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## How Risk Reduction Promotes Change

Based on an interview with Edith Springer, ACSW

### Start by making the client the boss

In risk reduction, the *client* is in charge.

The overriding philosophy is to put the power back into the client's hands, where it belongs. As opposed to a provider-centric, worker-controlled approach.

### Recognize that change is a process

Risk reduction takes into account the **way** that people make changes in their behavior.

People don't change all at once; they change slowly and incrementally.

Scientists have identified six stages of change:

- Pre-contemplation
- Contemplation
- Preparation
- Action
- Maintenance
- Termination.

We need to let go of outcome hysteria and realize that change is a process.

One step leads to another. No steps can be left out or glossed over.

We have to have patience. Recognize the stages of change.

The first stage of change is precontemplation. Precontemplation means they haven't thought about changing. Or they don't want to change.

So you start with what they *are* doing, what they're *willing* to do.

We would never say that something is not good enough.

That's the message that the populations we serve hear all the time.

For example, if a client has started to use drugs more safely, traditional providers would not perceive this as a meaningful change.

A risk reductionist would say:

‘It's great that you're willing to do this one thing. That's fantastic.’

‘Let me support you in doing that one thing.’

Risk reduction works for people where they're at.

It recognizes that change is internal; it comes at *their* cadence.

**“Most clients are reluctant to tell the worker what the real deal is unless there is a relationship.”**

### Use risk reduction to help build a trusting relationship

Treating clients with dignity and believing in each person's potential to change, to have a good life, are key to establishing trusting relationships.

Most clients are reluctant to tell the worker what the real deal is – unless there is a relationship.

The biggest mistake we make as HIV workers is not taking the time to get to know people.

For example, there's a woman with a lot of problems: mental illness, legally blind, homeless, gets SSI, and uses crack cocaine.

When she was going to other agencies they tried to get her housed or into drug treatment.

She wasn't interested. She has a guy she stays with and she wants to use her money for cocaine.

She says this openly at agencies and they don't like her.

They try to coerce her into reaching goals that *they* have set.

They consider her a problem client and have threatened to tell SSI and have her benefits revoked.

Now that she's in a risk reduction program, she's doing incredibly well.

In less than a year, she's become well fed, she's getting mental health care, and the other agencies are off her back.

With the other agencies, she isn't interested in discussing HIV because she's in a struggle with them.

But with risk reduction people, she's perfectly willing to discuss HIV and to get tested.

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**“The client thinks,  
'I can't do this,'  
and you give them  
the courage to try.  
You believe in them.”**

## Communicate mattering

Even a ‘regular person’ can have difficulty giving up—say—cigarettes.

A person who has a lot of issues and a history of trauma cannot easily add a prevention behavior. They have no stable structure to add it *to*.

Many clients believe that they don't matter, so what they do to themselves doesn't matter.

When you effectively communicate that they matter to *you*, they may see themselves in *your* eyes.

A new, more true reflection of themselves.

As they begin to believe that they matter—they begin to see that their health and wellbeing matter.

And now they have a reason to change.

## Keep hope alive

When working with stigmatized people, hope is a powerful emotion.

A non-judgmental counseling model is more effective than punishing people for telling the truth about a relapse.

Penalizing a client for having a symptom that recurs is like giving consequences to a diabetic for having a blood sugar flare-up.

Never make an issue of the drug use.

For most of the people we see who have drug problems, drug use is a coping mechanism.

It must be validated and appreciated as such before it can be moderated or relinquished.

In risk reduction, you treat clients with great respect and dignity, as the human being that they are.

You make it clear that you value them as people.

See yourself as a consultant, not a parent or judge.

If someone doesn't love themselves or care for themselves in any way, safer sex won't fit in.

A lot of clients were neglected, if not abused; they don't care for themselves because they weren't *taught* to care for themselves.

Then we try to make them have safe sex or take an HIV test.

Most of the models we use were created for people who don't have stigma and other issues.

We need to intervene with people in a way that puts *them* in the driver's seat.

Hope and self-confidence are important in any intervention, and particularly in behavior change.

With people who are damaged and hurt, the educational model is insufficient.

Often, the client feels hopeless. They think, “I can't do this.”

And without hope, they're right. But *you* can believe in them. You can keep hope alive.