

## REDUCING HARM: A VERY GOOD IDEA

Robert W. Westermeyer, Ph.D.

*"In essence, a policy of harm reduction requires an approach of pragmatism rather than purism--an acceptance that it may sometimes be better to go for a probable silver than a possible gold."*

---John Strang

The paradigm of Harm Reduction is a kindergarten-simple. This approach to addiction is viewed by some as compassionate and pragmatic; by others as selfish and dangerous. Thankfully, Harm Reduction is not a novel idea, and the most common techniques of Harm Reduction have been supported empirically. Harm Reduction is the addiction care policy of some cities in the Netherlands and The UK. Furthermore, interventions driven by the model are rapidly becoming incorporated into the addiction care agenda of several US cities.

Harm Reduction approaches to addictive behavior are based on three central beliefs:

**1. Excessive behaviors occur along a continuum of risk ranging from minimal to extreme.** Addictive behaviors are not all-or-nothing phenomena. Though a drug or alcohol abstainer is at risk of less harm than a drug or alcohol user, a moderate drinker is causing less harm than a binge drinker; a crystal methamphetamine smoker or sniffer is causing less harm than a crystal injector.

**2. Changing addictive behavior is a stepwise process, complete abstinence being the final step.** Those who embrace the harm reduction model believe that any movement in the direction of reduced harm, no matter how small, is positive in and of itself.

**3. Sobriety simply isn't for everybody.** Bold and radical, this statement requires the acceptance that many people live in horrible circumstances. Some are able to cope without the use of drugs, and others use drugs as a primary means of coping. Until we are in a

position to offer an alternative means of survival to these folks, we are in no position to cast moral judgment.

It is held that the health and well-being of the individual is of primary concern; if individuals are unwilling or unable to change addictive behavior at this time, they should not be denied services. Attempts should be made to reduce the harm of their habits as much as possible.

G. Alan Marlatt, Ph.D. of the University of Washington, pioneer in the area of addiction research and long time advocate of harm reduction, spoke of the difference between the Dutch and American approach to addiction at the first Harm Reduction Conference in Seattle, January 13 of this year. The Dutch approach addiction from a standpoint of normalcy. Rather than viewing all addicts as base individuals, they are viewed simply as people, who, like the "rest of us," are trying to cope the best they can. Addictions are viewed from a public health standpoint, not a criminal justice standpoint. Though the Dutch uphold laws regarding the sale and possession of drugs, the health and well being of people, even addicts, is more important than locking people up for drug use. As opposed to the "no tolerance" approach to addiction upheld by most treatment providers and policy makers in the United States (substance abuse is viewed as an all-or- nothing problem; If you use, you lose; Abstinence equates to health and well-being while the use of substance in any quantity equates to pathology), soft drugs are differentiated from hard drugs.

Certainly the legalization of Marijuana is evidence of this. Cannabis products can be purchased only at designated places, most of which are coffee houses, in Amsterdam and other large Dutch cities. The Dutch would rather that cannabis use occurs "out in the open" where it can be monitored. Further, offering hemp products in this form lessens the likelihood that initial experimentation with pot will occur by way of a relationship with a drug dealer, many of whom are very interested in getting users off cannabis and on harder, more profitable drugs. There has not been an increase in marijuana use since the legalization of marijuana in 1976, and the prevalence of hard drug use such as heroin and crack has remained low.

Prostitution is viewed the same way, no big deal and something to be

kept out in the open. The profession is both accepted and respected. Prostitutes are licensed, are mandated to use condoms and required to have periodic HIV tests.

Rather than a black and white view of change, the Dutch see high risk behavior occurring along a continuum from excess to moderation to abstinence. A spectrum of treatment approaches are offered to drug and alcohol users. As opposed to extreme change requirements, individuals are encouraged to move toward reduced harm and improved health at a speed which is commensurate to existing values and standards.

It is believed that the Dutch have an 80% connection rate with the addicted population. This is as opposed to the US, where we are approximately 80% out of touch. Advocates of Harm Reduction recognize that people vary tremendously in terms of level of severity, goals and motivation for change and that a high threshold approach to change (e.g. "You must consent to abstinence now," or "you must detoxify before we will render you services.") leaves a great many people unserved, as they are unable or unwilling to comply to all-or-nothing requirements. Furthermore, dichotomous requirements actually lead to more harm than health, as the majority of addicted persons are ambivalent about change and keep away from resources, thus making them more vulnerable to the sequelae of their addictions and putting others with whom they come into contact at risk.

Harm Reduction approaches attempt to connect with the addicted community, by having an "open door policy." This means that individuals are welcome to take part in services, regardless of level of motivation for change, goals or personal ideology. Harm Reduction proponents differentiate between the *functional model* and the *Community model*. A functional model works like this:

"I'm a substance abuse professional and I'd like to help people change their addictive habits. So I'll open an agency and all the addicts can come to me because I'm an expert and I can help them. But gosh, I really don't want to work in a bad area of town, so I'll set up shop in a desirable part of town. And you know, I will need to work hours which are conducive to other aspects of my lifestyle. 9 to 5 is

what every one else does, so I'll do that. Oh, and also, I don't want to work with people who are "in denial." I only wish to work with those who "truly want to change."

Well, good intentions aside, this approach results in a potential hit rate of about 5-10% of the addicted population. Though we would like to believe that we are making a big dent providing services to the motivated elite, 90-95 % of folks with addiction problems are not going to go to the agency, even if the services are affordable. Why? First, most addicts don't trust treatment providers. Most service providers have dichotomous requirements and if drug use is occurring, there is the potential for further life disruption if discovered (e.g. If she is pregnant and still using, for example, there is the risk of Child Protective Services being notified, resulting in the loss of custody of her other children because she is deemed neglectful). Also, there is the phenomenon of ambivalence (A term rarely used by addiction professionals who opt for more pejorative terms like "denial" or "resistance." For many, the use of substances is the primary means of coping. It is all but maladaptive to refuse to give up a primary means of survival without a fight. Many people experiencing ambivalence don't come into treatment agencies because they don't want their ambivalence attacked. Some people have no intention of giving up their addictive habits. This is very hard for many to accept. Not surprisingly, unless they are court mandated these folks are not going to come in to treatment agencies either. These folks are actively engaging in high risk behavior, behavior which may be influencing others as well (if they are engaging in needle sharing or sex without a condom) and are completely out of touch with resources that could potentially influence their behavior.

The community approach embraces outreach as its primary intervention. As opposed to the functional model, the addict is met on his or her turf. This is done either by placing an agency in a convenient and unthreatening location with hours which are conducive to the addict, or by leaving the shelter of the agency all together, going to where the addicts dwell. Outreach workers must be respectful that the therapist/client dichotomy is different "out there." "What can I do to help you?" must be asked instead of "Here is what you must do." Sometimes the answer will be "Nothing, get lost." Other times needs will be expressed, often having nothing to do with the

reduction of substance use.

Edith Springer, at the Harm Reduction Conference in Seattle, spoke of the growing problem of HIV infection of prostitutes in New York City. Professionals approaching prostitutes with aids information were met with abrupt responses like, "Get the hell out of here." This makes sense, they have a lot to lose if their pimp sees them, further, they are on the job trying to make a living. The way they were "hooked" was really quite ingenious. The women were offered their fee to meet for a designated amount of time. a group of prostitutes were collected in a hotel room and all asked what was most difficult about their jobs. Many complained of their feet hurting due to wearing high heel shoes all night. The workers then offered free foot massages, services rendered by students of a foot massage school. They were also offered make-up classes. After taking part in these services, the outreach workers were asked, "I know you didn't bring us here to talk about our feet, what do you really want?" They were then asked if they worried about AIDS. Unanimously they answered in the affirmative. At that point they were open to discussing methods for reducing high risk behavior, open to accepting bleach and needle cleaning supplies, open to hearing about needle exchange and condom distribution, open to spreading the word. This contact, which probably will save lives, would have been impossible had the women not been respected for their time and priorities.

Approaches such as this are radical in that they require the acknowledgment and acceptance that some people are not ready to give up high risk behavior. Making connection by helping them in other ways can reduce harm and open the door to further intervention. Of course, advocates of Harm Reduction hope that addicted individuals will ultimately come to eliminate high risk behavior completely, though it is accepted that the only way to get many people moving in the direction of abstinence is to connect with them "where they're at."