Harm Reduction: A New Perspective on Substance Abuse Services

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This article provides information on harm reduction, a recent development in substance abuse services in response to the HIV/AIDS epidemic. The author outlines abstinence and harm reduction perspectives and the stages of change model and discusses how these perspectives can be integrated in social work practice. He proposes using harm reduction strategies for individuals for whom the abstinence perspective may not be appropriate.

Together, the traditional abstinence and harm reduction perspectives provide a basis for a more comprehensive continuum of care for individuals experiencing problems related to their substance use.

Key words: harm reduction; nonabstinence treatment; stages of change; substance abuse; theoretical perspectives

Complete abstinence from nonmedical drugs has been the goal of most substance abuse treatment in the United States. Although nonabstinence-based interventions have existed since the inception of substance abuse treatment, the harm reduction model provides a new perspective on these services. Harm reduction is increasingly used in substance abuse practice. Viewed from the perspective of the stages of change (Prochaska & DiClemente, 1982) model, strict adherence to an abstinence-only perspective is questionable. This issue is critical to all social workers, because individuals with substance abuse issues are encountered in every practice setting. This article outlines the abstinence and harm-reduction perspectives and the stages of change model and discusses how these perspectives can be integrated in social work practice in substance abuse. Examples of how these perspectives inform services provision and a discussion of the fit of harm reduction with social work ethics are also provided.

Abstinence-Only Orientation

Drug policy in the United States is one of general prohibition in a criminal justice framework. Although the federal government did not regulate drug use until passage of the Harrison Act in 1914, abstinence and prohibition of most substance use (with the obvious exception of substances such as alcohol, nicotine, and caffeine), has characterized drug policy for most of this century (Zimring & Hawkins, 1992). Although alcohol remains legal for those over age 21, there are similar “zero-tolerance” mandates for under-age drinking (Office of National Drug Control Policy [ONDCP], 1999). The Drug-Free Schools and Communities Act Amendment of 1989 (P.L. 101-226) requires all elementary and secondary schools and colleges to implement and enforce abstinence-based policies related to substance use by students (U.S. Department of Education, 1999). The Anti-Drug Abuse Act of 1988 (P.L. 100-690) mandates abstinence-based drug policy. Current drug policy is based on section 6201 of this act, which established the goal of a drug-free America and provided congressional requirements to reduce drug abuse and its consequences (ONDCP). This policy states that all nonmedical drug use is illegal, there are fines and imprisonment for substance abuse, and help is only extended to those who have a desire to abstain from...
all use (Brown, 1995). Although prohibition has been the dominant drug policy for most of this century, the significant rise in the number of people serving time for drug-related offenses, (more than 1,000 percent between 1980 and 1997), did not begin until 1980 (Bureau of Justice Statistics, 1998).

The Anti-Drug Abuse Act of 1988, which instituted mandatory minimum sentencing, requires that proposals to combat sale and use of illicit drugs by legalization be rejected; and that consideration be given only to proposals to attack directly the supply of and demand for illicit drugs (Zimring & Hawkins, 1992). The second clause often underlies arguments of proponents of abstinence-only programs. Barry McCaffery, director of the Office of the National Drug Control Policy, reported that “at best, harm reduction is a halfway measure, a half-hearted approach that would accept defeat. Increasing help is better than decreasing harm. Pretending that harmful activity will be reduced if we condone it under the law is foolish and irresponsible” (McCaffery, 2000).

Implicitly or explicitly, the goal of most substance abuse services is the elimination of nonmedical substance use. A national study of substance abuse treatment centers found that 99 percent reported an abstinence orientation to treatment. In addition, 93 percent of all drug and alcohol treatment centers in the United States base their programs on the 12-step model of treatment (Roman & Blum, 1997). The 12-step model is consistent with current drug policy because it requires a commitment to abstinence on behalf of service users and often relies heavily on confrontation of service users (Miller et al., 1995).

Abstinence may not be a practical approach for all substance users. The literature on abstinence-based substance abuse treatment suggests that most service users do not abstain and often do not complete programs (Booth, Crowle, & Zhang, 1996; Higgins et al., 1993; Kang et al., 1991). Research also suggests that substance users are more likely to use “low threshold” programs where admissions criteria are relaxed, few initial demands are made on service users, and punitive sanctions are not placed on continued substance use (Ward, Darke, Hall, & Mattick, 1992). Also, abstinence-based substance abuse services are not accessible to everyone because of financial and other constraints (Hay Group, 1998; Wenger & Rosenbaum, 1994).

Of particular importance to the present discussion, the abstinence orientation views individuals who are not immediately interested in complete abstinence as resistant or unsolvable (Miller & Rollnick, 1991). The failure to provide services to substance users who do not have an interest in abstinence is at least in part related to the concept of enabling, which posits that family members and friends often allow or facilitate substance use (Miller & Millman, 1989; Murphy, 1984; Thomas, Yoshioka, & Ager, 1996). In the enabling concept, any intervention or program that stops short of requiring abstinence is not likely to be effective and may facilitate or enable substance use. The result is a mutually exclusive choice between abstinence-oriented interventions and all other services.

Stages of Change Model
The transtheoretical stages of change model (Prochaska & DiClemente, 1982) as applied to behavior change involving substance use (Prochaska, DiClemente, & Norcross, 1992) suggests a five-stage process that clients must cycle through:

1. Precontemplation. During this stage there is no intention to change. Often this is due to a lack of awareness; the solution may be visible to the individual, but the perception of the need to personalize that solution is missing. A client may present to substance abuse services in this stage because of outside influences; however, the individual resists recognizing that there is a problem.

2. Contemplation. An awareness of the problem develops at this point in the process, as the individual weighs the pros and cons of taking action. The individual begins to consider that he or she may want to overcome the problem, but has not made a commitment to act.

3. Preparation. This stage combines intention to change with behavioral criteria; the individual in this stage has decided to act and makes plans to do so in the near future.

4. Action. At this point in the process the individual modifies his or her behavior, experiences, or environment to overcome the problems.

5. Maintenance. The behavior that occurred in the action stage is maintained as the
individual works to prevent relapse and consolidate the gains that have been attained (Prochaska et al., 1992).

Rather than viewing these individuals as treatment failures or questioning the efficacy of substance abuse treatment, it is important to provide services relevant to the individual's needs. Continued use after initiating treatment services is not blamed on poor treatment models or a client's lack of ability. Relapse is seen as a natural and expected occurrence. It is the rule rather than the exception for an individual with substance abuse problems to continue use, even after entering treatment. Prochaska and colleagues (1992) suggested that the vast majority (85 percent to 90 percent) of addicted people seeking substance abuse services are not in the action stage. Engagement of the individual can be accomplished by providing services that meet an individual's present level of change, rather than providing services that are only relevant to an individual in the action or maintenance stage.

**Harm Reduction Perspective**

Harm reduction is a conceptual framework that provides for individuals willing to be engaged in services, but not immediately seeking abstinence. Based on a public health model of social problems, harm reduction seeks to eliminate the negative consequences of phenomena for the members of a society without necessarily eliminating the phenomena (Des Jarlais, 1995). Primarily viewed as a policy framework, it is not synonymous with legalization, although the two are often confused (United Nations International Drug Control Programme [UNIDCP], 1997). Practitioners using this perspective develop interventions that reduce drug-related harm without necessarily promoting abstinence as the only solution. Common to discussions of harm reduction (Des Jarlais; Drucker, 1995; Harm Reduction Coalition, 1996; Scavuzzo, 1996; Springer, 1991, 1996; van Laar, de Zwart, & Mensink, 1996) are five assumptions:

1. Substance use has and will be part of our world; accepting this reality leads to a focus on reducing drug-related harm rather than reducing drug use.
2. Abstinence from substances is clearly effective at reducing substance-related harm, but it is only one of many possible objectives of services to substance users.

3. Substance use inherently causes harm; however, many of the most harmful consequences of substance use (HIV/AIDS, hepatitis C, overdoses, automobile accidents, and so forth) can be eliminated without complete abstinence.
4. Services to substance users must be relevant and user friendly if they are to be effective in helping people minimize their substance-related harm.
5. Substance use must be understood from a broad perspective and not solely as an individual act; accepting this idea moves interventions from coercion and criminal justice solutions to a public health or social work perspective.

Harm reduction has been the basis of substance abuse polices and practices in several Western European countries. Harm reduction was originally suggested in the 1920s in the United Kingdom as part of the Rolleston Committee’s recommendations regarding drug policy and later emerged as a pragmatic response to a rise in hepatitis C rates related to injection drug use in the early 1980s (Scavuzzo, 1996). Harm reduction has been the underpinning of drug policy and practice in the Netherlands for almost 30 years (van Laar et al., 1996). The Dutch have used harm reduction since the recommendations of the 1971 Hulsman Report became the basis for Dutch harm reduction strategies in the Revised Opium Act of 1976 (Cohen, 1994). Switzerland and Germany also have used harm reduction as a basis for some or all of their substance use policy (UNIDCP, 1997).

A recent development is the rapid adoption of harm reduction among HIV/AIDS services providers in the United States in response to the association between HIV/AIDS risk and injection drug use (Clapp & Burke, 1999). In this context, HIV/AIDS prevention took priority over preventing substance use. The preventable harm caused by HIV/AIDS clearly outweighs the need to adhere to the abstinence-based perspective. Quite simply, "dead addicts don’t recover" (Vail & Stokes, 1999).

**Applications of Harm Reduction Strategies to Social Work Practice**

The stages of change model suggests that abstinence may not be a reasonable initial expectation for most service users. Abstinence may only be relevant for the estimated 10 percent to 15 percent
of service recipients who seek services at the action stage of change (Prochaska et al., 1992). It is more important to provide services that target the individual’s stage of change and try to increase the client’s motivation to make continued changes. Thus, harm reduction provides a framework for service users at earlier stages.

Comparisons between abstinence-oriented and harm reduction services often are made on a mutually exclusive basis (McCafferty, 2000). This is an artificial contention, because the two perspectives can be incorporated to provide a more comprehensive continuum of services. Progression through the stages of change model can continue for individuals who use nonabstinence-based services. Rather than stopping or slowing this progression, involvement in harm reduction services could accelerate an individual’s potential for continued change. Harm reduction services also can fill the void for service recipients who are not at the action stage and are by definition not eligible or appropriate for abstinence-based services. These individuals have service needs despite their lack of expressed desire to remain substance free.

The idea of reducing harm is consistent with standard social work practice with individuals using substances and in social work practice in general. As social workers, our role is to facilitate positive change for our clients. Although almost any social work intervention is by definition harm reducing, harm reduction strategies have been implemented in services to injection drug users and college-age drinkers. In a study of a culturally relevant harm reduction program for African American heroin users in Cleveland, Ohio, ancillary services beyond needle exchange (for example, distribution of bleach kits and other safer injection supplies; distribution of literature on safer drug use; and support groups for users) facilitated behavior changes and served as a conduit for abstinence-based programming (MacMaster, Vail, & Neff, 2002). Needle exchange has gained the most notoriety. This harm reduction strategy has been used with increasing regularity in this country, despite a ban on federal funding (Paone, Des Jarlais, Singh, Grove, & Shi, 1998; Paone et al., 1995). Needle exchange attempts to remove the agent through which HIV/AIDS is spread (the shared needle). Although not using injection drugs would also reduce HIV/AIDS transmission, abstinence would only be an appropriate intervention for individuals at the action stage. Because 80 percent to 90 percent of all injection drug users are out of treatment at any given time (Sisk, Hatziant andreu, & Hughes, 1990), interventions for most injection drug users are necessary regardless of their motivation to abstain.

There is evidence that this strategy facilitates positive changes for injection drug users who are not seeking abstinence. The targeted outcome, the reduction of HIV infection rate, has been shown to occur (Des Jarlais et al., 1996; Heimer, Kaplan, & Cadman, 1992; Hurley, Jolley, & Kaldor, 1997; Kaplan & Heimer, 1994). These programs also have been shown to facilitate other positive changes in injection-related behaviors. The prevalence of sharing injection equipment has been shown to decrease (Blumenthal, Kral, Erringer, & Edlin, 1998; Guydish, Bucardo, Young, Grinstead, & Clark, 1993; Guydish, Clark, Garcia, & Bucardo, 1995; Hagan et al., 1993; Heimer, Khosnood, Bigg, Guydish, & Junge, 1988; Robles et al., 1998; Watter, Estilo, Clark, & Lorvick, 1994), and prevalence of disinfecting injection equipment has been shown to increase (Hagan et al.). Needle exchanges also have been conduits for abstinence-based drug treatment for program participants (Brooner et al., 1998; Heimer, 1998; Vlahov et al., 1997). These reports exemplify possibility of progress within the stages of change model, despite the use of nonabstinence-based strategies.

In contrast to the controversy surrounding needle exchange is the relatively ready acceptance of similar strategies used with individuals who are at risk of harm related to their alcohol use. Many interventions, from suggesting the use of designated drivers and wearing seatbelts to attending Alcoholics Anonymous meetings, reduce alcohol-related harm. Harm reduction strategies have been shown to reduce problems associated with alcohol use among college students. For example, the Alcohol Skills Training Program (ASTP), a six-week program for young adult drinkers, uses a cognitive–behavioral approach to prevent alcohol
problems by stressing moderate use of, or abstinence from, addictive substances (Fromme, Marlatt, Baer, & Kivlahan, 1994). The program provides skills training about setting drinking limits, monitoring one’s own drinking, rehearsing drink refusal, and practicing other useful behaviors through role play. The Brief Alcohol Screening and Intervention for College Students (BASICS) (Dimeff, Baer, Kivlahan, & Marlatt, 1998), based on the ASTP model, is a non-confrontational harm reduction approach to help students reduce their alcohol consumption and reduce the behavioral and health risks associated with heavy drinking. As with needle exchange programs, the goal of the program is not to eliminate all alcohol use but to facilitate change that will reduce the negative consequences associated with drinking, particularly binge drinking.

Some evidence supports the effectiveness of these programs. Evaluations of ASTP have found it superior to educational interventions in a one-year follow-up measure of alcohol consumption rates (Kivlahan, Marlatt, Fromme, Coppel, & Brand, 1990). Participants in the BASICS program at the University of Washington reduced the amount of alcohol consumed each time they drank to a larger extent than a control group of other high-risk drinkers. Program participants also reported that alcohol-related problems (that is, fighting, vandalism, driving under the influence, having blackouts, missing classes, and having unprotected sex) also were reduced to a larger extent compared with a control group (Marlatt et al., 1998). In keeping with the stages of change perspective, participants in these programs also were referred to traditional abstinence-based programs if deemed necessary. This, again, exemplifies the ability of participants to progress in the stages of change model despite the use of non-abstinence-based strategies.

**Harm Reduction and Social Work Values**

Social work is a value-driven profession. Values, both professional and personal, have been described as the primary determinants of the service decisions that social workers make on behalf of their clients (McGowan & Mattison, 1998). The potential fit between harm reduction and social work values and ethics must be considered before this, or any other new approach or perspective, can be implemented. Two standards of the Code of Ethics of the National Association of Social Workers (NASW, 2000) that appear particularly relevant to harm reduction interventions are “Commitment to Clients” (1.01) and “Self-Determination” (1.02). According to the ethical standard “Commitment to Clients,” clients’ interests are primary:

Social workers’ primary responsibility is to promote the well-being of clients. In general, clients’ interests are primary. However, social workers’ responsibility to the larger society or specific legal obligations may on limited occasions supersede the loyalty owed clients, and clients should be so advised. (Examples include when a social worker is required by law to report that a client has abused a child or has threatened to harm self or others.) (NASW, 2000, p. 7)

Harm reduction interventions, if successful, reduce the negative consequences of substance use, thus promoting the well-being of the client. Abstinence from substance use also promotes the well-being of the client; however, many of the harmful consequences related to substance use can be reduced without abstinence. Compared with not providing services to individuals who are not seeking abstinence, facilitating some change that reduces negative consequences is better than not facilitating any change.

Although most abused substances remain illegal in this country, the NASW Code of Ethics contains no ethical obligations for social workers to require their clients to remain abstinent to obtain services (NASW, 2000). Social workers may work with other professionals, such as probation and parole officers who do have such mandates, but these mandates do not directly apply to the social worker. The social worker’s only obligation is to the person with whom he or she is working. According to the ethical standard “Self-Determination,”

Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals. Social workers may limit clients’ right to self-determination when, in the social workers’ professional judgment, clients’ actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others.

(NASW, 2000, p. 7)

An ethical concern about the use of harm-reduction strategies is related to the limits placed on
self-determination, because it could be suggested that the use of harm reduction may cause risks for clients. As discussed earlier, most clients do not present with abstinence as the goal of treatment. Social workers using an abstinence perspective may supersede the client’s desires and require abstinence believing that any continued use would pose a foreseeable, imminent risk to the client. From a harm reduction perspective, the social workers’ superseding the clients’ rights to self-determination would be viewed as paternalistic. Harm reduction and social work ethics require that clients be met where they are and not where the social worker or agency believes they should be. The question then becomes whether harm reduction interventions perpetuate or enable “clients’ actions or potential actions that pose a serious, foreseeable, and imminent risk to themselves or others” (NASW, 2000, p. 7). If the goal of harm reduction is to reduce the harm associated with substance use, then clearly the answer would be “no.” Furthermore, if a client is not likely to engage in abstinence-based treatment, the greater potential for reduced risk is harm reduction services, which may facilitate movement in the stages of change model.

Conclusion
The traditional abstinence-based perspective clearly provides an appropriate treatment approach for many individuals experiencing problems associated with their substance use. This article provides a complementary or alternative perspective for work with individuals for whom abstinence may not be immediately appropriate or useful. When used in conjunction with the stages of change model, harm reduction and abstinence-based interventions can inform separate portions of the same continuum. An important skill in the art of social work practice is determining the best fit when matching client needs with interventions. In some instances, harm reduction services provide a better fit with clients’ needs than abstinence-based interventions. In other instances, abstinence-based services may be the more appropriate choice.

Harm reduction interventions have been found effective. These interventions did not remove the possibility of future abstinence-based interventions and engaged clients by meeting them where they were. This perspective can be used with populations who could benefit from low-thresh-

old programs, that is, individuals whose motivation for change is not yet at the action stage in the stages of change model. Such individuals would include college-age drinkers who have experienced minimal harmful consequences from their substance use and may not recognize their use as a problem. Similarly, injection drug users aware of the consequences of their use but who lack the motivation to make major changes may benefit from programs that foster positive change. The key to any successful social work program is matching client needs with the appropriate intervention. Practitioners need to be aware of their clients’ motivation and use the best fitting model to provide appropriate services. The harm reduction perspective is one such model. Just as there are groups who will benefit from harm reduction programs, highly motivated clients seeking abstinence or who could quickly move into the action stage of the stages of change model would not be appropriate candidates for harm reduction interventions.

No ethical dilemma seems to be created by using a harm reduction perspective. It could be suggested that harm reduction provides a better fit than an abstinence-only perspective to social workers’ mandates to maintain a commitment to clients’ needs and to facilitate client self-determination. As social workers become more familiar with the perspective, it is hoped that other innovative interventions will be developed, both in work with individuals experiencing problems related to their substance use and in work with other social problems.

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