Substance Use & Misuse, 45:2411–2427

ISSN: 1082-6084 (print); 1532-2491 (online)
DOI: 10.3109/10826081003712060

informa
healthcare

Harm Reduction

"Everyone Deserves Services No Matter What": Defining Success in Harm-Reduction-Based Substance User Treatment

HEATHER SOPHIA LEE[1] AND ASSATA ZERAI[2]

[1]School of Public Health, University of Illinois at Chicago, Chicago, Illinois, USA
[2]Department of Sociology, University of Illinois at Urbana-Champaign, Urbana, Illinois, USA

This article reports qualitative interview data from a study of participant-generated outcomes of two harm reduction programs in the United States. We address the question: "What does success in harm-reduction-based substance user treatment look like?" Providers in this study understood harm reduction to adhere to notions of "any positive change," client centeredness, and low-threshold services. Participants reported changes in demarginalization, engagement in the program, quality of life, social functioning, changes in substance use, and changes in future goals and plans. The nature of these changes is difficult to articulate within traditional notions of success (i.e., abstinence, program completion, etc.). We conclude that participants in harm reduction programs experience tangible positive changes but that legitimation of these changes calls for a reconceptualization of "outcomes" and "success" in the current context of substance user treatment and research.

Keywords demarginalization; harm reduction; legitimation; low-threshold services; quality of life

Introduction

The emergence of harm reduction programs in substance user treatment and their goal of "any positive change" challenges stakeholders to identify "successful" outcomes for individual participants in such programs. Arguably success is nuanced and includes a component that is individually defined, but this greatly challenges standardization of outcomes. Harm reduction programs in the United States operate in a context where positive outcomes in substance user treatment[1] are often dualistically conceived, where long-term sobriety is

Address correspondence to Heather Sophia Lee, School of Public Health, University of Illinois at Chicago, 1603 W. Taylor Street (MC 923), Chicago, IL 60612-4394; E-mail: hsophialee@gmail.com.

[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

considered to be success, and where "failure"—which is anticipated as part of the relatively new medicalized diagnosis of a chronic "substance use disorder"—is the norm rather than the exception, given low abstinence and treatment completion rates. (Attention has rightly been drawn to the limited and problematic character of defining success in terms of sobriety/abstinence.) The harm reduction movement has been polarized at one extreme as "harm promotion" and at the other as an approach that "keeps drug/alcohol users alive long enough so that positive change can happen." To be expected, the definition of harm reduction is also contested. In this article, harm reduction is defined as a "public health approach to dealing with drug-related issues that places first priority on reducing the negative consequences of drug use rather than on eliminating drug use or ensuring abstinence" (Riley et al., 1999, p. 10; see also Pallone and Hennessy, 2003; Zajdow, 2005, p. 185; Zerai and Banks (2002a, 2002b).

This article describes the way in which staff members and participants in two harm reduction programs understand, describe, and define success as it relates to harm-reduction-based substance user treatment. Interview data are taken from a larger study in which staff members and participants of two programs were interviewed to generate participant-defined outcomes of harm-reduction-based treatment (Lee, 2006). The first program site was located in a Midwestern city that provided drop-in services (i.e., case management, counseling, meals, and a link to other services in the broader social service agency and community), targeting homeless, active drug and alcohol users. The second site was a nonprofit agency in the Bay Area of California that provided individual and couples counseling based on a private practice model to a clientele able to pay for services. Face-to-face, semistructured interviews were conducted with a total of 18 staff members and 32 participants. Interviews were designed to capture the perceived impact of programs as understood by participants. Staff member interviews served as a secondary source of data to validate participant reports. A dearth of literature on individual outcomes of harm reduction efforts (Myers, Aggleton, and Kippax, 2004) and the inherent challenge in measuring harm reduction outcomes (notable exceptions include Allman et al., 2006; Heinzerling et al., 2006; Stockwell, 2006) called for a grounded theory approach to identify outcomes that would emerge without a preconceived idea of what outcomes should be. Consistent with the harm reduction philosophy, outcomes are defined as an incremental process, which emerged across both sites, that can be modeled as long-term change in which *demarginalization* leads to *engagement* in the program, which provides an avenue to changes in *quality of life*, *social functioning*, *changes in drug/alcohol use*, and the articulation of *future goals and plans*. Demarginalization and the motivation to engage in treatment programs are internal processes that show up in the participant interactions with staff in the program. Quality of life, social functioning, and articulation of goals are externally verifiable outcomes that are discussed in even some of the traditional treatment literature (Hartmann and Wolk, 1996; Hser, Huang, Teruya, and Anglin, 2003; Knight, Logan, and Simpson, 2001). Further, the model is recursive. Celebration of small successes by providers leads to consistent engagement in harm-reduction-based treatment programs that give rise to the achievement of additional externally verifiable outcomes (see Figure 1).

exogenous), which is *bounded* (by culture, place, time, etc.) and can be categorized into professional-based, tradition-based, mutual-help-based (AA, NA, etc.), and self-help ("natural recovery") models. There are no unique models or techniques used with substance users—of whatever types and heterogeneities—that aren't also used with nonsubstance users. In the West, with the relatively new ideology of "harm reduction" and the even newer "quality of life" 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. Editor's note.

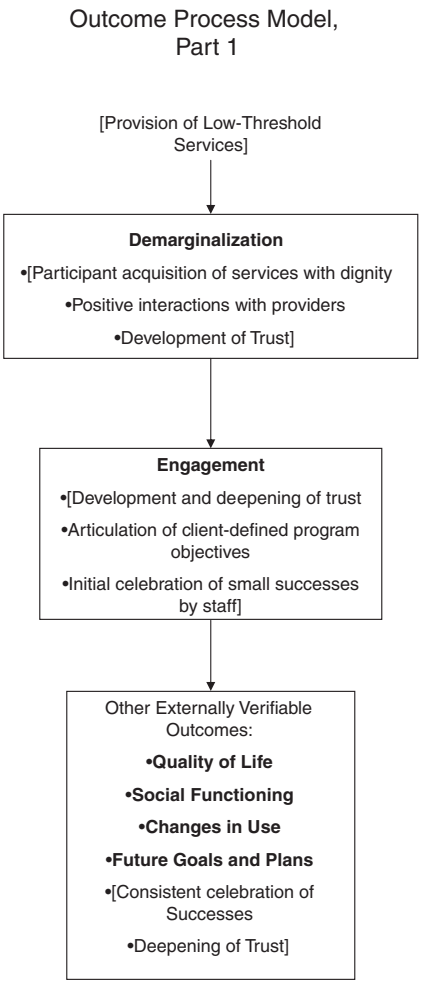
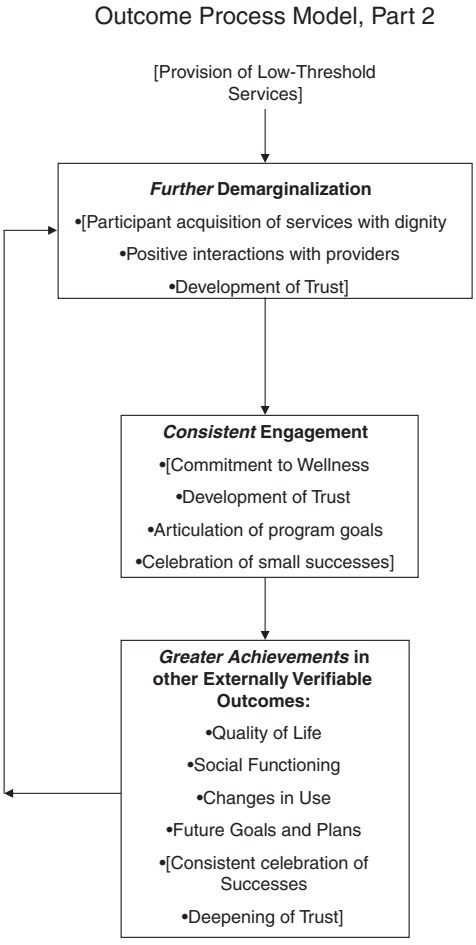


Figure 1.

Success narratives were abundant in staff member and participant interviews. In essence, providers accepted participants' definitions of success,[2] including the incremental changes leading to that success. The mere act of engaging in treatment services, for example, which had been resisted in the past by the vast majority of participants, was considered success. Providers typically perceived their programs as truly meeting the needs of clients when they established mutual trust with a participant. A key staff member at the community-based drop in center put it this way: "I define success for myself when I know that I've developed a relationship with the participant and then that participant is willing to come to me and talk to me in an open and honest way." Mutual trust is not only a pathway to positive change, but it is a source of provider satisfaction in working with the homeless, drug-using population:

[2]The reader can consider and explore the dimensions of and the relationships between "success" and "improvement." Editor's note



(*Continued*).

> It's just really satisfying . . . to [have] the great honor and privilege . . . of people disclosing experiences to me that they have never talked about in their lives and I think particularly for people who have experienced childhood trauma and sexual trauma, to be that person who finally they trusted enough to talk about that for the first time at the age of 50 . . . [T]hat's really huge and I do the best that I can to respond in a way that is helpful and not harmful and that's very satisfying.

The data discussed below show that demarginalization is the prerequisite for the development of this kind of trust. While demarginalization may be a common route to success in any type of social service, the harm reduction model's low-threshold requirements (i.e., a promise of abstinence is not required for entry into treatment) increases receptivity to program uptake by historically resistant participants (i.e., participants who reported negative past experiences and perceptions of substance user treatment). This low-threshold environment sets a foundation for trust and open dialog between participants and providers. Once trust is established and participants genuinely engage with harm-reduction-based

treatment programs, they typically accomplish (attain/realize) various externally verifiable outcomes. While meeting these objectives, the process of change itself—no matter how incremental—is celebrated. This leads to further demarginalization, engagement (a deeper commitment to the program and wellness), and additional (and/or consistent accomplishment of) externally verifiable outcomes (see part 2 of Figure 1).

Examples of success are organized thematically in this article. However the reader is encouraged to understand success as nuanced, subtle, and not as mutually exclusive by category. The success narrative below was reported by an outreach worker with the drop-in center and speaks to the fluid interconnectedness of positive life changes. It highlights trust in providers, engagement in services, attainment of housing, identification of goals, reduction of substance use, and disengagement from an abusive relationship:

> She's homeless 10 years. She was a victim of domestic violence. She also had a very troubled childhood and she has several children, and one of her ways of coping with it was to drink alcohol regularly, on probably a daily basis. When I met her she was involved with a man who was not treating her fairly, and eventually that broke up. It took about a year for me to work with her so that she would trust somebody and come into the program, and so she did it eventually. She entered the program, and she began to realize that she could have her own goals and her own sort of desires . . . , and the first thing that she circled . . . was housing. . . . Well of course the challenge with housing is that if you're intoxicated and if you're loud and disruptive it's difficult to keep housing. So she didn't make the connection right away that in order to keep her housing she had to do something else about the alcohol. So she stayed in about 5–6 months, and she got a warning and so she agreed to go for treatment. But she still drinks and she drinks a lot, and she got another warning and she eventually was asked to leave because she was a bit disruptive. But we were able to provide her with an alternative place for housing, so simple things have changed for her. She drinks a lot less for her. She says, "I don't drink the strong stuff anymore." And if you see her on the street she's nicely groomed; she wears attractive clothes, pleasant . . . [H]er hygiene is good; she's no longer shouting and yelling. It took about a year to get her in; she's probably been in the program about a year, maybe less, and housed 6, 7, 8 months now and it's incremental. And to me it's a brilliant thought that any kind of goals of progress are important, not necessarily the traditional one of you have to stop drinking right away and I find it's very effective with people.

The underlying theme of this article is the assertion that success must be reconceptualized beyond traditional measures to appreciate the positive changes that participants experience. The rest of the current article reports examples of success, organized thematically by the conceptual model above.

Demarginalization

Substance users are marginalized by their drug and alcohol use in most settings. They report this experience even in traditional treatment programs. When they encounter harm-reduction-based treatment programs, many indicate that despite their drug use they are treated with dignity for the first time since their use got out of control and that they are now able to gain access to services. Their needs are centered by harm-reduction-based programs.

Stigma does not interfere with their access to services. We understand this as a process of demarginalization. Demarginalization is an experience in which a person who is marginalized by their drug and alcohol use encounters a humanistic treatment setting in which their basic needs are normalized and unconditionally met (Lee and Petersen, 2009). The experience is significant, given participants' negative perceptions of traditional abstinence driven-only treatment. The opportunity to have basic needs met, to build trusting relationships with staff members, and to make incremental positive changes that are self-defined and acknowledged by staff facilitates a demarginalization of participants. It is so powerful that it prompts them to further engage in harm-reduction-based programs. The process potentially humanizes a historically dehumanized population. One participant displayed this when he defined harm reduction as a treatment model that "treats people like people."

Creating an environment that demarginalizes is equivalent to creating a safe space for drug and alcohol users. A drop-in center participant said that he could "speak with anyone about anything and you're not going to be shunned and ridiculed." In this safe space, important needs are met and trust is built. Participants validate staff member success in structuring a safe space. Participants report the genuine concern and "constant care" they experience from staff. As a result of programmatic efforts to avoid "set[ting] people up to fail" (by requiring abstinence), participants are willing to access and use services offered by harm reduction programs. Obtaining low-threshold services appears to be the dominant reason participants choose to consistently engage in these programs. Trust is built by the provision of services and interactions with staff. Open, nonjudgmental dialogue alleviates the guilt and shame so often experienced by substance users. One staff member had the following to say:

> The hardest thing in serving the population that we serve is to truly make people aware of the fact that this is a place to come and discuss openly and honestly their substance use. Just like racism can be internalized, I think even more so in our society the shame and guilt and stigma of substance users is internalized.

A young woman, who had been receiving counseling services for approximately 4 months at the time of the interview, discusses alleviation of stigma she had experienced as the largest benefit of treatment (Blume, 1990; Hser et al., 2003):

> Probably one of the biggest things, especially working with [my harm reduction therapist], is helping me to get rid of the shame and the guilt that I carry around with me about my use, past and present, you know, because I spent seven months in/at [a traditional abstinence-based] residential [facility] that basically said, "You're pretty much a junkie, you're always gonna be a junkie, and your best thinking got you where you are today," (and) that I wasn't capable of making a good decision for myself . . . [But my current therapist has] . . . really helped me realize that that stuff isn't true. And that whether I choose to use or not isn't like indicative of me as a person, it's just one facet of my life.

She went on to talk about the stability in her life that has resulted from having a place to go where she can speak without being judged, especially in the context of other stressors in her life (e.g., illness of her partner and getting through school). Indicators of this stability included the ability to formulate concrete plans to respond to her depression and drug use: "I'm not staying in bed all day anymore because I'm not feeling so depressed anymore . . . and I'm not using chaotically."

An individual and group therapy client found reprieve from attending Alcoholic's Anonymous (AA) meetings, which he did not experience as a good fit for himself. He experienced the harm reduction group in a very different way:

> People were really helpful and supportive, and I didn't get the usual coldness or snobbery that I've encountered at AA meetings.

He discussed "conquering stigma" in his harm-reduction-based program:

> Yes, that's what I liked the most about it [destigmatization]. And that's what I hope—that they can finally conquer that stigma, that idea that all junkies are street people who aren't to be trusted, who are losers. Just scum. This is a good start to getting rid of that myth.
>
> It's a lot less stressful. A lot less stressful to deal with my drug issues in this way than to . . . go see a city counselor who in my experience would never believe that my UAs [urine analyses] were always clean; he would always say something like "You just haven't been caught yet," and I really resented that because the only thing I've done is . . . taken methadone.

Engagement in the Program

The principles of the harm reduction philosophy require providing low-threshold services in hopes that participants will continue to engage in these treatment programs. Engagement in the program refers to frequency/length of participation and the value assigned to the program by participants. Therefore, consistent with the harm reduction philosophy, engagement is an outcome in and of itself in our model. When asked if their daily life was impacted by the drop-in services and counseling harm-reduction-based programs, the majority of clients responded affirmatively. Moreover, they expressed that they were highly satisfied by the services offered and their interactions with staff and were willing to encourage others to attend. Tremendous success was described by staff members in the mere receptivity to services by participants, including the following:

> making a change from just walking up here in that door and just seeking services that under normal circumstances they wouldn't even attempt to do—engaging, socializing with their peers, discussing openly their substance use issues, both the negative effects and the positive effects.

One mental health worker spoke of one of her favorite success stories that she witnessed in a man who experienced changes in his increased capacity for social engagement, reduced substance use, and attention to his physical health. She reiterated that for the population served, the participation in services itself is a tremendous success, given the population's past alienation from social service agencies:

> We have this one participant who had been engaged with outreach for months, and we'd try and get him to come up to the center and it was like [he] wouldn't have it. He basically had this standing invitation to come up to the center for months . . . [H]e finally came up with one of the outreach workers and left as

> soon as she left. And then we didn't see him. Then he comes back and he would kinda peek in the front door and if he saw the outreach worker he would maybe come in, [and] if not he wouldn't. And we would kind of go through this pattern with him where it was like okay well maybe, am I gonna come in? . . . Then finally we got him to come in and now he comes regularly. If he doesn't come everyday, he does come the majority of the week. He has gone through times when he has reduced his use. One time where he abstained from drinking for a month and a half at least and that was on his own and . . . He's a very heavy drinker so he went through some pretty uncomfortable withdrawal symptoms . . . And has been taking care of and following up more on his physical health. . . . He has also been housed so he's not on the streets anymore, and has been forming relationships with [other] staff.

Once participants have engaged in the drop in service and counseling programs and developed trusting relationships with providers, the potential for change in many areas is piqued. Engagement leads to various other outcomes that are discussed in the traditional treatment literature. Improvements in quality of life, is one such outcome.

Quality of Life

Quality of life improvements emerged at both sites, but varied by need and resource levels of the participant populations. At the drop-in center quality of life improvements referred to basic needs, more predictable behavior, and overall life satisfaction. At the private practice site, quality of life improvements occurred in three areas: mental health improvements, improved and increased social engagement, reliability, and stability. In other words, site 1 participants experienced greater gains in basic needs attainment (i.e., participants entered the program with greater needs and thus securing housing was a major outcome) and social engagement (i.e., it was a community-based program with a drop-in center space where peers and staff interacted). "Everyday basic needs" such as meals, laundry services, shower access, phone access, help in getting clothing, and shelter were just a few of the benefits reported. The program served as a gateway to other social services within and outside of the larger agency. An important mental health improvement reported by five participants was an end to suicidal ideation. The second site nurtured a range of mental health improvements such as an increase in happiness, a better outlook on life, decreased depression, moving past shame and guilt, reduced anxiety, bettering oneself, and finally living the way one wants to live. An increase in their ability to change and a strong belief in the efficacy of the program itself were also reported.

One woman contextualized her gains in the program by discussing where she was when she came into the program. Her quote speaks of her liberation from unhealthy relationships with men, improved attitude, and increased attention to hygiene and personal appearance and also her desire to repair damaged relationships with her children and grandchildren:

> At that time I was sleeping on the [train]; I was sleeping anywhere, 'cause it would get to a point once I would do drugs and live with a person and give them money, they smoke their money and then they turn around and want some money from you and then if you don't give to them they'll put you out. I was living with a man that I really didn't wanna be with. If I didn't want to have sex with him I would be put out in the cold. Even my brother done put me out in the cold in zero weather. Like I said, I've been through a lot for a woman my age.

> I never went home back to my mom. My mom put me out with my first child, and ever since then I had it hard. My life was like up and down, up and down until I came to a standing point. I can say life at the center has changed me. Even with my attitude it's much better. I know how to use my sense of humor toward people, 'cause I used to be a sad person inside, deep down inside. I'm much better than what I used to be. A whole hell of a lot better and through this program; this program helped me to open up my eyes and see what type of situation that I am and even the problems that you can quit doing drugs and drinking, but after that what about your attitude? I had to learn how to socialize again, how to dress again, how to be patient again, see all of that comes in too . . . Then you want to start looking good, taking care of yourself . . . I haven't got my kids yet but I know they're coming, or my grandkids. I know they're coming. I'm just taking little baby steps, and I'm asking God to help me each and every day.

Social Functioning

Social functioning is the capacity to accomplish a desired task or goal. Improved social functioning is the second externally verifiable outcome. Owing to differing baseline needs of participants, social functioning gains also diverged at sites. Engagement in services at the drop-in center led to increased abilities to apply for Medicaid/Medicare benefits, maintain housing, live on one's own, plan one's day rather than be aimless, increase capacity to work and pursue work opportunities, be productive, develop a sense of responsibility, further one's formal education, and gain knowledge of health and safety issues. Greater skill at managing mental health concerns was articulated (e.g., "quell[ing] anger," managing anger, and learning patience). One participant's "learning how to live again" translated into learning how to socialize, rediscovering use of humor, confrontation of trauma and abuse, and staying out of trouble.

At the private practice site, subthemes emerged as increases in self-understanding and awareness, obtaining work-related benefits, improved capacity to deal with personal relationships, and increased affect tolerance. Self-understanding and awareness were signified by coming to simple truths, "follow[ing] through the process of my own thoughts," becoming aware of and understanding the events leading to depressive episodes, confronting childhood trauma, helping to see "how controlling I am," discovering what one's capacities are, learning to set boundaries, and increasing understanding of one's past. Others reported healthier coping, a realization that they could quit drinking, a diagnosis of adult attention deficit disorder, and examination of their alcohol use in a de-emotionalized way. Staff members confirmed these experiences in describing the "critical consciousness" that emerged and the "notable movement in ways of thinking about things, behavior, and underlying mental health" that participants demonstrated.

The following man, who entered the individual therapy program in search of social support to maintain his abstinence from alcohol, greatly valued the structure that the program added to his life. A major benefit stemming from this was reconnection with formerly estranged family members. He attributed his achievements to shared past experiences with staff members and their sympathetic understanding:

> I'm able to plan my day today rather than just hang out and wonder what I'm gonna do [laughs]. I don't wonder anymore what I'm going to do. . . . Being around these guys . . . it's helped a lot because most of these case managers

> have been where I've been. . . . So that's why I'm able to talk to 'em 'cause if they hadn't, then I don't think they could be as understanding . . . so they know how I feel and they definitely . . . try to support me real good because they know what I'm trying to do—what they did. They know I'm trying to get where they are. So they push. They push. They take time. Whatever I need worked on, they help me work on. Now that I'm getting my life together I'm back talking to most of my family . . . [W]hen I came to this program I wasn't talking to any of my family; now I'm talking to almost everybody. It's time to come back and deal with my life.

Another 3-year, individual therapy client integrated harm reduction therapy with attendance at 12-step meetings:

> I just got out of prison at the end of [the month] and the question was "Did I want to go back to a sober living environment, to a treatment center, or live with my [family]?" And I'm living with my [family] because of the politic kind of stuff that goes on with treatment centers and the power control trips that they have with people who are also in recovery who are also sick trying to help you.

She found her harm reduction experience to offer something that was a void for her at 12-step meetings:

> I'm able to be completely honest about it, you know? If I say I used or I'm thinking about using, it's not like the big sin like it is in AA and NA or wherever. . . . If you do end up using, then you have to start counting your days again; . . . and there's good and bad to counting days . . . but I don't wanna count anymore; I don't think it's important. I like 12-step meetings. I go, but I don't wanna count anymore. I just wanna have a different way of life, and I think that harm reduction is more supportive of that than AA.

She attributes much of her success with abstinence to her involvement in harm reduction because she is now able to engage in open dialogue in a safe space with her therapist.

Changes in Drug/Alcohol Use

"Changes in use" refers to any positive change in substance use—reduced use, safer use, reduced use-related harm, managed use, or abstinence. Outcomes again diverged between the two sites. Participants at the second site had a burgeoning awareness of their use. This was described to a lesser extent at the first site.

At the drop-in center, reduced use and managed use are the two major changes in substance use that occur. Reduced amount and frequency of use was reported. Managed use translated into less chaotic use and "timelier" use in which responsibilities, such as paying one's rent, were prioritized over drug use. Safer methods of use such as the use of clean hypodermic needles was another change in drug use reported.

Many participants in both programs desired abstinence. This desire paved the way for entry into methadone maintenance treatment, short-term abstinence, or the use of social support of program staff and peers for maintenance of already-achieved abstinence. Such support led to wiser choices about environments that threaten their sobriety and to confronting underlying psychological struggles that may trigger relapse. As one female

participant in the drop in services facility stated, "The care and concern at the center makes a person want to stop."

At the private counseling center, changes in use included increased awareness and "consensual consciousness" around use, reduction in use, reduction in use-related harm, entry into methadone maintenance treatment, and abstinence. One man "stopped [his] rote, unconscious pattern of use." Another articulated greater awareness of feelings preceding impulses to drink. Others achieved long-term abstinence or upheld short-term breaks that were unimaginable to them in the past. One client reported that he could not have gotten through his sobriety program without the support of his harm reduction therapist. For another the "idea of abstinence [became] not as threatening anymore." Two clients spoke of their positive experience in the opiate treatment portion of the program that granted clients the freedom to obtain methadone from pharmacies with greater consumer control. This "made life a lot easier with work and school," and for another it "broke the pattern of being an irresponsible addict," decreasing the stigma of being on methadone. Reduced use was also reported in ways such as cutting alcohol use by 50% and cocaine use to only once in the past 4 years. These reports coincide with a staff member's claim that there is a "dramatic reduction in amount and frequency of [use of our clients'] primary and secondary drug [of choice]." Several participants reported reductions in harm as a result of changes in use of drugs and alcohol, including no longer drinking and driving, elimination of chaotic use, and setting limits on their behavior around use. Staff confirmed these changes stating, "People start to change their use or alter their change to a less harmful drug or change their route of administration to a less harmful way, and their goal may very well be abstinence or it might not."

The following individual therapy client, of 3 years, discusses his success in reducing his drinking-related harm and developing self-awareness around his use of alcohol. About the perceived impact of the program, he said:

> The treatment has allowed me to begin to examine my conduct in a way that's judgment neutral. . . . So if there's a time when I decide I want to get drunk, . . . I judge that activity now in the context of did I do it in a way that had integrity and by that I mean not driving, not ignoring my family, even silly things like you know consuming an alcohol that's the least caloric, whatever context I put it in of being aware of my environment, not going out and partying in an environment where it would be dangerous for me, physically dangerous.

He says that the ultimate benefit of the treatment is that he no longer drinks and drives and that he has increased tolerance for the goal of quitting drinking:

> That's not as threatening or frightening to me any longer. It's lost a lot of charge. And that's just a little bit; I just call it magic, I don't know how or why that happens but there's a certain emotional untangling that's going on. . . . And probably one of the things that was appealing about this program was that I could get treatment without having to both get treatment and quit drinking just as a rule.

For this participant, services and staff support for his safer use and other changes in use provided the possibility of entertaining abstinence as a future goal.

Articulation of Future Goals and Plans

Articulation of goals and plans is a shift in personal, career, and other objectives and in strategies to reach these outcomes attributed to program support. Almost all participants verbalized their future desires and where they envisioned themselves in 5 years. Many indicated that they could not vocalize future plans and goals before coming to the drop-in services and counseling programs. Participants attributed their ability to articulate goals and plans to a newfound sense of hope from the program. Aspirations for further education were expressed by four participants, and several participants wanted to save their own lives for the sake of their children and grandchildren. One man planned to return to his out-of-state home to assist his aging father. The desire to live a "normal, productive life," to have a home and family, and to self-sustain oneself were also mentioned. Others included getting rid of recurrent depression, applying for disability, abstaining from methadone, overall improvement, and "getting out of the neighborhood." Responses to "Where do you see yourself in 5 years?" included receiving disability, getting Social Security Income for depression, and getting a culinary degree. For another man, he did not know what it was yet, but he wanted something better for himself. He attributed this to his involvement in the drop-in center program because "people care about you [there], and sometimes you need people to care about you before you can care about yourself." When asked about whether or not he attributed his change in future goals to his involvement in the program, one man said the following:

> I hate to say yes, because when I was out there, there was nothing going for me, but close to death or jail. That's all I had. This is going on my third year I haven't been to the penitentiary yet. I've been to the penitentiary seven times. This is the longest I've been out.

Other examples included decreasing methadone dosage in order to try buprenorphine, abstaining from methadone, a relationship with alcohol that is not out of control, and continuing to live without alcohol. Also reported were a desire to be more "free mentally," to stay in touch with one's goals and interests, figuring out what to do with one's future, to finish school, and to continue to look at one's relationship with active users. One client reported being more optimistic because of her success in quitting drinking, which she never thought possible, and another reported that he was "happy to be who I am" and that he was "much more content to just do no harm."

The significance of the articulation of future goals and plans is driven home through references to one's past. The contextual situating of their stories highlights the importance of individual life circumstances, which for this population is embedded in trauma and disadvantage. The participant who endured seven stays in the state penitentiary spoke of the life-altering changes he has experienced as a result of the program:

> I think the center is one of the best things that ever happened to me. I spent off and on for 15 years on the streets and stuck in the same routine, working and using and stuff like that, damn near getting myself killed, and being in the program, it brought me back my self-esteem, that I'm worth something, I'm not a loser, all the negative things that we think about ourselves when we're fucking up out there, you know? And not to mention the way they care about you, how they talk to you and stuff like that.

When asked about what he wanted for his future, he articulated a common experience expressed by numerous participants—an articulation of future goals and plans that had been deferred but rediscovered through healing in the program:

> Well I got what I wanted, so as a start I got me a roof over my head; I'm semistable; I'm getting ready to go to school. Now what I want, I want an education, my diploma; I want my certificate so I can run an apartment complex, be self-sustained, kinda like branch out on my own, but at the same time stay with the center. 'Cause without this and God it wouldn't have been possible.

Discussion

One staff member's statement that "nothing ever ends here" cautions readers to view "outcomes" and "successes" as inclusive of ongoing changes (i.e., acknowledging the success of his programs). In harm-reduction-based treatment programs, any process of positive change—however slowly occurring—is as celebrated as traditionally measured outcomes. The change process is fluid and unpredictable. According to two staff members, "no one knows when the switch will kick in" and "human change in itself is an awkward process." Another staff member saw her own role as "planting a seed," accepting the work that she does as inevitably resulting in *long-term* changes. The inclusion of process (i.e., a series of changes that may or may not lead to an immediate tangible result) as a successful outcome captures the centrality of incremental change in the harm reduction model.

The previous paragraphs demonstrate a wide range of processes, outcomes, and success that align with provider aspirations. A key staff member spoke of her hopes for harm reduction program participants in the following way:

> What I like to say is that success in harm reduction is defined by harm reduction . . . What we want is to identify what are the harms that people have suffered and hopefully reduce a great many of those if not eliminate them. And if reducing or eliminating substance use is part of how somebody reduces harm, then we do that as well. A lot of our folks wanna be abstinent. A fair number of folks are in 12-step recovery, but they wanted something more. So we try and define the success really as "are you happy with your life?"

The purpose of this article was, in part, to problematize (or contextualize) the notion of success itself. Assuming that success itself can be defined, one must then accept that it is nuanced, idiosyncratic, and (at least in part) participant-defined. Success (within the context of harm reduction programs) is characterized as being "any positive change" and is conceptually understood in Figure 1 as being initialized in the demarginalizing experience, facilitating engagement in the program, and leading to changes in quality of life, social functioning, drug/alcohol use, and articulation of future goals and plans. Staff members further illuminated notions of success in their tendency toward viewing success as defined by participants' desires for their own lives (Drumm, McBride, Metsch, Neufeld, and Sawatsky, 2005). Staff believe that they achieve success in their role as providers when they have established a mutually trusting relationship with their participants. Success in harm-reduction-based treatment programs can be said to include the following.

- Demarginalization
- Mutually trusting relationship between participant and provider

- Engagement
- Participant identification of desired program outcomes
- Quality of Life
- Social functioning
- Changes in drug/alcohol use
- Articulation of future goals and plans
- Ultimately any positive change

Conclusion

Identifying common outcomes and successes that participants experience is a difficult task. The emphasis on incremental change and client-driven goals leaves participants with an infinite number of outcomes to desire, processes to experience, and successes to achieve. The partial summary of outcomes and successes provided herein is necessarily limited. Past, present, and future participants in harm-reduction-based treatment programs have defined and will continue to define appropriate outcomes for where they are in their trek toward wellness. However, to leave these outcomes and processes unarticulated risks leaving positive changes unrecognized, further silencing participant voices. The reduction of outcomes into concise categories, while a useful tool in this study, inevitably neglects idiosyncrasies that permeate the lived experience of both participants and staff members of the programs. Careful attention to the narratives of both staff and participants allows these variations to be seen.

Acknowledgment

The original dissertation research for this work was conducted at the University of Illinois at Urbana-Champaign. The writing of this article was supported by the NIDA San Francisco Treatment Research Center (P50 DA-09253) and the NIDA program for Postdoctoral Training in Drug Abuse Treatment and Services Research (T32 DA-007250). Most importantly we thank the study participants without whom this work would not have been possible.

Declaration of Interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

RÉSUMÉ

“Tout le monde mérite des services, quelle que soit la situation”: définir le succès des traitements basés sur la réduction des risques chez les usagers de drogues.

Cet article présente des résultats d’entretiens qualitatifs, provenant d’une étude aux résultats déterminés par les participants, sur deux programmes de réduction des risques aux Etats-Unis. Nous posons la question suivante: «A quoi ressemble le succès dans un traitement basé sur la réduction des risques chez les usagers de drogues?»

Dans cette étude, les prestataires de services comprenaient réduction des risques comme adhérant aux notions telles que “tout changement positif”, services centrés sur le client, et services a bas seuil. Les participants ont rendu compte de changements en terme de démarginalisation, engagement dans le programme, qualité de vie, fonctionnement social,

changements dans l'usage de drogues et changement dans les but et plans futures. La nature de ces changements est difficile à articuler à l'intérieur des notions traditionnelles de succès (par exemple abstinence, achèvement du programme, etc.). Nous concluons que les participants aux programmes de réduction des risques connaissent des changements positifs tangibles mais que la légitimation de ces changements nécessite une reconceptualisation de "résultats" et "succès" dans le contexte actuel du traitement des toxicomanes ainsi que de la recherche.

Mots Clés: démarginalisation, légitimation

RESUMEN

"No importa la razón, todos merecen servicios": definiendo al éxito en tratamientos de usadores de sustancias basados en la reducción de daño

Este artículo reporta datos cualitativos de entrevista de un estudio donde los resultados fueron generados por participantes de dos programas de reducción de daño en los Estados Unidos. Respondemos a la pregunta: "¿En que manera vemos éxito en el tratamiento de usadores de sustancias basado en la reducción de daño?" Los proveedores en este estudio entendieron que la reducción de daño se adhiere a las nociones de "cualquier tipo de cambio positivo," estar centrado en el cliente y servicios de baja tolerancia. Los participantes reportaron cambios en desmargenalización, interés en el programa, calidad de vida, funcionamiento social, cambios en uso de sustancias y cambios en metas y planes para el futuro. La naturaleza de estos cambios es difícil de articular dentro de las nociones tradicionales de éxito, como por ejemplo abstinencia, completar el programa, etc. Concluimos que participantes en programas de reducción de daño experimentan cambios tangibles y positivos pero que la legitimación de estos cambios llama para una reconceptualización de "resultados" y "éxito" en el contexto actual de tratamiento e investigación de usadores de sustancias.

Palabras claves: desmargenalización, legitimación

THE AUTHORS

Heather Sophia Lee, Ph.D., is a social worker in training and a qualitative researcher. She is currently a Center for Disease Control and Prevention fellow in the School of Public Health at the University of Illinois at Chicago and is simultaneously pursuing a master's degree in clinical social work at the University of Chicago. She received her Ph.D. in educational policy studies at the University of Illinois at Urbana-Champaign in 2006, where she conducted dissertation research on harm reduction in substance user treatment. From there she went on to be a National Institute on Drug Abuse postdoctoral fellow at the University of California at San Francisco from 2006 to 2008. Her research has focused mostly on qualitative understandings of access to and engagement in substance user treatment with a particular

interest in the homeless population. Her next research project is a phenomenological study of retrospective understandings of early parental loss.

Assata Zerai, Ph.D, is an Associate Professor and the Director of Graduate Studies of the Sociology Department at the University of Illinois at Urbana-Champaign. She received her Ph.D. in sociology in 1993 from the University of Chicago. Her scholarship focuses on the ways that race, class, and gender as interlocking spheres are reflected in maternal and child health and antiwar activism. She is currently working on a project titled "An Africana Feminist Analysis of Maternal and Child Health in South Africa and Zimbabwe." Her recent publications include *Dehumanizing Discourse, Anti-Drug Law and Policy in America: A "Crack Mother's" Nightmare*, co-authored with Rae Banks (2002); "A Black Feminist Critique of American Religious Anti-War (Dis)engagements" (forthcoming);"A Black Feminist Analysis of Responses to War, Racism, and Repression" (with Zakia Salime, 2006) in *Critical Sociology*; "Health Seeking Behavior in Times of Economic Crisis in Nigeria" (2004); and " 'Tell No Lies; Claim No Easy Victories': A Critical Analysis of the BRC Congress 2003" in *Socialism and Democracy*, co-authored with Horace Campbell (2004). She co-edited an issue of *Social Science and Medicine* that was published in 2007, entitled "HIV/AIDS in Africa: Gender, Agency and Empowerment," with Ezekiel Kalipeni.

Glossary

Articulation of future goals and plans: Shift in personal, career, and other objectives and in strategies to reach these outcomes attributed to program support.

Changes in use: Any positive change in substance use—reduced use, safer use, managed use, or abstinence.

Demarginalization: An experience where one marginalized by their drug and alcohol use encounters a humanistic treatment setting in which their basic needs are normalized and unconditionally met.

Engagement: Frequency and length of participation as well as the perceived meaning and value assigned to the program by participants.

Legitmation: A process whereby a formerly contested phenomenon becomes acknowledged as valid and acceptable.

Quality of life: Sense of basic needs and predictability being met and overall life satisfaction.

Social functioning: The capacity to accomplish a desired task or goal.

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