Harm Reduction: Is There a Debate or a Lack of Communication? A Response to Balmer and Schwartz

Frederick Rotgers, PsyD, ABPP
Philadelphia College of Osteopathic Medicine

Jeannie Little, MSW
Harm Reduction Therapy Center

Patt Denning, PhD
Harm Reduction Therapy Center

In reading Balmer and Schwartz's article in the November, 2003 issue of *The Addiction Professional* we found ourselves in great agreement with much of what they wrote, but also chagrined to find that they persist in many misunderstandings of harm reduction and its basic philosophy and practices. In this article we attempt to clarify misconceptions about harm reduction in a way that we hope will move from "debate" to "integration" among professionals working to help people overcome addiction.

We agree that "there is typically more heat than light generated from" debates about harm reduction. We have found from our long experience of training substance abuse and mental health treatment providers, however, that if enough time and attention is given to defining the many varieties of harm reduction interventions, differences and hostilities diminish. We will discuss several aspects of harm reduction in this article in the hope that we can continue to narrow the divide between "recovery" and harm reduction providers.

Definitions and Their Relation to Practice

Balmer and Schwartz present a definition of "harm reduction" proposed by the International Harm Reduction Development Program (IHRDP). Unfortunately, they reproduce only part of the definition, omitting a critical aspect of harm reduction practice and values. The complete definition is (with the portion omitted by Balmer and Schwartz italicized):

> "Harm reduction is a pragmatic and humanistic approach to diminishing the individual and social harms associated with drug use, especially the risk of HIV infection. *It seeks to lessen the problems associated with drug use through methodologies that safeguard the dignity, humanity and human rights of people who use drugs.*"

Research has shown that the vast majority of drug users never seek treatment. From studies of treatment avoidance, it is clear that negative views of treatment programs and perception of their methods play a major role in substance abusers' decisions to avoid treatment. Harm reduction methods, such as the harm reduction psychotherapy approach developed by one of us (Denning, 2000), seek to reduce resistance to treatment by offering a broader array of options for ameliorating the problems of addiction, options that are well supported by research

on how people change (i.e. Prochaska, DiClemente & Norcross, 1992; Miller & Rollnick, 2002; Ryan & Deci, 2001.)

The primary problem with Balmer and Schwartz's characterization of harm reduction is that they refer only to the public health programs of harm reduction which they attempt to compare to abstinence-based treatment programs. By assuming that harm reduction = public health, they say nothing about all of the *treatment* options that have developed under the harm reduction umbrella or that are now considered part of the harm reduction armamentarium. It makes comparison of the two paradigms at best unbalanced, at worst virtually impossible.

Having said that, if we focus for a just moment on a public health program like needle exchange, we see a small subgroup of active "addicts" (IV drug users), who are typically barred from drug treatment programs, mental health programs, and many doctors offices, being cared for by another group of people, drug users and non-users alike. In developing public health programs for active users, harm reduction extends the continuum of care to everyone, regardless of the status of a given addict's drug use. Far from "condoning" a culture of addiction, which seems to be insinuated by Balmer and Schwartz as a "value" of harm reduction, harm reductionists are conducting the most effective outreach ever developed for drug users. In a 2001 overview of research on the efficacy of needle exchange, Dr. Eric Goosby of the White House Office of HIV/AIDS Policy found that "syringe exchange programs reach and serve the most disenfranchised populations at high risk for HIV infection. In this regard, [they] play a unique role in facilitating the engagement of these populations in meaningful prevention interventions and treatment opportunities, when implemented as part of a comprehensive HIV prevention and substance abuse strategy (p. 1)." The core values underlying needle exchange programs are caring, respect, and understanding. The message to the addict is "take care of yourself and others." We fail to see how this differs from the values of abstinence-based "recovery" programs. We also fail to see the problem with keeping people alive, since a dead addict can't recover.

Balmer and Schwartz claim the IHRDP definition "…emphasizes reducing harm from drug use rather than focusing on drug use or on abstinence. (p 14.)." The phrase "rather than" is problematic. They seem to assume that drug use and abstinence are not concerns of harm reductionists simply because the *primary* goal of public health harm reduction programs is to control the most grave risks of IV drug use – not only HIV, hepatitis, and STD's, but abscesses and overdoses. The focus on *how* one uses drugs as a target of intervention of public health harm reduction does not render *whether* one uses drugs a non-issue.

We often find that confusion about harm reduction arises because there are actually three arms of the harm reduction movement:

Public health is a respectable field that has given birth to sewage systems, vaccination programs, seat belt laws, and designated driver programs. Public health interventions are, by definition, targeted to specific behaviors and have as their goal the minimization of harm that results from those behaviors. The interventions and programs mentioned by Balmer and Schwartz fit under the public health umbrella.

Public policy and advocacy concern themselves with the effects of discriminatory policies – in housing, in treatment programs, in healthcare, and in the criminal justice system – on the majority of people with drug problems who have not chosen the traditional abstinence route to solving their problems.

Treatment refers to the multitude of programs and interventions designed to help people with drug problems solve those problems. Most of these predate the term harm reduction, some have been created as a part of the harm reduction movement. Harm reduction is such a broad concept, and such a comprehensive paradigm, that it has come to umbrella all interventions that have formerly simply been alternatives to 12-step recovery programs. Many of these interventions have substantial research support for their efficacy (i.e the Behavioral Self-Control Training program developed by Miller and colleagues at the University of New Mexico (see Walters, 2000)) .Treatment from a harm reduction perspective employs certain principles (values) that are also employed by the public health and public policy fields.

Values and Harm Reduction Practice:

Balmer and Schwartz outline six points that illustrate the values that guide practice at their program, Dawn Farm. In the main, we have no argument with these values. However, we believe it may be helpful to present for consideration the principles of harm reduction as they are integrated into practice at the Harm Reduction Therapy Center.

- Not all drug use is abuse: people use drugs on a continuum from benign to chaotic.
- People use drugs for reasons, reasons that must be understood, appreciated, and treated, not confronted; people are doing their best to cope with problems, even if their methods aren't working.
- Change in addictive behavior is usually gradual, relies on the resolution of ambivalence (not denial) about one's relationship with drugs, and passes through a series of stages (Prochaska, et al, 1992). These stages are best negotiated with the help of motivational enhancement (Miller and Rollnick 2002), as well as other empirically validated and psychodynamic approaches to treatment.
- People vary widely in their ability to manage drugs. They can and do make rational decisions while using drugs, and do not have to quit to do less harm to self or others. In fact, research shows that many people manage formerly abusive or dependent drug use patterns by spontaneous recovery (Klingemann, et al., 2001); moderation (Rotgers, Kern, and Hoetzel 2002), or *reduction* in drug use or drug-related harms (Baer, Kivlahan, Blume, McKnight & Marlatt, 2001; McCambridge & Strang, 2004)
- Each person's relationship with drugs is unique. Therefore, harm reduction is a collaborative model in which the goals and the pace of treatment are established together between client and treatment professional, not preordained by "the program."
- Rather than a disease, we consider addiction a biopsychosocial phenomenon in which the relative importance of biology (for example, genetics, health status, age), psychology (mental health/illness, identity, motivation and expectation), and environment (environmental stressors as well as setting of use) vary from individual to individual.

This biopsychosocial model, (drug, set, setting – Zinberg, 1984) forms the basis of both assessment and treatment interventions.

- Denial is not a phenomenon unique to addicts. It is a psychological defense against overwhelming knowledge or experience and, as such, must be treated with respect, not confronted and overcome.

A Harm Reduction Treatment Model

Based on the values outlined above and empirically validated approaches, harm reduction psychotherapy uses multiple interventions, depending on the precise problems (harms) suffered by each individual and the goals agreed upon by client and clinician. The overriding goal of treatment is to help each individual rid themselves of the grip of addiction. We differ, however, in our methods, in our starting point, and in our definition of success. We work with addicts where they are, not in order to keep them in "the culture of addiction," but in order to influence them to change behaviors. Our methods are as varied as the individuals we are trying to help. Following is an overview of our treatment approach:

- Low-threshold entry: We assume that when someone calls us, they want to change *something*. We welcome them and do not demand any changes as a precondition of treatment.
- Biopsychosocial assessment: We base our assessment on the above-described biopsychosocial model in order to determine *with the client* the full extent of all the problems that brought them into treatment.
- Challenging dangerous behaviors: If it becomes clear that any drug-using or other behavior poses an acute risk to the client or others (drinking and driving, using and working in a high-risk job, sharing needles, mixing central nervous system depressants, using stimulants at a pace that would risk a heart-attack or stroke), we immediately challenge the client to change those behaviors immediately. The focus of treatment remains on those behaviors and any resistance to changing them until we are satisfied that immediate dangers are alleviated.
- Treating co-existing psychiatric, medical, and social problems: We refer anyone with an obvious psychiatric or medical problem to our clinic psychiatrist, to a physician, or we provide case management (for housing or financial benefits) to alleviate conditions that might be inducing some self-medicating drug use.
- Cost/benefit analysis: We conduct a cost/benefit analysis of a client's use of each drug in order to help him or her understand the complexity of their relationship with substances and to understand what losses s/he will incur by changing and/or giving up substance use.
- Setting goals: It is important to make very specific and realistic decisions about change in order to minimize failure and maximize success. One change can lead to another, so change in a positive direction is more important than determining the ultimate outcome of treatment at the outset.
- Redefining success: Since successful actions lead to improved self-efficacy, and since self-efficacy is a predictor of further success, we congratulate *any positive change,* knowing that it is the start of a life-changing cycle of events. "Any positive change" is the harm reduction

version of "one step at a time." Ongoing treatment: Just as some people develop a lifelong relationship with AA or its sister 12-step groups, people can remain in harm reduction treatment for a long time, changing their goals and changing the intensity of treatment as they go along depending on their life circumstances.

Treatment and the Community: Some Concluding Thoughts:

Balmer and Schwartz assert that treatment (not harm reduction) is the best way to respond to community needs. We believe that this misconceives the place of harm reduction in the treatment continuum. Typically, treatment leaves out all but those most motivated to quit substances, or who have the impetus of family or the criminal justice system pushing them toward a program. In our view, one of the cruelest harms produced by traditional treatment results from the refusal of many such programs to allow active substance users into the culture of recovery if they are not abstinent. Interestingly, this approach is directly counter to the spirit of the guiding philosophy of many of these programs—the philosophy of AA and the 12-steps. Many of these programs seem to forget that the only requirement for membership in AA as stated in Tradition 3 is "a *desire* to stop drinking (emphasis added)." Programs that forget this are, in our view, leaving users in a culture of addiction, and essentially keeping them apart from the care of treatment *and* public health providers.

Such "high threshold" entry requirements are one of the issues that harm reduction treatments attempt to eliminate. By making a variety of change options available, harm reduction programs hope to (and do—see Klaw, Luft & Humphreys, 2003) attract many users who otherwise would never seek abstinence-only treatment, and introduce them into a "culture of change." From a harm reduction perspective, it behooves therapists to assist clients in moving beyond use to a "desire to be healthier", with one way of achieving greater health being to reduce use to at or near zero. However, we do not believe that such a reduction should be the price of admission to programs designed to facilitate that very change!

Of most benefit to any community is a true partnership of harm reduction and abstinence-based recovery. Traditional abstinence-based "recovery" proponents and we harm reductionists, whether we work in public health, mental health, drug treatment, or public policy, share the same motivations – concern about the damage done by drug use and interest in the the welfare of the people who use them. We also value "recovery." We suspect that it is not our motivations or values that differ, it is our definitions and our methods. With respect to the latter, harm reductionists are willing (and are supported by research in this willingness) to take what has been called a "gradualist" approach to helping people change their substance use (Kellogg, 2004). This is consistent with the work of Miller & Rollnick (2002), Bill W. (see his chapter on "Working With Others" in *Alcoholics Anonymous,* 2001), and others, focusing on the fact that there is another person in the therapy room who also has goals, values, and personal autonomy, as well as a particular degree of readiness to adopt particular goals as his/her own. In the spirit of respectfulness and humanity, and consistent with research findings, harm reductionists recognize that we need to work *with* our patients, not *on* them if healthy, lasting change is to occur. One need not ignore the harms and hazards of drug use in order to adopt such an approach, as Balmer

and Schwartz imply. One need only read the now voluminous research on how best to facilitate behavior change!

References

Alcoholics Anonymous World Service, Inc (2001). *Alcoholics Anonymous: The Story of how many thousands of men and women have recovered from alcoholism, 4th Edition.* New York: Author.

Baer, J.S., Kivlahan, D.R., Blume, A.W., McKnight, P. & Marlatt, G.A. (2001). Brief intervention for heavy-drinking college students: a 4 year follow-up and natural history. *American Journal of Public Health, 91,* 1310-1316.

Denning, P. (2000). *Practicing Harm Reduction Psychotherapy: An Alternative Approach to Addictions.* New York: Guilford Publications.

Goosby, Eric P. (2001) Evidence based research on the efficacy of needle exchange programs: An overview. Monograph: San Francisco Department of Public Health.

Kellogg, S. H. (2003). On "gradualism" and the building of the harm reduction-abstinence continuum. *Journal of Substance Abuse Treatment, 25,* 241-247.

Klaw, E., Luft, S., & Humphreys, K. (2003). Characteristics and motives of problem drinkers seeking help from Moderation Management self-help groups. *Cognitive and Behavioral Practice, 10,* 384-389.

Klingemann, H., Sobell, L., Barker, J. Bloomqvist, J., Cloud, W., et al. (2001). *Promoting Self-change from Problem Substance Use: Practical Implications for Policy, Prevention and Treatment.* Boston: Kluwer Academic Publishers.

McCambridge, J. & Strang, J. (2004). The efficacy of single-session motivational interviewing in reducing drug consumption and perceptions of drug-related risk and harm among young people: Results from a multi-site cluster randomized trial. *Addiction, 99,* 39-52.

Miller, W.R. & Rollnick, S. (2002). *Motivational Interviewing: Preparing People to Change, 2nd Edition.*. New York: Guilford Publications.

Prochaska, J.O., DiClemente, C.c., & Norcross, J.C. (1992). In search of how people change : Applications to addictive behaviors. *American Psychologist, 47,* 1102-1110.

Rotgers, F., Kern, M., & Hoeltzel, R. (2002). *Responsible Drinking: a MODERATION MANAGEMENT Approach for Problem Drinkers.* Oakland: New Harbinger Publications, Inc.

Ryan, R.M. & Deci, E.L. (2001). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist, 55,* 68-78.

Walters, G.D. (2000). Behavioral self-control training for problem drinkers: A meta-analysis of randomized control studies. *Behavior Therapy, 31,* 135-149.

Zinberg, N.E. (1984). *Drug, Set and Setting: The Basis for Controlled Intoxicant Use.* New Haven, Yale University Press.

Author Bios

Frederick Rotgers, PsyD, ABPP is a Board Certified Clinical Psychologist. He is Associate Professor of Psychology at the Philadelphia College of Osteopathic Medicine, and a member of the Board of Directors of the Harm Reduction Therapy Center in San Francisco, CA.

Jeannie Little, LCSW is a Certified Group Psychotherapist and Executive Director of the Harm Reduction Therapy Center in San Francisco, CA. She is co-author, along with Patt Denning and Adina Glickman of the book *Over the Influence: The Harm Reduction Approach for Managing Drugs and Alcohol,* published by Guilford Publications.

Patt Denning, PhD is a Licensed Clinical Psychologist and Director of Clinical Services and Training for the Harm Reduction Therapy Center. She has done training and lecturing worldwide on the integration of harm reduction with mental health and substance abuse treatment.