

BIS Capstone Project Support Paper: Changing Attitudes about Harm Reduction

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Among the array of harms plaguing society are the negative consequences associated with drug use, both for drug users and for society as a whole. In order to alleviate the damage caused by drug use, “harm reduction” practices should be considered. Harm reduction refers to a set of ideas and practical strategies intending to reduce negative consequences that are associated with drug use. Harm reduction also embraces advocacy and social justice for people who use drugs. Largely, in the United States, harm reduction ideas and practices have been rejected. Much of this rejection stems from a misunderstanding of what harm reduction is and the ways in which it can be, and has been, successfully implemented. Harm reduction ideology accepts that drug use will exist in society and seeks primarily to reduce the negative consequences associated with drug use rather than focus on the elimination of use. Harm reduction grows from the need for a conscious and deliberate response to substance use other than criminal law enforcement and incarceration (Principles of Harm Reduction, n.d.). For the purpose of this project, and in an effort to raise awareness and change attitudes about harm reduction, a website was created. The following sections of this paper outline the motivation and need for said project, as well as highlight the applicability of harm reduction to the fields of Social Work, Ethnic Studies, and Psychology.

U.S. Drug Policy is failing: Building the Case for Harm Reduction

History of U.S. Drug Policy

Though the United States has banned use of particular substances even in early history, the focus on banning and criminalizing the use of illicit drugs has largely exploded in the last half-century. In June 1971, President Nixon declared a “war on drugs” (A brief history of the drug war, n.d.). With this decision came dramatic increases in the size and presence of federal

drug control agencies. It also enforced measures such as mandatory sentencing and no-knock warrants. This set the stage for the zero tolerance policies implemented in the mid-to-late 1980s. Even more recently, with George W. Bush in presidential office, more money than ever was dedicated to fighting this “war on drugs” (A brief history of the drug war, n.d.). While rates of illicit drug use remained constant, overdose fatalities rose rapidly. The Bush administration also called for dramatically heightened use of militarization to enforce domestic drug law. For example, paramilitary-style SWAT raids are conducted in large numbers every year. Many of these raids are performed on persons for nonviolent drug law offenses, even misdemeanors. (A brief history of the drug war, n.d.)

Psychology of U.S. Drug Policy

The motivations and perspectives that govern current drug policy in the United States stem from several places. MacCoun (1993) suggests one of the earliest and long-standing roots is founded in classical deterrence theory. This political philosophy assumes human nature to be essentially hedonistic, arguing that “crime is motivated by the potential for gain but can be deterred by the prospect of certain, swift, and severe punishment” (p. 498). Thus, our current focus on policing and punishment for drug offenses serves the goals of “retribution and incapacitation” as well as contributes to general deterrence from commission of such offenses. However, research has shown that “severity-based deterrence is largely misguided and often counterproductive” (MacCoun 1993, p. 508). Why, then, do we persist in enforcing ineffective policies?

Evidence of Ineffectiveness

Increased Drug Use. While the tactics currently employed intend to do good—by eliminating drug use, and therefore the negative effects of drug use—evidence suggests that

current U.S. drug policies are arguably ineffective at decreasing drug use. On the contrary, data shows that illicit drug use is actually increasing. According to the Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Survey on Drug Use and Health, 23.5 million persons aged 12 or older needed treatment for an illicit drug or alcohol abuse problem in 2009. Of these, only 2.6 million—11.2 percent of those who needed treatment—received it at a specialty facility. (Drug Facts: Treatment Statistics, 2011, p.1)

Additionally, opioid deaths across the United States have erupted. According to data from the Centers for Disease Control and Prevention, there were 4,030 opioid deaths, and 1,960 heroin deaths in 1999 in United States. By 2014, opioid deaths had risen 369 percent to 18,893 deaths, and deaths from heroin jumped 439 percent to 10,574.

Skyrocketing Incarceration. In addition to drug use itself being high, incarceration rates for drug related charges are skyrocketing. Federal and state governments have embraced harsh punitive measures in order to battle the use of drugs and their sale to consumers. They have adopted policies that increase the arrest rates of low-level drug offenders, increase the likelihood of a prison sentence upon conviction of a drug offense, and increase the length of such prison sentences (Fellner, 2009).

Due to the unprecedented expansion of the drug war in the 1980's and 90's, the number of people behind bars for nonviolent drug law offenses increased from 50,000 in 1980 to over 400,000 by 1997 (A brief history of the drug war, n.d.). The number of people arrested in 2013 in the U.S. on nonviolent drug charges was 1.5 million. The number of Americans incarcerated in 2013 in federal, state and local prisons and jails was 2,220,300. This number represents about 1 in every 110 adults, the highest incarceration rate in the world (Drug War Statistics, n.d.).

Racial Inequality. Though drug use is spread across the race spectrum, non-white males—particularly Black and Latino—are disproportionately arrested and incarcerated for drug possession. According to the 2006 surveys conducted SAMHSA, an estimated 49% of whites and 42.9% of blacks age twelve or older have used illicit drugs in their lifetimes; 14.5% of whites and 16% of blacks have used them in the past year; and 8.5% of whites and 9.8% of blacks have used them in the past month (Fellner 2009).

In the two decades following 1980, the national drug arrest rate among blacks increased from roughly 650 to 2,907 per 100,000 population, while the national drug arrest rate among whites increased from approximately 350 to 463 per 100,000 persons. Latinos are as likely as blacks to be incarcerated in state prison for drug offenses, and nearly 80 percent of those currently serving time in state prison for drug offenses are black and/or Latino. (Beckett, Nyrop, Pfingst, & Bowen, 2005, p. 419)

An explanation: Racialized History of U.S. Drug Policy. As noted by Fellner (2009), “when asked to close their eyes and envision a drug offender, Americans did not picture a white middle class man snorting powder cocaine or college students smoking marijuana. They pictured unkempt African-American men and women slouched in alleyways or young blacks hanging around urban street corners” (p. 266). History suggests that the punitive anti-drug efforts that have been and continue to be employed are often triggered by concerns about the “use of consciousness-altering substances by members of a racially or ethnically stigmatized group” (Beckett, Nyrop, Pfingst, & Bowen, 2005, p. 437). Examples of these concerns throughout early American history include Chinese immigrants and the use of opium, Mexican immigrants and the use of marijuana, the “cocaine-crazed Negro” exaggerations, as well as the more recent focus on blacks and use of crack (Beckett, Nyrop, Pfingst, & Bowen, 2005).

Unfortunately, the United States has failed to identify and eliminate public policies and practices that have an unjustifiable racially disparate impact, regardless of whether they are accompanied by racist intent. Racial disparities in the war on drugs may be one of the most striking examples of this country's failure to satisfy ICERD [International Convention on the Elimination of All Forms of Racial Discrimination] (Fellner, 2009, p. 259).

Without reaching, it can be argued that the obvious racial disparities may not be just an unfortunate by-product of drug wars. It seems, rather, that those disparities might be a "constitutive component of those campaigns" (Beckett, Nyrop, Pfingst, & Bowen, 2005, p. 437).

Incarceration as behavior change. Current drug policy lends itself to the belief that incarceration of drug offenders creates, or at least facilitates, a change in future behavior. Lurigio and Loose (2008) argue that the experience of imprisonment is more "likely to produce people who are stigmatized, disenfranchised, dispirited, and unemployable. They leave prison more inclined to resume illicit drug use and criminal pursuits and, ultimately, they are re-incarcerated...Public policymakers must recognize that incarceration of nonviolent, drug-involved offenders is not an effective or efficient return on the investment of taxpayer dollars" (Lurigio & Loose, 2008, p. 243).

In addition to time spent in jail or prison, drug-related charges have lasting effects even after release. For example, if convicted of a felony drug charge, potential losses include license to drive, right to vote, receipt of welfare and food stamp benefits, access to federal financial aid, approval for government housing, and employment opportunities.

Limitations of Treatment as an Alternative to Incarceration. One increasingly popular alternative to incarceration of drug offenders, is that of requiring them to participate in a drug

treatment program. However, even with this rehabilitative approach, discouraging limitations exist. Current treatment models are largely abstinence-based, meaning participants are required to abstain from substance use. Unfortunately, such programs are often ineffective—at least in their stated goals of abstinence. It is widely understood and accepted among treatment professionals that substance addiction is a chronic disease that needs continued maintenance. Relapse in substance use is expected. Why, then, is the focus so largely on how to “stay clean” rather than how to use safely? The mentality of abstinence-based treatment perpetuates a cycle of failure and shame for the drug user who commits to abstinence and then relapses.

Considering an alternative approach: Harm Reduction

The data above suggest there is a need for a conscious and deliberate response to substance use other than criminal law enforcement and incarceration (Principles of Harm Reduction, n.d.). Harm reduction ideology accepts, for better and or worse, that licit and illicit drug use is part of our world. And while it does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use, it does choose to work to minimize its harmful effects rather than simply ignore or condemn them (Principles of Harm Reduction, n.d.).

We already embrace and use harm reduction practices in a multitude of ways. We all engage in risky behaviors of some sort and generally seek to prevent potential damage. For example, we drive cars, so we wear seat belts. We play sports, so we wear helmets and other protective gear. In addition to preventing harm, we seek to alleviate suffering of others. Soup kitchens provide food to those who cannot provide it for themselves. Homeless shelters house people without another refuge. The principles behind harm reduction are familiar. Our next

obligation is to allow them to relate to prevention and alleviation of the negative consequences of drug use.

Health risks associated with substance use include contracting diseases such as hepatitis and HIV, as well as loss of life due to substance overdose. Mental and emotional distress related to drug use is significant and affects not only the user, but other persons involved in the user's life. Substance use is also often intertwined with other high-risk behaviors such as driving under the influence, risky sexual behaviors, and the commission of crime. As it relates to drug use, harm reduction supports the idea that the risky behaviors people engage in occur on a continuum from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others (Principles of Harm Reduction, n.d). The United States government has aggressively resisted harm reduction policies in its approach to the drug problem. MacCoun (1998) believes the United States' continued resistance to supporting harm reduction strategies has allowed the harms of substance use to remain.

The harm reduction critique of the enforcement oriented U.S. drug strategy is twofold.

First prevalence-reduction policies have failed to eliminate drug use, leaving its harms largely intact. Second, these harsh enforcement policies are themselves a source of many drug-related harms, either directly or by exacerbating the harmful consequences of drug use. (p. 1199)

Harm Reduction as Social Work

Social workers are most often the "front line" of social welfare policies and practices. Constant evaluation of best practices is an expectation in the field. The ideas involved in harm reduction are now being considered when evaluating best practice ideologies. Bigler (2005) explains a clear and important link between social work and harm reduction.

Although harm reduction originally grew out of interventions specific to drug use and chemical dependency, the philosophy and strategies of harm reduction are applicable to a variety of social welfare and public health issues, particularly those affecting marginalized individuals and communities that are so often served by social workers. Consequently, the harm reduction approach seems to be ideally suited as a guide to practice in virtually every social service or health care setting (p. 74).

A Public Health Approach to Harm Reduction. Rather than focus on eliminating the harmful behavior itself, harm reduction emphasizes reducing the harmful consequences associated with behavior. Supporters of harm reduction shift the focus away from drug use itself to the consequences or effects of the addictive behavior. Such effects are evaluated primarily in terms of whether they are harmful or helpful to the drug user and to the larger society. (Marlatt, 1998, p. 50) Similar to traditional treatment, the goal of harm reduction strategies is to move the individual along the continuum toward abstinence, thereby reducing the harmful consequences of such behaviors. However, while the continuum model accepts abstinence as the ideal risk-reductions strategy, any movement along the continuum in the direction of abstinence is seen as progress, even if total abstinence is not attained (Marlatt and Tapert, 1993). Some examples of implementing harm reduction strategies from a public health standpoint are: needle exchange programs, opioid replacement therapy, safe injection sites, decriminalization of non-violent drug offenses, and the distribution of naloxone.

Example: InSite and OnSite. InSite is North America's first legal supervised injection site, located in downtown Vancouver, British Columbia, and is an example of how harm reduction practices can be implemented. It has 13 injection booths where clients inject pre-obtained illicit drugs under the supervision of nurses and health care staff. InSite also supplies

clean injection equipment such as syringes, cookers, filters, water and tourniquets. If an overdose occurs, healthcare staff are available to intervene immediately. Nurses also provide other health care services, like wound care and immunizations. InSite also has addictions counselors, mental health workers, and peer staff who connect clients to community resources such as housing, addictions treatment, and other supportive services.

OnSite, another program focused on harm reduction practices, is a withdrawal management facility for users wishing to detox. On the first floor of OnSite, there are 12 rooms with private bathrooms where clients can detox. Mental health workers, counselors, nurses and doctors work together to help people stabilize and plan their next steps. If desired, people can then move up to the next floor of OnSite, which provides transitional recovery housing for further stabilization and connection to community support, treatment programs and housing.

While this facility has been extremely controversial, data has given argument to the benefits of its existence. In a summary of the research conducted in evaluation of InSite, Wood, Tyndall, Montaner, and Kerr (2006) reported a number of findings suggesting positive outcomes. It was reported that the facility attracted IDUs who were hard to reach through conventional public health programs. As well, the opening of InSite coincided with a significant reduction of public injection drug use and publicly discarded syringes, suggesting that the facility may have contributed to an increase in public order. Among its clientel, InSite also significantly reduced the rate of syringe sharing, a practice that has been identified as a primary mode of HIV transmission. Individuals who used InSite were also significantly more likely to enter into addiction treatment services. Finally, the opening of InSite was not associated with an increase in levels of drug- dealing or other drug-related crime in the area in which the facility is located. In short, the opening of InSite was associated with an array of community and public health

benefits and, despite rigorous evaluation, no identified adverse impacts (Wood, Tyndall, Montaner, & Kerr, 2006).

Harm Reduction in Drug Treatment. Embracing harm reduction practices in treatment and prevention is a more compassionate and beneficial model for the drug user, and thereby, for society as well. Marlatt & Tapert (1993) see harm reduction approaches as...

...offering at-risk populations simple behavior changes that reduce the harm of high-risk activities, often with abstinence as the end point, but accepting that abstinence is not a realistic goal for all people. As relapse is common, people need skills to prevent harm if a relapse should occur. Harm reduction approaches work to empower rather than to marginalize high-risk groups. (p. 250)

While current substance abuse treatment has the express goal of eliminating all drug use, harm reduction seeks to first stabilize the problem behavior in order to prevent further harmful consequences, and then to encourage education about said harmful consequences (Marlatt 1998). Tatarsky and Kellogg (2010) note that “the abandonment of the abstinence requirement enables the therapy to begin with whatever brings the patient for help...A good therapeutic relationship facilitates the other therapeutic activities: skills building and active strategizing to support positive changes in substance use, exploration of the meanings of problem substance use, and the discovery of new, more effective solutions to related vulnerability factors” (p.124).

While cessation of drug use may remain an “end goal” for many practitioners and patients, harm reduction allows for a different approach. Harm reduction allows for help and success to be available without abstinence being the qualifier. Amongst the complexities of harm reduction practices, MacCoun (1998) offers a simplified statement. He says, “If harm reduction service providers intend to send a message, it is something like this: ‘We view drugs as harmful.

We discourage you from using them, and we are eager to help you to quit if you've started. But if you will not quit using drugs, we can help you to use them less harmfully” (p. 1202).

Example: The Center for Harm Reduction Therapy. The Center for Harm Reduction Therapy (CHT) has three offices located in northern California and is a certified drug and alcohol treatment program staffed by mental health professionals. Their program offers pragmatic, proven solutions to substance misuse. The approach to treatment there is a client-therapist collaboration that combines substance misuse treatment with psychotherapy, so clients can address both their substance use and the issues that are behind it (*The Center for Harm Reduction Therapy*, n.d.).

Unlike traditional “quit now and forever” programs, we do not ask that clients stop all substance use, unless that is their goal... The therapist helps the client to lay out, clearly and honestly, the harm being done to themselves and to others... Together, client and therapist then work to reduce the harm that is being done, establishing goals and implementing gradual, realistic steps to achieve them. (*The Center for Harm Reduction Therapy*, n.d.)

While CHT gives no specific label to the model of psychotherapy offered there, Motivational Interviewing is a model of therapy with a very similar explanation of methods and goals. Motivational Interviewing is defined as “a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence” (Hunt et al., 2003, p. 35). It is a way of talking with clients about changing aspects of their behavior in a way that minimizes resistance and increases the probability that some change will occur (Hunt et al., 2003).

Harm Reduction as it relates to Ethnic Studies

In order to illicit any change for racial and ethnic minorities in our “war on drugs”, public policies must consider the implications of current laws, strategies, and practices that perpetuate racial disparities and harm individuals, families and communities (Lurigio & Loose, 2008). As Fellner (2009) points out, the “emphasis on harsh penal sanctions cannot be divorced from the widespread and deeply rooted public association of racial minorities with crime and drugs” (p. 277). By detaching non-violent drug use and possession from criminal punishment, individual and societal harms can be greatly decreased, especially for racial and ethnic minorities.

Facing the rising epidemic of drug use, the United States may establish a measure of racial equality in offering solutions more focused on public health and harm reduction. These options may include increased access to substance abuse treatment and medical assistance for marginalized racial and ethnic minorities. Additionally, a focus on reducing poverty, improving education, and providing support to vulnerable families could reduce the spread of drug use. An increase in employment opportunities in poverty stricken neighborhoods—which very often coincide with high populations of Blacks and Latinos—may put off the temptations to engage in the drug trade as a means of income (Fellner, 2009).

Harm Reduction as it relates to Psychology

Rejection of Harm Reduction. MacCoun (1998) proposes several explanations for the rejection of harm reduction as a viable set of practices—two of which are: consequentialist grounds, and the propriety of helping drug users. In regard to the first, he states, “The consequentialist grounds for opposing harm reduction are characterized primarily by the belief that harm reduction will be counterproductive, either by failing to reduce average harm or by increasing drug use enough to increase total harm” (p. 1205). He argues that those who oppose harm reduction on consequentialist grounds will likely be willing to change their opinion and

support it if they are provided with facts suggesting that an intervention reduces harm without producing increases in use. An example of this is the growing support of needle exchange programs. Growing numbers of studies have produced results suggesting that such programs greatly reduce the risk and prevalence of HIV in a participating community without increasing intravenous drug use.

A second explanation to the common rejection of harm reduction is the propriety of helping drug users. Among Americans, there is a general antagonism toward hard drug users. Part of this stems from the strong association between drugs and street violence in U.S. cities. The current response to this is incarceration. MacCoun (1998) states, “Even in the absence of malice, many people may feel that addicts should suffer the consequences of their actions” (p. 1206). MacCoun goes on to mention that addiction is often viewed as voluntary state, in spite of many experts’ beliefs to the contrary. Many Americans, especially conservatives, will not extend help to those who are perceived to be responsible for their own suffering; they are seen as undeserving. Opposition to harm reduction likely stems from the Puritan and Calvinist roots that give foundation to our nation’s government. Judeo-Christian and Protestant fundamentalist traditions hold that bad acts require punishment (MacCoun, 1998).

Changing Attitudes about Harm Reduction. While recognizing the potential grounds for opposing harm reduction is helpful in understanding current attitudes, and resulting policy, it does not create change. If change in attitude regarding harm reduction is possible, further examination of the formation and changing of attitudes is required. When considering cognitive attitude formation and attitudes regarding harm reduction, one particular study became of great interest. Goddard (2003) studied drug treatment professionals who attended an educational presentation about harm reduction. They were asked to take a survey consisting of 25 questions

before and after the presentation in order to measure their level of acceptance toward harm reduction. Participants had significantly more positive attitudes following the presentation, suggesting that increased knowledge about harm reduction techniques leads to a more positive attitude towards said techniques (Goddard, 2003).

Conclusion and Application to Project

U.S. drug policies are failing to reduce drug use. They fail to protect human rights of drug users, as well as further marginalize racial and ethnic minorities. As an alternative to current policy, harm reduction practices should be considered. In order to implement harm reduction practices, many national and local drug policies must change. Before those changes can take place, social attitudes must be changed. In an attempt to begin changing attitudes, a website was built with information and links on harm reduction. Particularly, the site includes information most pertinent in attracting a more religious and politically conservative audience. Already in existence are several very informative sites on harm reduction, however, the hope in creating this one is that the targeted audience will be more inclined to investigate the benefits of harm reduction practices when the suggestion is coming from familiar standpoint and voice. If the target audience will utilize and spread the website amongst peers, conversation about harm reduction will increase. Focusing on beginning conversation about harm reduction in local conservative communities is the initial and preliminary step to moving toward a practice of harm reduction.

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