

Harm Reduction Messaging within Prevention and Intervention Efforts for College Students and Young Adults



@cshrb_uw

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Overview of this presentation

- Special thank you to Alex Sirotzki, Meghan King, Justin Mauger, and the Washington Poison Center
- What I said I'd cover
 - In this presentation, we will review what it means to "do" harm reduction, including a focus on how messages can be delivered within a motivational enhancement framework. Specific guidelines for reducing the harms associated with alcohol use and with cannabis use will be discussed, as will opportunities for prevention and intervention.

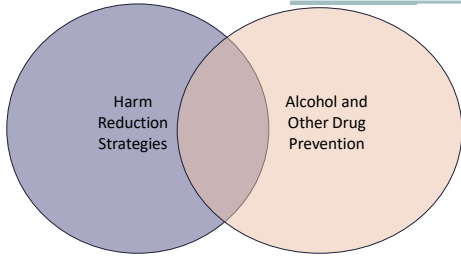


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Today's topic



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Traditional Messages

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Just Say No

- "Just Say No..."
- In 1982, while speaking with schoolchildren in Oakland, California, First Lady Nancy Reagan was asked what to do if someone were to be offered drugs.
- She answered, "Well, you just say no."
- By the end of President Reagan's term, over 12,000 "Just Say No" clubs had started



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Just Say No

- However, research at the time on prevention strategies acknowledged that while knowledge might increase following involvement in a program, attitudes were more difficult to change, and most studies showed no change in actual patterns of use (Hanson, 1982).

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Harm Reduction

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G. Alan Marlatt, Ph.D.
November 26, 1941–March 14, 2011



“In a world so often focused on “treating” addiction with tough love, Marlatt showed through his work and his life that kindness simply works better.”

Time Magazine, March 15, 2011

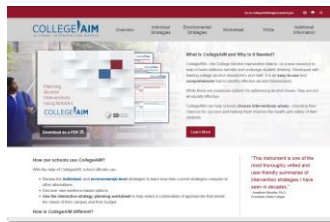
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Alan developed...

The Alcohol Skills Training Program (ASTP) – delivered in a group using motivational enhancement strategies and focusing on strategies for reducing harm when students make the choice to drink

Brief Alcohol Screening and Intervention for College Students (BASICS) – delivered one-on-one with a facilitator using motivational interviewing working with a student, the provider elicits personally relevant reasons to change and, when change is discussed, includes harm reduction strategies

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COLLEGE AIM

www.collegedrinkingprevention.gov/CollegeAIM

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INDIVIDUAL-LEVEL STRATEGIES: Revised and Updated*
 Estimated Relative Effectiveness, Costs, and Barriers, Public Health Reach, Research Amount, and Primary Modality

Lowest costs (\$)		Mid-range costs (\$)		Highest costs (\$)	
High effectiveness	RD-3 Narrative on education... RD-10 Skills training, alcohol harm... RD-24 Personalized feedback intervention...	RD-13 Skills training, alcohol harm... RD-14 Skills training, alcohol harm... RD-15 Brief alcohol education... RD-26 Personalized feedback intervention...	RD-16 Narrative on education... RD-17 Skills training, alcohol harm... RD-18 Skills training, alcohol harm... RD-19 Brief alcohol education... RD-20 Brief alcohol education... RD-21 Multi-component education...	RD-11 Multi-component education... RD-12 Multi-component education... RD-22 Personalized feedback intervention... RD-23 Personalized feedback intervention...	Public health reach + = 100% reach + = 75% reach + = 50% reach + = 25% reach + = 10% reach + = 5% reach + = 1% reach + = 0% reach
Medium effectiveness	RD-17 Skills training, alcohol harm... RD-18 Skills training, alcohol harm... RD-19 Brief alcohol education... RD-20 Brief alcohol education...	RD-13 Skills training, alcohol harm... RD-14 Skills training, alcohol harm... RD-15 Brief alcohol education... RD-26 Personalized feedback intervention...	RD-16 Narrative on education... RD-17 Skills training, alcohol harm... RD-18 Skills training, alcohol harm... RD-19 Brief alcohol education... RD-20 Brief alcohol education... RD-21 Multi-component education...	RD-11 Multi-component education... RD-12 Multi-component education... RD-22 Personalized feedback intervention... RD-23 Personalized feedback intervention...	Research amount/quality + = 100% research + = 75% research + = 50% research + = 25% research + = 10% research + = 5% research + = 1% research + = 0% research
Low effectiveness	RD-17 Skills training, alcohol harm... RD-18 Skills training, alcohol harm... RD-19 Brief alcohol education... RD-20 Brief alcohol education...	RD-13 Skills training, alcohol harm... RD-14 Skills training, alcohol harm... RD-15 Brief alcohol education... RD-26 Personalized feedback intervention...	RD-16 Narrative on education... RD-17 Skills training, alcohol harm... RD-18 Skills training, alcohol harm... RD-19 Brief alcohol education... RD-20 Brief alcohol education... RD-21 Multi-component education...	RD-11 Multi-component education... RD-12 Multi-component education... RD-22 Personalized feedback intervention... RD-23 Personalized feedback intervention...	Primary modality + = 100% individual + = 75% individual + = 50% individual + = 25% individual + = 10% group + = 5% group + = 1% group + = 0% group
Not effective	RD-22 Personalized feedback intervention... RD-23 Personalized feedback intervention... RD-24 Personalized feedback intervention...	RD-13 Skills training, alcohol harm... RD-14 Skills training, alcohol harm... RD-15 Brief alcohol education... RD-26 Personalized feedback intervention...	RD-16 Narrative on education... RD-17 Skills training, alcohol harm... RD-18 Skills training, alcohol harm... RD-19 Brief alcohol education... RD-20 Brief alcohol education... RD-21 Multi-component education...	RD-11 Multi-component education... RD-12 Multi-component education... RD-22 Personalized feedback intervention... RD-23 Personalized feedback intervention...	Barriers + = 100% barrier + = 75% barrier + = 50% barrier + = 25% barrier + = 10% barrier + = 5% barrier + = 1% barrier + = 0% barrier

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How are these principles typically implemented in a way that minimizes the likelihood of a mixed message?

- Legal issues are acknowledged.
- Skills and strategies for abstinence are offered.
- However, if one makes the choice to drink, skills are described on ways to do so in a less dangerous and less risky way.
- A program provider must elicit personally relevant reasons for changing.
 - This is done using the Stages of Change model and Motivational Interviewing.

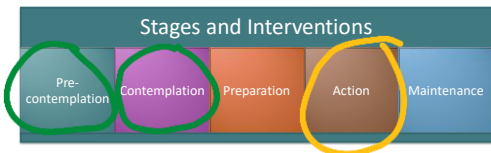
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Being aware of “action” stage suggestions, no matter what your message is

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The Stages of Change Model

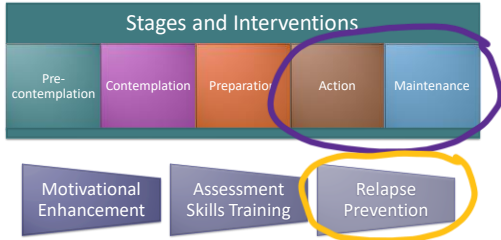
(Prochaska & DiClemente, 1982, 1984, 1985, 1986)



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The Stages of Change Model

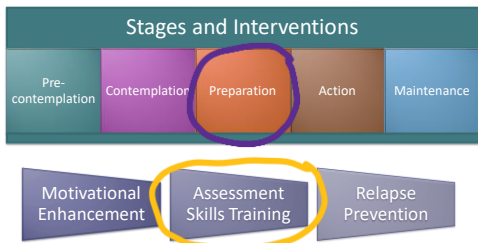
(Prochaska & DiClemente, 1982, 1984, 1985, 1986)



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The Stages of Change Model

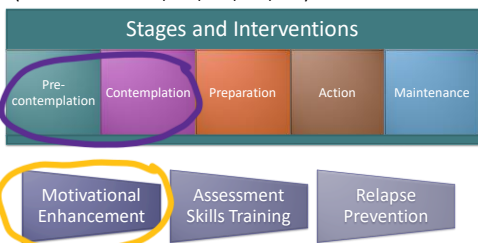
(Prochaska & DiClemente, 1982, 1984, 1985, 1986)



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The Stages of Change Model

(Prochaska & DiClemente, 1982, 1984, 1985, 1986)



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Be mindful of not contributing to misperceived norms – know what stories are in your data!

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So many evidence-based harm reduction approaches are informed by Motivational Interviewing, and we've learned some valuable lessons about messaging.

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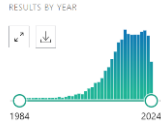
Motivational Interviewing



Miller & Rollnick, 1992, 2002, 2012, 2023

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As of August 13, 2024 (in a PubMed search for “Motivational Interviewing”)...
1,947 published clinical trials (including 1,832 randomized controlled trials)



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Brief Interventions and Motivational Interviewing

Non-judgmental	Non-confrontational	Meet people where they are
Elicit personally relevant reasons to change	Explore and resolve ambivalence	Discuss behavioral change strategies when relevant

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What is resistance?

- Resistance is verbal behaviors
- It is expected and normal
- It is a function of interpersonal communication
- Continued resistance is predictive of (non) change
- Resistance is highly responsive to style of the facilitator
- Getting resistance? Change strategies.

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Goals of a Brief Intervention

- When there are signs of potential risks and/or existing harms, provide early intervention
- If ultimately in line with what motivates the individual, prompt contemplation of change
- If ultimately in line with what motivates the individual, prompt commitment to change or even initial action
- Reduce resistance/defensiveness
- Explore behavior change strategies and discuss skills to reduce harms

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Limitations to direct persuasion

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The Spirit of Motivational Interviewing

- Direct persuasion is not an effective method for resolving ambivalence.
- We are directive in helping the person we're talking to examine and resolve ambivalence.

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Reconsidering "denial"

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Motivational Interviewing

Basic Principles

(Miller and Rollnick, 1991, 2002)



1. Express Empathy
2. Develop Discrepancy
3. Roll with Resistance
4. Support Self-Efficacy

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Four Principles of Motivational Interviewing

- Roll with Resistance
 - Avoid argumentation
 - Confrontation increases resistance to change
 - Labeling is unnecessary
 - Our role is to reduce resistance, since this is correlated with poorer outcomes
 - If resistance increases, shift to different strategies
 - Objections or minimization do not demand a response

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Even what we call
"consequences" matters

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OARS:
Building Blocks for a Foundation

- **Ask Open-Ended Questions**
 - Cannot be answered with yes or no
 - Facilitator does not know where answer will lead
 - "What do you make of this?"
 - "Where do you want to go with this now?"
 - "What ideas do you have about things that might work for you?"
 - "How are you feeling about everything?"
 - "How's the year going for you?"
 - "Tell me more about that."
 - This is different than the closed-ended "Can you tell me more about that?" or "Could you tell me more about that?"

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What open-ended
questions could you ask
that might prompt
consideration of
"consequences"?

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Finding potential hooks: An Example

- “What are the good things about _____ use for you?”
- “What are the ‘not-so-good’ things about _____ use?”
- “What would it be like if some of those not-so-good things happened less often?”
- “What might make some of those not-so-good things happen less often?”

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Closed-ended questions are discouraged

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•Closed-ended questions

- “Don’t you want to feel better?”
- “ Do you think you have a problem?”
- “There’s nothing I need to know about, is there?”
- “Is everything going o.k.?”
- “Couldn’t you just cut down?”
- “Have you thought of trying this?”
- “Do you think you could try this?”

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So are there mixed messages if we discuss harm reduction?

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If someone is struggling, the question becomes what works now?

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There's not too much controversial about "I care about you and don't want you to die"

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SPORTS

Most skiers, snowboarders now wearing helmets

By Dan
Jan 15, 2018



<https://www.ctpost.com/sports/article/Most-skiers-snowboarders-now-wearing-helmets-12510721.php>

“The study concluded that ski and snowboard helmets are very effective in preventing skull fractures, and virtually eliminated scalp lacerations.”

“Helmets aren’t going to save you from serious injuries in extreme cases of reckless skiing, speed, and collisions.”

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DOI: 10.1520/STP158220140079 • Corpus ID: 106782233

Role of Helmets in Mitigation of Head Injuries: Epidemiologic Study of Head Injuries to Skiers

J. Shealy, R. Johnson, Cf. Ettlinger, Irving S. Scher, B. Greenwald [less](#) • Published 1 July 2015 • Medicine

Helmets have been proposed as a means of injury mitigation. Head injuries are of particular interest due to the potential for death or permanent cognitive impairment. The objective of this paper was to determine the degree that a recreational ski sports helmet can mitigate head injuries. The authors conducted a prospective epidemiological study of all medically significant skiing injuries at the Sugarbush Resort. All injuries were

“During the time period of this study (17 seasons from the 1995/1996 season through the 2011/2012 season), within the population at risk, helmet usage increased from 8 to 84%.”

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This "campaign was instrumental in achieving a 10% decrease in alcohol-related fatalities between 1990 and 1991 – the single largest one-year drop in alcohol-related fatalities ever recorded."

Association of National Advertisers (ANA) Educational Foundation

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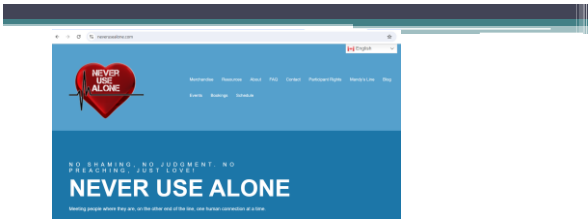
It's not "friends don't let friends drink"

It's harm reduction...

Friends don't let friends drink and drive

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NeverUseAlone.com

As of December 21, 2022, the hotline has received 17,800 calls, served 7,600 people, and assisted in reversing 88 drug overdoses.

Source: Addiction Prevention Coalition
<https://apcbham.org/the-never-use-alone-hotline-is-helping-prevent-drug-overdose-deaths/>

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What are harm reduction strategies with alcohol and cannabis?

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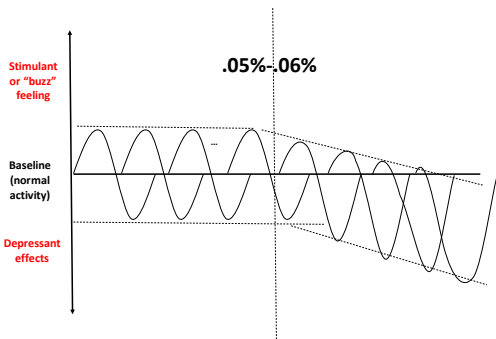


Questions...



- When people start to lose their buzz, what do they usually do?
- Do they ever get that same buzz back?

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Specific Tips for Reducing the Risk of Alcohol Use

- Set limits

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Setting a Limit

180 pound female

Number of Drinks	Number of Hours					
	1	2	3	4	5	6
1	.060	0	0	0	0	0
2	.043	.016	.007	0	0	0
3	.029	.043	.047	.011	0	0
4	.018	.046	.074	.070	.020	.004
5	.010	.043	.077	.073	.051	.014
6	.014	.018	.040	.090	.070	.054
7	.020	.043	.037	.031	.026	.016
8	.044	.040	.052	.030	.020	.014
9	.066	.044	.047	.037	.024	.016
10	.084	.048	.040	.030	.018	.012
11	.099	.049	.033	.021	.013	.008
12	.112	.048	.024	.010	.006	.004

180 pound male

Number of Drinks	Number of Hours					
	1	2	3	4	5	6
1	.025	0	0	0	0	0
2	.016	.010	0	0	0	0
3	.017	.031	.015	0	0	0
4	.017	.024	.036	.017	0	0
5	.018	.017	.040	.040	.014	.003
6	.020	.011	.037	.041	.045	.020
7	.030	.014	.026	.024	.016	.010
8	.033	.015	.019	.013	.017	.011
9	.032	.016	.040	.044	.046	.023
10	.032	.016	.040	.044	.046	.023
11	.033	.017	.043	.045	.049	.023
12	.034	.016	.037	.036	.030	.019

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Specific Tips for Reducing the Risk of Alcohol Use

- Set limits
- Eat prior to or while drinking
- Keep track of how much you drink
- Space your drinks
 - Alternate alcoholic drinks w/non-alcoholic drinks
- Avoid trying to "out drink" or keep up with others
- Avoid or alter approach to drinking games
- If you choose to drink, drink slowly
- Use a designated driver
- Don't accept a drink when you don't know what's in it
- Have a friend let you know when you've had enough
- Avoid combining alcohol with cannabis (or other substances)

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Review
Lower-Risk Cannabis Use Guidelines (LRCUG) for reducing health harms from non-medical cannabis use: A comprehensive evidence and recommendations update

Resoëlle Fischer^{1,2,3,4}, Tessa Robinson^{5,6}, Chris Bullen^{7,8}, Valerie Curran⁹, Didier Rehm^{10,11}, Maria Elena Medina-Mora¹², Rosalio Liccardo Pacula¹³, Jürgen Rehm¹⁴, Ralf R. Ross¹⁵, Wim van den Brink¹⁶, Wayne Hall¹⁷

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Fischer, B., Robinson, T., Bullen, C., Curran, V., Jutras-Aswad, D., Medina-Mora, M. E., Pacula, R. L., Rehm, J., Room, R., Brink, W. V. D., & Hall, W. (2022). Lower-Risk Cannabis Use Guidelines (LRCUG) for reducing health harms from non-medical cannabis use: A comprehensive evidence and recommendations update. *The International Journal on Drug Policy*, 99, 103381.

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General Precaution A:

“There is no universally safe level of cannabis use; thus, the only reliable way to avoid any risk for harm from using cannabis is to abstain from its use.”

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Among other recommendations:

- People who use cannabis should use low potency cannabis products
- “Overall, there is no categorically ‘safe’ route of use for cannabis and each route option brings some level of distinct risks that needs to be taken into account for use.” That said, smoking is particularly risky.
- Keep use occasional (no more than 1 or 2 days a week, weekend only)
- If a person notices impacts to attention, concentration, or memory, “consider temporarily suspending or substantially reducing the intensity (e.g., frequency/potency) of their cannabis use.”
- Avoid driving while under the influence (waiting at least 6-8 hours after inhaling, 8-12 hours after use of edibles)

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Recommendation #11: *Some specific groups of people are at elevated risk for cannabis use-related health problems because of biological pre-dispositions or co-morbidities. They should accordingly (and possibly on medical advice as required) avoid or adjust their cannabis use.* Higher risks for harm extend to individuals with a genetic predisposition (e.g., a first-degree family or personal history) for, or an active psychosis, mood (e.g., depressive) disorder, or substance use disorder.

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Can you address harm reduction through norms-based approaches?

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YES!

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Wrapping up...

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As you considered messaging, some great resources on the words we use

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Great resource from CDC:

https://www.cdc.gov/healthcommunication/Health_Equity.html



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Avoid saying target, tackle, combat, or other terms with violent connotation when referring to people, groups, or communities.

These terms should also be avoided, in general, when communicating about public health activities.

Instead of this...

- Target communities for interventions
- Target population
- Tackle issues within the community
- Aimed at communities
- Combat or fight against [disease]
- War against [disease]

Try this...

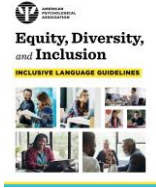
- Engage/prioritize/collaborate with/serve [population of focus]
- Population of focus
- Consider the needs of/Tailor to the needs of [population of focus]
- Communities/populations of focus
- Intended audience
- Eliminate/eradicate [issue/disease]
- Prevent/control spread of [disease]

https://www.cdc.gov/healthcommunication/Key_Principles.html

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Great resource from APA

<https://www.apa.org/about/apa/equity-diversity-inclusion/language-guidelines.pdf>



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Thank you!

- Jason Kilmer
 - jkilmer@uw.edu
 - [@cshrb_uw](https://twitter.com/cshrb_uw)
- Thank you to Alex Sirotzki, Meghan King, Justin Mauger, and the Washington Poison Center

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