# Harm Reduction:

# A Review of the Literature

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## Introduction

The primary purpose of this literature review is to provide a foundation from the literature to support the use of harm reduction strategies for interventions targeting the following groups at risk for HIV infection: women, African American men, Latino men and men who have sex with men. The thesis guiding this literature review is that while harm reduction grew out of grassroots movements to address the spread of HIV related to drug use, the principles guiding its practice parallel those principles commonly accepted in prevention, public health and behavioral change, as well as in mental health and substance abuse treatment. Points of divergence with standard practice seem to emerge in definitions of the "problem" to be solved and the "successful" intervention. If this thesis proves to be accurate, then harm reduction presents a challenge to policy and practice not in its methodology itself, but in the application of this methodology to drug use and sexual behavior.

A major body of literature related to harm reduction was found that focused almost exclusively on injection drug use and needle exchange. In addition, a good number of articles focused on the history of harm reduction and related policy considerations. Also, within the literature is much discussion that focuses on the perceived or feared impact of harm reduction strategies (especially needle exchange) on drug use and the movement toward the legalization of drug use. Although this debate is vital to the development of policies that will permit successful implementation of harm reduction strategies targeting needle use, it is less helpful in understanding harm reduction within the context of science-based practices and principles. Therefore, in this

review, we have attempted to build a conceptual framework for harm reduction that encompasses components including the social context of harm reduction, its unique understanding of drug use behavior, its principles and strategies, and practices that harm reduction shares with other accepted helping disciplines.

### History of Harm Reduction

Harm reduction can be seen as a set of principles and strategies about human behavior, which when incorporated into a prevention or treatment program, seek to reduce the negative consequences of high-risk behaviors such as alcohol and drug use and unprotected sex. This approach has also been called damage limitation, casualty reduction, harm minimization (Duncan et al., 1994; Des Jarlais, 1995), or risk reduction (Marlatt & Tapert, 1993). It accepts that the nonmedical use of psychoactive drugs is inevitable in any society that has access to such drugs (Des Jarlais, 1995) and stresses understanding that drug use is a complex and multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence (Principles of Harm Reduction, n.d.). Whichever name the strategy is given, harm reduction is concerned with reducing abuse, heavy use and the problems associated with use (Resnicow & Drucker, 1999).

Harm reduction is a developing approach to substance abuse and HIV prevention and treatment interventions that is growing from the need for a conscientious response to substance use other than criminal law enforcement and incarceration (Principles of Harm Reduction, n.d.). Harm reduction operates on a set of principles and assumptions about how individuals make changes (Ostrow, 1996). These principles include recognizing that the desire for change must reside within the individual, that long-term change begins with

small, realistic and attainable steps, and that "low threshold" strategies wherein the individual need not commit to abstinence can be effective in bringing about desired change. Harm reduction also affirms individuals as the primary agents in reducing the harm from their at-risk behavior and establishes the quality of individual and community life and well being, not simply cessation of all high-risk behavior, as the criteria for successful interventions (Principles of Harm Reduction, n.d.). 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)

The responsible use approach to alcohol education that emerged in the early 1970's was one of the earliest applications of a harm reduction strategy (Dolan, 1976, cited in Duncan et al., 1994). Methadone maintenance programs pioneered in the United States in the 1960s were also an early form of this strategy. Beginning in the 1980's, grassroots harm reduction movements began in Amsterdam, Rotterdam and Liverpool in response to pervasive drug-related public health problems resulting from injection drug use (Heather et al., 1993). The first needle exchange program was started in Amsterdam in 1984, prompted by a "Junky Union," a recognized organization of injection drug users (Scavuzzo, 1996). In 1986, needle exchanges also started in the United Kingdom and Sweden (Christensson & Ljungberg, 1991). These movements gradually spread to many other European cities, eventually influencing the policies of several nations (MacCoun et al., 1993) including Canada, New Zealand, Australia, Thailand, Nepal and most European countries. The first American needle exchange was started in Tacoma, WA, in

August 1988 (Marlatt & Tapert, 1993), and by 1990, San Francisco, Seattle, New Haven, Portland, Spokane, Boulder, Honolulu, New York, Berkeley, Fairbanks and a few other cities around the country also offered needle exchange, operated either legally by health departments or clinics or illegally by AIDS activists (Marlatt & Tapert, 1993).

A look at the Australian experience provides a national case study demonstrating that early and vigorous implementation of harm reduction prevention strategies were effective in controlling HIV in injecting drug users (Wodak & Lurie, 1996). A new Australian policy on drug use was adopted in April 1985 and stressed a harm reduction approach that placed more emphasis on health and less on interdiction (Blewett, 1987). A number of countries and organizations have now adopted harm reduction as both policy and practice. The British Advisory Council on the Misuse of Drugs concluded that the spread of HIV is a greater danger to individual and public health than drug misuse (Scavuzzo, 1996). The World Health Organization has stated that attempts to reduce drug use must not compromise measures against the spread of AIDS. In 1987, the Canadian government adopted harm reduction as the framework for Canada's National Drug Strategy.

Kirp and Bayer (1993) and Reuter and MacCoun (1995) both find that with remarkable consistency, the United States government has aggressively resisted harm reduction policies in its approach to the drug problem.

> Our almost exclusive emphasis on use reduction rather than harm reduction probably has many causes. One is the fear that harm reduction is a Trojan horse for the drug legalization movement. Another factor might be that whereas harm reduction focuses on harms to users, drug-related violence and other harms to *nonusers* are more salient in the U.S. than in Europe. (MacCoun, 1998, p. 1200)

MacCoun (1998) believes that 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)

## A Harm Reduction Framework and Approach

One of the challenges in understanding harm reduction is that it does not exist easily within a generally defined category. In fact, harm reduction challenges existing distinctions between prevention and treatment, medicine and public health, use and abuse and healthy and unhealthy behaviors. It appears that harm reduction may be best understood as an ecological approach. Various writers discuss integrating a harm reduction approach at individual, community and/or policy levels. A harm reduction approach can be applied at any of these levels but is not solely linked to any one.

> We envision a prevention strategy that can be built by matching interventions to levels of risk, focusing on policies and communities as well as on individuals, and applying a spectrum of approaches—some preventing the problem from getting started, others preventing progression once the problem has occurred. The emerging harm reduction strategy can provide new energy for a revamping of the delivery system. Harm reduction is a new synthesis, a paradigm to guide action—in a Kuhnian sense, a scientific revolution. (Abrams & Lewis in Marlatt (1998), p.xii)

Although the literature reflects the lack of a clear consensus concerning a definition of harm reduction, certain themes did emerge which appeared to establish common elements that, together, provide a framework for understanding harm reduction. The central components of this framework might be organized in the following manner: 1) overall approach, 2) social context, 3) understanding drug use, 4) nature of interventions, 5) locus of control, 6) definition of the problem, and 7) definition of success.

The first component, above, relates to the *approach* itself. Several writers describe the harm reduction approach as "pragmatic" (Des Jarlais, 1995; Marlatt, 1998).

There is strong emphasis throughout the literature on finding practical solutions to the harmful effects associated with drug use. Reflected in this approach is a desire not to simply eliminate drugs and drug use, but rather to assist individuals in learning how to live safely and healthfully in a world where drug use is a reality. This is much like the way one would not seek to completely eliminate germs in the environment, but would instead learn practical skills needed to live safely and healthfully with bacteria.

A second term commonly used in defining the harm reduction approach is "low-threshold. Such an approach places few if any requirements on the individual seeking support as a condition of receiving services. Marlatt (1998) describes the philosophy of this approach in the following way:

> The supporters of a low-threshold approach are willing to meet the individual on his or her own terms—to "meet you where you are" rather than "where you should be." Input from members of the targeted population is encouraged and promoted, in an attempt to forge a partnership or alliance between those providing services and those receiving them (even when both groups consist of active users). New programs are developed in collaboration with those directly involved and affected. (p. 55)

A third term reflected in the literature is "non-judgmental." As described in the literature, a harm reduction approach does not impose judgment upon the individual nor individual behavior itself, but seeks to understand the harm associated with the behavior and to reduce that harm. Clatts, et al. (2000), describe the principle public health goal of harm reduction as:

> . . . one of providing risk-reduction choices rather than of seeking to impose a uniform code of behavior or using access to service-related resources as a condition for access to care. (p. 11)

There appears to be general agreement in the literature on understanding the *social context* component of harm reduction. Primary among these elements is the acceptance as fact that some individuals will continue to engage in high-risk behaviors

despite efforts to eradicate the behavior (Duncan, et al., 1994). Several writers describe non-medical drug use as inevitable (Des Jarlais, 1995; Principles of Harm Reduction, n.d.), with social and individual harm as the unavoidable result (Des Jarlais, 1995; Resnicow & Drucker, 1999).

> Harm reduction accepts, for better and for worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them. (Principles of Harm Reduction, n.d., p. 1)

Harm reduction strategies thus seek to reduce the potential harms related to a behavior rather than to require total abstinence from the behavior itself (Duncan et al., 1994; Resnicow & Drucker, 1999). An emphasis exists on modifying the behavior of at-risk individuals and the conditions in which they engage in the high-risk behaviors in order to reduce potential harm to public health and safety (MacCoun, 1998). In the area of HIV prevention, interventions designed to assist an individual to deal with the complexity of human decision-making and behavior in sexual negotiation when he/she is under the influence of alcohol or drugs would be an example of a strategy aimed at reducing potential harms to the health of individuals in the community.

Although there are strong differences of opinion concerning the legalization of drugs and drug use, common *understandings of drug use* behavior appear throughout the literature (Des Jarlais, 1995; Marlatt, 1998). Most notable is a consistent distinction that is made between drug use and abuse, i.e., use of drugs does not in and of itself constitute abuse (Resnicow & Drucker, 1999). It is cautioned, however, that the harm reduction approach, "Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use" (Scavuzzo, 1996). There also clearly exists a commonly expressed perspective that "understands drug use as a complex, multi-faceted

phenomenon that encompasses a continuum of behaviors 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., p.1)

A harm reduction model for prevention and treatment of such behaviors as drug and alcohol use and high-risk sexual behavior places these behaviors on a continuum ranging from serious abuse to abstinence (Marlatt & Tapert, 1993). The goal of harm reduction strategies is to move the individual along the continuum toward abstinence, thereby reducing the harmful consequences of the behavior. The continuum model accepts abstinence as the ideal risk-reduction strategy; however, any movement in the right direction along this continuum is seen as progress, even if total abstinence is not attained (Marlatt & Tapert, 1993).

Many of the principles guiding harm reduction *interventions* described in the literature are not significantly different from accepted practice in prevention, behavioral change, and mental health and substance abuse treatment. These shared principles include:

> Respecting the individual's right to self-determination. A strong emphasis is placed on personal choice and responsibility and on effective self-management.
>
> Maintaining the dignity and rights of the individual.
>
> Affirming that the individual is the primary agent in reducing the harm from his/her at-risk behavior.
>
> Considering that individuals are the best source for the description of their problem, and they should be empowered to join with service providers to determine the best interventions for those problems.
>
> Believing that intervening at an early stage of a problem is preferable to waiting until the individual has hit "rock bottom."
>
> Beginning interventions "where the person is" and identifying a hierarchy of goals, with the immediate focus on addressing the most pressing needs.
>
> Emphasizing positive peer support.

Removing programmatic and individual barriers which limit individuals' access to needed services.

The harm reduction approach, however, goes on to expand upon these shared principles by accepting that:

The drug user's decision to use drugs is his or her choice. No moralistic judgment is made either to condemn or to support the use of drugs, regardless of the level of use or mode of intake. The extent of a person's drug use is of secondary importance to the harms resulting from use (Riley & O'Hare, 2000).

The quality of individual and community life and well being, not simply the cessation of all high-risk behavior, is the criteria for successful interventions (Principles of Harm Reduction, n.d.). Each client is considered to be the best judge of the success of interventions for his/her problem.

Substance use behavior can be placed on a continuum ranging from serious abuse to abstinence (Marlatt & Tapert, 1993). Abstinence may be the desired state, however, any movement in the right direction along this continuum is seen as progress.

The decision to become active or to remain abstinent can be informed by a discussion of the relative pros and cons of each choice (Marlatt, 2000)

Movement toward reduced use or abstinence is acceptable in small, immediate and realistic steps. Interventions can take place without the client being completely abstinent for a defined period of time.

Educational services and treatment interventions should be provided to people who use drugs and the communities in which they live in a non-judgmental and non-coercive manner as a way to reduce the attendant harm of drug use.

Education is the key to the prevention and minimization of harms related to high-risk drug use and sexual behavior. Educational programs should include input from participants in program design, encourage active discussion throughout, and exchange information on an interpersonal basis, avoiding "lectures" by experts (Marlatt, 2000).

Since drug use produces individual and social harms through many and varied mechanisms, a wide range of interventions may be needed to address these harms.

Harm reduction strategies include enhancing awareness of high-risk behaviors and their consequences (both helpful and harmful), training in coping skills to deal effectively with high-risk situations involving drugs or sex, and facilitating health-promoting and risk-reducing behaviors (Marlatt, 2000).

The realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people's vulnerability to, and capacity for, effectively dealing with drug-related harm. (Principles of Harm Reduction, n.d.).

A common perspective in the harm reduction literature relates to the *locus of control* for interventions and services. Consistently throughout harm reduction strategies,

the locus of control resides with the *user.* This is clearly stated in the Harm Reduction Coalition's *Principles of Harm Reduction* (n.d.):

> [Harm reduction] affirms drug users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies which meet their actual conditions of use." (p. 1).

This concept is reflected also throughout the writings of others (Toumbourou & Hamilton, 1994; Scavuzzo, 1996; Martlatt, 1998). Emphasis is placed upon peer support, education and user empowerment in decisions related to individual's drug use and in the provision of services. Educational efforts also support the locus of control residing within the individual. "Education requires an open dialogue with the young and respect for individuals' rights to make their own decisions" (Scavuzzo, 1996, p. 11).

Perhaps the clearest distinction between harm reduction as it is represented in the literature and other approaches to working with drug users is in its *definition of the problem* and its *definition of success.* Throughout the literature, there is an emphasis on harm associated with behavior rather than on the behavior itself.

> "Supporters of harm reduction shift 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." (Marlatt, 1998, p. 50).

It is commonly understood from a harm reduction perspective, that a difference exists between use and abuse and that some forms of use are more harmful than others. Thus, the definition of the "problem" is based on the harm related to use behavior as perceived by the user him/herself. This approach to problem definition differs from standard substance abuse treatment practice and highlights a distinguishing characteristic of the harm reduction approach.

Just as harm reduction's problem definition distinguishes it from other approaches, so, too, does its definition of success differ from other approaches to substance abuse treatment. Whereas substance abuse treatment has the goal of elimination of all drug use, harm reduction seeks, instead, to initially stabilize the client's problem behavior and prevent further exacerbation of harmful consequences, and then to encourage education of harmful consequences (Marlatt, 1998.) As its name implies, the harm reduction has as its goal to minimize the negative consequences of problem behaviors rather than to eliminate the behaviors themselves.

### Harm Reduction and Principles of Prevention

Although the literature does not specifically address the relationship between harm reduction and the evidenced-based guiding principles emerging out of the field of substance abuse prevention, it appears that there exists much common ground between the principles guiding these two approaches. This may be an uncomfortable comparison for some because there are clear differences in understanding between the use of substances and the goals of prevention. Certainly there are strong disagreements concerning the use of drugs, the goal of interventions, and the focus on abstinence verses the focus on harms associated with use. Yet, there are clear similarities in how each approach seeks to work with its target populations:

> Each approach sees itself as rooted within public health, and each seeks to reduce the harmful impact of substance use on individuals, families, and communities.
>
> Each approach affirms the importance of knowing the target population(s) and being sensitive to the needs and motivations of the individuals within those populations.
>
> Each approach recognizes the importance of families and peers in supporting behavior change.

> Each approach affirms that interventions should provide information that is accurate, relevant, credible, culturally appropriate, age appropriate and sensitive to individuals' needs and motivations.
>
> Each approach stresses the importance of interactive approaches that are peer led and that promote the development of new skills.
>
> Each approach sees the importance of multi-modal efforts with a variety of strategies.
>
> Finally, both approaches emphasize the importance of intervening early and often to address the harmful effects of high-risk behaviors.

No doubt there will be challenges from each approach that we have distorted critical principles of their understanding, yet the invitation is for each approach to seek to understand where the differences lay and where, in fact, they share principles but disagree on the appropriateness of extending these principles to a particular population (i.e., drug users).

It appears from a review of the literature that the differences between harm reduction approaches and other standard approaches to behavioral change are not found in the principles that guide methodology. The practice of harm reduction is grounded in accepted methods. Its difference lays in the application of its methods to drug using populations and in its goal of reducing harm rather than eliminating use.

After reviewing the harm reduction literature, one is left with the question, "What is it about drug use *per se* that precludes the application of commonly accepted practice as a strategy for reducing risk for the spread of HIV?" It would seem that the debate concerning harm reduction should shift from questioning the methodology of harm reduction to exploring what is the perceived uniqueness of drug use and/or the drug using population that precludes the application of commonly accepted practice in the arenas of prevention, public health, and behavioral change.

### Harm Reduction and Change Theories

Through this literature search, it was found that established and research-based change theories support the principles of harm reduction. Although harm reduction might be seen as “a new paradigm in the field of drug education,”(Duncan, et al., 1994), in fact, its principles and practices have grown from cognitive behavioral theories (Marlatt & Tapert, 1993), the public health model (Toumbourou & Hamilton, 1994), the stages and process of change (DiClemmenti, 1999) and, rational-emotive theory (Tripmey, 1992, cited in Marlatt & Tapert, 1993) as well as secondary and tertiary prevention strategies. Taking the common themes and assumptions of harm reduction practices and principles and viewing them under the umbrella of what we know “works” or has been effective, the literature supports that the above-mentioned theories and intervention modalities readily inform principles of harm reduction.

Based on Rationale Emotive Therapy, self-help groups are cost-effective, have their roots in the public health model, are peer lead, and provide more choices for low cost harm reduction strategies. “Most self-help groups have emerged out of the experience of people directly affected by the problem they are trying to address,” (Toumbouro & Hamilton, 1994). This direct experience lends credibility to the messenger in self-help venues. The major divergence in the exchange between harm reduction and self-help is that individuals who have had problems with alcohol and continue to actively use alcohol are not welcome in a self-help environment, such as Alcoholics Anonymous. In a self-help group, the individual must have “hit rock bottom” and thus be ready to change (i.e., total abstinence from alcohol), while in a harm reduction approach, the individual is encouraged to make small changes so that he/she doesn’t hit rock bottom (Toumbouro & Hamilton, 1994). To reconcile these divergent

philosophies, Toumbouro & Hamilton (1994) advocate that as self-help groups continue to develop and be refined through changing community expectations, these groups should do so in line with harm reduction principles. Figure 1 depicts the philosophical differences between harm reduction and self-help approaches.

*Figure 1: Philosophical differences between harm reduction and self-help approaches*

| Philosophy | Harm Reduction | Self-Help/Treatment |
|---|---|---|
| Valid Knowledge (Epistemological roots) | Objective/research | Subjective/Experience |
| Intervention Source | Professionals | Mutual Support |
| Intervention Timing | Earlier intervention | "Hit bottom" (12-step) |
| Nature of interventions | | |
| Spirituality | Not mentioned | Central |
| Treatment Goals | Problem oriented. Might include Controlled use | Abstinence |
| Relapse | Expectancies/relapse Prevention | "Powerlessness"/Loss of control (12-step) |

From Toumbouro & Hamilton, 1994, p.152.

Another important theme stressed in the harm reduction literature is the concept of meeting the client "where the client is." For a harm reduction program to be successful and have the greatest impact, it must operate using a "low–threshold" philosophy. A low threshold philosophy does not require the client to make a commitment to abstinence or drug testing as a requirement to participate in the program.

All that is required of the client is a willingness to show up and, it is hoped, to begin taking steps in the direction of reducing harm associated with his/her behavior (Marlatt and Tapert, 1993).

The premise of the low threshold philosophy and corresponding program design is seen in DiClimmenti and Prochaska's (1998) work on the stages of change. The "stages of change" recognize the motivational, temporal and the developmental nature of the process of change. The stages of change theory also incorporates the basic tenant of harm reduction, requiring that interventions start where the client is:

> Individuals move from Precontemplation (not considering initiaiting change or changing a behavior) to Contemplation (seriously considering using or stopping) to Preparation (committed to planning) to Action (performing the actual behavior) to Maintenance (sustaining the behavior change over time). (DiClimenti, 1999, p. 478)

Often, program design, as evidenced in some self-help groups, requires that clients begin at the preparation stage. This leaves out a large segment of potential clientele because the threshold is too high. To further support low-threshold access, MacCoun (1998), a leading researcher in harm reduction, states that, "Whenever feasible, harm reduction interventions should be coupled with credible primary and secondary prevention efforts as well as low threshold to treatment." (p. 1207)

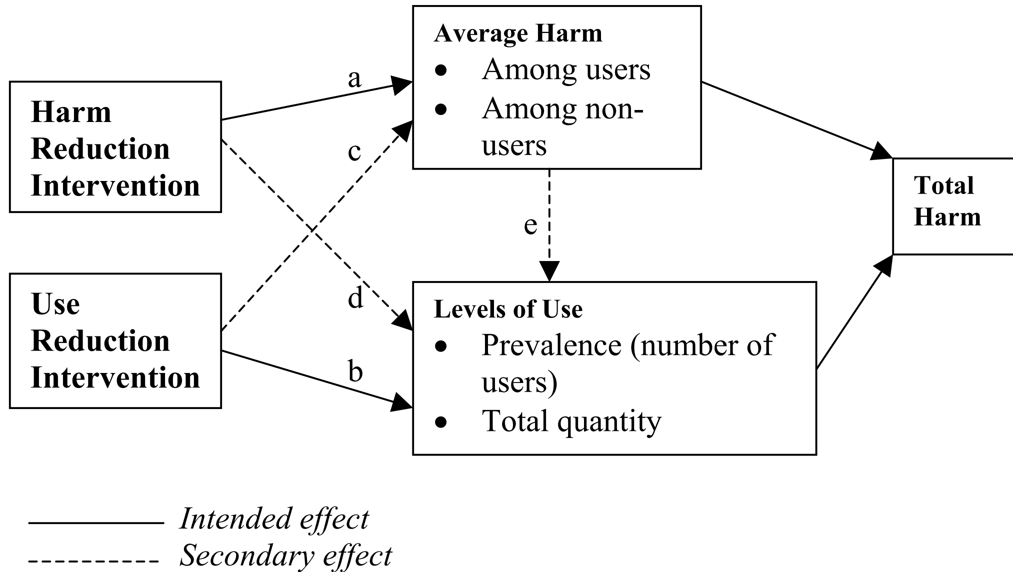
DiClimmenti (1999) emphasizes in his stages of change theory, that harm reduction and recovery are not incompatible. In fact, these two goals can be synergistic when properly done. DiClimmenti further states that:

> In fact, assisting an individual to reduce associated potential harm can be a motivational intervention in its own right. Harm-reduction programs should be designed using current information and research results to assist in walking the narrow line between removing harm and avoiding any inadvertent enabling of the continued addiction. Harm reduction and recovery are not incompatible. (p. 482)

MacCoun (1998) has begun to look at a truism that is often overlooked in the harm reduction debate: *Total Harm = Average Harm per Use x Total Use.* To explain this equation further, Total Use is defined as the number of users and the quantity that each user consumes. Average Harm per Use is a function of two vectors of specific drug related harms, one involving harms to users (e.g., overdoses, addiction, AIDS) and the other involving harm to non-users (e.g., HIV transmission, criminal victimization) (Rueter & MacCoun, 1995; MacCoun & Caulkins, 1996).

The central argument from critics of harm reduction is that harm reduction actually promotes drug use, sexual behavior, and other risky behaviors. MacCoun (1998) frames this argument in a different way. He states that harm reduction policies and use reduction policies can work synergistically. Using the equation *Total Harm = Average Harm per Use x Total Use*, Figure 2 depicts the relationship between harm reduction policies and use reduction policies.

Figure 2:
*Use Reduction and Harm Reduction: An Integrative Framework*




From Nadleman, 1989, in MacCoun, 1998, p 1202.

Links *a* and *b* depict the intended effects of harm reduction and use reduction policies, respectively. Links *c, d* and *e* depict the ancillary harmful effects – unintended and often unanticipated – these policies might have. For example, link *c* denotes the unintended harms caused by prohibiting a risky behavior (e.g., the lack of clean needles, availability of condoms, income generating crime, etc.) However, MacCoun (1998) focuses also on a second set of unintended consequences, those resulting from harm reduction policies, to determine whether objections to harm reduction have merit: If harm reduction strategies reduce the harm per incident but lead to increased drug use or sexual practice (links *d* and *e*) the policy still might achieve *net* harm reduction.

Given the gray areas between harm reduction and use reduction, effective substance abuse (as well as prevention of risky sexual behavior) should, at the minimum, present a hierarchy of risk. Scavuzzo (1996) recommends that harm reduction, "establish a hierarchy of goals, with the more immediate and realistic ones to be achieved as first steps toward risk-free use or, if appropriate, abstinence." (p. 5). This approach must be supported by messages couched in a rational decision-making framework rather than in abstinence only, moralistic or punitive terms (Resnicow & Drucker, 1999), with the goal being not to eradicate all risky behavior but to eradicate the negative consequences of behavior. As such, harm reduction approaches work to empower rather than marginalize high-risk groups if relapse should occur (Marlatt & Tapert, 1993).

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