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CONCEPTUAL ARTICLES

Integrating Solution Focused Brief Therapy and Harm Reduction: A Strengths-Based Framework for Working With People Who Use Substances

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Solution focused brief therapy (SFBT) and Harm Reduction (HR) have each demonstrated effectiveness with people who use substances, yet they have largely been treated as separate domains, with limited attention paid to their potential integration. This paper argues that the two approaches are philosophically and technically convergent, sharing a commitment to client autonomy, pragmatism, and a strengths-based orientation, and proposes a unified framework, Solution focused harm reduction (SFHR), for working with people who are ambivalent about change or who have not responded to abstinence-oriented treatment. Drawing on the theoretical and empirical literature underpinning both approaches, five areas of convergence are identified: self-autonomy and self-determination, a strengths-based orientation, pragmatism, a shared hierarchy of outcomes, and a common origin in clinical practice rather than theory. Two clinical vignettes illustrate the integrated framework, showing how a not-knowing stance, exception-finding, and HR information offered as a menu of options can support meaningful, client-paced change without requiring abstinence as a precondition of care. SFHR is presented as a clinically coherent, person-centred model that respects the client's pace and expertise while reducing harm and building on existing strengths. Implications for practice, training, and service development are discussed, along with the need for a fidelity framework to support future empirical evaluation of the integrated approach.

The treatment of substance use disorders has been shaped, over several decades, by a tension between two broad orientations: the abstinence paradigm, which can often be rooted in disease conceptualisations of addiction and associated with the Twelve Step tradition and Minnesota Model approaches (Lewis, 2015; Peele, 1989) and a harm reduction model which accepts continued use as a starting point for clinical engagement rather than evidence of treatment failure. This tension has not been resolved. It persists in clinical cultures, in funding structures, and in the expectations

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that many service users bring with them when they first encounter treatment. Within this contested landscape, two approaches have emerged which share a commitment to meeting the client where they are: Solution-focused brief therapy (SFBT) and Harm Reduction (HR). Each has an established evidence base. Each is explicitly non coercive. Each regards the client as the primary expert on their own life and circumstance. Yet the theoretical and clinical literature has, until recently, treated them as separate domains, SFBT belonging to the psychotherapy literature and HR to the public health and policy literature, with limited attention paid to their potential integration as a unified clinical framework (Foy, 2017; Pichot, 2009). The present paper extends and updates the framework set out in Foy (2017), applying it to a range of contemporary clinical contexts. It draws in particular on the existing literature applying solution-focused principles specifically to substance use, most notably Berg's own clinical writing (Berg & Miller, 1992; Berg & Reuss, 1998) and Isebaert's Bruges model (de Shazer & Isebaert, 2004; Isebaert, 2016), rather than treating SFBT as an undifferentiated general psychotherapy.

This paper proposes that SFBT and HR are not merely compatible but are philosophically and technically aligned in ways that make their integration both coherent and clinically powerful. The paper presents a conceptual framework for Solution-focused harm reduction (SFHR), drawing on the theoretical literature of both approaches, the empirical evidence for each, and clinical illustration. It argues that SFHR is particularly well-suited to working with people who are ambivalent about change, who have not responded to abstinence-orientated programmes, or who present with chronic, complex substance use in contexts of social marginalisation.

The paper is organised as follows. Section 2 provides a brief theoretical overview of SFBT. Section 3 provides an equivalent overview of HR. Section 4 presents the case for their integration, identifying points of philosophical and technical convergence. Section 5 examines the clinical application of the integrated framework, with case illustration. Section 6 discusses implications for practice, training, and service development, and Section 7 offers conclusions.

SOLUTION-FOCUSED BRIEF THERAPY: THEORETICAL OVERVIEW

Solution-focused Brief Therapy was developed by de Shazer and Berg at the Brief Family Therapy Center, Milwaukee, evolving from systematic observation of what helped rather than from a pre-existing theoretical architecture (de Shazer, 1985, 1988). This practical origin continues to shape the model's orientation toward what works over what explains. McKergow (2021) describes a 'next generation' of solution-focused practice, grounded in enactive cognition, with an even stronger emphasis on co-creating descriptions of preferred futures rather than importing therapeutic frameworks into the client's world.

Its theoretical foundations lie in social constructionism (Burr, 1995) and the systemic tradition of the Mental Research Institute at Palo Alto. Its core premise, that exceptions to the presenting problem always exist and contain the seeds of solution (de Shazer et al., 2007), positions the therapist's task as identifying and amplifying existing capacities rather than analysing or resolving the problem itself.

For readers less familiar with the model, its core techniques can be summarised briefly. The not-knowing stance (Anderson & Goolishian, 1992) positions the therapist as informed by the client rather than informing them, leading from behind (de Shazer, 1994). Pre-session change inquiry and previous solutions questions draw attention to change and competence already present before the session begins. The miracle question (de Shazer, 1988) generates a detailed, person-authored picture of a preferred future, typically expressed in ordinary, achievable terms rather than fantastical ones (Ratner et al., 2012). Scaling questions assess the person's own view of their problem, motivation, and confidence, with the concept of 'good enough' respecting that the goal need not be a 10 (Ratner et al., 2012).

Exception questions identify times when the presenting problem could have occurred but did not, described by BRIEF as instances of the preferred future already happening (George, 2024), and explored through the EARS sequence: Elicit, Amplify, Reinforce, Start again (Bannick, 2007). Homework, or experiments, are co-constructed collaboratively rather than prescribed: small, self-authored actions, behavioural or observational, that extend the solution-building conversation into daily life and honour the person's autonomy (De Jong & Berg, 2013).

Evidence Base

The evidence base for SFBT has grown substantially and continues to expand at pace. The foundational meta-analyses by Kim (2008) and Stams et al. (2006), and the systematic review by Gingerich and Peterson (2013) which identified 43 controlled outcome studies of which 32 reported positive outcomes, established a solid empirical foundation for the approach across a range of presentations. More recently, a comprehensive meta-analysis synthesising 72 studies published between 1993 and 2023 confirmed a consistent positive treatment effect for SFBT across diverse populations, settings, and cultural contexts, with group-based delivery showing particularly strong outcomes (Vermeulen-Oskam et al., 2024). An umbrella review of 25 systematic reviews and meta-analyses, drawing on studies up to 2023, further confirmed the effectiveness of SFBT across multiple populations and settings, consolidating its status as an empirically supported approach (Żak & Pękala, 2024). The European Brief Therapy Association Research Task Group, which maintains a continuously updated database of solution-focused research, reported 120 published papers on the solution-focused approach in 2023 alone, more than double the output of the previous year, reflecting a research community that is growing rapidly in both volume and methodological rigour (Pakrosnis & Żak, 2024). The approach has been

applied to substance use disorders, domestic violence, youth offending, mental health presentations, and educational settings, with consistent positive results across populations. Across studies, SFBT is typically delivered in approximately six sessions, achieving outcomes comparable to more established and considerably more resource-intensive therapies (Neipp & Beyebach, 2024).

HARM REDUCTION: THEORETICAL OVERVIEW

Harm Reduction (HR), also described as harm minimisation, risk reduction, or damage limitation is an approach to substance use that prioritises the reduction of the negative consequences of use rather than the achievement of abstinence as a necessary precondition of care. The International Harm Reduction Association defines it as: "Policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption" (IHRA, 2010).

The roots of HR in a substance use context can be traced to the Rolleston Report (1926) in the United Kingdom, which recognised long-term prescribing as a legitimate therapeutic response for people who were unable to achieve abstinence (Roe, 2005). Its contemporary form emerged from activist and public health responses to the HIV epidemic of the 1980s, when needle and syringe exchanges and community-based outreach programmes proliferated as pragmatic responses to rising infection rates (Inciardi & Harrison, 2000). The 'Mersey Model' developed in Liverpool in the mid-1980s is widely regarded as an early archetype of a structured, integrated HR approach (O'Hare et al., 1992). Ireland's own adoption of harm reduction has followed a similarly gradual and, at times, ambivalent path, with harm reduction measures often coexisting uneasily alongside a treatment culture and funding environment that remains substantially abstinence-oriented (Butler & Mayock, 2005).

Core Characteristics

Inciardi and Harrison (2000) identify several characteristics that define a coherent HR approach. Pragmatism acknowledges that some individuals are unwilling or unable to change their drug use and that services should engage with this reality rather than exclude people on account of it. Humanistic values reflect respect for the dignity and autonomy of people who use drugs, regardless of their readiness to change. A focus on harm places the reduction of adverse consequences, to the individual and the community, as the primary outcome of interest, not the achievement of abstinence. This distinction matters clinically because different substances, and different patterns of use, carry substantially different levels of harm to the person and to others, meaning that a genuinely harm-focused response requires a differentiated, rather than a uniform, view of risk (Nutt et al., 2010). A hierarchy of outcomes reflects the view that any movement in the direction of reduced

harm represents clinical progress: moving from injecting to smoking, from street heroin to prescribed methadone, from daily use to weekend use, from using alone to using with others present.

This hierarchy of goals is clinically important because it defines success inclusively rather than exclusively. Traditional abstinence-orientated frameworks define success narrowly and therefore define most clients as failing most of the time. HR reverses this: any reduction in harm is a success, and success builds capacity for further change (Peele, 2002).

Theoretical Context: Environment and Connection

The theoretical underpinning of HR has been enriched by a body of research challenging the assumption that substance dependence is solely a pharmacological phenomenon. Alexander et al.'s (1981) 'Rat Park' experiments at Simon Fraser University demonstrated that rats housed in enriched social environments consumed substantially less morphine-laced water than rats housed in isolation, challenging the prevailing view that opiates were inherently and irresistibly addictive. The implications for human populations were illustrated by the return of Vietnam veterans: approximately 20 per cent of American soldiers in Vietnam met criteria for heroin addiction during service, yet only 5 per cent continued use after returning home, a finding consistent with the hypothesis that environment, connection, and meaning are as central to dependence as the pharmacology of the drug itself (Robins et al., 2010).

Zinberg's (1984) epidemiological triangle, drug, set and setting, formalised this multidimensional view, arguing that any account of substance use must attend to the properties of the drug, the psychology and biography of the person using it, and the social and environmental context in which use occurs. This framework supports a person-centred clinical response that does not treat the drug as the sole locus of the problem.

Evidence Base

The evidence base for harm reduction (HR) interventions is substantial and continues to grow. Reviews spanning alcohol, tobacco, and illicit drugs have consistently found evidence of effectiveness for harm reduction strategies across multiple outcome domains, rather than this being an artefact of any single intervention or substance (Ritter & Cameron, 2006). Needle and syringe exchange programmes have been consistently shown across multiple systematic reviews to reduce HIV and hepatitis C transmission among people who inject drugs by as much as half, while simultaneously increasing uptake of treatment and acting as points of entry for otherwise hidden populations (Aspinall et al., 2014; WHO, 2024). Opioid agonist treatments, including methadone and buprenorphine, have been shown to reduce overdose mortality by up to fifty per cent and significantly improve retention in treatment compared to non-medication approaches (Sordo et al., 2021). A broader review of harm reduction policy literature confirms that the accumulated evidence is sufficient to support HR as a legitimate and effective

overarching framework for responding to substance use at both clinical and policy levels (HRI Global, 2022). The heroin-assisted treatment programmes operating in Switzerland since 1994, now embedded in national legislation and serving approximately 1,600 patients across 23 specialist centres, continue to demonstrate well-documented reductions in illicit drug use, improvements in social functioning, and high treatment retention rates (Federal Office of Public Health, Switzerland, 2025; Smart & Reuter, 2022), findings consistent with the wider European evidence base on supervised injectable heroin treatment (Strang et al., 2012). Beyond these clinical outcomes, harm reduction has also been shown to be a cost-effective approach relative to the health and social costs associated with untreated substance use (Wilson et al., 2015).

THE CASE FOR INTEGRATION: PHILOSOPHICAL AND TECHNICAL CONVERGENCE

The convergence between SFBT and HR is not merely surface level or convenient. It is deep, structural, and rooted in a shared set of philosophical commitments about the nature of the therapeutic relationship, the role of the clinician, and the locus of expertise in clinical work. This section identifies five key areas of convergence.

1. Self-Autonomy and Self-Determination

Both SFBT and HR place the person's autonomy at the centre of the clinical relationship. In SFBT, this is operationalised through the not-knowing stance and the explicit positioning of the client as the expert on their own life. The therapist does not bring a predetermined destination for the client: goals are established by the client, defined by the client, and evaluated by the client (de Shazer, 1994). In HR, client autonomy is expressed through the acceptance of the client's decision to use substances, the provision of information and support without coercion, and the recognition that the individual's definition of a good outcome may differ from the clinician's. Both approaches explicitly reject the paternalism and expert-led approach that has historically characterised much of addiction treatment.

It is worth being precise, however, about what each approach means by autonomy, since the two commitments, though closely allied, are not identical. HR's autonomy principle is primarily a commitment to non-coercion around a decision the client has already made: the person's right to continue using is accepted, and is not itself made the target of intervention. SFBT's autonomy commitment is broader, and in one respect more radical, because it concerns who defines the destination of the work at all, not only which specific decisions a service declines to override. In SFBT, the client's own goal is not merely tolerated; it is the organising principle of the entire conversation, and that goal need not have anything to do with substance use at all. This distinction matters for the integration proposed here, because it clarifies a central claim of SFHR that is easy to state imprecisely: neither abstinence nor harm reduction is, properly speaking, the goal of solution-

focused work with people who use substances. The goal is whatever positively stated preferred future the client identifies for themselves, of which reduced use, continued use, or abstinence may all be possible contents, but none of which is supplied by the therapist, or by either treatment philosophy, as the destination.

This is not an abstract point. Berg's own clinical writing on substance use makes it explicit: solution-focused work with drinkers is oriented toward addressing 'problem drinking' as a pattern of behaviour to be worked with collaboratively, rather than toward correcting 'the problem drinker' as a person requiring movement to a predetermined endpoint (Berg & Miller, 1992), an orientation extended into a structured treatment manual built around exception-finding across a wider range of substances by Berg and Reuss (1998). Isebaert's Bruges model, developed over three decades of psychiatric practice at St John's Hospital and set out with de Shazer in a dedicated account of its application to problem drinking, operationalises the same principle still more concretely: clients in the Bruges programme could choose between an abstinence-based track and a controlled-drinking track, were free to move between them, and neither track was treated by the service as the more legitimate outcome (de Shazer & Isebaert, 2004; Isebaert, 2016). At four-year follow-up, the substantial majority of both inpatients and outpatients had maintained whichever of these two goals they had originally chosen (de Shazer & Isebaert, 2004), which is itself evidence that a service can remain genuinely agnostic between abstinence and continued, controlled use as destinations without losing therapeutic traction. It is this existing literature on solution-focused work with substance use specifically, rather than SFBT theory considered in the abstract, that grounds the claim being made here.

This shared commitment to autonomy is clinically significant because it addresses one of the most consistent findings in the addictions literature: that therapeutic alliance is a stronger predictor of outcome than treatment modality, and that alliance is undermined by confrontational, directive, or coercive approaches (Miller & Rollnick, 2009). Both SFBT and HR build alliance through respect, curiosity, and a genuine orientation towards the client's own goals or preferred futures.

2. Strengths-Based Orientation

Both SFBT and HR orient towards people's strengths, capacities, and resources rather than their deficits, pathology, or failures. In SFBT, however, strengths are not actively sought by the therapist; to do so would risk importing a therapist-led agenda into what should be a person-centred conversation. Rather, strengths emerge organically through the process of curious, collaborative dialogue and are then noticed, reflected back, and amplified by the practitioner. The therapist does not arrive with a strengths lens already in place; instead, the person's capacities reveal themselves through the conversation and are acknowledged as they appear.

In many instances, people are doing their best, but this may not be picked up by the person or those around them. One technique that illustrates this orientation is the 'advertisement for someone who uses drugs' exercise (described in the clinical section below), which invites the person to articulate the skills required to manage their current circumstances, often revealing significant unremarked competence. This is complemented by the consistent practice of verbal affirmation and complimenting. In HR, a strengths-based orientation is expressed through the recognition that any person who continues to engage with a service, even one who continues to use substances, is demonstrating a form of resilience and capacity for relationship, and that any reduction in harm represents genuine achievement.

This shared orientation matters because people with substance use issues frequently arrive in services having been told, repeatedly, that they have failed, that they lack willpower, moral fibre, or commitment to recovery. A consistent strengths based message, maintained across both the therapeutic relationship and the service philosophy, represents a meaningful corrective to this accumulated narrative of failure.

3. Pragmatism

Both SFBT and HR are explicitly pragmatic: they are interested in what works in the real world, with real people, under real conditions, rather than in what ought to work in theory. De Shazer's (1985) famous formulation, if it ain't broke, don't fix it; if it works, do more of it; if it doesn't work, do something different, is a distillation of pragmatic clinical philosophy. HR is equally pragmatic: it begins with an acknowledgement that not all people who use substances will choose abstinence, and that excluding those who do not from care is not a therapeutic response but an abdication of it.

This pragmatism has important implications for how success is defined. Both approaches resist the binary of success (abstinence) and failure (continued use) that characterises much of the addiction treatment literature, replacing it with a continuous, multidimensional assessment of movement in the direction of greater wellbeing, reduced harm, and expanded capacity.

4. The Hierarchy of Outcomes

HR's concept of a hierarchy of outcomes, the idea that there is a spectrum of outcomes from engagement through to abstinence, and that movement along this spectrum represents clinical progress, maps directly onto SFBT's concept of scaling and the identification of small, achievable steps towards a preferred future. Rather than requiring a person to articulate a complete destination before the journey begins, SFHR treats each step forward as a waypoint in its own right, valuable and worth acknowledging regardless of what follows. This mirrors the spirit captured in the well known BRIEF illustration: a taxi driver does not refuse a fare because the passenger cannot describe their entire route; they simply begin moving in the right direction, one turn at a time (Ratner et al., 2012). In SFHR, clinical progress is understood in precisely these terms, not as a linear march toward a

predetermined endpoint, but as a series of meaningful movements, each one affirmed and built upon. This is consistent with what McKergow (2021) describes as 'stretching the world' of the client, enabling the person to perceive and describe possibilities that had not previously been available to them.

This alignment is particularly important in working with people showing low treatment engagement or ambivalence about change. In a purely abstinence-orientated framework, someone who reduces their heroin use from four bags to two bags per day but does not achieve abstinence has failed. Critically, within SFHR the clinical gaze is oriented not toward what the person is moving away from, but toward what they are moving toward, their own imagined and articulated preferred future. Reduction in harmful use is not framed as retreat from a problem but as progress toward a life the person themselves has described as worth living. In an integrated SF/HR framework, this person has achieved a significant exception, demonstrated capacity for change, and provided clinical material for exception amplification and solution building. The framework treats this as success and names it as such to the client.

5. Evolved from Practice

A final point of convergence is historical and epistemological: both SFBT and HR evolved from practice rather than from theory. SFBT emerged from systematic observation of what helped, in real clinical settings, with real people (de Shazer, 1988). HR emerged from the practical experience of workers on the ground in wet services (where people are allowed to consume alcohol on the premises), needle exchanges, and outreach programmes, who recognised that an abstinence-only stance left many of the people they were working with without any meaningful support (Roe, 2005). This shared origin in practical wisdom gives both approaches a flexibility and responsiveness that more theory-driven models can lack.

CLINICAL APPLICATION: SOLUTION-FOCUSED HARM REDUCTION IN PRACTICE

The integration of SFBT and HR into a unified clinical framework, described here as Solution-focused Harm Reduction (SFHR), produces a therapeutic approach characterised by the following elements. The practitioner adopts a not-knowing stance, approaching each person with genuine curiosity about their unique experience, values, and goals and acknowledging them. The first session attends to pre-session change and establishes, through the miracle or preferred future question, a self-authored picture of what a better life would look like, or what they would notice first. Scaling questions assess the person's own view of their substance use, their motivation, and their confidence in change, without privileging abstinence as the necessary or only destination. Exceptions to problematic use are systematically sought, explored and amplified. HR information is offered, on

safer use, on available services, on pharmacological options such as opioid substitution therapy, as part of a menu of options rather than a directive to change.

The menu extends beyond information and practical resources to include SF conversational tools each offered as an open invitation rather than a clinical intervention, preserving the person's freedom to engage with, adapt, or set aside whatever feels most useful to them at that point in time.

The following clinical vignettes illustrate this framework in practice. Names and identifying details have been changed to protect confidentiality.

Vignette 1: Ambivalence and the Value of Small Steps

Jim was a 26-year-old man who presented to a drug service having been referred by his GP. At initial assessment he stated that he was happy to attend but was 'not really interested in stopping, to be honest.' In a purely abstinence-orientated framework, Jim would present as low motivation and a poor prognosis for treatment engagement. Within a Stages of Change framework (Prochaska & DiClemente, 1983), Jim would be positioned as pre-contemplative, not yet weighing the costs and benefits of change, and therefore considered a poor candidate for active intervention. A traditional motivational approach might focus on moving Jim along the change cycle, nudging him toward contemplation through psychoeducation or structured feedback about the consequences of his use. The risk of this approach, however, is that it locates the problem of ambivalence within Jim rather than within the framework being applied to him. SFHR does not seek to move Jim through a predetermined sequence of stages. Instead, it accepts his stated position as an honest and legitimate expression of where he is right now and begins building from that point rather than against it. His attendance itself, however ambivalent, is treated as a meaningful exception: he showed up. That is enough to begin.

Jim's statement that he is 'not really interested in stopping, to be honest' is received within SFHR not as resistance to be overcome or ambivalence to be resolved, but as an act of radical honesty that is itself clinically valuable. Jim is telling the truth about where he is, and that truth is welcomed. The not-knowing stance invites the practitioner to respond with genuine curiosity, 'that's really helpful to know, what made you decide to come today?', rather than with psychoeducation, challenge, or premature outcome-setting. In SFBT terms, this is not a problem to be managed but a foundation to be built upon; the person who tells you honestly where they stand has already given you something real to work with. This stance is consistent with Connie and Metcalf's (2009) emphasis on attentive listening as the route to the client's preferred future, transforming apparent resistance into clinical resource.

Early sessions focused on building relationship and understanding Jim's world rather than on identifying treatment goals. HR information, regarding safer injecting practices, needle exchange, and stabilisation programmes, was offered as information, not prescription.

Over time, exception-finding questions revealed that Jim had significant periods in his drug-using career during which he had been either abstinent or using substantially less. These periods had occurred both deliberately, when Jim had 'tested himself,' and randomly, when circumstances had made use more difficult. The identification of these exceptions, and respectful curiosity about how Jim had managed them, reframed his presentation entirely: from a man with low motivation for change to a man who had already demonstrated substantial capacity for change, most of which had gone unacknowledged in previous treatment encounters.

After approximately eighteen months of engagement, sustained by the HR principle of meeting the client where they are and the SFBT principle of building therapeutic alliance through curiosity and affirmation, Jim decided to 'give treatment a go.' This was his decision, arrived at in his own time, consistent with his own values and goals. It is worth noting that Jim's eighteen months of engagement sits comfortably within an SFBT orientation, despite the common assumption that 'brief' implies speed. In SFBT, brevity refers not to the number of sessions or the duration of contact but to the economy and intentionality of the approach, using what is needed and no more. As de Shazer is reputed to have said, therapy should last 'as long as the person needs, and not one session more.' For Jim, eighteen months was exactly as brief as it needed to be.

Vignette 2: HR Strategies as Solution Building

Mark was a man in his late sixties, alcohol-dependent, living in a residential HR service (a 'wet service'). His use was stable at approximately nine cans of high-strength cider daily. Previous treatment contacts had resulted in loss of accommodation. The SFHR approach began with relationship building and systematic exception-finding. Exceptions to Mark's drinking, though few, were present: he consistently reduced his intake before major events, like meeting his family, whom he met infrequently throughout the year, and he drank less when engaged with a western or cowboy film on television, as he described: 'I enjoy it more when I'm drinking just a little less'.

When Mark expressed a desire to reduce, his proposed reduction was modest: half a can per day. In a conventional treatment framework, this would be regarded as clinically insignificant. Within an SFHR framework, it was received as an exception in the making, a client-authored, client-paced movement in the direction of less harm and supported practically and clinically. The use of a pub coaster to cover the half can overnight, and the social ritual of going to the pub on St Patrick's Day dressed in new clothes, represented HR strategies that also served SFBT functions: they were co-constructed experiments, anchored in Mark's own identified exceptions and preferred future, that built confidence and self-efficacy incrementally, consistent with McKergow's (2021) account of SF practice as working with the client's existing patterns, rituals, and social contexts as resources rather than as obstacles to be managed. Over two years, Mark's daily intake reduced from nine to three cans.

Strengths-Based Assessment: The Advertisement for Someone Who Uses Drugs

A specific clinical technique that illustrates the SFHR synthesis is the 'advertisement for someone who uses drugs' developed by the author in practice. The technique invites the client to co-construct a job advertisement for the role of living their current life, complete with all its stressors, competing demands, and challenges, as it stands for the next six months, with no change. The purpose is to generate, through the exercise of writing a personal specification for this job, a detailed account of the skills, resilience, and capacities that the client's current life actually requires.

People in substance use treatment have often been told, explicitly and implicitly, that their lives are defined by failure, moral deficit, or disease. The advertisement exercise consistently reveals something different: a person managing extraordinary levels of stress, navigating complex social relationships, maintaining commitments (to children, to work, to family) against considerable odds. This reframing does not minimise the problem; it provides a richer and more accurate account of the person, and it generates clinical material, strengths, values, commitments, that can be built upon in subsequent sessions.

IMPLICATIONS FOR PRACTICE, TRAINING, AND SERVICE DEVELOPMENT

For Practitioners

The SFHR framework is accessible to practitioners across a range of professional backgrounds and settings. It does not require specialist addiction training, though familiarity with both SFBT and HR approaches is desirable. The core skills, adopting a not-knowing stance, asking exception-finding and scaling questions, co-constructing homework experiments, looking at preferred futures and providing HR information as part of a menu of options, can be developed through training and refined through reflective supervision.

A key implication for practitioners is the importance of holding one's nerve in the face of ambivalence and apparent non-engagement and trusting in the person we are seeing to have the answers. The SFHR framework does not define the pace of change; the person does. Practitioners who can sustain a respectful, curious, non-coercive presence over extended periods of engagement, without requiring people to move faster or further than they are able, are more likely to witness the gradual, internally motivated change that the approach supports.

For Services

Services seeking to implement an SFHR approach face structural challenges where abstinence-orientated funding or commissioning requirements conflict with an HR philosophy. These tensions are real and

cannot be resolved at the level of individual clinical practice alone. However, much of the SFHR framework can be integrated into existing services without requiring a wholesale change of service philosophy: exception-finding questions, the miracle question, scaling, and the advertisement exercise can all be incorporated into standard assessment and keyworking practice within services whose primary orientation remains different.

The SFHR framework is particularly well-suited to services working with multiply excluded populations, people experiencing homelessness, people with low treatment engagement, people with co-occurring mental health difficulties, where the evidence for abstinence-oriented approaches is limited and the therapeutic alliance is typically harder to establish and maintain.

For Training

The integration of SFBT and HR into a single, coherent clinical framework argues for training curricula that address both approaches in tandem, rather than as separate modules in separate courses. Practitioners who understand the philosophical alignment of the two approaches are better positioned to apply them flexibly and coherently in complex clinical situations. Reflective practice, attending not only to what went wrong but to what worked, and how, is an essential complement to technical skill development in SFHR work.

DISCUSSION

This paper has argued that Solution-focused Brief Therapy and Harm Reduction are not merely compatible but are philosophically and technically convergent in ways that support their integration into a unified clinical framework. Both approaches are humanistic, strengths-based, autonomy-respecting, and pragmatic. Both evolved from practice. Both resist the binary of success and failure that has characterised much of the addiction treatment literature. And both are supported by substantial and growing evidence bases.

The integration of the two approaches, which the author terms Solution-focused Harm Reduction (SFHR), addresses several limitations that each approach faces when applied in isolation. HR, applied without a structured psychotherapeutic component, can become primarily transactional: the provision of needles, methadone, or medical care without the depth of therapeutic relationship that supports sustained change. SFBT, properly practised, does not itself supply abstinence as a goal; as argued above, this is precisely the point on which its own substance-use literature is most explicit (Berg & Miller, 1992; Berg & Reuss, 1998; de Shazer & Isebaert, 2004; Isebaert, 2016). The risk is organisational and practical rather than theoretical: a preferred-future conversation can drift toward an unstated assumption that less use is the relevant axis of improvement, particularly where the surrounding service culture, funding requirements, or an individual practitioner's own training has oriented them toward abstinence as the tacit standard of success, even where the model itself does not require this. HR's explicit naming of a hierarchy of outcomes, and its institutional

commitment to accountability without termination, function as a safeguard against this drift, making the absence of an abstinence requirement an explicit service commitment rather than something left to depend on each practitioner's individual fidelity to the not-knowing stance. This observation is reinforced by Connie and Froerer (2021), who argue that the transformative potential of the SFBT stance operates not only at the level of the client but at the level of the practitioner: when clinicians consistently orient toward capability and preferred futures, it reshapes their fundamental relationship to the people they work with. Their integration addresses both limitations: HR provides the philosophical foundation that makes engagement possible with ambivalent or resistant clients, while SFBT provides the technical toolkit for building a therapeutic relationship and identifying, amplifying, and sustaining movement in the direction of the client's own preferred future.

SFHR is a versatile and adaptive approach that can be applied across a wide range of clinical presentations and contexts. Rather than identifying circumstances in which SFHR cannot be used, it is more accurate to describe how the approach recalibrates itself to meet the specific demands of different situations. With clients in acute medical crisis, the practitioner draws selectively on the toolkit, using affirmation, curiosity, and the not-knowing stance to maintain therapeutic connection while medical needs are prioritised. With clients presenting with severe co-occurring mental health difficulties, the pace of solution building may slow and simpler scaling questions may replace more elaborate future-focused work, but the philosophical orientation remains intact. For clients actively seeking abstinence, SFHR is entirely compatible: their stated desire for a substance-free life is itself a preferred future to be honoured, explored, and built toward collaboratively. In each of these contexts, SFHR is not replaced or suspended but recalibrated: the core commitments to curiosity, autonomy, and the primacy of the person's own goals remain constant throughout.

A limitation of this paper is that it presents a conceptual framework rather than the results of empirical research specifically designed to evaluate the integrated SFHR approach. While the evidence bases for SFBT and HR individually are robust, there is a need for research that specifically evaluates their integration, through cohort studies, or ultimately randomised controlled designs. The author would argue that process research, examining how the therapeutic mechanisms of each approach operate in tandem, is as important as outcome research in advancing the field. A further prerequisite for rigorous empirical evaluation of SFHR is the development of a fidelity framework, a manual or structured checklist that operationalises the core components and competencies of the approach, specifying what SFHR looks like in practice, how it differs from either SFBT or HR applied in isolation, and how adherence to the model can be reliably assessed. Without such a tool, meaningful evaluation of the integrated framework remains methodologically

incomplete, and its development is therefore identified here as an urgent and necessary next step in establishing SFHR as a formally evidenced clinical approach.

CONCLUSIONS

Solution-focused Harm Reduction represents a clinically coherent, philosophically grounded, and evidence-informed approach to working with people who misuse substances. Its core claim is simple: that meeting people where they are, building on what they already do well, and working collaboratively towards their own definition of a preferred future is more effective and more humane than requiring them to meet the clinician's definition of success before engaging with care.

The approach does not require abandoning abstinence as a goal; many people who begin in an SFHR framework will, over time, arrive at abstinence as their own choice. What it requires is abandoning abstinence as a precondition of care. In a field where too many people with substance use disorders remain outside treatment because services cannot or will not meet them where they are, this is not a minor clinical adjustment. It is a reorientation of the therapeutic relationship that has the potential to significantly expand the reach and effectiveness of care.

The integration of SFBT and HR into a unified clinical framework offers practitioners, services, and commissioners a model that is flexible, resource-efficient, and respectful of the complex realities of people's lives. It deserves wider adoption, and further research, as part of a broader commitment to making treatment genuinely available to all who need it.

Conflict of interest

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Ethical approval

This paper presents a conceptual framework with clinical illustration. All case details have been changed to protect confidentiality.

Use of Artificial Intelligence

Generative AI was used in the preparation of this manuscript in a limited, supportive capacity, specifically for grammar, spelling, punctuation, and tightening of language, consistent with the journal's AI policy. Generative AI was not used to create the substantive content, arguments, or conclusions of this paper, which are entirely the author's own.

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