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# Case Management: Using Harm Reduction with Chemically Addicted Clients

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# Case Management: Using Harm Reduction with Chemically Addicted Clients

by  
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MSW Clinical Research Paper

Presented to the Faculty of the  
School of Social Work  
St. Catherine University and the University of St. Thomas  
St. Paul, Minnesota  
in Partial fulfillment of the Requirements for the Degree of  
Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

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### **Abstract**

The research surrounding the outcomes of harm reduction is gaining momentum, and the awareness of the harm reduction philosophy is becoming more widespread among social workers. Providers who utilize harm reduction are often the people that work directly with the most disenfranchised people in our nation. These providers most often deal with clients who are chemically addicted. Current research indicates that harm reduction can be beneficial for the clients who use chemicals. This research project sought to collect information about the experiences of case managers who implement harm reduction. The case managers expressed that the utilization of harm reduction could be difficult at times because there is a need for more provider trainings on the model; and harm reduction could be hard to implement when working with professionals from cross-disciplinary fields and chemical health professionals from the abstinence-based community. However, case managers felt that implementing harm reduction supported their ability to create a meaningful relationship with their clients, and it also lowered their general stress level. The results of this research will be used to inform social service providers about the struggles and successes that some case managers who implement harm reduction experience when working with chemically addicted clients.

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## Introduction

Chemicals have been used for medicinal and recreational purposes, and even for sacred rites, for hundreds of years in many societies. These chemicals include drugs, such as opium, cocaine and prescription drugs, as well as alcohol. The overuse of chemicals may start as a way to cope with the daily stressors of life. Unfortunately, the overuse of chemicals also leads to addiction. Over half of the adults in the United States have consumed alcohol in the past 30 days; five percent report having drunk heavily and seventeen percent binge drank (Center for Disease Control and Prevention, 2013). As a result of addiction, many people begin to lose control of their lives. People become homeless, contract chronic diseases, suffer from exacerbated mental health symptoms and often lose supportive familial and social relationships. The use of chemicals is strongly interwoven into many aspects of our society.

Society has tried to address the problem of chemical addiction through regulation and by offering treatment. Many people in our society continue to use and overuse chemicals despite knowing the legal ramifications. Historically, drug laws have been punitive, which has led to overpopulated prisons. Over half of the adult inmates in federal prison were sentenced due to drug charges (Grant, 2009). The criminalization of drug crimes puts people in the prison system without adequate resources to address the deeper social and emotional issues that are intertwined with their drug use (DiNitto, 2002).

Governing entities throughout the United States have spent vast amounts of money regulating illegal chemical use, and a disproportionate number of minorities have been criminalized and punished (Windsor & Dunlap, 2010). The same types of drug crimes are occurring between people of all colors and socioeconomic brackets; it is the poor people of color who are being penalized. The laws surrounding the use of chemicals have instigated social

concerns about racial discrimination and socioeconomic equality of those who use chemicals (Barr, et al., 1993).

Abstinent-based treatment programs, the dominant treatment method today, began with Alcoholics Anonymous (AA) in the 1930's. AA emerged as a way for addicts to engage and seek support from others who share similar experiences regarding their addiction. Abstinence-based treatment models are often based on the premise that addicts should seek healing through acknowledgement of this powerlessness over their addiction (MacMaster, 2004). Traditional treatment models require participants to adhere to a predetermined curriculum to reach and maintain sobriety.

While there are undeniable benefits to abstinence-based treatment, there has been a growing awareness that an abstinence-based approach to treatment is not well suited for all people who use and overuse chemicals (Gross, 2010). One major problem that can arise in abstinence-based treatment is failure to recognize the benefits that chemical use bestows on the user. While chemicals can take an extreme toll on a person's physical wellness, it is rarely acknowledged, that for the addict, chemicals can bring emotional relief. Chemicals are often mood altering and can mask feelings of trauma, isolation and other negative feelings. Alcoholism rates confirm that twenty-eight percent of people experiencing chronic pain utilize alcohol to alleviate their distress (National Institute on Alcohol Abuse and Alcoholism, 2013). Still, the relief provided by chemical use is not being recognized by our current treatment system (Kellogg & Tetarsky, 2012).

Abstinent-based treatment models tend to define relapse as a failure. Some addicts are unable to remain sober even when they have been through abstinence-based treatment programs many times (Kellogg & Tetarsky, 2012). It also leads to vulnerable populations being cut off

from the very services, such as housing assistance, that support their recovery. Traditional treatment models are so proscriptive that the programs cannot be tailored to fit individual client needs. Many traditional treatment models do not encourage addicts to define what recovery means to them; they are not encouraged to create their own goals that are more tailored and attainable in the framework of their own lives. The concept of being “in recovery” can feel too idealistic for some addicts (Kellogg & Tetarsky, 2012). The inability to maintain sobriety can lead to feelings of shame and embarrassment, which undermines the intent of recovery. In these cases, abstinence-based treatment models can be damaging and demoralizing.

Harm reduction programs have emerged as an alternative to abstinence-based programs. General awareness surrounding harm reduction has increased in the last thirty years (Denning, et al., 2012). This movement has proven to serve a more realistic treatment solution for those people who either cannot or chose not to completely abstain from the use and overuse of chemicals. Even though it has its own flaws, the harm reduction movement has been successful in reaching and supporting a population of addicts that have strayed or have been isolated from traditional treatment models (Carvajal, 1995).

There is existing very little research on the experiences of case managers and clients who utilize harm reduction. This research is often difficult to find, and it often seeks to identify specific client outcomes. This paper will provide an in-depth description of a qualitative research study that will examine the experiences of case managers who implement harm reduction in their direct practice with clients. The paper will address the first-hand experiences of case managers and how their experiences of implementing harm reduction impact their work as social service providers.

## **Literature Review**

The emergence of the harm-reduction philosophy has impacted the way that chemical health treatment has been perceived and implemented in the United States. The purpose of this literature review is to collect and integrate existing research and information on the topic of chemical use and overuse in our nation; it is important to have a context for how chemical health treatment options have evolved in the last several decades. After contextualizing the progression of chemical health treatment, as well as the social and moral thoughts that surround addiction, the literature review will outline the impetus for the emergence of harm reduction and the impact that harm reduction has had on the chemical health treatment culture. The remainder of the literature review will provide a context for why harm reduction is an empowering and successful philosophy to implement with clients who identify as addicts. While the current research supports the needs for chemical health treatment, including harm reduction, it does not provide enough information about the experiences of the providers who implement harm reduction strategies. Information about the experiences of providers who implement harm reduction will not be included in the literature review because the current research is limited and difficult to locate.

## **History of Societal Perceptions of Chemical Use and Overuse**

As governing entities in the United States have become more involved in the control and distribution of chemicals, moral issues surrounding chemical use have evolved. In order to understand the interrelatedness between social work practice and chemical health treatment, including harm reduction, it is important to identify a historical framework of the social perceptions of chemical use and overuse. Throughout history, society has attributed different

meanings to the use and overuse of chemicals, and therefore, society's reaction to chemical use has varied (Richman, 1985).

The first attempt to regulate the use of chemicals is known as The Harrison Narcotics Act of 1914. This Act was intended to stop the trafficking of Opium by Chinese Immigrants entering the United States (U.S.). Initially, the Harrison Narcotics Act of 1914 was implemented as a way for the government to take control of the revenue the Chinese Immigrants gained from selling Opium to U.S. citizens. The social stratification between the middle-class and poor became more pronounced as a result of the act. The act placed limitations on availability of the drug, but it did not eliminate the desire for the physical and mental effects the drugs provided to people. The difference was that the middle-class could access different drugs that were still legal from their physicians, but the poor people, including the Chinese immigrants, did not have the same access, and therefore, continued to seek out what was now deemed as an illicit drug (Housenbold Seiger, 2005)

The Prohibition Act was approved in 1919 as a reaction to the continued dissemination of both drugs and alcohol. Prohibition was enacted as an even harder force than the Harrison Act of 1914. Prohibition not only attempted to control the drugs deemed illegal by the Harrison Act that were being legally prescribed by physicians, but it also began to control the use and sale of alcohol (Saper, 1974). There existed a political coalition of two groups of people; one group who believed in the complete abstinence of alcohol consumption, and one group who objected only to public displays of immoral drunkenness (Kennedy, 2003). As a result of even stricter government control, drugs and alcohol began to be sold on the black market. As the black market began to expand, so did the development of organized crime in the United States (Hall, 2010). People still wanted to use chemicals, particularly those who had become addicted to the use of

their once prescribed chemicals. The black market expanded the criminalization for the use of drugs and alcohol (Saper, 1974).

Throughout the 20<sup>th</sup> Century, governing entities in the U.S. continued to control the use of illegal chemicals using strategies that have been criminalizing and dehumanizing. During the Nixon and Reagan administrations, the infamous phrase, “The War on Drugs,” was appropriated by governmental leaders and society at large. The idea that the new drug laws could disproportionately impact people of color and people from lower socioeconomic backgrounds was dismissed, or not even acknowledged (Windsor & Dunlap, 2010). The phrase “Just Say No!” came out of a campaign and a curriculum directed towards school-aged youth. It taught young people the realistic dangers of drug abuse, but the social implications of the movement were disastrous for disenfranchised communities (DiNitto, 2002). People of color, particularly black men, were being punitively profiled and criminalized for drug crimes, and school age children were exposed to the discrimination and segregation that was implied by media images, and school-based curriculum regarding education about chemical abuse (Johnson, 2008).

It is vital to recognize the impact drug laws have on disenfranchised communities because social work as a profession strives to address such disparities. The social separations and stigmatization that drug laws have created requires social workers to compensate for a failing treatment system. As the impact of drug laws have unfolded over time, so has the progression of our treatment system. The need for social workers to create and implement alternative treatment strategies for the health and healing of disenfranchised communities is abundant (Kellogg & Tetarsky, 2012).

## **History of Treatment**

Prior to the 21<sup>st</sup> Century, addiction was considered to be the cause of spiritually deviant behavior and addiction was treated by spiritual leaders. As the 21<sup>st</sup> Century has progressed, so has the knowledge base surrounding science and medicine (Brent, 1996). There continues to be a spiritual element in relatively current treatment models. There is also an emphasis placed on the biology of the disease, which includes the connection between addiction and mental health (Brent, 1996). One of the most widely known treatment models, which includes both a biological and spiritual component, is Alcoholics Anonymous (AA). Narcotics Anonymous (NA), AA's successor, has developed out of the same tenets as AA in more recent years (Gross, 2010).

Alcoholics Anonymous (AA) started in 1935 through the work of Doctor Bob Smith, a surgeon, and a stockbroker named Bill Wilson. The principles of AA were heavily influenced by the beliefs of the Oxford Group, a group that followed a Christian doctrine. The AA model included inpatient detoxification and psychoanalysis for those people who could afford the treatment (Gross, 2010). The AA movement was designed for people who made a choice to abstain from the use of alcohol. The tenants of the AA movement have guided followers towards abstinence; the movement does not identify as a treatment model. The AA movement deeply values the concept of camaraderie, and participants self-identify as having a common addiction. This commonality provides participants of AA with a sense of solidarity to support one another in abstinence from alcohol (Gross, 2010).

The AA model is historically significant because it identified the chronic overuse of alcohol as a disease. AA identified people who overused alcohol as having little control over their ability to manage their consumption of alcohol and the behaviors that resulted as a consequence. As the disease model became more understood, the perception of immorality associated with drinking began to dissipate. However, there was still a focus on complete

sobriety, and the concept of relapse carried a connotation of failure (Roy & Miller, 2012). The identification of what people were not doing leading up to a relapse was acknowledged, but the consideration that there was something to learn from the relapse was not as recognized (Roy & Miller, 2012).

Other treatment models have emerged in more recent years, including the Minnesota Model and the Health Realization Model. While these models vary from AA in some ways, they all share the same major belief that complete abstinence is vital for recovery (Banerjee, Howard, Mansheim, & Beattie, 2007). In addition to complete abstinence, there is also a spiritual component to the existing treatment models that does not appeal to all people seeking treatment for their chemical health. The acceptance of a higher power is strongly expected as part of the treatment process in the AA and other abstinence-based models (Johnson, 2008).

Treatment models encompassed a spiritual component, primarily based on Christian values that did not resonate with all people interested in chemical health treatment. While participants were encouraged to interpret those values to fit their own spiritual needs, there exists a subtle pressure to accept a higher power. Some addicts were incredibly turned off by this element, and did not feel accepted by the abstinence-based treatment community (Windsor & Dunlap, 2010).

### **Emergence of Harm Reduction Out of Abstinence-Based Treatment**

Harm reduction gained notoriety following the emergence of the HIV and AIDS virus in the 1980's and early 1990's. As the spread of HIV and AIDS became rampant, the concept of harm reduction was encouraged and implemented among injection drug users to reduce the risk of spreading HIV by sharing needles (Brocato & Wagner, 2003). The revelation that abstinence-based treatment was not working for a large number of addicts, particularly among vulnerable

populations, caused a wider public health concern due to the spread of HIV and other diseases. Grass roots organizations started to comprehend that injection drug use continued in communities that were oppressed despite the staggering numbers of people becoming infected with the HIV virus (Seiger, 2005).

Efforts from the emerging harm reduction community attempted to reduce the health and legal risks that drug users faced. Still, the use of drugs continued to be criminalized, and, as a result, marginalized people of color. People of color disproportionately received jail sentences for their involvement with drugs as compared to their white counterparts. Treatment outcomes were exclusively founded on abstinence-based models; drug users' success and the resolution of their legal issues were hinged on sobriety rather than any sort of acknowledgement of improvement. Due to the strict rule and curriculum of abstinence-based treatment programming, drug users from disenfranchised populations were not provided a treatment environment that considered and supported the real life inequities that they faced because of their race and socioeconomic status (Garland & Bumphus, 2012).

The realization that existing treatment models for chemically addicted people may not be sufficient or realistic for people from varying demographic backgrounds has gained momentum in recent years. The notion that even reducing the exposure to harm would result in improved health outcomes has become more meaningful to providers and drug users who previously sought out abstinence-based treatment models. The need for additional treatment models and strategies became wildly apparent (Kellogg & Tetarsky, 2012).

### **Harm Reduction as a Viable Treatment Option**

Harm reduction is often discussed in regards to the relationship between the use and overuse of chemicals and the harm that is caused by the use and overuse of chemicals. Harm can

be defined in many different ways, including, but not limited to, negative physical and emotional health symptoms, financial distress, and the dissolution of significant relationships. The ultimate goal of the harm reduction model is to reduce the harm of a specific behavior or action, which is most often defined as the overuse of chemicals (MacMaster, 2004). The Harm Reduction Coalition defines harm reduction:

Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs (Harm Reduction Coalition, <http://harmreduction.org/about-us/principles-of-harm-reduction/>).

Jeannie Little (2006), LCSW, Executive Director of The Harm Reduction Therapy Center in San Francisco, California provides the following examples of harm reduction in action in one of her journal articles,

For example, one person has quit crack, learned to drink moderately, and continues to use medical marijuana, while another has stopped shooting heroin, goes on methadone maintenance, but still struggles with a long history of alcohol abuse. A third, in danger of losing her job, has quit all psychoactive substances, while a fourth who is HIV positive committed to using condoms during all sexual activity even while still using crystal meth (speed) and a fifth now hands his car keys to the bartender as soon as he enters the bar (Little, p. 69).

As highlighted in the above examples, harm reduction asserts that it is imperative to provide services that are relevant to the life of an individual that overuses chemicals. This can

vary depending on the current life circumstances and personal desires or goals of the individual. The contextualization of a person's use and overuse of chemicals can vary dramatically. Likewise, the success of an individual's treatment can also vary dramatically. Harm reduction embraces a variety of behavioral modifications with the assumption that peoples' needs are different, often times based on their race, culture, gender and socioeconomic status (MacMaster, 2004).

Harm reduction aims to reduce the shame that is often associated with the overuse of chemicals. The shame that often accompanies the overuse of chemicals is replaced with a sense of self-empowerment and self-determination through harm reduction practice. Harm reduction does not promote powerlessness, but rather requires that people who overuse take ownership of their ability to reduce harm in their own lives (Denning et al, 2012). The promotion of relapse as being a failure is not condoned by the harm reduction model; instead, relapse is not acknowledged unless an individual that overuses chemicals identified abstinence from chemicals as a personal successful harm reduction strategy. If a person identifies that complete abstinence from chemicals is an important personal value, and then experiences a relapse, the focus is then placed on what could be implemented that would be more helpful in fulfilling their goal of complete abstinence from chemicals. In other words, the "failure" is placed on the treatment plan and not on the individual (Gross, 2010).

### **Assumptions Regarding Harm Reduction**

Harm reduction is often viewed as being exclusively effective for people who are unwilling or unable to stop overusing chemicals. Further, it is often assumed, especially by proponents of abstinence-based treatment methods, that harm reduction excludes abstinence-based treatment methods. In actuality, abstinence-based treatment methods are

considered to be an effective harm reduction strategy for some people (Denning et. al., 2012). In the first publication by the Harm Reduction Coalition in the fall of 1995, Peter Carvajal poignantly writes about the division between the harm reduction community and supporters of the abstinence based programs:

This division exists institutionally—as there are harm reduction programs and there are drug treatment programs—and with the discourse. This gulf is artificial and its efforts are crippling. Harm reduction and drug treatment can coexist on a continuum, and as complimentary parts of a pluralistic drug service system. Such a system offers relevant and helpful services to drug users at different stages of their use. Where such systems exist, the results are markedly more effective and productive than our present catastrophe (Carvajal, p. 1).

There is a polarization between the treatment community and harm reductionists, when in fact both methods are trying to achieve the same goal: to increase the quality of life of people who overuse chemicals. There is a common assumption in the treatment community that harm reduction enables and encourages individuals to participate in self-destructive behaviors. Even with the implementation of the disease model, there still exists a great amount of discrimination towards people who use and overuse chemicals, especially if they actively make a decision to use or overuse as opposed to participating in treatment (Bigler, 2005). One of the basic tenants of AA requires that an individual be willing to accept treatment and engage in a predetermined set of guidelines in order for treatment to be considered successful and to be accepted by the AA community.

Harm reduction does not offer a predetermined curriculum for its participants. The recipe for change is defined by the addict, with the support of providers. While harm reduction is not

about giving an individual permission to use, it is about providing support and education that allows people to reduce the harm that results from their using behaviors (Kellogg & Tetarsky, 2012).

### **Intersection of Social Work and Harm Reduction**

While abstinence-based chemical health treatment is a successful fit for some individuals who use and overuse chemicals, there are deeper societal issues that can impede the efficacy of the abstinence-based treatment process and outcomes (Collins, et al., 2012). Factors such as race, culture and socioeconomic status can significantly inhibit an individual's ability to participate in more traditional treatment programs (Collins, et al., 2012).

It has only been since the early 1990s that research has addressed the barriers to the accessibility of chemical health treatment among racial minorities (Schmidt et al., 2006). Racial minorities are less likely to seek treatment because of the social stigma and the racial profiling that shadow people of color in accordance with the punishment of crimes involving illegal drug activity (Johnson, 2008). Research in the years after the implementation of the Anti-Drug Abuse Act of 1988 illustrates the shortcomings of having strict and authoritative ways of dealing with drug education and drug use (Windsor & Dunlap, 2010). Research also suggests that marginalized populations face barriers that may keep them from successfully adhering to an abstinence-based treatment model.

While the abstinence-based treatment programs do not overtly discriminate against people from marginalized communities, there are factors that people from these communities face that are not always taken into consideration by the abstinence-based treatment community. These factors can be as simple as not being able to afford bus fare to an AA meeting. More complex obstacles may be induced by deeply rooted cultural beliefs. Clients from cultures that

shame consumers of alcohol may risk being completely ostracized from their culture of origin if it discovered they attended an AA meeting; openly addressing their addiction may instigate isolation and fear and keep them from seeking the support of an abstinence-based community.

The goal of social workers is to meet the client's needs by providing support and guidance that is appropriate for their current level of motivation and their ability to cope with the coinciding feelings that therapy often evokes. Psychotherapy will not be successful if the client is not prepared to participate in therapeutic conversations that may push them in a way that is uncomfortable or frightening (Little, 2006). Illicit chemicals can be used as a means to manage the feelings that surface after a long history of trauma, or other issues addressed during therapy. Using chemicals can temporarily mask the intense and reoccurring feelings of pain that may result from significant childhood trauma. In this regard, harm reduction combined with the implementation of social work values may be a more manageable way to address issues surrounding mental health issues. The utilization of harm reduction provides an opportunity, and an emotionally safe place, for clients to deal with their mental health issues, without having to feel ashamed by their inability to remain abstinent from chemicals. In addition, these opportunities allow social workers to implement one of the significant philosophies of the social work profession: human dignity (Denning et al., 2012).

### **Harm Reduction and Strengths-Based Social Work Practice**

The strengths perspective is a theory that is often utilized in the practice of social work. The strengths perspective requires the social worker to assume that each client has competencies and part of the social worker's job is to seek out those competencies. When client strengths are recognized and acknowledged, clients become empowered to utilize those strengths in the context of their own lives. Ideally, this allows clients to reach goals that are realistic and appropriate for them. Clients are able to define their own successes rather than work toward goals that are set on their behalf that may not be meaningful or pertinent to the realities of their life circumstances (Allman et al., 2007).

The strengths perspective is particularly relevant among social service providers who utilize harm reduction in their practice. The strengths perspective and harm reduction have many similarities and share the sentiment that clients are the experts of their own lives. As noted earlier, according to the Harm Reduction Coalition,

[h]arm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs (Harm Reduction Coalition, <http://harmreduction.org/about-us/principles-of-harm-reduction/>).

The above statement makes it clear that harm reduction is based in a strengths perspective. Harm reduction focuses on the competencies and capabilities of clients, as does the strengths-based perspective. When people, especially those who are disenfranchised, are acknowledged for their abilities, they gain self-confidence and a more authentic feeling of

control over their own lives. They are more likely to feel a sense of self-competence that empowers them to make healthier and safer decisions.

The strengths perspective proposes that collaborating with the client is necessary, and the client needs to be recognized for her resources. The strengths perspective confirms that even the most disenfranchised people have resources that can be utilized to better enable them to reach their goals (Allman et al., 2007). In the context of this paper, an addict living on the street may work closely with her case manager to brainstorm a harm reduction strategy to increase her physical safety when using drugs. Implementing that harm reduction strategy becomes her strength. They may still use drugs, but they have succeeded in reducing their chances of being physically assaulted. From both the strengths perspective and the harm reduction philosophy, this is a success.

When implementing the strengths-based perspective, the social worker is also responsible for recognizing the assets that their clients possess. It is important to understand that assets can vary tremendously among people; some people excel at accomplishing certain tasks and not others. For instance, a man may be a successful car mechanic, but those skills may not translate into allowing him to succeed as a waiter in a chaotic restaurant. This does not suggest that certain people are higher functioning or cognitively superior to other people; it simply means that people strengths and specialties can be diverse (Miley, O'Melia, & DuBois, 2011). Utilizing a strengths-based approach and implementing harm reduction can easily go hand-in-hand. Social workers need to strive to understand the assets that their clients have and can apply as they identify harm reduction strategies suited to reducing the possible harm when using chemicals. For instance, a client may be very knowledgeable and motivated to seek out local housing resources; a social

worker should encourage the client to use those skills. Obviously, it would be less effective for a social worker to encourage a client to use an asset that the client lacks.

Another important aspect of the strengths-based perspective is that it acknowledges and gives credit to the resiliency that people learn and develop through times of hardship. This is particularly applicable when working with clients who are survivors of abuse, neglect or forms of systematic oppression. An individual's ability to cope with hardships, even if the coping mechanisms are somewhat unhealthy or unsafe, is a strength to be identified; the individual is still persevering and continuing to survive. Social workers have the opportunity to reframe what a client may perceive as a personal failure, or something to be ashamed of, as a success and a reason to feel empowered. People have the capacity to be incredibly resilient, and the philosophy of harm reduction provides a framework for social workers to help their clients recognize and feel proud of their strengths (Miley, O'Melia, & DuBois, 2011).

Regardless of whether a social worker is doing clinical psychotherapy in a private setting or works with multiple clients in a large homeless shelter, there is a place for harm reduction in social work. The first sentence in the Preamble of the National Association of Social Worker's Code of Ethics reads, "The primary mission of the social work profession is to enhance human well-being and help meet the basic needs of all people who are vulnerable, oppressed, and living in poverty" (Code of Ethics of the National Association of Social Workers (NASW), 1996, p. 1). Harm reduction is a model that is especially relevant to these populations; people who are vulnerable, oppressed and impoverished often do not have the resources to be successful using the abstinence-based framework. Social workers have tremendous opportunities to use the harm reduction model in their practice; the fundamental principles of the strengths-based perspective

and the harm reduction principles efficiently coincide and make for an effective way to communicate with people in need of a non-abstinence-based approach to recovery.

### **Intention of Research**

Social workers have a responsibility to respond to the issues surrounding chemical addiction and treatment at a policy level as well as in their direct service practice. Social work values deeply coincide with the concepts of harm reduction and non-abstinent-based responses to drug abuse and the outcomes that result from drug abuse. The people who are most negatively impacted by drug laws are often the people who lose their voice or do not have a way to use their voice in the democratic process. Social workers have a responsibility to advocate for these populations and to be the voice for people who are overlooked and underserved. Harm reduction is an appropriate philosophy for social workers to base their advocacy work on because it promotes the humanistic values in which key concepts of diplomacy and respect are provided to the drug user (Barr, Farrell, Barnes, & Welte, 1993).

While the upsurge of social workers who use harm reduction continues to increase, there is little research about their experiences. Social workers who use harm reduction are faced with a unique challenge. Even as they serve clients who are empowered to make their own decisions, social workers know that client decisions can often lead to negative outcomes. This research project strives to gain a better understanding of the experiences of social workers who are providing direct service and are experiencing first-hand interactions with clients using harm reduction. These experiences need to be understood and shared, both good and bad, to enable future social workers to uphold the profession and its values.

## Methodology

**Research Question:** *What are the experiences of case managers who utilize the harm reduction model in their direct practice with clients who overuse chemicals?*

### Data Gathering

The nonscheduled-standardized interview process was used for this research. A set of uniform questions was asked of all of the respondents. Respondents were given the opportunity to elaborate on their unique experiences as case managers who uses harm reduction in their practices (Monette, et al., 2011). The interview process was a qualitative data collection mechanism and was well suited for this research question because it created an opportunity for the respondents to expand on their experiences in a way that would not be limited by a set of predetermined answers. Berg writes, “Qualitative research, thus, refers to the meanings, concepts, definitions, characteristics, metaphors, symbols and descriptions of things... [C]ertain experiences cannot be meaningfully expressed by numbers (Berg, p. 3). Quantitative data collection gives the participants an opportunity to explain what makes their experiences unique to their direct practice. The process of working with clients who have diverse backgrounds and a wide range of needs create experiences for the case managers that are complicated. It would be difficult to thoroughly summarize and articulate these experiences using a survey (Berg, 2009).

The interview questions were categorized into clusters according to topic. The questions asked the respondents to reflect on their experiences of using harm reduction strategies in their work with chemically addicted clients. The interview questions were framed to gather information about the respondents’ professional experiences as well as personal feelings and beliefs that have surfaced as a result of their direct service. The questions prompted the respondents to explore and recall their experiences learning about and implementing harm

reduction. They were also asked to share their feelings about the professional and personal support they receive. The questions also asked the respondents about how they manage any stressors that arise during their work with clients. All of the questions were open-ended, and simply worded (Monette, et al., 2011).

The respondent and the researcher were the only two people present during the interview. The interviews took place in a public location of the case manager's choosing; some of the case manager came to the office of the researcher, and the researcher met some respondents at the agency where they were employed. All of the interviews took place in a quiet and confidential space where the interview would not be interrupted.

The interviews were recorded so the researcher could transcribe the respondents' answers at a later date. The data collection process used a semi-structured interview process, and the researcher asked the same set of questions of every respondent during each interview. The following questions were asked:

1. How long have you been implementing harm reduction in your practice?
2. In your experience, what type of client does harm reduction strategies work best for?
3. How did you get involved in utilizing harm reduction in your direct practice with clients? What is it like for you?
4. How has the utilization of harm reduction strategies evolved overtime in your direct service with clients?
5. What sort of support do you get for your work? Is the support from colleagues from your agency? Is the support from personal relationships outside of the work environment?
6. Do you find this support adequate? How is it helpful? How is it lacking?
7. Do you have experiences using abstinence-based interventions? If so, how do you find using harm reduction different from abstinence-based strategies?
8. How much contact do you have with your clients (face-to-face meetings, phone calls, emails, etc.)? Does the level of contact that you have with clients affect your experiences implementing harm reduction?
9. How does your agency measure client success in regards to chemical addiction?
10. Does using harm reduction with clients who use chemicals affect your experiences, for example, your level of stress? Does using harm reduction ever decrease your level of stress?
11. What are your personal ethics regarding harm reduction? If your personal ethics do not align with harm reduction, how do you reconcile the differences?

## **Sampling**

The respondents were case managers who are employed at local agencies and hospital-based clinics throughout the metropolitan area of Minneapolis, Minnesota. The researcher interviewed a total of eight respondents. The modified snowball strategy (Monette et al, 2011) was used to find case managers who were interested in participating in the research study. The researcher started by contacting at least one known case manager at each agency by email. After making initial contact, the researcher asked the respondents if they had any professional peers who would be willing to participate in the research study. The researcher contacted the referrals by email to provide a more thorough explanation of the research project, and the involvement required from them as a participant.

The case managers all have a college education with a degree in the social services field. One respondent had one year of experience working as a case manager. The other seven respondents had at least three years of experience working as case managers. All of the respondents had some formal training about the harm reduction philosophy; many of the respondents learned about the harm reduction philosophy from their managers or co-workers. The respondents were not required to personally agree with the philosophy of harm reduction, but they were required to strategize and implement harm reduction in their professional work with clients.

The respondents were employed at a total of five different agencies. This created an opportunity for the researcher to interview respondents who come from a variety of different working environments. This also created an opportunity to find case managers who did not necessarily work closely with one another. Interviewing case managers from

a variety of different agencies that serve clients from a variety of different backgrounds increased the variety of experiences that the respondents reported on.

### **Data Analysis**

The data were transcribed by the researcher following each interview to avoid any confusion. The researcher was the only person to transcribe and code the answers, which increased the consistency of how the respondents' answers were interpreted. The data were typed up using a computer and then coded to reveal themes and sub-themes. The information that was coded and disseminated in the research paper does not include any information that identifies the names of the participants, or the agencies where they are employed (Berg, 2009).

### **Human Subjects**

The researcher treated the information shared by each participant with the utmost respect. The researcher thoroughly explained to participants that the information they share would be kept confidential. After each recording was transcribed, the interviews were immediately deleted. The computer was used during the transcription process is in a locked office that only the researcher may access. The transcription of each interview is saved on a hard-drive, rather than a flash drive, to maintain a higher level of protection.

The researcher clarified with each participant that her participation in the research project was voluntary and she could decline to answer individual questions throughout the interview. The participants were told that they could choose to withdraw their complete participation in the research process up until one week after the day of their interview. The researcher explained to participants that if they chose to withdraw their complete participation from the research, it would have no impact on their relationship with the researcher nor would it impact their current

or future relationship with The University of St. Thomas or St. Catherine University. None of the researches withdrew their participation.

### **Possible Biases of Researcher**

The researcher has a strong background and personal commitment to employing harm reduction strategies in her professional life as well as her personal life. The researcher genuinely believes that abstinence-based treatment methods are successful and necessary for some people; and firmly believes that the practice of using a harm reduction framework encompasses abstinence-based approaches to chemical health treatment as one approach. However, the researcher also believes that there are flaws in the abstinence-based approaches that can be detrimental, particularly when working with people from diverse cultures, religions and socioeconomic backgrounds.

During the research collection process, the researcher recognized a need to remain mindful about being focused and undistracted during the interviews, as well as during the transcription process. This ensured that the researcher provided an unbiased interpretation and analysis of the experiences the case managers chose to disclose. The researcher was also cognizant of not entering the interviews with previous assumptions about the respondents' experiences, and was non-judgmental of the personal and professional views that occasionally deviated from the researcher's personal and professional views.

## **Findings**

Collectively, the respondents were proponents of utilizing harm reduction strategies in their direct practice with clients. The majority of the respondents worked at agencies that incorporated harm reduction into the agency's mission, or they had direct supervisors that supported the tenants of harm reduction and encouraged and coached them to use harm reduction strategies. During the interviews, the respondents did not verbalize that they had experienced any moral or ethical dilemmas on a personal level with the utilization of harm reduction. Many of the respondents had experiences incorporating abstinence-based approaches as part of their harm-reduction approach at their current place of employment. Few respondents had experiences exclusively using abstinence-based approaches in previous professional experiences; they felt that exclusively using abstinence-based models would considerably limit their ability to meet the needs of their clients.

## **Training**

All of the respondents recognized that the understanding of harm-reduction is becoming more wide-spread, but that training professionals about harm reduction is lacking. Many respondents thought that living in Minnesota created barriers because of the state's history of hosting abstinence-based treatment programs such as Hazelden. Respondents indicated that other abstinence-based models, including the Minnesota Model and the Health Realization model are also well known in the chemical dependency communities in the Minnesota. Generally, respondents felt like there was an abundance of training involving abstinence-based approaches, and very little available trainings involving harm reduction. Respondents felt urgency for harm reduction to be more prominent in the local chemical addiction communities.

One respondent reported having access to formal trainings surrounding harm reduction. This respondent confirmed that her agency provided formal training surrounding harm reduction for her orientation when she started her current position; she acknowledged this was unusual compared to her peers from other agencies. Some respondents commented that they learned about harm reduction in college or graduate school, but in a very abstract manner that did not feel applicable to their direct practice. One respondent confirmed that he was not aware of any training opportunities, while other respondents said they had been to a few trainings outside of their agency but primarily learned about harm reduction through reading scholarly articles and books and watching documentaries.

Over half of the respondents explained that they felt that their co-workers, or even supervisors, needed more training about harm reduction. Respondents felt like people they worked with who did not have direct client interaction had little awareness of harm reduction and why harm reduction strategies are beneficial for some clients. One respondent confirmed that she works at agency where a particular client has been served for many years and the client has cycled through several case managers. This respondent felt like there was a certain level of apathy from previous case managers towards this client. Previous case managers expressed that the client's behaviors surrounding addiction had shown deterioration or very little improvement over the years. The respondent explains,

I was told, you're not going to be able to do anything with this client, and it just felt so wrong. My co-workers were good people, they just weren't really, they just had nothing but negative things to say, so you know, I didn't have a formal social work background either, so I guess I just kind of thought, well...let's try something different.

This respondent explained that she felt like this particular client would benefit from harm reduction because it redefines success; the client does not have to be sober to be successful. She felt disappointed that the previous case managers who had worked with this client did not find alternative ways, such as harm reduction, to work with the client. This respondent learned early in her career that if she were going to be able to work with these clients and build any sort of relationship, she would have to come up with a different strategy that would be more engaging and productive.

Often, respondents used the term “mind set” when discussing their experiences with harm reduction. The tenants of harm reduction felt like common sense. They acknowledged further trainings on harm reduction would be beneficial, but they still felt confident about their capability in implementing the model. One respondent explained,

I think it's a mind-set. I think you can learn more to help you make a case for your mind-set, but for me, I think when I learned about institutional inequality and had more training about social justice and privilege, that helped me have more arguments for my beliefs and to be able to back them up, but I've always had that mind-set based on my own experience, and life.

Harm reduction felt like a logical and ethical model to approach addiction as well as other self-harming behaviors. Respondents explained that as they have gained more direct client experience, they feel as though they have gained a deeper sense of commitment to using harm reduction. Respondents explained that harm reduction has provided a framework for approaches they have already been implementing with their clients.

### **Struggles with Abstinence-Based Practice**

The notion of shame was repeatedly brought up by respondents. As they reflected on their experiences with clients, they said they regularly heard their clients describe feelings of shame and guilt as a result of a relapse or their general struggles with abusing chemicals. One respondent stated,

The shaming. The shaming is the biggest thing that jumps out at me, and clients feel like, you know, I've heard it time and time again, they feel like a failure and there's so much guilt and shame from other people that are around, you know, like from their friends that are going through the same programs, if they're not on their meds or if they're not sober, the shame and guilt that comes with that, it is pretty crushing, and it's a time when they need more support than ever, it's pretty tragic and there's so many people that are in that situation, in Minnesota specifically, at least in the chemical dependency world, it's so structured because of the Minnesota Model. It's changing, not as fast as the rest of the world, but it's changing. I think people are coming around to realize an abstinence-based approach is not going to work for all people.

Respondents explained that many clients defined themselves by their relapses. They felt like they had failed, let themselves down, and disappointed the people who helped them with their periods of sobriety. The feeling of success was greatly diminished after experiencing a relapse.

The respondents expressed that the use of harm reduction allowed their clients an opportunity to reframe and compartmentalize their chemical health as one aspect of their entire selves. Respondents reported that clients felt that relapse does not carry the same connotation of

failure and defeat when using harm reduction. In an effort to prevent and counteract some of these feelings, a respondent stated,

I've always encouraged clients to continue to pay attention to the gains they've made, even if they don't sustain abstinence, because there are still gains that are made, like having more self-awareness, more of an ability to reduce harm to oneself, the ability to make other choices if they desire, all of that I try to refocus so there's not despair, and they don't just give up and go back.

This respondent provides a poignant example of how harm reduction can encompass efforts to completely abstain from chemicals, and if a client experiences a relapse, the hard work and determination is not minimized. Respondents felt like harm reduction differed from abstinence-based models because it allowed clients to utilize a relapse as an opportunity to stop and reflect on their lives with a diminished sense of disappointment and self-deprecation. Respondents recognized that the shame and guilt still existed within the clients, but to a lesser degree, and they experienced less anxiety about losing services as compared to their experiences in abstinence-based treatment programs.

Some of the respondents felt very strongly that utilizing harm reduction should be the only approach to working with clients who have chemical health issues. They felt harm reduction was the only ethical approach to treating chemical addiction. During the interviews, most respondents reiterated the importance of allowing clients to set their own goals and admitted that expressing guidelines for what clients should not do could be damaging to their working relationship. Respondents expressed that talking about options in a realistic and honest manner facilitated a better working relationship with their clients. Respondents felt like their clients began to learn and trust that their case manager was not going to abandon them if they relapsed.

One respondent explained how she expected her clients to have goals, but the language she used when discussing goals emphasized that change was an ongoing process. When a client was encouraged and reminded that life is a process, there was less of an opportunity for them to feel as though they had failed. Respondents felt that working with clients was about building their capacity to manage their lives in a way that was meaningful to the client.

Overall, the respondents were able to recognize that using harm reduction created an opportunity for their clients to build confidence in their ability to change and to reduce their self-harm. Respondents felt as though the connections they made with their clients helped counteract some bad experiences their clients had had with case managers in abstinence-based relationships. The respondents explained that abstinence-based programming was not well suited for their clients, but it did not mean there was no need for abstinence-based programming.

### **Relationships with Clients**

The respondents continued to reflect on the importance of having a quality relationship with their clients. They placed a great amount of value in the harm reduction framework because it allowed them to see their client as a multidimensional person. Many of the clients the respondents worked with came from long histories of failing out of abstinence-based treatment programs. These clients rarely had long-lasting relationships with their case managers due to being discharged from programs. Many of the respondents felt as though abstinence-based approaches require providers to exclusively view their clients through the lens of addiction, which ultimately tends to discredit the strengths they may possess in other areas of their lives. One respondent explained,

You really have to develop the relationship before you can implement change. So, it's really about consistency, being there for them despite what they do, and that

the therapeutic relationship isn't contingent on a certain behavior, like sobriety, once they recognize, that they know you're a safe person that is genuine and you're real with them, they they're more likely to implement change.

Respondents found that when a client began to recognize that the relationship with a case manager was not dependent on their sobriety, they may push back in anticipation of being left behind, but generally, they began to contemplate their own self-worth. They began to learn that their addiction was not the only thing that defined who they were as a person. They might continue to use drugs, but they could also claim or reclaim their identity as a friend or a student or a leader. Respondents did not insinuate that a client's addiction could be completely ignored or dismissed, but taking a break from primarily focusing on the addiction could be beneficial to the working relationship.

Case managers expressed that the process of reframing client goals was incredibly gratifying for themselves as well as for their clients. They felt much more connected to their clients because they felt it decreased the power dynamic in the relationship, and it allowed and reminded the case managers to stay focused on the goals of their clients rather than the goals they may have for their client. Although respondents admitted this was not always easy, because they wanted health and safety for their clients, respondents identified that there was something really moving about the process of empowering clients to define what success means in terms of their own lives.

One respondent emphasized that when clients struggled with their addiction, it indicated they were not getting enough social and professional support. Using drugs is a reflection of an issue that may be deeply rooted in their identity. Utilizing harm reduction allowed respondents to dig deeper into what was at the root of the client's addiction, allowing the client to be vulnerable.

Respondents stated that most of their clients had experienced trauma or neglect in their lives, and it was hard to be successful using any form of chemical health treatment strategies if they did not start to address their underlying issues. One respondent worked with clients who had very persistent and extensive mental health histories. This respondent said that when she started to use harm reduction with these clients, it reframed her entire outlook, and helped her stay motivated and committed to her clients:

There is so much more to a person than that part of their life, and so you know, there would be people who are extremely talented and have a lot of strengths and a lot of personality gifts, but they would have to be terminated because of their addiction? When they were that mentally ill and vulnerable? Looking back, it's really hard to think about.

The respondent explained that it was very clear that her clients had been craving the positive attention and recognition. Celebrating strengths with the clients re-energized them; their addiction may not have improved, but it did not get worse.

All of the respondents worked at agencies that primarily served clients who were disenfranchised in some capacity. With the exception of one respondent, all of the case managers confirmed they exclusively worked with clients from very low socio-economic brackets and the majority of their clients were people of color. The case managers admitted to feeling a great awareness of the lack of social justice within the treatment community. Respondents recurrently discussed how they felt as though abstinence-based approaches did not take into consideration the barriers that disenfranchised populations faced. Although they reported that according to their client's reports, it was not necessarily intentional, it was still a barrier to feeling welcomed and accepted. Relating to other participants from higher socio-economic brackets was a struggle.

### **Struggles with Multi-Disciplinary Teams**

All of the respondents reported that they frequently engaged on a professional level with providers from cross-disciplinary backgrounds. Generally, the respondents expressed a high level of dissonance regarding how success was defined by professionals from different disciplines. As professional proponents of harm reduction, the respondents frequently felt dismissed or misunderstood by other providers. This theme was recognized by every participant who was interviewed.

The respondents expressed feeling a strong professional investment in the necessity of allowing their clients to define their own values and goals. Respondents recognized a general understanding that motivational interviewing was a wonderful tool to learn about their clients in the words of their own clients. Respondents confirmed that it was often challenging to practice this way if they worked on a multi-disciplinary team. According to many of the physicians, clients' success was strictly measured by an improvement in physical health outcome. One respondent had an experience during a large group meeting between social service providers and physicians who served the same clients. There was a discussion about one client in particular, and the physician made a statement about a client that the case manager found demeaning and judgmental. The respondent shared,

There was just one time when I did ask to speak with a provider separately, after rounds, and I did meet with him in his office, and I said, you know, what you said was not okay, and I don't appreciate it, it upset me, your patient wouldn't like to hear you say that about them.

While this particular respondent acknowledged that this was an extreme situation, and was not reflective of all of the physicians she works with, she did feel it was an accurate example

of some of the conflicting conversations between professionals. Respondents recognized that there still exists systemic questions about the morality of people who use drugs. Ultimately, the sentiment is that they are less deserving of services.

Respondents indicated physicians wanted to see concrete and measureable improvements in the clients' ability to remain sober. They felt there was little interest in understanding their clients in terms of stages of change and the reasons behind their clients' addictions. The respondents placed more value in their clients' ability to identify and attain personal goals. While the physicians were invested in improving the physical health of their clients, there was less of an investment in the mental wellness of their clients and how mental wellness may influence physical wellbeing. Respondents indicated that they frequently felt as though they had to emphasize the big picture and create opportunities to redefine success in the presence of physicians. Some physicians were responsive to their efforts, but other physicians struggled to recognize these connections.

In addition to the discrepancies in defining client goals, the respondents expressed feeling as though they needed to go the extra mile to advocate for their clients, often in a protective manner. The tone and language used by other professionals during care meetings often created unease for the respondents. Some respondents felt as though their clients were not treated with the same respect as other clients that practiced sobriety. One respondent stated,

They want to be punitive with clients. They lose their sympathy, or their empathy, or their ability to even behave professionally when they're watching someone self-sabotage or when they're watching somebody use. We have a lot of resources we can offer our clients and I get frustrated when I see my co-workers not

offering those resources because somebody is using. Like, I try to treat all my clients the same.

Clients who had repeatedly failed out of chemical health treatment programs, or who failed multiple appointments with their case manager, were thought to be a lost cause by many providers.

In addition to interpersonal conflicts with other professionals, some respondents expressed feeling as though they had to manipulate the rules and expectations of their agency so they could support their clients in implementing harm reduction strategies; they felt this was necessary if they wanted to ethically serve their clients. A few of the respondents indicated that their direct supervisor supported and expected that they use harm reduction, but the wider agency rules were different. These respondents explained that the rules were set by people with an administrative role, someone who was not a case manager providing direct service.

Respondents who had experience working in shelter systems noted that they would often overlook agency rules surrounding mandated sobriety so they could allow their clients to enter the shelter for the night. For instance, one respondent was expected to enforce complete sobriety at the overnight shelter where she was employed. The respondent said that she would allow clients who were clearly not sober to enter the shelter as long as they could safely walk down the stairs to the sleeping area and not be disruptive to the general environment. Another respondent explained that if he knew a client had returned to the shelter after drinking, he would intentionally forgo the breathalyzer. Respondents did not state that they feared being punished or felt as though they risked losing their job, but they did express a sense of dissatisfaction and inability to equitably serve their clients without utilizing harm reduction strategies.

Respondents repeatedly expressed that working with marginalized clients demands a certain level of flexibility; applying the same set of rules to all clients is difficult and not always possible. Unfortunately, most agencies have a set of blanket rules that are applied to all of the clients served. Respondents frequently reiterated that clients are very diverse in their needs and abilities and providers need to be able to recognize and credit clients for their strengths on a case-by-case basis that is not framed by a set of specific rules including complete sobriety. The respondents who work in setting with very strict rules felt as though they were constantly bucking up against agency rules or their supervisors' expectations. Feeling stuck between meeting the needs of the client and the expectations of other professionals was identified as a challenge and barrier to their ability to serve clients in a manner they felt was authentic and appropriate.

### **Stress and Self-Care**

Respondents eagerly expressed that using harm reduction decreased their professional level of stress. Respondents felt as though they could let go of a deep sense of responsibility and a sense of pressure to make sure their clients followed the rules of sobriety so they would not be penalized. One respondent expressed that using harm reduction was less stressful, but working with other agencies that do not utilize harm reduction is difficult. The respondent stated,

I definitely think it decreases my level of stress, you know, in terms of my relationship with my clients on a one-to-one basis, I think the difficulty I have in addressing harm reduction is that other agencies increase my stress!

Respondents often described that not being able to practice harm reduction creates a power differential between the provider and clients that makes it difficult to encourage clients to

think critically about their own life goals. Respondents felt that if they were not able to utilize harm reduction, they would feel like a rule enforcer instead of an advocate. Respondents shared that harm reduction allows them to reframe how failure is discussed in therapeutic conversations and to instill a sense of hope and motivation in their clients, as opposed to the notion that all of the work they put into a goal is lost if a relapse or other set-back occurs.

The respondents recognized that their jobs are generally chaotic because of the population and life circumstances of clients they serve. Respondents commented that some clients are more stable and self-sufficient, but many clients rely on their case manager for their own crisis management. This was a part of the job that respondents expected and were prepared to experience. In some instances, respondents recognized they did their best work when they were working in a frenzied environment. Respondents did not find their jobs to be excessively stressful, and they did not feel like using harm reduction increased their level of stress.

Respondents found that utilizing harm reduction allowed for more flexibility in their relationships with clients. They also remarked that their relationships with clients were not contingent on a specific outcome, so there were fewer expectations for both the client and the case manager. Generally, respondents felt that their client's sobriety or goals surrounding chemical addiction were the responsibility of the client, and they were able to avoid taking on those responsibilities. Respondents felt their job was to support their clients, and witness their struggles and progress without judgment. One respondent stated,

I think it 100% decreases my level of stress, it's easier to get through to clients, it's easier to follow through, it's easier to have a positive mind-set and a good outlook with clients who are using harm reduction and when I'm using harm reduction. It's not putting the weight of the world on one situation, it's making the

best of a situation, and that's a mindset I've used and adapted throughout my entire life, and not just working with clients, it's made me more forgiving and more accepting of others, and more accepting of my own situations and issues.

Several of the respondents stated that they used harm reduction in their own lives in some capacity. Respondents often used the word "mindset" to articulate that the harm reduction model was well aligned with their personal morals and world view. While they did not share their personal stories with clients, respondents felt it reminded them that all people have struggles, and to struggle is a natural part of life.

## **Discussion**

The majority of literature that exists on harm reduction addresses the need for new and more viable ways to address the issues surrounding addiction (Kellogg, et. al, 2012). The existing research has strongly emphasized the need for harm-reduction as an alternative to abstinence-based models, but little of the research has integrated the first-hand experiences of social workers who utilize harm-reduction. The research conducted during this project is a collection of interviews from case managers who utilize harm reduction. During the interviews, respondents shared their experiences of being in harm reductionist relationships with their clients.

The respondents discussed a general lack of training and awareness on behalf of other providers, and felt there is a lot of misunderstanding about the harm reduction model. As advocates, respondents often felt as though they had to educate other providers about harm reduction, which took away from their time and ability to work on their clients' greater goals. Still, the respondents recognized that harm reduction created a platform to create meaningful and productive relationships with their clients. The respondents generally felt that using harm reduction contributed to a decrease in their stress level in the workplace, and admitted they integrated harm reduction into their personal lives as a way to manage angst and create balance.

### **Training**

The existing research informs readers that there is a necessary place for the utilization of harm-reduction in the addiction treatment community (Little, 2006). The respondents reiterated this during their interviews; they passionately agreed that harm reduction met the needs of clients that had been previously overlooked and underserved. Regardless of research, there still exists a significant division between the harm reductionists and the rest of the providers within human

services communities. Respondents felt that this division could be decreased if the abstinence-based community would be more willing to critically consider the high rates of relapse that clients who use chemicals experience when getting their basic needs met is solely contingent on their sobriety. The need for more training on harm reduction within both the harm reductionist community and the abstinence-based community is vital if professionals are going to do a more sufficient job of supporting and meeting the needs of their client.

The reflections that the respondents shared on their relationships with clients exemplifies that abstinence-based practices are actively included under the umbrella of harm-reduction. Harm reductionists do not deny, and in fact welcome, the idea that abstinence-based strategies can be successful. In agreement with existing research, respondents felt that the bigger concern is that many clients are not given an opportunity to set their own long-term goals without having to follow a rigid set of expectations (Denning & Little, 2012).

In regards to their own training on harm reduction, a few of the respondents confirmed they had received some training in school or professional setting, but they did not feel like these learning opportunities were sufficient or applicable to their direct work with clients as case managers. For some of the respondents, this lack of training contributed to a higher level of incongruence with the missions and goals of the agencies where they were employed. Research has shown that case managers need to feel supported by their direct co-workers and supervisors, particularly when they feel isolated by the wider treatment community (Altman, et al, 2006). Still, the respondents that expressed feelings of isolation by their agency did not cease to utilize harm-reduction. Respondents recognized that if they did, their clients would be turned away from receiving housing, and their commitment to what they felt was ethical outweighed any concerns they had about being disciplined.

### **Struggles with Abstinence-Based Practice**

Existing research supports the idea that abstinence-based treatment is a one-size-fits-all approach to addressing addictive behaviors (Tidderington, et al., 2007). The reflections of the respondents illustrate these findings. Respondents shared powerful stories of their clients' difficult experiences in abstinence-based treatment programs. The respondents shared that their clients felt alienated and unproductive following repeated attempts to adhere to an abstinence-based program; the more they failed, the less motivation they had to continue their participation and commitment to being sober. A few respondents explained that not only did their clients feel ashamed of themselves, they were often shunned by their abstinence-based peers after a relapse. This is especially problematic given research that emphasizes the importance of acceptance and respect from peers and leaders (Altman et al, 2006). Respondents stated that the insinuations of failure from the abstinence-based community was really damaging. If a client belongs to an abstinence-based community, they are expected to be sober. If there comes a time when they are no longer sober, they no longer belong to the community; their sense of belonging is contingent on their sobriety. They need to feel supported for exactly who they are and where they are, and harm reduction embraces and promotes that sentiment.

The needs and preferences surrounding the chemical health treatment of their clients varied tremendously based on many variables, including socioeconomic status, race and merely their level of motivation to change their addictive behaviors (MacMaster, 2004). Several respondents explained that many of their clients felt uncomfortable in abstinence-based programs because of their race, and because they were poor. These clients often felt preoccupied by their immediate needs, and lacked an ability or interest in thinking about their long-term goals surrounding sobriety. Also, some respondents shared that they had clients from the Gay, Lesbian,

Bisexual, Transgender and Queer Community (GLBTQ) that felt incredibly isolated, especially from the Alcoholics Anonymous (AA) community. All of these clients did not necessarily disagree with the abstinence-based model, and some had a desire to be sober but felt as though there was little recognition and empathy about how their life circumstances impacted their ability to be successful in meeting their chemical health goals. The experiences that respondents shared parallel previous research surrounding topics of how social inequalities impact clients' success (Barr et al, 1993).

Themes surrounding shame and regret arose in the stories of the respondents in regards to abstinence-based treatment programs that their clients had experienced. As a way to counteract these feelings, and as a way to meet the needs of their clients, respondents collaborated with their clients to support incremental changes surrounding their addiction. Research indicates that breaking drastic and life-changing goals down into steps makes change more realistic, and it provides the client with an opportunity to reflect on what is driving their addiction (Kellogg et al, 2012). Respondents felt this gave their clients an opportunity to celebrate successes and took away from the anxiety of failing to reach an end date, which is often recognized as a graduation. This supported the ongoing motivation of their clients and increased their self-worth. Respondents identified with breaking change down into manageable steps and thinking of change as an evolving process (Little, 2006).

### **Relationships with Clients**

Harm reduction allows the client to set her own goals and attain those goals at their own pace. Respondents felt this created an opportunity to empower their clients and to encourage their clients to talk about progress in a way that was meaningful to their unique life experiences. Respondents felt that when their clients were in control, they became less guarded and more

willing to share information about their life, in particular about their chemical use. Utilizing harm reduction meant that respondents did not have to terminate relationships with their clients because of a relapse. Respondents identified relapse as being a time when clients needed the most support, and to terminate a client during that time felt unethical. Likewise, clients can make decisions about their drug use without feeling like they are risking their relationship with their case manager. Research on harm reduction backs this sentiment (Kellogg, 2003). Self-determination is deeply rooted in the practice of social work.

### **Struggles with Multi-Disciplinary Teams**

There is some research regarding the need to bridge the gap between harm reductionists and providers who are more accustomed to abstinence-based work. Respondents recognized this gap, and felt that it was most apparent when working with professionals from a variety of trainings. The undertones concerning the immorality or misunderstandings of harm reduction continue to exist, according to respondents. Respondents continue to struggle with using harm reduction if and when they were collaborating with multidisciplinary providers such as medical doctors and mental health providers. Respondents shared that there was very little recognition of incremental change or an ability to view clients from a bio-psycho-social perspective. Some respondents admitted having positive experiences with providers from different trainings. Still, many of the respondents commented on their concerns about how their clients were brushed off as less deserving of services because of their choices concerning their chemical health.

### **Stress and Self-Care**

While there is a great deal of research on provider stress and self-care, there is little research available that addresses stress and self-care specifically regarding case managers who implement harm reduction. Overall, the instant research shows that respondents did not experience an overwhelming amount of job stress and even felt as though harm reduction has relieved them of stress. Some respondents compared themselves to case managers who did not work in settings that implement harm reduction and they felt their stress level was very comparable. Respondents admitted that it is only natural to experience some level of stress in helping professions, but they felt like the support they needed to remain motivated and inspired by their work was readily available. Some respondents utilized harm reduction in their personal lives, and felt as though it was a helpful tool to implement their own self-care and balance in their lives. Further research is necessary for a more a thorough and accurate understanding of this theme.

## Conclusion

A significant division between the harm reduction and abstinence-based philosophies continues to exist. While harm-reduction is gaining momentum in the addiction treatment world, there is still an assumption that the two philosophies cannot be integrated. Proponents of both approaches need to combine efforts to increase the knowledge base surrounding addiction issues.

It is clear that abstinence-based programs are not a good fit for many addicts. We need to put more funding into programs that support clients where they are without judgment or by imposing a specific set of behavioral expectations. The services offered to clients should not be contingent on their sobriety. Social workers can support clients if they wish to be sober, but too-stringent expectations of clients is not successful, and it is not guided by the principles of social work. Providers need to approach their practices with a client-centered approach. Social workers are taught that clients are the experts of their own lives; to make services contingent on sobriety simply does not align with the tenants of social work. If a client chooses not to be sober, she is too often underserved. Not only is this unethical, it is a crisis in the nationwide addiction community.

When clients begin to feel supported, they will begin to trust their providers, and when clients trusts their providers, they will begin to address some of the underlying mental health issues that so often accompany chemical dependency. Addicts use chemicals to escape pain and trauma. We need to start talking about mental health in a way that does not stigmatize people with mental health diagnoses, and affirms that their addiction serves a purpose in their lives. Addressing mental health, particularly trauma, can take many months or years to process. Similarly, chemical health treatment can be treated as a process. Immediate sobriety may not be

the answer for some addicts, but that does not mean they are not committed to improving their health.

Harm reduction is often viewed as an alternative approach to dealing with addiction. The ideas behind harm reduction need to be taught to people from all backgrounds, whether it be at a formal educational institution or in a workplace setting. The tenants of harm reduction need to be mainstreamed instead of being thought of as a “last resort.” The providers who are on the frontlines providing direct services to clients need to be supported by the greater system. Providers need to feel supported by their agencies, as well as the communities in which work.

## References

- Allman, D., Myers T., Schellenberg J., Strike C., Cockerill R., Cavalieri. (2007). Improving health and social care relationships for harm reduction. *International Journal of Drug Policy*, 18, 194-203. doi: 10.1016/j.drugpo.2006.07.005
- Banerjee, Kakoli, Howard, Mark, Mansheim, Kristen, Beattie, Martha. (2007). Comparison of health realization and 12-step treatment for women's residential substance abuse treatment programs. *The American Journal of Drug and Alcohol Abuse*, 33, 207-215. doi: 10.1080/00952990601174758
- Barr, Kellie E.M., Farrell, Michael P., Barnes, Grace M., Welte, John W. (1993). Race, Class and gender differences in substance abuse: evidence of middle-class/underclass polarization among black males. *Social Problems*, 40, 314-327.
- Berg, B. L. (2009). *Qualitative Research Methods for Social Sciences*. Boston, MA: Allyn & Bacon.
- Bigler, Mark O. (2005). Harm reduction as a practice and prevention model for social work. *The Journal of Baccalaureate Social Work*, 10, 69-86.
- Brent, Suzanne S. (1996). The history of alcoholism treatment in the United States. Retrieved from ProQuest Dissertations and Theses; 1996, Sociological Abstracts
- Brocato, Jo, Wagner Eric F. (2003). Harm reduction: a social work practice model and social justice agenda. *Health & Social Work*, 28(2), 117-125.
- Carvajal, Paul. (Fall 1995). Integration of Harm Reduction and other Treatment Approaches. *Harm Reduction Coalition*. Retrieved from <http://harmreduction.org/publication-type/newsletter/communication-one/>
- Center for Disease Control and Prevention. (2013). Public health surveillance. Retrieved from <http://www.cdc.gov/alcohol/data-stats.htm>
- Denning, Patt, Little Jeannie. (2012). *Practicing Harm Reduction Psychotherapy: An Alternative Approach to Addictions*. New York, NY: Guilford Press.
- Collins, Susan E., Clifasefi, Seema L., Dana, Elizabeth A., Andrasik, Michele O., Stahl, Megan Kirouac, ...Malone, Daniel. (2012). Where harm reduction meets housing first: Exploring alcohol's role in a project based housing first setting. *International Journal of Drug Policy*, 23, 111-119. doi: 10.1016/j.drugpo.2011.07.010
- Denning, Patt, Little, Jeannie, Glickman, Adina. (2004). *Over the Influence: The Harm Reduction Guide For Managing Drugs and Alcohol*. New York, NY: Guilford Press.

- DiNitto, Diana M. (2002). War and peace: social work and the state of chemical dependency treatment in the united states. *Journal of Social Work Practice in the Addictions*, 2(3/4), 7-29.
- Garland, Tammy S. & Bumphus, Vic W. (2012). Race, bias, and attitudes toward drug control policy. *Journal of Ethnicity in Criminal Justice*, 10, 148-161. doi: 10.1080/15377938.2012.669654
- Grant, Judith. (2009). A profile of substance abuse, gender, crime, and drug policy in the United States and Canada. *Journal of Offender Rehabilitation*, 48, 654-668. doi: 10.1080/10509670903287667
- Gross, M. (2010). Alcoholics anonymous: still sober after 75 years. *American Journal of Public Health*, (100)12, 2361-2363
- Housenbold Seiger, Belinda. (2005). An exploratory study of social workers' attitudes towards harm reduction with substance abusing individuals utilizing the substance abuse treatment survey (SATS). Retrieved from ProQuest Information and Learning Company, UMI Number: 3175071
- Johnson, Devon. (2008). Racial prejudice, perceived injustice, and the black-white gap in punitive attitudes. *Journal of Criminal Justice*, 36, 198-206. doi: 10.1016/j.jcrimjus.2008.02.009
- Kellogg, S.H., & Tetarsky, A. (2012). Re-envisioning addition treatment: a six point plan. *Alcoholism Treatment Quarterly*, 30, 109-128. doi:10.1080/0734734.2012.635544
- Kennedy, Joseph E., (2003). Drug wars in black and white. *Law and Contemporary Problems*, 66(3), 153-181. Retrieved from <http://www.jstor.org/stable/20059191>
- Little, Jeannie. (2006). Harm reduction therapy groups: Engaging drinkers and drug users in a process of change. *Journal of Groups in Addiction & Recovery*, 1, 69-93. doi: 10.1300/J384v01n01\_05
- MacMaster, S. A. (2004). Harm reduction: a new perspective on substance abuse services. *Social Work*, 49(3), 356-363.
- Miley, K. K., O'Melia, M., DuBois, B. (2011). *Generalist Social Work Practice*. Boston, MA: Allyn & Bacon.
- Monette, D.R., Sullivan, T. J., DeJong, C.R. (2011). *Applied Social Research: A Tool for the Human Services*. Bemont, CA: Brooks & Cole.
- National Institute on Alcohol Abuse and Alcoholism. Retrieved from [http://pubs.niaaa.nih.gov/publications/PainFactsheet/Pain\\_Alcohol.pdf](http://pubs.niaaa.nih.gov/publications/PainFactsheet/Pain_Alcohol.pdf)

- Richman, Judith. (1985). Sociological perspectives on illegal drug use: definitional, reactional, and etiological insights. *Behavioral Science & the Law*, 3(3), 249-258.
- Roy, A. Kennison III, Miller, Michael M. (2012). The medicalization of addiction treatment professionals. *Journal of Psychoactive Drugs*, 44(2), 107-118. doi: 10.1080/02791072.2012.684618
- Saper, Anthony. (1974). The making of policy through myth, fantasy and historical accident: the making of America's narcotics laws. *British Journal of Addiction*, 69, 183-193.
- Schmidt, Laura, Greenfield, Thomas, Mulia, Nina. (2006). Unequal treatment: Racial and ethnic disparities in alcoholism treatment. *Alcohol Research and Health*, 29, 49-54.
- Tiderington, Emmy, Stanhope, Victoria, Hennwood, Benjamin F. (2013). A qualitative analysis of case managers' use of harm reduction in practice. *Journal of Substance Abuse Treatment*, 44, 71-77. <http://dx.doi.org/10.1016/j.jsat.2012.03.007>
- Windsor, Liliane Cambraia & Dunlap, Eloise. (2010). What is substance use about? assumptions in New York's drug policies and the perceptions of African Americans who are low-income and using drugs. *Journal of Ethnicity in Substance Abuse*, 9, 64-87. doi: 10.1080/15332640903539260