Chapter

Comprehensive Attention with a Harm Reduction Perspective for Psychoactive Substances Consumers in a Third Level Hospital

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Abstract

The great problem of addictions during the last five decades has been investigated through the behavioral analysis of social determinants involving multiple risk factors of initiation and maintenance of legal and illegal substances consumption, as well as the search of protective factors that allow preventing and achieving abstinence of drug abuse. Currently there is no solution and we are at the crossroads of lacking comprehensive attention, since there are treatments focused only on achieving abstinence and do not pay attention to the physical consequences of substance consumption, such as: infectious and non-communicable diseases. It is important to treat the addictions problem with a holistic approach, which facilitates access to effective medical services, based on scientific evidence, applied to adherence to treatment and adapted to patient diagnosis. With the aim of preventing or reducing the physical and mental damages that these substances can cause to the health of the users, allowing to achieve a better quality of life.

Keywords: addictions, behavior analysis, harm reduction, adherence to treatment, comprehensive attention

1. Introduction

Regarding *addictions* of psychoactive substances, there are multiple definitions since it is a multifactorial phenomenon ranging from the moment of the vital development in which the subject is, in which the gender influences the process of addition, both physically and socially, up to the pattern of consumption, the type of substance ingested, the route of administration, among others. However, one of the main characteristics of addiction is that it generates changes at a functional level in the brain by altering the reward and self-control systems [1]. According to the World Health Organization the addiction is a physical and psycho-emotional disease, related to a set of signs and symptoms, in which biological, genetic, psychological and social factors are compromised [2]. Considering that over the years

new substances producing greater damage to consumers' health [3] have emerged, the WHO has made changes to the classification of substance abuse disorders, in order to improve the prevention and treatment of these problems, these modifications will be reflected in the CIE-11, which is expected to take effect in January 2022. So far, one of the effective models to follow in the intervention of addictions is the Harm Reduction to improve the quality of life of the substance abusers, with or without achieving abstinence, but improving physical and mental health [4].

2. Global epidemiology

Inequality at a global level represents a social problem that influenced the phenomenon of drug abuse, which has experienced a serious growth, since only in a decade the number of people abusing drugs increased by 30% worldwide, from 2009 with 210 million people to 2019 with 271 million consumers of psychoactive substances, representing 5.5% of the population between 15 and 64 years of age, of which 17 million abusers suffer from infectious diseases such as HIV/AIDS, Tuberculosis and Hepatitis C; in the latter, the main cause was the increase of "opioids" consumers, with approximately 53.4 million people consuming it worldwide, being the main responsible for the majority of the 585,000 deaths; in addition of the lost years of healthy life due to disabilities entitled to drug abuse, with about 42 million years of healthy life [5] (Cited [6]). Besides, an alarming fact are respiratory diseases, cardiovascular pathologies, as well as cancer associated with drug abuse, without undermining of deaths due to injected drugs overdose, with a higher risk of suicide, in addition to psychiatric comorbidities; being a focus of attention for health systems in the world since only 1 in 6 drug abusers receives medical treatment [7].

In America, the consumption of abused substances is not less alarming, considering that the start of the consumption of any psychoactive substance, including alcohol and tobacco, starts during high school and it is decreasing even further. An important fact in the continent is the systematic decrease shown by the use of tobacco over time, probably due to the creation of the WHO Framework Convention on Tobacco Control arising from the need to combat this pandemic in 2003 [8] and having a positive impact on the legislation of its use worldwide. In the America continent, tobacco shows decreases in its use in most of the countries monitoring it, as is the case in Chile, even with the highest level, going from 44 to 33.4% from 2000 to 2016 in the consumption of the last month; but in terms of alcohol consumption, there is a decrease in consumers but those that exist are taking more and more [9]; in the case of illegal drugs, trends in use are increasing, especially cannabis and cocaine. These increases in consumption have also been identified in other substances, such as new psychoactive substances (NPS), opioids and benzodiazepines, which produce new challenges for the treatment of patients with dependency, for public health and drug policies in general [10].

3. Epidemiology in Mexico

In Mexico, poppy cultivation had a 21% increase from 2016 to 2017, keeping the country in third place worldwide in its production [6], mainly in the "Golden Triangle" formed by Sonora, Durango and Chihuahua, north of Nayarit and the state of Guerrero, which responds to the socioeconomic situation of poverty in the population [7]. Our country has become the main distributor of the United States of America with 86% of the total of this drug [11].

According to the National Survey of Drug, Alcohol and Tobacco Consumption (ENCODAT) 2016–2017 [12], alcohol is the most consumed and 1.8 million people in the country already have dependence; while in the population from 12 to 65 years old, the excessive consumption of alcohol increased from 12.3% in 2011 to 19.8% in 2016.

Tobacco is the second most consumed psychoactive substance; its prevalence in the population from 12 to 65 years old remained stable between 2011 and 2016 with 17 and 17.6%, respectively [12].

The consumption of any illegal drug increased from 7.2% in 2011 to 9.9% in 2016, the preferred drugs abused at some time in life continue to be marijuana (8.6%) and cocaine (3.5%) [12]. The use of illicit drugs (marijuana, cocaine, heroin), substances of abuse (solvents and inhalants) and non-prescription drugs (stimulants, depressants), as well as new psychoactive substances, show a lower prevalence compared to tobacco and alcohol statistics. However, the seriousness of the matter is the severe damage they generate in the individual health, with implications for family members, the community and society in general, as it is associated with greater emphasis on insecurity and violence problems [13].

Regarding medical care, in the *Report on the situation of drug abuse in Mexico and its comprehensive care 2019*, from 2010 to 2017 of the 22,856 deaths directly related to drug abuse, the largest number with 21,920 are caused by the consumption of alcohol, this is the reason why it continues to be the main drug for which attention is requested in medical emergencies, followed by the consumption of cocaine, volatile solvents and marijuana. Among the diseases prior to admission due to medical emergency under the influence of a drug, the appearance of the following were mainly reported: musculoskeletal condition, alcoholic/substance psychosis, diabetes mellitus, gastritis, cirrhosis and hypertension. As relevant data in the last deaths register of 2017, in our country 2597 people died, of which the highest percentage of deaths were between 30 and 49 years of age [14] which are one of the most productive stages in the lives of human beings, reflecting the lack of effective educational activities and campaigns for the prevention and early and timely detection of conditions to guide consumers regarding these chronic degenerative non-communicable diseases (NCDs) that represent a serious problem for public health in Mexico. Only in 2016, two of the main health care institutions in our country, Instituto Mexicano del Seguro Social (IMSS) and Instituto de Servicio y Seguro Social de los Trabajadores del Estado (ISSSTE), together allocated 31.4% of their budget for the attention of diseases such as: diabetes, hypertension, renal impairment and cancer [15], being mainly those of greater demand, combined with the low budget that the Mexican health system has received and the lack of specialized coverage that prevents it from reaching poorer populations.

4. Psychosocial determinants of addictions and epigenetics

The coverage in universal health is a worldwide problem. The burden of a disease is observed in disadvantaged groups resulting in disability at a very young age. The dynamics in the social hierarchy and the social flow of the disease are the bases on which the Social Determinants of Health (SDH) model is based, explaining the majority of inequalities in and between countries when directing interventions in the structural determinants and intermediates underlying health inequity: the former includes the political and economic context where social hierarchical patterns originate, modify and maintain within cultural norms and values; these determinants shape the health of the individuals based on their social position, gender, age, employment, race and ethnic group, income, and education; while the intermediate

determinants are the means by which the structural determinants operate, allowing the exposure to conditions damaging the health of the subject such as: housing quality, physical work environment, social support networks, healthy lifestyles, genetic factors, social cohesion and the structure of the health system [16, 17].

In Mexico, based on measurements carried out by the "Consejo Nacional de Evaluación de la Política de Desarrollo Social" (CONEVAL), some of the social determinants show that 52.4 million people are in poverty, which represents 41.9% in 2018 compared to 44.4% in 2008. On the other hand there are 9.3 million people in extreme poverty (7.4%) and 37.7 million vulnerable people due to social deprivations, whose main indicators of the total Mexican population include: educational lag (16.9%), access to health services (16.2%) access to social security (57.3%), access to food (20.4%), housing quality and spaces (11.1%) and access to basic housing services (19.8%) [18].

Therefore the social determinants describe addictions as a public health problem caused by the lack of a public health policy. The economic and basic education inequality, as structural determinants, hinder the development of all the physical and intellectual potential of people, since these would have to operate as protective factors in society; therefore, their absence affects and impacts directly on the intermediate determinants, which are distorted, when observed without a basic system in the health condition, in the family, culture and nutrition of the population to name the most important [19].

Consequently, addressing the risk factors fills the gaps that the traditional medical model has left in the search for the causes related to NCD and that will prevent its progress. The use of this concept has its importance and historical development in medicine with the improvement of techniques in the treatment of infectious diseases based on microbial theory, considering that humanity has gone through an epidemiological transition, in which the increase and appearing of non-communicable diseases, such as cardiovascular, cancer, chronic obstructive pulmonary disease and diabetes, cannot be treated as infectious diseases were treated, where there was a pathogen, because the causes of NCDs are multifactorial, among which the consumption of addictive substances, physical inactivity and deficit in eating behavior stand out [20].

Considering that the causal relationship with the health condition is different for each consumer, it will be difficult to identify a specific factor for each one. However, it has been possible to find functional relationships in which the consumption pattern will be characterized in the one hand by the type of substance abused, and in the other hand in the chain of functional background in the case of structural determinants, understood as "those circumstances in which people are born, grow, live, work and grow old as a result of the distribution of money, power and resources that will depend on the public policies adopted" [21] will play an important role.

Within each functional analysis of the behavior of drug abusers, they report in the background that the psychosocial determinants of addictions are in a cultural context that molds and shapes values in people, structuring their personality [22], which makes them more vulnerable to drug abuse in the short, medium or long term. The abuse of psychoactive substances operates as a positive reinforcement before situations that, after their consumption, are gratifying because allow avoiding such a displeasing situation for a moment [23], a feeling of relaxation due to excessive work hours, the attachment to consumers receiving support from the same when there is no affection in the family or the ease of consumption in recreational spaces such as bars, allows consumers to maintain unhealthy lifestyles [24].

The use of addictive substances is a complex behavior. To begin understanding the different variables related, it is necessary to comprehend that people are

acquiring different behaviors based on learning, whether they are transmitted verbally, or if the person observes the behavior and then executes it [25].

As already mentioned, the etiology of the use of addictive substances is classified as multifactorial, because there is not only one factor determining an addictive behavior. But it can be confirmed that the main factors related to a substance abuse problem are usually environmental, psychological and genetic [7, 26]. Since the interaction between genes and the environment can cause the expression of genes to undergo some modification, i.e., the individual experience of consumers produces changes in genes, which in turn influence memory, cognition, emotions and behavior, it can lead to a psychiatric disorder [27]. Sometimes, these genetic changes are not reversible and, unfortunately, not only influence the person who uses addictive substances, but also can be inherited. Consequently, substance abuse decreases the quality of life of the current and future generations. Among the environmental factors that lead to epigenetic changes, the following stand out: prenatal and postnatal factors, such as malnutrition, drug abuse of the parents during pregnancy, abuse or stress [28]. To address the problem of substance abuse, the traditional medical model is insufficient to achieve adherence to treatment, because it only contemplates the biological factor. For that reason, it is relevant to focus the intervention towards a flexible treatment which adapts to the different factors influencing substance abuse. Interdisciplinary treatments have been reported to produce benefits to maintain or improve the quality of life of people with chronic degenerative diseases [29]. This style of treatment is characterized by relying on different areas of knowledge to improve or maintain effectively the health of people who consume addictive substances.

It is important to note that addictions treatment, although predominantly of a psychological type, must be duly complemented by medical specialists who focus their action not only on the pharmacological treatment of the addiction, while also emphasizing the timely diagnosis of conditions as well as the reference - counter-reference of patients with conditions, associated with consumption, as this action will be decisive in the adherence that drug abusers will have to the medical treatment and which, in turn, will promote their decision of abstinence [30] (**Figure 1**).

The definition based on the above, in which the strong relationship of the psychosocial determinants in addictions is observed, as well as some of the risk factors for medical and psychiatric comorbidities due to the use of addictive substances, becomes the implementation of treatments in the three levels of health care emergent; considering that entering in the topic of addictions is relatively new for health professionals, in addition to the fact that this interventions are not so simple, since treating an individual with addictions is carried out with marked parameters of preventive medicine and not only from the cure of the medical and psychiatric comorbidities that these consumptions cause. The treatment needs to be transdisciplinary and must include health protection, promotion and maintenance parameters, as well as the abstinence from substance abuse, since the user and abuse are committed in a multifactorial way.

Different treatments have been implemented in patients who have problems with the use of addictive substances. In the 60s, they were treated with psychological therapies with the aim of modifying behavior based on punishment. These patients have a high rate of remission that over time presented a relapse [31]. Interventions via telephone, online and self-help manuals are also effective but over the months the relapse rate was significant [32].

With the advance of research and the development of psychology, programs were created that tried to improve treatments to increase adherence to treatment. To be able to work with the problem of additions it was done from the multidisciplinary, involving different areas of knowledge in such a way that adequate

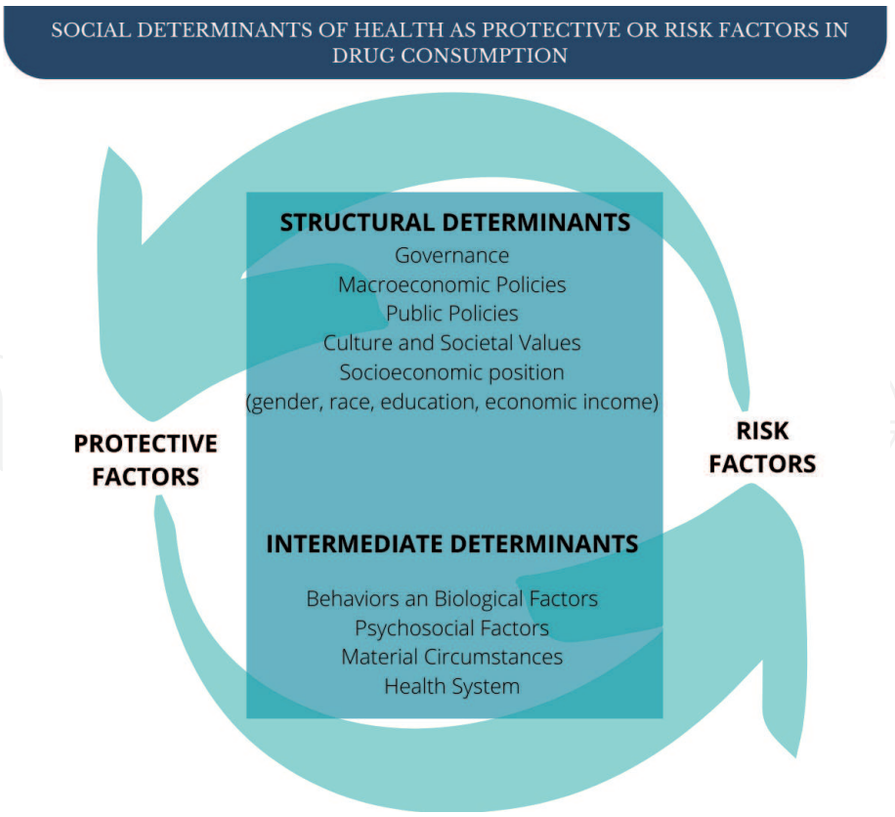

Figure 1.
Mexico presents inequality between its population and the social determinants allow us to understand the consumption of psychoactive substances in the country [18, 19].

treatments will be provided to maintain or improve the quality of life of patients. The results are positive and supported by different investigations.

A Meta-analysis conducted by Schwartz [33] to a total of 416 clinical trials of different treatments for smokers and complemented by Becoña [34] recognizes the relevance of multimodal or multidisciplinary treatments to achieve abstinence, placing them as the most effective treatment. These results are supported by the work of Sanz et al. [35] who provided interdisciplinary treatment for people who use tobacco, granted psychological treatment, supported by nicotine replacement therapies, bupropion and other medical alternatives according to the patient's characteristics. At the end of the treatment approximately 70% of the participants were in withdrawal.

It is suggested that integrated care may provide long-term benefits in terms of medical and wellness outcomes 6 months after treatment, for example Sterling [36] reports that in several studies conducted by Drug and Alcohol Research Team (DART) integrated care in the treatment of people with consumption of alcohol and other drugs and with medical or psychiatric conditions have 69% withdrawal compared to 55%. In a systematic review by Savic [37], it indicates that one of the objectives of comprehensive care is to improve the quality of life, incorporating the harm reduction strategy to achieve success. On the other hand, within the important strategies for comprehensive care, staff training, training on alcohol and other drugs to doctors who have no attention to consumers is relevant, the reference to other instances for medical care is also indicated as An important strategy.

5. Harm reduction

If we examine the increase in the use of legal and illegal psychoactive substances during the last five decades, they have led us to the search for the best clinical

practices, in which their user will benefit from treatment and rehabilitation schemes to find the "cure"; that it is not only when consumption is abandoned in hospitalizations since, sadly for our health institutions, all the efforts made in these schemes do not contemplate the approaches for medical and psychiatric comorbidities derived from consumption, reducing the effectiveness from the discharge of the substance abusers, believing that the clinical setting that led them to this will not be repeated. Most of the time, when users are facing their daily life associated with consumption they restart the intake of psychoactive substances, discarding that all professional efforts in clinical treatments are extinguished with their relapse.

The World Drug Report [7] mentions the urgent need to redouble efforts in order to facilitate access to effective medical services, based on scientific evidence, in terms of prevention, treatment and care for people who consume psychoactive substances and desperately need them.

An example of these measures can be identified in the need to accelerate the accessibility to Hepatitis C treatment, a disease whose harmful health consequences for "drug" users are much greater than those of HIV/AIDS. It is very important to frame that in the latter, the transmission of the virus was one of the main diseases that emerged as an epidemic in the early 1980s through injected drugs (opiates) and at the end there will be the exchange of syringes in consumers of heroin in Liverpool or the decriminalization of the personal dose (amount without being lethal or illegal) in Holland in 1976 [38]. When total abstinence is not met, it is important to considered that one of the fundamental basis is to reduce or avoid further damage [39] by decreasing morbidity-mortality and achieving family stability and the possibility of obtaining and keeping a job, family, besides to health, which is a priority [40].

Mexico has also implemented projects for harm reduction, such as the Syringe Program, as well as Methadone substitution therapy in Ciudad Juárez and Tijuana, managed by Non Governmental Organizations [41], which support people with physiological dependencies to prevent them from sharing the same syringe and avoid more complications.

In the context of demonstrating the benefits that can be obtained through multidisciplinary treatments, in which the aim is to achieve comprehensive health and improve the quality of life of the patients who consume any substance harmful to their health, which leads to non-communicable and infectious diseases also by the relationship of unhealthy behaviors. *Harm Reduction* is one element where it has been proven that it is not only about abstinence of substance abuse, it is also reducing the risks and damages associated to it.

Due to the relevance of the application of this strategy, we will now discern its meaning and scope in the current medicine. *Reduction* comes from the Latin *reductio* and means "action of returning something where or how it was." Its lexical components are: the prefix re- (backwards); the word Damage (discomfort, pain, deterioration or injure) comes from the Latin *damnum* (condemnation, punishment) [42]. For purposes of having an understanding updated and focused on the objective of finding a definition expressing the subject under study regarding the chore of health professionals' work within the intervention, we find that reduction is everything that implies *reducing the measure of a factor* with actions leading to the original state or closest to it.

It should be mentioned that Harm Reduction differs from Risk Reduction, since the first is to avoid as much as possible the negative effects due to the use of substances, i.e., it pretends to reduce the harmful aspects that such practice may cause, promoting healthy and hygienic habits, so that the drug abusers will have an active participation in the event of consumption and their habits regarding such consumption. While the second term becomes an educational-health activity involving

the problem regarding the consequences of drug abuse and the main population targeted is the one with no treatment related with its consumption [43].

The program for the patient with alcohol consumption started in 1974 at the Hospital General de México and in 1982 with the first Anti-Smoking Clinic (CCT), the latter program, ahead of their age, carried out multidisciplinary protocols addressed to the prevention, early and timely detection of diseases consequence of tobacco consumption, where therapeutic adherence played a very important role for the rehabilitation of the patient, as well as health education programs that will allow users know from their addiction to nicotine to their physical illness, in addition to a whole range of activities that will allow them modify their thoughts, behaviors and emotions that surround the consumption of the substance, achieving through this model the reduction of the damages [30]. The research carried out at the General Hospital of Mexico in which it compares two therapeutic techniques: cognitive restructuring and health education; the cessation obtained with the first was 52% while the second was 56%, important results because they indicate that by only applying health education the person can reach the cessation of the use of psychoactive substances [44].

In 2015 the treatment focused on all psychoactive substances, since the changes of the time were observed in the lifestyles of the population attending the anti-smoking clinic, because of which, from 2000 to 2010, 934 patients were studied demonstrating that 47% of users used more than one drug. Likewise, the inadequate processes were investigated in lifestyles where uncontrolled intake of soda and coffee was found between 64.1 and 68.4% [45] and sedentary life 61.8%. Other studies in this population also showed low level of assertiveness and social skills deficit [46]. Given these findings, the proposal is made through a holistic approach with the sum of the different medical specialties and subspecialties for the comorbidities by apparatus and system, as well as the psychological intervention, to abandon the different consumptions of psychoactive substances, widening their field of attention, monitoring the medical guidelines with therapeutic adherence, with a psychoeducational and active orientation in which it is intended to generate, strengthen and use the protective factors of each individual with therapies based on learning theories for the recovery of their physical and mental health and creating an intervention where the priority is still to reduce harm.

In the anti-smoking and other addictive substances clinics, the objective is for medical personnel to resume their activity in adherence to treatment as a fundamental tool for their work versus psychologists who are involved in the recovery and compliance of the treatment of medical or psychiatric comorbidities and not only work with cessation. Since we can observe that intrinsically the most important were bad habits in lifestyles, the discipline in self-care is responsible for playing a good role in their health and their execution is responsible for not consuming substances. Thus, within Harm Reduction Intervention proposed in a comprehensive care model, adherence to treatment has an important weight in the recovery of the person with substance abuse.

6. Adherence to treatment

Adherence to treatment allows patient to have greater control over chronic degenerative diseases. Commitment of patients, along with their motivation, is essential to continue such treatment, since it is relatively complex, prolonged and requires discipline, planning and adaptation to change. Chronic complications related to the use of psychoactive substances or drugs can be avoided or delayed if the person follows the instructions given by health specialists. The treatment that

patients with dependence receive focuses on the modification of addictive behaviors but unfortunately poor adherence is a very common situation and the high dropout rate is one of the factors that generate the greatest concern in the consumption of drugs [47].

The World Health Organization conducted an investigation to determine the level of adherence to treatment of people with chronic diseases living in developed countries. The results indicated that about only 50% of the people followed the indications and assumed that this deficiency would be greater in developing countries (such as Mexico) due to the scarcity of resources and inequities in access to medical care a fact still present nowadays [48].

The WHO [48] considers the lack of adherence to treatments and its negative clinical and economic consequences a priority public health issue. It also considers that compliance with treatments will result in a reduction of the overall health budget, due to the reduction in the need for expensive interventions, such as frequent and prolonged hospitalizations, the unnecessary use of emergency services and costly intensive care services. If patients fail to have a good adherence, they will have great losses at a personal (physical and psychological), family and social level. In the United States, for example, poor adherence to taking the medication is related to 33–69% of hospitalizations [49]. An important point is that once again, the social determinants of health play an important role in allowing patients to adhere to their treatment, as well as on their socioeconomic status, public policies regarding social protection or the structure of the health system where they belong.

There are different definitions of adherence to treatment, one of the definitions that has been most widely accepted and which the WHO resumed in 2003 is the one proposed by Haynes [50] who defines it as "the degree to which a patient's behavior in relation to taking medications, following a diet or changing lifestyle habits, coincides with the instructions provided by the doctor or healthcare staff." It can be said that there is adherence when patients collaborate and participate proactively and voluntarily with their treatment, promoting better health conditions, which go beyond passive compliance with the indications [51].

Adherence is influenced by several psychosocial factors, such as beliefs, attitudes, attributions, mental representation of the disease and social support [52, 53]. Adherence as a health behavior will be closely related to the general health values or motivation for health, it will also be modulated by the experimentation of risk or perceived vulnerability, the consideration of the severity of the disease and self-efficacy [54] (**Figure 2**).

For the consumers to change their lifestyle, they first need to modify their belief system, since this is an important modulating factor in compliance with medical and/or health recommendations. The person follows the indications based on the considerations of his/her personal beliefs and on the perception of the origin of his/her illness or the way he/she thinks he/she should face his/her health condition [55]. Patients have a representation of what a threat to their health means, their fears are concepts based on social learning in their relationships with others [56]. There are several sources that influence beliefs about their health: friends, family, media and information from other health professionals [57]. Patient beliefs regarding the treatment produce and maintain healthy behaviors. The specialist has to establish realistic expectations about the benefits patients will get when changing their lifestyle but take into consideration the time and effort required.

A strategic source of adherence to treatment is assertive communication, which occurs between the patient with addiction and the specialist. During the communication exercise presented during the first approaches, especially during the first interview, it is essential to identify the level of predisposition that the person has to modify his/her addictive behavior. This level is directly related to the degree

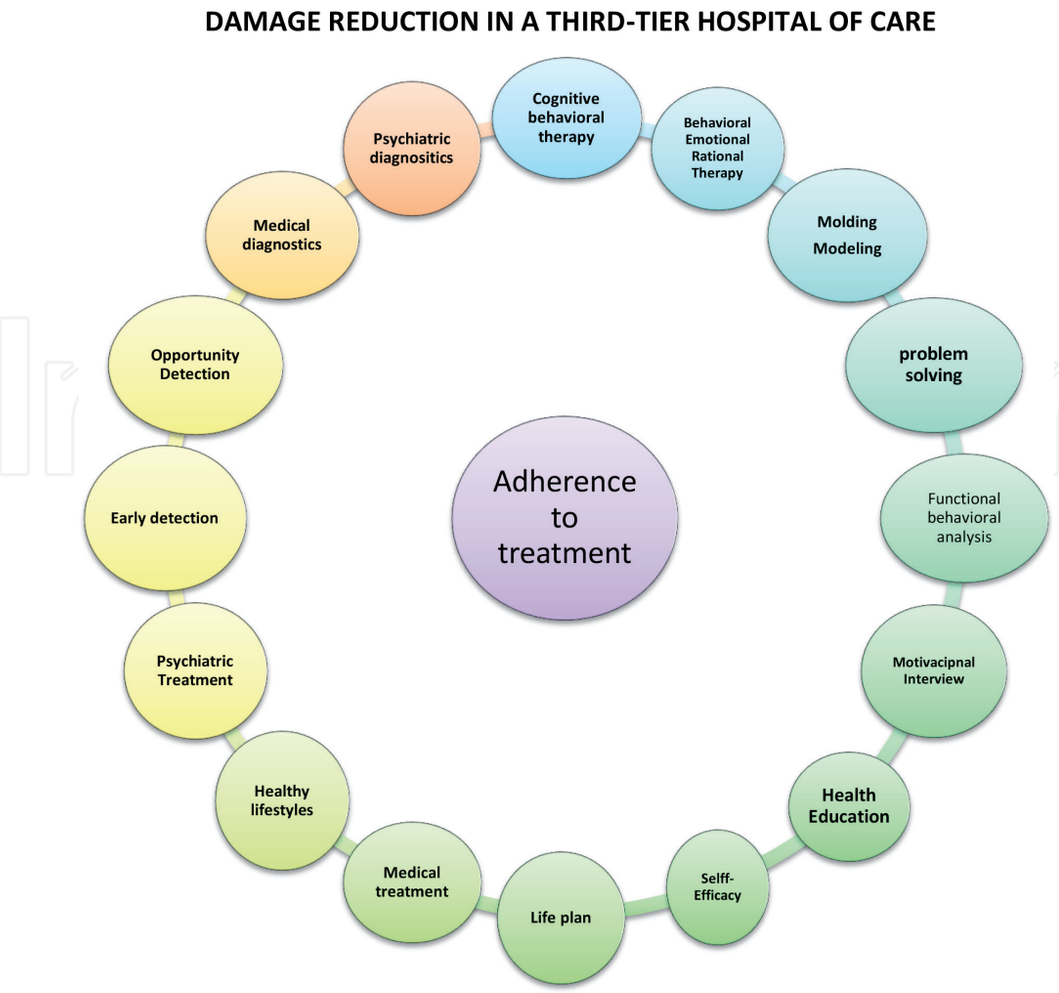

Figure 2.
The treatment is directed towards the prevention of physical and psychiatric risk factors through a multidisciplinary intervention with the intervention of psychology, psychiatry and the different medical specialties [47].

of motivation of a patient, since it predicts whether consumption will remain the same or will change favorably [58]. To recognize and work on the motivation to change, the Transteoric Change Model and the Motivational Interview formulated by Prochaska and DiClemente [59] stand out in order to identify different levels of predisposition that a person can show -*stages of change*- when it is proposed to modify his/her addictive behavior [60]. Thus, favoring respect for the patient, his/her beliefs and scale of values, trying to stimulate his/her motivation and favor his/her positioning towards healthy habits, emphasizing his/her own point of view and his/her freedom to choose. Progressively increasing the willingness to change, becoming aware of the problem and developing the necessary strategies to overcome it, including the skills to overcome contingencies and relapse. To go through the process of motivation to change in a stable and constant way, promoting his/her level of self-efficacy and allowing him/her to have greater adherence. Besides, by emphasizing the discovery of his/her risk factors we will also work on protective factors, since both have a relevant role during the onset, development, maintenance and treatment of addictions [59].

7. Conclusion

In order to globally address the consumption of psychoactive substances, the clinical history is the indispensable information tool that will establish the meeting

point with precision and the scientific, ethical, technological criteria that will be included in it, through their participation in its preparation between the different health professionals [61]. The integration will generate a unique file resulting in comprehensive management and attention, which serves as an effective communication meeting point for the treatment and evolution of the disciplines that converge, as well as the homogenization of decision-making subsequent to the diagnosis established by the consumption of legal and illegal substances, and will influence with good practices on the diagnosis, treatment, rehabilitation, of the "drug" abusers and achieve healthy lifestyles, with the priority of enriching his/her quality of life, decreasing the risks, as well as motivating the user as far as possible to eradicate substance abuse through techniques for restructuring his/her beliefs, behaviors and emotions. Besides, the health professional will accept, in a more committed way, that the consumer may feel worried about his/her health even if he/she does not succeed or does not want to stop its consumption.

Finally, the first thing to conceive in the field of health, what we have been working on for decades, is to state that the harm reduction intervention focuses on the tertiary prevention framework, which is carried out once the problem has appeared and its objective is to avoid complications, reducing risks [62], transcending in the general improvement of patients (adherence to treatment/self-efficacy, self-care) and increasing their physical and psychological recovery by encouraging abstinence and preventing relapses; reaching an approach that achieves the integral health of the users with interdisciplinary interventions, reducing the cost and increasing the benefit for the hospital users and their families, as well as for the psychological institution, reducing the cost and increasing the benefit for the hospital users and their families as well as for the institution.

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