Safety, Compassion, and Dignity

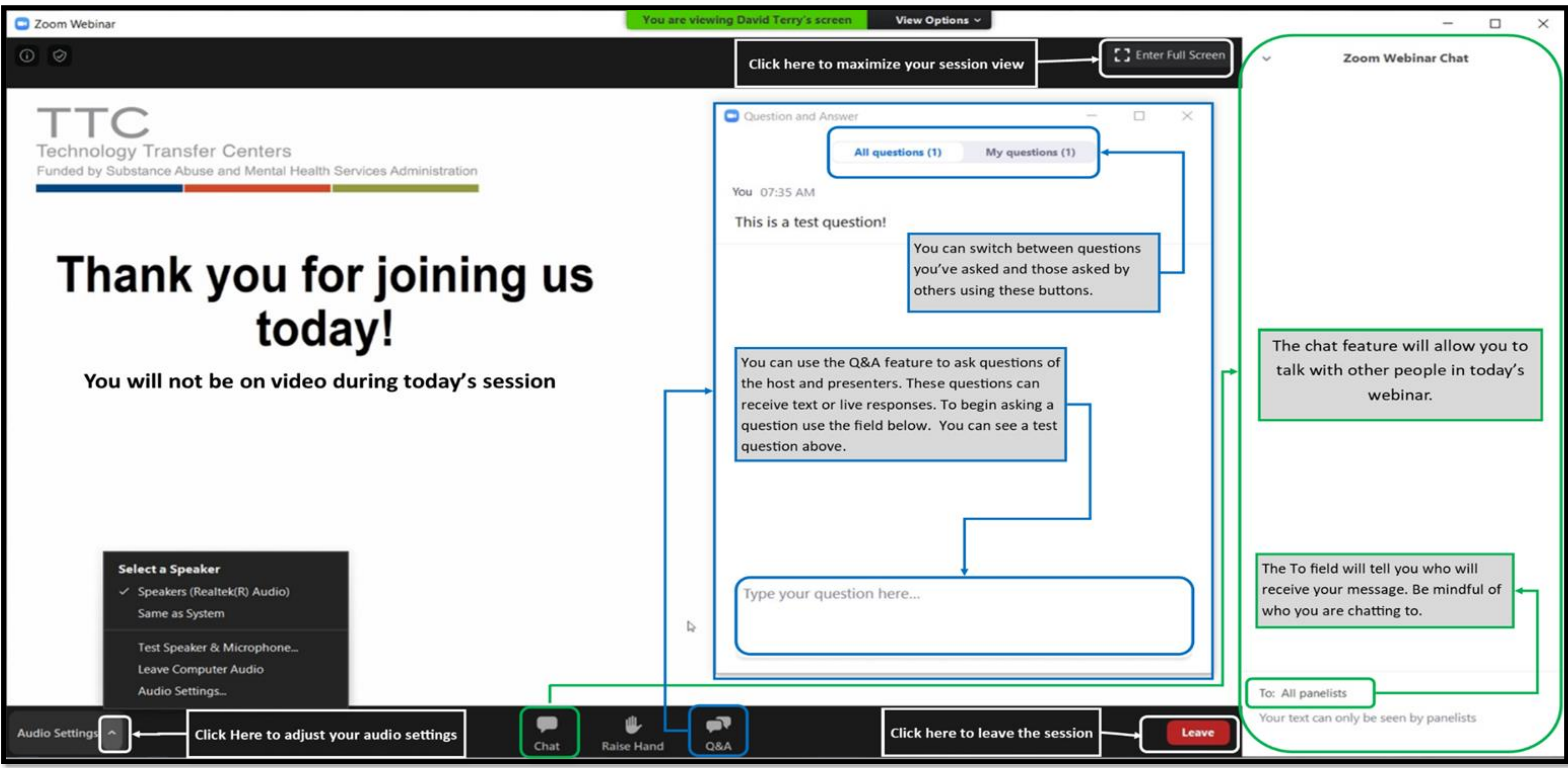
A One Day Symposium on Harm Reduction, Healing Justice, and Mental Health Approaches

Opening & Welcome

9:00 am PT - 9:30 am PT / 10:00 am -10:30 pm MT / 11:00 am - 11:30 am CT / 12:00 pm -12:30 pm ET

Pacific Southwest MHTTC Staff

Get to Know the Zoom Webinar Interface



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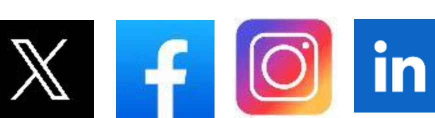

Please Note

Session recordings, slides, and materials will be posted on our website within 1 week.

Acknowledgment

Presented in 2021 by the Mental Health Technology Transfer Center (MHTTC) Network

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At the time of this publication, Miriam E. Delphin-Rittmon, Ph.D., served as Assistant Secretary for Mental Health and Substance Use in the U.S. Department of Health and Human Services and the Administrator of the Substance Abuse and Mental Health Services Administration.

The opinions expressed herein are the view of TTC Network and do not reflect the official position of the Department of Health and Human Services (DHHS), SAMHSA. No official support or endorsement of DHHS, SAMHSA, for the opinions described in this document is intended or should be inferred.

This work is supported by grant 13542175 from the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

Presented 2021

Mental Health Technology Transfer Center
Funded by SAMHSA

Pacific Southwest Mental Health Technology Transfer Center (PS MHTTC) Region 9

General Mental Health Workforce

Youth & Young Adult Services and Supports

School Mental Health Workforce

Harm Reduction, Healing Justice and Mental Health

Why today and why now?

Art by Favianna Rodriguez

What might today feel like?

Opening & Welcome	**PS MHTTC Staff**	**9:00 am - 9:30 am**
Keynote: *Compliance Versus Care: Exploring the Root Questions of Harm Reduction*	**Jen Leland, MFT (she/her/fluid)** **Maurice Byrd, LMFT (he/him)**	**9:30 am - 10:10 am**
Overview of Day	**PS MHTTC Staff**	**10:10 am - 10:20 am**
Break		***10:20 am - 10:30 am***
Workshop: *Non-suicidal Self-harm & Injury Reduction*	**Priscilla Ward, LCSW (she/her)**	**10:30 am - 12:00 pm**
Break		***12:00 pm - 12:15 pm***
Panel: *Honoring Voices of Lived Experience & Allyship*	**Dylan Thomas (he/him)** **Gabriela Zapata-Alma, LCSW, CADC (they/them)** **Janis Whitlock, Ph.D., MPH (she/her)**	**12:15 pm - 1:45 pm**
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Regional Spotlights: *Shining Light on Ways to Approach Harm Reduction in Practice*	**Erin Hughes, MSW, PPSC (she/her)** **Lilinoe Kauahikaua, MSW (she/her/'o ia)** **Stacey Cope (they/them)**	**2:00 pm - 3:15 pm**
Break		***3:15 pm - 3:30 pm***
Discussion, Integration, & Closing	**PS MHTTC Staff**	**3:30 pm - 4:00 pm**

** All times are Pacific Time*

Creating the Container
Settling into Purpose,
Ourselves, and the Land

The MHTTC Network uses affirming, respectful and recovery-oriented language in all activities. That language is:

- Strengths-based and hopeful
- Inclusive and accepting of diverse cultures, genders, perspectives, and experiences
- Healing-centered/trauma-responsive
- Inviting to individuals participating in their own journeys
- Person-first and free of labels
- Non-judgmental and avoiding assumptions
- Respectful, clear and understandable
- Consistent with our actions, policies, and products

La Red de los Centros de Transferencia de Tecnología sobre Salud Mental (MHTTC, por sus siglas en inglés) utiliza un lenguaje afirmativo, respetuoso y orientado a la recuperación de las personas, en todas sus actividades.
Este lenguaje es:

- Basado en las fortalezas y en la esperanza
- Inclusivo y de aceptación a diversas culturas, géneros, perspectivas y experiencias
- Centrado en la sanación y sensible al trauma
- Motiva a que las personas decidan su camino
- Centrado en la persona y libre de etiquetas
- Libre de suposiciones y juicios
- Respetuoso, claro y comprensible
- Consistente con nuestras acciones, políticas y productos

Adapted from: https://mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

Working Agreements for Our Time Together

1) **Safety and self-preservation first.** You know yourself best. If you need to shake it out, find something green in the room, hydrate - please do.

2) **We are each our own best expert.** Stick with “I” statements and avoid advice-giving. Your experience is yours and please honor and respect that others’ experiences are theirs. If you’d like to hear specific advice or insight about other’s strategies and practices during this time, just ask.

3) **Be as present as possible:** We’ve all got a lot going on. And this time is for us and our growth and learning.

4) **Sharing isn’t mandatory:** While we invite you to share in the chat, there’s not requirement to share.

5) **Recognize that no two experiences are the same**. Let’s listen to each other with care, respect and dignity.

6) **Expect and accept a lack of closure.** This symposium will not be able to speak to everything, but it will speak to some things. Take what feels resonant and translate what might not feel central but could be impactful. Know that there is always room for more learning, listening and leading.

Community Connector

Round 1: When **safety** is present, how do you feel? Physically? Emotionally? What are signs that **safety** is present?

Round 2: When **compassion** is present, how do you feel? Physically? Emotionally? What are signs that **compassion** is present?

Round 3: When **dignity** is present, how do you feel? Physically? Emotionally? What are signs that **dignity** is present?

“Healing Justice…identifies how we can holistically respond to and intervene on generational trauma and violence, and bring collective practices that can impact and transform the consequences of oppression on our bodies, hearts, and minds.”

- Cara Page & Kindred Healing Collective

”

Harm reduction is not antithetical to treatment; it is a guidepost on the recovery continuum with the lowest barriers to access, the highest potential for optimism and backed by a wide body of science.

As members of the treatment provider community, we have a moral imperative to engage and care for all people in need, not just those who find themselves on our doorstep.

~

Harm Reduction is About Hope and Saving People’s Lives - National Council for Mental Wellbeing
https://www.thenationalcouncil.org/harm-reduction-is-about-hope-and-saving-peoples-lives

Today, we come together to explore these questions:

1) By centering the lived and living experience of people and communities, how might community-driven public health strategies help us care for our clients and patients differently?

2) How might we as service providers listen and learn from communities who are already taking care of each other, saving each other's lives in ways that might be uncomfortable but necessary?

Settling Into This Moment

Take the next thirty seconds to engage in any of the following practices:

1. Drop your shoulders.
2. Exhale deeply.
3. Unclench your jaw, then your belly.
4. Take a big stretch.
5. Sip water.
6. Shake it out a little.
7. Offer gratitude.
8. Feel into your feet. Wiggle your toes.

Keynote Speakers

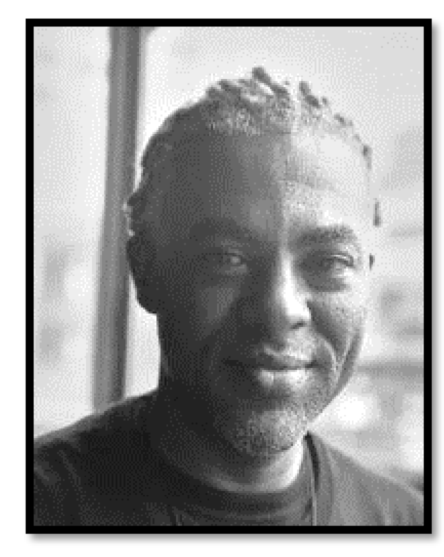
9:15 am PT - 9:45 am PT / 10:15 am - 10:45 pm MT / 11:15 am - 11:45 am CT / 12:15 pm - 12:45 pm ET

Compliance Versus Care:
Exploring the Root Questions of Harm Reduction

Jen Leland, MFT (she/her/fluid)

Jen Leland is a white, queer, licensed marriage and family therapist who spent her adolescence in psychiatric, substance abuse, and group residential care programs using abstinence and high control, coercive approaches. These experiences of harm spurred her 25-year commitment to working in public systems and youth programs, organizing around harm reduction and healing justice principles to create more stories of healing and fewer stories of institutional trauma and harm. She currently works at the RYSE Center in Richmond, California, as Clinical Director, working with young people to build the health justice spaces and practices they deserve.

Maurice Byrd, LMFT (he/him)



Maurice Byrd is a licensed Marriage and Family Therapist working as a harm reductionist for the past 20 years. He is a clinical supervisor and has collaborated in the development and implementation of community mental health programs for people experiencing chronic mental health disorders, substance use disorders, and experiencing homelessness. He has provided mental health services in middle schools, high schools, private practice settings, the San Francisco County Jail system, San Quentin prison, homeless drop-in centers, needle exchanges, and on the sidewalk with people experiencing homelessness.

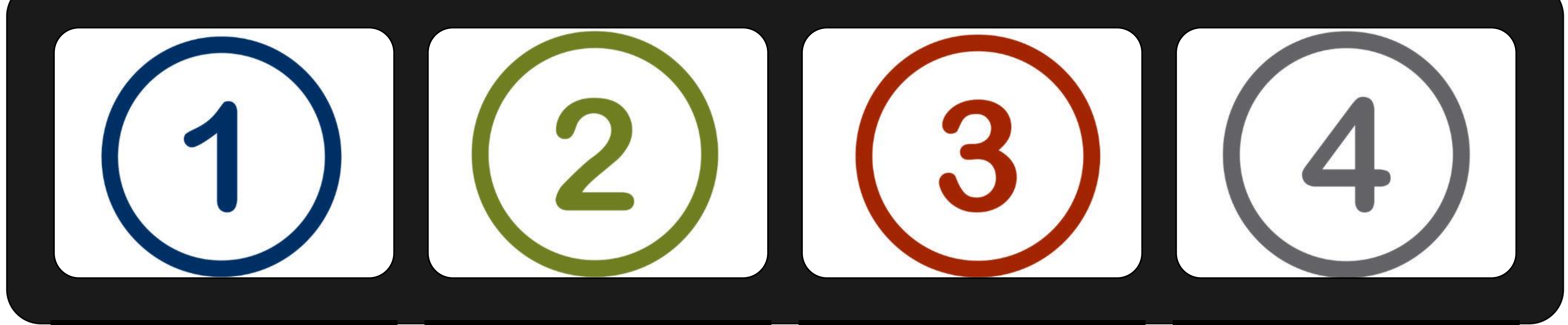
Maurice trains, teaches, supervises, and provides consultation to both clinical and non-clinical staff at several non-profit agencies across the country and specializes in teaching the fundamentals of practicing Harm Reduction Psychotherapy. Maurice has taught in the MFT program at Holy Names University in Oakland, California, focusing on substance use interventions and community mental health.

Coercion vs Care: Exploring Roots, Parts, and Principles of Harm Reduction Therapy

A Conversation With Maurice Byrd and Jen Leland

Graphics Designed by RYSE Center

Four-Part U.S Harm Reduction Movement



Grassroots Public Health

Saves Lives and Prevent Illness

Housing First and Food Equity

Health, Safety, and Stability of Indoor Living

Human Rights

Ending the War on Drugs

Treatment

Relationship and ANY Positive Change

**Healthy Food Access and Equity*

Guiding Principles of Harm Reduction Therapy

The Spirit of Harm Reduction

Parts and Principles

1

- Not all drug use (sex, eating, self-injury behaviors) is abuse
- There is a continuum of use/behaviors
- Harm reduction is agnostic as to behavior

Right to be messy.

2

- Drug use/abuse are health issues, not moral or legal issues
- People should not be punished or denied resources for what they do with their bodies

**People need more than what systems, healthcare, schools can provide*

Bodily Autonomy + Right to Resources

3

- People use drugs and engage in complicated behaviors for reasons

*because it works
*harm is relative

We don’t define what harm is for others.

SHARE

Conversation and Collective Inquiry

Please share your thoughts in the zoom *poll.*

Conversational Inquiry: Concepts + Tensions

Incremental change is normal, motivation is fluid, and can be influenced by skilled interventions.

AND

Harm reduction is more than incrementalism.

Conversational Inquiry: Concepts + Tensions

Is a collaborative process,
not an outcome model.

The relationship is as important
as the intention or the goal.

Harm reduction is* ***not* *a pathway
to treatment or abstinence.*

”

Harm reduction disconnects the ideas of sobriety and healing. We center all of our lived experiences and don’t create false hierarchies with sobriety at the top. We honor decisions to be off medications, use herbs, or engage in the street economy through the sex trade of selling drugs.

Se hold each other close and fall in love with each other’s survival and survival strategies.

- Shira Hassan

From the closing of the book ~ Saving Our Own Lives a Liberatory Practice of Harm Reduction (2022), Shira Nassan asks those in harm reduction conversations that we remember:

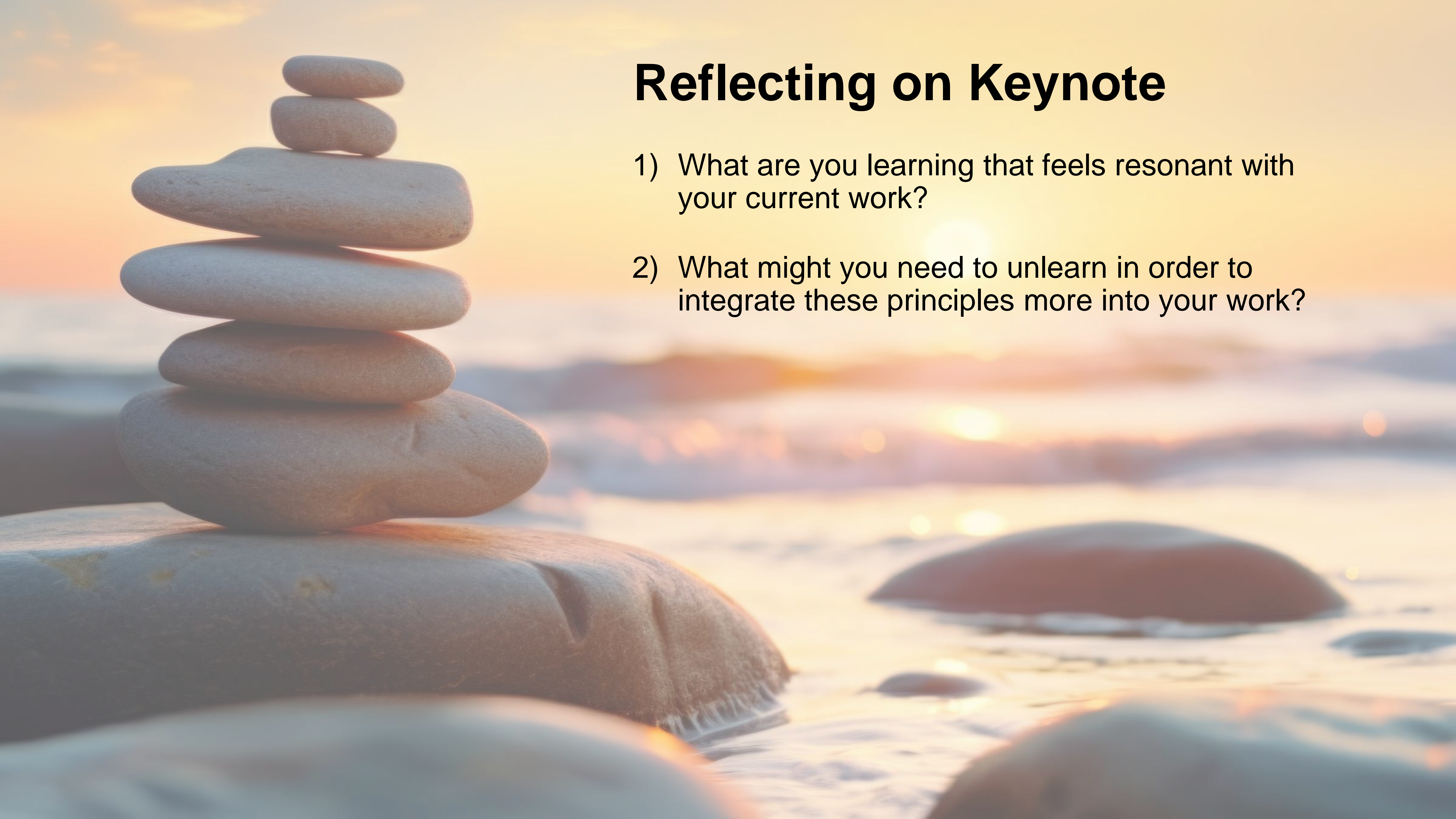
"That harm reduction was started by BIPOC organizers, by people in the sex trade, by trans people, by disabled/chronically ill people, by sex workers, by drug users, by young people, by antiracist activists…

To remember we have everything we need to survive inside our relationships with one another; Inside our creative and brilliant community connections, inside our coping strategies, inside our joy and grief

To release the shame that comes with our struggle and live into our complexity;

To carry ourselves with rage and glamour, love and fury, creativity and despondence, generosity and curiosity.

They (~book contributors) don't want us to be anything but here…"


Reflecting on Keynote
1) What are you learning that feels resonant with your current work?
2) What might you need to unlearn in order to integrate these principles more into your work?

Overview of the Day

10:10 am PT - 10:20 am PT / 11:10 am -11:20 pm MT / 12:10 pm - 12:20 pm CT / 1:10 pm -1:20 pm ET

Pacific Southwest MHTTC Staff

Coming Up Next

Break		***10:20 am - 10:30 am***
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Discussion, Integration, & Closing	**PS MHTTC Staff**	**3:30 pm - 4:00 pm**

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It's Break Time!

Exhale.

Roll shoulders.

Eat.

Shake.

Look at something green.

Hydrate.

Be.

Session 1: Workshop

10:30 am PT - 12:00 pm PT / 11:30 am - 1:00 pm MT / 12:30 pm - 2:00 pm CT / 1:30 pm - 3:00 pm ET

Non-Suicidal Self-Harm & Injury Reduction

Strategies to Reduce Harm from NSSI

Moderated by

Danielle Raghib, LCSW (she/her)

Technical Assistance Specialist

Center for Applied Research Solutions (CARS)

About Our Time Together

- Welcome and Housekeeping: Non-Suicidal Self-Harm & Injury Reduction
- Meet Our Faculty
- Outcomes
  - Understand the etiology and psychological functions of non-suicidal self-injury behaviors (NSSIB).
  - Effectively assess and identify appropriate NSSIB interventions that promote resolution and recovery in the least restrictive settings.
- Q&A with our Faculty
- Reflections and Closing

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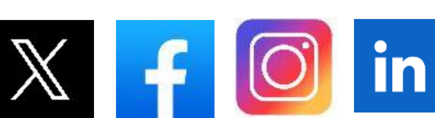

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Meet the Faculty

Priscilla Ward, LCSW (she/her)

Priscilla is a Licensed Clinical Social Worker who has dedicated the past 19 years of her life to the helping profession by supporting youth, young adults, and families across a variety of settings. Priscilla earned her Bachelor of Science degree in Human Services from California State University, Fullerton and her Masters in Social Work from the University of Southern California.

Priscilla's work has included leading and managing mental health teams across the Orange County Department of Education in alternative education settings, including correctional facilities. She has trained law enforcement personnel, educators, interns, church staff, performing artists facilitating arts programs and community members on topics ranging from trauma informed care, mental health treatment, crisis intervention, suicide assessment and safety, school based mental health, substance abuse treatment, and managing the impact of vicarious trauma and secondary traumatic stress.

Harm Reduction & Non-Suicidal Self-Injury

Strategies to Reduce Harm from NSSI

Presented by: Priscilla Ward, LCSW

ACTIVATION WARNING

"The content covered here is meant to enhance the knowledge of mobile crisis team members; however, the topic of Non-Suicidal Self Injury can be triggering."

"We encourage you to take care of yourself during this presentation if you find yourself becoming activated. Take breaks when you need them, turn off your camera when needed, step away if needed. Do what feels best for you."

Understanding NSSI

What is NSSI?

Center for Substance Abuse Treatment

"NSSI is distinguished from a suicide attempt or suicide because it does not include suicidal intent." (2009)

Behaviors

Intentional external injuries include cutting, burning, scratching, carving into the skin, picking the skin, head banging or hitting oneself, hair pulling, and preventing wounds from healing.

Key Points

- Distinctions from SI: No suicidal intent
- Risks associated with NSSI

NSSI, or non-suicidal self-injury, involves intentionally harming one's own body tissue WITHOUT suicidal intent. While it may provide temporary relief, NSSI can lead to more dangerous behaviors over time and those who engage in NSSI are at higher risk of suicide without intervention.

Why Do People Engage in NSSI?

Psychopathology

Occurrence of NSSIB within the context of other disorders (Ex: mood disorders, borderline personality disorder)

Internal Motivators

Emotional pain, hopelessness, and a desire to escape (Intrapersonal).

External Factors

Conflicts with parents, friends, and significant others, social pressures promoting suicide, and a desire for help from others (Interpersonal).

Motivation may vary from person to person...

Method of coping with emotional distress • Finding relief (emotional release) • Feeling in control • To displace emotional pain to the body • To distract from overwhelming emotions • To make the pain visible (ex. needing to feel something) • A method of self-expression • Seeking intense feelings of euphoria (endorphin release) • Punishing one-self • Eliciting an interpersonal response (Example: In the context of Borderline Personality Disorder • An alternative to suicide

NSSI Assessment Tools

Self-Injurious Thoughts and Behaviors Interview (SITBI)

- Structured interview
  Assesses the presence, frequency, and characteristics of self-injurious thoughts and behaviors
- Includes assessment of suicidal ideation, suicide plans, suicide gestures, suicide attempts, and non-suicidal self-injury
- Long form – 169 questions
- Short form – 72 questions

Ottawa Self-Injury Inventory

- Self-report measure
- Comprehensive assessment - including measurement of its functions and addictive features

Name: ______________________ **Sex**: ☐ Male ☐ Female

Today's Date: ____ DD ____ MM ____ YY **Date of Birth**:____ DD ____ MM ____YY **Age**: ____

1.

How often in the past <u>month</u> have you: *circle "0" if not at all and circle "3" if daily*	not at all	at least once	weekly	daily
Thought about injuring yourself without the intention to kill yourself?	0	1	2	3
Actually injured yourself, without the intention to kill yourself?	0	1	2	3

2.

How often in the past <u>6 months</u> have you: *circle "0" if not at all and circle "4" if daily*	not at all	1 to 5 times	monthly	weekly	daily
Thought about injuring yourself without the intention to kill yourself?	0	1	2	3	4
Actually injured yourself, without the intention to kill yourself?	0	1	2	3	4

3.

How often in the past <u>year</u> have you: *circle "0" if not at all and circle "4" if daily*	not at all	1 to 5 times	monthly	weekly	daily
Thought about taking your life (killing yourself)?	0	1	2	3	4

4. **Have you ever made an actual attempt to take your life?** ☐ no ☐ yes

If yes, then please indicate the number of times:

in the past month: ____ in the past 6 months: ____ in the past year: ____ prior to one year ago: ____

5. **Have you ever been treated by a doctor after injuring yourself on purpose? (e.g., stitches, wound dressings, etc.)** ☐ no ☐ yes

If yes, how often did a doctor treat you in the *past year* for hurting yourself on purpose?________________ time(s)

6. **Have you been kept in hospital because of hurting yourself on purpose?** ☐ no ☐ yes

If yes, how many times in the *past year* did you stay overnight in emergency? ______________________________

If yes, how many times in the *past year* did you get admitted to a hospital unit?______________________________

Mary Kay Nixon, M.D. & Paula Cloutier, M.A.
Copyright 2005

Researchers and clinicians working in non-profit or publicly owned settings (including universities, non-profit hospitals, and government institutions) may make single copies of the OSI instrument for their own clinical and research use.

7. **If you indicated that you had thought about or actually injured yourself in questions 1-4:**
How old were you when you started to self-injure? ______________________ (years old)

8. **The first time you hurt yourself, where did you get the idea?** (please ☑ only one)

- ☐ I read about it on an internet website
- ☐ I read about it on a Web Blog
- ☐ I read about it in a book or magazine
- ☐ I saw it happen in a movie or on television
- ☐ I saw other people do it in a non-hospital setting
- ☐ I heard about it from other people in a non-hospital setting
- ☐ I heard about it from other people in a hospital setting
- ☐ I saw other people do it in a hospital setting
- ☐ It was my own idea
- ☐ Other (please list)______________________

9.

When you get the urge to hurt yourself: *circle "0" if not at all and circle "4" if extremely*	Not at all		somewhat		extremely
The urge is distressing / upsetting	0	1	2	3	4
The urge is comforting	0	1	2	3	4
The urge is intrusive / invasive	0	1	2	3	4

10. **Do you <u>only</u> harm yourself after taking drugs or alcohol?** ☐ no ☐ yes

11. **Do you let other people know that you harm yourself?**

- ☐ no one
- ☐ some people
- ☐ most people

who do you tell? →

- ☐ friend(s)
- ☐ psychologist/psychiatrist
- ☐ other Mental Health Professional
- ☐ telephone helpline
- ☐ family member(s)
- ☐ family doctor
- ☐ school counsellor
- ☐ other (specify)

____

12. a) **What areas of your body did/do you injure?**

Please (√) all that apply

	WHEN YOU FIRST STARTED	CURRENTLY (past month if still self-injuring)
Scalp		
Eye(s)		
Ear(s)		
Face		
Nose		
Lips		
Inside of mouth		
Neck/throat		
Chest		
Breast(s)		
Back		
Shoulder(s)		
Abdomen		
Hips/buttock(s)		
Genitals		
Rectum		
Upper arm/elbow		
Lower arm/wrist		
Hand/fingers		
Thigh/knee		
Lower leg/ankle		
Foot/toes		
Other (specify):		

b) *Above, please circle the part that you currently injure the most*

13. a) **How did/do you injure yourself (without meaning to kill yourself)?**

Please (√) all that apply

	WHEN YOU FIRST STARTED	CURRENTLY (past month if still self-injuring)
Cutting		
Scratching		
Interfering with wound healing		
Burning		
Biting		
Hitting		
Hair pulling		
Severe nail biting and/or nail injuries		
Piercing skin with sharp pointy objects		
Piercing of body parts		
Excessive use of street drugs		
Excessive use of alcohol		
Trying to break bones		
Headbanging		
Taking too much medication		
Taking too little medication		
Eating or drinking things that are not food		
Other (specify):		

b) *Above, please circle the method that you currently use the most*

14.

Why do you think you started and if you continue, why do you still self-injure (without meaning to kill yourself)? *Please circle the number that best represents how much your self-injury is due to that reason. Circle "0" if it has never been a reason that you self-injure and "4" if it has always been a reason that you self-injure.*	Why did you start? Never a reason		Sometimes a reason		Always a reason	If you continue, why do you continue? Never a reason		Sometimes a reason		Always a reason
1. to release unbearable tension	0	1	2	3	4	0	1	2	3	4
2. to experience a "high" that feels like a drug high	0	1	2	3	4	0	1	2	3	4
3. to stop my parents from being angry with me	0	1	2	3	4	0	1	2	3	4
4. to stop feeling alone and empty	0	1	2	3	4	0	1	2	3	4
5. to get care or attention from other people	0	1	2	3	4	0	1	2	3	4
6. to punish myself	0	1	2	3	4	0	1	2	3	4
7. to provide a sense of excitement that feels exhilarating	0	1	2	3	4	0	1	2	3	4
8. to avoid getting into trouble for something I did	0	1	2	3	4	0	1	2	3	4
9. to distract me from unpleasant memories	0	1	2	3	4	0	1	2	3	4
10. to change my body image and/or appearance	0	1	2	3	4	0	1	2	3	4
11. to belong to a group	0	1	2	3	4	0	1	2	3	4
12. to release anger	0	1	2	3	4	0	1	2	3	4
13. to show others how hurt or damaged I am	0	1	2	3	4	0	1	2	3	4
14. to experience physical pain in one area, when the other pain I feel is unbearable	0	1	2	3	4	0	1	2	3	4
15. to stop people from expecting so much from me	0	1	2	3	4	0	1	2	3	4
16. to relieve feelings of sadness or feeling "down"	0	1	2	3	4	0	1	2	3	4
17. to stop me from thinking about ideas of killing myself	0	1	2	3	4	0	1	2	3	4
18. to stop me from acting out ideas of killing myself	0	1	2	3	4	0	1	2	3	4
19. to produce a sense of being real when I feel numb and "unreal"	0	1	2	3	4	0	1	2	3	4
20. to release frustration	0	1	2	3	4	0	1	2	3	4
21. to get out of doing something that I don't want to do	0	1	2	3	4	0	1	2	3	4
22. to prove to myself how much I can take	0	1	2	3	4	0	1	2	3	4
23. for sexual excitement	0	1	2	3	4	0	1	2	3	4
24. to diminish feeling of sexual arousal	0	1	2	3	4	0	1	2	3	4
25. other (please specify):	0	1	2	3	4	0	1	2	3	4

15.

If you indicated that you had thought about or actually injured yourself in questions 1-4, do you feel relief (better) after harming yourself?	Never		Sometimes		Always
circle "0" if never and circle "4" if always	0	1	2	3	4

If you feel relief, how long does the relief last? *(please (√) only one)*

- ☐ less than 1minute ☐ 1 to 5 minutes ☐ 6 to 30 minutes
- ☐ 31 to 60 minutes ☐ hours ☐ days

16. Once you think about harming yourself, do you always do it? ☐ yes ☐ no

17. When you hurt yourself on purpose, on average, how much time goes by between thinking about it and doing it? (Please (√) 1 item only)

- ☐ less than 1 minute
- ☐ 1 minute to 5 minutes
- ☐ 6 minutes to 30 minutes
- ☐ over 30 minutes but less than 1 hour
- ☐ hours
- ☐ days

18.

Do you feel physical pain when you harm yourself?	Never		Sometimes		Always
circle "0" if never and circle "4" if always	0	1	2	3	4

19.

Do you hurt or think about hurting yourself after stressful things happen?	Never		Sometimes		Always
circle "0" if never and circle "4" if always	0	1	2	3	4

↓

If you indicated that you thought about or actually injured yourself in questions 1-4, what kinds of stressful situation(s) typically led to self-injury?

- ☐ abandonment (please specify)____________________
- ☐ failure (please specify)____________________
- ☐ loss (please specify)____________________
- ☐ rejection (please specify)____________________
- ☐ other (please specify)____________________

20.

Since you started to self-injure, have you found that: *circle "0" if never and circle "4" if always*	Never		Sometimes		Always
1.The self-injurious behaviour occurs more often than intended?	0	1	2	3	4
2. The severity in which the self-injurious behaviour occurs has increased (e.g., deeper cuts, more extensive parts of your body)?	0	1	2	3	4
3. If the self-injurious behaviour produced an effect when started, you now need to self-injure more frequently or with greater intensity to produce the same effect?	0	1	2	3	4
4. This behaviour or thinking about it consumes a significant amount of your time (e.g., planning and thinking about it, collecting and hiding sharp objects, doing it and recovering from it)?	0	1	2	3	4
5. Despite a desire to cut down or control this behaviour, you are unable to do so?	0	1	2	3	4
6. You continue this behaviour despite recognizing that it is harmful to you physically and/or emotionally?	0	1	2	3	4
7. Important social, family, academic or recreational activities are given up or reduced because of this behaviour?	0	1	2	3	4

21.

If you are trying to resist hurting yourself, what do you do instead? *Please (√) all that apply*	
Never try to resist	
Talk with someone	
Exercise / sports	
Reading writing, music, dance	
Watch television, play video or computer games	
Do things to relax (e.g., hot bath, yoga, deep breathing)	
Use alcohol and or street drugs	
Do anything to keep hands busy	
Other (specify):	

b) For question 21, *please* (*circle*) *the* *most helpful thing* *you do to resist hurting yourself.*

22.

How motivated are you at this time to stop self-injuring?	Not at all Motivated		Somewhat Motivated		Extremely Motivated
	0	1	2	3	4

23. **What treatment(s) if any, have you received with the goal of reducing and/or eliminating your self-harm?**

(Please (√) all items that apply)

☐ I have not had treatment ☐ I declined treatment ☐ Self help (e.g., self-help books, internet)
☐ individual therapy ☐ school counselling ☐ group therapy
☐ family therapy ☐ medication (please specify) ____________

other (please specify)____________

24. **What treatment(s) if any, have you found the most helpful in reducing and/or eliminating your self-harm?**

(Please (√) all items that apply)

☐ I have not had treatment ☐ I declined treatment ☐ Self help (e.g., self-help books, internet)
☐ individual therapy ☐ school counselling ☐ group therapy
☐ family therapy ☐ medication (please specify) ____________

other (please specify) ____________

25.

I feel that this questionnaire has fully described my experience of Self-Injury	Strongly Disagree		Somewhat Agree		Strongly Agree
	0	1	2	3	4

26. **Is there anything else you would like to share with us regarding your self-injury behaviour?**

____
____
____
____
____
____
____

____

SITBI-Short Form

These questions ask about your thoughts and feelings of suicide and self-injurious behaviors. Please listen carefully and respond as accurately as you can. Do you have questions before we begin?

Suicidal Ideation

1) Have you ever had thoughts of killing yourself? 1)____________
   0) no 1) yes

2) How old were you the first time you had thoughts of killing yourself? *(age)* 2)____________

3) How old were you the last time? *(age)* 3)____________

4) During how many separate times in your life have you had thoughts of killing yourself? (Please give your best estimate.) 4)____________

5) How many separate times in the past year? 5)____________

6) How many separate times in the past month? 6)____________

7) How many separate times in the past week? 7)____________

8) When was the last time? 8)____________

Hand respondent 0-4 rating scale
Here is a scale we will use for a number of the upcoming questions.

9) On this scale of 0 to 4, at the worst point how intense were your thoughts of killing yourself? 9)____________

10) On average, how intense were these thoughts? 10)____________

11) When you've had a thought, what method did you think of using? 11)____________

1) own prescription drugs	7) hanging	13) drowning
2) illicit drugs (not rx)	8) sharp object	14) suffocation
3) over-counter drugs	9) auto exhaust	15) other's rx drugs
4) poison	10) other gases	16) other ____
5) firearms	11) train/ car	17) multiple methods _____
6) immolation	12) jump from height	88) not applicable
		99) unknown

12) When you have thoughts of killing yourself, how long do they usually last? 12)____________

0) 0 seconds	5) 1-2 days
1) 1-60 seconds	6) more than 2 days
2) 2-15 minutes	7) wide range (spans > 2 responses)
3) 16-60 minutes	88) not applicable
4) less than one day	99) unknown

13) On the scale of 0 to 4, what is the likelihood that you will have thoughts of killing yourself in the future? 13)____________

Suicide Plan

14) Have you ever actually made a plan to kill yourself? 14)____________
   0) no 1) yes

We will refer to this as a suicide plan.

15) How old were you the first time you made such a plan? *(age)* 15)____________

16) How old were you the last time? *(age)* 16)____________

17) During how many separate times in your life have you made a plan? 17)____________

18) How many separate times in the past year? 18)____________

19) How many separate times in the past month? 19)____________

20) How many separate times in the past week? 20)____________

21) On the scale of 0 to 4, at the worst point, how seriously did you consider acting on the plan? 21)____________

22) On average, how seriously have you considered acting on them? 22)____________

23) When you've had a plan, what method did you think of using? 23)____________

1) own prescription drugs	7) hanging	13) drowning
2) illicit drugs (not rx)	8) sharp object	14) suffocation
3) over-counter drugs	9) auto exhaust	15) other's rx drugs
4) poison	10) other gases	16) other ____
5) firearms	11) train/ car	17) multiple methods _____
6) immolation	12) jump from height	88) not applicable
		99) unknown

24) When you've had a plan, how long have you thought about it before either moving onto something else or acting on the plan? 24)____________

0) 0 seconds	5) 1-2 days
1) 1-60 seconds	6) more than 2 days
2) 2-15 minutes	7) wide range (spans > 2 responses)
3) 16-60 minutes	88) not applicable
4) less than one day	99) unknown

25) On the scale of 0 to 4, what do you think the likelihood is that you will make a plan to kill yourself in the future? 25)____________

Suicide Gesture

Say slowly - make sure they understand exactly what you are saying

26) Have you ever done something to lead someone to believe that you wanted to kill yourself when you really had no intention of doing so? 26)____________
0) no 1) yes

Only score if there was NO suicidal intent, and they wanted someone else to BELIEVE they wanted to make a suicide attempt

We will refer to this as a suicide gesture.

27) How old were you the first time you made a suicide gesture? *(age)* 27)____________

28) How old were you the last time? *(age)* 28)____________

29) During how many separate times in your life have you made a suicide gesture? 29)____________

30) How many have you made in the past year? 30)____________

31) How many have you made in the past month? 31)____________

32) How many have you made in the past week? 32)____________

33) What have you done? 33)____________

____

34) When you've made a suicide gesture, for how long have you thought about it before doing it? 34)____________

0) 0 seconds	5) 1-2 days
1) 1-60 seconds	6) more than 2 days
2) 2-15 minutes	7) wide range (spans > 2 responses)
3) 16-60 minutes	88) not applicable
4) less than one day	99) unknown

35) On the scale of 0 to 4, what do you think the likelihood is that you will make a suicide gesture in the future? 35)____________

Suicide Attempt

36) Have you ever made an actual attempt to kill yourself in which you had at least some intent to die? 36)____________
0) no 1) yes

We will refer to this as a suicide attempt.

37) How old were you the first time you made a suicide attempt? *(age)* 37)____________

38) When was the **most recent** attempt? 38)___/___/____

39) How many days was that from today? *39)*____________
88) not applicable
99) time unknown

40) How many suicide attempts have you made in your lifetime? 40)____________

41) How many have you made in the past year? 41)____________

42) How many have you made in the past month? 42)____________

43) How many have you made in the past week? 43)____________

44) What method did you use for your most recent attempt? 44)____________

1) own prescription drugs	7) hanging	13) drowning
2) illicit drugs (not rx)	8) sharp object	14) suffocation
3) over-counter drugs	9) auto exhaust	15) other's rx drugs
4) poison	10) other gases	16) other ____
5) firearms	11) train/ car	17) multiple methods _____
6) immolation	12) jump from height	88) not applicable
		99) unknown

45) What were the circumstances that contributed most to your most recent attempt?
Put in order of importance.

1) job loss/ job stress/ academic failure	8) psychiatric symptoms
2) dispute with family or friends	9) humiliating event
3) dispute with spouse/lover	10) other: ___________
4) financial problems	11) refuses to answer
5) eviction	88) not applicable
6) health problems	99) unknown
7) death of another person	

45a)____________
45b)____________
45c)____________

46) What kind of injuries did you have as a result of this attempt? 46)____________

Regarding the **most lethal** attempt:

47) When did it occur? 47)___/___/____

Thoughts of Non-Suicidal Self-Injury

51) Have you ever had thoughts of purposely hurting yourself without wanting to die? (for example, cutting or burning) 51)____________
0) no 1) yes

We will refer to this as non-suicidal self-injury.

52) How old were you the first time you thought about engaging in NSSI? *(age)* 52)____________

53) How old were you the last time? *(age)* 53)____________

54) During how many separate times in your life have you thought about engaging in NSSI? 54)____________

55) How many separate times in the past year? 55)____________

56) How many separate times in the past month? 56)____________

57) How many separate times in the past week? 57)____________

58) On the scale of 0 to 4, at the worst point, how intense were your thoughts about engaging in NSSI? 58)____________

59) On average, how intense were these thoughts? 59)____________

60) When you have had these thoughts, how long have they usually lasted? 60)____________

0) 0 seconds	5) 1-2 days
1) 1-60 seconds	6) more than 2 days
2) 2-15 minutes	7) wide range (spans > 2 responses)
3) 16-60 minutes	88) not applicable
4) less than one day	99) unknown

61) On the scale of 0 to 4, what do you think the likelihood is that you will have thoughts about engaging in NSSI in the future? 61)____________

Non-Suicidal Self-Injury

62) Have you ever actually engaged in NSSI? 62)____________
0) no 1) yes

63) How old were you the first time? *(age)* 63)____________

64) How old were you the last time? *(age)* 64)____________

65) How many times in your life have you engaged in NSSI? 65)____________

66) How many times in the past year? 66)____________

67) How many times in the past month? 67)____________

68) How many times in the past week? 68)____________

69) Now I'm going to go through a list of things that people have done to harm themselves. Please let me know which of these you've done:
1) cut or carved skin
2) hit yourself on purpose
3) pulled your hair out
4) gave yourself a tattoo
5) picked at a wound
6) burned your skin (i.e., with a cigarette, match or other hot object)
7) inserted objects under your nails or skin
8) bit yourself (e.g., your mouth or lip)
9) picked areas of your body to the point of drawing blood
10) scraped your skin
11) "erased" your skin to the point of drawing blood
12) other (specify):________________________
88) not applicable
99) unknown

69a)____________
69b)____________
69c)____________
69d)____________
69e)____________

70) Have you ever received medical treatment for harm caused by NSSI? 70)____________

0) no	88) not applicable
1) yes	99) unknown

71) On average, for how long have you thought about NSSI before engaging in it? 71)____________

0) 0 seconds	5) 1-2 days
1) 1-60 seconds	6) more than 2 days
2) 2-15 minutes	7) wide range (spans > 2 responses)
3) 16-60 minutes	88) not applicable
4) less than one day	99) unknown

72) On the scale of 0 to 4, what do you think the likelihood is that you will engage in NSSI in the future? 72)____________

Important Factors

There are higher rates if NSSI in youth compared to adults. Rates of high school students reporting purposefully hurting themselves without wanting to die over the past 12 months ranged from 6.4 to 14.8 percent for males and 17.7 to 30.8 percent for females in 2015. (Monto, McRee, & Deryck, 2018)

Treatment of underlying mental health conditions is critical to successful outcomes for those that engage in NSSI.

Protective factors that include interpersonal and community connectedness, problem solving skills, adaptability, effective clinical care for physical and mental disorders, and cultural and religious beliefs are critical.

Prevention and early interventions must include identification of individuals in crisis and at highest risk while increasing access to care.

Important Factors

The impact of secrecy and shame

Dangers associated with stigma

Maintaining a trauma-informed, person-centered lens

Personal discomfort

Responding to NSSI

Saftey Planning

Collaboratively developing a personalized list of coping strategies, the individual can use during times of increased risk. Safety planning is brief, effective, and can be done by any health professional with training. Some safety planning approaches include a focus on building hope and reasons for living, helping youth understand their signs and patterns of emotional escalation, and identifying strategies to stay safe.

Treatment Responses

The goal is to reduce the frequency, recurrence, and intensity of NSSI and most effective strategies are conducted over the course of multiple sessions by a licensed mental health professional.

Mental Health Disorders

When self-harm behavior or suicide risk is associated with a mental illness, providers need to identify that condition and modify treatment plans to specifically address the risk of suicide.

Approaching NSSI with understanding and patience can build trust to explore healthier long-term coping skills.

Treatment: Evidence-Based Practices

Overall, outcomes in efficacy to reduce NSSI have not been significant (Muehlenkamp, 2006; Davies et al., 2022).

At this time, there are no interventions that meet the threshold of being evidence-based for self harm/NSSI specifically (Rees et al., 2015; Preston and West, 2022).

DBT is evidence based to treat individuals with Borderline Personality Disorder, in which NSSI and suicidal behaviors are prominent symptoms. This is different than individuals who present with NSSI separate from a BPD diagnosis, however, many studies on DBT have blended the concepts of NSSI and suicidal behaviors (parasuicide) which further limits the usefulness of research when honing in on NSSI (Muehlenkamp, 2006).

LITERATURE LIMITATIONS

Treatment: Evidence-Based Practices

Data is still emerging on harm reduction for NSSI, which is consistent with the history of harm reduction.

Harm reduction is at times viewed as risky (legally and ethically), even in the context of studies that include harm reduction for self-harm but we do have some data from practitioners who provided patients tools to self-harm more safely (Dickens and Hosie, 2018; Haris et al., 2022).

Current approaches include: DBT, CBT, Problem Solving Therapy, Harm Reduction

LITERATURE LIMITATIONS

Harm Reduction Strategies for Non-Suicidal Self-Injury

Training Staff on Self-harm Management

Provide education and training to staff on identifying self-harm behaviors and implementing effective support strategies.

Empowering Individual Choice

Collaborate with the individual to develop alternative coping strategies that provide a sense of control and agency.

Access to Mental Health Resources

Ensure individuals have access to professional counseling and other mental health supports as needed.

A compassionate, non-judgmental approach that focuses on harm reduction rather than elimination can help support individuals who engage in self-harm.

Treatment Evidenced-Based Practices YOUTH

"Clinical management of suicidal behaviors can be complex, and **specific evidence-based interventions to address suicidal ideation and self-harm behaviors are often underutilized or not available**."

-SAMHSA Treatment for Suicidal Ideation, Self-Harm and Suicide Attempts Among Youth (SAMHSA, 2020).

Barriers to Treatment

- Stigma associated with seeking help, mental illness, and suicide
- Practical barriers to engaging in treatment (e.g., cost, transportation, time)
- Lack of parental support for treatment
- Resistance or limited readiness and motivation to seek treatment - When individuals feel they do not have acceptable treatment options, they are less likely to engage in treatment and adhere to care plans.
- Lack of culturally responsive treatments .
- Insurance limitations
- Absence of affordable treatment options
- Clinicians are often uncomfortable with their skill set for treating of youth experiencing suicidal thoughts and behaviors or are not adequately trained to address these concerns in this age group.

Treatment: Evidenced-Based Practices - YOUTH

Dialectical Behavior Therapy (DBT) Data Outcomes (Youth): Reduction in non-suicidal self harm (SAMHSA, 2020) Considerations: Many of the participants presented with symptoms of BPD, including diagnosed BPD, depression and other mood disorders.

Attachment-Based Family Therapy (ABFT) Data Outcomes (Youth): The studies did not measure self-harm (non-suicidal or intent unknown) outcomes (SAMHSA, 2020).

Multisystemic Therapy-Psychiatric (MST-Psych)   Data Outcomes (Youth): MST-Psych did not demonstrate a reduction in suicidal ideation. The study did not measure self-harm (non-suicidal or intent unknown) outcome (SAMHSA, 2020).

Safe Alternatives for Teens and Youth (SAFETY) Data Outcomes (Youth): Reductions in non-suicidal self-harm were observed Considerations: The RCT included in the evidence review did not find statistically significant improvements in non-suicidal self-harm. The studies reviewed did not measure self-harm (intent unknown) outcomes (SAMHSA, 2020).

Integrated Cognitive Behavioral Therapy (I-CBT) Data Outcomes (Youth): The study did not measure self-harm (non-suicidal or intent unknown) outcomes (SAMHSA, 2020).

Youth-Nominated Support Team-Version II (YST-II) Data Outcomes (Youth): The study did not measure self-harm (non-suicidal or intent unknown) outcomes (SAMHSA, 2020)

Understanding Harm Reduction

Abstinence Only + Harm Reduction

Harm Reduction is a philosophy combined with a set of strategies that aims to reduce the negative consequences, or harm that results from risky behaviors.

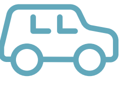
Focus

- Helpful > Appealing
- Grounded in kindness, compassion, and respect for people
- Meeting people where they are and supporting positive change at their pace and autonomy
- Recognizes that issues like substance abuse, NSSI, and other health conditions occur on a spectrum and progress is not dependent on an abstinence-only approach

Core Beliefs

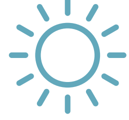
- Substance use and other high-risk behaviors are a part of our world - we can work to minimize harmful effects rather than ignoring or condoning
- All people are capable of change
- Preservation of life and preservation of health are more important than abstinence-only focus (for example, keeping drug users alive)
- Engagement in risky behavior does NOT disqualify a person's right to access health care and social services
- Honoring the dignity and humanity of all people who engage in high-risk behaviors, along with offering them respect and compassionate support without requiring abstinence as a pre-condition is foundational

Daily Harm Reduction Practices


Wearing a seatbelt

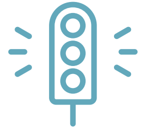
Taking birth control

During the height of COVID, we wore masks


Applying sunscreen

Smoking cigarettes with filters

Brushing our teeth


Adhering to speed limits

We engage in harm reduction practices every day.

The goal is to reduce harm!

Harm Reduction = Trauma-Informed Strategies

Harm reduction approaches are…

- person-centered.
- recovery-oriented.
- culturally responsive.

Harm reduction strategies…

- meet people where they are.
- understand NSSI as a coping mechanism.
- prioritize small, practical changes.
- use non-judgmental affirming language.
- make collaborative decision with the beneficiary.
- assess individual needs + preferences to identify best-fit interventions.

"I had been coerced into treatment by people who said they're trying to help...These things all re-stimulated the feelings of futility, reawakening the sense of hopelessness, loss of control I experienced when being abused. Without exception, these episodes reinforced my sense of distrust in people and belief that help meant humiliation, loss of control, and loss of dignity."

Laura Prescott

Kraybill & Morrisson (2007). Assessing Health, Promoting Wellness: A Guide for Non-Medical Providers of Care for People Experiencing Homelessness. SAMHSA: Homelessness Resource Center, p. 38

NSSI Through the Lens of Harm Reduction

Harm Reduction + NSSI

Traditional approaches view NSSI as something that needs to be controlled or stopped, which can drive self-harm behaviors underground making them more dangerous. Harm reduction in NSSI responses is important and can bring non-judgmental compassion.

- We don't want to be perceived as condoning clients hurting themselves or as "giving them ideas.
- We may feel ethical conflicts when examining the spectrum of NSSI harm reduction approaches.
- We know NSSI is a risk factor for suicide.
- We need to have the uncomfortable conversations because our clients are engaging in these behaviors and our discomfort perpetuates secrecy and shame - causing further harm.
- The more open we can be, the more open clients will be open and this slowly creates an opportunity to help clients engage in alternatives to addressing the underlying causes of their self harm (i.e. trauma).
- Providers need to be curious about client’s self-harm and aim to understand how it’s helping them.

Harm Reduction + NSSI

Key Factors of Successful Harm Reduction Strategies for NSSI

There is no "one side fits all" approach.

- What is safer for one client may be triggering and exacerbate risk and harm in another client! This is more complex than SUD Harm Reduction Strategies.
- A clinical assessment to understand each individual's presentation of NSSI, including triggers, types of harm engaged in, and the relief/outcome they experience is critical.
- NSSI is complex, without adequate clinical assessments, we can perpetuate harm. (Ex. Cutting implements).
- Peer supports are an important part of the process.

NSSI Goals: Preserve life and minimize the risk of serious damage and infection.

Harm Reduction + NSSI

Harm reduction recognizes that self harm meets a need for those who do it and full cessation at any given moment is unrealistic.

Harm reduction is not intended to condone NSSI and the goal is for individuals to also be linked to treatment services in order to continue to address their needs in a therapeutic setting outside of their interaction with mobile crisis response teams. The emphasis is on working with people, not against them (Dickens and Hosie, 2018).

Harm Reduction + NSSI

STRATEGIES

REMINDER: It's important for providers to approach self-harm with empathy, respect, and non-judgment. These harm reduction approaches should always be coupled with appropriate therapeutic interventions to address the underlying emotional distress and support the client in their journey towards healing and recovery.

Gradual Reduction: For individuals who are not ready or able to stop self-harming immediately, harm reduction strategies can focus on reducing the frequency or severity of self-harm over time. Encourage individuals to set achievable goals and track progress, while continually working towards healthier alternatives.

It is important to note that while harm reduction strategies can be helpful, they should always be **accompanied by appropriate mental health support and interventions from trained professionals**. Self-harm is a complex issue, and individuals struggling with it should be encouraged to seek professional guidance to address the underlying emotional distress and work towards long-term recovery.

Harm Reduction + NSSI

STRATEGIES

Safety Planning: Collaboratively creating a safety plan with the client is crucial. This plan should outline specific steps to take when self-harm urges arise, including alternative coping strategies, emergency contact information, and a list of professional supports and resources. Having a safety plan in place can provide individuals with a sense of control and preparedness during challenging moments.

Identifying Triggers and Warning Signs: Providers can work with clients to identify their triggers and warning signs that precede self-harm episodes. By increasing self-awareness, individuals can learn to recognize when they are at heightened risk and develop proactive strategies to manage those moments. This may involve practicing mindfulness techniques, utilizing grounding exercises, or employing distraction techniques when triggers arise.

Harm Reduction + NSSI

STRATEGIES

Self-Care Strategies: Providers can emphasize the importance of self-care as a harm reduction strategy. Encouraging clients to engage in activities that promote self-soothing and self-nurturing can help reduce the frequency and intensity of self-harming behaviors. This may involve developing routines for adequate sleep, practicing healthy eating habits, engaging in regular exercise, and finding activities that bring joy and relaxation.

Healthy Coping Skills: Providers can help clients build a repertoire of healthy coping skills to replace self-harming behaviors. This can include teaching problem-solving techniques, stress management strategies, emotional regulation skills, and healthy communication skills. By providing clients with a range of effective coping mechanisms, they can gradually reduce reliance on self-harm as a primary coping strategy.

Harm Reduction + NSSI

STRATEGIES

Alternative Behaviors

- Snapping rubber bands on wrist
- Pinching self
- Drawing/painting lines on arms, wrists, legs
- Running hands hot water
- Placing extremely spicy or sour candies under the tongue (ex. warheads)
- Holding ice tightly
- Rubbing ice along sensitive areas
- Cold caps
- Distraction techniques: deep breathing, PMR, music, drawing, journaling, fidgets/stress balls

Harm Reduction + NSSI

STRATEGIES

Safer Self-Harm

- Help clients identify their self-harm behaviors on a continuum of safety so they can see their options (safer > unsafe > very unsafe) - allow them to keep a written list to offer the opportunity to choose less harmful options (Example: scratching instead of cutting)
- Consider up to date Tetanus vaccine for clients who cut
- Harm in a safe location (Ex. Home with someone there)
- Use clean and sterile implements
- Understand the risks of dull blades and risks of sharp blades
- Don’t share self harm implements with others
- Limit the length and depth of cuts
- Burn for a shorter amount of time and limit the area being burned
- For burns, after removing the source of heat, run under lukewarm water to stop the progression of the burn (do not use ice, iced water, cold water or any creams or greasy substances like butter).

Harm Reduction + NSSI

STRATEGIES

Safer Self-Harm

- Try to avoid burning hands or places that are already burned - the injury can be deeper and more severe than intended.
- Keep cutting or other self harm tools in another room so they are still accessible but do not contribute to impulsive self-harm
- Consider not removing all self-harm implements (example: removing all clean sterile blades may result in the use of a dirty blade to cut, thus more harm and risk)
- Have alternatives to self-harm easily visible and accessible at all times
- Consider not self-harming while under the influence - less control = higher risk
- Be careful cutting over scars, the additional pressure on the surface may lead to deeper and more damage to tissue below and scars are more difficult to heal.
- Leave doors open or unlocked in case severe injury results in loss of consciousness before help arrives
- Self-harm when others are home or around to help in case of an emergency.

Harm Reduction + NSSI

STRATEGIES

Safer Self-Harm

Anatomical Safety

Note: This content is NOT appropriate for all clients who engage in self-injurious behavior – it is critical that adequate clinical assessment of risk has been completed and a provider is using sound clinical judgement.

- Clients can review anatomical charts with physicians, nurses, and wound care specialists showing the most dangerous and safer places to cut
- If possible, avoid cutting on the neck, the wrist, and the groin due to major arteries, blood vessels and tendons that can be harmed.
- Cut along the direction of muscles and tendons, for example length wise on the arms, to reduce the risk of cutting through tendons, muscles and larger nerves.
- Cut on fleshy parts of the body to reduce risk of damage to structures underneath

Harm Reduction + NSSI

STRATEGIES

Aftercare: Medical Attention + Wound Care

- Provider can give or encourage creation of a safety kit with first aid supplies (gauze, bandages, alcohol pads, etc.) and learning of basic first aid techniques
- Clients should be prepared to call 911 in case damage is done to an artery - blood loss will be rapid - apply pressure to minimize bleeding and follow instructions of dispatcher
- If bleeding occurs, stop cutting and assess the harm before continuing
- Seek medical attention if you need help caring for your wound, cannot stop the bleeding, pain is unmanageable, you have done more damage than intended (example gaping wounds will require stitches), loss of movement (possible nerve damage), or infection sets in.
- Use clean and sterile gauze or cloth to put pressure on bleeding wounds and if blood seeps through, add another clean gauze on top and continue the pressure
- Monitor wound daily: wash hands before caring for the wound, keep wound clean, protect the wound from further trauma and follow professional wound care strategies and seek medical attention.

Harm Reduction + NSSI

STRATEGIES

Aftercare: Referral + Linkage

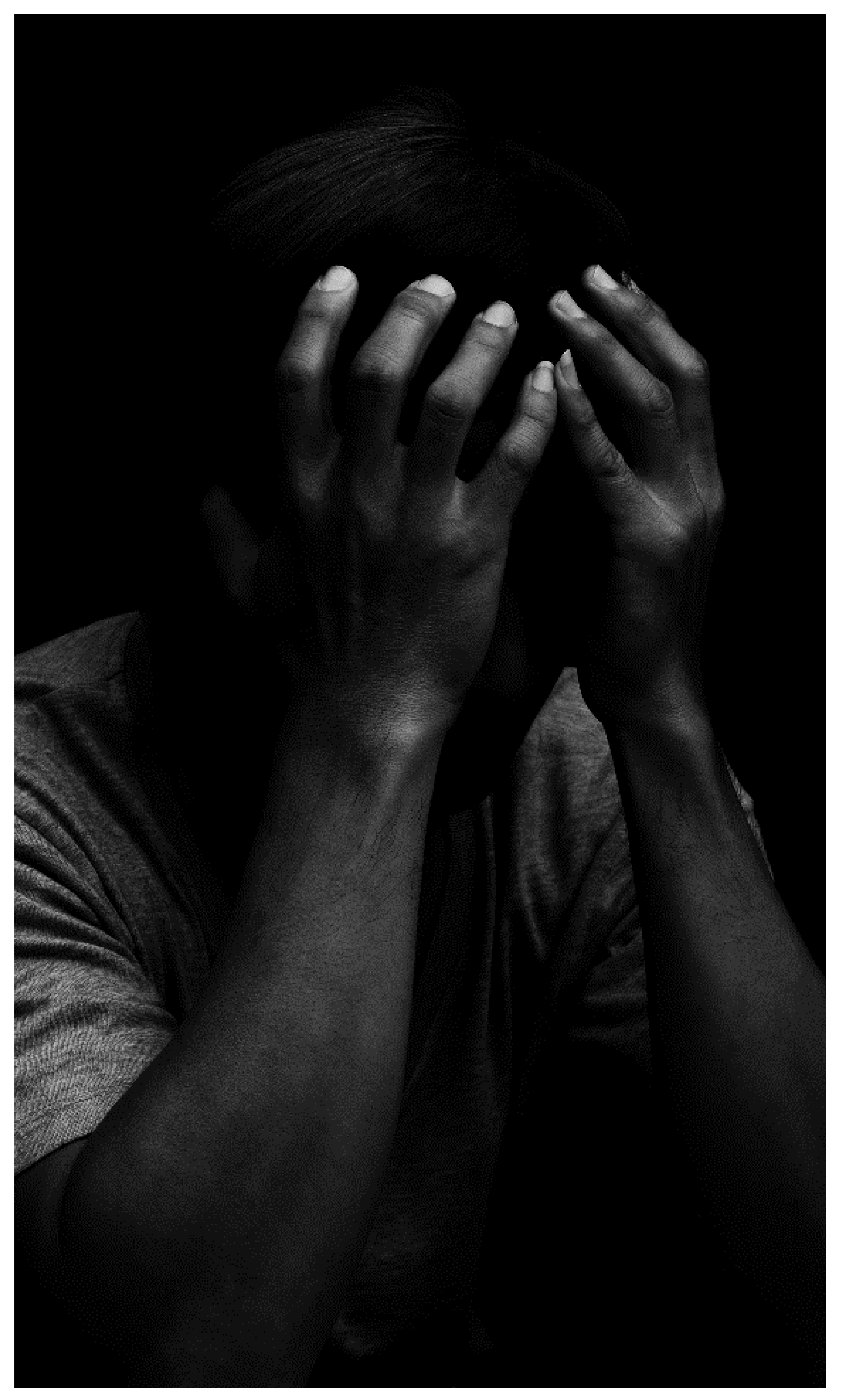
- Providers - Be aware of what ongoing treatment options exist in your community.
- Be prepared to address barriers to treatment access.
- Always provide linkage for ongoing care, harm reduction will not resolve an individual's struggle. Long term care is required.

Harm Reduction Strategies In Practice

CASE STUDY

You meet a 19-year-old client with history of Bipolar I, OCD, self-harm and substance use (marijuana, methamphetamine and alcohol). He presents with symptoms of depression (isolation, hopelessness, sense of foreshortened future) and is making statements including "I'm worthless and "I'm unlovable". He denies current suicidal ideation. He endorses strong urges to self-harm. He denies that he has engaged in any self-harm. You notice that there is a substantial amount of dried blood on his jeans as though it has bled through.

- What is your assessment of risk based on the information provided?
- Is there anything you would need to know more about?
- What are the options to minimize risk?
- What follow up referrals would be necessary?

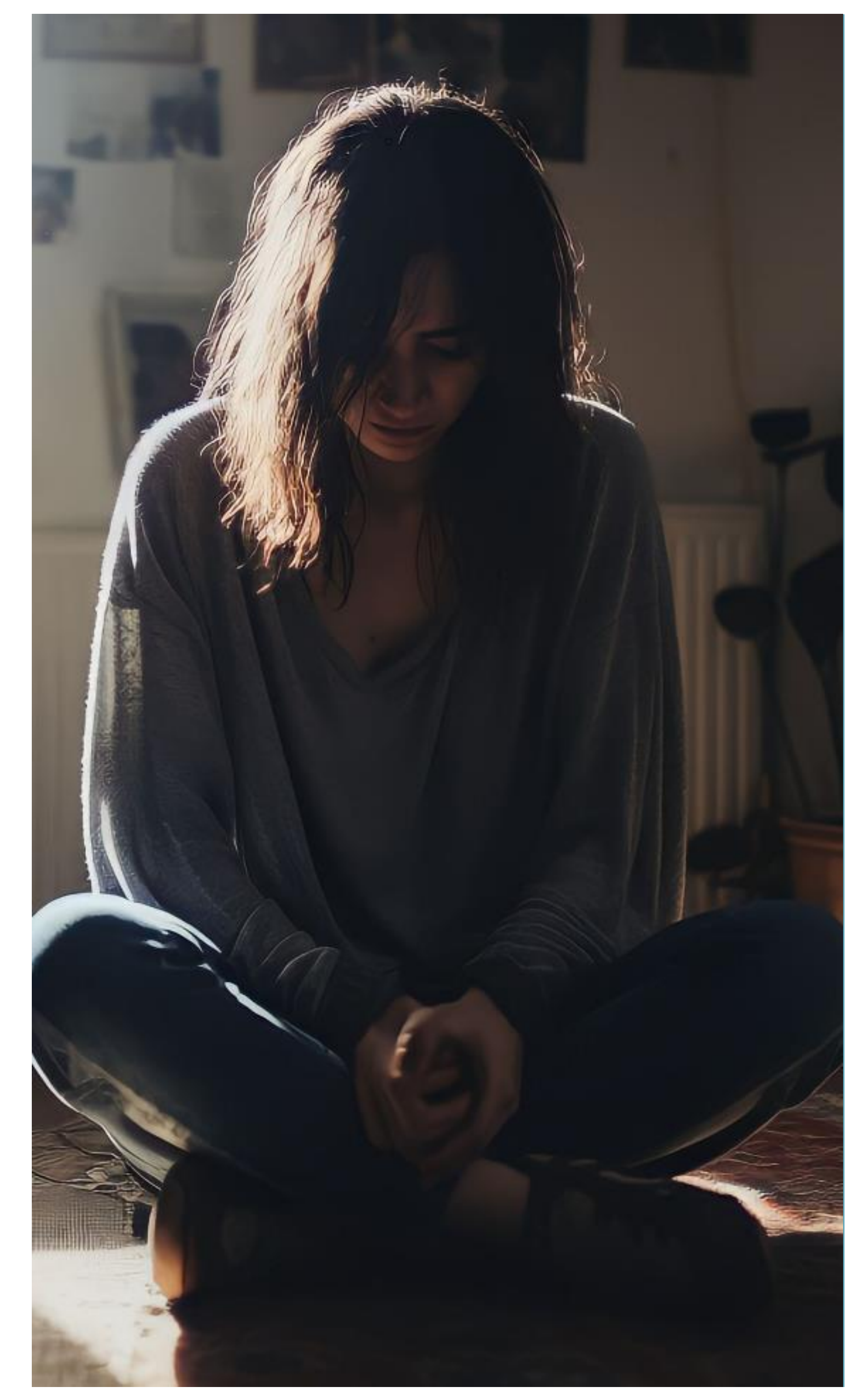


Harm Reduction Strategies In Practice

CASE STUDY

You meet a 20 -year-old female college students with history of depression, self-harm and dissociation. Her dorm mates reported her to the Dean after reading her journal because they fear she is suicidal. The young lady has been isolating, struggling to connect with other people on her campus, and her grades have dropped. She discloses to you that over the course of the last 2 weeks, she has been consuming significant amounts of cannabis and she often feels dissociated. She admits to engaging in cutting behavior. You notice a significantly deep, fresh, uncovered cut on her forearm, but no other visible cuts or scarring. You review the journal entries that started all of this and there is only one entry that mentions anything about death or dying. You read, "I don't want to die. I want to figure out what the meaning of my life is because I don't know."

- What is your assessment of risk based on the information provided?
- Is there anything you would need to know more about?
- What are the options to minimize risk?
- What follow up referrals would be necessary?



Harm Reduction + NSSI

FINAL REMINDERS

- Provides non-judgmental, compassionate care and consistent positive regard while meeting clients where they are, but does not strive to leave them there.
- Focus on the harm, not eradicating the behavior.
- Provides practical options to minimize harm, not to condone risky behavior.
- Clients are the experts on themselves and lead the process - allow people to be empowered to reduce their harm.
- Recovery is a nonlinear process and success includes multiple small steps rather than a couple huge steps (SAMHSA recovery wheel: health, home, purpose, community). Characterized by continued growth and managing setbacks. Resilience develops over time.
- Accepts that individuals are doing the best they can based on the conditions and resources they have - people are treated with dignity and respect regardless of their recovery status.
- Ham reduction reinforces safe interactions with helpers and promotes the development of intrinsic motivation.
- Harm reduction is person centered care - individuals can help themselves - they are a resource.

Questions?

Recommended Reading:

Safe with Self-Injury: A Practical Guide to Understanding, Responding and Harm-Reduction by Kay Inckle

Literature

Brown, R. C., & Plener, P. L. (2017). Non-suicidal self-injury in adolescence. Current Psychiatry Reports, 19(3), 20. https://doi.org/10.1007/s11920- 017-0767-9

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Inckle, K. (2017). Safe with self injury a practical guide to understanding, responding, and harm-reduction. PCCS Books.

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Rees, C.S., Hasking, P., Breen, L.J., Lipp, O.V., Mamotte, C. (2015). Group mindfulness based cognitive therapy vs group support for self-injury among young people: study protocol for a randomised controlled trial. BMC Psychiatry. 2015 Jul 8;15:154. doi: 10.1186/s12888-015-0527-5. PMID: 26152135; PMCID: PMC4495689.

Substance Abuse and Mental Health Services Administration (SAMHSA): Treatment for Suicidal Ideation, Self-harm, and Suicide Attempts Among Youth. SAMHSA Publication No. PEP20-06-01-002 Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2020.

Zila, L. M., & Kiselica, M. S. (2001). Understanding and counseling self-mutilation in female adolescents and young adults. Journal of Counseling and Development, 79, 46–53.

Reflecting on the Workshop

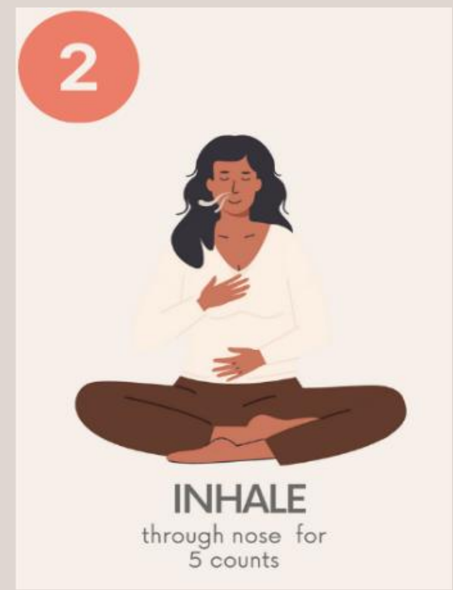
1) What might you integrate into your practice and work?
2) What might you need to study further?
3) What might need strengthening?

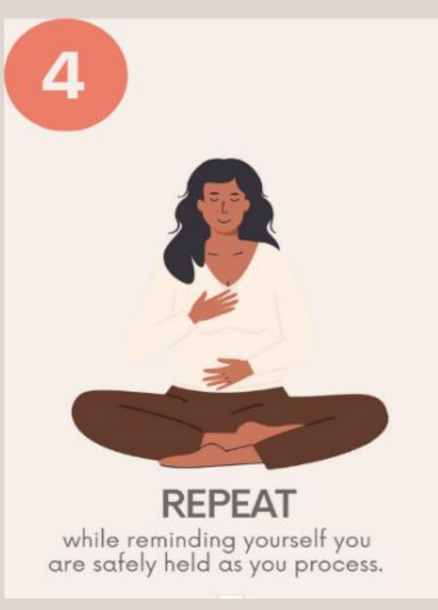
Coming Up Next

Break		***12:00 pm - 12:15 pm***
Panel: *Honoring Voices of Lived Experience & Allyship*	**Dylan Thomas (he/him)** **Gabriela Zapata-Alma, LCSW, CADC (they/them)** **Janis Whitlock, Ph.D., MPH (she/her)**	**12:15 pm - 1:45 pm**
Break		***1:45 pm - 2:00 pm***
Regional Spotlights: *Shining Light on Ways to Approach Harm Reduction in Practice*	**Erin Hughes, MSW, PPSC (she/her)** **Lilinoe Kauahikaua, MSW (she/her/'o ia)** **Stacey Cope (they/them)**	**2:00 pm - 3:15 pm**
Break		***3:15 pm - 3:30 pm***
Discussion, Integration, & Closing	**PS MHTTC Staff**	**3:30 pm - 4:00 pm**

** All times are Pacific Time*

It's Break Time!





There is no such thing as a "safe space" -
We exist in the real world.
We all carry scars and have caused wounds.
This space
seeks to turn down the volume of the world outside,
and amplify voices that have to fight to be heard elsewhere.
This space will not be perfect.
It will not always be what we wish it to be
But
It will be our space together,
and we will work on it side by side.

- Untitled Poem by Beth Strano

Session 2: Lived Experience Panel

12:15 pm PT - 1:45 pm PT / 1:15 pm - 2:45 pm MT / 2:15 pm - 3:45 pm CT / 3:15 pm - 4:45 pm ET

Honoring Voices of
Lived Experience and Allyship

Moderated by

Kristi Silva (she/her/ella)

Associate Project Director, Pacific Southwest MHTTC

Center for Applied Research Solutions (CARS)

About Our Time Together

- An Overview Of What Brings Us In Conversation: Honoring Voices of Lived Experience & Allyship
- Meet Our Panelists!
- What will we explore together today?
  - Learn about harm reduction in practice through three voices of lived experience and allyship.
  - Identify policies and practices that support a healing-centered approach to harm reduction for individuals who have experienced harm.
  - Gain concrete strategies and guidance for family, friends, and other allies who wish to support the healing and recovery journey of a loved one.
- Q&A with Our Panelists
- Reflections and Closing

Housekeeping Items

- We have made every attempt to make today's presentation secure. If we need to end the presentation unexpectedly, we will follow-up using your registration information.
- Have a question for the symposium's faculty? Use the Q & A button
- Have a comment or link for all attendees? Use the chat and write to "all attendees"
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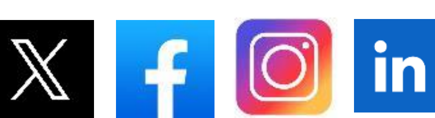
- Follow us on social media: @MHTTCNetwork



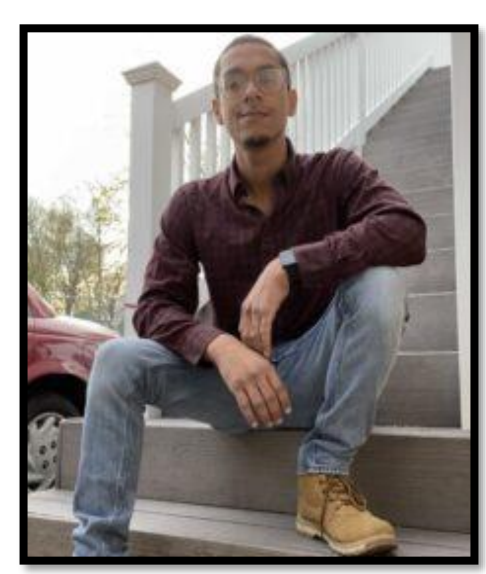
Please Note

Session recordings, slides, and materials will be posted on our website within 1 week.

What brings us into conversation about lived experience in the context of harm reduction today?

Meet Our Panelists

Gabriela Zapata-Alma, LCSW, CADC (they/them)



Dylan Thomas (he/him)

Janis Whitlock, PhD, MPH (she/her)

Grounding Exercise

Butterfly Hug Technique

1 Interlock your thumbs over your chest, & flap your palms steadily like a butterfly.

2 Breathe slowly and deeply while noticing your thoughts & body. Notice the sounds & aroma around.

3 Continue flapping your palms while observing these thoughts, without any judgment.

Questions to Guide Our Conversation

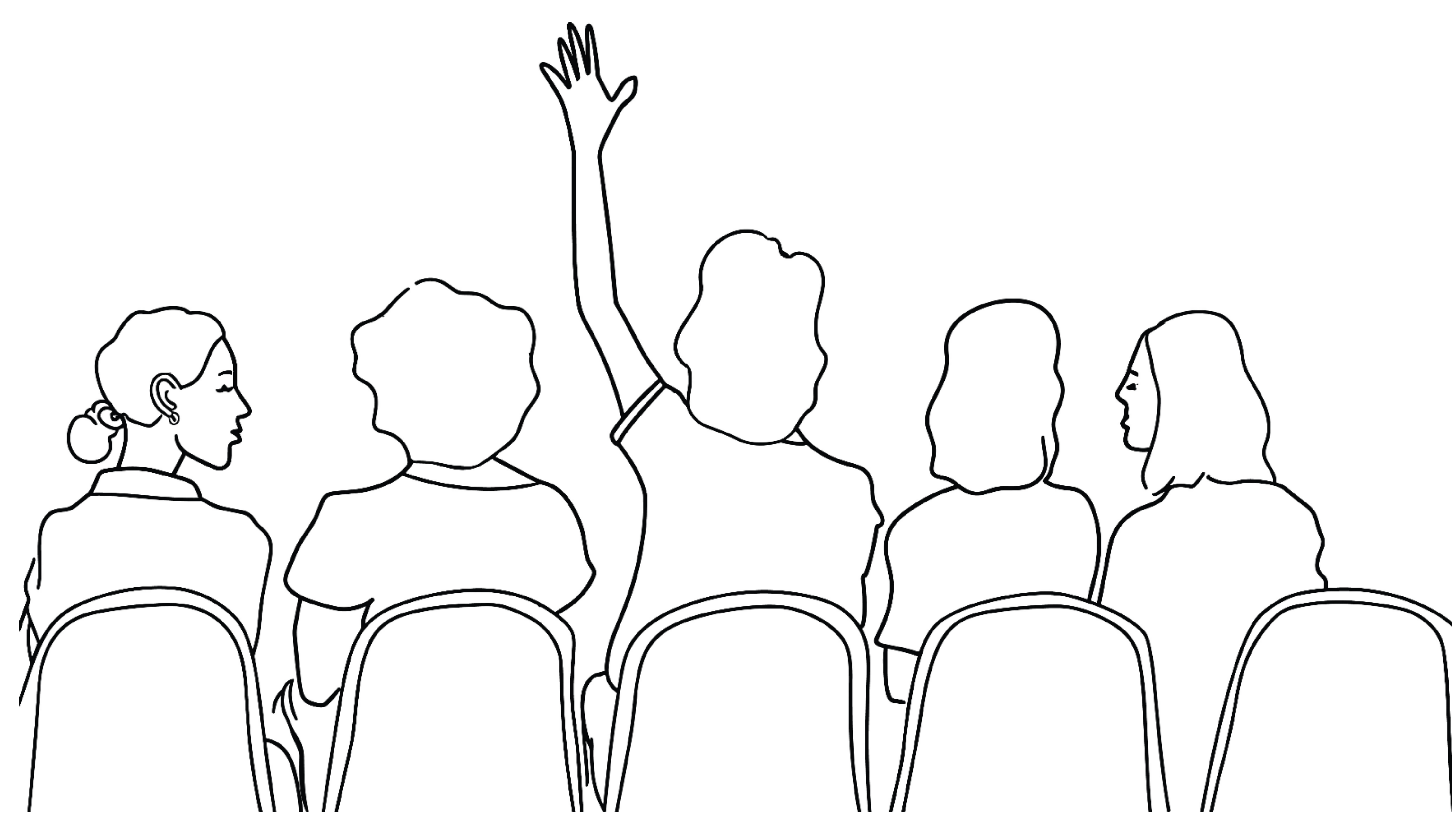
- In your experience, what are the most effective approaches for families, friends, and other allies to support the harm reduction and healing journey of a loved one?

- Harm reduction has historically been thought of in relation to drug use. What additional applications of harm reduction are emerging that should be elevated?

- Healing justice is conducive to harm reduction because the process is holistic and compassionate, seeking to repair harm and create change rather than punish and isolate. What does healing justice mean to you and why is it important to talk about healing-centered harm reduction?

- The healing practices of our ancestors have historically been taken from us by means of slavery, imperialism, and systemic oppression. How has the reclamation of these ancestral, culturally-rooted healing practices shifted the landscape of harm reduction?

Audience Questions and Discussion



Reflecting on the Panel
1) What might you integrate into your practice and work?
2) What might you need to study further?
3) What might need strengthening?

Coming Up Next

Break		***1:45 pm - 2:00 pm***
Regional Spotlights: *Shining Light on Ways to Approach Harm Reduction in Practice*	**Erin Hughes, MSW, PPSC (she/her)** **Lilinoe Kauahikaua, MSW (she/her/'o ia)** **Stacey Cope (they/them)**	**2:00 pm - 3:15 pm**
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Discussion, Integration, & Closing	**PS MHTTC Staff**	**3:30 pm - 4:00 pm**

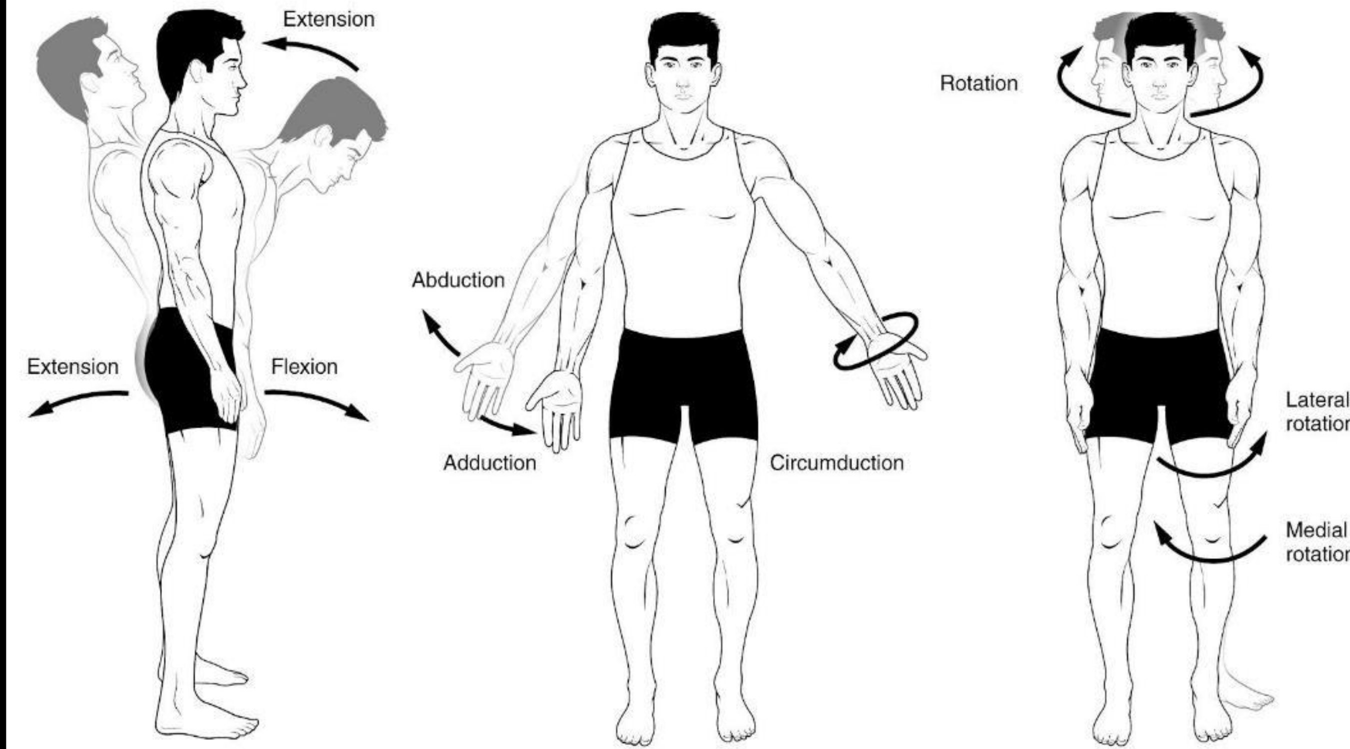
** All times are Pacific Time*

It's Break Time!

Flexion
Extension
Flexion
Extension
Extension
Extension
Flexion

(a) and (b) Angular movements: flexion and extension at the shoulder and knees

(c) Angular movements: flexion and extension of the neck



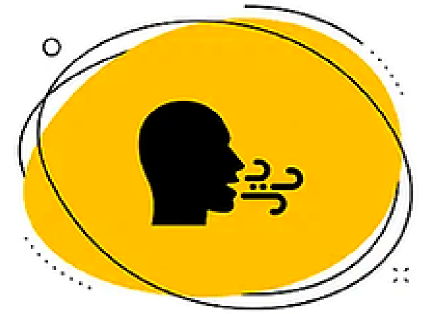
(d) Angular movements: flexion and extension of the vertebral column

(e) Angular movements: abduction, adduction, and circumduction of the upper limb at the shoulder

(f) Rotation of the head, neck, and lower limb

3 Breathing Exercises for Stress Management

Deep breathing is beneficial to **stay calm** during a stressful situation.



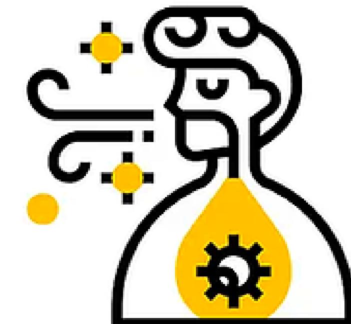
Pursed Lips Breathing

- Inhale through the nose for 2 seconds.
- Pucker your lips, then exhale for 4-6 seconds.
- Repeat several times until you feel a slowed rate of breathing.

Square Breathing

- Sit upright with your back straight.
- Inhale for 4 seconds, then hold your breath for 4 seconds.
- Exhale for 4 seconds, then hold your breath for 4 seconds.
- Repeat.

4-7-8 Breathing



- Sit upright.
- Put your tongue on the roof of your mouth near your teeth.
- Close your mouth, then inhale through the nose for 4 seconds.
- Hold your breath for 7 seconds.
- Exhale completely through pursed lips for 8 seconds.
- Repeat.

Session 3: Regional Spotlights

2:00 pm PT - 3:15 pm PT / 3:00 pm - 4:15 pm MT / 4:00 pm - 5:15 pm CT / 5:00 pm - 6:15 pm ET

Shining Light on Ways to Approach Harm Reduction in Practice

Moderated by

Leora Wolf-Prusan, EdD (she/her)

School Mental Health Field Director, Pacific Southwest MHTTC

Center for Applied Research Solutions (CARS)

About Our Time Together

- **Welcome!** An Introduction to the Pacific Southwest MHTTC and to the Rising Practices & Policies Series
- **An Overview Of What Brings Us In Conversation**: Regional Spotlights- Putting Harm Reduction and Healing Justice Into Practice
- **Outcomes**
  - Glean tangible policy and practice applications of the intersections of harm reduction and mental health that are creative, innovative, and responsive
  - Identify peer solutions and ideas from organizations and agencies based in our SAMHSA Region 9 (Arizona, California, Hawaii, Nevada, and U.S. Pacific Islands of American Samoa, Guam, Marshall Islands, Northern Mariana Islands, Federated States of Micronesia, and Palau)
- **Questions and Answers With and From Our Speakers**
- **Closing and Next Steps**

Housekeeping Items

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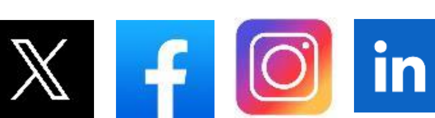

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Meet Our Panelists

Erin Hughes, MSW, PPSC (she/her)

Lilinoe Kauahikaua, MSW (she/her/'o ia)

Stacey Cope (they/them)

Erin Hughes, MSW PPSC (she/her)

Wellness Coordinator
June Jordan School for Equity,
San Francisco Unified School District, CA

Erin Hughes is a school based social worker who has spent her career working with adolescents in San Francisco. For the past 17 years, she has been the Wellness Coordinator at June Jordan School for Equity, a small social justice high school in the Excelsior neighborhood.

Her work primarily focuses on supporting the well-being of students and families through mental health services, case management, crisis prevention and intervention, and health education.

Erin uses a trauma informed, strength-based approach in her work with students that centers harm reduction and empowerment. She believes that harm reduction is a powerful approach to use with adolescents because it is rooted in justice and human rights, meets clients where they are at, honors their voice and choice, and aligns with their developmental needs.

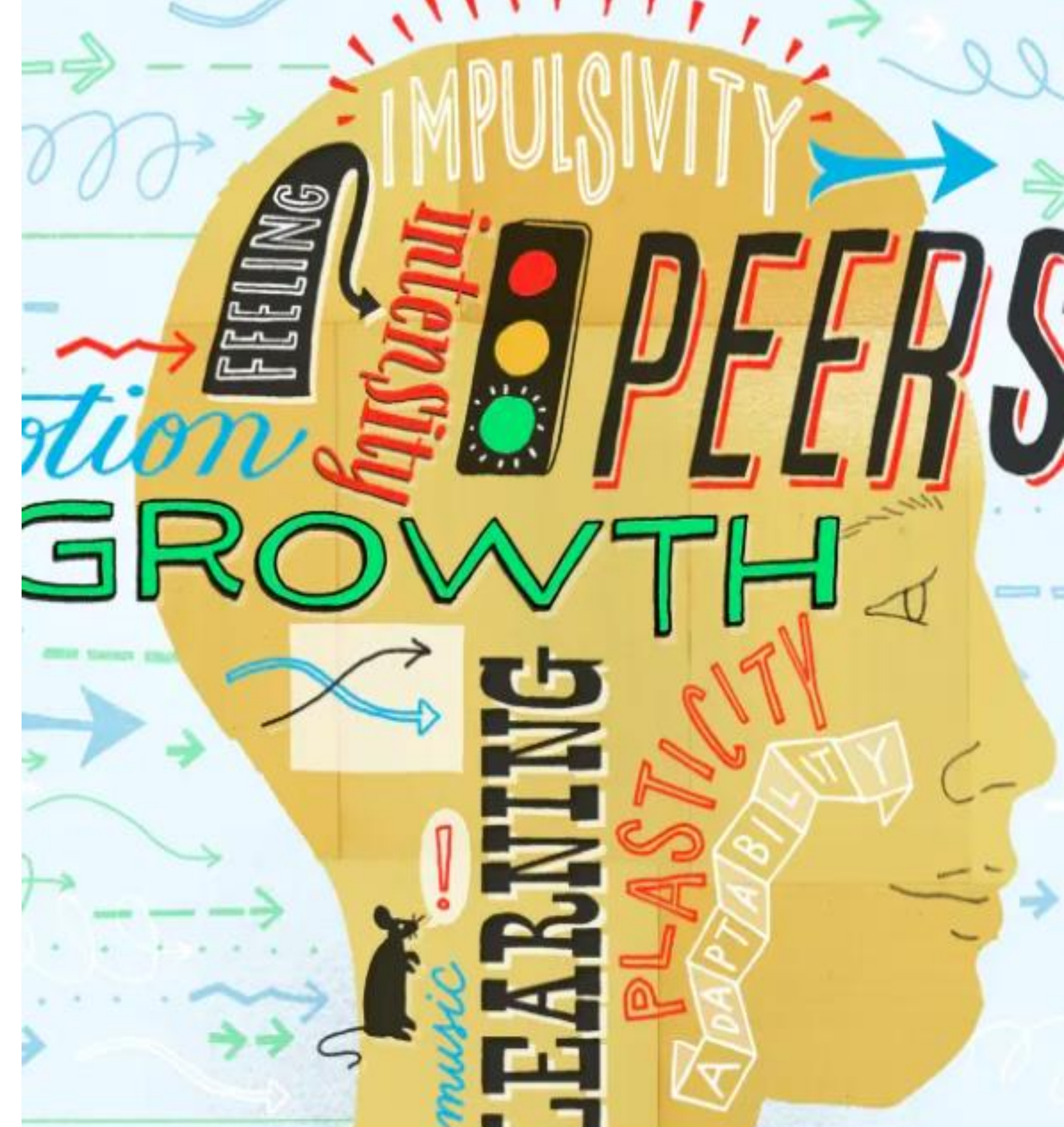
Harm Reduction and Adolescent Development

Key Adolescent Developmental Needs

- Identity formation – establishing a sense of self
- Experimentation and risk-taking
- Desire for autonomy and independence
- Peer influence and social acceptance

Challenges

- Balancing independence with safety
- Navigating peer influence and societal expectations

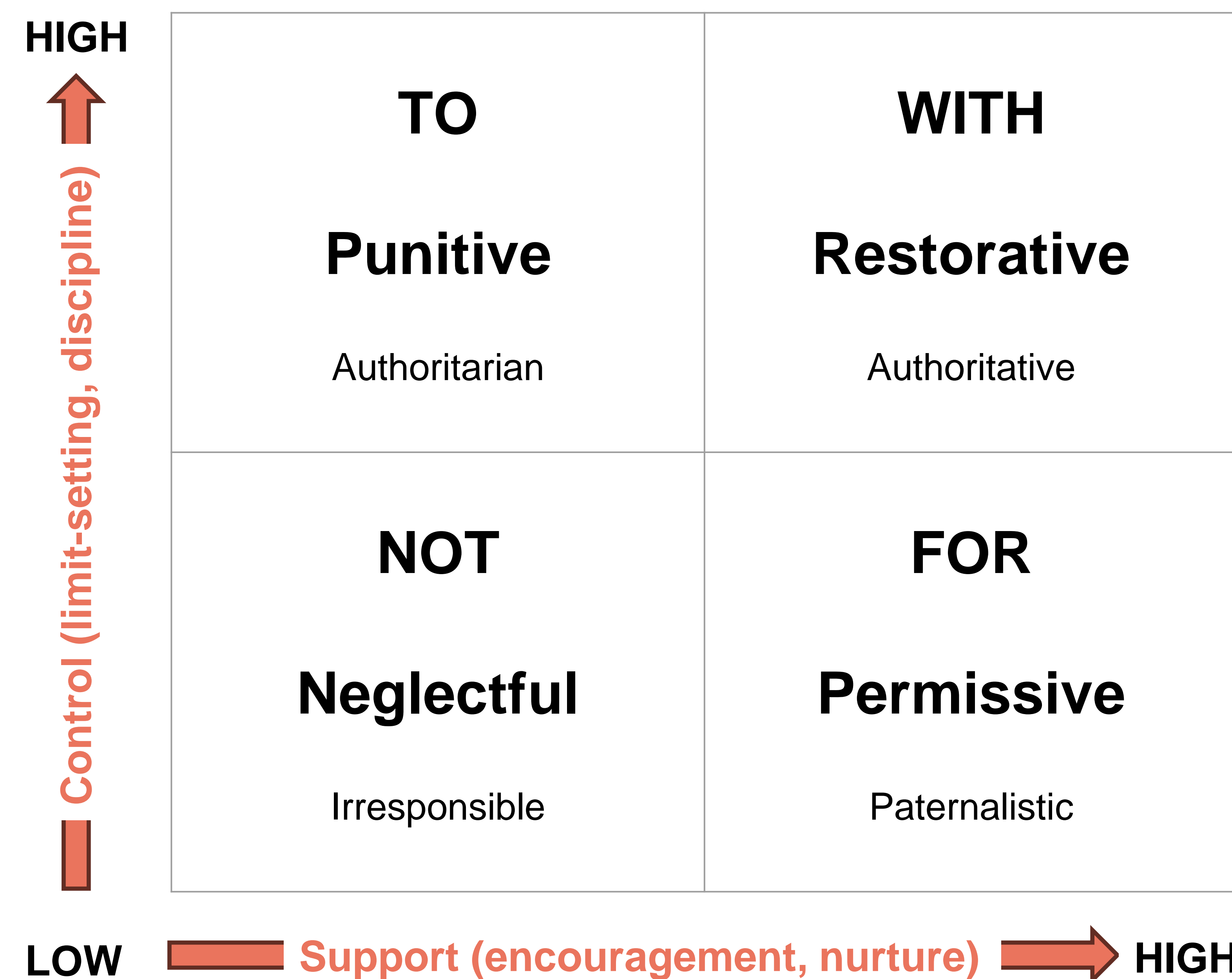


Harm Reduction Aligns with the Developmental Needs of Adolescence:

- A respect for autonomy that fosters trust and empowerment
- Guides students through reflection
- Offers non-stigmatizing support
- Meets students where they are at
- It is both individual and collective in nature
- Changes the power dynamic inherent in many staff to student relationships.

Interdisciplinary Teams

- It is beneficial to the students and school community to have adults that play different roles and have different areas of expertise.
- We need to move beyond the misconception that a student receiving support after they have caused harm means that we are enabling them to violate community norms or not “teaching them a lesson”. Structure and support can go hand in hand.



Social Discipline Window

School-Based Harm Reduction Policies

- We need structures and policies in place in our schools that reflect best practices in supporting the well-being of students.

  Examples

  – Students who are found on campus under the influence or in possession of substances can opt into 3 mandatory Brief Intervention Sessions as an alternative to suspension for their first incidence

  – Students have a right to access free sexual health services at community-based clinics during school hours under minor consent

- School based health centers increase students' access to health services. Removing barriers to care is an essential way to support the well-being of students and families.

Takeaways

- Work collaboratively with students to identify the needs behind their behavior. When we acknowledge and honor their needs, we can support them in discovering different ways to address them while reducing harm to self and others.
- Teenagers expect adults to police their behavior and enforce the rules. Structure and safety are essential aspects of trauma informed schools, and we also need to build authentic relationships where students are seen and heard. We need high levels of support and connection along with high expectations.
- Ask students to share what they enjoy about the behavior you are addressing. If you create space to acknowledge that there is something they are gaining or avoiding through their actions, there will be more openness for dialogue and change.
- Establish policies within your school system that connect students to harm reduction services.
- Schools benefit from interdisciplinary teams. To serve the whole child, we need staff that can provide different forms of support while working collaboratively to establish a healthy school culture.

Stacey Cope (they/them)

Capacity Building & Education Manager
BS & PSS

Stacey Cope is a queer parent, a plant nerd, a dancer, a sensory and pleasure seeking troll. Stacey is one of the original members of Sonoran Prevention Works, in Tempe, Arizona and is so excited to explore their new role. They see harm reduction as the foundation for all liberatory paths forward; an orientation toward love and building a future we want our children to live in. They center harm reduction in their internal, interpersonal, communal and professional relationships. Harm reduction has saved Stacey's life, more times than they can count. Stacey sees harm reduction as an invitation to more feeling, more dignity, and more choice. You can catch them resting, exploring libraries, talking to plants and birds and leaning into play with their magical kid.

Our Mission

Building a *healthy Arizona* with people who use drugs.

Harm Reduction in Arizona

- Proximity to the so-called US/Mexico border
- Colonization/Land Theft
- High rates of poverty/lack of resources
- Structural abandonment
- Syringe Service Programs legalized in 2021

Trust the people and the people will be trustworthy.

- Lots of trial and error
- Lots of loss
- Outside consultants
- Lots of space just for process/ing
- Lots of space for fun/celebration
- Really intentional hiring process
- Humility - together we know a lot
- Lots of professional development opportunities
- <u>**Focus on relationships**</u>

Harm Reduction in our Workplace

- No background checks
- No drug tests
- You can talk openly about past/current drug use, sex work, mental health
- Donated vacation/sick time
- Lived Experience Caucus
- Union
- Short term disability
- Healing Justice Fund
- Focus on behavior NOT drug use/diagnosis/etc

Risks & Benefits

Funding

Stuck in process

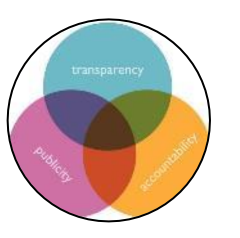
More work/time

Conflict

We like each other

We like our jobs

Clarity/Framework



Accountability

Thank You

For free Naloxone, educational workshops, technical assistance, collaboration or to learn more about our programs, contact us at:

info@spwaz.org | training@spwaz.org

Lilinoe Kauahikaua, MSW (she/her/'o ia)

Program Coordinator: Substance Use & Mental Health
Project Manager: ‘Ohana Center of Excellence for AANHPI Behavioral Health
Papa Ola Lokahi – Native Hawaiian Health Board

Lilinoe Kauahikaua, MSW, is from Pi‘ihonua, Hilo on Moku o Keawe (Hawai‘i Island) but has lived and grown in many other spaces throughout her journey, including O‘ahu, California, and Arizona. She serves as Program Coordinator for all substance use and mental health projects, as well as Project Manager for the AANHPI ‘Ohana Center of Excellence focusing on behavioral/mental health and substance use.

Her research focuses include data disaggregation, and Indigenous approaches to: behavioral/mental health, reentry services, incarceration, and substance misuse. She has a Masters of Social Work, B.A. in the Administration of Justice, with a minor in Hawaiian Studies, along with a certificate in Hawai‘i Lifestyles. Lilinoe was appointed by Governor Ige to the Hawai‘i Advisory Commission on Drug Abuse and Controlled Substances and serves on the boards of Going Home Hawai‘i, Kinohi Mana Nui, and as the Cultural Committee Co-chair for The Going Home Hawai‘i Consortium, organizations serving the Native Hawaiian community impacted by incarceration and substance misuse. Lilinoe also serves on committees for the Institute of Violence and Trauma (IVAT), the Syringe Exchange Oversight Committee, and the Hawai‘i SUPD (Substance Use Professional Development) initiative.

Our Time Together Today

- Hoʻolauna - Introduction
- Who We Are – Papa Ola Lokahi & ʻOhana Center of Excellence
- What is Harm Reduction From a Native Hawaiian Lens? – E hoʻi i ka piko
- E hui ana nā moku (The Islands Shall Unite): A Cultural Resource Guide for Reducing the Harms Caused By Colonization in Native Hawaiian Communities
- Culture is Healing
- Person First Language, Shame & Stigma
- Lessons Learned

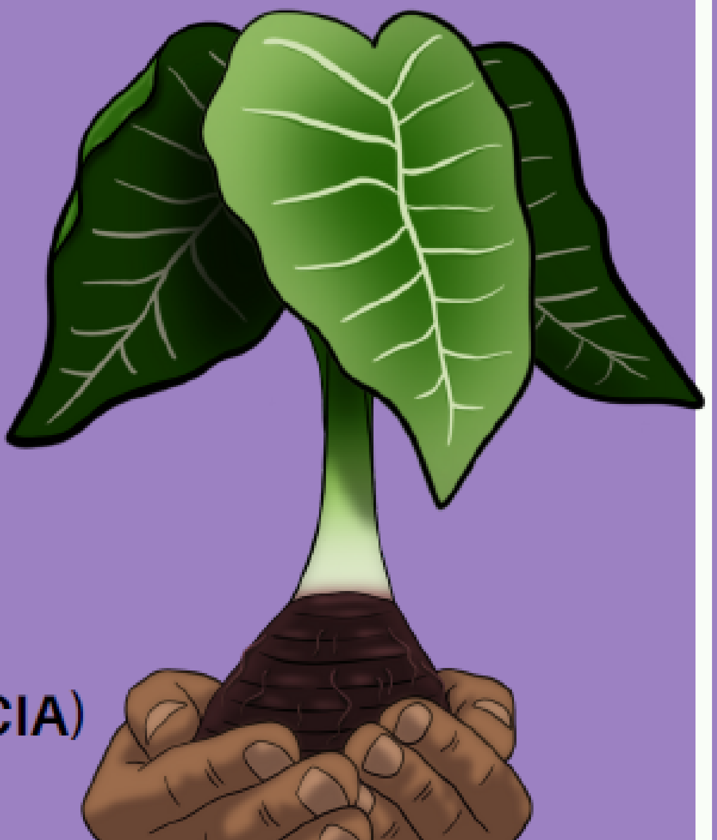
Papa Ola Lōkahi

Native Hawaiian Health Care Improvement Act

The Congress hereby declares that it is the policy of the United States in fulfillment of its special responsibilities and legal obligations to the Indigenous People of Hawaiʻi resulting from the unique and historical relationship between the United States and the government of the Indigenous People of Hawaiʻi:

•To raise the health status of Native Hawaiians to the highest health level

•To provide existing Native Hawaiian health programs with all resources necessary to effectuate this policy



Reauthorized in 1992 as Native Hawaiian Health Care Improvement Act (NHHCIA) (P.L. 102-396).

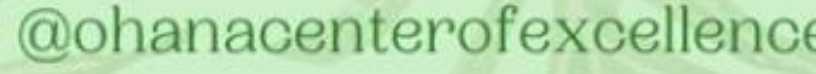
Reauthorized in 2010 via the Affordable Care Act.

AANHPI ‘Ohana Center of Excellence

Empowerment, education, and support
Behavioral health resources, support, training
Serving Asian American, Native Hawaiian, and Pacific Islander communities

The AANHPI ‘Ohana Center of Excellence is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and is coordinated by the Hawai‘i State Department of Health in partnership with California State University – East Bay, Papa Ola Lōkahi, the Native Hawaiian & Pacific Islander Hawaii Response, Recovery & Resilience Team, and San José State University.

aanhpi-ohana.org



CULTURAL TRAUMA

LIKE OTHER NATIVE PEOPLES, THE EFFECTS OF COLONIZATION, ASSIMILATION, AND ACCULTURATION HAVE BEEN DEVASTING FOR NATIVE HAWAIIANS. THE CHANCE ARRIVAL OF CAPTAIN JAMES COOK IN 1778 UNLEASHED FIVE DEVASTATING INTERRELATED FORCES STILL EVIDENT TODAY:

1) RAPID DEPOPULATION,
2) FOREIGN EXPLOITATION,
3) CULTURAL CONFLICT,
4) ADOPTION OF HARMFUL FOREIGN WAYS, AND
5) NEGLECT, INSENSITIVITY, AND MALICE FROM THE DOMINANT SOCIETY (BLAISDELL AND MOKUAU, 1991).

Papa Ola Lokahi

Client

Need for safe spaces and tools such as fentanyl test strips and naloxone, or culturally-appropriate tools. While some stakeholders discussed the need for using Hawaiian terms and context for this part of the continuum, others discussed embracing the term harm reduction and working to understand what it means

‘Ohana

Need for education around what harm reduction is. This education would be helpful in addressing confusion and misunderstanding related to the function and use of harm reduction and how it relates to ‘ohana

Community

Community should provide 24/7 services; a need to understand what the responsibility of harm reduction is within kaiaulu, and what the community‘s role is in this phase

Provider

Benefits of having needle exchange programs, drug take back events and related incentives, as well as damp and wet houses to assist with transitions away from substance use. A way for providers to celebrate small milestones and progress, not perfection, of individuals and clients on their journey

System as a Whole

Define what Hawaiian harm reduction looks like and how it can be supported through laws

What does this look like, sound like, feel like within harm reduction care?

From perspective of client? ‘ohana? community? provider? system as whole?

HARM REDUCTION

HAWAIʻI HARM REDUCTION MODEL INCLUDES THE ATTITUDES, ACTIONS, AND UNDERSTANDING OF KĀNAKA, ʻOHANA, COMMUNITY MEMBERS, AND HEALTH CARE SERVICE PROVIDERS. IT ALSO ACKNOWLEDGES THE HARMFUL IMPACTS OF COLONIZATION, WHILE CREATING SPACE FOR HEALING CONVERSATIONS, CULTURE, AND CONNECTIONS.

IT IS A PROCESS TO ELEVATE HAWAIIAN WAYS OF KNOWING AND BEING, WHICH ARE STRONGLY CONNECTED TO (W)HOLISM, SPIRITUALITY, AND RELATIONSHIP TO ʻĀINA.

FRAMEWORK FOR THE HAWAIIAN PERSPECTIVE

SOURCE: RICHARD "LIKEKE" PAGLINAWAN

AKUA/NĀ AUMĀKUA
(HIGHER POWER, SPIRITUAL GUARDIANS)

MACRO LEVEL
(WORLD VIEW)

LŌKAHI/PONO
(UNITY ,
HARMONY,
BALANCE)

KĀNAKA
(PEOPLE)

ʻĀINA, MOANA, LANI
(NATURAL ENVIRONMENT)

ʻUHANE (SPRIT)

MICRO LEVEL
(INDIVIDUAL VIEW)

LŌKAHI/PONO
(UNITY ,
HARMONY,
BALANCE)

MANAʻO, NAʻAU
(MIND, GUT FEELING)

KINO (BODY)

Papa Ola Lokahi

I KA WĀ MA MUA, I KA WĀ MA HOPE

PRIOR TO EUROPEAN CONTACT, NATIVE HAWAIIANS UNDERSTOOD THAT HEALTH MUST INCLUDE BALANCE BETWEEN

- MIND
- BODY
- SPIRIT

- INDIVIDUAL/FAMILY /COMMUNITY
- ENVIRONMENT
- SPIRITUALITY

=MAULIOLA

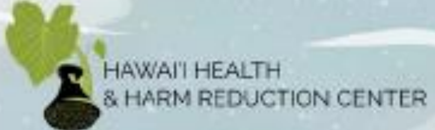
WESTERN INFLUENCE & COLONIZATION

= IMBALANCE, SHIFTED PARADIGMS, CULTURAL/HISTORICAL/INTERGENERATIONAL TRAUMA, HEALTH DISPARITIES

E HUI ANA NĀ MOKU

(THE ISLANDS SHALL UNITE)

HARM REDUCTION COMMUNITY RESOURCE GUIDE 2022



A message - Papa Ola Lōkahi & Culture & Addictions Advisory Council

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He mau nīnau? Questions?

Please Visit Our Website for Resources

Please Visit Our Website for Resources

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”

Discussion

How do we strive for wellness when we are taking on so much pain, particularly when working in an often death saturated field, such as harm reduction?

- B.C. Shepard

Shepard, B.C. Between harm reduction, loss and wellness: on the occupational hazards of work. Harm Reduct J 10, 5 (2013). https://doi.org/10.1186/1477-7517-10-5

”

Discussion

The goal of harm reduction is to move people to the place where they are most realized, healthy and safe.

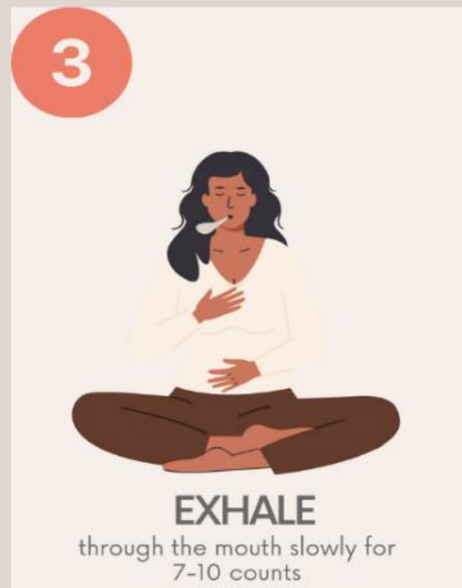
Reflecting on the
Regional Spotlights
1) What might you integrate into your practice and work?
2) What might you need to study further?
3) What might need strengthening?

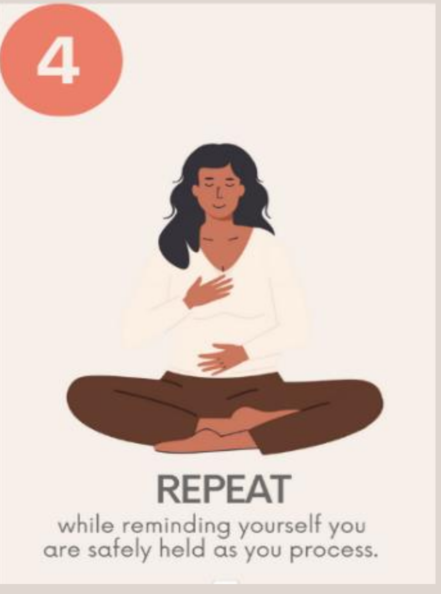
Coming Up Next

Break		*3:15 pm - 3:30 pm*
Discussion, Integration, & Closing	**PS MHTTC Staff**	**3:30 pm - 4:00 pm**

** All times are Pacific Time*

It's Break Time!





Closing Our Whole Day

3:30 pm PT - 4:00 pm PT / 4:30 pm - 5:00 pm MT / 5:30 pm - 6:00 pm CT / 6:30 pm - 7:00 pm ET

Pacific Southwest MHTTC Staff

What new healing might Harm Reduction make possible for you and your community?

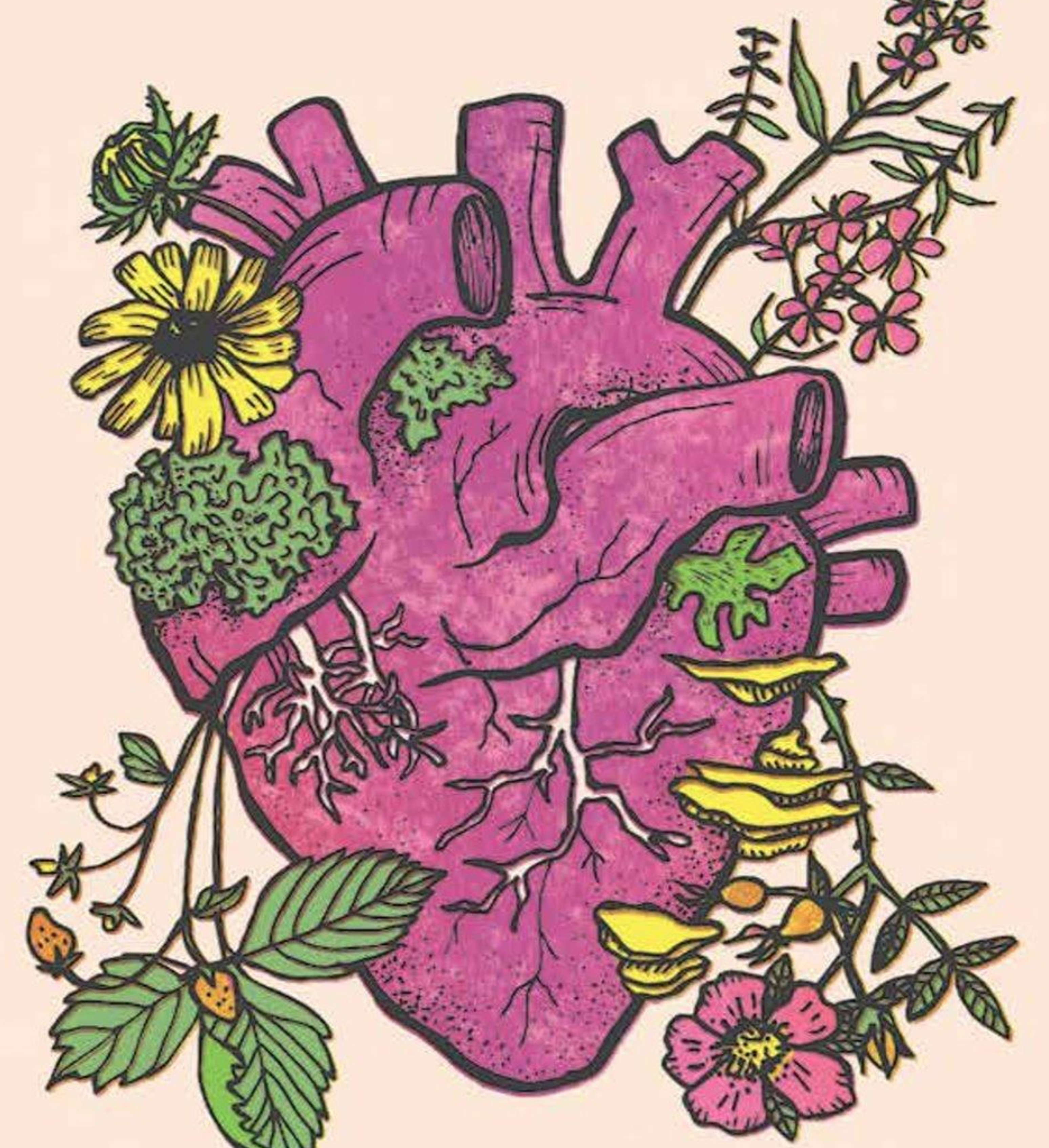
Moving forward, what do you hope for the approach of harm reduction?

What I **received** / What I **learned**…

What I **valued** in this space…

What I’m still **wondering**…

Closing Practice



Next Steps

Thank you for attending!

The Pacific Southwest MHTTC Network is funded through SAMHSA to provide this training. As part of receiving this funding, we are required to submit data related to the quality of this event.

We would greatly appreciate it if you could please take a moment to complete a **brief** survey about today's Symposium.

FAQs

Will Continuing Education Credits be available?

Up to four Continuing Education Hours (CEH) will be available through verified participation in the session(s) as listed below. The next slide will tell you how!

- 1.5 CEH for Session 1
- 1.25 CEH for Session 2
- 1.25 CEH for Session 3

Will the symposium be recorded?

This event will be recorded and published on the Pacific Southwest MHTTC website within two weeks of the event.

Optional No-Cost Continuing Education Hours

Optional CEHs are available at no cost following the event. One CEH is available for each hour of training for ASW, BRN, LCSW, LEP, LMFT, LPCC, and/or PPS as required by the California Association of Marriage and Family Therapists (CAMFT) and California Board of Registered Nurses. CARS is an approved provider for: CA Board of Registered Nurses #16303 and CAMFT #131736.

To request optional CEHs, please complete the survey after the event. You will then be directed to the appropriate link to provide your information. For questions regarding CEHs, please email pacificsouthwest@mhttcnetwork.org.

Please allow 4 weeks for CEH certificates to be issued via email.

Upcoming Distance Learning Opportunities

Join us for upcoming events!

Theater as Therapy: Drama Therapy Approaches to Support Incarcerated and Re-Entry Populations
May 15 | 3:00 - 4:30 pm PT
Register Now

Rooting Young Adult Mental Health Services in Culturally Sustaining Values & Practices, Session 4
May 22 | 3:00 - 4:30 pm PT
Register Now

Session 5 in the Provider Plática Learning Collaborative
May 28 | 12:00 - 1:15 pm PT
Register Now

Foundations in Perinatal Mental Health & Navigating Culturally Concordant Care; *A Two-Part Series for Community Mental Health Care Providers*
June 4 & 6 | 2:00 - 4:00 pm PT
Register Now

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Archived Recordings

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https://mhttcnetwork.org/centers/content/pacific-southwest-mhttc