Understanding the Risk Principle: How and Why Correctional Interventions Can Harm Low-Risk Offenders

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Over the last several years, the importance of the risk principle has been well established in many correctional settings. Simply stated, the risk principle indicates that offenders should be provided with supervision and treatment levels that are commensurate with their risk levels. However, there continues to be some confusion regarding the implications of the risk principle and why the trends predicted by the risk principle are observed. The purpose of this article is to discuss what the risk principle is, what it means for corrections, and why we see intensive treatments and supervision leading to no effect or increased recidivism for low-risk offenders.

Perhaps it is important that we begin by defining the concept of "risk" as it pertains to offender recidivism. For some, "risk" is a concept associated with the seriousness of the crime—for example, in the sense that a felon poses a higher risk than a misdemeanant. In actuality, however, though a felon has been convicted of a more serious offense than a misdemeanant, his or her relative risk of reoffending may have nothing to do with the seriousness of the crime.

For our purposes, "risk" refers to the probability of reoffending. A low-risk offender is one with a relatively low probability of reoffending (few risk factors), while a high-risk offender has a high probability (many risk factors). The application of the concept in corrections is similar to that in most actuarial sciences. For example, life insurance is cheaper for a nonsmoker in his 40s than for a smoker of the same age. The reason insurance costs more for the smoker is that smokers have a risk factor that is significantly correlated with health problems. Similarly, an offender who uses drugs has a higher chance of reoffending than someone who does not use drugs.

In 1990, Andrews, Bonta, and Hoge discussed the importance of the risk principle as it relates to the assessment of offenders. Their article makes clear that the risk principle calls for the administration and delivery of more intense services and supervision to higher-risk offenders. In contrast, lower-risk offenders should receive lower levels of supervision and treatment. Since 1990, considerable research has investigated how adhering to the risk principle can impact a correctional program's effectiveness.

Meta-Analyses Involving the Risk Principle

Meta-analysis after meta-analysis has revealed a similar trend when the risk principle is empirically investigated. Table 1, page 4, shows the results of seven meta-

analyses conducted on juvenile and adult offenders in correctional programs or school-aged youth in school-based intervention programs.

The first row of the table lists the results from a study conducted by Andrews, Zinger, Hoge, et al. (1990). This study investigated the effects of correctional interventions from 85 studies. Overall, they found that the correctional programs were much more effective when the correctional program took in mostly higher-risk offenders. Reductions in recidivism of 11% were noted in programs that had mostly higher-risk offenders versus 2% reductions for programs that took in both low- and high-risk offenders (re-analysis by Andrews and Bonta, 1998).

The second, third, and fourth rows summarize the findings of studies conducted by Dowden and Andrews. These three meta-analyses all indicate that programs serving a greater percentage of higher-risk offenders were more effective than those that did not. This finding was observed when looking at juvenile offenders, female offenders, and violence as an outcome measure.

The fifth row reports on the results of a meta-analysis that reviewed the effectiveness of drug courts. Again, drug courts where over half the offenders served had a prior record were twice as effective (10% versus 5% reduction) as drug courts where more than half the offenders served were first-time offenders. Finally, two meta-analyses report on the effectiveness of school-based interventions in reducing delinquent and analogous behaviors (Wilson, Gottfredson, and Najaka, 2002) and aggressive behavior (Wilson, Lipsey, and Derzon, 2003). Both studies indicate better effects when targeting youths who are at risk for the particular behaviors that are to be prevented.

Table 1. Summary of Meta-Analyses Investigating the Risk Principle

Study	No. of Studies Reviewed	Type of Studies Reviewed	Findings
Andrews et al. (1990)	85	Juvenile, mixed	Effect size 5 times as great when focusing on high-risk
Dowden and Andrews (1999a)	26	Juvenile and adult female, or mainly female	Effect size 6 times as great when following risk principle
Dowden and Andrews (1999b)	229	Young offenders	Effect size 4 times as great when when following risk principle
Dowden and Andrews (2000)	35	Juvenile and adult violent outcomes only	Effect size 2 times as great when when following risk principle
Lowenkamp et al. (2002)	33	Juvenile and adult drug courts	Effect size 2 times as great when when following risk principle
Wilson et al. (2002)	165	School-based interventions	Effect size 3 times as great when when targeting high-risk youth
Wilson et al. (2003)	221	School-based interventions targeting aggression	Effect size 4 times as great when when targeting high-risk youth

Differing Treatment Effects for High- and Low-Risk Offenders

While Table 1 provides plenty of support for the risk principle, a recent study that Lowenkamp and Latessa (2002) conducted in Ohio offers even more evidence. This study is the largest ever conducted of community-based correctional treatment facilities. The authors tracked a total of 13,221 offenders who were placed in one of 38 halfway houses and 15 community-based correctional facilities throughout the state. A 2-year follow-up was conducted on all offenders, and recidivism measures included new arrests and incarceration in state penal institutions. Treatments effects were calculated, which represent the difference in recidivism rates for the treatment group (those offenders with a residential placement) and the comparison group (those offenders that received just supervision with no residential placement).

Figure 1 shows the effect for low-risk offenders, using incarceration as the outcome measure. The negative numbers show the programs that were associated with increases in recidivism rates for low-risk offenders. The positive numbers show the few programs that were actually associated with reductions in recidivism for low-risk offenders. As you can see from this figure, the majority of programs in this study were associated with increases in the failure rates for low-risk offenders. Only a handful of programs reduced recidivism for this group, and the largest reduction was 9%.

Fig. 1 Changes in the Probability of Recidivism by Program for Low-Risk Offenders

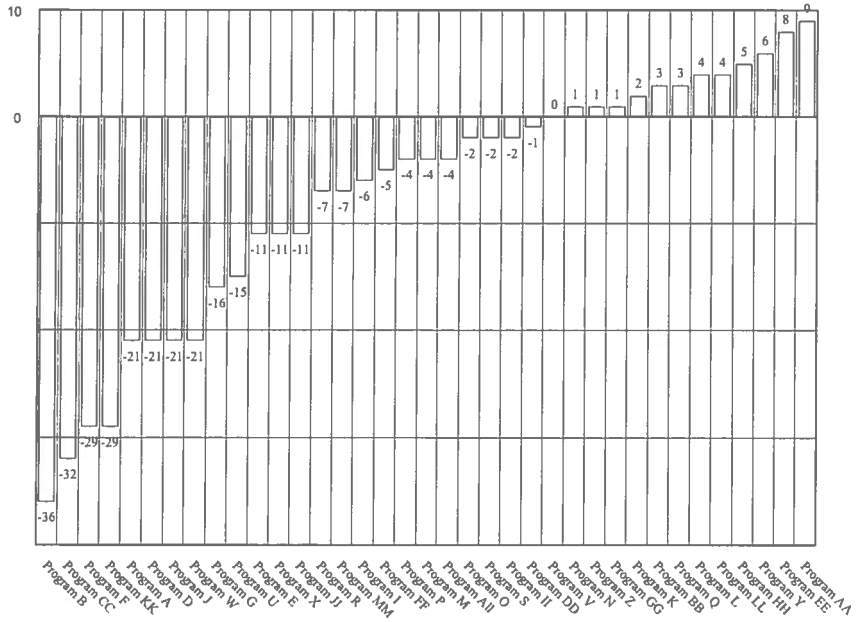
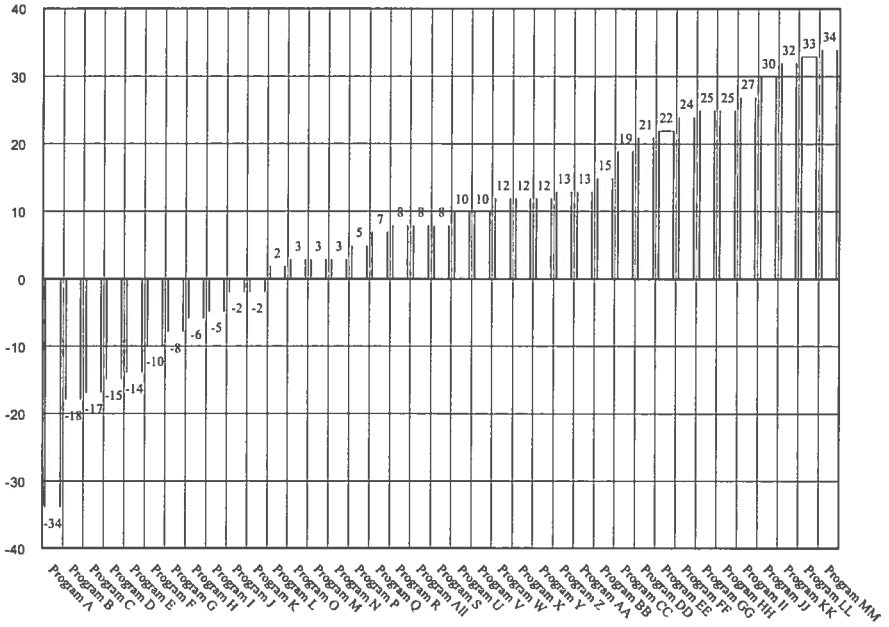


Figure 2 shows the results for high-risk offenders. Not only were most programs associated with reductions in recidivism for this group, but there were also eight programs that reduced recidivism over 20% and three programs that reduced recidivism over 30%. (Note that there were some programs in Ohio that did not reduce recidivism at any level of risk. This is likely related to program integrity. See Lowenkamp and Latessa, 2004.)

Fig. 2. Change in the Probability of Recidivism by Program for High-Risk Offenders



The best illustration of the risk principle can be seen by looking at the programs that had the greatest effect on high-risk offenders. Programs KK and MM each reduced recidivism for high-risk offenders by over 30%, yet looking at their effect for low-risk offenders, we see that Program MM increased recidivism for this group by 7% and Program KK by 29%. Thus, the same programs that reduced recidivism for higher-risk offenders actually increased it for low-risk offenders. The risk principle held across geographic location (rural, metro, urban) and with sex offenders (Lowenkamp and Latessa, 2002).

When taken together, these meta-analyses and individual studies provide strong evidence that more intense correctional interventions are more effective when delivered to higher-risk offenders, and that they can increase the failure rates of low-risk offenders. Recall the meta-analyses and the Ohio study, as well as Hanley (2003) and Bonta, Wallace-Capretta, and Rooney (2000), which both found that intensive supervision reduces recidivism for higher-risk offenders but increases the recidivism rates of lower-risk offenders.

Why Interventions Are More Successful with High-Risk Offenders

A question that continues to arise is why an intervention can have the intended consequences for a high-risk offender but have undesired and unintended consequences for a low-risk offender. To answer this question, one only need look at the risk factors for offending behavior. A review of the meta-analyses on the risk predictors consistently reveals antisocial attitudes, associates, personality, and a history of antisocial behavior as the strongest predictors (Andrews and Bonta, 1998). Other risk factors include substance abuse and alcohol problems, family characteristics, education, and employment (Gendreau, Little, and Goggin, 1996).

Given these risk factors, consider what a high-risk and a low-risk offender would look like. High-risk offenders would have antisocial attitudes, associates, and personalities, or a long criminal history, or substance abuse problems, or poor family relations, and would likely be unemployed. Low-risk offenders, on the other hand, would be fairly prosocial and have good jobs with some, if not many, prosocial contacts. That is, low-risk offenders likely have good jobs, good relationships with their families, good relationships with prosocial acquaintances, fairly prosocial attitudes, a limited criminal history, and few if any substance abuse problems. What happens to that low-risk offender when he/she is placed in a residential facility with high-risk offenders? You have likely come to an explanation for why we see low-risk offenders being harmed by intense correctional interventions.

The increased failure rates of low-risk offenders can largely be understood when considering the following three explanations:

- When we place low-risk offenders in the more intense correctional interventions, we are probably exposing them to higher-risk offenders, and we know that who your associates are is an important risk factor. Practically speaking, placing high- and low-risk offenders together is never a good idea. If you had a son or daughter who got into some trouble, would you want him or her placed in a group with high-risk kids?

- When we take lower-risk offenders, who by definition are fairly prosocial (if they weren't, they wouldn't be low-risk), and place them in a highly structured, restrictive program, we actually disrupt the factors that make them low-risk. For example, if I were to be placed in a correctional treatment program for 6 months, I would lose my job, I would experience family disruption, and my prosocial attitudes and prosocial contacts would be cut off and replaced with antisocial thoughts and antisocial peers. I don't think my neighbors would have a "welcome home from the correctional program" party for me when I was released. In other words, my risk would be increased, not reduced.

- Other factors such as IQ, intellectual functioning, and maturity might be at work. We rarely find programs that assess these important responsivity factors when they place offenders into groups. It could be the case that there

are some low-functioning, low-risk offenders who are manipulated by more sophisticated, higher-risk, predatory offenders.

What all this means for corrections is that low-risk offenders should be identified and excluded, as a general rule, from higher-end correctional interventions. We are pragmatists and therefore say "general rule," as we realize that programs are often at the mercy of the court or parole board in terms of who is referred to the program. Even so, programs that end up receiving low-risk offenders should make sure that those offenders are returned back to the environments that made them "low-risk." This can be achieved by developing programming (both treatment and supervision) that is based on the risk level of the offender.

In addition, the research reviewed here and the risk principle also dictate that we should direct the majority of services and supervision to higher-risk offenders because it is with this group of offenders that such interventions are most effective. The first step in meeting the risk principle is identifying the appropriate targets (higher-risk offenders). To achieve this, agencies must assess offenders with standardized and objective risk assessment instruments. Risk assessment is now considered the cornerstone of effective correctional intervention. ■

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Harm Reduction Therapy: A Practice-Friendly Review of Research

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Harm reduction is an umbrella term for interventions aiming to reduce the problematic effects of behaviors. Although harm reduction was originally and most frequently associated with substance use, it is increasingly being applied to a multitude of other behavioral disorders. This article reviews the state of empirical research on harm reduction practices including alcohol interventions for youth, college students, and a variety of other adult interventions. We also review nicotine replacement and opioid substitution, as well as needle exchanges and safe injection sites for intravenous drug users. Dozens of peer-reviewed controlled trial publications provide support for the effectiveness of harm reduction for a multitude of clients and disorders without indications of iatrogenic effects. Harm reduction interventions provide additional tools for clinicians working with clients who, for whatever reason, may not be ready, willing, or able to pursue full abstinence as a goal. © 2010 Wiley Periodicals, Inc. J Clin Psychol: In Session 66: 201–214, 2010.

Keywords: harm reduction; alcohol; drugs; psychotherapy; clinical research

Harm reduction is an umbrella term for interventions aiming to reduce the problematic effects of behaviors (Marlatt, 1998). Most frequently associated with substance use, harm reduction also applies to any decisions that have negative consequences associated with them. For example, at one end of the spectrum, harm reduction may seek to reduce the risk of HIV transmission by supporting needle exchange programs. Harm reduction techniques may also prioritize less risky drinking habits for underage college students to reduce the risk of alcohol poisoning. Other suggestions may include encouraging safe sex, replacing binge eating with healthier alternatives, providing clean razors for those engaging in cutting/self-harm behaviors, or supporting even 5 minutes of exercise per day.

Work on this article was partially supported by a National Institute on Alcohol Abuse and Alcoholism grant (F31 AA018238-01A1) awarded to Diane E. Logan.

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Published online in Wiley InterScience (www.interscience.wiley.com). DOI: 10.1002/jclp.20669

At its core, harm reduction supports any steps in the right direction. Critics may contend that harm reduction somehow enables or excuses poor choices. Although abstinence may be the ultimate goal, and is of course the only way to avoid all negative consequences associated with substance abuse, the harm reduction practitioner seeks to meet with the client where he or she is in regards to motivation and ability to change. The practitioner's goals are secondary to what the client wants. This does not imply that the practitioner has no opinion; rather, the practitioner respects the client's decisions both for and against change.

The harm reduction practitioner frequently uses nonjudgmental but directive techniques, including motivational interviewing (MI; Miller & Rollnick, 2002), to allow the client to explore reasons for change. MI entails expressing empathy to build rapport with the client, developing discrepancy between what the client wants and where he or she is currently, rolling with client resistance to build the relationship and move toward change, and supporting self-efficacy in the client to take the necessary steps. Within a cognitive-behavioral framework, the practitioner may also assist in setting reasonable goals, practicing refusal skills, identifying alternative behaviors, and considering relapse prevention.

One major difference between harm reduction and abstinence-based programs is the definition of therapeutic progress. If a client presents after 1 month of treatment and reports consuming five drinks on each of the past three nights, a traditional program would count that as a failure. If abstinence was required for certain services, including housing, that client may be turned away from further treatment. Alternatively, a harm reduction practitioner would first ask how much the client drank at the beginning of therapy. If the client were drinking 10 drinks every day, then the consumption of five drinks a day would be a therapeutic success, or steps in the right direction. If the client's goal were to abstain, then the therapist would continue to work with the client to troubleshoot the problematic areas and develop other coping skills. If the client's goal was to avoid blacking out, and five drinks would keep the blood alcohol level below the risk of blacking out, then treatment would be a success. The therapist might continue to explore with the client any other negative consequences that he or she would prefer to avoid, but ultimately the client's goal has been met.

Harm reduction researchers use those same harm reduction goals when disseminating techniques and research findings. In this review of research, we acknowledge that some techniques may receive more support while others are more controversial. For example, discussing moderate drinking with a 22-year old college senior may raise fewer eyebrows than supporting a safe injection site in your neighborhood. Although our review attempts to be comprehensive for many practices that fall under that harm reduction umbrella, we in no way expect that supporting one technique means accepting them all. Our goal is to meet you where you are and hope that harm reduction can fit as one tool in your practice toolbox.

In this article, we review the results of empirical research on the effectiveness of harm reduction with alcohol and substance abuse in a myriad of settings and with a multitude of client populations. Our review is limited to a selection of clinical trials on the effectiveness of harm reduction published in English-language journals; thus unpublished studies, process investigations, theoretical papers, and articles published in other languages have not been included. For space considerations, we have also notably left out discussions of policy changes and other societal/global considerations to focus on options for individual patients.

Alcohol Harm Reduction

Harm reduction includes techniques ranging from prevention to intervention to maintenance. In this section, we review the research on interventions with school-based programs, college students, and adult populations.

School-Based Programs

The most effective way to reduce harm associated with alcohol use is to prevent initiation and misuse in the first place. Age at initiation is inversely related to later problems with use and most frequently occurs during adolescence (Johnston, O'Malley, Bachman, & Schulenberg, 2007a; Warner & White, 2003). According to recent national surveys, mare than one third of eighth graders report past year alcohol use. This percent rises to over half of 10th graders.

Given the high prevalence in this population, many interventions have been designed and tested. Some abstinence-based programs, such as Project DARE (Drug Abuse Resistance Education), have produced either no effects or potentially harmful effects with this population (Lilienfeld, 2007; Lynam et al., 1999).

Other programs take a tack more consistent with harm reduction and include social skills, resistance skills training, and normative education (Bosworth, 1997). Specifically, two published interventions have explicit harm reduction goals: the Integrated School- and Community-Based Demonstration Intervention Addressing Drug Use among Adolescents (Poulin & Nicholson, 2005) and School Health and Alcohol Harm Reduction Project (McBride, Farringdon, Midford, Meuleners, & Phillips, 2004). Although neither intervention resulted in significant changes in long-term prevalence (Poulin & Nicholson, 2005) or compared with no-treatment control (McBride et al., 2004), both resulted in significant reductions in harmful alcohol use.

For prevention, the research leads us to three interrelated conclusions. First, Project DARE and similar programs are not effective at reducing substance use in the short-term or in the long-term. Second, harm reduction methods result in significant reductions in alcohol use in the short-term but not preventative effects in the long-term. And third, we have a long way to go in developing effective prevention strategies for at-risk youth and alcohol abuse.

College Students

College students are probably the most studied group in terms of alcohol harm reduction programs. Although part of this is likely because of the accessibility and incentive options working with college students, this group has a high prevalence of use and continues to struggle with problematic drinking. National surveys report past year alcohol use of college students at 82% and 30-day prevalence at 65% (Johnston et al., 2007b). Over one third of full-time college students report at least one episode of five or more drinks in the past 2 weeks, with rates ranging from 37% of women to 45% of men (Johnston et al., 2007b). Additionally, although college-bound students tend to engage in less heavy episodic drinking than their noncollege bound peers, they become more likely to engage in heavy drinking during college (Timberlake et al., 2007). Frequent heavy drinkers are at particular risk for meeting DSM-IV criteria for alcohol abuse (13 times increased likelihood) and alcohol dependence (19 times increased likelihood) compared with peers who drink alcohol but not heavily (Knight et al., 2002). Overall, the college age cohort has the

highest prevalence of diagnosable alcohol use disorders (Department of Health and Human Services [DHHS], 2007).

Dozens of studies evaluating college student interventions over the past 2 decades have identified strategies with promising outcomes. The National Institute on Alcohol Abuse and Alcoholism (NIAAA, 2002) has designated Tier 1 interventions that have favorable outcomes with college students in at least two independent studies (NIAAA, 2002). Two harm reduction approaches were provided as specific examples of the general approaches listed as Tier 1 interventions: Alcohol Skills Training Program (ASTP) and Brief Alcohol Screening and Intervention for College Students (BASICS).

ASTP combines cognitive-behavioral skills, norms clarification, and motivational enhancement techniques in a group setting (Miller, Kilmer, Kim, Weingardt, & Marlatt, 2001). Multiple-session ASTP groups have repeatedly demonstrated effectiveness at significantly reducing alcohol intake (decreases of 40%–50%) as well as negative consequences with reductions sustained at 2-year follow-up (Baer et al., 1992; Fromme, Marlatt, Baer, & Kivlahan, 1994; Kivlahan, Marlatt, Fromme, Coppel, & Williams, 1990). Specifically, Kivlahan and colleagues (1990) found postintervention weekly drinking decreased from 14.8 drinks at baseline to 6.6 drinks 12 months later, compared with an alcohol information group reduction of 19.4 drinks at baseline to 12.7 drinks at follow-up, and an assessment only condition increase of 15.6 drinks at baseline to 16.8 drinks at the same follow-up. Most recently, the ASTP has also demonstrated generalizability of effectiveness with multicultural and international college students (Hernandez et al., 2006; Stahlbrandt, Johnsson, & Berglund, 2007).

Individual BASICS feedback interventions incorporate personalized feedback with MI in a brief, one-on-one setting (Dimeff, Baer, Kivlahan, & Marlatt, 1999). Both single-session and two-session BASICS have demonstrated similar effectiveness in reducing drinking amounts and consequences for extensive follow-up periods (e.g., Baer, Kivlahan, Blume, McKnight, & Marlatt, 2001; Borsari & Carey, 2000; Larimer et al., 2001; Larimer & Cronce, 2002; Marlatt et al., 1998; Murphy et al., 2001).

In addition to these in-person interventions, harm reduction therapy is also being implemented via Web-based or computer-mediated forms. Web- or computer-based interventions have been developed for a variety of problematic behaviors, including alcohol use, tobacco use, physical activity, nutrition and weight loss, eating disorders, and violence. Multiple Web-based controlled trials with alcohol or substance abuse have been conducted and published (e.g., Chiauzzi, Green, Lord, Thum, & Goldstein, 2005; Kypri & McAnally, 2005; Kypri et al., 2004; Neighbors, Larimer, & Lewis, 2004; Neighbors, Larimer, Lostutter, & Woods, 2006; Walters et al., 2007). The findings of these studies are consistently promising and include reductions in alcohol use (Kypri et al., 2004; Lewis & Neighbors, 2007; Neighbors et al., 2004, 2006; Walters, Vader, & Harris, 2007) and alcohol-related problems (Kypri et al., 2004; Neighbors et al., 2004; Walters et al., 2007) relative to controls, and prevention of escalating use in adolescent samples.

Why is harm reduction so important for college students? Most students attend college during a developmental stage referred to as emerging adulthood (Arnett, 2000, 2001) This unique developmental stage between adolescence and adulthood allows for increased responsibility and independence while still retaining some reliance and interdependence characterized in adolescence. Students in emerging adulthood tend to identify themselves as more independent (Arnett, 2000; Hornsey & Jetten, 2005; Markus, Mullally, & Kitayama, 1997), although they do not see

themselves as having reached adulthood. This developmental period is critical to the development of an identity that is separate from parents as well as peers.

Effective interventions for college student drinking are, therefore, different than some designed for adults. As many students do not view their alcohol use as a problem (Vik, Culbertson, & Sellers, 2000), an abstinence-based program may seem too extreme and not match social norms of the environment. Education-only programs provide students with information, but these emerging adults are more likely to test this alcohol-related information rather than internalize it based on the word of an adult (Crundall, 1995; Neighbors, Larimer, Lostutter, & Woods, 2006). When discrepancies are found between the provided information and actual experiences, students tends to discount the previous information as either being incorrect or inapplicable. In addition, even when students learn the educational material, it does not necessarily lead to behavior change (Larimer et al., 1998; Larimer & Cronce, 2007). Further, college student interventions also occur during a unique developmental phase of drinking behaviors, as most students have initiated use only within the previous few years, and most are on the ascending limb of their drinking trajectory (Johnston et al., 2007b; Nelson, Heath, & Kessler, 1998; O'Malley & Johnston, 2002).

Thus, we can safely conclude from dozens of controlled trials with alcohol-using college students that harm reduction has long-term benefits for this unique population. The pragmatic goals and nonjudgmental attitude offered by harm reduction therapy work with college students.

Other Adult Populations

We will review here the research on harm reduction interventions that are specifically designed to meet adult populations where they are, both figuratively and literally. Below, we track the effectiveness of harm reduction designed for workplace interventions, brief interventions in trauma centers, cooccurring disorder treatments, and finally homeless alcoholics. These populations are typically less responsive to traditional methods, or may be less likely to seek treatment for problematic use.

Workplace programs. National surveys have estimated that over 70% of heavy drinkers and drug users are employed full-time (Substance Abuse and Mental Health Services Administration [SAMHSA], 1999), frequently in workplace cultures that support alcohol and drug use (Ames, Grube, & Moore, 2000). This problematic use has substantial costs to worker health and productivity, as well as financial increases in health care plans (Trudeau, Deitz, & Cook, 2002). One harm reduction intervention in the workplace is an interactive Web site called CopingMatters (Matano et al., 2000). This pilot project has found significant reductions in heavy drinking episodes for over 3 months following the intervention (Matano et al., 2007).

Osilla and colleagues (2008) found that adding a brief intervention to an employee assistance program's treatment as usual (TAU) produced decreases in drinking and associated consequences at 3-month follow-up. Specifically, the intervention participants reported decreases of 7.56 peak drinks per occasion at baseline to 4.78 peak drinks at follow-up (TAU participants decreased from 6.27 drinks to 6.07 drinks). These decreases were associated with a decrease in blood alcohol level from 0.10 at baseline to 0.05 at follow-up for the intervention group, and an increase from 0.07 to 0.08 in the TAU condition.

Other workplace programs have taken a health promotion approach (Cook, Back, & Trudeau, 1996), including stress management (Kline & Snow, 1994), health

counseling (Heirich & Sieck, 2000), worksite wellness (Deitz, Cook, & Hersch, 2005), and Workplace Managed Care (Galvin, 2000). Although these latter studies have often lacked rigorous designs, had low statistical power and participation rates, and used nonstandardized outcome measures (Cook & Schlenger, 2002), they were all shown to reduce substance use and improve attitudes toward changing use.

Trauma centers. Alcohol and drug abuse was associated with over 1.7 million trauma center and emergency room visits in the United States in 2006 (SAMHSA, 2008). Further, at the time of admission, almost one quarter of trauma patients screened positive for substance-related risky behaviors, abuse, or dependence (Madras et al., 2009). These patients are not likely to recognize a substance use problem or be motivated to change their behavior and may not have sought treatment in the past (Daeppen et al., 2007). Identifying these times of crisis as an opportunity for patients to acknowledge consequences and risky behavior (O'Toole et al., 2008), the World Health Organization developed screening measures and recommendations for interventions in health settings (Babor & Higgins-Biddle, 2001). Outcomes reflected that these brief interventions resulted in significant reductions in use and other problematic consequences (Gentilello et al., 1999; Schermer, Moyers, Miller, & Bloomfield, 2006), and further recommendations and guides have been created to assist health care providers (e.g., Rollnick, Miller, & Butler, 2007).

Cooccurring disorders. Substance abuse is prevalent among individuals with serious mental health conditions, affecting over half of those with cooccurring disorders (Drake et al., 2005). Many practitioners require that these individuals abstain from substances before they will treat the dual psychological diagnosis. Harm reduction recognizes that, although abstinence may reduce some of the harms experienced by the individual, often these diagnoses are intertwined and cannot be simply pulled apart and treated in a vacuum (Denning, 2000). Harm reduction psychotherapy (Denning, 2000; Tatarsky, 2002) includes additional assessment and treatment approaches than traditional substance use or psychiatric treatment, including not requiring abstinence to access treatment.

Several treatments consistent with this harm reduction approach have shown optimistic findings for dual diagnoses. Seeking Safety (Najavits, 2002) was effective at reducing substance use and symptoms of posttraumatic stress disorder and in improving family and social functioning (Najavits, Schmitz, Gotthardt, & Weiss, 2005). Mindfulness-based relapse prevention (Bowen, Chawla, & Marlatt, 2008) has been successful in decreasing substance use, craving, and related problems in clients with cooccurring psychiatric conditions (Bowen et al., 2008).

Homeless alcoholics. Perhaps one of the most at-risk and treatment-resistant populations include homeless individuals with alcohol use disorders and cooccurring psychiatric and/or substance use conditions. These "chronic public inebriates" incur public expenses estimated over $80,000 per person, per year (Larimer et al., 2009). Most treatment programs and traditional housing opportunities require the maintenance of abstinence and require eviction in the case of relapse (Tsemberis, Gulcur, & Nakae, 2004). Harm reduction protocols, on the other hand, seek to offer housing and services without contingencies. Although one study found no difference in contingent versus noncontingent housing in changes in substance use or symptoms, there was a decrease in time spent homeless and an increase in stable housing maintenance for the noncontingent group (Tsemberis, Gulcur, & Nakae,

2004). Further exploring the outcomes associated with noncontingent housing, the Housing First study found that, compared with a wait-list control, individuals in housing reported not only less drinking and less intoxication, but also saved an average of $2,449 per person monthly in medical and social service expenses (Larimer et al., 2009).

Substance Use Harm Reduction

Most of our research review thus far has focused on alcohol-related prevention and intervention, although some of the programs have addressed other substances. At this point, we turn our focus to harm reduction programs targeting primarily substance use, including nicotine replacement, opioid substitution, needle exchange programs, and safe injection sites.

Nicotine Replacement

The well-documented deleterious health effects of smoking cigarettes, combined with the legal status of nicotine, has led to the creation and testing of multiple alternatives designed to lower health problems and risks associated with nicotine. Consumers have multiple options, both over-the-counter and by prescription, including patches, lozenges, gum, spray, inhaler, and tablets. Dozens of studies on nicotine replacement have shown an increase in cessation rates by 1.5 to 2 times compared with placebo or no additional aid (e.g., McMurray, 2006; Shiffman, 2007; Sweeny, Fant, Fagerstrom, McGovern, & Henningfield, 2001; West et al., 2001) and can improve moderation attempts as well (Etter, Laszlo, Zellweger, Perrot, & Perneger, 2002; Rose, Behm, Westman, & Kukovich, 2006). These findings are independent of other factors typically associated with cessation success, such as social support, although it is most effective when combined with a behavioral intervention (Molyneux, 2004). Further, nicotine replacement can also increase cessation and moderation with traditionally difficult-to-treat individuals including homeless (Okuyemi et al., 2006) and inpatient populations (Saxon, McGuffin, & Walker, 1997).

Opioid Substitution

Similar to nicotine replacement, opioid substitution therapies have been developed for drugs such as heroin, oxycodone, oxycontin, and morphine. The therapies (agonist pharmacotherapy and methadone maintenance) were identified to provide a less harmful opioid (e.g., methadone) or an opioid-receptor agonist (e.g., buprenorphine) under medical supervision in both specialty and outpatient clinics (Krantz & Mehler, 2004; Merrill et al., 2005; World Health Organization [WHO], 2004). Several reviews have identified opioid substitution therapy as effective in reducing illicit opioid use, HIV risk behaviors, criminal activity, and opioid-related death (Connock et al., 2007; WHO, 2004). Yet, they remain controversial and under strict government regulation, which limits accessibility (Kleber, 2008).

Needle Exchange Programs and Safe Injection Sites

Needle and syringe exchange programs were developed to reduce the spread of blood-borne diseases (e.g., HIV and hepatitis) among injection drug users. These programs have been around since the mid 1980s, often include drug treatment referrals, peer education, and HIV prevention, and were implemented in Amsterdam, Australia, Canada, United States, and many parts of Europe.

Regarding their effectiveness, a thorough review of 45 studies from 1989 to 2002 concluded that these programs are effective, safe, and cost effective (Wodak & Cooney, 2006) with no evidence of deleterious effects (Strathdee & Vlahov, 2001). Although there has been a ban in the United States on federal funding for these programs since 1988 (Strathdee & Pollini, 2007), a recent House of Representative vote for the 2010 Labor Health and Human Services Education appropriations bill included language to lift that ban.

Furthering the intent of the needle exchange programs, there are several governments that provide safe injection sites. In these countries—Spain, Norway, Germany, Switzerland, the Netherlands, Luxembourg, Canada, and Australia, among them—injection drug users can inject their own drugs using clean equipment in the presence of medically trained personnel (Elliot, 2002). Over 25 studies have been published documenting significant reductions in needle sharing and reuse, overdoses, injecting/discarding needles in public places (Strathdee & Pollini, 2007), reduced fatalities due to overdose (Kerr, Tyndall, Lai, Montaner, & Wood, 2006), and increased enrollment in detoxification and other addition treatments (Wood, Tyndall, Zhang, Montaner, & Kerr, 2007). Although controversial, the research supports the reduced harms to both individuals and communities associated with needle exchange programs and safe injection sites.

Research Summary and Clinical Practices

We have reviewed, to the best of our ability, the research on harm reduction treatments most relevant to clinical practitioners. As described, harm reduction interventions are demonstrably effective for alcohol and substance abuse in many settings and with many populations. They are also effective in recruiting a larger proportion of afflicted clients and in reaching several populations (e.g., worksite, homeless) that conventional treatment programs rarely reach. As the use of harm reduction progresses from substance use to mental health more broadly, we will witness further research in these emerging areas as well.

As a practitioner, is harm reduction right for you and your clients? That depends on where your clients are when they come to you for help. And that depends on your beliefs regarding the acceptability of working with less than complete success or abstinence.

If someone arrives with clear motivation and a goal of abstinence, then as a practitioner, we should do all we can to support that decision. The harm reduction approach relevant in that situation would be identical to abstinence models. If, however, a client is ambivalent toward or, in fact, resistant to change, then harm reduction gives us an opportunity to build rapport and help our client make steps in the right direction. Ideally, the client will make the choice to stop the problematic behavior. However, in the absence of a commitment to abstinence, a clinical success is any client improvement and reduction in harm.

The clinician's belief in the effectiveness and the acceptability of harm reduction is a crucial determinant of its use in clinical practice. Our research review was intended to address the question of effectiveness, but the question of acceptability rests within each clinician. Can you meet your clients where they are? Can you work with half a loaf if that is all your clients desire or can afford at this time? Many psychotherapists originally trained in abstinence-only treatments are gradually shifting their practices to recognize the clinical utility of harm reduction. Just as we suggest with ambivalent clients, harm reduction is not an all-or-nothing practice. There are occasions where

harm reduction may not be the best or only option, and we rely on your clinical judgment to identify those situations. What we offer is a beginning point, or an alternative, when abstinence-only methods are not effective or realistic for a specific client.

Consideration of harm reduction therapy does not mean a therapist doesn't see any consequences or potential problems with a client's decisions and use of a substance. Harm reduction means a therapist can see the client's situation in more than black and white, all-or-nothing terms. A reduction in harm may or may not be sufficient for a client, but at least it's a starting point to build rapport, encourage change, and support efficacy. Harm reduction therapy means not withholding services when a client can't, or won't, meet our treatment outcome ideals. Harm reduction therapy means we meet the client where they are and help them along for as far as they will let us.

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Harm Reduction: A New Perspective on Substance Abuse Services

Samuel A. MacMaster

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

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

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

Abstinence-Only Orientation

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

all use (Brown, 1995). Although prohibition has been the dominant drug policy for most of this century, the significant rise in the number of people serving time for drug-related offenses, (more than 1,000 percent between 1980 and 1997), did not begin until 1980 (Bureau of Justice Statistics, 1998).

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

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

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

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

Stages of Change Model

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

1. **Precontemplation.** During this stage there is no intention to change. Often this is due to a lack of awareness; the solution may be visible to the individual, but the perception of the need to personalize that solution is missing. A client may present to substance abuse services in this stage because of outside influences; however, the individual resists recognizing that there is a problem.
2. **Contemplation.** An awareness of the problem develops at this point in the process, as the individual weighs the pros and cons of taking action. The individual begins to consider that he or she may want to overcome the problem, but has not made a commitment to act.
3. **Preparation.** This stage combines intention to change with behavioral criteria; the individual in this stage has decided to act and makes plans to do so in the near future.
4. **Action.** At this point in the process the individual modifies his or her behavior, experiences, or environment to overcome the problems.
5. **Maintenance.** The behavior that occurred in the action stage is maintained as the

individual works to prevent relapse and consolidate the gains that have been attained (Prochaska et al., 1992).

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

Harm Reduction Perspective

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

1. Substance use has and will be part of our world; accepting this reality leads to a focus on reducing drug-related harm rather than reducing drug use.
2. Abstinence from substances is clearly effective at reducing substance-related harm, but it is only one of many possible objectives of services to substance users.
3. Substance use inherently causes harm; however, many of the most harmful consequences of substance use (HIV/AIDS, hepatitis C, overdoses, automobile accidents, and so forth) can be eliminated without complete abstinence.
4. Services to substance users must be relevant and user friendly if they are to be effective in helping people minimize their substance-related harm.
5. Substance use must be understood from a broad perspective and not solely as an individual act; accepting this idea moves interventions from coercion and criminal justice solutions to a public health or social work perspective.

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

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

Applications of Harm Reduction Strategies to Social Work Practice

The stages of change model suggests that abstinence may not be a reasonable initial expectation for most service users. Abstinence may only be relevant for the estimated 10 percent to 15 percent

of service recipients who seek services at the action stage of change (Prochaska et al., 1992). It is more important to provide services that target the individual's stage of change and try to increase the client's motivation to make continued changes. Thus, harm reduction provides a framework for service users at earlier stages.

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

Involvement in harm reduction services could accelerate an individual's potential for continued change.

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

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

In contrast to the controversy surrounding needle exchange is the relatively ready acceptance of similar strategies used with individuals who are at risk of harm related to their alcohol use. Many interventions, from suggesting the use of designated drivers and wearing seatbelts to attending Alcoholics Anonymous meetings, reduce alcohol-related harm. Harm reduction strategies have been shown to reduce problems associated with alcohol use among college students. For example, the Alcohol Skills Training Program (ASTP), a six-week program for young adult drinkers, uses a cognitive–behavioral approach to prevent alcohol

problems by stressing moderate use of, or abstinence from, addictive substances (Fromme, Marlatt, Baer, & Kivlahan, 1994). The program provides skills training about setting drinking limits, monitoring one's own drinking, rehearsing drink refusal, and practicing other useful behaviors through role play. The Brief Alcohol Screening and Intervention for College Students (BASICS) (Dimeff, Baer, Kivlahan, & Marlatt, 1998), based on the ASTP model, is a nonconfrontational harm reduction approach to help students reduce their alcohol consumption and reduce the behavioral and health risks associated with heavy drinking. As with needle exchange programs, the goal of the program is not to eliminate all alcohol use but to facilitate change that will reduce the negative consequences associated with drinking, particularly binge drinking.

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

Harm Reduction and Social Work Values

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

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

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

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

According to the ethical standard "Self-Determination,"

> Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals. Social workers may limit clients' right to self-determination when, in the social workers' professional judgment, clients' actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others. (NASW, 2000, p. 7)

An ethical concern about the use of harm-reduction strategies is related to the limits placed on

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

Conclusion

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

Harm reduction interventions have been found effective. These interventions did not remove the possibility of future abstinence-based interventions and engaged clients by meeting them where they were. This perspective can be used with populations who could benefit from low-threshold programs, that is, individuals whose motivation for change is not yet at the action stage in the stages of change model. Such individuals would include college-age drinkers who have experienced minimal harmful consequences from their substance use and may not recognize their use as a problem. Similarly, injection drug users aware of the consequences of their use but who lack the motivation to make major changes may benefit from programs that foster positive change. The key to any successful social work program is matching client needs with the appropriate intervention. Practitioners need to be aware of their clients' motivation and use the best fitting model to provide appropriate services. The harm reduction perspective is one such model. Just as there are groups who will benefit from harm reduction programs, highly motivated clients seeking abstinence or who could quickly move into the action stage of the stages of change model would not be appropriate candidates for harm reduction interventions.

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

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