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III. Drug Abuse: G. Alan Marlatt, Chair

HARM REDUCTION: COME AS YOU ARE

G. ALAN MARLATT
University of Washington

Abstract — The purpose of this paper is to describe what harm reduction is, how it developed, how it works, and why it is becoming a major approach in the addictive behaviors field. Based on principles of public health, harm reduction offers a pragmatic yet compassionate set of strategies designed to reduce the harmful consequences of addictive behavior for both drug consumers and the communities in which they live. To illustrate how harm reduction has been applied to both the prevention and treatment of addiction problems, highlights of a national conference on harm reduction are presented. The historical roots of harm reduction programs in Europe (Netherlands and the United Kingdom) are described. The paper concludes with a discussion of four basic assumptions central to harm reduction: (a) harm reduction is a public health alternative to the moral/criminal and disease models of drug use and addiction; (b) it recognizes abstinence as an ideal outcome but accepts alternatives that reduce harm; (c) it has emerged primarily as a "bottom-up" approach based on addict advocacy, rather than a "top-down" policy established by addiction professionals; and (d) it promotes low threshold access to services as an alternative to traditional high threshold approaches.

Harm reduction is coming to the U.S.A. The purpose of this paper is to describe what harm reduction is, how it developed, how it works, and why it is becoming a major revolutionary force in the way we respond to human problems ranging from addiction to AIDS. Although, as we shall see, harm reduction has its origins in Europe, it is quickly taking hold as a middle-road alternative to the two established traditional approaches favored in this country: the moral model (War on Drugs) and the disease model of addiction. Based on public-health principles and founded by "grassroots" advocacy among drug users themselves, harm reduction offers a pragmatic yet compassionate set of principles and procedures designed to reduce the harmful consequences of addictive behavior for both drug consumers and for the society in which they live.

In August, 1995, a public health working group published a set of recommendations to redefine American drug policy in the *American Journal of Public Health* (Reuter & Caulkins, 1995). These recommendations were aimed at the Office of National Drug Control Policy which sets forth national goals for drug policy in the United States. All previous strategy recommendations issued by this office (under both the Bush and Clinton administrations) have stressed "use reduction" rather than harm reduction.

The public health working group strongly recommends that the goal be shifted toward a greater balance of harm reduction and use reduction policies:

> The principal goal for drug policy should instead be to reduce the harms to society arising from the production, consumption, and control of drugs. Total harm (to users and the rest of society) can be expressed as the product of total use and the average harm per unit of use and thus can be lowered by reducing either component. Attention has been focused on the first; greater attention to the second would be

Requests for reprints should be sent to G. Alan Marlatt, Ph.D., Addictive Behaviors Research Center, Department of Psychology, Box 351525, University of Washington, Seattle, Washington, 98195-1525.
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> beneficial. . . . Based on experience since 1985, the rhetorical and policy-oriented emphasis on making drug use less acceptable and drugs less available, as well as the focus on drug prevalence as the dominant indicator of program success, has probably outlived its usefulness. (Reuter & Caulkins, 1995, pp. 1059–1060)

The report makes a number of recommendations, including the integration of alcohol and nicotine as part of the overall national drug control strategy, enhancing secondary prevention programs for drug users (including giving them information about harms associated with different modes of drug use), and decreasing funding and support for "source-country drug control programs" (e.g., reducing cocaine supply in Latin American countries). Instead, the report favors harm reduction as an alternative policy:

> Conceptually, harm reduction is much more attractive. Each policy or programmatic decision is assessed for its expected impact on society. If a policy or program is expected to reduce aggregate harm it should be accepted; it is expected to increase aggregate harm, it should be rejected. The prevalence of drug use should play no special and separate role. . . . In terms of harms, shifting a drug injector to a less dangerous form of drug use may be more important than persuading an occasional user of marijuana to cease consumption. (Reuter & Caulkins, 1995, p. 1060)

EXAMPLES OF HARM REDUCTION

In October, 1995, the Drug Policy Foundation (DPF) sponsored its Ninth International Conference on Drug Policy Reform. Held in Santa Monica, California, the conference was entitled, "Harm Reduction: Bringing the International Community Together." With its headquarters in Washington, DC,[1] the DPF is the largest non-profit foundation in the US to provide a forum for open debate on drug policy and discussion of alternatives, including decriminalization, legalization, and medical treatment. To illustrate the scope and applications of harm reduction, here are some highlights of the 1995 DPF conference.

The conference was chaired by the President and founder of DPF, Arnold Trebach, a Professor at The American University. He introduced the first speaker, George Bushnell Jr., Immediate-Past President of the American Bar Association, who spoke in favor of drug legalization as a potential solution to the growing problems of drugs and crime in America. David Condliffe, Executive Director of DPF, remarked on the increasingly racist flavor of the American War on Drugs, reminding the audience that one out of three African-American males is currently under criminal justice supervision (either in jail, on probation, or on parole), and that there has been a 500% increase in the number of incarcerations for drug offenses in the decade 1983–1993. He noted that minorities (especially African-Americans and Latinos) are at the highest risk for AIDS.

Ira Glasser, Executive Director of the American Civil Liberties Union (ACLU) reported the results of a national telephone survey conducted in the United States by ACLU on the topic of marijuana as medicine. Although the results showed that over 90% of the respondents were aware that marijuana had been advocated in the treatment of certain medical problems (e.g., glaucoma, cancer-related nausea and pain, appetite-enhancement in AIDS patients, etc.), and that 23% of the sample reported that they knew someone who had used marijuana for medical purposes, only a minority

[1]The Drug Policy Foundation, 4455 Connecticut Ave., NW, Suite B-500, Washington, D.C. 20008-2302; (202) 537-5005.

(36%) endorsed open legalization of marijuana sales. On the other hand, over 80% agreed that if research supported the efficacy of marijuana as a treatment for specific disorders, it should then be made available by doctors on a prescription basis. Glasser noted that the government now bans research on the potential medical benefits of marijuana (now restricted by the placement of marijuana as a "Schedule I" drug with no known medical benefits). This standoff between public opinion (support marijuana as medicine if research documents positive treatment effects) and government policy (rejects research on possible therapeutic benefits of marijuana) has created a classic "Catch-22" situation, with the result that many individuals who seek access to marijuana for medicinal purposes are unable to gain access to the plant.

In another symposium on marijuana, Lester Grinspoon, a psychiatrist on the faculty of the Harvard School of Medicine, and co-author of a recent book on the medical uses of marijuana (Grinspoon & Bakalar, 1993) introduced Dennis Peron, founder of the Cannabis Buyers Club in San Francisco. Only patients with cancer or AIDS and who have a physician's letter testifying to their diagnosis can become members and can purchase marijuana from the Buyers Club. Until August 1996, the police in San Francisco maintained a "hands-off" policy in terms of the Club's operation.

Another symposium focused on U.S. drug education programs and policies. Here the main speaker was Joel Brown, Project Director of the Pacific Institute for Research and Evaluation in Berkeley, CA, who described the results of a recent project designed to evaluate drug education programs in California schools. In this project, over 5,000 students in Grades 1 through 12 who participated in the drug education program were surveyed. The program itself, called DATE, is similar to the national DARE program (Drug Abuse Resistance Education) in that it employs police officers to conduct an antidrug campaign in school classrooms. The survey results showed that students did not rate the program as favorable: 70% of the students reported that the program was negative or neutral in impact, and less than 15% said that the program affected their decisions regarding personal drug use. Students disliked the "no use" message and some complained that drug-using students are singled out for punishment (often expulsion from school) and are thus stigmatized and marginalized by society as a result. Another panel member, Nancy Tobler (Research Professor at the State University at Albany, New York), reported the results of a meta-analysis evaluating American drug education programs. She defined programs such as DARE, in which students are lectured to by "experts" (e.g., police officers or recovered addicts) as "noninteractive" and compared them with "interactive" programs in which students and teachers discuss drug use and engage in open dialogues about the pros and cons of this behavior. In the results of her meta-analysis, only the interactive programs were found to have any positive effect size outcomes.

In another symposium on youth and drugs, Sara Kershnar (Program Director of the Harm Reduction Coalition) reminded the audience that unless policy makers and educators interact with youth in the development of programs designed to deal with the problems of drugs, AIDS, and violence, young people will continue to see them as condescending and patronizing in their approach. Kershnar was particularly critical of adults who blame youth as the primary cause of violence and drug use in our society, rather than focusing on the most important contributing factors: poverty, racism, sexism, and ageism (e.g., authoritarian attitudes and behavior of those police and policy makers who suppress and demean many young people—the perceived ownership of youth by adults). Youth involved with drug use are double-stigmatized, she said, for being both underage and substance abusers. Kershnar promoted harm reduction as a

promising bridge to integrate the divided camps, but only if adults are willing to meet youth halfway, in order to develop a partnership, as compared to the top-down "adults know best" attitude. Harm reduction is a humane approach that breaks down the "provider-client" role barrier and allows people to provide their peers with the resources and tools they need to cope with the risks of drugs, sex, and violence, Kershnar concluded.

An example of a peer-based program to work with high-risk youth was presented by another panelist, Heather Edney, the Director of the Santa Cruz Needle Exchange Program in California. She first criticized the original needle-exchange programs in Santa Cruz as being dominated by older, recovered male addicts who tended to ignore the population of younger IV drug users (many of whom were female). Now the program has expanded to include active drug users along with recovered addicts and other volunteers who provide services. Services include responding to basic food and housing needs, needle exchange (both in the street and on a "housecall" basis), information on safer drug use and sex (sample poster: "Fuck Safe and Shoot Clean"), injection procedures, "shooting-gallery" motel rooms to provide a safer place to inject drugs and exchange needles—"all totally illegal" according to Edney (California continues to ban needle-exchange programs of any kind). Edney pleaded with the audience not to restrict needle-exchange staff to ex-users, but to include active users who are often in a better position to contact drug-using peers on an outreach basis. She emphasized that the purpose of the Santa Cruz program is not to "help" young people—rather, young people want to learn how to do it for themselves; the program tries to provide them with the services and tools to do just that.

Similar points were made in another symposium on the application of harm reduction and other drug programs in African-American communities. Unless members of the target community are directly involved in the development of culturally appropriate programs and services, they will fail, noted Imani Woods, an internationally known harm-reduction specialist and educator who holds a faculty position at the University of Washington. Woods admonished drug policy makers on the outside who "parachute in" to African-American communities in an attempt to implement imported programs in the absence of community input. It is critical to match the harm reduction message to the population you are working with, Woods concluded. Her message was echoed by another panelist, Cheryl Simmons, Director of the SISTERS project for African-American women in San Leandro, California. Remember that "we wear different coats in different neighborhoods," she told the audience, reminding us to "meet us in the house where we live" and that harm reduction programs will not work unless they include a strong spiritual component, acceptance of ceremony and ritual, and "acknowledgment of our beauty as black women."

Jocelyn Elders, former U.S. Surgeon General and Professor at the University of Arkansas School of Medicine, was presented with a DPF Award for outstanding achievement in the field of drug policy reform. During her acceptance speech, Dr. Elders continued to voice her request that "studies on legalization need to be done" as a possible means of reducing violence in America. She also noted that much of U.S. drug policy is racist in its consequences, particularly in terms of the number of African-Americans in prison for drug offenses. An example is the U.S. federal mandatory minimum sentencing requirements for first-time drug offenders. These sentences are to be imposed with no chance of parole, regardless of the defendant's role in the offense, his or her culpability, likelihood of rehabilitation, or any other mitigating factors. The minimum sentence for possession of five grams of crack cocaine (favored by African-Ameri-

cans) is 5 years imprisonment—yet possession of cocaine in powder form (favored by whites) does not carry the same 5-year sentence unless possession is 500 grams (100 times as much of the same drug, cocaine).

Dr. Elders mentioned that the United States Sentencing Commission recommended that the 100-to-1 disparity in sentencing between crack cocaine and powdered cocaine offenses be eliminated. According to estimates by the Commission, about 14,000 of the 90,000 Federal prison inmates are serving sentences for crack cocaine offenses. A study of the 1993 convictions showed that 88.3% of offenders were Black, 7.1% Hispanic, and 4.1% White. Of those convicted for powdered cocaine offenses in 1993, 32% were White, 27.4% Black, and 39.3% Hispanic (Smothers, 1995). As stated by Cynthia Tucker, an African-American syndicated columnist:

> Here is the way current federal drug laws work: simple possession of 5 grams of powdered cocaine, typically used by the middle class, is often handled with a sentence of probation. But simple possession of 5 grams of "crack" cocaine, typically used by the Black and Brown poor, draws an automatic sentence of five years in prison. Many state drug laws contain similar disparities. . . . A disproportionate number of those incarcerated drug offenders are Black. While Blacks make up 13% of drug users, they represent 35% of narcotics arrests, 55% of convictions, and 74% of those receiving prison sentences, according to an advocacy group called the Sentencing Project. (Tucker, 1995)

Despite these statistics, the U.S. House of Representatives rejected the recommendations of the Sentencing Commission to remedy the disparity in cocaine mandatory sentencing requirements by a vote of 332 to 83. The vote was taken the same week as Jocelyn Elder's speech to the DPF on October 20, 1995. Dr. Elders also endorsed the call for lifting the federal ban on funding for needle-exchange programs in the United States. Although dismissed from her post as Surgeon-General because of her controversial views on drug legalization and sex education, Dr. Elders plans to remain active in promoting a more humane drug policy, one based both on scientific studies and a public-health (vs. criminal justice) approach. After her talk, the enthusiastic audience at DPF gave her a long standing ovation.

HISTORY AND DEVELOPMENT OF HARM REDUCTION

A. The Dutch model

Foreign visitors to Amsterdam and other major cities in the Netherlands are often struck with what appears to be a liberal and permissive approach to drugs and sex. Special "coffee shops" sell marijuana and hashish, which can be consumed in the shop or taken home. In the red light district, prostitutes can be viewed sitting in their parlor rooms along many streets, beckoning to prospective "window-shopping" clients. Prices for sexual services are fixed and condom use is mandatory. Pornography shops and "live sex" shows are predominant throughout the district, where police on bicycles patrol the streets, providing protection for both prostitutes and their customers. In another part of the city, one of several mobile vans known as the Methadone Bus is parked on a side street, servicing addicts who line up for oral methadone, condoms, and clean hypodermic syringes (given in exchange for their "dirty" needles). How did all this come to be?

As stated by the Dutch sociologist, E. M. Engelsman (1989), a leading proponent of this perspective:

> The Dutch being sober and pragmatic people, they opt rather for a realistic and practical approach to the drug problem than for a moralistic or over-dramatized one. The drug abuse problem should not be primarily seen as a problem of police and justice. It is essentially a matter of health and social well-being (p. 212).

Changes in the traditional drug policy began to occur in the Netherlands as early as 1972. In that year the Narcotics Working Party published a document concluding that the basic premises of drug policy should be congruent with the extent of the risks involved in drug use (Narcotics Working Party 1972). This policy change led to the adoption of a revised Dutch Opium Act in 1976, when a distinction was made in the law between drugs of "unacceptable risk" (heroin, cocaine, amphetamines, and LSD) and drugs with lower risk such as marijuana and hashish (Wijngaart, 1991). Commenting on this distinction, Engelsman notes: "In this regard the Dutch prove very pragmatic and try to avoid a situation in which consumers of cannabis suffer more damage from the criminal proceedings than from the use of the drug itself. (Engelsman, 1989, p. 213).

This movement toward a more humane and pragmatic approach was stimulated in large part by direct input from Dutch drug users and addicts themselves. In 1980 the "Junkiebond" (Junkie League) was established in Rotterdam as a kind of trade union for concerned hard-drug users. There are now local groups in most major cities, with national representation in the Federation of Dutch Junkie Leagues. As described by Wijngaart (1991):

> The starting point of the "Junkiebond" is to look after the interests of the drug users. The most important thing is to combat the deterioration of the user or, to put it another way, to improve the housing and general situation of the addict. Their philosophy is that drug users themselves know best what their problems are. The work of the "Junkiebond" involves consultations with government officials about matters like the distribution of methadone, the availability of free sterile syringes, the policy of the lawmakers and police, and housing problems. (p. 39)

Input from addicts associated with the "Junkiebond" led to the development of the first needle exchange program in Amsterdam in 1984 (Buning, 1989). The Municipal Health Service delivered disposable needles and syringes in large quantities once a week to the "Junkiebond" for distribution and collection of used needles. As AIDS and the risk for HIV infection through shared needles increased in the mid-1980s, the number of exchanged needles and syringes rose from 100,000 in 1985 to 720,000 in 1988 (Brussel & Buning, 1988).

B. The U.K. (Merseyside) model

The first international conference on harm reduction was held in Liverpool, England, under the sponsorship of the Merseyside Health Authority, in 1990 (O'Hare, Newcombe, Matthews, Buning, & Drucker, 1992). The United Kingdom pioneered the "medicalization" approach in which drug abusers can be prescribed drugs such as heroin and cocaine on a maintenance basis. The prescribing of drugs to addicts dates back to the Rolleston Committee of the 1920s in which a group of prominent British physicians recommended that in certain cases addicts be prescribed narcotics in order to reduce the harm of their drug use and to help them lead useful lives (Rolleston, 1926). Although prescribing drugs for addicts fell into disfavor over the ensuing years, this policy continues to be practiced in Merseyside, England, serving the population around the city of Liverpool (Marks, 1991).

Other countries have also had experience with harm reduction programs. Australia has planned a trial of providing heroin and other opiates to injecting drug users (Bammer, Douglas, Moore, & Chappell, 1993). The Third International Conference on the Reduction of Drug-Related Harm was held in Melbourne in 1992 (Heather, Wodak, Nadelman, & O'Hare, 1993). Another international conference on harm reduction, the first to be held in North America, was held in Toronto, Canada, in 1994 (Erickson, Riley, Cheung, & O'Hare, 1996).

HARM REDUCTION: CENTRAL ASSUMPTIONS, PRINCIPLES, AND VALUES

1. Harm reduction is a public health alternative to the moral/criminal and disease models of drug use and addiction

American views of drug use and addiction have been based on two competing and sometimes conflicting models: the moral model and disease model. In terms of the moral model, American drug-control policy has determined that illegal drug use and/or distribution of such drugs is a crime deserving of punishment. As an extension of the moral model (assumption: illicit drug use is morally wrong), the criminal justice system has collaborated with national drug policy makers in pursuing the "War on Drugs," the ultimate aim of which is to foster the development of a drug-free society. The majority of federal funding for drug controls has been based on a "supply reduction" approach. Federal enforcement agencies (i.e., the U.S. Drug Enforcement Agency) are funded primarily to promote interdiction programs designed to reduce the supply of drugs coming into this country (e.g., to destroy the supply of coca plants used to produce cocaine in Colombia and other Latin countries). National, state, and city police are funded to arrest drug dealers and users alike in an attempt to further reduce the supply of drugs. As we have already noted, American courts and prisons are overcrowded with inmates convicted of drug offenses.

The second approach is to define addiction (e.g., alcoholism or heroin addiction) as a biological/genetic disease that requires treatment and rehabilitation. Here the emphasis is on prevention and treatment programs that focus on remediation of the individual's desire or demand for drugs, a "demand reduction" approach. Despite the apparent contradiction between viewing the drug user as either a criminal deserving of punishment or as a sick person in need of treatment, both the supply reduction and the demand reduction models are in agreement that the ultimate aim of both approaches is to reduce and eventually eliminate the prevalence of drug use by focusing primarily on the drug user ("use reduction").

Harm reduction, with its philosophical roots in pragmatism and its compatibility with a public health approach, offers a practical alternative to either the moral or disease models. Unlike proponents of the moral model, who view drug use as bad or illegal and who advocate supply reduction (via prohibition and punishment), harm reduction shifts the focus away from drug use itself to the consequences or effects of 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, and not on the basis of whether the behavior itself is considered morally right or wrong. Unlike supporters of the disease model, who view addiction as a biological/genetic pathology and promote demand reduction as the primary goal of prevention and abstinence as the only acceptable goal of treatment, harm reduction offers a wide range of policies and procedures designed to reduce the harmful consequences of addictive behavior. Harm re-

duction accepts the practical fact that many people use drugs and engage in other high-risk behaviors and that idealistic visions of a drug-free society are unlikely to become reality.

2. Harm reduction recognizes abstinence as an ideal outcome but accepts alternatives that reduce harm

The moral model and the disease model also share one strong common value: the insistence upon total abstinence as the only acceptable goal of either incarceration or treatment. Despite the harsh reality of high recidivism rates for released drug prisoners and the correspondingly high rate of relapse for treated addicts, there has been no relaxation of this absolute insistence upon abstinence. Contemporary American drug policy is based on the ultimate criterion of "zero tolerance"—a policy that states that any illegal drug use, including the occasional smoking of marijuana, is as intolerable as a daily pattern of intravenous heroin injection. Similarly, the only acceptable goal of almost all American alcohol and drug treatment programs is lifelong abstinence along with continued attendance at twelve-step recovery groups. In fact, abstinence is almost always required as a precondition for treatment, since most chemical dependency treatment programs refuse to admit patients who are still using drugs. One must first abstain in order to receive treatment designed to maintain abstinence!

Harm reduction is not anti-abstinence. Harmful effects of unsafe drug use or sexual activity can be placed along a continuum, much like the span of temperature on a thermometer. When things get too hot or too dangerous, harm reduction promotes "turning down the heat" to a more temperate level. This gradual "step-down" approach encourages individuals with excessive or high-risk behavior to take it "one step at a time" to reduce the harmful consequences of their behavior. The ultimate goal of abstinence greatly reduces or entirely eliminates the risk of harm associated with excessive drug use or unsafe sex. In this sense, abstinence is included as an ideal end-point along a continuum ranging from excessively harmful to less harmful consequences. By placing the harmful effects of drug use or sexual behavior along a continuum rather than by dichotomizing drug use as legal or illegal or by diagnosing drug use as indicating the presence or absence of an addictive disease, supporters of harm reduction encourage any movement toward decreased harm as steps in the right direction (Marlatt & Tapert, 1993).

Harm reduction strategies also apply to the use of legal drugs, including tobacco and alcohol. For smokers who are unable to quit "cold turkey," nicotine patches, gum, and sprays are available as less harmful (decreased cancer risk) than smoking cigarettes. Although nicotine replacement therapies were initially designed as an aid to quitting, some people use these products to maintain a safer level of nicotine use. On the alcohol front, the harmful effects of excessive drinking can be reduced by teaching moderation skills.

3. Harm reduction has emerged primarily as a "bottom-up" approach based on addict advocacy, rather than a "top-down" policy

Recall that needle-exchange programs for IV drug users began in the Netherlands in response to input from addicts who belonged to the "Junkiebond" group and who advocated drug policy changes that would permit the legal exchange of needles in order to reduce the risk of HIV infection. Many of the harm-reduction projects reviewed in this article originated at the local level, often promoted by grass-roots advocacy by those directly involved in receiving and providing services.

Addiction and AIDS are problems that are so plagued with stigma and tainted with moral condemnation that individuals who suffer from these problems are often marginalized by society. Unlike other disorders such as cancer or heart disease, in which those who are afflicted or affected have formed powerful lobbying groups and "patient advocacy" societies (e.g., American Cancer Society), it is rare to find parallel advocacy groups in the addictions field. Although the gay community has rallied in support of advocating better prevention (e.g., safe sex programs) and treatment services for those who are HIV positive, the community of IV drug users in the United States has had little or no impact on the provision of services for addicts. There are some indications, however, that something similar to the Dutch "junkiebond" union may be developing in America. An example is the International Coalition for Addict Self-Help, located in New York.[2] This group publishes a newsletter entitled *The Addict Advocate.*

4. Harm reduction promotes low-threshold access to services as an alternative to traditional high-threshold approaches

Street-outreach programs provide an example of the low-threshold approach to harm reduction. Rather than setting abstinence as a high-threshold requirement or precondition for receiving addiction treatment or other assistance, advocates of harm reduction are willing to reduce such barriers, thereby making it easier to "get on board," get involved, and get started. Low-threshold programs do this by several means: by reaching out and achieving partnership and cooperation with the population in need of developing new programs and services, by reducing stigma associated with getting help for these kinds of problems, and by providing an integrative, normalized approach to high-risk substance use and sexual practices.

A second component of low-threshold approaches involves reducing the stigma associated with problems of addiction, substance abuse, and high-risk sexual practices. How can this stigma be reduced? In a recent review of the literature on determinants of help-seeking by individuals with substance use problems, it was found that the primary factor that motivates people to seek treatment or other help is their experience of the problematic consequences or harmful effects of using drugs (e.g., problems in personal health, family and relationship difficulties, financial problems, etc.), rather than identifying "substance abuse" itself as the problem (Marlatt, Tucker, Donovan, & Vuchinich, 1996). By switching the focus to reducing the harm associated with drug use or high-risk sex and away from labeling the problem as one of addiction or deviance, prospective help-seekers are more likely to come "out of the shadow" and seek assistance. On this basis, a higher proportion of the population at risk will become registered in some kind of harm reduction program, as is currently the case in the Netherlands.

The third aspect of a low-threshold approach is the capacity for harm reduction to embrace and consolidate a variety of high-risk behaviors that span substance use and other high-risk behaviors. Drug use is rarely independent of other high-risk behaviors such as unsafe sexual practices, driving under the influence, aggression and violence, attempted suicide, etc. With a common focus on the harm such behaviors cause, rather than on pathologizing or condemning the person who engaged in these same behaviors, doors can be opened that are currently padlocked by stigma and shame. Harm reduction normalizes these high-risk behaviors by placing them in the context of ac-

[2]P.O. Box 20882, Tomkins Square Station, New York, NY 10009.

quired habits, learned behaviors that are strengthened by the influence of powerful reinforcers. Harm reduction defines much drug use, and perhaps certain high-risk sexual activities as well, as maladaptive coping responses rather than as indicators of either physical illness or personal immorality. As defined by the Harm Reduction Coalition, "Harm reduction does not remove a person's primary coping mechanisms until others are in place" (Harm Reduction Coalition, 1995). A comprehensive, low-threshold approach is designed to promote the development of more adaptive coping mechanisms and mechanisms of social support. People's problems are best conceptualized within an integrative, holistic perspective that views drug use and/or high-risk sexual behaviors as interdependent and reciprocally interactive components of one's lifestyle. By adopting a comprehensive response to lifestyle problems that includes substance use, sexual practices, exercise, nutrition, and other personal and interpersonal habits (both helpful and harmful), harm reduction can offer an attractive, low-threshold gateway to welcome anyone who is willing to "come as they are."

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