Position Statement on Harm Reduction in Substance Use Disorder Treatment

Effective Date: 2/6/2012
Date of Approval by Committee: 06/04/2020
Date Updated in Database: 06/08/2020

Harm reduction is a philosophy of public health. Harm reduction policies and programs are part of both prevention programs and an attitude about treatment. The term harm reduction has not been defined by an official body and as a result is used with a variety of different interpretations. The World Health Organization uses the term "harm reduction in the sense of preventing adverse consequences of drug use without setting out primarily to reduce drug consumption."[1] Essentially the harm reduction view of minimizing the consequences associated with use of alcohol, tobacco, or other drugs has led to the development of two applications. One application of the harm reduction philosophy resulted in the development of the secondary prevention programs and initiatives. There are a number of well-established programs and initiatives that have proven to be successful in reducing the health, social, and economic consequences of drug/alcohol use without necessarily reducing drug/alcohol consumption.[2] Examples include needle-exchange programs for IV drug users; designated driver programs; training programs for individuals who serve alcoholic beverages; dispensing free nicotine patches; and methadone buprenorphine maintenance. As secondary prevention these programs are effective and generally accepted as a means of preventing/diminishing health consequences associated with the targeted substances but not necessarily diminishing use of these agents. Behavioral health supports the use of these harm reduction methodology such as methadone or buprenophine maintenance in conjunction with active participation in recovery programs and community support groups.

The second application of these concepts aims to address individuals seeking substance use disorder treatment. Some harm reductionists argue that some people will always engage in high-risk behaviors such as substance abuse. Therefore, rather than abstinence as the goal of substance use disorder treatment, treatment goals are set by the clinician and the patient, with the patient setting the specific goals. This treatment model is predicated on the belief that one can reduce the potential harm associated with substance abuse without attempting to prohibit the behaviors.[3] While harm reduction as used in the first application has been extensively proven as effective as a secondary prevention model, there is no published evidence indicating the use of the second application for individual treatment has any efficacy. The belief that giving the substance abuser the pros and cons of using or abstinence they would then be in a position of making their own decision would appear to be contradictory and at odds with mainstream principles of addiction and its treatment, as well as, the disease model of substance use disorders. Some harm reduction supporters use the success of such programs as methadone maintenance, as a supporting argument of why the same concepts work in individual treatment. Behavioral health does not support the application of harm reduction to individual treatment without any clinical evidence or peer reviewed studies supporting this perspective.

WHO, Expert Committee on Drug Dependence. *WHO Technical Report Series (28th Report).* Geneva, Switzerland: WHO.
Harm Reduction as an Approach to Treatment, Wodak A. *American Society of Addiction Medicine Textbook, 2003;* Chapter 10:533-541.

Additional information:
Schukit M; *Drug and Alcohol Abuse5th ed. 2000;* Chapter 16:355-357.

Galanter M & Kelber H; *APA Press Textbook of Substance Abuse Treatment1997;* Chapter 20: 285-286, 292.