A History of the Harm Reduction Movement

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Historical Methodology and Theoretical Framework

- History is considered to be a social science (Tuchman, 1994; Tyson, 1995)
  - According to Tuchman: "Any social phenomenon must be understood in its historical context"
- In historical research, time is the primary variable: "…history is the record of events, and of patterns of problems, proceeding through time…" (Elton, 1967, 2002; p. 117).
- Memory, both individual and collective ("social memory" Bentley, 1999, p. 155), is another, although this variable is more often related to biographical and autobiographical, or life, history (Carr, 1986; Cohler, 1994; Smith, 1994).

Historical Methodology and Theoretical Framework

- Concepts of time in the West, until recently, have been "divided" into past, present, and future time (Koselleck, 1985; Lowith, 1949).
- More recently, concepts of pre-modern, modern, and now post-modern time have been articulated (Giddens, 1991; Jameson, 1990).

Historical Methodology and Theoretical Framework

- According to Rosen, “From the postmodern viewpoint, there are no totalizing ‘grand narratives’ that hold true, transcending all cultures across time” (Rosen, 1998, p. 265)

Historical Methodology and Theoretical Framework

- Social constructionist theory emerged in the field of sociology with the publication of The Social Construction of Reality (Berger & Luckman, 1966; Franklin, 1998).
- Social constructionism posits that there is no "objective" reality or truth, but multiple realities and truths that are socially 'engineered,' 'created,' or 'constructed.'

Historical Methodology and Theoretical Framework

As Joan Laird, a social work educator has written,

- "Postmodernists teach us that history itself is a changing narrative, open to endless recasting, that experiences are not 'real' until they are interpreted, given meaning in language; meanings themselves are contextual and intersubjective, co-created in dialogue with others. Knowledge does not develop from 'proven' or empirically-tested theory or hypothesis, it does not reflect an objective truth but is rather a product of social discourse; particular 'knowledges' are seen as social constructions, stories that have been shaped in contexts of relationships or power. Certain knowledges achieve dominance, become accepted as truth, re-creating, then, the contexts of power relationships in which they were crafted (Laird, 1993, p. 4).

Historical Approaches in the U.S. to Address Alcohol/Drug Use

- Creating categories of 'licit' and 'illicit'
  - Most substances that are now illicit were legal at one time: morphine, cocaine, marijuana/cannabis; LSD; Ecstasy
- Locating the problem in the person, not the substance (Solution: Demand reduction; moral theory)
- Locating the problem in the substance, not the person (Solution: Prohibition; Criminal justice model: 'War on drugs'; Supply reduction)
- Harm reduction movement: Locates the problem in the relationship between the person and the substance (drug, set, and setting), which may change over time

Harm Reduction and Health Promotion

- Definition: Harm Reduction is a perspective and a set of practical strategies to reduce the negative consequences of drug use, incorporating a spectrum of strategies from safer use to abstinence.

Harm Reduction Movement: Conceptually Four Phases Implicit and Explicit

- Implicit harm reduction strategies
- 1960's in US: Growing awareness of the health consequences of tobacco and excessive alcohol consumption
- Framed in public health terms as a threat to the health of the community with social costs
- Banning these substances was unrealistic, so new measures were devised to reduce harm

Phase One: Implicit Harm Reduction for Alcohol

- Prevention models (Public Health): “Be Smart, Don’t Start”-type campaigns
- Policy Models
  - Minimum drinking age laws
  - Drunk driving laws
  - Alcohol server training and interventions
  - Restricted sales and taxation
  - Designated driver and van initiatives
  - Bottle labeling: Alcohol content; warnings to pregnant women

Phase One: Implicit Harm Reduction for Nicotine

- 1964: Surgeon General's report linked smoking to cancer and heart disease
- Simplistic public health message: "Don't start; if you already smoke, quit."

Strategies for Addictive Use of Nicotine

- Prevention strategies: reduce recruitment of new smokers (regulate advertising)
- Increase cessation (pubic information; taxation)
- Reduce risks of smoking (“safer cigarettes” such as filters; lower tar and nicotine; “switching” to nicotine enhanced chewing gum)
- Reduce second-hand smoke (environmental policies)

Phase Two: Implicit Harm Reduction 1970's

- Methadone treatment
- Approved for substitution therapy for dependence to opiates
- Used in detox: to alleviate withdrawal symptoms
- Used in MTA models of treatment: Methadone to Abstinence in "short" timeframe (usually 6 months)
- MMTP: Methadone maintenance: Potentially and practically: Lifelong intervention

Six Domains of Psychosocial Functioning

- Social (including family relationships) or recreational
- Physical health
- Mental health
- Spirituality
- Legal or financial
- Vocational (work or school)

Phase Three: Explicit Harm Reduction: Late 1970's –1990's

- Disease prevention model: To reduce transmission (primary or secondary prevention) of blood-borne pathogens such as HIV or Viral Hepatitis
  - 1970's: Drug user organizing in Netherlands to reduce spread of viral Hepatitis B ("Junkie Unions")
  - 80's HIV/AIDS prevention from activists: Needle exchange
  - 1990: Birth of a "Movement" at the First International Conference on the Reduction of Drug Related Harm, Liverpool, UK

Harm Reduction in the U.S.

- 1988 Presentation: “The Mersey Harm-Reduction Model: A Strategy for Dealing with Drug Users,” given by Russell Newcombe and Allan Parry at the International Conference on Drug Policy Reform, Bethesda, Maryland

Principles of Harm Reduction
The Merseyside Model

- HIV is a greater threat than drug use
- Abstinence therefore should not be the only goal, or necessarily the first goal
- Reach out to users and engage them
- Provide innovative services
- Use a multi-disciplinary approach

Harm Reduction in the U.S. Disease Prevention and Social Justice

- Late 1980's: Edith Springer, a trainer from New York, visits UK and the Netherlands and returns to promote harm reduction and create a harm reduction movement through training
- 1988: First above ground needle exchange: Tacoma, Washington
- 1988: Needle exchange in New York City-DOH
- 1993: Harm Reduction Working Group formed; half of whom are people of color who saw harm reduction as a social justice movement

Phase Four: Explicit Harm Reduction 2000's

- Broader applications than disease prevention
- Using behavior change models and motivational enhancements, harm reduction strategies are used in: DV/IPV programs ("safety planning"); dual diagnosis programs (medication adherence); housing programs ("housing first")

Harm Reduction in the U.S. Disease Prevention and Social Justice

- 1994: Harm Reduction Coalition incorporated in San Francisco
- 1995: First Regional Harm Reduction conference held in New York City
- 1996: Oakland and New York offices of HRC opened
- 1996: First National Harm Reduction Conference held in Oakland, CA
- 1998: Bridging the Gap conference held in SF (http://www.harmreduction.org/pubs/news/spring99/garcia.html)

San Francisco's Treatment on Demand Guidelines

- 1. Providers of services for those who misuse or abuse alcohol or other drugs shall deliver care in a culturally competent, nonjudgmental manner which demonstrates respect for individual dignity, personal strength, and self-determination**.**
- 2. Service providers are responsible to the wider community for delivering interventions which will reduce the economic, social, and physical consequences of substance abuse and misuse.
- 3. Because those engaged in active substance use are often difficult to reach through traditional service venues, in order to reduce risk the service continuum must seek creative opportunities and develop new strategies to engage, motivate, and intervene with potential clients.

San Francisco's Treatment on Demand Guidelines

- 4. The goal of substance abuse treatment services is to decrease the short and long term adverse consequences of substance abuse, even for those who continue to use drugs.
- 5. Comprehensive treatments for those who misuse or abuse drugs and/or alcohol must include strategies that reduce harm for those clients who are unable or unwilling to stop using, and for their loved ones.
- 6. Relapse or periods of return to use should not be equated with or conceptualized as "failures of treatment."

San Francisco's Treatment on Demand Guidelines

- 7. Medical services are an important component of comprehensive substance abuse treatment; patients prescribed medications for the treatment of medical and psychiatric conditions, including addiction, must have full access to substance abuse treatment services. Many methadone consumers, patients with serious medical conditions, and dually or triply diagnosed patients are prohibited from accessing services and support from substance abuse treatment programs. As more medications are shown to be effective in treating addictive, physical, and mental conditions, programs must broaden their treatment philosophies in order to provide quality comprehensive care. Patients should never be denied access to, restricted from participation in, or terminated from treatment in a substance abuse program solely on the basis of their use of a medication prescribed for their treatment. Medications include, but are not limited to, methadone, anti-depressants, and psychotropics.
- 8. Each program within a system of comprehensive services will be stronger by working collaboratively with other programs in the system.

Elements of Harm Reduction Programs

- ✓User involvement
- ✓Any positive change
- ✓Supportive agency policy
- ✓Collaborations with other providers

Harm Reduction Movement in the Present

- **2006: Sixth National Harm Reduction Conference to be held in November in Oakland, CA**
- www.harmreduction.org