

CHAPTER 1



Current Status, Historical Highlights, and Basic Principles of Harm Reduction

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Some 14 years after the publication of the first edition of this book, harm reduction remains both highly promising and highly controversial. Few approaches these days show as much potential for global reach in reducing harm associated with high-risk behaviors and improving quality of life (QoL), particularly among marginalized and underserved populations (World Health Organization, 2009). At the same time, harm reduction in its various manifestations continues to engender heated debate that has frustrated proponents (e.g., Ball, 2007) and opponents (e.g., Leshner, 2008) alike.

Paradoxically, the growing controversy surrounding harm reduction, its operationalization, and its application likely reflect the fact that arguments for harm reduction have finally joined the mainstream on how to more effectively approach high-risk behaviors. A recent Google search on the term *harm reduction* revealed more than 5 million hits, and a PubMed

search yielded more than 2,000 articles, nearly two-thirds of which were published within the last 5 years. In 2010, *Lancet* and the *British Medical Journal* ran a feature and a series, respectively, on harm reduction approaches for HIV prevention. The Council of the European Union (2004), UNAIDS (2010), and the World Health Organization (2009) have all recently recommended comprehensive harm reduction packages affecting policy, prevention, intervention, community-based education, and advocacy efforts. In many ways, harm reduction has truly hit its stride as a worldwide movement.

In the previous edition of this book, we started Chapter 1 with the sentence, “Harm reduction has finally arrived in the United States.” Indeed it had arrived, but to a relatively cool reception from U.S. policymakers. In previous federal administrations, proponents of harm reduction were marginalized, and harm reduction approaches were often criminalized (Moskalewicz et al., 2007; Riley & O’Hare, 2000). Fortunately, at the time we are writing this chapter, harm reduction is enjoying a warmer welcome. The current Obama administration has reconceptualized drug policy as “both a public safety and a public health problem” instead of a “war on drugs” (Kerlikowske, 2010), and has removed the federal ban on needle and syringe programs (Consolidated Appropriations Act, 2010). Of course, the recent movement toward integration of harm reduction policy into U.S. law has occurred long after the enactment of more comprehensive harm reduction policies in many countries in Europe, South America, the Middle East, and Asia (Ball, 2007).

This movement toward less restrictive policy in the United States has not, however, lessened the confusion and controversy surrounding what constitutes harm reduction. On the one hand, harm reduction approaches, such as low-barrier, nonabstinence-based Housing First programs, have been embraced by Housing and Urban Development (HUD) Secretary Shaun Donovan, who has noted, “For people experiencing chronic homelessness, the research is clear that permanent supportive housing using a Housing First approach is the solution.” On the other hand, “drug czar” Gil Kerlikowske (2010) has expressed concerns about explicit use of the term *harm reduction*:

You know, oftentimes we get asked about, “Well, how do you think about or talk about harm reduction here in the United States?” We actually don’t use that term. And we don’t use that term for a very specific reason, and that is because it is so subject to everyone’s own individual interpretation. I have heard people talk about harm reduction in a discussion about legalization, and I have heard people talk about harm reduction as mentioned in these other ways: decriminalization and et cetera.

This seeming contradiction in U.S. policy reflects the confusion about the definition of harm reduction. Many involved in HIV/AIDS, homelessness,

and substance abuse prevention, policy, treatment and advocacy are appreciative of the specific, practical, and effective solutions that fit under the umbrella of harm reduction (e.g., low-barrier supportive housing, needle and syringe programs, drinking and driving prevention). Many question, however, whether the term “harm reduction” has become too broadly conceived to be useful (Ball, 2007). Others have resorted to alternative terms (e.g., risk reduction, harm minimization) to avoid the harm reduction label and its associated controversy (Ball, 2007). Still others would choose to abolish the term altogether out of concern that it has been misappropriated by drug legalization advocates (Leshner, 2008).

There are also concerns within the harm reduction movement. For example, the emphasis on comprehensive harm reduction policy, prevention, and treatment packages that have been championed by public health officials (e.g., Beyrer et al., 2010), have often used a more top-down policy approach without integrating voices of the “user”-driven grassroots movements (Friedman et al., 2007). Others believe that harm reduction is and must be a fundamentally “user”-driven approach, as its successful implementation ultimately depends on the participation of affected individuals (Hathaway & Tousaw, 2008). These various concerns reflect not only the lack of clear definition but also the differing senses of ownership of harm reduction: Is it a grassroots movement for affected individuals to empower, educate, and protect themselves? Is it a public health stance that influences worldwide drug control policy? Is it a psychotherapy? Is it sex education? Is it drug decriminalization?

The fact is that these various definitions reflect a diverse movement that values contributions of both communities and individuals, of scientific discovery and human rights advocacy, of grassroots and public health movements. This diversity of approaches and impetus to work in a more multilevel, multidisciplinary way can be energizing and ultimately more effective at various levels of society. Viewed through this lens, the growing confusion and controversy surrounding harm reduction may simply indicate its accelerating growth in various fields and acceptance by those working with affected individuals and their communities. The richness of this movement suggests that now is the time to embrace this diversity and use it as an opportunity to more effectively link top-down, global public health approaches with bottom-up grassroots advocacy to extract maximum effectiveness and reach from harm reduction applications (Stimson, 1998).

In this book, we therefore seek to explore and embrace the diversity of harm reduction instead of trying to simplify its definition or constrain its reach. In this chapter, we define and examine harm reduction as a set of compassionate and pragmatic approaches for reducing harm associated with high-risk behaviors and improving quality of life (QoL). Next, we review historical highlights of harm reduction, emphasizing the equally important

contributions of bottom-up, grassroots movements and top-down, public health contributions at key points during its historical development. We then discuss the principles of harm reduction, which were formed by this historical development and have reframed our understanding of high-risk behaviors. Finally, we discuss harm reduction's future promise in integrating grassroots and public health efforts to reduce the harms associated with high-risk behaviors and to improve QoL for affected individuals and their communities.

DEFINING HARM REDUCTION

David Purchase, the director of the North American Syringe Exchange Network, has noted that harm reduction is more of an “attitude” than a fixed set of rules or regulations, and has described this attitude as a humanitarian stance that accepts the inherent dignity of life and facilitates the ability to “see oneself in the eyes of others” (Marlatt, 1998a, p. 6). This overarching attitude has given rise to a set of compassionate and pragmatic approaches that span various fields, including public health policy, prevention, intervention, education, peer support, and advocacy. These approaches aim to reduce harm stemming from health-related behaviors (e.g., substance use, risky sexual behavior) that are considered to put the affected individuals and/or their communities at risk for negative consequences, which we refer to in this book as “high-risk behaviors.” These approaches also seek to improve QoL for affected individuals and their communities (Harm Reduction Coalition, 2010). The application of pragmatic and compassionate approaches to achieve harm reduction and QoL enhancement grew out of a recognition that some people will continue to engage in high-risk behaviors even as they experience associated harms. For these individuals, harm reduction approaches provide a middle way alternative between total abstinence and continued harmful use/behavior and thereby open other pathways for change, while reducing negative consequences for both the affected individual and their communities.

Compassionate Stance

The compassionate aspect of harm reduction refers to understanding and approaching high-risk behaviors in a way that is respected and inclusive of individuals affected by these behaviors and their communities (Denning, 2000; World Health Organization, 2004). Harm reduction reflects a humanistic perspective: people will make more health-positive choices if they have access to adequate support, empowerment, and education. Although the name “harm reduction” does not hide its directive stance, it

is increasingly recommended that affected individuals and their communities be involved in devising their own means to reducing harm and defining their own ends as to what harm reduction will comprise (UNAIDS, 2010). Thus, harm reduction approaches can more flexibly accommodate affected individuals' and communities' specific needs than other top-down, theory-oriented approaches.

Pragmatic Strategies

The pragmatic aspect of harm reduction refers to the application of what works to reduce overall harm in a scientifically demonstrable way that is in accordance with human rights protections (Degenhardt et al., 2010; Juergens, Csete, Amon, Baral, & Beyrer, 2010). Others have suggested that pragmatism in harm reduction also entails working within the belief system of the specific culture to create culturally competent and acceptable strategies (Ball, 2007; UNAIDS, 2010). In addition to introducing effective programs that reduce harm, pragmatism stipulates ending programs that, despite their apparently neutral effect, may do more harm than good in the overall public health scope. To illustrate this point, we provide an example from the recent literature on school-based sex education in the United States. Scientific review of the literature showed that abstinence-only sex education programs do not appear to be effective in consistently reducing teenage pregnancy (Bennett & Assefi, 2005). Abstinence-plus programs, which add instruction on appropriate condom use, likewise do not appear to have an effect on reducing teenage pregnancy, but do increase self-reported condom use and knowledge (Bennett & Assefi, 2005). In this case, application of a harm reduction approach would support the withdrawal of abstinence-only programs and the introduction of the abstinence-plus programs, because in the balance, the latter is likely to produce a greater overall reduction in harm (e.g., increased condom use would be associated with lower risk of transmission of sexually transmitted diseases). In this example, the pragmatic harm reduction approach might counter current popular, scientific, treatment, public health, or political belief systems. It is perhaps this aspect of harm reduction that engenders controversy, and thus requires a strong alignment of the proposed measures with scientific evidence, human rights standards, and cultural competence and knowledge to achieve acceptance, adoption, and, ultimately, effectiveness.

Defining Harm

Another important aspect of harm reduction is understanding what constitutes harm (Ball, 2007). Defining harm depends on various factors, including the culture, the level (e.g., individual, community, and societal),

and the constellation of targeted behaviors in the context of which harm is considered (Ball, 2007). To demonstrate this multifactor approach, we will use injection drug use and HIV risk as an example. We may consider harm on (1) an individual level (e.g., HIV contraction from shared needles, necrotizing skin infections); (2) a community level (e.g., unsafe drug use environments posing risks to the affected individual and their community, overburdened local police); and (3) a societal level (economic loss due high emergent use of publicly funded health services, increasing infection rates) (Riley & O'Hare, 2000). Given the particular set of circumstances in a specific culture and setting, what constitutes "harm" may look very different. The assessment should also take into account how damaging effects could potentially spill over into other levels and behaviors. For example, HIV contraction on the individual level may add up to increased infection rates and economic losses at the societal level, or HIV contraction may make the individual more susceptible to other blood-borne illness such as hepatitis C. It should also be noted that definitions of harm for individuals, communities, and larger societies may be at odds with one another, which taps into the long-standing debate in public health regarding the protection of individual civil liberties versus serving the collective good (Ashcroft, 2006; Bayer, 2007; Buchanan, 2008). Considering its complexities, defining harm in different situations warrants a thorough and tailored assessment with consideration of its contextual factors (i.e., culture, level, target behaviors) and their potentially transactional nature.

Defining Harm Reduction

Definitions of what constitutes harm reduction have varied widely in the literature and have not been without controversy (Ball, 2007; Heather, 2006; Leshner, 2008; Riley & O'Hare, 2000; Single, 1995). Deciding what a harm reduction approach will entail in a given situation requires a thorough analysis of the targeted harm, the context (i.e., culture, feasible approaches, targeted level and areas), and additional harms that might be encountered in other areas as harm is reduced in one (Degenhardt et al., 2010). Considering the hierarchy we discussed in the previous section, a comprehensive harm reduction approach might involve (1) peer education about safer injection on the individual level, (2) establishment of safe-injection centers on the community level, and (3) decriminalization of certain aspects of personal drug use on the societal level. Comprehensive harm reduction packages should encompass the various levels (individual, community, societal) and areas (grassroots advocacy/education, environmental, policy) to which they are applied. Such a multidimensional understanding of harm reduction is key to ensuring acceptability, feasibility, effectiveness, and reach of the approach in specific applications (Ball, 2007; Merzel & D'Aflitti, 2003).

What constitutes adequate evidence of harm reduction may also vary based on the scope of the evaluation. Targeted outcomes may range from individual-level micromovements toward harm reduction (e.g., performing high-risk behaviors more consciously) (Denning, Little, & Glickman, 2004), to more clinically significant risk reduction (e.g., increased condom use to reduce risk of HIV transmission) (Harm Reduction Coalition, 2010), to decreased community-level (e.g., lower neighborhood crime) and societal (e.g., lower publicly funded health care expenditures) burden. Effective harm reduction ideally should also lead to benefits in other areas (e.g., drug decriminalization on the policy level could lead to less burdened local police departments) but not to extra, unforeseen costs (Riley & O'Hare, 2000). In keeping with the spirit of harm reduction, perhaps the key to evaluating outcomes is defining and working toward clinically significant change while acknowledging any positive movement toward reducing harm.

Defining QoL

QoL was originally operationalized as the absence of disease using researcher-defined medical and psychological limitations as markers (Cummins, Lau, & Stokes, 2004). More recently, QoL has been more broadly conceived (Valderas et al., 2008), which might explain why a consistent definition has been elusive (Dijkers, 2007). Recent research has made a distinction between QoL, or subjective satisfaction with life generally and/or across more specific domains, and health-related QoL (HRQoL), or the presence or absence of disorders. HRQoL is often incorporated under the umbrella QoL term, particularly when multiple domains are included. For example, the World Health Organization has included traditional physical and psychological domains (HRQoL) as well as social and environmental domains in their QoL assessments (Harper, Power, & WHOQOL Group, 1998). Another popular QoL measure, the Short Form Health Survey (i.e., SF-36 and SF-12) measures eight domains, including role limitations due to health-related problems, as well as health promotion constructs, including vitality and social functioning (Ware, Kosinski, & Keller, 1996; Ware & Sherbourne, 1992).

Despite the difficulty in operationalizing the term, health-related research has consistently emphasized the importance of focusing on QoL (Connor, Saunders, & Feeney, 2006) as a key goal in interventions (Institute of Medicine, 2006), as well as an integral part of defining successful outcomes (Betty Ford Consensus Panel, 2007). Implicit in nearly all QoL measures to date, however, is a unilateral focus on assessing and improving researcher- or clinician-defined QoL versus aligning with affected individuals and communities to understand what aspects of QoL are relevant to them. Such a one-sided focus may provide inaccurate or irrelevant information (De Maeyer, Vanderplasschen, & Broekaert, 2010). Thus, a harm

reduction approach to defining QoL would involve working with affected individuals and communities to create an appropriately tailored QoL definition. Such procedures will likely yield more acceptable, relevant, and obtainable goals toward achieving healthier and more satisfying lives for individuals, communities, and society at large.

EXPLORING THE ORIGINS OF HARM REDUCTION

We have alluded to the push and pull between the relatively top-down public health approaches and bottom-up grassroots advocacy that have shaped harm reduction principles and practice. At any given point in its historical development, typically one of these two integral aspects of harm reduction has gathered more momentum and driven advancements in the field. In this section, we review key historical events highlighting the predominance of one or the other and the necessity of their eventual alliance. This list of events is not exhaustive and does not take into account the more recent infusion of harm reduction strategies around the globe (for comprehensive reviews of harm reduction work worldwide, see Aceijas, Hickman, Donoghoe, Burrows, & Stuijke, 2007; Ball, 2007; Bergstrom & Abdul-Quader, 2010; Mathers et al., 2010; Shahmanesh, Patel, Mabey, & Cowan, 2008). However, the following historical highlights provided the impetus for the development of harm reduction and have been instrumental in shaping the way we think about high-risk behaviors today.

The British System and the Rolleston Report

Harm reduction in one way or another has certainly been practiced since the earliest days of substance use. However, the beginnings of the modern harm reduction movement may be traced back to the early 1920s in Great Britain, when harm reduction approaches were officially indoctrinated into British law and medical best practices (Ashton, 2006).

During the 19th century, Great Britain had come to dominate the worldwide opium trade. At this time, opium- and cocaine-derived tinctures and preparations were readily available—at first through unregulated shops and later exclusively from pharmacists (Berridge, 1979). During the 19th and early 20th centuries, pharmacists and physicians in Great Britain worked together to provide, police, and prescribe opium and other drugs to the British public as well as to provide maintenance treatment to those who had become dependent (Berridge, 1979). At this time in Great Britain, substance dependence was widely viewed as individual pathology and a “very minor problem . . . a middle-class phenomenon confined to a large extent to the medical profession itself” (Berridge, 1984, p. 27). However,

the U.S. government became increasingly opposed to the opium trade and widespread opium use—including its prescription by physicians (Berridge, 1977; Rouse, 1990). Ultimately, a series of treaties were signed by Western powers throughout the early 1900s, which ended Great Britain's commercial opium trade. These treaties relegated the use of opiates and cocaine to legal sanction except for certain “legitimate” applications by the medical profession (Berridge, 1984, p. 19).

In 1920, Great Britain signed into law the Dangerous Drug Act (Ministry of Health Papers, 1919), which prohibited the importation and exportation of certain substances, including opium derivatives and cocaine. The Dangerous Drug Act, however, was vague about the licensing and regulatory framework governing the manufacture, sale, prescription, possession, and distribution of these drugs, including whether physicians and pharmacists could prescribe and distribute them as maintenance treatment (Berridge, 1980). Despite a keen interest in criminalizing all substance use, the vagueness of this Act reflected an admitted uncertainty among government officials about what would constitute appropriate use and prescription (Berridge, 1984). This lack of clarity was also a concern for physicians who were left open to prosecution for prescribing substances described in the Act. These concerns led to increased organization in the medical profession to oppose it.

Grudgingly acknowledging the fact that cooperation of the medical profession was needed to determine the appropriateness of the new drug policies, the regulating agency, the British Home Office, partnered with elite members of the British medical profession to reshape the policy (Berridge, 1984). Dr. John Rolleston, chairman of the Royal College of Physicians and a noted advocate of the disease model of substance use, headed up the resulting committee of physicians and government officials to draft what would be referred to as the Rolleston Report (Departmental Committee on Morphine and Heroin Addiction, 1926). This report was endorsed by the government (Ashton, 2006), and set up a means for physicians to prescribe and distribute cocaine and opium derivatives to registered patients “for relief of the morbid conditions intimately associated with the addiction” (Berridge, 1984, p. 27).

The legacy of the Rolleston Report is essential to our understanding of substance use, dependence, and treatment for many reasons. First, it institutionalized a now commonplace, top-down collaboration between governmental agencies and medical organizations in policing substance use and determining to whom and how controlled substances may legally be distributed. There was, at the time, very little involvement of the public and affected populations in these decisions (Berridge, 1984). As a result, the Rolleston Report also introduced the disease model of substance dependence and treatment into policy and practice. That said, the pairing of the disease model with harm reduction approaches (e.g., assisted heroin treat-

ment) was only maintained in the British system as long as the affected individuals were a relatively “limited, middle-class and respectable addict clientele” (Berridge, 1984, p. 28). By the 1960s and 1970s, when rates of substance use increased, particularly among the working classes, the pairing of the disease model with a zero-tolerance, abstinence-based policing approach became more widespread (Berridge, 1984).

Despite some negative aspects of its legacy, proponents of the British model recognized that substance use need not be criminalized. Instead, it was asserted that substance use could be regulated in such a way that affected individuals, who may be unable or unwilling to achieve abstinence, could continue to pursue their lives without fear of criminal prosecution or forced marginalization. In fact, the resurgence of interest in what is now called “assisted-heroin treatment” may be the Rolleston Report’s most recent legacy. As of 2007, seven countries in Europe and North America had completed trials on assisted-heroin treatment (Fischer et al., 2007). Today, five Western European countries, including Great Britain, currently support this practice as part of their national health systems. Although initially restricted to more privileged classes, the pragmatism and compassion that undergird the British model of drug maintenance provided the initial policy platform for current harm reduction approaches.

The Dutch Model and the Junkiebond

During the 1960s, the Netherlands recorded escalating drug use believed to be associated with its increasing availability and acceptability during the counterculture movements (Leuw, 1994). In response, state-sponsored and governmental agencies commissioned two primary advisory committees—the “official” Baan Committee (“Working Group on Narcotic Substances”) and the privately commissioned Hulsman Committee—with studying the addictive properties and risks of various drugs and ultimately proposing scientifically informed drug policy. In the early 1970s, these committees released their proposals, both of which recommended the decriminalization of personal drug use (vs. drug dealing and trade) and further differentiated between cannabis-derived products and “hard drugs” based on the perceived harm that could result from their use (Leuw, 1994). Furthermore, both committees recommended that penal drug policy should be compatible with social drug policy, and thus primary and secondary prevention should take priority over legal sanctions. Finally, they noted that certain risks associated with substance use may be more acceptable than others. This first “harm reduction”-oriented policy was enacted, with some revisions, in the 1976 Dutch Opium Act, which provided *de facto* decriminalization of the use of so-called “soft drugs” (Leuw, 1994; Ossebard & van de Wijngaart, 1998).

At first, harm reduction policies being introduced in the Netherlands supported tolerance for softer drugs but relied on the more traditional disease model and policing policies for “hard drugs” such as cocaine and opiates (Leuw, 1994). During the 1970s, however, use of opiates and cocaine—substances that had not previously been widely available—was on the rise. In the 1980s, the Dutch government responded by introducing harm reduction as the official approach to dealing with all kinds of substance use (Engelsman, 1989). This practice is still firmly embedded in Dutch drug policy today (van der Gouwe, Ehrlich, & van Laar, 2009).

The Dutch government’s continued pursuit of harm reduction policy is credited in part to the advocacy of the *Rotterdamse Junkiebond* (Rotterdam Junkie Union), an activist group of drug users started by Nico Adriaans in 1981. Adriaans has been described as a charismatic individual and eloquent speaker, who was respected by fellow heroin users, researchers, clinicians, government officials, and the general public alike (Grund, 1995). Under his leadership, the *Junkiebond* was able to advocate for basic rights and health care for substance users in an organized and systematic way. Specifically, members of the *Junkiebond* educated fellow users and the general public about substance use and its associated risks via popular media, organized demonstrations advocating for users’ access to methadone, began the distribution of sterile syringes, and collaborated with researchers to inform the field’s understanding of risky drug use practices (Friedman et al., 2007; Grund, Kaplan, & Adriaans, 1991; Grund, Stern, Kaplan, Adriaans, & Drucker, 1992).

One particularly important harm reduction approach advanced by the *Junkiebond* was the introduction of the world’s first government-backed needle exchange program in 1984. Although the *Junkiebond* had been distributing sterile syringes to users since 1981, the rise of the HIV/AIDS epidemic further mobilized its efforts. Members persuaded the Municipal and Regional Health Service to provide them with disposable needles and syringes in bulk once a week, which they distributed and exchanged (Marlatt, 1998b). After realizing the potential public health impact of this grassroots movement, the National Ministry of Health provided additional funding, and locally run programs were organized in 60 Dutch cities by the late 1980s (Friedman et al., 2007). As this program gained prominence, the number of exchanged needles and syringes rose from 100,000 in 1985 to over a million per year by the early 1990s (van Ameijden, van den Hoek, & Coutinho, 1994). As of 2009, needle and syringe programs had been implemented in 82 countries worldwide (Mathers et al., 2010). Although the effectiveness of singularly applied harm reduction techniques, such as needle and syringe programs alone, was not as consistent as initially hoped (van Ameijden et al., 1994), there is strong evidence supporting the effectiveness of comprehensive harm reduction efforts in reducing HIV transmission in the Netherlands (van den Berg, Smit, van

Brussel, Coutinho, & Prins, 2007), and around the world (Wodak & Cooney, 2006).

By the mid-1980s, there were some 35 *Junkiebonden* operating in 28 Dutch cities (Friedman et al., 2007). Since this time, likely due both to widespread acceptance of the policy and practices they helped introduce and struggles within management and leadership, the *Junkiebonden* have decreased in numbers and exposure (Friedman, de Jong, & Wodak, 1993). However, their success in influencing government policy, local action, and public acceptance clearly demonstrates the importance of grassroots, user-driver activism in harm reduction.

The Mersey (Liverpool) Harm Reduction Model

From the early- to mid-1980s, there was an influx of inexpensive brown heroin and a corresponding increase in intravenous heroin use documented in Liverpool, United Kingdom (Ashton & Seymour, 2010). The rising numbers of affected individuals outgrew the primarily abstinence-based and detoxification treatment services available in the region (Seymour & Eaton, 1997), and the link between HIV/AIDS and injection drug use had become apparent. After having met with HIV/AIDS activists and educators from the United States, key figures at the Mersey Regional Health Authority (MRHA) became increasingly interested in harm reduction techniques to address rising intravenous drug use and the impending HIV/AIDS crisis (Ashton & Seymour, 2010; O'Hare, 2007). Specifically, the aim was to lessen the impact of intravenous drug use on the health of affected individuals and the larger community (Seymour & Eaton, 1997).

The Mersey model advanced from a top-down public health imperative, yet sought to involve injecting drug users (IDUs) in the community in designing their own care. This model had three primary objectives: to facilitate contact with the "hard-to-reach" members of the IDU population via outreach efforts (Ashton & Seymour, 2010, p. 95); to maintain contact with IDUs; and to help IDUs make changes in their behavior to reduce harm (Seymour & Eaton, 1997). In 1985, MRHA set up the Mersey Drug Training and Information Center (MDTIC) as a centrally located drop-in office with convenient, accessible hours of operation. The staff used a non-judgmental approach in providing needle and syringe exchange and information on safer drug use and health care tips (O'Hare, 2007). Maintenance prescriptions were also available for methadone and, in difficult-to-treat cases, heroin, an approach that harkened back to the early harm reduction techniques indoctrinated in the Rolleston Report. This approach allows overseeing physicians to regulate the quality, amount, and dispensation of opiates, which thereby reduces the risks associated with street drugs (e.g., adulterants, unknown potency, involvement in the illegal drug trade). This unique, comprehensive approach aimed to foster a sense of community

among IDUs and thereby focused on reducing harm on both community and individual levels to have a more extensive population-based effect.

This model has since become known as the Mersey (or Liverpool) Harm Reduction Model (O'Hare, 2007). Although there are no controlled outcome trials evaluating this model, a recent study indicated that the worldwide rates of HIV infections among IDUs are rising dramatically, with some Southeast Asian and Eastern European countries showing rates of infection between 40 and 70% among the IDU population (Degenhardt et al., 2010). In contrast, a recent study estimated that only 2% of IDUs in the United Kingdom are HIV-positive (Mathers et al., 2010). The authors of this work cited the swift and early introduction of comprehensive harm reduction strategies in the United Kingdom as a key contributing factor to this relatively low rate of infection.

In addition to the development of the Mersey Model, the MHRA's efforts also led to the founding in 1987 of the influential *Mersey Drugs Journal*, now known as the *International Journal of Drug Policy* (O'Hare, 2007). In 1990, MHRA also sponsored the First International Conference on the Reduction of Drug-Related Harm in Liverpool (O'Hare, 2007). It was here that drug users, scientists, public health professionals, and government officials met to share perspectives on global health issues. This conference also led to the founding of Harm Reduction International (formerly known as the International Harm Reduction Association) in 1996 and has since provided a forum for advances in international harm reduction efforts. For example, the 1998 conference held in São Paulo, Brazil, provided impetus for the State of São Paulo to legalize needle and syringe exchange programs. In 2002, WHO representatives attended and confirmed their support of the conference and the comprehensive harm reduction strategies introduced within the Mersey Model (O'Hare, 2007).

HIV/AIDS in the United States: Tipping the Balance toward Harm Reduction

Since the early days of drug policy, the United States has taken a zero-tolerance stand on substance use ranging from the Harrison Narcotics Act of 1914 to the Prohibition Act of 1919 to the "Just Say No" campaign of the 1980s. Fortunately, there have been some pockets of harm reduction in the long history of our war on drugs. As noted previously in this chapter, these pockets have launched what may be a harm reduction détente and have spurred on more unified grassroots and public health efforts to this end. In this section, we review parallel historical movements in response to the HIV/AIDS crisis that could be viewed as the tipping point toward harm reduction approaches in the United States.

Although recent evidence has indicated that HIV may have first transferred to humans as far back as 18th century (Worobey et al., 2008), the

first known cases of AIDS were identified in gay men in New York City in 1981 (Hymes et al., 1981). Mainstream community and government agencies were initially slow to respond to the AIDS epidemic, perhaps due to the marginalization of the gay community at the time (Peterson, Dimeff, Tapert, Stern, & Gorman, 1998). However, grassroots advocacy groups, such as the Gay Men's Health Crisis in New York City and the STOP AIDS program in San Francisco, were started by individuals from affected communities, who mobilized resources to provide information and peer-based education on avoiding known HIV risk behaviors, as well as to provide services to those who had acquired HIV/AIDS (Peterson et al., 1998).

Later in 1981, the first cases of AIDS-related illness in IDUs were detected in New York City (Masur et al., 1981). As news of the Dutch needle and syringe exchange efforts spread to the United States, activists either working alone (i.e., primarily ex- and current IDUs; Friedman et al., 2007; Lane & Needle Exchange Program Evaluation Project, 1993) or in nascent organizations (e.g., North American Syringe Exchange Network in Tacoma, WA, in 1988) began distributing and exchanging clean needles and syringes to members of the IDU community. This harm reduction approach was inspired by top-down public health research on HIV/AIDS but primarily was being applied via bottom-up grassroots networks.

Taken together, these grassroots advocacy efforts combating HIV/AIDS in the United States, both in the gay community and among IDUs, were ultimately successful in empowering affected individuals to take control of their health care, pressuring the scientific and medical communities to expedite HIV/AIDS treatment development, increasing health care equity, and providing services to those marginalized by traditional health care programs (Keefe, Lane, & Swarts, 2006). These grassroots activists often applied harm reduction approaches at great personal and organizational risk. For example, peer education materials on high-risk sex behavior was often subject to U.S. government-backed censure (Peterson et al., 1998), and the distribution of needles and syringes was illegal in many affected communities at the height of the HIV/AIDS crisis (Lane & Needle Exchange Program Evaluation Project, 1993).

Ahead of the Curve in North America: Canadian Efforts toward Harm Reduction

In contrast to the proliferation of grassroots and underground harm reduction programs in the United States, Canada's publicly funded programs have brought harm reduction into the mainstream, which has made Canada the leader in the wider adoption of harm reduction strategies in North America. The first government-backed needle and syringe exchange program in North America began in Vancouver in 1989, and by 2007 similar programs were supported by Health Ministries in every province. Likewise,

opioid substitution therapies, including both methadone and buprenorphine, are available in all Canadian provinces, and programs distributing safer crack kits operate in a number of cities including Toronto, Winnipeg, Montreal, Ottawa, and Vancouver (Toronto Department of Public Health, 2006). Canada was also one of seven countries worldwide that conducted controlled trials of assisted heroin treatment (Oviedo-Joekes et al., 2009). Findings indicated favorable results compared to oral methadone for individuals for whom traditional treatment had failed.

Perhaps the most recent Canadian developments in harm reduction began in 2009, when researchers undertook the largest randomized controlled trial in Canadian history, comparing the effectiveness of low-barrier, nonabstinence-based Housing First and traditional continuum-of-care housing models in five cities: Vancouver, Winnipeg, Toronto, Montreal, and Moncton. At a cost of over \$110 million CDN, the results of this trial are expected to have a direct bearing on policies associated with harm reduction and housing in Canada.

Despite Canada's adoption of publicly funded harm reduction interventions, government support of these programs is still subject to the dominant political ideology of the day. For example, Vancouver's "Insite," the only legal, supervised injection facility in North America, is currently facing opposition from the Canadian Conservative Federal Government. Insite opened in 2003 and receives more than 700 visits per day on average (Vancouver Coastal Health, 2010). Research has shown Insite's positive, community-wide effects on health and public safety (Expert Advisory Committee to the Federal Health Minister, 2008), and it has drawn support from several Canadian cities (Expert Advisory Committee to the Federal Health Minister, 2008; Harnett, 2007) and the province of British Columbia. As we prepare this chapter to go to press, however, the fate of this organization is now in the hands of the Supreme Court of Canada, which will determine whether the Canadian government has the authority to close this program and thereby constrain the growth of similar facilities throughout the country.

Reflections on the Historical Highlights of Harm Reduction

In this section, we have touched on key historical highlights that have shaped the development of harm reduction and have represented the individual and combined effects of both bottom-up grassroots activism and top-down public health approaches. The most effective approaches that have created lasting effects have involved both of these perspectives. In fact, recent publications from international nongovernmental organizations (NGOs), including UNAIDS (2010) and the World Health Organization (2009), have recommended the worldwide expansion of harm reduction packages that capitalize on both the strengths of community-based and

large-scale public health efforts. Furthermore, now that harm reduction has spread far beyond its Western European and North American roots to countries in Asia, Africa, South America, and Eastern Europe, it will need to be further tailored to meet the specific needs of these diverse cultures and communities. Thus, in the 21st century, harm reduction efforts will need to bolster support on multiple levels—ranging from affected individuals to community-based grassroots organizations to worldwide public health agencies—to generate effective solutions with global reach.

OUTLINING THE PRINCIPLES OF HARM REDUCTION

Some of the controversy surrounding harm reduction stems from the fact that it has, in part, been articulated and championed by affected individuals and their communities (e.g., *Junkiebond* in the Netherlands, Gay Men's Health Crisis Network in New York) and other grassroots activists (e.g., Harm Reduction Coalition). Thus, harm reduction approaches are often developed and applied outside of the exclusive control of the more powerful institutions that typically shape mainstream beliefs about high-risk behaviors (Denning, 2000; Marlatt, 1996; Moskalewicz et al., 2007), including religious organizations, biomedical/academic institutions, and legislative bodies. There has been, however, a move toward increasing integration of the grassroots advocacy (Berger & Luckmann, 1966; Burr, 2003) and global public health arms of the harm reduction movement. While this positive step toward integration with mainstream efforts has shaped the development of the harm reduction field, its key tenets have remained stable since the first edition of this book and have begun to reshape mainstream conceptualizations of substance use and other high-risk behaviors.

“High-Risk Behaviors” Are a Social Construction

Within the harm reduction framework, it is acknowledged that our belief systems surrounding high-risk behaviors are products of a given time and culture and their associated values, norms, and beliefs (Denning, 2000). The ways in which these behaviors are positively or negatively viewed depend on the specific behavior as well as with whom and under what circumstances it is performed, and these norms have fluctuated greatly over time and culture (Dean, 1996; Edwards, 2000; Gately, 2008). Thus, how we think about high-risk behaviors, what we choose to call high-risk behaviors, and, obviously, how we refer to these behaviors (e.g., as “high risk”) is, like many socially constructed belief systems (Berger & Luckmann, 1966; Burr, 2003), neither absolute nor stable (Goode & Ben-Yehuda, 2009). Viewing beliefs about high-risk behaviors as fluid and dynamic social constructs is helpful in setting aside judgment and more fully aligning with affected individuals (Denning, 2000), which can be key to “meeting clients where they're at”

(Marlatt, 1996) and developing truly “user”-driven policy, treatment, prevention, advocacy, and education.

High-Risk Behaviors Are Here to Stay

Although the social constructions defining them change with time, it is generally agreed that these behaviors, in their various forms, are consistent aspects of the human condition (Dean, 1996; Edwards, 2000; Gately, 2008). Furthermore, historical evidence would indicate that relatively recent attempts to eradicate high-risk behaviors, including the U.S. alcohol prohibition of the 1920s (Levine, 2003), abstinence-only sex education (Bennett & Assefi, 2005), and the widespread D.A.R.E. “just say no” substance-use campaign (Lynam et al., 1999; Pan & Bai, 2009), to name a few, have not only failed but have been associated with higher levels of crime, large public expenditures, and, sometimes, increases in the targeted high-risk behaviors. Harm reduction adherents therefore posit that time and effort spent in the eradication of intractable human behaviors would be better spent working with affected individuals to find ways to reduce the associated negative consequences (Harm Reduction Coalition, 2010).

High-Risk Behaviors May Be Both Adaptive and Maladaptive

Harm reduction adherents acknowledge not only the fact that high-risk behaviors occur, but that they occur for a reason (Denning, 2000). Behavioral economics and self-control theories provide accepted scientific explanations for high-risk behaviors, such as substance use (Glautier, 2004), and suggest that smaller effects delivered sooner (e.g., sex without a condom, a hit off a crack pipe) may be more salient and immediately rewarding than larger effects delivered later (e.g., avoidance of HIV, better lung functioning). Research has shown that even the expectation of reward (i.e., positive expectancy) is enough to predict engagement in high-risk behaviors (Patel & Fromme, 2009), and may also have crossover effects by precipitating engagement in other, related high-risk behaviors (e.g., engaging in unprotected sex while consuming substances) (Hendershot, Stoner, George, & Norris, 2007). Furthermore, our recent research with chronically homeless individuals with severe alcohol use disorders indicated that continued alcohol use may even be considered adaptive in some cases. For example, in this population, drinking together can build community on the streets, and alcohol use can stave off life-threatening alcohol withdrawal as well as reduce the experience of psychiatric symptoms (Collins et al., in press). Harm reduction adherents, therefore, take care to acknowledge and openly explore individuals’ perceptions of *both* the pros and the cons of their behaviors. This recognition is not only evidence based (Collins, Carey, & Otto, 2009; Collins, Eck, Torchalla, Schröter, & Batra, 2010); it can build insights into motivations for engaging in the high-risk behavior as well as

a more compassionate base from which tailored and effective interventions may be launched. It is, however, also important to note that harm reduction does not undervalue or ignore the real harms associated with high-risk behaviors (Denning, 2000; Harm Reduction Coalition, 2010). Instead, harm reduction encourages open, nonjudgmental assessment of both pros and cons to promote a thorough understanding of high-risk behaviors, their interconnectedness with other lifestyle factors, and their meaning and contexts (Denning, 2000b).

Harm Reduction Does Not Seek to Pathologize High-Risk Behaviors

Harm reduction principles reflect a differentiated view of potential harm associated with substance use and other high-risk behaviors. Harm reduction adherents accept that prolonged and chronic substance use may precipitate but does not automatically confer or signify the presence of a “persistent addiction” (Peele, 1991). Furthermore, as has been shown in the natural recovery and spontaneous remission literature, even heavier substance users can show intermittent or sustained periods of non-problem use often without formal treatment (Hughes, Keely, & Naud, 2004; Schutte, Moos, & Brennan, 2006; Sobell, Ellingstad, & Sobell, 2000). Because pathologizing high-risk behaviors does not appear to improve outcomes, harm reduction principles would instead indicate more pragmatic and holistic prevention and resolution of problems resulting from high-risk behaviors such as substance use (Denning, 2000).

Harm and Harm Reduction Exist on a Spectrum

Harm reduction principles recognize that some ways of engaging in high-risk behaviors are less risky than others and that levels of risk may be considered on various spectrums (Harm Reduction Coalition, 2010). Within this model, harm reduction advocates seek to educate, support and empower individuals and communities to explore and understand various options for reducing harm. Harm reduction advocates recognize any change toward reduced harm and increased QoL as a “step in the right direction” (Marlatt & Tapert, 1993) and celebrate the “power of any positive change.”¹

Individual Behavior Is Embedded in the Larger Social Context

As discussed in previous sections, harm reduction approaches seek to understand individual-level factors associated with high-risk behaviors and

¹ From a T-shirt by the Chicago Recovery Alliance as quoted in the first edition of this book by Marlatt (1998a).

their associated harms (Denning, 2000). It is also acknowledged, however, that high-risk behaviors are influenced by multiple underlying, precipitating, and maintaining variables (Rhodes, 2009; Strathdee et al., 2010). Public health researchers are beginning to reinterpret traditional biomedical endpoints, such as publicly funded health care utilization, from an ecological systems perspective (Bronfenbrenner, 1979), instead of the traditional, exclusive focus on individual agency (Malone, 1995). In using this broader perspective, which takes into account the socioeconomic disparities that affect many high-systems users, we can, for example, reframe high-level public health care utilization as a sign of the overall deterioration of social and health care safety nets instead of individuals' "abuse of the system" (Malone, 1995, p. 472). Thus, although some applications, such as harm reduction psychotherapy, may focus on treatment of the individual, it is important to affect change on the social, economic, and political environment as well (Juergens et al., 2010).

Harm Reduction Is Fundamentally Pragmatic, Not Theory Driven

It is recognized that traditional ideological or theoretical explanations of the etiology of high-risk behaviors and associated interventions are not always generalizable and may impede development and application of effective, tailored harm reduction interventions. Thus, harm reduction adherents tend to deemphasize general theory and ideology and seek out acceptable, feasible, and effective solutions that are applicable to specific situations. A pragmatic, tailored approach to developing harm reduction solutions is a cornerstone of this framework (Harm Reduction Coalition, 2010).

Harm Reduction Is an Ethical Practice

Harm reduction has been referred to as "value neutral" because of its focus on a pragmatic versus ideological approach to reducing harm and improving QoL for the individual and society (Keane, 2003). Traditionally, harm reduction's pragmatic stance and conceptualization of problems stemming from high-risk behaviors as "technical versus moral" have been considered essential to provide a neutral counterpoint to an otherwise highly value-laden debate (Keane, 2003). More recently, however, there have been calls to further articulate an underlying framework in moral, human rights, and larger public health terms (Ezard, 2001; Fry, Khoshnood, Power, & Sharma, 2008; Fry, Treloar, & Maher, 2005; Hathaway, 2001). Recent developments in the ethical discourse as well as sweeping policy reforms have pushed arguments for community-based engagement, social justice, and human rights to the forefront as candidate moral frameworks. Patterson and Panessa's (2008) assertion of the ethical imperative for *com-*

munity-based engagement with affected individuals and communities is reflected in recent NGO guidelines (UNAIDS, 2010; World Health Organization, 2004), and shows the growing interest in community-based participatory research and action (Minkler & Wallerstein, 2008). The proposed *social justice framework* aims to identify harms to affected individuals that have been precipitated by the larger social context and seeks to use harm reduction strategies as a means of reducing the associated disparities (Pauly, 2008). The *human rights framework*, put forth by Hathaway and Tousaw (2008), echoes the grassroots movements of the *Junkiebond* and asserts that harm reduction is a human right that should primarily be in the control of the affected individual. The harm reduction policies recently put in place (Council of the European Union, 2004; UNAIDS, 2010; World Health Organization, 2009) as well as the new public health discourse on harm reduction (e.g. Juergens et al., 2010), appear to draw most heavily on the social justice framework. With so many timely developments in this area, it will be interesting to see how this work on ethics, values, and moral frameworks in the harm reduction context will progress into the future.

DIFFERENTIATING BETWEEN HARM REDUCTION AND ABSTINENCE-BASED APPROACHES

There has been much discussion about what differentiates harm reduction approaches from other approaches that may also use an empathetic, client-centered style and may also aim to reduce harm and improve QoL (Ball, 2007; Erickson, 1995; Leshner, 2008; Marlatt, 1996; Single, 1995). We posit that the focus on *harm* reduction versus *use* reduction (or reduction in the engagement of other high-risk behaviors) provides the clearest point of differentiation. This shift of intervention priorities requires a focus on whatever compassionate and pragmatic means can result in a reduction in risk, regardless of whether that involves reduction in the actual behavior. That said, behavior reduction and abstinence-based goals are not necessarily incompatible with harm reduction (Riley & O'Hare, 2000); they may be included in personalized goal setting or in a tailored menu of options if they are deemed to be acceptable to the individual as viable and effective means of reducing their harm. Abstinence may be integrated into tailored intervention plans if it is generally acceptable to the individual (e.g., long-term abstinence as a goal) and/or is acceptable in certain situations (e.g., abstinence while working or driving). Ultimately, harm reduction supports any movement along the risk hierarchy that minimizes harm and improves QoL (Marlatt & Tapert, 1993), while providing additional pathways to positive change for individuals who are not ready, willing, and/or able to attain and maintain total abstinence from high-risk behaviors.

ADVANTAGES OF USING A HARM REDUCTION APPROACH

As we explored in our recounting of its development, harm reduction has been most effective when it is integrated into communities as a grassroots, compassionate approach that utilizes pragmatic strategies to engage and empower affected individuals to reduce harm (World Health Organization, 2004). Although harm reduction approaches were not necessarily developed as an abreaction to abstinence-based approaches, much of the heated discussion for or against harm reduction has echoed the strong societal polemics regarding the high-risk behaviors themselves: whether they are moral and whether they should be tolerated (Denning, 2000). Unfortunately, the cultivation of such black-and-white arguments often forges artificial and intractable divisions between two sides instead of open discussion and integration of relevant concerns and potential solutions (Foucault, 1997). It may, therefore, be most helpful to set aside the harm reduction–abstinence-only polemic by exploring harm reduction’s compatibility with abstinence-based goals as well as its ability to provide additional tangible benefits to individuals, communities, and society at large.

Harm Reduction Does Not Threaten Abstinence-Based Goals

Harm reduction neither precludes nor discourages abstinence-based goals, as long as they are generated by and acceptable to the affected individual and do not impose additional harm (Denning, 2000; Riley & O’Hare, 2000). Far from threatening an individual’s interest in abstinence, harm reduction techniques can be used to support abstinence as it would any positive step toward harm reduction and QoL improvement. On the other hand, harm reduction neither prescribes abstinence nor uses coercive tactics to elicit it, because such tactics may inadvertently induce further harm (Denning, 2000).

We can illustrate this latter point using the homelessness and supportive housing literature. Substance use abstinence and treatment requirements are commonplace in traditional continuum-of-care supportive housing because it has long been asserted that non-abstinence-based housing would “enable” residents’ substance use (Denning, 2000). Such requirements, however, have received increasing attention and concern as a potential human rights violation because they subject people who are unwilling or unable to maintain substance use abstinence to continued homelessness (Allen, 2003; Robbins, Callahan, & Monahan, 2009). In contrast to the “enabling” hypothesis, recent findings suggest that Housing First projects, which provide low-barrier, non-abstinence-based, supportive housing, offer substantial harm reduction and QoL-enhancing benefits to the individual, local community, and larger society. On the individual level, residents have stable, permanent housing, report greater satisfaction with

living in housing versus on the street, and despite the non-abstinence-based programming, they evince decreased alcohol use and related harm (Collins, Clifasefi, et al., in press; Collins, Malone, et al., in press). On the community level, residents report a strong sense of belonging and mutual support in their housing (Collins, Clifasefi, et al., in press). On the societal level, there have been significant reductions in the use of emergent and other publicly funded health care and associated costs (Larimer et al., 2009). Thus, whereas abstinence-based goals keep some individuals who cannot or will not stop using substances from obtaining housing, harm reduction approaches may promote use reduction and even abstinence while providing other empirically supported net benefits to the individual, community, and society (MacCoun, 1998). Far from “enabling” high-risk behaviors, these harm reduction approaches provide an alternative to otherwise “disabling” abstinence-only approaches.

Harm Reduction Supports Human Rights

Since the early grassroots beginnings (e.g., *Junkiebond*, Gay Men’s Health Crisis), harm reduction activists have fought for the basic human rights of affected individuals who have been marginalized and/or disenfranchised because of their high-risk behaviors and associated consequences. Currently, the harm reduction movement is expanding beyond its grassroots beginnings and has more fully engaged with the biomedical sciences, public health, and human rights fields resulting in an expansion of its reach and effectiveness (Beyrer et al., 2010; Moskalewicz et al., 2007). As harm reduction principles become more deeply engrained in policy, prevention, treatment, education, and advocacy on a large scale, equal rights to health care and housing may become even more attainable. Effectively integrating the efforts of grassroots activist approaches with global public health initiatives is key to ensuring continued progress toward the defense of human rights for affected individuals (Friedman et al., 2007; Stimson, 1998; UNAIDS, 2010). Fortunately, these efforts are considered to be increasingly compatible; as Breyer and colleagues (2010) noted, “The right things to do to limit spread of disease are also the right things to do to protect human rights” (p. 552).

Harm Reduction Allows for Flexible, Tailored, and Culturally Competent Approaches

In line with human rights advocacy is the philosophy that affected individuals and their communities have local knowledge that could inform culturally sensitive alliances between public health and grassroots efforts toward harm reduction (UNAIDS, 2010; World Health Organization,

2004). Because harm reduction may be easily tailored to the specific needs of communities, it may be more flexible across cultures, target behaviors, area, and level of impact than other preformed, theory-based approaches. Harm reduction goals may be tailored on an individual level in the case of one-on-one interventions, such as harm reduction psychotherapy, counseling, brief interventions, or peer education. In the case of larger community- or population-based interventions, it may be informed by local knowledge and culturally specific information gathered through community-based participatory research and action networks (Minkler & Wallerstein, 2008; UNAIDS, 2010). This makes harm reduction more flexible and amenable to tailoring to the specific needs of affected individuals as well as more sensitive to the strengths and challenges of the communities in which they live. In these ways, harm reduction approaches are in line with current standards of culturally competent intervention (Sue, Zane, Nagayama Hall, & Berger, 2009) and with international calls for more comprehensive, community-based approaches to health care (Institute of Medicine, 2002; UNAIDS, 2010; World Health Organization, 2004).

Harm Reduction Can Be Empowering

As the example in the Preface illustrated, the focus on abstinence as a top-down, one-size-fits-all goal can be disempowering to affected individuals. Research studies examining therapist–client interactions in one-on-one psychotherapy interventions have corroborated this anecdotal illustration and have shown that people are more receptive to interventions that are affirming and empowering versus confrontational and overtly directive (Gaume, Gmel, Faouzi, & Daepfen, 2008; Moyers et al., 2007; Vader, Walters, Prabhu, Houck, & Field, 2010). Furthermore, with appropriate training, implementation of harm reduction approaches is perceived as less stressful and more effective by counselors, case managers, and treatment providers who work with affected individuals on the front lines (Collins, Clifasefi, et al., in press; Henwood, Stanhope, & Padgett, 2011). Finally, research findings to date indicate that prevention, intervention, policy, education, and advocacy that is more client driven may be more acceptable, feasible, and empowering than approaches that involve predetermined goals based on researchers, and treatment providers' own values, norms, and interests (Israel et al., 2010; Morisky et al., 2010).

Harm Reduction Approaches Can Be Efficacious

When the previous edition of this book was released, far less information was available about the efficacy and effectiveness of different harm reduction interventions, primarily because these approaches had long been

relegated to the fringes of policy, prevention, treatment, and education. Over the past decade, however, research on harm reduction approaches has flourished and has produced encouraging findings as to their effectiveness. By not solely focusing on reduction of the behaviors themselves, harm reduction—ranging from societal-level drug policy reform (e.g., Greenwald, 2009) to community-level provision of non-abstinence-based housing for chronically homeless individuals (Larimer et al., 2009) to individual-level harm reduction psychotherapy (Hope et al., 2001; Mattick, Breen, Kimber, & Davoli, 2009; van den Berg et al., 2007)—has been shown to decrease not only harm for the affected individuals and their communities, but in some cases, the high-risk behaviors themselves. Benefits of harm reduction approaches have also been shown in cost savings and in decreases in the use of publicly funded services related to the individuals' high-risk behaviors (e.g., Anderson, Chisholm, & Fuhr, 2009; Chisholm, Doran, Shibuya, & Rehm, 2006; Larimer et al., 2009). Thus, harm reduction is positioned to have positive effects across levels of outcomes (e.g., individual, community-wide, population-based levels) and types of outcomes (e.g., behavioral, biomedical, economic) in diverse cultures. In the chapters that follow, our colleagues expound upon relevant and timely efficacy and effectiveness findings for harm reduction approaches.

CONCLUSION

Since the first edition of this book, we have seen harm reduction join the mainstream discourse on policy, prevention, treatment, advocacy, and education addressing high-risk behaviors. From its grassroots and activist beginnings, harm reduction has expanded to become an even more inclusive and globally applied platform for a broad range of approaches that are focused toward reducing harm and increasing QoL among individuals engaging in high-risk behaviors and their communities. Gauging from its historical development and current applications, which we briefly reviewed in this chapter, harm reduction goals appear to be best served in a symbiotic relationship that pairs the community-based strengths of grassroots activism and the global reach of public health approaches.

This integration requires placing traditional ideas about high-risk behaviors and approaches aside and more fully aligning with the needs of affected individuals and their communities. In this chapter, we therefore reviewed some principles that facilitate harm reduction goals. Specifically, harm reduction requires recognizing the complexities of high-risk behaviors instead of pathologizing them. In doing so, the harm reduction practitioner seeks to understand both the rewarding qualities and the associated harms

of high-risk behaviors from the perspectives of the affected individual and within the larger social context. It also involves conceptualizing harm on a continuous spectrum and supporting any movement in the direction of its reduction. This practical, incremental, and “user”-defined approach to reducing harm differs from traditional top-down, theory-driven, abstinence-based approaches that stipulate discontinuation of the target behavior as the ultimate and preferred objective.

In this chapter, we also discussed why shifting to a harm reduction approach can provide various tangible benefits to individuals, communities, and society at large. First, although this approach focuses on reducing harm versus reducing the behavior, it does not preclude abstinence as a “user”-defined goal and is thus compatible with many existing programs. Second, harm reduction promotes equal human rights and seeks to reduce social and other health care disparities in the larger social context. Harm reduction seeks to empower individuals to educate and advocate for their own needs and interests. Given the flexibility of its approaches, harm reduction applications can also be readily tailored to fit the needs of individuals and their communities. Finally, empirical research has indicated that harm reduction approaches—ranging from individual harm reduction interventions to non-abstinence-based supportive housing to large-scale policy reform—can be efficacious in reducing harm, promoting QoL, and even decreasing high-risk behaviors themselves.

With this second edition of *Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviors*, we aim to help readers navigate the burgeoning and diverse harm reduction field. Although harm reduction continues to be the subject of heated polemics and political agendas, we hope that readers will embrace its diversity and explore its capacity to bridge fields and connect people. Its thoughtful application will more effectively link top-down global public health efforts with bottom-up grassroots advocacy to extract from these diverse approaches their maximum effectiveness and reach. Despite the ongoing controversy and many changes that have ensued since the first edition of this book, the take-home message is fundamentally the same: Let people come as they are, meet them where they’re at, and recognize the power of any positive change.

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