambivalence, for lived experience, and for the protective functions behaviors may serve. It centers safety, collaboration, and incremental change. It recognizes that the goal isn't to control behavior – it's to build trust, reduce harm, and support development in the real world as it is, not as we wish it were.

This book is grounded in that philosophy. We build on the foundational work of harm reduction pioneers such as Alan Marlatt, Patt Denning, Jeannie Little, Andrew Tatarsky, Stanton Peele and Scott Kellogg – each of whom challenged the moralism, rigidity, and false binaries of conventional substance use treatment. We've adapted their insights for the evolving needs of adolescents and for the adults – both professional and familial – working to support them.

Our perspective is also shaped by our work as drug policy advocates, focused on undoing the legacy of the War on Drugs. We have seen how criminalization, surveillance, and stigma have fractured families, denied people care, and turned adolescence into a high-stakes battleground. Families have not failed treatment – treatment has failed families by offering narrow, one-size-fits-all models that do not reflect the realities of young people's lives.

This book is dedicated to those families. To those who have experienced loss, stigma, and systemic exclusion – not because they didn't care, but because they weren't given real options. Their persistence, advocacy, and refusal to give up continue to shape the direction of this work.

We also write this book for the next generation of clinicians, educators, and helpers – those entering the field with a commitment to showing up for young people with integrity and clarity. We offer strategies that integrate harm reduction principles with developmentally responsive applications of Motivational Interviewing (MI), Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), and CRAFT (Community Reinforcement and Family Training). These approaches are not presented as protocols to follow, but as tools to be used with flexibility, curiosity, and respect.

Many say that engaging with adolescents can feel like a burden, but we view it as a privilege. It is exciting and humbling to witness a young person struggle, reflect, take risks, and discover who they are becoming. This book is a contribution to the ongoing effort to make that work more humane, more just, and more attuned to the realities of adolescence. We hope it supports your practice, affirms your instincts, and helps grow a future where care is centered not in fear, but in relationship.

Part I

Welcome to Harm Reduction

Amanda Reiman Ph.D., MSW

Welcome to Harm Reduction

Why did we write this book?

Talking about drug use is difficult. Not only are there real mental and physical health outcomes at stake, our society has attached mortality to the use of illicit substances (Duster, 1970; Peele, 1998). People who use drugs are often viewed as mentally ill, weak, lazy, and out of control. The United States has not only bought into the message that those who use drugs are "less than", we have gone so far as to say that people who use drugs are criminals. Drug offenses account for a significant portion of the federal prison population. As of recent reports, approximately 45% of federal inmates are incarcerated for drug-related offenses, equating to about 60,000–65,000 individuals. In state prisons, the percentage of individuals incarcerated for drug offenses is smaller compared to violence or property crimes. Drug offenses account for about 15–20% of state prisoners, translating to roughly 200,000–250,000 individuals annually. Many people are held in local jails on drug charges, often pretrial or for short sentences. On an annual basis, several hundred thousand individuals may cycle through jails for drug-related offenses, with some estimates ranging from 400,000–500,000 admissions. Annually, around 650,000–750,000 adults may be incarcerated (including federal, state, and local facilities) for drug-related charges, though this number can vary based on law enforcement practices, sentencing laws, and reforms like decriminalization or diversion programs (Department of Justice, 2024). This sends the message that people who use drugs are dangerous to society and must be kept separate from them. It also suggests that using drugs is an easy way to ruin your future and condemn you to a lifetime of criminal justice involvement. After all, those convicted of felony drug crimes continue to experience punishment after they are released from prison. Collateral sanctions for drug offenses can include the inability to vote, receive federal funding for college or access to public housing, obtain employment or a professional license, and adopt a child (Kimball & Grawert, 2021). And while 80% of people who use illicit substances do not enter addiction, the belief spouted from anti-drug propaganda is that even one time will get you "hooked" (Hart, 2021).

Because of the societal framing of drug use, the impact that a drug charge can have on your present and future, and the belief that drug addiction happens to 100% of drug users, it is no wonder that parents and educators feel that they must prevent teen substance use at all costs. To be clear, intoxicating substances of any kind, including alcohol and non-prescribed pharmaceutical drugs, are not appropriate for teens for reasons we will discuss. However, the going strategy has been to deploy the same basic tactics used on adult substance users to teens who

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are caught using drugs. Punishment, mandating traditional treatment, denial of privileges, detainment, and shaming are common current methods for deterring teen substance use. But we feel that there is a better way, rooted in public health and safety, and sensitive to the teen experience and family dynamics: harm reduction. (For the sake of consistency, we will use the term "traditional treatment" to refer to one-size-fits-all, abstinence-only models.)

There are four main reasons that we decided to write this book.

1. *To acknowledge the current "Just Say No" approach and the difficulty parents have with honest, pragmatic, and safety-based conversations with their teens about substance use*.

As we mentioned, drug users are framed as dangerous people with no future. There is also the belief that everyone who uses an illicit drug becomes addicted to it. Those who care about young people think that simply telling them not to use drugs because they are dangerous and addictive is enough. Unfortunately for them, developmental related impulses in teenagers sometimes make rational decision making a problem, and desire to be accepted by peers can influence behavior in ways that will not exist in adulthood. Looking at the data on teen substance use is enough to know that, while rare, teens ARE using drugs. In 2023, 6.5%, 11.3%, and 19.8% of 8th, 10th, and 12th graders, respectively, reported using an illicit drug in the past 30 days (Monitoring the Future, 2023). If we can accept that teen drug use happens, we should also acknowledge the failure of an abstinence only approach and the need for conversations about drugs that revolve around support and safety.

2. *To teach students about the traditional concepts of harm reduction and how they can be related to adolescent substance use and family therapy*.

Family systems theory tells us that the family is a connected web of established roles and ways of communicating that predict its functionality (McGinnis & Wright, 2023). Family therapy often focuses on these roles and connections as a way of detangling maladaptive patterns. When a teen in the family is using substances, regardless of whether that is a problem in and of itself, it can be disruptive to the system. Using techniques from the field of harm reduction can minimize the ripples caused by the substance use and instead invite the conversation about underlying factors without blame and judgment. The substance use itself should not be viewed as the cause of the rift, it is a warning sign that a rift exists and must be addressed. We explore this concept later in the book by examining the CRAFT method.

3. *To differentiate between experimentation and problematic use in the context of potential harms for all adolescent use of drugs and alcohol. And to also recognize the risks of drug and alcohol use during this time of personal development*.

"All use is abuse." This is a common trope in the discussions about drug use and addiction, fueled by the War on Drugs, abstinence-only treatment programs, and the Just Say No programs of the 1980s and 1990s. Interestingly, this claim only seems to apply to those who use illicit substances, as most of us know plenty of people who drink alcohol only occasionally and without incident. But, when it comes to adolescents, there is a zero tolerance policy for both alcohol and illicit drugs, as we will explore later in this book. But is it warranted? Should the same approach, for example, be taken with a kid who is doing well in school, has good relationships with his family, and close, supportive friends but gets caught smoking a joint in a park on a Saturday, and a kid who is having behavioral issues at school, trouble at home,

and is getting drunk every morning before cutting class? The point is, that for everyone, including teens, all use is NOT abuse. Furthermore, all use is not the same and does warrant the same approach. We want to present a spectrum of substance use for adolescents that can guide a pragmatic and realistic response.

As previously mentioned, intoxicating substances of any kind not prescribed by their doctor are not appropriate for adolescents. Not only are adolescent brains still forming and developing, the developmental issues around behavior and risk taking mentioned earlier deem them not mature enough to always make rational decisions about drugs and alcohol. There is a reason we don't let teens drive until they are 16, vote when they are 18, and buy alcohol and cannabis (in legal markets) until they are 21. We are saying that their minds and bodies have not matured to a place where we can count on them to make sound and smart decisions about risky behaviors. Some may argue that kids should be able to buy alcohol at 18 since they are already finding ways to obtain it. But the point is that we restrict certain activities because of the risks of an immature and less developed approach to the behavior. But while we can acknowledge the risks of teen substance use, we have already established that it exists, even if we wish all teens abstained until they were old enough to handle the behavior responsibly.

4. *To allow students to practice what can sometimes be difficult discussions with parents and teens around this highly charged, emotional issue*.

By now it should be evident that approaching the topic of teen substance use with parents and families can be emotionally intense and met with fear. This fear of THEIR children succumbing to drug addiction and all of the societal scarlet letters that come with it can encourage them to take the antiquated "Just Say No" approach. And while a harm reduction approach is much more likely to keep their teen safe and encourage open and honest communication, doing anything but admonishing and punishing substance use feels like they are giving their teen a pass to use drugs. In this book you will find exercises that will allow you to practice the harm reduction approach, as well as the conversations you may have with parents concerned about their teen. These conversations may not be easy, but practicing them and learning more about harm reduction will up your skill level and confidence.

Chapter 1

Harm Reduction History and Concepts

Harm Reduction: History and Concepts

History

In this book, we are discussing harm reduction in the context of adolescent substance use. And while harm reduction has not always been centered on the issue of substance use, it has always been related to public health and personal safety, and rooted in compassion and activism. Programs that feed those who cannot afford food without passing judgment or asking for anything in return. Providing people who use drugs with access to alternative health and wellness treatments. Safe access to health services like abortion. These services and programs follow the concepts of harm reduction (National Harm Reduction Coalition, 2024: https://harmreduction.org/movement/evolution/). The public health crisis of HIV/AIDS in the 1980s is what sped up the evolution of harm reduction. The spread of HIV/AIDS was like a steam engine racing through the gay community as well as the community of people who used intravenous drugs. At the time, these communities were blamed for the spread, with talk centering around their moral choices. Some even thought that HIV/AIDS was a punishment for their lifestyles. As we later discovered (not soon enough to prevent the decimation of entire enclaves of people), the reason these communities were hit especially hard was because of the ways in which HIV/AIDS was contracted: through the exchange of blood and/or sexual fluids. Harm reduction seeks to provide strategies for making behaviors safer, without demanding that the behavior cease. In this case, providing condoms and clean needle kits. Without judgment. The message was simple. We do not want you to die. Using these safety tools will help you live (O'Hare, 2007). And thus, the concept of harm reduction places survival and good health above morally driven demands of abstinence. But harm reduction does not downplay or ignore the risks associated with sexual activity or substance use. Rather, harm reduction believes that there are ways to help people live healthier, longer lives, EVEN IF they continue to use substances (Marlatt, 1996).

One of the first places to implement a harm reduction approach to substance use was in Merseyside, United Kingdom, in response to heroin use. Relying on the framework of the old British system, the clinic in Merseyside reasoned that, for some people, heroin maintenance might be necessary to successfully treat them for other mental and physical health issues and for them to live a valuable life. Today, patients in Merseyside are still prescribed injectable heroin. Merseyside also started one of the first syringe exchange programs and gave their clients access to fresh food, knowing the importance of nutrition on physical and mental health. The program also had the support of local police, which helped remove criminal justice sanctions from the environment (Inciardi, 2000). In 1985, the Mersey Drug Training and

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Information Center (MDTIC) opened. Next door to the Liverpool Drug Dependency Unit (LDDU), the MDTIC had a mission to provide public health-based, safety-focused information about drug use to anyone who wanted it and to train public health professionals on how to approach substance use and people who use drugs from a harm reduction perspective (O'Hare, 2007).

The idea of providing those who are drug dependent their drug of choice to stave off withdrawals and help them maintain a productive life used to be the law of the land in the United States. Up until the Harrison Narcotics Act of 1914, doctors routinely prescribed drugs to people simply to prevent withdrawals and maintain normalcy. When the act was passed, doctors were no longer allowed to engage in this practice and could only prescribe drugs for a "bonafide medical reason". Almost overnight, the illicit drug market was born (Herzberg, 2020).

The actions taken in Merseyside influenced the implementation of harm reduction programs in North America and Switzerland. The first harm reduction conference – The International Conference on the Reduction of Drug Related Harm – was held in 1990 in Liverpool, Merseyside's largest city. The International Harm Reduction Coalition was established at the conference in Warsaw in 1996. The conference has been used as a jumping off point for regions of the world interested in this innovative approach for substance use. When the conference was held in São Paulo, Brazil, in 1998, it ignited discussions about harm reduction in South America. The concept and practice of harm reduction also began getting endorsements from major health entities such as the World Health Organization, which announced their support at the 2002 conference in Slovenia (O'Hare, 2007).

Concepts

The concepts behind harm reduction were developed by the Harm Reduction Coalition (https://harmreduction.org/about-us/principles-of-harm-reduction/) and have been adopted by harm reduction focused programs and centers around the world. Below is a review of these concepts and Exercise 1 will allow you to brainstorm ways in which these concepts apply to working with adolescents.

1. Accepts that substance use is a part of society. Believes that working to reduce the harms associated with use is more beneficial than ignoring or condemning use.
   The War on Drugs established a militaristic and criminal justice approach to people who sell and use drugs. These policies supported the belief that long prison sentences and collateral sanctions such as voter disenfranchisement would discourage and even eliminate the use of illegal drugs. As a result, the US ended up as the country with the largest percentage of their population incarcerated in the world (Fair & Walmsley, 2021). The harm reduction approach moved away from punishment and towards a public health framework for substance use. People participate in potentially harmful activities every day. From sexual intercourse, to driving a car. Rather than forbid or condemn these activities due to risk, we educate people on how to make these activities safer. We discuss condom use and consent. We provide cars with seat belts and install traffic signals. These methods are more effective at reducing the harms associated with having sex or driving a car than simply outlawing these behaviors or ignoring the risks associated with them.
2. Acknowledges that substance use is complicated and multi-faceted. Recognizes that there is a spectrum of use, from abstinence to experimentation to regular use, and that there are steps that can be taken to reduce the chance of harm across the spectrum of use.