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ORIGINAL ARTICLE

Harm Reduction and 12 Steps: Complementary, Oppositional, or Something In-Between?

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***Background*: Initially born of the desire to prevent the transmission of HIV among injection drug users, harm reduction presents a relatively new option for assisting individuals who struggle with drug and alcohol use. Twelve-step programs such as Alcoholics Anonymous (AA) are widely recognized as being a representative example of abstinence-based treatment and are often seen as oppositional to harm reduction. *Methods*: The purpose of this study is to examine the ways in which harm reduction workers interpret the relationship between harm reduction and 12-step approaches to treatment. The study draws upon qualitative interviews with 18 staff members from two harm reduction-based substance use treatment programs.[1] *Results*: Two central themes emerge from the qualitative data: (1) harm reduction and 12-step approaches can be complementary; and (2) 12-step approaches in high-threshold treatment settings may differ significantly from their original philosophy and intent. A third, much less prominent theme reflects some respondents' skepticism about the capacity of the two approaches to work together given the resistance to harm reduction by some in the 12-step community. *Conclusion*: Complementary conceptualizations of harm reduction and 12-step approaches have the potential to broaden the range of options available to people experiencing substance use problems.**

Keywords harm reduction, 12 steps, substance use treatment, integrative treatment

INTRODUCTION

Harm reduction is a public health approach to substance use and other high-risk behaviors that seeks, as its name implies, to reduce harms associated with substance use. Riley et al. (1999) describe that harm reduction "places first priority on reducing the negative consequences of drug use rather than on eliminating drug use or ensuring abstinence" (p. 10). As a result, services informed by harm reduction provide assistance to people with drug-use-related problems even if they continue to use substances. Noting prevailing conceptual fuzziness regarding harm reduction, Riley et al. (1999) report that practitioners who employ abstinence-based approaches sometimes consider their work to be harm reduction. While many social interventions contain some element of reducing harm, harm reduction practices not only seek harm reduction as a goal, but also employ harm reduction as a strategy. As an intervention strategy, harm reduction is considered "a policy or program directed toward decreasing the adverse health, social, and economic consequences of drug use without requiring abstinence from drug use" (Riley et al., 1999, p. 21). While this approach can include abstinence, harm reduction services are generally low-threshold in that abstinence is not required to obtain services and multiple barriers to service access

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[1]Treatment can be briefly and usefully defined as a planned, goal-directed, temporally structured change process of necessary quality, appropriateness, and conditions (endogenous and exogenous), which is *bounded* (culture, place, time, etc.) and can be categorized into professional-based, tradition-based, mutual help-based (AA, Narcotics Anonymous [NA], etc.) and self-help ("natural recovery") models. There are no unique models or techniques used with substance users—of whatever types and heterogeneities—which are not also used with nonsubstance users. In the West, with the relatively new ideology of "harm reduction" and the even newer Quality of Life (QOL) treatment-driven model, there are now a new set of goals in addition to those derived from/associated with the older tradition of abstinence-driven models. Treatment is implemented in a range of environments, including ambulatory settings and within institutions that have controlled environments. Editor's note.

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are removed. Removing barriers to service access can include providing services through street-based outreach and private offices, meeting people "'where [they are]' rather than 'where [they] should be,"' striving to reduce stigma, encouraging collaborative participation of service users, and framing drug use as a coping strategy that has become problematic, rather than as an illness (Marlatt, 1998, pp. 54–56). Abstinence requirements—given their high-threshold nature—conflict with low-threshold services made available by harm reduction programs (Marlatt, 1996).

The 12-Step Approach to Treatment

The origin of the 12 steps lies in Alcoholics Anonymous (AA) founded in 1935. AA conceptualizes alcoholism as a disease. It draws upon the study and practice of the 12 steps and participation in peer-based fellowship and sponsorship to facilitate sobriety. AA membership is open to anyone who wants to stop drinking (Alcoholics Anonymous World Services, 2001). In addition to offering general fellowship and sponsorship to members, it connects members through regularly scheduled, peer-facilitated meetings. AA's nonprofessional and self-supported meetings are structured around "closed" meetings for people who want to stop drinking and "open" meetings that anyone can attend (Nace, 2005).

The 12 steps of AA involve a largely spiritual pathway to recovery (Mahoney, Engstrom, & Marsh, 2006; Miller & Hester, 1995; Miller & Kurtz, 1994). The 12 steps include acknowledging one's powerlessness over alcohol, engaging in a healing relationship with God as understood by each individual, making amends to people who may have been harmed by one's alcohol-use-related problems, heightening self-awareness, accepting responsibility for errors, and sharing the 12-step message with others experiencing alcohol-use-related problems (Alcoholics Anonymous, 2008). AA's 12 steps have been adapted by numerous groups, including Narcotics Anonymous and Overeaters Anonymous, and have been widely incorporated into professional treatment. Findings from the National Treatment Center Study suggest that the 12 steps are the primary orientation of 59.7% of publicly funded substance use treatment programs (Roman & Johnson, 2004a) and 75.6% of those that are privately funded (Roman & Johnson, 2004b). However, while other programs may draw primarily upon cognitive-behavioral or eclectic approaches, most incorporate the 12 steps as an aspect of their programs, suggesting that the presence of the 12 steps in treatment centers across the United States is much higher than 60%–75%. It is important to note that there is great variation in the ways in which service providers utilize the 12 steps in their professional practice with clients. Research with doctoral-level experts in a disease model approach, for example, demonstrated differential ranking of key ingredients in 12-step-oriented treatment, e.g., greater attention to addressing denial and affiliating with AA and less attention to spiritual aspects of AA (Humphreys et al., 2004; Morgenstern & McCrady, 1993).

The Relationship Between Harm Reduction and the 12 Steps

Since harm reduction's emergence in the 1980s, it is sometimes seen to be "at odds" with traditional paradigms and approaches that prioritize abstinence as the treatment goal (Kellogg, 2003; Mahoney et al., 2006; Zelvin & Davis, 2001). While the original language and philosophy of AA promotes inclusion of everyone with a desire to stop drinking and does not preclude the possibility of moderate alcohol consumption for some people who have experienced problems with drinking, 12-step and disease-based approaches generally prioritize abstinence as the goal, and often as a condition, of treatment (Novak, 1996; Miller & Kurtz, 1994). Harm reduction's pragmatic approach to goal-setting regarding substance use (e.g., recognizing that any positive change is beneficial; Marlatt, 1998) is frequently pitted against abstinence-based approaches (McVinney, 2006). As described by McLellan (2003), this controversial positioning has yielded "more heat than light," and has generally involved the compilation of teams that speak mainly to those on their side (p. 239). However, a growing body of literature addresses the integration and compatibility of harm reduction and abstinence-based approaches (Denning, 2001; Futterman, Lorente, & Silverman, 2004; Housenbold Seiger, 2004; Kellogg, 2003; Marlatt, Blume, & Parks, 2001; Zweben, 2000). Pratt (2003) suggests that many individuals involved in the harm reduction movement are simultaneously involved in 12-step programs, a natural occurrence given the alignment between the two: AA's only requirement for membership is a *desire* to stop drinking. Such overlapping involvements counter the myth that the two models operate in a mutually exclusive way. Similarly, Miller and Kurtz (1994) note that the dispositional disease model which privileges abstinence as the only acceptable outcome of treatment is not endorsed by AA. The authors highlight that AA literature does not insist on abstinence for all people with a drinking problem. Further, AA literature does not rule out the possibility of controlled drinking for some. They add that ". . . more than any other reality born in modern times, Alcoholics Anonymous has become the proverbial elephant described by unsighted examiners" (p. 165), suggesting that numerous ideas attributed to AA may in fact be inaccurate or misconstrued.

Critiques of harm reduction address several intersecting, and at times misperceived, elements of the approach. In particular, critiques include perceptions that harm reduction is opposed to abstinence, that it "enables" increased substance use, that it advocates drug legalization, that it "sends the wrong message" regarding drug use, that it does not reach for the potential of people who use substances, and that it fosters stagnation (Futterman et al., 2004; Kellogg, 2003; Mancini, Linhorst, Broderick, & Bayliff, 2008, p. 384; Marlatt et al., 2001). Further, there are very real ethical issues with which providers of all types struggle over in the course of their work

with people who use substances. Imani Woods (1998) has written about her transformation from an outspoken opponent to a firm supporter of needle exchange, one particularly well-known harm reduction intervention. She highlights the responses in some African American communities where harm reduction has been seen as "making peace with genocide," giving up on people, and reflecting public health abuses African Americans have historically experienced. After witnessing the effectiveness of harm reduction outreach efforts, she now views harm reduction as an approach that can "'break the fall' into self-destruction," meaning that it can reduce harms and minimize further destruction, rather than signify resignation about one's potential for change (1998, p. 305).

Harm reduction advocates assert that harm reduction and its "compassionate pragmatism" provide an important public health alternative to moral and disease models of substance use (Marlatt, 1998, p. 56; Tatarsky, 2003). Cited advantages of harm reduction include its:

- public health attention to multifaceted programs and policies that can reduce harms associated with substance use;
- focus on meeting people "where they are at," which involves identifying client-driven, individualized goals;
- openness to abstinence as a goal, while recognizing that (1) this goal may not be the goal of all clients, (2) an emphasis on abstinence as a goal may prevent people from seeking and remaining in services, (3) positive changes regarding substance use are valuable, (4) addressing substance use may be just one part of helping clients make positive changes in their lives, and (5) improved individual and community well-being are important indicators of effective programs and policies;
- provision of low-threshold services that reduce obstacles to seeking services;
- emphasis on the importance of the helping relationship;
- recognition of substance use as coping strategy that has become problematic and the importance of strengthening alternative coping mechanisms;
- explicit consideration of the ways in which social injustice and trauma contribute to people's substance use and need to be addressed in efforts to reduce harms related to substance use;
- investment in "bottom-up" approaches that emerge from grassroots efforts, particularly those that include people who use substances; and
- efforts to destigmatize substance use and substance users (Harm Reduction Coalition, http://www.harmreduction.org/article.php?list=type&type=62; Mancini, Linhorst et al., 2008; Marlatt, 1998; Rotgers, 1996; Tatarsky, 2002, 2003).

Further, a growing body of research suggests that harm reduction strategies, such as needle exchange, motivational interviewing approaches, cognitive-behavioral relapse prevention, and behavioral self-control training (BSCT), yield positive gains for people who use substances. Such positive gains include needle exchange's effect on reduced HIV transmission among people who use injection drugs (Gibson, Flynn, & Perales, 2001); motivational interviewing's positive effect on treatment adherence, substance use, and abstinence among people experiencing a range of substance use problems (Miller, Yahne, & Tonigan, 2003); relapse prevention's capacity to minimize the negative consequences of a return to use following a period of abstinence (Larimer, Palmer, & Marlatt, 1999; Weingardt & Marlatt, 1998); and BSCT's role in reducing alcohol use and enhancing sobriety among people experiencing problematic alcohol use (Miller & Page, 1991; Saladin & Santa Ana, 2004; Walters, 2000).

In addition to philosophical and practical differences, efforts to bridge harm reduction and 12-step approaches are challenged by variations in their implementation across settings. Given that there is no universal definition of harm reduction and that there is a wide spectrum of harm reduction programs, there is some confusion regarding the definitions and aims of such programs (Mancini, Linhorst et al., 2008). According to Kellogg (2003), harm reduction goals are situated on a continuum that includes "staying alive," "maintaining health," and "getting better." The goals and associated interventions target different populations (p. 241). While it can be argued that strengths of harm reduction include flexibility and capacity to individualize goals and strategies to achieve them (Harm Reduction Coalition, http://www.harmreduction.org/article.php?list=type&type=62), these strengths yield variation in practices that may make it difficult for various stakeholders to define, implement, and assess harm reduction approaches.

Similarly, 12-step approaches, as originally conceived by the founders of AA, may vary in their application in treatment settings. For example, according to Narcotics Anonymous (NA; 2008), "[T]radition Three says that the only requirement for NA membership is a desire to stop using. There are no exceptions to this. Desire itself establishes membership; nothing else matters, not even abstinence. It is up to the individual, no one else, to determine membership. Therefore, someone who is using and who has a desire to stop using, can be a member of NA" (http://web.na.org/?ID = bulletins-bull29). Membership does not require abstinence. Abstinence requirements in 12-step programs contradict the spirit of this tradition, which is aligned with harm reduction strategies except in the expectation that the person has to desire to stop using. An expectation of desiring abstinence runs contrary to low-threshold aspects of harm reduction strategies, which serve people regardless of their desire for abstinence. While it may not be readily apparent, AA's Big Book includes multiple references to ideas that are highly compatible with and even reflective of certain harm reduction principles: "attraction rather than promotion" [AAWS (Alcoholics Anonymous World Services), 2001, p. 562]; the pursuit of "... progress not ... perfection" (AAWS, 2001, p. 80); the recognition that change occurs "sometimes quickly, sometimes slowly" (AAWS, 2001, p. 84); allowing the individual to "draw his own conclusion"

regarding the definition of his/her problem (AAWS, 2001, p. 92); setting the table by "laying out the kit of spiritual tools for inspection" (AAWS, 2001, pp. 94–95); encouraging individuals to try other approaches (including moderation) before committing to the 12 steps (AAWS, 2001, pp. 32–33); and acknowledging that AA "surely [has] no monopoly" on therapy (AAWS, 2001, p. xxi). Similarly, often-heard statements at AA meetings, including the validation that "there are many roads to recovery," and the encouragement to "keep coming back," reflect the spirit of individualized options, inclusion, and continued engagement, which frequently characterizes harm reduction. The complicated relationship between harm reduction and the 12 steps warrants further examination to strengthen understanding of the ways in which these approaches are considered and implemented in practice. Additionally, further examination may support greater availability of a full range of treatment options, particularly when clients desire an integration of the two approaches.

Despite significant controversy, prior literature suggests that harm reduction and abstinence-based, 12-step approaches can be compatible (Denning, 2001; Futterman et al., 2004; Kellogg, 2003; Mancini, Linhorst et al., 2008; Marlatt et al., 2001; McVinney, 2003; Zelvin & Davis, 2001; Zweben, 2000); however, little is known about the ways in which service providers understand the relationship between these two approaches. This study aims to address this gap in knowledge by exploring this topic with service providers working in two harm reduction-based programs.

METHODS

The current analyses are drawn from a larger study that investigated individual qualitative outcomes of participation in two harm reduction programs. The study included 18 staff member respondents.

Site One

The first program, located in the western United States, provided fee-for-service psychotherapy with adults experiencing substance use problems. In this program, six of nine (66.7%) staff members were interviewed. All staff interviewed at this site held master's degrees and were working as therapists. As displayed in Table 1, participants were predominantly female (83.3%), had an average age of 38.8 (standard deviation [*SD*] = 5.9; age information for one staff participant was missing), and included four White respondents and two respondents from other racial groups.

Site Two

The second program, located in the midwestern United States, was a grant-funded, drop-in center designed to provide intensive case management services with adults experiencing substance use problems and homelessness. In this program, 12 of 15 total staff members (80.0%) were interviewed. Educational training of the drop-in center staff ranged from high school to graduate degrees. The drop-in center staff held direct service, supervisory, and administrative positions. As displayed in Table 1, the staff participants were 41.7% female. The average age was 40.7 (*SD* = 11.8; ages for five staff participants were missing). Staff included eight White participants, three Black participants, and one participant from another racial group.

TABLE 1. Age, race and gender of participants

	Site 1 ($n = 6$)	Site 2 ($n = 12$)	Combined ($N = 18$)
Mean age in years (*SD*)	38.8 (5.9)[a]	40.7 (11.8)[b]	39.9 (9.5)[c]
	n (%)	*n* (%)	*n* (%)
Race			
Black	0	3 (25.0)	3 (16.7)
White	4 (66.7)	8 (66.7)	12 (66.7)
Other[d]	2 (33.3)	1 (8.3)	3 (16.7)[e]
Gender			
Female	5 (83.3)	5 (41.7)	10 (55.6)

[a]Missing data for one participant.
[b]Missing data for five participants.
[c]Missing data for six participants across both sites.
[d]Race coded as "other" to protect confidentiality of participants.
[e]Sum of percentages exceeds 100 due to rounding.

Staff members were notified of the study by the clinical supervisor or executive director of the agencies and informed that the researcher would be contacting them to ask for their voluntary participation in the study (i.e., approached in person at the community-based drop-in center and contacted by phone at the private practice center).

Each staff member participated in semi-structured interviews which included questions about defining harm reduction, determining success in harm reduction, the mission of the organization, desired outcomes for clients, perceived impact of services, unintended consequences of services, and descriptions of clients served. The interviews included explicit attention to provider perspectives regarding the relationship between harm reduction and 12-step approaches. The study procedures were approved by the institutional review board at the University of Illinois at Urbana-Champaign and by the study sites.

The study employed principles of grounded theory (Strauss & Corbin, 1998) to analyze the qualitative data from these interviews, which were digitally recorded and transcribed. The current analysis involved extracting interview responses to the question asked of staff members: "How do you view harm reduction programs in relation to 12-step programs?" Both open and axial coding procedures were conducted to identify salient themes and relationships between them (Corbin & Strauss, 2008).

FINDINGS

Three central themes regarding the relationship between harm reduction and 12-step approaches emerged from the qualitative data analysis. The predominant theme to emerge was that many providers view the relationship

between harm reduction and 12-step programs as complementary, in that the only requirement for AA membership is the desire to stop drinking. This finding ties into a second theme wherein providers discussed ways in which many treatment centers have taken 12 steps to mean abstinence-only, which was not necessarily the intent of the founders of AA. The final, least pervasive theme to emerge from some staff members was the understanding that the two approaches can theoretically work together, but with skepticism about it in practice. This skepticism related to the belief that while harm reduction is an "umbrella" approach that can involve a range of approaches, including 12 steps, 12-step approaches were seen as less inclusive.

Theme One: 12 Steps and Harm Reduction as Complementary

Many staff members perceived 12-step approaches—as conceived by the founders of AA—to be highly compatible with harm reduction, even among participants who draw primarily upon the 12 steps in addressing their own substance use. As one respondent described, AA is about "come as you are," "progress not perfection," "exclusive of none, inclusive to all," and where "everyone needs a seat at the table." Referring to the 12 steps in their origin, he describes their harm reductionist nature when he says the following:

> . . . as developed by the founders of AA and NA, absolutely—entirely harm reduction . . . they're very much about "come as you are" . . . "attraction not promotion." What they do is they talk about "here's what we have to offer," you know, "if you're interested, come check it out, if you're not, that's cool, it's okay." I also know that they talk about "progress not perfection." That sounds like incremental change to me . . . so walk into any AA or NA meeting and, I know it varies, but to me, there's a lot of harm reduction going on in there . . . the only requirement for membership [in AA or NA] is the desire to stop using.

Another staff member further articulates the "hand-in-hand" relationship that he believes the two models can potentially have:

> The relationship between harm reduction and twelve steps—they go in hand in hand, they meet, they do meet. Because twelve steps state that the only requirement for membership is the desire [to stop drinking or using drugs], it doesn't say an individual has to be abstinent and . . . I try to emphasize to them that treatment facilities are not twelve steps . . . I think there's a lot of confusion with all these treatment centers popping up and thinking that they're AA or NA or CA, and they're not . . . we don't throw people out [in our harm reduction program] for any reason . . . so I think that if a person's goal is abstinence or not, twelve steps go hand in hand with that because our model is just "keep coming back" and most of the time . . . when someone has a relapse or something and they come [here] . . . they are treated with compassion.

Another staff member describes the relationship between the two and dispels the stereotype that practitioners who are committed to abstinence in their own recovery cannot also be committed to harm reduction:

> I'm convinced they can work together. I'm convinced. . .I'm a CADC, I follow the twelve step program, and I am very committed to abstinence. I'm also committed to the process of human change and personally, in my observation of others, it's a slow, awkward process that has its ups and downs, its back and forth, and what harm reduction does is simply create space for the twelve steps or other programs to be effective so that it [sobriety] can be the ultimate goal for many people.

In speaking about the clients with whom she works who are interested in 12-step work in the context of the harm reduction program in which they participate, another staff member describes the following:

> Out of the people that I see, I would say about maybe 1/3 are interested [in twelve step work], but some of them do it once in a while even though it ends up being kind of a painful process for them for many reasons, but mostly what I hear from them is that, "I go and I feel like I'm doing really well and I benefit from the community aspect of it [of twelve step meetings] and the support and the contact with other people."

While most respondents spoke of the possibility of a natural compatibility between the two models, one male staff member spoke of his personal history of 12-step recovery, saying that coming to understand and accept harm reduction was initially a "hard pill to swallow." Although he was heavily invested in an abstinence-only approach early in his career, his viewpoint shifted in a professional development training during which a trainer stated that "dead addicts can't recover." Relatedly, it was noted that 12-step approaches were impossible to avoid given their perceived pathway to sobriety, which is a goal of many clients engaged in harm reduction programs.

Theme Two: Distinction Between the 12 Steps in Origin and the "Co-Optation" of the 12 Steps in Treatment Centers

In clarifying the distinction between the 12 steps in their origin and their adaptation in formalized treatment programs, there is an unfortunate attitude of "either do exactly what we say you do or pack your stuff and move" as described by one staff member. This approach was characterized as a "brutal form of harm reduction." Another staff member described the abstinence-only requirement of the majority of treatment programs as an ideology wherein "you have to be cured before you can get treatment" and, one where, "when you most need it [treatment], you can't get it" (i.e., in cases of relapse). In spite of negative attitudes toward 12-step approaches reported by many participants, according to one staff member, the 12 steps topics group held at the agency was well attended. This high level of participation speaks to the fact that it is not necessarily the 12-step model that participants harbor negative feelings toward, but rather the highly selective service delivery model that they have encountered. When reflecting on his past experience as a staff member in an abstinence-only treatment setting, one staff member expressed doubt that long-term abstinence rates are any higher in traditional settings where the overarching goal is abstinence,

than at the drop-in center where "successful" outcomes are defined more flexibly.

Provider conceptions regarding the coexistence of harm reduction and 12-step programs show potential for their integration to meet complex client needs, but some staff members were skeptical about the feasibility of such integration. One female staff member stated that she saw harm reduction as an approach allowing for a continuum of outcomes, but that 12-step approaches did not allow the same. For another, they were viewed as two separate schools of thought with harm reduction being much more "open." Another staff member stated that she believes the two can work together, but that there is still much "resistance from the twelve step community" and that the relationship is a "work in progress." Another staff member spoke about his initial anti-12-step sentiments, stating that it came from a misunderstanding of the approach. He now says that he chooses not to view them in relation to each other, but rather to embrace harm reduction as an umbrella that covers everything, including the 12 steps. He further states:

> . . . so I don't see them as opposed, mutually exclusive. I see abstinence as very much a part of the harm reduction continuum and I see the twelve steps in their "true spirit," not how they've been co-opted by the treatment community, certainly as something as a buffet table of options.

To further illustrate the disparity between the way in which the 12-step approach has been translated into service delivery and its original intent, this staff member says the following:

> [The] principles of Alcoholics Anonymous, the way they are often practiced, the way they've been co-opted by treatment centers, is very much against the traditions of the program [in that the requirement for membership is the desire to stop using, not abstinence].

While there was convergence in themes between staff members from each site, staff members in the private practice setting did express slightly more skepticism about the potential for integration between the two approaches.

For example, one staff member expressed that while many of her clients benefit from the community aspect of 12-step meetings, they are often shamed in the event of relapse. She typically works with clients to tailor treatment for the individual, drawing upon components of both models.

Another staff member described the harm reduction continuum by stating that reducing harm lies at one end and abstinence lies at the other end; however, she made the point that, "If you truly look at harms, sometimes even abstinence can be harmful in some ways to folks." For many of the highly marginalized, homeless adults with whom she works, removing a coping mechanism (i.e., substance use) without offering a replacement which is tolerable to the individual may place one at risk for self-destructive behavior greater than the use of substances. Another staff member described 12-step approaches as paternalistic, which works well for some people, but expressed that "harm reduction is about saving everybody," developing intrinsic rather than extrinsic motivation for change, and viewing relapse as a natural part of the change process. The next staff member described how she engages the two approaches with clients who desire it:

> [Clients] have worked with me to kind of, I guess, tailor their recovery around what works for them about the twelve step model and looking at what doesn't and how to kind of make it work for them and sort of personalize and pick and choose, take some things from harm reduction, some things from twelve steps and kind of meld them together. And I feel like because I've had that experience personally, I'm really good at helping people do that. And as long as people don't get real stuck in a lot of twelve step speak or complete rejection of abstinence altogether in any way, then I'm able to kind of go there with them without a problem.

It is perhaps the belief that the 12-step approach in its origin has been greatly misunderstood that gives way to the third theme. In this theme, some staff members expressed that while they understand that the two models are not necessarily antithetical, they doubt the feasibility of complementarity in practice.

Theme Three: Perceptions of Resistance to the Complementary Relationship Between Harm Reduction and 12-Step Approaches

As illustrated above, many staff members express a high degree of support for the ability to integrate 12-step and harm reduction approaches; however, there was an additional set of responses that reflected perceived challenges to their integration. One staff member expressed this sentiment by saying:

> I understand that . . . they can fit together, but I think I've encountered some difficulties 'cause . . . there's just a lot of resistance from the twelve step community. We've even seen it in our staff here who come from a traditional twelve step background, that it's sort of, you need that shift in thinking, even though they can fit together so well. I think that it's just, it's still a work in progress to get them to actually work together better, because I think the twelve step model can really work for some people, but then there's some people that it's just not really something that's going to work out.

DISCUSSION

While the final theme reflecting skepticism about harm reduction and 12-step approaches working together deserves mention, it is also the case that it was least mentioned by staff respondents. The predominant view was that the two models can indeed work together and that the 12-step model in origin and its adaptation in treatment settings are often conflated erroneously.

These findings are significant for several reasons. First, they can provide guidance for practitioners who may feel tension around managing the relationship between the two approaches for clients who desire them. Clinicians working in both settings may feel that the integration of the "other" model (i.e., harm reduction for those in 12-step, abstinence-based settings, and vice versa) is wrapped in complex contradictions and/or is unacceptable. For example, in her qualitative study with seven clinicians working in an Australian nonmethadone withdrawal program for

people injecting heroin, Koutroulis (2000) found that the clinicians often struggled to balance immediate attention to withdrawing from heroin and clients' interests in abstinence with efforts to reduce harms associated with the clients' high potential for returning to heroin use. In their qualitative study with approximately 10 service providers working in Assertive Community Treatment teams serving adults with co-occurring substance use and mental health concerns, Ackerson and Karoll (2005) found variation in the staff members' support of harm reduction in their traditionally abstinence-based treatment models. In addition to philosophical differences between harm reduction and abstinence-based treatment, Ackerson and Karoll (2005) noted the challenges faced by providers working in a harm reduction model when interfacing with agencies with an abstinence-based emphasis, such as legal and child welfare settings.

Additional challenges associated with the integration of harm reduction and abstinence-based approaches may include the lack of clearly defined techniques and a predictable pathway to positive outcomes in a harm reduction approach and provider perceptions that harm reduction has ambiguous expectations of clients in treatment, lacks clarity regarding long-term goals of intervention, and may condone or "enable" harmful drug use (Housenbold Seiger, 2004; Mancini, Hardiman, & Eversman, 2008; Mancini, Linhorst et al., 2008). Additionally, the dominance of the disease model and related zero-tolerance drug policies continue to influence attitudes and values surrounding substance use problems and appropriate outcomes for treatment (Goddard, 2003; Mancini, Linhorst et al., 2008; Mancini, Hardiman, & Eversman, 2008). Such stances are likely to influence service provider's concerns regarding supervisor and colleague perceptions of their work if clients are continuing to use substances (Housenbold Seiger, 2004). Finally, staff training and supervision, as well as institutional support, are seen as essential to adopting harm reduction (Housenbold Seiger, 2004; Mancini, Linhorst et al., 2008; Mancini, Hardiman, & Eversman, 2008; Miller, Sorensen, Selzer, & Brigham, 2006). However, resources for such activities are often limited by agency budgets and demands on staff time. While these challenges need to be addressed in efforts to integrate harm reduction and 12-step approaches, the staff member respondents in this study bring forth an important discourse that highlights converging elements of the underlying philosophy of both approaches and the way in which the conflation of abstinence-only and the 12 steps has contributed to the assumption that 12-step and harm reduction approaches are oppositional.

Second, in terms of clinical application, the staff members in this study emphasize the importance of maximizing options for clients, individualizing strategies to facilitate clients' goals, and conceptualizing harm reduction as an umbrella that can involve multifaceted approaches, including 12-step participation. Of particular importance, this model of complementarity between harm reduction and 12-step approaches offers a paradigm for assisting clients who desire elements of both approaches and reduces the risk that their needs will be neglected if an oppositional dichotomy is maintained. Further, this model, which offers clients harm reduction and 12-step options, is consistent with elements of the empirically-supported approach, motivational interviewing (Donovan, Carroll, Kadden, DiClemente, & Rounsaville, 2003; Miller et al., 2003; Miller & Longobaugh, 2003; Miller & Rollnick, 2002). Offering a menu of options is seen as an important ingredient in enhancing motivation to address substance use (Miller & Rollnick, 2002).

Others have offered additional strategies for integrating harm reduction and traditional treatment approaches. Emphasizing the importance of consumer input and individualized, integrative approaches in diverse programs, Denning (2001) suggests several key strategies for integrating harm reduction in traditional treatment programs. These strategies include assuming an inclusive, respectful, and collaborative stance with clients; placing the helping relationship at the center of services; drawing upon motivational interviewing strategies; transforming conversations about denial into conversations about ambivalence regarding change; increasing the availability of low-threshold services (e.g., drop-in informational groups and intakes); offering educational interventions to reduce harms associated with drug use in a relational context; engaging supportive family and friends not as "enablers," but as potential facilitators of change; and maximizing inclusion of clients when they experience relapse.

Zweben (2000) discusses two further ways to conceptualize the integration of harm reduction and traditional treatment approaches. First, drawing upon studies of the Combined Psychiatric and Addictive Disorders (COPAD) outpatient program at the Beth Israel Medical Center in New York, Zweben describes that in addition to providing integrated mental health and substance use treatment for people experiencing co-occurring psychiatric and substance use concerns, COPAD employed harm reduction to enhance engagement in the program. Participants were not required to be abstinent from substances to participate in the program; however, they were required to express interest in reducing their substance use. Additionally, the program avoided confrontational approaches and drew upon self-help groups and psychoeducation. Second, Zweben provides an overview of the integrative elements of the Harborview Advocates for Recovery and Rehabilitation Program (HARRP) in Seattle, Washington, which provides comprehensive services for people experiencing co-occurring mental health and substance use concerns. At HARRP, harm reduction and abstinence-focused strategies are integrated in the following ways. To begin, clients who do not want to address their substance use can be referred by their case managers to participate in a single group that involves refreshments, medication observation, and limited access to their financial benefits. This "low-demand" phase of services aims to facilitate participation in the next phase of services, which can involve additional groups, housing, and employment opportunities (p. 385). The second phase of services offers positive incentives for addressing substance use issues and

includes elements that aim to attract others to engage in treatment.

Yet another model for integrating harm reduction within a publicly-funded, abstinence-based outpatient treatment program is provided by Futterman et al. (2004). They describe the Growth and Recovery Program of the North Central Bronx Hospital and Jacobi Medical Center in the Bronx. While the goal of abstinence is a component of the program, it draws upon Marlatt and Gordon's (1985) relapse prevention framework to include attention to cognitive-behavioral aspects of substance abuse and effective coping with relapse. It also incorporates motivational interviewing (Miller & Rollnick, 2002) to focus on resolving ambivalence regarding change, and respectful, individualized treatment that emphasizes engagement and retention; fosters a sense of community; minimizes rules; and addresses important domains of clients' lives, including health, housing, and vocation. The harm reduction elements of these programs are not provided as prescriptive (and some harm reductionists may want them to be more boldly reflective of harm reduction philosophies). Rather, the examples provided by Zweben (2000) and Futterman et al. (2004) and the strategies proposed by Denning (2001) aim to convey additional ways in which integration of harm reduction and traditional approaches may be realized in diverse practice settings.

Emerging from the 1999 Bridging the Gap: Integrating Traditional Substance Abuse and Harm Reduction Services Conference held in San Francisco, Marlatt et al. (2001) discuss eight principles to inform the integration of harm reduction therapy in traditional treatment. These principles emphasize the importance of culturally-competent services that are provided in ways that honor clients' dignity and self-determination; reduce social, economic, and physical consequences of problematic substance use; enhance engagement and motivation; reduce harms associated with substance use among people who continue using substances and their family and friends; conceptualize relapse as lapses or slips rather than as failures of treatment; attend to clients' medical and psychiatric health; and collaboratively engage with other service providers. Prior research has found that interagency collaboration, particularly with organizations that focus on abstinence, is especially challenging for providers working in a harm reduction program (Ackerson & Karoll, 2005). Misinformation likely contributes to this challenge in two ways. First, Miller and Kurtz (1994) argue that AA has been mistakenly credited for numerous ideas drawn from moral-volitional, personality, and dispositional disease conceptualizations of problematic alcohol use. Our findings suggest that misunderstanding and misapplication of the 12 steps hinders the integration of harm reduction and traditional treatment approaches. As suggested by Miller and Kurtz (1994), immersion in AA literature and attendance at AA meetings may facilitate greater clarity regarding the tenets of the 12 steps and how they can be applied in treatment. Further, our findings indicate that such immersion and clarity may highlight philosophical common ground and integration of harm reduction and 12-step approaches.

Second, Gleghorn, Rosenbaum, and Garcia (2001) assert that traditional providers have not been well informed regarding the evidence in support of harm reduction and that harm reduction providers have been biased against traditional programs. Perhaps what is most important is their suggestion that this lack of information and bias results in "suspicion and alarm" on both sides and "missed opportunities to better serve clients through the integration of their services" (p. 3). Our study's finding regarding staff members' perceptions of the 12 steps in their origin and their "co-optation" by traditional treatment providers may reflect similar misunderstanding, realities of traditional treatment programs with which the staff are familiar, or some mixture of both. The combination of findings that staff members generally support the complementarity of harm reduction and 12-step approaches, but have reservations about the ways in which the 12 steps in treatment centers may differ from the 12 steps in their origin suggest that opportunities for cross-training and dialogue may be particularly helpful. Such cross-training holds potential to reduce the "suspicion and alarm" that may be experienced on both sides and to support the availability of a range of options to assist clients experiencing substance use problems. Research conducted by Goddard (2003) found that educational programming regarding harm reduction for service providers in the Midwest positively influenced their attitudes about harm reduction. These findings suggest that education may foster greater understanding, improved potential for interagency collaboration, and enhanced service options for clients.

The purpose of this article is not necessarily to suggest that all substance use treatment providers "should" embrace the notion of the two models as being complementary, but rather, to suggest that the potential for partnership does exist and that such partnership may enhance the availability of options for people experiencing substance use problems. Over time this integration may become a necessary marriage as the substance use treatment field evolves in response to complex client needs and to client input. More research is needed to advance understanding of the ways in which providers in all settings are responding to the emergence of the harm reduction model, the evolving recognition of the value of options for people addressing substance use-related issues, and the growing attention to the limitations of a "one-size-fits-all" approach to assisting people with substance use problems (Marlatt et al., 2001, p. 15). While this study is an important step in advancing understanding regarding the integration of harm reduction and 12 steps in practice, it is limited by its small sample size and its exclusive focus on harm reduction service providers. Knowledge in this area would be strengthened by future research attention to service providers in 12-step programs and traditional treatment settings.

This article presents an important discourse of complementarity between harm reduction and 12-step approaches. The staff responses in this study suggest that the two may work together and add to a menu of options for people experiencing substance use problems. In light of the complexity of client needs and preferences and the limitations of a "one-size-fits-all" model for addressing substance use problems and their multifaceted effects (Marlatt et al., 2001, p. 15), this discourse may reflect a valuable, integrative approach to enhancing the well-being of individuals, families, and communities affected by problematic substance use.

RÉSUMÉ

Réduction des méfaits et douze étapes: complémentaires, oppositionnels ou entre les deux?

Contexte: Née à l'origine du désir de prévenir la transmission du VIH parmi les utilisateurs de drogues injectables, la réduction des méfaits est une option relativement nouvelle d'aide aux personnes luttant contre l'usage de drogue et d'alcool. Des programmes douze étapes tels que celui des Alcooliques Anonymes (AA) sont largement reconnus comme un exemple représentatif du traitement fondé sur l'abstinence et sont souvent vus comme oppositionnels à la réduction des méfaits. *Méthodes*: Le présent article a pour objet d'examiner les manières dont les travailleurs de réduction des méfaits interprètent la relation entre la réduction des méfaits et les approches de traitement douze étapes. L'article est fondé sur des entrevues qualitatives avec 18 membres du personnel de deux programmes de traitement d'abus d'alcool et de drogues s'appuyant sur la réduction des méfaits. *Résultats*: Deux thèmes centraux ressortent des données qualitatives: 1) les approches réduction des méfaits et douze étapes peuvent être complémentaires; et 2) les approches douze étapes dans des programmes de traitement seuil élevé peuvent être nettement différentes de leur philosophie et intention d'origine. Un troisième thème, beaucoup moins dominant, laisse apparaître le scepticisme de certaines des personnes interrogées en ce qui concerne la capacité de ces deux approches à fonctionner ensemble compte tenu de la résistance à la réduction des méfaits de certains dans la communauté douze étapes. *Conclusion*: La conceptualisation complémentaire des approches réduction des méfaits et douze étapes peut potentiellement élargir l'éventail d'options à la disposition des personnes ayant des problèmes d'abus d'alcool et de drogues.

RESUMEN

La reducción de daño y los doce pasos: Complementario, en oposición o algo entremedio?

Información preliminar: Surgido inicialmente por el deseo de prevenir la transmisión de VIH entre la población de gente que usa drogas de inyección, los métodos para la reducción de daños entre está población se presenta como una opción relativamente nueva en su función de asistir a individuos quien sufren por su uso de drogas y alcohol. Programas de doce pasos, tal como el de Alcohólicos Anónimos (AA) son bastantemente reconocidos como ejemplo representativo de tratamiento fundado en la abstinencia y frecuentemente se perciben en oposición al tratamiento de reducción de daño. *Métodos:* El propósito de esté articulo es examinar las maneras en que los empleados del tratamiento de reducción de daño interpretan la reducción de daño y su relación a los métodos de tratamiento de los doce pasos. El articulo se basa en entrevistas cualitativas a 18 empleados dentro de dos programas fundados en el tratamiento de la reducción de daño para el alivio del abuso a las substancias. *Resultados:* Dos temas centrales surgieron de los datos cualitativos: 1) la reducción de daño y los métodos de los doce pasos pueden ser complementarios; y 2) los métodos de doce pasos dentro de situaciones de limites altos pueden divergirse de su filosofía y intención de origen. Un tercer, mucho menos prominente tema es el escepticismo de parte de algunos respondientes acerca del potencial de los dos métodos funcionando juntos debido a la resistencia que tienen varios miembros de la comunidad de los doce pasos a los métodos de reducción de daño. *Conclusión:* Concepciones complementarias de los métodos de la reducción de daño y los doce pasos tienen el potencial de brindarle un margen más amplio de opciones a la gente afectada por problemas relacionados al abuso de substancias.

Declaration of Interest

The authors have no actual or potential conflict of interest to declare.

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