Harm Reduction as a Practice and Prevention Model for Social Work

Mark O. Bigler

Harm reduction is an emerging prevention and practice model for helping professionals that views any positive change in undesired, problematic, or risky target behaviors as a successful outcome. Although it originated in the field of chemical dependency, the philosophy and strategies of harm reduction are pertinent to a wide variety of complex social welfare and public health issues. The harm reduction approach seems ideally suited as a guide to practice in virtually all social work settings and reflects fundamental values and beliefs of the social work profession including the inherent worth and dignity of individuals, client self-determination, and the strengths perspective. In addition, harm reduction is applicable at the micro-, mezzo-, and macrolevels of practice. This article introduces readers to the basic tenets of harm reduction and discusses the application of this model to social work practice. The author concludes by arguing for the integration of harm reduction into the undergraduate social work curriculum.

Key words: *harm reduction, prevention, social work education, social work practice*

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The preamble to the National Association of Social Worker's (NASW) Code of Ethics notes that the primary mission of the social work profession is to "enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty" (NASW, 1999, p. 1). Similarly, the Council on Social Work Education (CSWE), in the preamble to its Educational

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Policy and Accreditation Standards, states that ". . . social work practice promotes human well-being by strengthening opportunities, resources, and capacities of people in their environments and by creating policies and services to correct conditions that limit human rights and the quality of life" (CSWE, 2001, p. 3). In an earlier document, CSWE outlined a set of core values of social work as a profession: (a) social workers' professional relationships are built on regard for individuals' worth and dignity and are advanced by mutual participation, acceptance, confidentiality, honesty, and responsible handling of conflict; (b) social workers respect the individual's right to make independent decisions to participate actively in the helping process; (c) social workers are committed to assisting client systems to obtain needed resources; (d) social workers strive to make social institutions more humane and responsive to human needs; and (e) social workers demonstrate respect for and acceptance of the unique characteristics of diverse populations (CSWE, 1995).

As key trainers, socializers, and mentors of new professionals, social work educators have an obligation to instill these ideals in the minds of their students. It is not surprising, therefore, that these definitions of social work and the set of values that underlie professional practice are discussed in many of the textbooks found in both undergraduate and graduate social work programs. Such beliefs are not only the essence of social work's unique identity, they are also a framework for the mission and practice of the profession. Each statement of definition, value, and belief reaffirms social work's commitment to social justice and the responsibility of all practitioners to advocate for those who are most vulnerable or at risk.

The professional identity, values, and beliefs that guide social work practice are rooted in a rich history. From its very beginning, social work has dealt with many of the nation's most significant and challenging social, psychological, and public health problems. Since the early days of charity organization societies and settlement houses, the professional activities of social workers have focused on behavior change within the context of the social environment and the reduction of risk in day-to-day living to physical health, social functioning, and mental and emotional well-being (Popple & Leighninger, 2002; Zastrow, 2003). With the popularity of Freudian theory in the early twentieth century, social work set aside its distinctive person-in-environment philosophy from the 1920s to the early 1960s in favor of the medical model (Hepworth, Rooney, & Larsen, 2002; Zastrow, 2003, 2004). In recent years, however, there have been renewed efforts within the profession to address the complexities of modern social problems by supplanting the medical model with an ecological/systems model of human behavior (Burke & Clapp, 1997; McLaughlin, 2002; Weick, 1983; Zastrow, 2003, 2004). This approach to understanding human behavior and addressing social problems has been widely and enthusiastically embraced by social work educators and practitioners because it is consistent with the profession's historical origins and it reflects fundamental social work ideals including regard for human dignity and worth, self-determination, and the strengths perspective.

More recently, many within the profession have called for a shift in the paradigms that define and guide social work practice in an effort to more effectively address the diverse and dynamic populations and problems that social workers regularly encounter in the course of their professional activities today (Schriver, 2001). As the demographic composition of the United States has changed and social concerns have evolved, alternative models have emerged and theories have been proposed that attempt to account in professional practice for the unique experiences and resulting realities of individuals and groups that make up the clientele of social workers (Brammer, 2004; Devore & Schlesinger, 1998; Fong & Furuto, 2001; Lum, 2004). Increasingly, emphasis has shifted away from generic models to approaches that are more population and problem specific (Delgado, 1998; Fong & Furuto, 2001; Lecca, Quervalu, Nunes, & Gonzales, 1998; Lum, 2004; Morales & Sheafor, 2001; Shernoff, 1996).

Despite these efforts to improve services by considering alternative paradigms and models, in practice social workers often rely on traditional, medical-model thinking that emphasizes pathology over individual strengths and personal resources. When client concerns are reduced to diagnostic labels, human problems can be oversimplified and very complex issues may be approached from an all-or-nothing perspective. The reliance on models of practice that seek global change in target behaviors and the total elimination of risk (often referred to as abstinence-only in the subspecialties of addictions and sexuality) have resulted in interventions that are frequently based more on traditional paradigmatic expectations than on real-life outcomes. As a result, social workers often employ intervention strategies that are limited in their impact on target behaviors, frustrating both the client and the practitioner. Furthermore, prevention and treatment efforts that follow standard paradigms and theoretical formats often lack the creativity necessary to bring about desired changes in risky or unhealthy behavior.

Common practice decisions can be traced back to the programs that prepare social work professionals. Despite the call for social work to consider alternative paradigms and efforts to replace medical model thinking with a more ecological/systems orientation, training in methods of practice still includes significant content in traditional models and worldviews (Sheafor & Horejsi, 2003; Zastrow, 2003). Unfortunately, those most directly affected by reliance on these models are those who are entering their field ill-equipped to deal effectively with the dynamic and evolving social problems of today. As Devore and Schlesinger (1998) have noted: "Considerable work remains to be done in clarifying the relationships between what is known and believed about human behavior, the cause of problems, and the way in which social work uses that knowledge" (p. 129).

In this article it is argued that the harm reduction model, known primarily for its application in the area of substance abuse, reflects the most fundamental and cherished ideals of social work and provides an ideal framework for social work practice in a wide variety of settings. As such, harm reduction as a goal, a

philosophy, and an approach to practice should be a fully integrated component of social work education.

Harm Reduction

Nowhere have the limitations of traditional practice models been more apparent than in programs targeting drug addiction and the social and physical harms associated with drug use. While drug abuse is not a new phenomenon in the United States, the causes and effects of drug use have received increased attention and debate in recent years (Brems, Fisher, & Queen, 1998; Slobada, 2002; Wish & O'Neil, 1991). This attention seems quite appropriate as findings from numerous studies have linked drug use with such physical and social concerns as family disruption, gang involvement, criminal activity, violent behavior, overdoses, abscesses, HIV/AIDS, and hepatitis (Amato & Rogers, 1997; Datt & Feinmann, 1990; Diaz, des Jarlais, & Vlahov, 2001; Jenson & Howard, 1998; Lopez-Zetina, Kerndt, & Ford, 2001; Pennings, Leccese, & de Wolff, 2002; Sirpal, 2002; Warner-Smith, Darke, & Day, 2002; Wekerle & Wall, 2002; Yoder, Whitbeck, & Hoyt, 2003). Over the past 20 years, public and private entities have responded to this growing concern by making significant investments of time, money, and other resources to stop drug use and reduce drug-related harm (Network of Reform Groups, 1999). For example, at a recent conference on youth, drugs, and crime sponsored by the Hoover Institution at Stanford University, Joseph McNamara was quoted as saying, "In 1972, when President Nixon suggested a 'war on drugs,' the federal budget [for anti-drug measures] was $101 million. In the year 2000, the drug control budget will be $17.8 billion. If Social Security benefits had increased at the same rate, current monthly payments would be $30,444" (Hoover Institution, 2000). Similarly, Brocato and Wagner (2003) noted that, after adjusting for inflation, federal spending on drug control had increased tenfold from 1985 to 2000.

For more than a quarter of a century, U.S. drug policy has been driven by this militaristic philosophy, relying heavily on law enforcement, supply reduction, and, to a lesser degree, treatment and prevention services. Yet, after nearly three decades of a war-on-drugs strategy, certain realities remain: an upward trend in drug use among virtually every age group; a steady supply, decreased cost, and increased purity of street drugs; mounting emergency room visits and deaths from overdose and drug use-related diseases such as HIV/AIDS and hepatitis; and continued drug-related crime (Alter et al., 1999; Centers for Disease Control and Prevention, 1997; Garfein & Vlahov, 1996; HIV/AIDS Surveillance Program, 1998; Holmberg, 1996; National Drug Control Policy, 1999; National Institute on Drug Abuse, 1999; Network of Reform Groups, 1999; Office of National Drug Control Policy, 1999; Oxman et al., 2000; Snyder, 2000; Wagner, 2000). In fact, McNeece (2003) argues: ". . . the current federal policy for combatting drug use, endorsed by most state and local governments, has not only failed, but has exacerbated the problem" (p. 193). The limited impact that

the current national drug control strategy has on drug use and drug-related harm, despite significant investments of time, money, and other resources, has prompted a careful re-evaluation of this strategy and calls for innovative, creative, and perhaps even radical thinking about alternative paradigms to the all-or-nothing models that guide current efforts.

Harm reduction is a prevention and practice model that has emerged from the chemical dependency field in response to rising dissatisfaction with abstinence and prohibition efforts along with a growing epidemic of HIV/AIDS and hepatitis infections related to needle sharing among injection drug users (Burke & Clapp, 1997; Canadian Center on Substance Abuse, 1996; Castro & Foy, 2002; Inciardi & Harrison, 2000b; McNeece, 2003). In more recent years, the harm reduction model has gained a great deal of attention and support outside of the addictions arena in other areas of health and human services (Castro & Foy, 2002; Riley & O'Hare, 2000), though most major publications on the subject remain focused on drug-related harm (e.g., Erickson, 1997; Inciardi & Harrison, 2000a; Marlatt, 1998).

Although there appears to be no definitive definition of harm reduction (Canadian Centre on Substance Abuse National Working Group on Policy, 1996; Castro & Foy, 2002; Hilton, Thompson, Moore-Dempsey, & Janzen, 2001; Hunt et al., 2003; Inciardi & Harrison, 2000b; International Harm Reduction Association, n.d.; Riley & O'Hare, 2000; Single, 2000; Wieloch, 2002), most who are familiar with the concept agree that the overriding guiding principle is "reducing the harm associated with specific high-risk behavior" (Castro & Foy, 2002, p. 89). This central theme emphasizing the reduction of negative consequences of risky or problematic behaivor has been reiterated in definitions of harm reduction provided by major national and international health groups including the American Medical Association and the World Health Organization (American Medical Association, 1997; World Health Organization, 2004).

In contrast to programs, practices, and policies based on behavioral models that seek to eliminate risk altogether, the focus of harm reduction strategies is to maximize options that can be used to minimize the potential harm that results from risky behaviors in a person's life (American Medical Association, 1997; Burke & Clapp, 1997; Reid, 2002). Harm reduction is a model and set of strategies which assumes that risky activities vary greatly in their degree of potential harm (Castro & Foy, 2002; Harm Reduction Coalition, 2001). Harm-reduction-based interventions address both the range and the depth of harm through a combination of practical direct services and long-term humanitarian goals (International Harm Reduction Association, n.d.). The model recognizes that harm is multidimensional and accepts the reality that almost all behavior poses some degree of risk to the individual and/or to society as a whole (Castro & Foy, 2002; des Jarlais, 1995; Harm Reduction Coalition, 2001; Hilton, Thompson, Moore-Dempsey, & Janzen, 2001; Inciardi & Harrison, 2000b; McNeece, 2003; Reid, 2002). Furthermore, advocates of the model recognize that some people may be unwilling or perhaps unable to eliminate risks entirely (Canadian Centre on

Substance Abuse, 1996; des Jarlais, 1995). Therefore, programs based on harm-reduction principles encourage incremental behavior change toward safer behavior and view any positive change in undesired, problematic, or risky target behaviors as a successful educational and/or therapeutic outcome (Brocato & Wagner, 1997; Canadian Centre on Substance Abuse, 1996). In order to achieve these goals, the harm reduction model promotes non–punitive responses where mutual support and accountability exist between individuals and the communities in which they live (Brocato & Wagner, 1997; Reid, 2002). Simultaneously, harm-reduction approaches encourage individuals to be competent and responsible in their entire lives (Brocato & Wagner, 1997).

The essence of harm reduction has five primary principles: (a) pragmatism, doing what works; (b) humanistic values, respecting the dignity and rights of the person, regardless of the nature of the risk-taking behavior; (c) focus on harms, giving greatest attention to decreasing the negative consequences of a given behavior to self, others, or the broader society, rather than putting all effort into eliminating the problematic behavior itself; (d) balancing costs and benefits, determining whether the cost of an approach is warranted compared to some other intervention or to no intervention at all; and (e) hierarchy of goals, prioritizing goals and engaging a person to address the most pressing needs first (Riley & O'Hare, 2000).

Harm Reduction and Social Work

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. In recent years, such strategies have been expanding into many fields and issues, including safer sexual behavior, violence prevention, criminal justice, psychology, sociology, medicine, and education (Hilton, Thompson, Moore-Dempsey, & Janzen, 2001; Krebs, 2002; Laws, 1999; MacCoun, 1998; Weitzer, 1999). In an increasingly complex world, harm reduction is proving to be a simple, yet powerful alternative model for professional practice.

In a recent discussion of social work and drug treatment, Zelvin and Davis (2001) noted that the traditional values of social work clearly support the use of harm reduction strategies in professional practice. Brocato and Wagner (2003) echoed this sentiment, suggesting that "harm reduction has been conceptualized as a peace movement and is aligned with the humanistic values around which social work is organized" (p. 117). Winkelstein (2001) suggests that most social workers practice harm reduction every day, even though they may not recognize their actions as such or call them by this name.

Ironically, while fundamental principles of harm reduction reflect many of

the same values and ethical beliefs espoused by the social work profession, the model is given little, if any, mention in standard texts on social work methods and remains virtually unknown in undergraduate and graduate social work programs. Despite its simplicity, broad applicability, and congruence with key tenets of the profession, harm reduction plays only a minor role in the professional preparation of future social workers.

The remaining discussion in this article addresses the specific relationship between social work values and methods and the harm reduction model. The author also considers the application of harm reduction in various practice settings and attempts to build a case for the explicit inclusion of this perspective in the academic training of future social work professionals.

Levels of Practice

In his introductory text on generalist social work, Zastrow (2004) suggests that social workers deliver services at the micro-, mezzo-, and macrolevels of practice. Harm-reduction strategies can be applied by social workers at each of these levels: one-on-one with an individual, with families and other groups, or with communities, organizations, and/or social policies. For example, at the microlevel, a clinician working with a homeless client can help the individual develop more effective street survival skills, such as how to find food and shelter as the weather turns colder. Castro and Foy (2002), discussing the application of harm reduction to college health, noted how the integration of this model at the mezzolevel would enhance health promotion efforts in this environment: "In addition to the basic health information we currently provide peer educators, we could easily teach them harm-reduction strategies. By training peer health educators in harm-reduction principles and strategies, we strengthen the messages that we give and also increase the credibility of the medium" (p. 91). At the macrolevel, a social worker applying the harm reduction model to practice might follow the example of Margo St. James, founder of COYOTE (Call Off Your Old Tired Ethics), and assist a group of street sex workers to use their collective voice to address law enforcement efforts that unintentionally result in unprotected sexual activity and the possibility of disease transmission (Pheterson, 1989).

Regard for Individual Worth

In their day-to-day professional activities, social workers often deal with the most marginalized members of society such as ethnic minorities, people who are homeless, the chronically mentally ill, chemically dependent individuals, convicted criminals, and sexual minorities (i.e., lesbian, gay, bisexual, and transgendered individuals). Social workers are expected to approach their work with members of such disenfranchised groups, many of whom are considered throwaway people by mainstream America, based on regard for the individual worth and dignity of each person (Hepworth, Rooney, & Larsen, 2002). Furthermore,

relationships between professional social workers and those they serve are supposed to be built on honesty, acceptance, and mutual participation in problem solving (National Association of Social Workers, 1996). As Reid (2002) stated: ". . . it is the practitioner's role to minimize the harmful effects of [risky] behavior rather than ignore or condemn the individual" (p. 224). Such humanistic values, and the belief that the dignity and rights of the client, whomever that might be, must be respected and are also a central feature of harm reduction (Riley & O'Hare, 2000). Personhood stands above moral judgments regarding risky or socially negative behaviors. The worker keeps her/his own values in perspective and seeks humane solutions to difficult and perhaps even personally challenging problems. A person is not left to suffer simply because the experience, the disease, or the harm is a natural consequence of her/his own behavioral choices. For example, social workers engaged in prevention efforts for an AIDS services organization (ASO) are concerned about the possibility of HIV/AIDS transmission through anonymous sexual encounters between men in public environments such as parks, rest stops, and restrooms. The group engages in a concentrated HIV/AIDS prevention education campaign, distributes condoms and other safe sex materials during busy afternoon and weekend hours, offers free HIV-antibody testing at a local male-only gym, and enlists a public sex participant (i.e., an individual who seeks anonymous sexual partners in public environments such as restrooms, "cruising" areas, rest stops, etc.) as a research assistant to conduct structured interviews with other men as part of a qualitative study of such activity. Although the continuation of this behavior may not be the most desirable outcome, these strategies would be considered acceptable alternatives to strict, abstinence-only philosophies that often drive traditional public health approaches. Such traditional approaches seem to prefer to let men who participate in public sex with other men die from HIV/AIDS rather than offer more immediate and workable solutions to the negative outcomes that may result from this type of sexual activity (Segovia-Tadehara, Bigler, Ferguson, & Diarte, 2003). From both a social work and a harm-reduction perspective, the quality of individual and community life and well-being should be used as criteria for successful interventions and policies rather than the expectation that all undesirable behavior will cease and risk will be eliminated altogether.

Self-determination

It is a common social work adage that the professional begins where the client is. According to CSWE (1995), this means that whatever the worker wants to do with a client is informed by the client's own wants, needs, and perspectives, and is most appropriately accomplished collaboratively with a client. Problem solving is not something that social workers do for their clients, but rather a process that actively involves the person and respects the individual's right to make independent decisions (Sheafor & Horejsi, 2003). Likewise, harm-reduction strategies involve clients in the selection of clinical goals and in the creation and im-

plementation of programs and policies that are designed to serve them. "Harm reduction measures do not ascribe to a specific formula, but should reflect specific individual and community needs. Therefore, practitioners should always be conscious of starting 'where the client is' during the course of the therapeutic process" (Reid, 2002, p. 223). In fact, it is the client her/himself who is seen as the primary agent of change and the reduction of harm associated with whatever the problem behavior might be. A sexually active teen, for example, likely has more insight regarding adolescent sexuality and the risk of unintended pregnancy than the formally trained social worker does, and her participation and input should be a part of any intervention, program, or policy developed to reduce harms associated with teenage sex. Not only does involving clients in this process tap into an opinion that is seldom sought out by helping professionals, it also makes an important statement concerning the worker's belief in the innate capacity of each person to change and to grow given the opportunity to do so. Being a collaborator rather than an expert when working with a client is a key to empowering individuals and groups that have often been disempowered at every turn, often by helping professionals themselves (Johnson & Yanca, 2001).

Obtaining Needed Resources

Social workers are committed to assisting client systems to obtain needed resources (Zastrow, 2004). Yet the programs offered by many health or social service agencies, although well-intentioned, are often out of reach of the very populations they are intended to serve. The harm-reduction model is built on the understanding that excessive behavior occurs along a continuum of risk, ranging from minimal to extreme, and recognizes the complex, multifaceted nature of risk (Harm Reduction Coalition, 2001). Interventions and programs that are grounded in harm-reduction principles approach behavior change as a stepwise process and recognize that sobriety, abstinence, or no risk is simply not realistic for some (Brocato & Wagner, 2003). As a result, harm-reduction programs typically provide a wide range of services often under one roof (Reid, 2002).

An argument that is often raised by opponents of syringe exchange programs, which have stood as the embodiment of the harm-reduction model for more than a decade, is that by putting sterile injection equipment in the hands of drug users, one is actually perpetuating the drug use and giving the user another reason not to seek treatment for his/her chemical dependency. In reality, however, exchange programs, which frequently take their intervention to the streets where the client is most likely to be, not only deliver clean needles, but also serve as an initial point of contact between users and service providers. In addition, syringe exchange programs are often run by volunteers with backgrounds in nursing, public health, and social work who offer counseling related to health and mental health issues and provide referrals to individuals who might otherwise be unlikely to seek out such assistance on their own (Hunt et al., 2003; Riley & O'Hare, 2000).

Social Justice

Social workers value social institutions that are humane and responsive to human needs (Council on Social Work Education, 2001; Morales & Sheafor, 2001). Ironically, social service professionals are often quite impersonal service providers and can seem unaware of the basic human needs of their clients. In their role as planners and policy developers, social workers create and advocate for policies, practices, and programs that empower individuals and promote social and economic justice. As a part of this same professional role, social workers seek to change or eliminate policies, practices, and programs that are ineffective, inappropriate, or harmful to members of society, particularly those who have historically been oppressed and marginalized and do not have a strong enough voice of their own to make needed change occur. Harm reduction espouses a similar value (Brocato & Wagner, 2003).

Increasingly, ineffective drug policies and programs are being challenged and changed. The war-on-drugs approach to reducing drug-related harm has produced little positive change after nearly three decades. Social activists in the United States are now looking to other nations such as Switzerland, Great Britain, Australia, and Canada, where drug policies are more harm-reduction-based and where efforts to reduce the harms associated with drug use (e.g., overdoses, HIV/AIDS, hepatitis, crime, violence, family disruption) have produced more positive results (Klingemann, 1996; Lindesmith Center, 1998; Uchtenhagen, 1997).

Similar concerns have been voiced about the treatment of sex offenders. A growing number of helping professionals are applying the harm-reduction model to this population, which is often even more vilified and marginalized than drug users, and represents perhaps an even greater challenge for some to the professional value of social justice. These theorists and clinicians argue that harm reduction, and its social justice ideals, can provide a more useful framework for the management of sex offenders than do traditional treatment protocols (Hudson, Ward, & Laws, 2000; Laws, 1996, 1999; Stoner & George, 2000). Laws (1996, 1999), for example, contends that a harm-reduction-based relapse management approach in dealing with sex offenders is more humane, realistic, and ultimately more effective. Referring to clinical practice with this client population, Laws (1996) has stated:

> The domain of treatment is an imperfect one and we should openly acknowledge that. The treatment outcome data have been giving us this message for a number of years. In so doing, we must also acknowledge that all lapses and relapses to sexual offending cannot be prevented and that, perhaps, a harm reduction approach might better fit the reality of repeated sexual offending. (p. 246)

A harm-reduction-based approach to sexual aggression recognizes a continuum of offending behavior from excessive to moderate to abstinence and takes

the perspective of behavioral management rather than treatment. The goal is not solely to eliminate sexual aggression, but to move the client along this continuum away from excess toward less harmful behavior.

In working with sex offenders, harm reduction offers social workers an alternative to traditional treatment paradigms that is consistent with the professional value of social justice. Hudson, Ward, and Laws (2000) noted that, "Harm reduction is based on the principles of compassionate pragmatism rather than moralistic idealism" (p. 512). They further contend that "a public health approach [i.e. harm reduction] is, simply stated, a healthier way of dealing with our faulted and troublesome fellow humans. We do not deny the need to make society safer. We deny the necessity of using punishment to do it" (p. 511). In contrast to the punitive, abstinence-only models that characterize many sex offender treatment programs today, a harm-reduction-based approach appears to be more humane and responsive to client needs, and may, as Laws (1996, 1999) and others have noted, prove to be more effective in limiting the impact of sexual aggression (Hudson, Ward, & Laws, 2000; Stoner & George, 2000). In this challenging arena of professional practice, harm reduction offers social workers and other service providers an opportunity to achieve the ideal of social justice by promoting more effective management of sex offender behavior.

Respect for Diverse Populations

Social workers are taught the value of demonstrating respect for and acceptance of the unique characteristics of diverse populations (Council on Social Work Education, 2001; Devore & Schlesinger, 1996; Fong & Furuto, 2001; Lum, 2003, 2004; Morales & Sheafor, 2001). One cultural perspective is not viewed as superior to another. Alternative paradigms based in the diversity of the human experience are said to be given equal attention in the academic and workplace settings from which professional social workers emerge (Schriver, 2001). Like social work, harm reduction recognizes that poverty, social class, racism, homophobia, sex-based discrimination, and other social inequalities affect people's vulnerability and their capacity to deal effectively with the risks inherent in daily life (Canadian Centre on Substance Abuse, 1996; Castro & Foy, 2002). Oppression and discrimination are social forces that enhance the risks to health and well-being. Inciardi and Harrison (2000b) stated: "Less privileged people with fewer options are more vulnerable to deviant adaptations because of their lack of access to more conventional ones" (p. xvi). Women, people of color, and sexual minorities represent a significant portion of social work clients and those who stand to benefit from harm-reduction interventions.

Strengths Perspective

Over the past several decades, social work has integrated the strengths perspective as a core element of social work practice (Popple & Leighninger, 2002).

"In the strengths perspective the worker moves from looking at deficits to looking at abilities and assets. This approach recognizes the importance of empowerment, resilience, healing, and wholeness in working with people" (Johnson & Yanca, 2001, p. 13). In addition to looking for strengths over pathologies, social workers are taught to assist clients in identifying and accessing strengths and resources both within themselves and in their communities (Zastrow, 2003). According to Saleebey (2002), one of the original proponents of the strengths perspective, this philosophy of social work practice includes six guiding assumptions: 1) every individual, group, family, and community has strengths; 2) trauma and abuse, illness and struggle may be injurious but they may also be sources of challenge and opportunity; 3) assume that you do not know the upper limits of the capacity to grow and change and take individual, group, and community aspirations seriously; 4) we best serve clients by collaborating with them; 5) every environment is full of resources; and 6) caring, caretaking, and context (pp. 13–18).

Likewise, the harm-reduction model focuses on individual, group, and community strengths. The worker pays greater attention to the resourcefulness and survival skills of a homeless client than to her/his unusual behavior or unkempt appearance and, in the process, uncovers individual strengths that can assist in meeting her/his most immediate needs. A call to a suicide crisis line is seen as a strength and is used as the basis upon which a survival contract is established to carry the caller through until the risk of self-injury can be addressed more thoroughly. The harm-reductionist social worker focuses on the resiliency of a child who has been in numerous foster homes over several years and considers this strength as an important factor in working out future placements. The hospice worker collaborates with the caretaker of a terminally ill family member who declines respite services. Instead of taking a break away from the home, the worker and caretaker arrange for a respite volunteer to take over briefly for occasional periods of in-home time out. In each case, strength is emphasized over weakness, opportunity for growth is sought in even the most dire of circumstances, the capacity of the client to grow is accepted as a boundless given, collaboration is the standard mode of operation, every environment is seen as having its own set of resources, and compassion is the worker's driving force.

Conclusion

Many social workers are finding that traditional models of practice, which tend to view global change in target behaviors as the only acceptable outcome, are often impractical, inefficient, and ineffective. Social workers understand that many of today's problems require new and innovative thinking. Unfortunately, these insights are often gained at the frontline level where workers seem to apply harm reduction principles and strategies in their work almost intuitively because this model is so consistent with their core personal and professional beliefs.

Strangely, the academic programs that train these professionals are generally lagging behind, and still prefer to teach traditional models that are outdated. Despite its obvious application to professional practice, harm reduction receives little, if any, attention in academic settings where new generations of social workers are trained. As a result, newly graduated social workers are leaving the relative safety of the academic environment and are finding themselves ill-prepared to meet the demands of real-world practice.

The marriage of social work as a professional discipline and harm reduction as a model to guide practice is a natural one, with the potential for a long and productive relationship. Academic social work programs have a responsibility to equip young professionals with the tools needed to meet the challenges they will confront as they enter practice in an increasingly complex world. Including harm reduction as a central theme in the training of social workers would greatly strengthen the curriculum at both the undergraduate and graduate level and prepare prospective social workers to practice in a more rational, pragmatic, and humanistic way.

It is time for social work to put its professional values into practice. The harm-reduction model stands ready to turn principles into action. Faculty and academic administrators must now take the next step and begin to create ways to integrate harm reduction across the social work curriculum.

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