

The Role of Harm Reduction in Recovery-oriented Systems of Care: The Philadelphia Experience

Arthur C. Evans, Jr., PhD, William L. White, MA, and Roland Lamb, MA

While harm reduction can be viewed as an end in itself with a focus on mitigating harm to individuals, families and the community as a whole, harm reduction strategies can also be viewed collectively as a platform or point of access for promoting long-term health, and, for those with severe alcohol and other drug problems, long-term personal and family recovery. If our goal is to promote health and reclaim lives, then we must understand the direct and sometimes circuitous paths through which individuals and families achieve and sustain such health. We must meet each individual and family with fresh eyes in every encounter with a belief that each encounter is an opportunity for movement, no matter how small, towards health and wholeness. –Arthur C. Evans, Jr., 2013¹

Bridging the harm reduction and traditional addiction treatment and recovery worlds “requires openness to the possibility that our worldview and the cherished concepts we use to describe it may need to become subtler, more fine-grained, amended or even discarded; and, that approaches which don’t work for one person can, equally, be life-saving for others, when all the time our own beliefs, experiences, perhaps even our entire biography, shouts out that this can’t be so.” –Neil Hunt, 2012²

Executive Summary

In the United States, advocates of abstinence-based addiction treatment/recovery (AATR) and advocates of harm reduction (HR) have staked out opposing turf in one of the most polarized debates within the history of the alcohol and other drug (AOD) problems arena. The purpose of the present paper is not to add a new chapter in this ongoing debate but rather to transcend the debate by exploring areas of common ground upon which integration of AATR and HR approaches have been achieved over the past decade within the City of Philadelphia’s recovery-focused behavioral health systems transformation process.

Harm Reduction Basics

Harm reduction (HR) is a philosophy and menu of services aimed at minimizing injury to self, others, and community by AOD consumers—from the most casual users to those with the most severe drug dependencies. HR service programs include promotion

¹ Personal Communication with Arthur C. Evans, Jr. May 3, 2013.

² Hunt, N. (2012). Recovery and harm reduction: Time for a shared, development-oriented, programmatic approach? In R. Pates & D. Riley (Eds.), *Harm reduction in substance use and high-risk behaviors*. Chichester: Wiley-Blackwell.

and support for safer AOD use practices and provision of medical and social support to AOD users, including linkage to addiction and psychiatric treatment resources. The goal of HR has also historically shaped the design of particular treatment interventions, e.g., methadone maintenance and other maintenance pharmacotherapies. HR as policy, philosophy, and service menu has been profoundly shaped by the goals of reducing AOD-related transmission of HIV/AIDS and viral hepatitis and AOD overdose deaths, e.g., the development of needle and syringe exchange programs, medically supervised safer injection rooms, although HR as a philosophy targets much broader patterns of AOD use and related harms. Whether the focus of the HR movement should be on person- and population-focused public health interventions or broader advocacy of user rights and changes in drug policy (e.g., drug decriminalization or legalization) continues to be debated within the HR movement.

Harm Reduction and Abstinence-based Addiction Treatment/Recovery

In the vitriolic HR/AATR debates, radical abstentionists have contended that HR programs 1) divert funds that could be used to expand abstinence-based treatment, 2) prolong drug use/addiction careers, 3) encourage new drug users via a message of drug tolerance, and 4) are a “Trojan horse” masking the goal of drug legalization. Radical harm reductionists, in turn, have argued that traditional AATR programs: 1) do not voluntarily attract the majority of people with severe AOD problems, 2) use methods that are disrespectful and harmful, 3) refuse to admit patients who are on medications for psychosocial support services, 4) refuse to acknowledge the recovery status of medication-stabilized patients, 5) kick people out of treatment and/or deny readmission for becoming symptomatic (e.g., drug use), and 6) are a modern throwback of early religious and temperance movements. Mutual antagonisms across the HR/AATR chasm are slowly giving way to more reasoned communications and collaborations. Experiments in integrating HR and AATR are proceeding across the U.S. and internationally at both conceptual and practice levels.

AATR and HR in the City of Philadelphia

Through the leadership of the Department of Behavioral Health and Intellectual disAbilities Services (DBHIDS) / Office of Addiction Services (OAS), the City of Philadelphia has championed the integration of AATR and HR services as part of the larger recovery-focused systems transformation process initiated in 2004. Over the past decade, the systems transformation process has moved the relationships between Philadelphia’s AATR and HR programs from a stance of isolation, mutual suspicion, conflict, and competition for public support and resources to a stance of increased dialogue and collaboration.

HR and AATR Integration Profiles

AATR/HR integration is evident in four primary areas within the transformation of Philadelphia’s behavioral health care system: 1) assertive outreach and low-threshold service access points, 2) recovery-oriented methadone maintenance, 3) needle and

syringe exchange programs that integrate both HR and recovery goals and principles, and 4) a housing continuum that includes wet, damp, and dry housing support resources.

Key Understandings about the Course and Consequences of AOD Use and Related Problems and Their Resolution Process

AATR/HR integration efforts in Philadelphia have been built on a number of key understandings.

- HR-oriented services can preserve life during periods of active drug use and reduce the burdens on self, family, and community brought into a subsequent recovery process.
- Both AATR and HR programs have the responsibility of enhancing coping methods and increasing social supports as AOD use decelerates or ceases. Such supports are critical to prevent inadvertent harm resulting from the service intervention.
- Integrated AATR and HR principles and practices provide a way to reach, engage, and support positive change across the arenas of drug use, addiction, and recovery.
- AATR and HR represent not opposing strategies but approaches to reaching different populations and reaching the same individuals at different stages of their AOD use, addiction, and recovery careers.
- Integrated AATR and HR principles and practices are particularly important for addressing multiple, severe, complex, and chronic (often intergenerational) problems.
- Shifts in drug choice and changes in the frequency, methods of administration, and contexts for use can be viewed within an “all or none” view of addiction recovery or viewed as incremental experiments in problem resolution that constitute an important “recovery priming” process.
- Resistance and ambivalence are a natural—not pathological—response to internal and external pressure to change deeply engrained behaviors.
- Resistance and ambivalence are reduced when people have real choices and are empowered to choose.
- Recovery can be achieved with or without medication support—including recovery from opioid addiction with or without methadone or buprenorphine.

- Defining recovery as contingent upon cessation of medications such as methadone or buprenorphine flies in the face of scientific evidence and clinical experience and creates a “hierarchy of worthiness” that feeds stigma and discrimination against people in medication-assisted recovery.

Lessons from AATR and HR Integration Experiments

Philadelphia’s AATR/HR integration efforts have been based on a more nuanced understanding of the course and consequences of AOD use and related problems and how such problems can be managed and resolved as well as lessons learned about how integration efforts can best be facilitated. Thirteen such lessons are discussed:

1. AATR and HR integration is not easy.
2. Both AATR and HR as models of intervention must be publicly and professionally defended through the integration process.
3. Leadership and strategy at multiple levels are essential.
4. Ideas matter. AATR/HR integration involves processes of conceptual stretching within both the AATR and HR communities.
5. Science helps, but stories and direct experience are essential.
6. Relationships matter. AATR/HR integration involves relationship building and relationship maintenance across systems boundaries.
7. Money and public/professional recognition matter. AATR/HR integration must address issues of personal/professional/institutional interests that inhibit collaboration.
8. HR and AATR collaborations can be a win/win process.
9. HR and AATR are not either/or options.
10. Drug users may be viewed as “incompetent and pathological” and thus only “objects of intervention” or as “allies and participants in their own individual and collective health.”
11. Recovery initiation is about a synergy of pain and hope.
12. AATR and HR are the products of heterogeneous social movements made up of constituency groups with widely varying philosophies and service practices, all of whom cannot be expected to approve of or participate in processes of collaboration.
13. HR and AATR integration must be bi-directional.

Conclusions

The chasm between HR and AATR principles and practices is being bridged with hybrid approaches that integrate public health and clinical perspectives. Such integration may constitute the future for the management of the most severe, complex, and chronic AOD problems.

The Role of Harm Reduction in Recovery-oriented Systems of Care: The Philadelphia Experience

Harm reduction (HR), also referred to as harm minimization, rose to prominence in the 1980s and 1990s as a new organizing framework within the alcohol and drug (AOD) problems and larger public health arenas. Spawned in great measure by alarm over rising rates of HIV, HBV, and HCV infections,³ HR garnered considerable international support, but also generated heated opposition, particularly within the United States. While discussions of HR often deteriorated into “stale, endless and unproductive arguments between radical abstentionists and militant harm reductionists,”⁴ there are indications of movement beyond such polarized positions. Opposition to HR may be softening in the U.S. among addiction professionals, recovery advocates, and within particular local communities,⁵ even as more substantive critiques of HR emerge within the U.K. and Australia where harm reduction has been pursued as a central policy.⁶ In the past decade, recovery has also emerged as a conceptual framework for the redesign of addiction treatment and the emergence of new recovery support services within the U.S. and U.K.⁷

The confluence of these trends raises questions about the extent to which the HR and recovery organizing frameworks represent competing or complementary paradigms and, more importantly, if and how such orientations can be best integrated at the frontlines of local service planning and delivery. The purpose of the present paper is to describe how principles and practices of abstinence-based addiction treatment/recovery (AATR) and HR have been integrated over the past decade within the City of Philadelphia’s recovery-focused behavioral health systems transformation process.

Harm Reduction Basics

HR represents both a philosophy and a menu of service programs.⁸ HR programs extol the value of practical strategies for minimizing harm among those who continue to

³ Stimson, G. V. (2007). “Harm Reduction—Coming of Age”: A local movement with global impact. *International Journal of Drug Policy*, 18, 67-69. doi:10.1016/j.drugpo.2006.12.012

⁴ Humphreys, K. (2010). British drug and alcohol policy: V. What is “recovery” from addiction, and can medications be part of it? Retrieved May 7, 2013 from <http://www.samefacts.com/2010/09/drug-policy/british-drug-and-alcohol-policy-v-what-is-%E2%80%9Crecovery%E2%80%9D-from-addiction-and-can-medications-be-a-part-of-it/>

⁵ White, W., & Torres, L. (2010a). *Recovery-oriented methadone maintenance*. Chicago, IL: Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Mental Retardation Services and Northeast Addiction Technology Transfer Center.; White, W., & Torres, L. (2010b). Recovery-oriented methadone maintenance (Executive Summary). *Counselor*, 11(6), 44-53.

⁶ McKeganey, N. (2012). Harm reduction at the crossroads and the rediscovery of drug user abstinence. *Drugs: Education, Prevention, and Policy*, 19(4), 276-283. doi:10.3109/09687637.2012.671867; Miller, P. G. (2001). A critical review of the harm minimization ideology in Australia. *Critical Public Health*, 11(2), 167-178. doi:10.1080/09581590110039865

⁷ Berridge, V. (2012). The rise, fall, and revival of recovery in drug policy. *Lancet*, 379, 22-23. doi:10.1016/S0140-6736(12)60011-7; El-Guebaly, N. (2012). The meanings of recovery from addiction: Evolution and promises. *Journal of Addiction Medicine*, 6(1), 1-9. doi:10.1097/ADM.06013e31823ae540; Home Office. (2010). *Drug Strategy 2010. Reducing demand, restricting supply, building recovery: Supporting people to live a drug free life*. London: Home Office. Wardle, I. (2012). Five years of recovery: December 2005 to December 2010—From challenge to orthodoxy. *Drugs: Education, Prevention and Policy*, 19(4), 294-298. doi:10.3109/09687637.2012.671866; UKDPC. (2008). *A vision of recovery*. UK Drug Policy Commission. White, W. L. (2005). Recovery: Its history and renaissance as an organizing construct concerning alcohol and other drug problems. *Alcoholism Treatment Quarterly*, 23(1), 3-15. doi:10.1300/J020v23n01_02

⁸ Stimson, G. V. (2007). “Harm Reduction—Coming of Age”: A local movement with global impact. *International Journal of Drug Policy*, 18, 67-69. doi:10.1016/j.drugpo.2006.12.012

use alcohol and/or other drugs—strategies that address harm to individual users, their families, and the community as a whole. This is evident in programs seeking to reduce harm without seeking to diagnose or treat addiction as well as in programs that provide HR services while encouraging incremental changes toward long-term recovery and wellness for those with severe AOD problems.⁹ While many HR advocates also assert the rights of drug users to freedom from persecution, this is more an allied theme rather than a central Pillar of HR, although tension continues to exist within the HR movement as to whether the movement’s primary focus should be a public health or user rights agenda.¹⁰

HR programs view interventions within a “hierarchy of harm” framework and view reduction of harm related to AOD use as a more important and realistic goal than preventing or reducing AOD use.¹¹ Such a “hierarchy of harm” could be reflected in the acts of reducing the frequency of needle and syringe sharing, ceasing all needle and syringe sharing, reducing the frequency of drug injections, ceasing drug injections, reducing illicit drug use, ceasing illicit drug use, experimenting in abstinence, and achieving stable abstinence from all drug use. Within the HR framework, each such step is viewed as a valuable achievement in its own right.

Historically, “harm reduction neither excludes nor presumes the long-term treatment goal of abstinence.”¹² The HR concern has been with the potential fragility of abstinence and the harm accruing to individuals, families, and communities when abstinence is lost. For example, HR advocates do not deny the ability of particular individuals to move from injection drug use to stable recovery, but question the probabilities of sustained abstinence for the larger population of injection drug users. It’s a question of probabilities and creating safety nets when abstinence deteriorates into active drug use. Alan Marlatt,¹³ an early HR leader, consistently noted that sustained abstinence was the ultimate harm reduction strategy, but some HR advocacy groups today are less likely to include abstinence support within HR strategies and more likely to assert drug use as a right.

*Harm reduction is about active drug use. Harm reduction is the goal—not a step along the ‘road to recovery’ or the path to ‘freedom from dependence’. It is not, cannot and was never meant to be a point on a ‘continuum’ towards the ‘real’ goal of abstinence and a drug-free lifestyle.*¹⁴

⁹ Lenton, S., & Single, E. (1998). The definition of harm reduction. *Drug & Alcohol Review*, 17, 213-220.

doi:10.1080/09595239800187011; Zelvin, E., & Davis, D. R. (2001). Harm reduction and abstinence based recovery: A dialogue. *Journal of Social Work Practice in the Addictions*, 1(1), 121-133. doi:10.1300/J160v01n01_09

¹⁰ Hunt, N. (2004). Public health or human rights: What comes first? *The International Journal of Drug Policy*, 15, 231-237. doi:10.1016/j.drugpo.2004.02.001

¹¹ Harm Reduction International. (2013). What is harm reduction? Retrieved March 16, 2013 from <http://www.ihra.net/what-is-harm-reduction>; Wisely, C. (2013). The logic of recovery and injection drug use. *Journal of Substance Use*, 18, 56-64. doi: 10.3109/14659891.2013.761024.

¹² Hunt, N. (2003). A review of the evidence-base for harm reduction approaches to drug use. Retrieved March 23, 2013 from <http://www.forward-thinking-on-drugs.org/review2-print.html>

¹³ Marlatt, G. A. (1996). Harm reduction: Come as you are. *Addictive Behaviors*, 21(6), 779-788. doi:10.1016/0306-4603(96)00042-1; Marlatt, G. A. (1998). *Harm reduction: Pragmatic strategies for managing high-risk behaviors*. New York: Guildford Press.

¹⁴ AIVL. (2012). *‘New recovery’, harm reduction & drug use policy statement*. Australian Injecting & Illicit Drug Users League. Retrieved May 8, 2013 from <http://aivl.org.au/database/sites/default/files/New%20Recovery,%20Harm%20Reduction%20%26%20Drug%20Use%20-%20AIVL%20Policy%20Position%20Paper.pdf>

As we shall see in the coming pages, the issue of where abstinence and recovery support fits, and if it fits at all, into the HR service rubric is in a state of flux, as are the questions of if and how HR-oriented services can be integrated into traditional AATR programs.

Programmatically, HR is associated internationally with a wide spectrum of programs and services that are illustrated in Table 1.

Table 1: Spectrum of Harm Reduction Programs/Services

- Seatbelt, designated driver programs, breath alcohol ignition interlock devices
- Alcohol server training programs
- Education/coaching/treatment to support moderation of high risk drinking
- Testing of illicit drug samples and dissemination of information to users regarding misrepresentation and adulteration of illicit drugs
- HR-focused street outreach programs aimed at lowering risk behaviors of AOD users, particularly injection drug users
- Organizing injection drug users for AIDS prevention, mutual support, and inculcation of safer injection and safer sex practice, e.g., reshaping norms within the injection subculture¹⁵
- Social marketing of safer methods of drug use (encouragement for lower risk drug choice, dosages, frequency of use, routes of administration [i.e., non-injecting routes of administration], and settings for use)
- Needle and Syringe Exchange Programs, e.g., distribution of safer injection supplies (syringes, cookers, alcohol pads, cotton filters, water, bleach, antibiotic ointment, band aids) and safer sex supplies (male and female condoms, dental dams)
- Medically supervised safer injection rooms/centers
- Resources or sites for safe needle disposal
- Medical services for active users (e.g., first aid, HIV testing, and counseling)
- Education on safer injection techniques, needle and syringe disposal, and vein care
- Hepatitis B vaccination programs
- Distribution of bleach kits, condoms
- Overdose prevention and intervention programs (naloxone distribution and training), including family education on overdose management
- Linkage to addiction treatment and recovery support resources
- Advocacy for inclusion of active drug users in treatment activities
- Methadone maintenance & other maintenance pharmacotherapies
- Housing First Programs (housing not contingent on abstinence, including “wet” and “damp” housing)

¹⁵ Friedman, S. (1996). Theoretical bases for understanding drug users’ organizations. *International Journal of Drug Policy*, 7,(4), 212–219. Friedman, S. R., de Jong, W., & Des Jarlais, D. (1988). Problems and dynamics of organizing intravenous drug users for AIDS prevention. *Health Education Research*, 3(1), 49-57. doi:10.1093/her/3.1.49; Friedman, S. R., Des Jarlais, D. C., Sotheran, J. L., Garber, J., Cohen, H., & Smith, D. (1987). AIDS and self-organization among intravenous drug users. *International Journal of the Addictions*, 22, 201-219. doi:10.3109/10826088709027425.

- Voluntary linkage of active drug users to medical, psychiatric, legal services
- Smoking cessation support, including nicotine replacement pharmacotherapies.

Theoretically, HR's programmatic services are focused on supporting the health of all people who choose to use alcohol and other drugs, not just those with severe AOD problems. In reality, HR programs often serve the most marginalized drug users—persons with histories of severe drug dependencies, co-occurring medical/psychiatric illnesses, poverty, educational deficits, chronic unemployment, homelessness or unstable living arrangements, and limited social resources.¹⁶ Of particular note is the fact that HR programs serve individuals who do not seek addiction treatment and persons who are often not warmly welcomed by addiction treatment programs because of their history of multiple treatment admissions.

Several factors distinguish HR programs from traditional addiction treatment and recovery support programs, including:

- minimal if any service eligibility or service fee requirements,
- multiple points of service entry (versus a centralized intake),
- service delivery within the locations where clients live and use drugs,
- service goals set by each client rather than the program; abstinence not a requirement for service entry or retention,
- broad service menu encompassing numerous areas of life functioning,
- less hierarchical service relationships than in traditional professional service settings,
- the option of anonymity in service participation, and
- service duration (beginning and end) defined by the service consumer not the program or external funding/regulatory authorities.¹⁷

Harm Reduction and Abstinence-based Addiction Treatment/Recovery

AATR critics contend that HR programs 1) divert funds that could be used to expand abstinence-based treatment, 2) prolong drug use/addiction careers, 3) encourage new drug users via a message of drug tolerance, and 4) are a “Trojan horse” masking the goal of drug legalization.¹⁸ HR advocates counter by arguing that:

- HR programs serve those individuals not served by the current treatment system and those who have not achieved abstinence through that system of care,
- there is no definitive scientific evidence that HR services prolong addiction careers¹⁹ (only two studies of MMT were identified by the authors suggesting that

¹⁶ Rogers, S. J., & Ruefli, T. (2004). Does harm reduction programming make a difference in the lives of highly marginalized, at-risk drug users? *Harm Reduction Journal*, 1, 7. doi:10.1186/1477-7517-1-7

¹⁷ Rogers, S. J., & Ruefli, T. (2004). Does harm reduction programming make a difference in the lives of highly marginalized, at-risk drug users? *Harm Reduction Journal*, 1, 7. doi:10.1186/1477-7517-1-7

¹⁸ Hunt, N. (2003). A review of the evidence-base for harm reduction approaches to drug use. Retrieved March 23, 2013 from <http://www.forward-thinking-on-drugs.org/review2-print.html>

¹⁹ Hunt, N. (2003). A review of the evidence-base for harm reduction approaches to drug use. Retrieved March 23, 2013 from <http://www.forward-thinking-on-drugs.org/review2-print.html>

- MMT either prolongs the duration of drug injecting²⁰ or reduces mortality while exerting no effect on such duration²¹),
- local HR services increase the prevalence of drug use,²² and that
 - the degree to which HR advocates support, oppose, or are neutral on the question of drug legalization varies across communities and countries.²³

HR advocates have been equally critical of AATR programs, arguing that traditional AATR professional/peer programs: 1) do not voluntarily attract the majority of people with severe AOD problems, 2) use methods (e.g., confrontation techniques) that are disrespectful and harmful, 3) refuse to admit patients who are on medications (e.g., methadone, buprenorphine, psychotropics) for psychosocial support services, 4) refuse to acknowledge recovery status of medication-stabilized patients (e.g., denial of clean time, denial of opportunities for participation and leadership), 5) kick people out of treatment and/or deny readmission for becoming symptomatic (e.g., drug use), 6) infantilize and over-control people, 7) define any post-treatment drug use by a patient as a “failed” treatment, 8) blame patients for failed addiction treatment outcomes, and 9) are a modern throwback to religious and temperance movements.²⁴ AATR advocates counter that HR advocates have little understanding of addiction and what is required to successfully transition someone from addiction to long-term stable recovery.

Summarizing the stances of AATR and HR advocates and critics is challenged by the fact that AATR and HR are not homogenous movements.

Both AATR and HR advocates can suffer conceptual and practice blind spots. HR’s focus on immediate needs and realistically achievable goals in the present can blind HR advocates to the potential for short- and long-term transformative change. AATR’s focus on the vision of long-term stable recovery can blind them to the immediate needs of those who will not or cannot presently cease all drug use. Both AATR and HR advocates have been criticized for focusing almost exclusively on the individual and not on broader social contexts in which addiction flourishes or in which resilience and recovery flourish.²⁵

Polemics between many AATR and HR advocates are giving way to more reasoned exchanges. The past decade has witnessed a softening of attitudes toward HR

²⁰ Maddux, J.F. & Desmond, D.P. (1992). Ten-year follow-up after admission to methadone maintenance. *American Journal of Drug and Alcohol Abuse*, 18(3), 289-303.

²¹ Kimber, J., Copeland, L., Hickam, M., Macleod, J., McKenzie, J., De Angelis, D. & Roberston (2010). Survival and cessation in injecting drug users: prospective observational study of outcomes and effect of opiate substitution treatment. *BMJ*, 341, c3172. Accessed August 13, 2013 at <http://dx.doi.org/10.1136/bmj.c3172>.

²² Hunt, N. (2003). A review of the evidence-base for harm reduction approaches to drug use. Retrieved March 23, 2013 from <http://www.forward-thinking-on-drugs.org/review2-print.html>; Paone, D., Des Jarlais, D. C., Gangloff, R., Milliken, J., & Friedman, S. R. (1995). Syringe exchange: HIV prevention, key findings, and future directions. *International Journal of the Addictions*, 30, 1647-1683. doi:10.3109/10826089509104419; Watters, J. K., Estilo, M. J., Clark, G. L., & Lorvick, J. (1994). Syringe and needle exchange as HIV/AIDS prevention for injection drug users. *Journal of the American Medical Association*, 271, 115-120.

²³ Hunt, N. (2003). A review of the evidence-base for harm reduction approaches to drug use. Retrieved March 23, 2013 from <http://www.forward-thinking-on-drugs.org/review2-print.html>

²⁴ Gleghorn, A., Rosenbaum, M., & Garcia, B. A. (2001). Bridging the gap in San Francisco: The process of integrating harm reduction and traditional substance abuse services. *Journal of Psychoactive Drugs*, 33(1), 1-7. doi:10.1080/02791072.2001.10400461

²⁵ McKeganey, N. (2006). The lure and the loss of harm reduction in UK drug policy and practice. *Addiction Research & Theory*, 14, 557-588. doi:10.1080/16066350601002369; White, W. L., Evans, A. C., & Lamb, R. (2010). *Community recovery*. Posted at www.williamwhitepapers.com and www.facesandvoicesofrecovery.com

by addiction professionals in the United States,²⁶ including those working within 12-Step-oriented treatment programs.²⁷ This shift is particularly noteworthy among addiction professionals working in settings such as outpatient programs, DUI/DWI programs, or private practices who address less severe AOD problems than those seen in detoxification or inpatient rehabilitation settings.²⁸ Experiments in integrating HR and AATR are proceeding internationally at both conceptual and practice levels.²⁹

As the concepts of HR and recovery continue to become more nuanced through the processes of debate, accumulated experience, and scientific evaluation, efforts are increasing to integrate harm reduction efforts into mainstream addiction treatment and recovery support services.³⁰ Advocacy of such integration is bi-directional, with notable attempts to increase the HR orientation of addiction treatment and mutual aid programs³¹ and parallel efforts to increase the recovery orientation of HR programs.³²

There is growing consensus that working to reduce harm from current drug use is not incompatible with the goals of encouraging and supporting long-term recovery and

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- ²⁶ McLellan, A. T. (2003). What's the harm in discussing harm reduction: An introduction to a three-paper series. *Journal of Substance Abuse Treatment*, 25, 239-240. doi:10.1016/S0740-5472(03)00084-9; Davis, A., & Rosenberg, H. (2012). Acceptance of non-abstinence goals by addiction professionals in the United States. *Psychology of Addictive Behaviors*. Advance online publication. doi:10.1037/a0030563.
- ²⁷ Goddard, P. (2003). Changing attitudes towards harm reduction among treatment professionals. A Report from the American Midwest. *International Journal of Drug Policy*, 14, 257-260. doi:10.1016/S0955-3959(03)00075-6
- ²⁸ Davis, A., & Rosenberg, H. (2012). Acceptance of non-abstinence goals by addiction professionals in the United States. *Psychology of Addictive Behaviors*. Advance online publication. doi:10.1037/a0030563.
- ²⁹ Denning, P. (2001). Strategies for implementation of harm reduction in treatment settings. *Journal of Psychoactive Drugs*, 33(1), 23-26. doi:10.1080/02791072.2001.10400464; Futterman, R., Lorente, M., & Silverman, S. (2004). Integrating harm reduction in abstinence-based substance abuse treatment in the public sector. *Substance Abuse*, 25(1), 3-7. doi:10.1300/J465v25n01_02; Hunt, N. (2012). Recovery and harm reduction: Time for a shared, development-oriented, programmatic approach? In R. Pates & D. Riley (Eds.), *Harm reduction in substance use and high-risk behaviors*. Chichester: Wiley-Blackwell. Kellogg, S. H. (2003). On "gradualism" and the building of the harm reduction—abstinence continuum. *Journal of Substance Abuse Treatment*, 25, 241-247. doi:10.1016/S0740-5472(03)00068-0; Mancini, M. A., Hardiman, E. R., & Eversman, M. H. (2008). A review of the compatibility of harm reduction and recovery-oriented best practices for dual disorders. *Best Practices in Mental Health*, 42(2), 99-113. Marlatt, G. A., Blume, A. W., & Parks, G. A. (2001). Integrating harm reduction therapy and traditional substance abuse treatment. *Journal of Psychoactive Drugs*, 33(1), 13-21. doi:10.1080/02791072.2001.10400463; Ronel, N., Gueta, K., Abramsohn, Y., Caspi, N., & Adelson, M. (2010). Can a 12-step program work in methadone maintenance treatment? *International Journal of Offender Therapy and Comparative Criminology*, 55(7), 1135-1153. doi:10.1177/0306624X10382570; Sorensen, J. L., Andrews, S., Delucchi, K. L., Greenberg, B., Guldish, J., Masson, C. L., & Shopshire, M. (2009). Methadone patients in the therapeutic community: A test of equivalency. *Drug and Alcohol Dependence*, 100(1-2), 100-106. doi:10.1016/j.drugalcdep.2008.09.009; Tatarsky, A. (2003). Harm reduction psychotherapy: Extending the reach of traditional substance use treatment. *Journal of Substance Abuse Treatment*, 25, 249-256. doi:10.1016/S0740-5472(03)00085-0; Wisely, C. (2013). The logic of recovery and injection drug use. *Journal of Substance Use*, 18, 56-64. doi:10.3109/14659891.2013.761024
- ³⁰ Gleghorn, A., Rosenbaum, M., & Garcia, B. A. (2001). Bridging the gap in San Francisco: The process of integrating harm reduction and traditional substance abuse services. *Journal of Psychoactive Drugs*, 33(1), 1-7. doi:10.1080/02791072.2001.10400461; Lee, H. S., Engstrom, M., & Peterson, S. R. (2011). Harm reduction and 12 steps: Complementary, oppositional, or something in-between? *Substance Use and Misuse*, 46, 1151-1161. doi:10.3109/10826084.2010.548435; Greenberg, B., Hall, D. H., & Sorensen, J. I. (2007). Methadone maintenance therapy in residential therapeutic community settings: Challenges and promise. *Journal of Psychoactive Drugs*, 39, 203-210. doi:10.1080/02791072.2007.10400606; Sorensen, J. L., Andrews, S., Delucchi, K. L., Greenberg, B., Guldish, J., Masson, C. L., & Shopshire, M. (2009). Methadone patients in the therapeutic community: A test of equivalency. *Drug and Alcohol Dependence*, 100(1-2), 100-106. doi:10.1016/j.drugalcdep.2008.09.009; Zweben, J. E., Aly, T., Martin, J., Wengrofsky, S., Bacci, J., & Meddaugh, R. (1999). Making residential treatment available to methadone patients. *Journal of Substance Abuse Treatment*, 17(3), 249-256. doi:10.1016/S0740-5472(98)00073-7
- ³¹ Kellogg, S. H. (2003). On "gradualism" and the building of the harm reduction—abstinence continuum. *Journal of Substance Abuse Treatment*, 25, 241-247. doi:10.1016/S0740-5472(03)00068-0; Klaw, E., Horst, D., & Humphreys, K. (2006). Inquirers, triers, and buyers of an alcohol harm reduction self-help organization. *Addiction Research and Theory*, 14, 527-535. doi:10.1080/16066350500537580; Kosok, A. (2006). The Moderation Management programme in 2004: What type of drinker seeks controlled drinking? *International Journal of Drug Policy*, 17(4), 295-303. doi:10.1016/j.drugpo.2006.03.003
- ³² White, W., & Torres, L. (2010a). *Recovery-oriented methadone maintenance*. Chicago, IL: Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Mental Retardation Services and Northeast Addiction Technology Transfer Center. White, W., & Torres, L. (2010b). Recovery-oriented methadone maintenance (Executive Summary). *Counselor*, 11(6), 44-53. Wisely, C. (2013). The logic of recovery and injection drug use. *Journal of Substance Use*, 18, 56-64. doi:10.3109/14659891.2013.761024

global health,³³ and there are growing points of intersection between AATR and HR programs, e.g., low threshold engagement strategies, person-centered and strengths-based assessment and service planning, peer-based support services, growing emphasis on continuity of contact and support over time.³⁴ HR and AATR also rest on a shared understanding that change is a process often involving incremental steps toward full problem resolution.³⁵

In spite of such points of convergence, managing the ambiguities of integrating AATR and HR concepts and practices at the service practitioner or volunteer level can be quite difficult.³⁶

AATR and HR in the City of Philadelphia

The City of Philadelphia has played a critical role in the history of abstinence-based treatment and recovery in the United States. Dr. Benjamin Rush's early conceptualization of chronic drunkenness as a disease and his call for specialized institutions for its treatment were released from Philadelphia in the late eighteenth and early nineteenth centuries. Some of America's earliest detoxification institutions (Burn Brae, 1859), inebriate asylums (Pennsylvania Sanitarium, 1867), inebriate homes (Franklin Reformatory Home for Inebriates, 1872), recovery mutual aid societies (Godwin Association, 1872), and other recovery support institutions (Workingman's Central Coffeehouse, 1874) as well as private addiction cure institutes (Keeley Institute, 1895) were located in Philadelphia and surrounding communities.³⁷

Those early contributions continued with the research on opiate addiction conducted by Arthur B. Light and Edward G. Torrance at Philadelphia General Hospital under the auspices of the Philadelphia Committee for Clinical Study of Opium Addiction (1926-1928), the mid-century collaborations between Philadelphia hospitals and Alcoholics Anonymous, and the country's first (1935) integration of a recovering lay alcoholism therapist (Francis Chambers) within a multidisciplinary approach to the psychiatric treatment of alcoholism led by Dr. Edward Strecker at the Institute of the Pennsylvania Hospital. The Philadelphia area played key roles in the pre-modern era of addiction treatment and recovery in the United States and played a similarly prominent role in the rise of modern addiction treatment, including the early history of therapeutic communities³⁸ and the early integration of alcoholism and drug addiction treatment at Eagleville Hospital.

HR programs also have a distinguished history in Philadelphia. Consortium Inc.'s Drug Abuse Rehabilitation Program and Philadelphia General Hospital each began

³³ Wisely, C. (2013). The logic of recovery and injection drug use. *Journal of Substance Use*, 18, 56-64. doi:10.3109/14659891.2013.761024

³⁴ Mancini, M. A., Hardiman, E. R., & Eversman, M. H. (2008). A review of the compatibility of harm reduction and recovery-oriented best practices for dual disorders. *Best Practices in Mental Health*, 42(2), 99-113. White, W. (2008). Toward a philosophy of choice: A new era of addiction treatment. *Counselor*, 9(1), 38-43. White, W. (2009). *The recovery paradigm and the future of medication-assisted treatment*. Plenary address to the American Association for the Treatment of Opioid Dependence, April 28, 2009. Posted at www.facesandvoicesofrecovery.org

³⁵ Hunt, N. (2012). Recovery and harm reduction: Time for a shared, development-oriented, programmatic approach? In R. Pates & D. Riley (Eds.), *Harm reduction in substance use and high-risk behaviors*. Chichester: Wiley-Blackwell.

³⁶ Koutroulis, G. (2000). "That original tension": Negotiating abstinence in clinicians' accounts of harm reduction in nonresidential treatment of heroin withdrawal. *Journal of Substance Abuse Treatment*, 19, 89-98. doi:10.1016/S0740-5472(99)00087-2

³⁷ Leonard, E.C. (1997). The treatment of Philadelphia inebriates. *American Journal on Addictions*, 6, 1-10.

³⁸ Gaudenzia, 1968; White, W. L. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

dispensing methadone in 1968. Dr. Bill Wieland, an early pioneer in these efforts, became the first medical director of Philadelphia's Coordinating Office of Drug and Alcohol Programs. Dr. Wieland, Dr. Jacob Schut, and Dr. Richard Cohen oversaw the early expansion of methadone maintenance treatment in Philadelphia. Medication-assisted treatment for addicted pregnant women in Philadelphia was pioneered during this early period by Dr. Loretta Finnegan. The growing network of MMT clinics took on a great HR orientation in response to the AIDS epidemic in the 1980s, and syringe and needle exchange services were introduced by PreventionPoint Philadelphia in 1991.

In the earliest years of their co-existence, AATR and HR programs in Philadelphia existed in isolation from one another, and their relationship, if it could even be called that, was marked by one of mutual suspicion, conflict, and competition for public support and resources. The context for bridging this ideological chasm was a recovery-focused behavioral health systems transformation process initiated in Philadelphia in 2005.³⁹ Roland Lamb, Director, Office of Addiction Services, Philadelphia Department of Behavioral Health Intellectual disAbility Services, explains:

*There were times when an expansive ideological chasm existed between harm reduction organizations and most of our addiction treatment and recovery support organizations. Today, we are bridging that chasm through processes of mutual education and collaboration as we bridge public health and clinical models of intervention. Our traditional harm reduction organizations have moved from a position of isolation to become more integrated into the larger system of care in Philadelphia. They have also become more recovery-focused, with two of the earliest of such organizations—Action AIDS and the Mazzone Center—now having treatment licenses. At the same time, many of our traditional drug-free treatment programs are incorporating harm reduction principles and practices. The shared vision emerging from our systems transformation process has been that of long-term health and wellness as incremental and continual processes at individual, family, and community levels.*⁴⁰

This systems transformation process set the stage for increased communication and then collaboration between AATR programs, HR programs, and other community service entities. In the next section, we will outline four key programmatic areas where AATR and HR principles and practices were integrated, after which we will outline some of the key ideas and lessons that have emerged from these integration experiments.

HR and AATR Integration Profiles

³⁹ Achara-Abrahams, I., Evans, A. C., & King, J. K. (2011). Recovery-focused behavioral health systems transformation: A framework for change and lessons learned from Philadelphia. In J. F. Kelly & W. L. White (Eds.), *Addiction recovery management: Theory, science and practice* (pp. 187-208). New York: Springer Science. Evans, A. C. (2007). The recovery-focused transformation of an urban behavioral health care system: An interview with Arthur Evans, PhD. In W. L. White, *Perspectives on systems transformation: How visionary leaders are shifting addiction treatment toward a recovery-oriented system of care (Interviews with H. Westley Clark, Thomas A. Kirk, Jr., Arthur C. Evans, Michael Boyle, Phillip Valentine and Loretta Albright)*. Chicago, IL: Great Lakes Addiction Technology Transfer Center. Lamb, R., Evans, A. C., & White, W. (2009). The role of partnership in recovery-oriented systems of care: The Philadelphia experience. Posted www.facesandvoicesofrecovery.org

⁴⁰ Roland Lamb, personal communication, March 21, 2013

Assertive Outreach and Low-threshold Service Access Points. One of the Philadelphia systems transformation goals is to expand low threshold access points for those persons with behavioral health disorders who are at greatest risk for harm to themselves and others. A key mechanism for achieving this has been encouragement of traditional treatment providers to expand outreach and engagement services and by funding (via federal Access to Recovery funds) non-traditional service organizations (e.g., PreventionPoint, New Pathways, One Day at a Time, and the Recovery Community Center) to provide outreach and drop-in access points.

Public Health Management Corporation (PHMC) operates four programs that have an integrated HR and recovery orientation: New Pathways, New Pathways for Women, the HIV/HCV Prevention Street Outreach Project, and the Philadelphia Hepatitis Outreach Project. Between July 2012 and March 2013, these four programs collectively:

- logged more than 21,391 street encounters (engagement, information sharing, support, referral) by their respective outreach teams (see Figure One),
- hosted more than 7,615 drop-in center visits,
- conducted 278 HCV screenings and 216 HIV onsite rapid tests,
- linked 73 people to addiction treatment,
- hosted 2,728 visits for recovery support group meetings, and
- linked more than 1,620 individuals to other health and social service resources.⁴¹

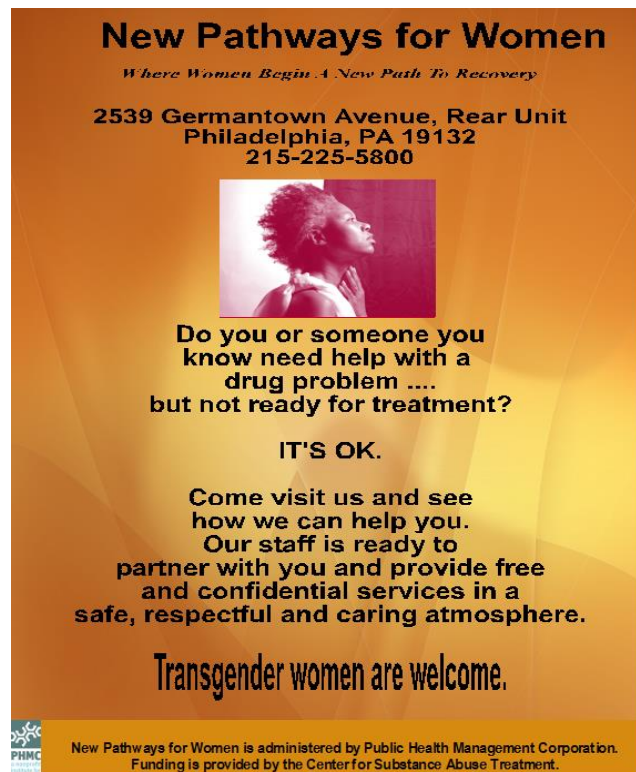


Figure One: New Pathways for Women Street Outreach Recruitment Flyer

⁴¹ Eugenia Argires, personal communication, April 15, 2013

Eugenia Argires, Program Director at New Pathways (a program of the Public Health Management Corporation, PHMC), explains how HR and recovery perspectives have been integrated:

We reframe harm reduction within an expanded purpose of health promotion rather than an end in itself. This occurs with a trauma-informed perspective that recognizes the impact that violence and victimization may have on individuals' capacity to minimize harm associated with their substance use while partnering with them to strengthen their capacity to initiate and maintain their recovery. Harm minimization can be viewed as an end in itself or as a first step towards recovery. At New Pathways, we view it as the latter. We engage persons active in their addiction in a relational model that supports self-determined, incremental steps towards full recovery. For us, minimizing immediate harm is about helping people move towards hope, healing and health over the long term as they themselves define it. We do that through our community-based assertive street outreach programs focused on serving homeless individuals, and those with chronic substance use problems, the integration of behavioral health with primary care in our service linkages for persons with HIV/AIDS or viral hepatitis among other conditions, and our two neighborhood-based drop-in centers, one for women only. These programs provide welcoming spaces where even the smallest steps toward recovery are supported and celebrated. These types of pre-recovery (recovery priming) support services began in 1999 and have been progressively enhanced and expanded since that time. To us, recovery is best initiated and maintained in the support of your peers. Our pre-recovery support programs are a means of reaching people and welcoming them into this community of recovering people.⁴²

The core values and central beliefs guiding the low threshold support services provided by New Pathways is illustrated in the following messages conveyed to each service recipient:

- *We practice an intentional hospitality and will be a powerful antidote to the brutality of the streets. We meet all who enter our offices with a gentle warm welcome and a drink of water or other beverage, access to a restroom, and a comfortable seat in a beautiful, clean and colorful environment. We will keep your waiting time to meet with us as short as possible.*
- *We believe that anyone can recover, and that recovery is often an incremental process that can be effectively managed over time. We will support abstinence as your ultimate goal, but we understand your recovery is beginning if your use of drugs decreases. We will celebrate every success and provide you with support to continue forward with hope.*

⁴² Eugenia Argires, personal communication, March 11, 2013

- *We believe there are many paths to recovery. Your path may be spiritual, clinical, cultural or peer-based. We will work with you to clear your path as you walk it.*
- *We are a trauma-informed recovery support program. We recognize that many individuals' lives have unfolded within violence and victimization, that their use of substances was their way to manage the distress of that violence and victimization, and that their continued use of substances puts them at further risk for more violence and victimization. We will never ask, "What is wrong with you?" but rather "What happened to you?" We will support you as you make the connections between your drug use and the losses you have suffered. We will partner with you as you explore the impact those losses have had on your life.*
- *We will help you if you ask us. Your participation in our projects will always be your choice and will only happen with your informed consent. We will proceed as your partner, at your pace.*
- *We will work hard to remove barriers to your recovery. You will not be mandated to enroll in our project as part of your parole requirement, or to maintain your housing, or to retain custody of your children, or to defer incarceration, or by any requirement other than a desire for recovery. We will support your recovery efforts because we believe you are entitled to receive our services and our help.*
- *We understand recovery is most consistently maintained in community, among the support of your peers. We believe that you will draw strength, resilience, and wisdom from each other.⁴³*

Assertive outreach and engagement within a healing community is aimed at creating continuing, empathic relationships with active drug users that over time exert risk-reducing and recovery seeking influences.

Recovery-oriented Methadone Maintenance. Methadone maintenance was developed as a treatment for chronic heroin addiction by Drs. Dole, Nyswander, and Kreek in New York City in the mid-1960s and subsequently replicated throughout the U.S. and internationally.⁴⁴ A series of scientific reviews confirmed that methadone maintenance treatment (MMT) delivered at sustained optimal daily dosages by competent practitioners combined with ancillary psychosocial services:

- 1) decreases the death rate of opioid-dependent individuals by as much as 50%;
- 2) reduces the transmission of HIV, Hepatitis B and C, and other infections;
- 3) eliminates or reduces illicit opioid use;
- 4) reduces criminal activity;
- 5) enhances productive behavior via employment and academic/vocational functioning;
- 6) improves global health and social functioning; and

⁴³ Argires, E. (2013). *FINAL REPORT New Pathways for Women: Submitted to the Center for Substance Abuse Treatment Targeted Capacity Expansion for Substance Abuse Treatment and HIV/AIDS Services Grants TCE/HIV and Outreach*. Philadelphia, PA: Public Health Management Corporation.

⁴⁴ White, W. L. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

- 7) is cost-effective.⁴⁵ (Evidence for 1, 2, 3, 4 & 7 is particularly strong; evidence for 5 and 6 is present but weaker.)

During the national and international diffusion of MMT, the emphasis within policy and clinical rationales for MMT shifted from a person-centered enhancement of global health and social functioning to an emphasis on reduction in personal and social harm—a shift that was profoundly influenced by concerns about addiction-related crime and the worldwide AIDS epidemic.⁴⁶ MMT can thus be designed as a primarily HR intervention or as a recovery-focused medical treatment for addiction. The former is focused primarily on what is reduced or removed from the life of service recipients (illicit opioid use, criminal activity, risk of HIV/AIDS and other infections) that poses risk of harm to oneself or the community. The latter includes but moves beyond HR to focus on what can be added to the life of service recipients (stable abstinence from alcohol and non-prescribed drugs, enhanced global—physical, emotional, relational, spiritual—health, and enhanced citizenship (community integration and community service)).⁴⁷

MMT has been provided in Philadelphia as a treatment for opioid addiction since 1967. Today (2013), between 4,600 and 5,000 MMT patients are enrolled on any given day within Philadelphia’s 13 DBHIDS-funded opioid treatment programs (11 organizational providers). The MMT-related goals within Philadelphia’s behavioral health systems transformation process were to enhance professional, recovery community, and public understanding of the rationale and scientific evidence supporting MMT while at the same time elevating the quality of MMT in areas critical to enhancing long-term recovery outcomes. More specifically, efforts were made to enhance access to MMT, eliminate arbitrary limits on the duration of MMT, ensure safe induction and individually optimal dosages of medication, enhance retention in MMT, and amplify psychosocial supports and ancillary services during and following MMT. A clear nexus exists between each of these goals and enhanced prognosis for long-term recovery.⁴⁸

The systems-level mechanisms for achieving these goals have included:

- using the Medication-assisted Treatment Providers (MATP) group as a forum for enhanced HR and recovery-focused transformation of MMT,

⁴⁵ Ducker, E., Lurie, P., Wodakt, A., & Alcabes, P. (1998). Measuring harm reduction: The effects of needle and syringe exchange programs and methadone maintenance on the ecology of HIV. *AIDS*, 12(suppl A), S217-S230. Institute of Medicine (1990). *Treating drug problems, Vol. 1*. Washington, DC: National Academy Press. Kreek, M. J., & Vocci, F. (2002). History and current status of opioid maintenance treatments. *Journal of Substance Abuse Treatment*, 23(2), 93-105. doi:10.1016/S0740-5472(02)00259-3; Mattick R.P., Breen, C., Kimber, J., & Davoli, M. (2003). Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence. *Cochrane Database of Systematic Reviews, (Issue 2):CD002209*. National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction. (1998). Effective medical treatment of opiate addiction. *Journal of the American Medical Association*, 280(22), 1936-1943. doi:10.1001/jama.280.22.1936; U.S. General Accounting Office. (1990). *Methadone maintenance: Some treatment programs are not effective; greater federal oversight needed* (GAO Report No. GAO/HRD-90-104). General Accounting Office.

⁴⁶ Clark, C. (2012). “Chemistry is the new hope”: Therapeutic communities and methadone maintenance, 1965-71. *Social History of Alcohol and Drugs*, 26(2), 192-216. White, W., & Torres, L. (2010a). *Recovery-oriented methadone maintenance*. Chicago, IL: Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Mental Retardation Services and Northeast Addiction Technology Transfer Center. White, W., & Torres, L. (2010b). *Recovery-oriented methadone maintenance (Executive Summary)*. *Counselor*, 11(6), 44-53.

⁴⁷ White, W., & Torres, L. (2010a). *Recovery-oriented methadone maintenance*. Chicago, IL: Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Mental Retardation Services and Northeast Addiction Technology Transfer Center. White, W., & Torres, L. (2010b). *Recovery-oriented methadone maintenance (Executive Summary)*. *Counselor*, 11(6), 44-53.

⁴⁸ White, W., & Torres, L. (2010a). *Recovery-oriented methadone maintenance*. Chicago, IL: Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Mental Retardation Services and Northeast Addiction Technology Transfer Center. White, W., & Torres, L. (2010b). *Recovery-oriented methadone maintenance (Executive Summary)*. *Counselor*, 11(6), 44-53.

- developing and widely disseminating the monograph, *Recovery-oriented Methadone Maintenance*,⁴⁹
- discussing how to improve clinical responses to continued drug use by MMT patients—including development of guidelines on the management of benzodiazepines in medication-assisted treatment,
- developing an MATP plan to address stigma related to medication-assisted treatment and publishing/posting a series of stigma-related papers,⁵⁰
- asserting a definition of recovery that embraces stabilized MMT patients who abstain from alcohol and non-prescribed drug use within the sobriety element of the emerging consensus definitions of recovery,⁵¹
- enhancing rates to lower MMT counselor-patient ratios, increase case management and psychiatric services, encourage peer support services, and expand use of recovery plans,
- encouraging development of MMT consumer councils or patient advisory committees and including MMT patients in policy discussions and local hearings related to MAT,
- reducing barriers for admission (co-enrollment) of MMT patients into other services and encouraging bi-directional referrals between MAT and other service modalities toward the goal of “No closed doors for MMT patients”,
- supporting integration of medication into traditionally drug-free treatment programs (e.g., Eagleville Hospital),⁵²
- ensuring that methadone is available across all levels of care within the system,
- ensuring access to methadone for incarcerated MAT patients and assertively linking incarcerated persons to clinics for recovery planning and community re-entry, and
- supporting PRO-ACT’s (local recovery advocacy organization) development of a consumer’s guide for medication-assisted addiction treatment.
- using community participatory art projects to increase understanding of addiction and MMT

⁴⁹ White, W. (2011b). Reflections on medication-assisted recovery. *Resource Links*, 10(1), 6-7. Northeast Addiction Technology Transfer Center. White, W. (2012a). Medication-assisted recovery from opioid addiction: Historical and contemporary perspectives. *Journal of Addictive Diseases*, 31(3), 199-206. doi:10.1080/10550887.2012.694597; White, W. (2012b). Recovery orientation in methadone maintenance: A definitional statement. Posted at www.williamwhitepapers.com; White, W., & Torres, L. (2010a). *Recovery-oriented methadone maintenance*. Chicago, IL: Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Mental Retardation Services and Northeast Addiction Technology Transfer Center. White, W., & Torres, L. (2010b). Recovery-oriented methadone maintenance (Executive Summary). *Counselor*, 11(6), 44-53. White, W. & Mojer-Torres, L. (2011). Recovery-oriented Methadone Maintenance: A coming of age. *Addiction Treatment Forum*, 21(1), 1, 5.

⁵⁰ White, W. (2009). *The recovery paradigm and the future of medication-assisted treatment*. Plenary address to the American Association for the Treatment of Opioid Dependence, April 28, 2009. Posted at www.facesandvoicesofrecovery.org; White, W. (2011b). Reflections on medication-assisted recovery. *Resource Links*, 10(1), 6-7. Northeast Addiction Technology Transfer Center. White, W. (2012a). Medication-assisted recovery from opioid addiction: Historical and contemporary perspectives. *Journal of Addictive Diseases*, 31(3), 199-206. doi:10.1080/10550887.2012.694597; White, W. (2012b). Recovery orientation in methadone maintenance: A definitional statement. Posted at www.williamwhitepapers.com; White, W., Parrino, M., & Ginter, W. (2011). *A dialogue on the psychopharmacology in behavioral healthcare: The acceptance of medication-assisted treatment in addictions*. Briefing paper for SAMHSA’s A Dialogue on Psychopharmacology in Behavioral Healthcare meeting, October 11-12, 2011. Posted at www.williamwhitepapers.com

⁵¹ Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment*, 33, 221-228. doi:10.1016/j.jsat.2007.06.001; White, W. L. (2007). Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment*, 33, 229-241. doi:10.1016/j.jsat.2007.04.015

⁵² Deal, D., Folks, C., & White, W. (2011). Methadone maintenance patients in a residential rehabilitation program: The Eagleville experience. Posted at www.williamwhitepapers.com

A forthcoming paper on the 10-year evaluation of Philadelphia's systems transformation will report the results of the measurable benchmarks being used to evaluate these efforts.

Needle and Syringe Exchange Programs (NSEP). NSEPs exchange sterile needles and syringes used for injections as a vehicle for reducing the transmission of infectious diseases and providing other harm reduction-related information and services. They are intended to promote individual and public health by reducing the length of time each potentially contaminated needle and syringe is in circulation, increasing the availability of sterile needles and syringes, and increasing the speed at which used needles/syringes are removed from the community environment.⁵³ NSEPs have been among the most controversial of HR services, with the U.S. banning use of federal funds for NSEPs and for a time even banning use of federal funds to evaluate the effectiveness of NSEPs.⁵⁴

PreventionPoint Philadelphia (PPP), catalyzed by Philadelphia's chapter of ACT UP (AIDS Coalition to Unleash Power), began providing needle and syringe exchange services in 1991 at a time this activity was still illegal. PPP worked with Philadelphia Mayor Ed Rendell's office to issue a 1992 executive order declaring AIDS a public health emergency warranting legal expansion of syringe exchange operations. PPP's syringe exchange and other harm reduction initiatives have since been funded by the City's behavioral health and public health departments and through the support of private foundations.

PPP's service menu currently includes eight syringe exchange sites, a drop-in center, and a free medical clinic. Collectively, these sites provide syringe exchange, confidential HIV testing and counseling, Hepatitis C screening, opiate overdose prevention trainings with naloxone distribution, and referrals to drug treatment, medical care, legal services, case management, public assistance, and medical assistance. In FY 2011, PPP distributed more than 1.3 million syringes (94.9% exchange rate) in 14,845 exchange transactions to 3,894 individuals at its eight syringe exchange sites.⁵⁵

PPP has served more than 15,000 individuals since its inception in 1991 and has worked in tandem with other organizations such as Project SAFE that works with female sex workers, some of whom are also injection drug users. Since PPP's inception, the percentage of injection drug users within new cases of HIV infection in Philadelphia has dropped from 50.5% of new cases in 1992 to 17.5% of new cases in 2007⁵⁶ while the cumulative representation of injection drug users within all cases dropped from 33.2% of prevalent cases in 1980-2007 to 10.2% of cases in 2010.⁵⁷ The estimated cost for each case of HIV infection averted through syringe exchange services in Philadelphia has been estimated to be between \$2300-4200, compared to the estimated lifetime cost of HIV treatment of nearly one million dollars.⁵⁸

⁵³ Ducker, E., Lurie, P., Wodakt, A., & Alcabes, P. (1998). Measuring harm reduction: The effects of needle and syringe exchange programs and methadone maintenance on the ecology of HIV. *AIDS*, 12(suppl A), S217-S230.

⁵⁴ Strathdee, S. A., & Pollini, R. A. (2007). A 21st-century Lazarus: The role of safer injection sites in harm reduction and recovery. *Addiction*, 102, 848-849. doi:10.1111/j.1360-0443.2007.01859.x

⁵⁵ Prevention Point Philadelphia Reports provided by José Benitez, March 12, 2013

⁵⁶ Schwarz, D. F., Feyler, N., Cella, J., & Brady, K. A. (2008). *AIDS in Philadelphia: 2008 Report on HIV/AIDS Care and Prevention in the City of Philadelphia*.

⁵⁷ Shpaner, M., Brady, Kathleen, & Eberhart, M. (2010). *Surveillance Report 2010*. Program Manager. Philadelphia.

⁵⁸ Harris, Z. K. (2006). Efficient allocation of resources to prevent HIV infection among injection drug users: The Prevention Point Philadelphia (PPP) needle exchange program. *Health Economics*, 15(2), 147-58. doi:10.1002/hec.1021

José Benitez describes the role of choice in the PreventionPoint philosophy.

*We are creating a buffet of service and support choices. Even within PreventionPoint Philadelphia, we have people who bring a diversity of past experiences and orientations to our work. That diversity itself is part of the buffet. Flexibility and openness to multiple pathways and styles of moving toward healing and wellness are part of our organizational DNA.*⁵⁹

Stephen Bamber from the UK has described how NSEPs may integrate increased recovery orientation into a more traditional HR perspective.

*A recovery focused NSP will be driven by a vision that creates a therapeutic space conducive not only to safer injection practices, but also to actively promoting and supporting engagement for long-term recovery from problematic substance use. Ideally, this means making visible recovery successes and articulating a robust, realistic narrative of recovery that is meaningful and appropriate to the injecting population. ...if there is an authentic, realistic possibility of recovery, then there is arguably an ethical imperative to promote and provide access to services that deliver recovery-oriented change....The Journey towards a full and meaningful life that is recovery can begin in the most unlikely of places. Why not through the doors of a needle exchange programme?*⁶⁰

While there are anecdotal accounts of people finding recovery through contact with NSEP staff and volunteers and NSEP studies evaluating effects of NSEPs on mortality and health, the authors know of no study to date that has investigated recovery outcomes of NSEP participants. The dichotomous worlds of harm reduction and recovery have precluded examination of this type of outcome.

Housing Support Continuum. Housing support is a critical issue for homeless persons/families affected by substance use disorders and related medical and psychiatric disorders, with many such individuals/families living on the streets or using shelters, jails, hospitals, and various treatment facilities for temporary shelter. The most recent (Winter 2013) point-in-time count of homeless persons in Philadelphia revealed 388 homeless individuals within the street; 127 individuals at St. John's Coffeehouse, Navigation Center, or Bethesda Café; and 1,172 individuals and 1,673 members of family units residing in Philadelphia's shelter services.⁶¹

A review of death data for Philadelphia's homeless population underscores the need for assertive outreach and engagement. Of homeless persons who died in 2009-2010, 74% had one or more chronic medical illnesses at the time of death, 63% had a history of excessive substance use (with 44% having substance intoxication as a primary or contributing cause of death), and 52% had a prior history of mental illness. Discovery

⁵⁹ José Benitez, March 12, 2013

⁶⁰ Bamber, S. (2010). The role of syringe and needle programmes in a recovery-oriented treatment system. *Recovery writing: Volume one, 2009-2010*, pp. 48-54. Retrieved February 12, 2013 from www.theartoflifeitself.org/publications/recovery_Writing_Volume_One.2009_2010.pdf

⁶¹ Health & Opportunity, Quarterly Point in Time Homeless Count, Winter, 2013

that over one-third of homeless persons who died had been in contact with at least one community service agency in the 30 days prior to their death fueled the decision to expand assertive outreach, housing supports, low threshold behavioral health treatment services, and allied health services.⁶²

“Housing First” is a term used to characterize programs that address homelessness by providing rapid access to housing that is not contingent upon broader changes in behavior, e.g., immediate entry into psychiatric or addiction treatment. The goal is to provide housing stability and offer a wide spectrum of ancillary services that promote health and social functioning without requiring either abstinence or continued service participation. Housing First was developed as an alternative to the more traditional approach of requiring treatment participation for entry into and maintenance of housing support toward the long-term goal of stable recovery and permanent housing. Housing First emerged due to problems attracting and retaining individuals experiencing homelessness within traditional service venues, particularly psychiatric treatment, as well as problems with post-treatment resumption of addiction, homelessness, and related problems.⁶³ Housing First programs have been able to achieve high rates of housing placement and high rates of housing retention without increasing AOD use and have been able to provide support services that enhance recovery readiness.⁶⁴

Philadelphia has developed an array of supportive housing options to address the need for affordable and supportive housing for persons with and recovering from AOD-related problems, including those with co-occurring mental illness. Beginning in the late 1980s with the development of 1260 Housing Development Corporation, the Philadelphia Department of Behavioral Health and Intellectual disability Services (DBHIDS) partnered with Housing Funding sources and used county resources to increase access to housing supports. Since the early 1990s, Philadelphia DBHIDS has partnered with the McKinney Vento Continuum of Care (COC) to develop both project-based and scattered site supportive housing.

In 2003, Philadelphia began its first Housing First program, with Horizon House Inc. and 1260 Housing Development Corporation. In 2008, the city began a partnership with the Philadelphia Housing Authority for 200 set aside vouchers a year, to support the city’s 10 Year Plan to End Homelessness. Using these and other housing resources, Philadelphia has been able to house 1,916 persons since 2007, including 1,461 individuals with a history of chronic homelessness and living on the streets. Housing options include programs with an AATR perspective, as well as programs that take an HR approach. Most “clean and sober” housing was developed from the early ’90s to the early ’00s, and most of the Housing First programs were developed after that. Many of these early programs primarily served individuals experiencing severe mental illness, e.g., New Keys (2003), Home First (2004), and Pathways to Housing (2008).

Pathways to Housing recently (2010) initiated the CHIPS program, a 10-bed Housing First project specifically designed to address chronic alcoholism. Pathways’ Housing First initiative reported serving 22 individuals with chronic alcohol dependence, prolonged homelessness, and high rates of comorbid psychiatric and physical illnesses.

⁶² City of Philadelphia Homeless Death Review, 2009-2010

⁶³ Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health, 94*(4), 651-656.

⁶⁴ Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health, 94*(4), 651-656.

Preliminary results include a high rate of stable housing (72%), improved rates of sobriety (from 1-20 months), and enhanced rates of engagement in addiction treatment and medical/psychiatric services.⁶⁵ Other Philadelphia-based low threshold programs that combine housing access with addiction and/or psychiatric treatment include six Journey of Hope Project (JHP) sites developed in collaboration between DBHIDS and the Office of Supportive Housing (2007-2008). A report on the JHP sites has been recently published.⁶⁶

Collectively, these programs provide strategies of assertive outreach, warm welcome, and resistance management (motivational interviewing); a continuum of wet, damp, and dry housing; transitional, supported, and permanent housing; health screenings; evidence-based interventions (e.g., cognitive behavioral and contingency management strategies) modified for this population; intensive case management and assertive linkage to recovery community resources (e.g., recovery mutual aid meetings, recovery homes, recovery community center, recovery advocacy activities). In FY 2012, DBHIDS-funded street outreach and housing programs made 37,687 contacts with 5,570 individuals (unduplicated), placing 1,616 individuals in resources ranging from shelters, hospitals, detox programs, overnight cafes, recovery homes, boarding houses, and family or friends. 428 of these individuals were placed multiple times during FY 2012.⁶⁷

The growing continuum of wet, damp, and dry housing poses challenges about how to personally match such services. Dr. Marcella Maguire, Director, DBHIDS Homeless Services, explains:

*The question we face with this growing menu of services is how to improve our screening and assessment processes to assure the best possible match between person and program. We now have this broad continuum of housing services. The critical challenge we face is determining which services are best suited to help each individual reduce the threat of imminent harm to self and others while enhancing his or her chances for long-term recovery and community reintegration. For example, we serve people who are in the process of early disconnection from family and community and those with prolonged histories of such disconnection; we need better ways to differentiate how to best match services to these different populations.*⁶⁸

Supporting traditional abstinence-based programs to integrate HR principles to address the conjoined problems of addiction and homelessness has not been easy.

Supporting programs that have a strong abstinence orientation in their DNA to broaden their perspective to include support for people in pre-recovery stages of change is difficult but we are finding areas of common ground between these two perspectives. Most of the deaths of homeless people in Philadelphia are a direct

⁶⁵ Dichter, H., Fussaro, A., Weinsteion, L., Tynanon, R., & Ellington, K. (2013). *Outcome evaluation for Pathway's Chronic Inebriate Program*. Submitted to DBHIDS February 11, 2013.

⁶⁶ Maguire, M, Sheahan, T. M., & White, W. L. (2011). "I wanted a new beginning" Innovations in recovery management for people experiencing prolonged homelessness in the City of Philadelphia. *Alcoholism Treatment Quarterly*, 30, 3-21. doi:10.1080/07347324.2012.635548; personal communication with Marcella Maguire and Timothy Sheahan, April 9, 2013

⁶⁷ Marcella Maguire, personal communication, April 9, 2013

⁶⁸ Personal communication, Marcella Maguire, April 9, 2013

*result of alcohol and drugs. The treatment system has a responsibility to reach this population at highest risk of addiction-related death.*⁶⁹

Cross-initiative Themes. There are several connecting themes within the four areas of HR and AATR integration we have profiled. By blending HR and recovery support, Philadelphia is:

- identifying and engaging people at earlier stages of AOD problem development,
- identifying and (re)engaging people in the latest stages of addiction who have resisted treatment involvement or who have been repeatedly recycled through brief episodes of acute stabilization via medical treatment, detoxification, or addiction treatment,
- lowering access barriers to stable housing, addiction treatment, and related health and social services for those in greatest need, e.g., warm welcome and open readmission policies,
- streamlining assessment and intake procedures (e.g., registration in less than a minute at PPP syringe exchange sites),
- altering administrative discharge policies that in the past have kicked people out of treatment for confirming their diagnosis,
- enhancing linkages between HR and AATR resources, e.g., placement of DBHIDS staff person within PreventionPoint to facilitate direct and rapid entry into the treatment system and a pilot project to link needle exchange clients to suboxone treatment,
- shifting from short-term fixed lengths of stay to open-ended lengths of stay in housing programs,
- ensuring continuous and integrated care across multiple levels of care, and
- elevating the visibility of recovery role models (living proof) and peer support at all points of service contact.

Roland Lamb, Director of the Office of Addiction Services, describes the philosophy behind low threshold services that integrate HR and AATR:

*Recovery has within it an implicit and explicit goal of reducing harm. Stable recovery is the ultimate harm reduction strategy. Our mantra is “no closed doorways to recovery.” We will meet people where they are on any day and support on that day even the smallest steps towards recovery and wellness that the individual is willing to take, all the while affirming their potential for full recovery and our willingness to walk this path with them.*⁷⁰

Such low threshold services are garnering considerable scientific support as well. For example, reviews of studies of assertive community-based outreach programs aimed at injection drug users have shown positive outcomes related to reduction/cessation of injection drug use, reduction/cessation of reuse and sharing of injection equipment, reduction/cessation of other drug use (e.g., crack cocaine), increased use of condoms, and

⁶⁹ Personal Communication, Marcella Maguire, April 9, 2013

⁷⁰ Roland Lamb, Personal Communication, March 21, 2013

increased treatment entry.⁷¹ Such outcomes can reduce harm to multiple parties while simultaneously enhancing recovery prospects and reducing multiple burdens of illness potentially brought into a long-term recovery process.

Dr. Arthur Evans, Jr., DBHIDS Commissioner, explains how HR and AATR perspectives are integrated within these low threshold services.

Traditional harm reduction programs have pioneered low threshold services, but they have often also been characterized by low expectations. Our vision is to expand low threshold services that at the same time elevate peoples' sense of what is possible for them. We do this by exposing them to living proof that recovery is possible even under the most difficult of circumstances, confirming that there are people who will walk this path with them, and offering stage-appropriate services to support people in their journeys from addiction to recovery.⁷²

One of the lessons we are learning in this process is how to stay engaged with people who at one point may not be interested in embarking on this recovery journey who, through repeated encounters with people in recovery, may be so interested at a later point in time.

Key Understandings about the Course and Consequences of AOD Use and Related Problems and Their Resolution Process

In the remainder of this article, we will explore some of the key understandings that can form a foundation for greater AATR/HR collaboration and integration. Many of these ideas have been influential within the recovery-focused transformation of the behavioral health care system in the City of Philadelphia.

AOD Use and Harm to Self and Others

HR-oriented services can preserve life during periods of active drug use and reduce the baggage (burdens) brought into a subsequent recovery process. Irreparable harm to individuals, families, and communities can occur as a result of AOD use—both from a single episode of use and from prolonged use. A major goal of HR is to prevent such irreparable harm.⁷³ For that population of people who will end up defining themselves as persons in recovery, HR serves to preserve life and the future option of recovery while reducing the harmful burdens and legacies of addiction brought into the recovery process, e.g., HIV/AIDS, viral hepatitis, and other potentially chronic and life-threatening health conditions; injury to others. Reductions in drug-related harm to self and others can be achieved for some individuals with or without their movement toward complete abstinence; however, sustained abstinence, when personally chosen and

⁷¹ Coyle, S. L., Needle, R. H., & Normand, J. (1999). Outreach-based HIV prevention for injecting drug users: A review of published outcomes data. *Public Health, 113*(Supplement 1), 19-30.

⁷² Personal Communication, Dr. Arthur Evans, Jr. March 20, 2013

⁷³ IHRA, 2013 What is harm reduction. Accessed May 30, 2013 at http://www.ihra.net/files/2010/08/10/Briefing_What_is_HR_English.pdf

achieved, remains the ultimate strategy for eliminating AOD-related harm to self and others.⁷⁴

Both AATR and HR programs have the responsibility of enhancing coping methods and increasing social supports as AOD use decelerates or ceases. Such supports are critical to prevent inadvertent harm resulting from the service intervention. AOD use can be viewed as attempted acts of self-care (self-prescription)⁷⁵ that for some morph through neurobiological processes into drug addiction and compulsive acts of self-destruction.⁷⁶ In persons using alcohol and other drugs to self-medicate other conditions, particularly severe emotional distress and symptoms of severe psychiatric illness, abstinence or even deceleration of AOD use could result in harm if healthier alternatives for management of these conditions are not developed.⁷⁷ There is, for example, evidence of the potential for psychiatric deterioration during and following addiction treatment.⁷⁸ Further, a complex relationship exists between AOD use and the risk of aggression towards self and others, with AOD use potentially having inhibiting as well as promoting effects on such aggression.⁷⁹ Effective AATR and HR programs combine enhancement of alternative coping skills, social support, and reshaping norms and behavioral practices within community social networks.

AATR, HR, and Addiction/Recovery Careers

Integrated AATR and HR principles and practices provide a way to reach, engage, and support positive change across the arenas of drug use, addiction, and recovery.

Addiction careers—measured from onset of AOD-related problems to the stable resolution of these problems either through abstinence or decelerated patterns of use—are for most individuals measured not in months or years but in decades.⁸⁰

AATR and HR represent not opposing strategies but approaches to reaching different populations and reaching the same individuals at different stages of their AOD use, addiction, and recovery careers. Addiction careers become careers rather than brief developmental episodes primarily because of the combination of problem severity/complexity and the absence of personal, family, and community recovery capital (resources that can be mobilized to initiate and sustain long-term recovery). We need more nuanced, actionable models that deepen our understanding of AOD use and the

⁷⁴ Marlatt, G. A. (1996). Harm reduction: Come as you are. *Addictive Behaviors*, 21(6), 779-788. doi:10.1016/0306-4603(96)00042-1; Marlatt, G. A. (1998). *Harm reduction: Pragmatic strategies for managing high-risk behaviors*. New York: Guildford Press.

⁷⁵ Denning, P. (2001). Strategies for implementation of harm reduction in treatment settings. *Journal of Psychoactive Drugs*, 33(1), 23-26. doi:10.1080/02791072.2001.10400464; Khantzian, E. J. (1989). Addiction: self-destruction or self-repair? *Journal of Substance Abuse Treatment*, 6(2), 75. doi:10.1016/0740-5472(89)90032-9; Khantzian, E. J. (1990). Self-regulation and self-medication factors in alcoholism and the addictions. Similarities and differences. *Recent Developments in Alcoholism*, 8, 255-271.

⁷⁶ Volkow, N., & Li, T-K. (2006). The neuroscience of addiction. *Nature*, 8(11), 1429-1430. Shaham, Y., & Hope, B. (2006). The role of neuroadaptations in relapse to drug seeking. *Nature*, 8(11), 1437-1439.

⁷⁷ Hunt, N. (2012). Recovery and harm reduction: Time for a shared, development-oriented, programmatic approach? In R. Pates & D. Riley (Eds.), *Harm reduction in substance use and high-risk behaviors*. Chichester: Wiley-Blackwell.

⁷⁸ Ilgen M. A., & Moos R. (2006). Exacerbation of psychiatric symptoms during substance use disorder treatment. *Psychiatric Services*, 57, 1758-1764. doi:10.1176/appi.ps.57.12.1758

⁷⁹ White, W. (2004). Substance use and violence: Understanding the nuances of the relationship. *Addiction Professional*, 2(1), 13-19.

⁸⁰ Hser, Y.-I., Anglin, M. D., Grella, C., Longshore, D., & Prendergast, M. L. (1997). Drug treatment careers: A conceptual framework and existing research findings. *Journal of Substance Abuse Treatment*, 14(6), 543-558. doi:10.1016/S0740-5472(97)00016-0; Hser, Y., Hoffman, V., Grella, C., & Anglin, D. (2001). A 33-year follow-up of narcotics addicts. *Archives of General Psychiatry*, 58(5), 503-508. doi:10.1001/archpsyc.58.5.503; Dennis, M. L., Scott, C. K., Funk, R., & Foss, M. A. (2005). The duration and correlates of addiction and treatment careers. *Journal of Substance Abuse Treatment*, 28, S51-S62. doi:10.1016/j.jsat.2004.10.013

onset, maintenance, and resolution of AOD problems within these longer developmental perspectives.

Addiction/Recovery in the Context of Multiple Disabling Conditions

Integrated AATR and HR principles and practices are particularly important for addressing multiple, severe, complex, and chronic (often intergenerational) problems.

The most severe patterns of addiction are often marked by multiple problems that interact concurrently and sequentially to impede the resolution of any single problem in isolation from the larger cluster. Such problem multiplicity characterizes those who are in greatest need of HR, addiction treatment, and recovery support resources.

While HR and AATR are often portrayed as either/or options and that participation in HR programs may prevent participation in more mainstream service interventions, that is not the case in Philadelphia. Most of those involved in the most controversial of HR programs (from syringe exchange to methadone maintenance programs) in Philadelphia (and we assume other cities as well) present with complex service histories within mainstream organizations that have not resulted in sustainable recovery. The failure of traditional service programs with this population is to a great extent related to the issue of problem complexity: the interaction of severe (often intergenerational) patterns of addiction with co-occurring psychiatric illness, co-occurring medical illness (including presence or risk for HIV/AIDS and viral hepatitis), malnutrition, involvement in criminal justice and child protection systems, episodic or prolonged homelessness, isolation from or turbulence of family and intimate relationships, educational deficits, prolonged unemployment, and lack of financial capital.⁸¹

Most individuals participating in Philadelphia's HR programs are economically and socially marginalized, have already been involved in prior addiction treatment programs (94% in one recent study sample)⁸² and other service programs, and report that they are not warmly welcomed within mainstream health and human service organizations because of the duration, severity, and complexity of their problems and their equally long and complex service histories. Addressing problems of these individuals and families requires service designs by AATR and HR programs that address these twin challenges of high problem severity, complexity, and chronicity and low recovery capital. To state that this population faces significant obstacles to change does not mean that positive incremental changes and even stable long-term recoveries are impossible. The question is how to incite and sustain such incremental steps in the change process on a community-wide level and have stage-focused benchmarks to evaluate individual progress and systems performance.

Changes in Drug Use during the Course of AOD Problems and the Stages of Resolution

Shifts in drug choice and changes in the frequency, methods of administration, and contexts for use can be viewed within an "all or none" view of addiction recovery or viewed as incremental movement towards problem resolution that constitute an

⁸¹ This is the pattern presented by most persons using needle exchange services in Philadelphia, with as many as 80% of those using PreventionPoint's syringe exchange services either homeless or experiencing unstable/unsafe housing (José Benitez, personal communication, March 12, 2013).

⁸² Kecojevic, A., Silva, K., Benitez, J., Gibble, E., & Lankenau, S. (2011). *Initial evaluation of overdose prevention program in Philadelphia*. Poster presented at the 2011 annual meeting of the American Public Health Association.

important “recovery priming” process that should be acknowledged and supported. Stepping stone patterns of drug use can involve patterns of accelerating (stepping up), decelerating patterns of risk related to patterns of drug use (stepping down), or cessation of use of all substances (stepping off).⁸³ While risks of multiple drug use and secondary drug dependencies are a concern within stepping down strategies, some individuals use a shift to an alternative drug choice as a permanent strategy or a transitional stage in their efforts to reduce harms related to their drug use or escape drug dependency.⁸⁴

There are numerous reports of persons dependent upon opiates or alcohol achieving abstinence from these substances by using cannabis as a substitute,⁸⁵ including medical marijuana patients who use cannabis substitution as a strategy for resolving problems of alcohol and other drug dependencies.⁸⁶ While some addictionologists have even suggested the development of 12-step groups for those who only use cannabis as a support for abstinence from other drugs,⁸⁷ there is no evidence yet to support this strategy. The risks of this strategy must be viewed within the “hierarchy of harms” framework, the growing evidence of the potential for cannabis dependence,⁸⁸ and the lower rates of remission from cannabis dependence for individuals who fit the profile of those using HR services (e.g., lower income, lower education, high substance use severity, and co-occurring psychiatric illness).⁸⁹

Similarly, illicit methadone or buprenorphine use may be used for self-medication for heroin withdrawal or self-administered detoxification from heroin, rather than for purposes of intoxication, and such use can be a prelude to entry into medication-assisted treatment.⁹⁰ Several recent studies have confirmed the use of illicit buprenorphine for purposes of self-medication of withdrawal symptoms or for self-treatment opioid addiction via progressive self-detoxification.⁹¹ Persons involved in such patterns could

⁸³ Sifaneck, S. J. & Kaplan, C. D. (1995). Keeping off: stepping on and stepping off: The stepping stone theory reevaluated in the context of the Dutch cannabis experience. *Contemporary Drug Problems*, 22(8), 483-512.

⁸⁴ Labigalini, E., Rodrigues, L. R., & Da Silveria, D. X. (1999). Therapeutic use of cannabis by crack addicts in Brazil. *Journal of Psychoactive Drugs*, 31, 451-455. doi:10.1080/02791072.1999.10471776; Reiman, A. (2009). Cannabis as a substitute for alcohol and other drugs. *Harm Reduction Journal*, 6, 35. doi:10.1186/1477-7517-6-35

⁸⁵ Best, D., Gossop, M., Greenwood, J., Marsden, J., Lehman, P. & Strang, J. (1999). Cannabis use in relation to illicit drug use and health problems among opiate misusers in treatment. *Drug and Alcohol Review*, 18, 31-38; Schiff, M., Levitt, S. & Moreno, R.C. (2007). Retention and illicit drug use among methadone patients in Israel: A gender comparison. *Addictive Behaviors*, 32, 2108-2119; Mikuriya, T. (2004). Cannabis as a substitute for alcohol: A harm reduction approach. *Journal of Cannabis Therapeutics*, 4, 79-93. doi:10.1300/J175v04n01_04

⁸⁶ Reiman, A. (2009). Cannabis as a substitute for alcohol and other drugs. *Harm Reduction Journal*, 6, 35. doi:10.1186/1477-7517-6-35

⁸⁷ Mikuriya, T. (2004). Cannabis as a substitute for alcohol: A harm reduction approach. *Journal of Cannabis Therapeutics*, 4, 79-93. doi:10.1300/J175v04n01_04

⁸⁸ Hathway, A. D. (1997). Cannabis effects and dependency concerns in long-term frequent users: A missing piece of the public health puzzle. *Addiction Research & Theory*, 11, 441-458. Hathaway, A. D., Callaghan, R. C., Macdonald, S., & Erickson, P. G. (2009). Cannabis dependence as a primary drug use-related problem: The case for harm reduction-oriented treatment options. *Substance Use and Misuse*, 44, 990-1008. doi:10.1080/10826080802494875

⁸⁹ Flórez-Salamanca, L., Secades-Villa, R., Budney, A. J., García-Rodríguez, O., Wang, S., & Blanco, C. (2013). Probability and predictors of cannabis use disorders relapse: results of the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC). *Drug and Alcohol Dependence*. Advance online publication. doi:10.1016/j.drugalcdep.2013.01.013

⁹⁰ Gwin Mitchell, S. G., Kelly, S. M., Brown, B. S., Schacht Reisinger, H., Peterson, J. A., Ruhf, A.,...Schwartz, R. P. (2009). Uses of diverted methadone and buprenorphine by opioid-addicted individuals in Baltimore, Maryland. *The American Journal on Addictions*, 18, 346-355.

⁹¹ Bazazi, A. R., Yokell, M., Fu, J. J., Rich, J. D., & Zaller, N. D. (2011). Illicit use of buprenorphine/naloxone among injecting and noninjecting opioid users. *Journal of Addiction Medicine*, 5(3), 175–80. doi:10.1097/ADM.0b013e3182034e31; Daniulaityte, R., Falck, R., & Carlson, R. G. (2012). Illicit use of buprenorphine in a community sample of young adult non-medical users of pharmaceutical opioids. *Drug and Alcohol Dependence*, 122(3), 201–207. doi:10.1016/j.drugalcdep.2011.09.029; Yokell, M., & Zaller, N. (2011). Buprenorphine and buprenorphine/naloxone diversion, misuse, and illicit use: An international review. *Current Drug Abuse Reviews*, 39(3), 236–247. doi:10.1016/j.jsat.2010.06.004.

be targeted for intense outreach and treatment engagement via the kind of low-threshold service programs described above.

Resistance and ambivalence are a natural—not pathological—response to internal and external pressure to change deeply engrained behaviors. Working through such resistance and ambivalence is an expected part of the process of incremental change. The ‘tipping point’ in overcoming such resistance occurs in our experience within the context of contact with individuals with whom one can identify and within sustained relationships with such individuals that are free of contempt and marked by moral equality and emotional authenticity.

Resistance and ambivalence are reduced when people have real choices and are empowered to choose. A research review by Ambrogne⁹² drew two important conclusions: 1) people seeking help for AOD problems have better outcomes when they are given multiple options related to goals and methods of help and the opportunity to assert their own choices and control over these options, and 2) people who seek non-abstinent goals are more amenable to abstinence goals when the non-abstinent goals prove to be unattainable or unsustainable.

Medication-assisted Addiction Recovery

Recovery can be achieved with or without medication support—including recovery from opioid addiction with or without methadone or buprenorphine. This position has been supported by major recovery definition consensus conferences in the U.S. and the U.K. The Betty Ford Institute (BFI) Consensus Panel⁹³ specifically addressed the question of Opioid Treatment Program (OTP) medications and recovery status by defining recovery in terms of sobriety, global health, and citizenship, and then by clearly stating that

...formerly opioid-dependent individuals who take naltrexone, buprenorphine, or methadone as prescribed and are abstinent from alcohol and all other nonprescribed drugs would meet this definition of sobriety.

Similar propositions have been asserted by the U.K.

*Recovery may be achieved in a variety of ways including through medically-maintained abstinence.*⁹⁴

While some ill-conceived policy documents assert or imply that recovery is conditioned upon cessation of medication maintenance⁹⁵ and while much of the international criticism of increased recovery orientation of opioid addiction treatment derives from such narrow

⁹² Ambrogne, J. A. (2002). Reduced-risk drinking as a treatment goal: What clinicians need to know. *Journal of Substance Abuse Treatment*, 22, 45-53. doi:10.1016/S0740-5472(01)00210-0

⁹³ Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment*, 33, 221-228. doi:10.1016/j.jsat.2007.06.001; McLellan, A. T. (2010). What is recovery? Revisiting the Betty Ford Institute Consensus Panel definition. *Journal of Substance Abuse Treatment*, 38, 200-201. doi:10.1016/j.jsat.2009.11.002

⁹⁴ UKDPC. (2008). *A vision of recovery*. UK Drug Policy Commission.

⁹⁵ Inter-ministerial Group on Drugs (2012). Putting full recovery first. Retrieved May 7, 2013 from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98010/recovery-roadmap.pdf

definitions,⁹⁶ every effort has been made in Philadelphia to dispel such a limited understanding of recovery. Defining recovery as contingent upon cessation of medications such as methadone or buprenorphine flies in the face of scientific evidence and clinical experience and risks either categorically depriving all people in MAT recovery status or creating a “hierarchy of worthiness, with people whose recovery was supported by medications being looked down on and, in some cases, actively discriminated against.”⁹⁷

The original *Recovery-oriented Methadone Maintenance (ROMM)* monograph⁹⁸ and subsequent papers co-sponsored by DBHIDS are unequivocal on this point: ROMM is NOT an effort to:

- 1) Raise the motivational bar of admission to MMT.
- 2) Limit methadone dosages or the duration of MMT.
- 3) Define methadone cessation as a criterion for recovery status.
- 4) Pressure MMT patients to end medication maintenance.
- 5) Deny or discourage MMT patients access to other treatment modalities or harm reduction information or services.
- 6) Mandate counseling or peer support services for stabilized patients who do not need or desire such services.
- 7) Extrude patients who do not adopt the goal of recovery without medication support.
- 8) Deny stabilized patients access to interim or office-based treatment.
- 9) Impose remission/recovery criteria on MMT patients different than the remission/recovery criteria applied to all persons with substance use disorders.⁹⁹

To defend the role methadone can play in recovery initiation and maintenance does not mean that MMT is an adequate recovery support system as currently designed. ROMM, as an aspirational vision for MMT in Philadelphia, calls for such changes as:

- increased representation of current/former MMT patients/families at all levels of decision-making within the treatment system,
- assertive approaches to outreach and early intervention,
- accelerated access to services,
- personally optimum dose stabilization,

⁹⁶ AIVL. (2012). ‘New recovery’, harm reduction & drug use policy statement. Australian Injecting & Illicit Drug Users League. Retrieved May 8, 2013 from

<http://aivl.org.au/database/sites/default/files/New%20Recovery.%20Harm%20Reduction%20%26%20Drug%20Use%20-%20AIVL%20Policy%20Position%20Paper.pdf>; McGrail, S. (2012). Opinion: The “new recovery” movement—A warning. Retrieved May 7, 2013 from

http://www.nuaa.org.au/index.php?option=com_content&view=article&id=1020:the-qnew-recoveryq-movement-a-warning&catid=41:users-news-issue-no-69-winter-2012&Itemid=92

⁹⁷ McGrail, S. (2012). Opinion: The “new recovery” movement—A warning. Retrieved May 7, 2013 from

http://www.nuaa.org.au/index.php?option=com_content&view=article&id=1020:the-qnew-recoveryq-movement-a-warning&catid=41:users-news-issue-no-69-winter-2012&Itemid=92

⁹⁸ White, W., & Torres, L. (2010a). *Recovery-oriented methadone maintenance*. Chicago, IL: Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Mental Retardation Services and Northeast Addiction Technology Transfer Center. White, W., & Torres, L. (2010b). Recovery-oriented methadone maintenance (Executive Summary). *Counselor*, 11(6), 44-53.

⁹⁹ White, W. (2012b). Recovery orientation in methadone maintenance: A definitional statement. Posted at www.williamwhitepapers.com

- the use of global, strengths-based assessment protocols,
- phased transition from professionally directed treatment plans to patient-directed recovery plans,
- focused retention strategies,
- a partnership/consultant versus expert relational model,
- development of strong recovery cultures¹⁰⁰ within MMT settings,
- recovery-focused patient/family education,
- an expanded menu of professional and peer recovery support services,
- tri-directional integration of primary health care, mental health care, and addiction treatment,
- assertive linkage to community-based recovery support resources,
- enhanced supports for any patient choosing to taper,
- post-treatment Recovery Check-ups that include stage-appropriate recovery education and when needed, early re-intervention,
- opportunities for recovery advocacy/support and community service, and
- professional and public education about the potential role of medication in recovery initiation and recovery maintenance.¹⁰¹

Critical to this understanding of the role medications such as methadone and buprenorphine can play in recovery initiation and maintenance is the distinction between a *drug* and a *medication*. Robert DuPont, MD, and Mark Gold, MD, two long-tenured and leading addiction treatment experts, offer several useful distinctions between psychoactive medications that are used to support health and recovery and psychoactive substances, including medicines, that are used as “drugs.”

The motivation to use medications is to prevent and treat illness; the motivation to use drugs is brain reward (euphoria). The pattern of using medication is marked by dosages, dosing schedules, and methods of administration that produce steady blood levels of the medication; the pattern of using drugs is marked by dosages and methods of administration (e.g., injection, smoking) that create spikes and troughs in blood levels and an associated escalation in the dosage and frequency of administration. Control and monitoring of medication is maintained via open, honest communication with physicians and family members; drug use is characterized by self-monitoring, a progressive loss of control over drug intake, and secrecy and dishonesty related to the presence or patterns of use. The net effect of medication use is a progressive improvement in quality of life; the net effect of drug use is a progressive deterioration in quality of life. Medication is taken within the laws established to govern its manufacture, sale, possession, and use; drug use (other than alcohol use for adults) often involves breeches of law. To these distinctions might be added that taking medication is often nested within other health-promoting and recovery-enhancing behaviors; drug use is often

¹⁰⁰ By “strong recovery cultures” we mean visible and diverse recovery role models; language, literature, symbols, art, film and music that promote recovery; close connections with indigenous communities of recovery, and norms within the milieu that inhibit the presentation of “street rituals.”

¹⁰¹ White, W. (2012b). Recovery orientation in methadone maintenance: A definitional statement. Posted at www.williamwhitepapers.com

*nested within other self-destructive and socially harmful behaviors. Medication use is also nested within a pro-recovery social network; drug use is often nested within a drug-saturated social network.*¹⁰²

Lessons from AATR and HR Integration Experiments

Here are eight critical lessons we have learned from AATR and HR integration efforts within the city of Philadelphia.

AATR and HR integration is not easy. In this stigma-laden arena, efforts to integrate AATR and HR inevitably unfold amidst periodic challenges to each and to integration experiments from the wider political and cultural environment. AATR is under increased scrutiny and criticism¹⁰³ and HR faces limited funding, continued areas of complete funding restriction (e.g., ban on federal funds for NSEPs), arbitrary regulations (e.g., efforts to impose limitations on the duration of MMT), discriminatory exclusions (e.g., denial of MMT patients access to residential services), and professional and social criticism. Both AATR and HR programs face stigma-laden neighborhood resistance to siting of new programs and relocation of existing programs. And within the field itself, AATR and HR integration efforts—even the establishment of mutual respect—often requires transcendence of long-standing differences in program philosophies, competition for scarce resources, and competition for leadership within the AOD problems arena. Key areas of integration of AATR and HR principles and practices are possible, but the process requires vision, commitment, mutual support, and patience—not unlike the recovery process itself.

AATR and HR integration is difficult even under the best of circumstances. For example, there is an inherent tension in supporting an individual's self-reported goal of long-term abstinence with the need to provide harm reduction information to address the likelihood of some future episodes of AOD use.¹⁰⁴ Can we, for example, provide support for recovery initiation and maintenance at the same time we provide information on safe injection procedures? That is the dilemma of the caregiver, whether working from an HR or recovery orientation, when working with individuals vacillating between the cultural worlds of addiction and recovery. Within what may be a prolonged course of AOD use and AOD problems, motivation to use, reduce use, or cease use each ebbs and flows, with ambivalence being perhaps the one constant. Great harm can come to self and others during those periods of high use and low motivation for change. HR services provide a means, a safety net, for reducing harm to self or others pending more substantive decisions regarding drug use.

Both AATR and HR as models of intervention must be publicly and professionally defended through the integration process. Integration efforts must promote the cultural legitimacy, clinical effectiveness, and cost-effectiveness of both AATR and HR and the value of integrating AATR and HR principles and practices. We have found it helpful in

¹⁰² White, W. L. (2011a). *Narcotics Anonymous and the pharmacotherapeutic treatment of opioid addiction*. Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Intellectual disability Services. P. 35-36

¹⁰³ Fletcher, A. M. (2013). *Inside rehab*. New York: Viking.

¹⁰⁴ Koutroulis, G. (2000). "That original tension": Negotiating abstinence in clinicians' accounts of harm reduction in nonresidential treatment of heroin withdrawal. *Journal of Substance Abuse Treatment*, 19, 89-98. doi:10.1016/S0740-5472(99)00087-2

Philadelphia to shift from thinking of this as a major obstacle to thinking of this as a major opportunity for professional and public engagement and education.

Leadership and strategy at multiple levels are essential. For AATR and HR to begin moving from open conflict to peaceful coexistence to collaboration in Philadelphia required political and professional leadership affirming the legitimacy and complementarity of these approaches. Of particular importance was more open support for HR services as a valued component of the behavioral health systems transformation effort. What must be modeled by policy leaders to set the tone for all integration efforts is the theme of collaboration without co-optation or colonization. Also of import are leaders respected by both AATR and HR camps who can serve as hosts, negotiators, and peacemakers. The strategy of integration involved expanding structures of contact (e.g., meetings and forums) that increased relationship building and communication between diverse system constituents and professional and institutional incentives for collaboration and integrated approaches.

Ideas Matter. Both AATR and HR rest on a set of propositions whose validity and universality have been bitterly argued for decades. Some of these propositions reflect value statements while others represent allegations of fact that can be clinically and scientifically tested. Extremists within both sides of the AATR and HR debates are so ideologically committed to their positions (as tenets of faith) that little dialogue is possible; however, the mass of people working in AATR and HR can be engaged in a process of self-examination of these core ideas and through such a process, find areas of common ground. The key is to create a milieu in which debate can move to discussion and where discussion of differences can move to sharing concerns and new possibilities. The ideas outlined in the previous section illustrate some of the bridging ideas that have emerged from this collaborative process in Philadelphia.

Science helps, but stories and direct experience are essential. Injecting the findings of scientific studies related to AATR and HR assumptions and outcomes created windows of openness for self-examination but rarely led to radical shifts in thinking or commitments to AATR and HR integration. What did matter were the following. First, directly experiencing AATR or HR service processes through program visits, staff exchanges, or internships softened previously polarized positions on these services. Second, encounters (hearing the stories of individuals) whose lives had been profoundly helped by AATR and/or HR services offered living proof of the values of these services. That AATR and HR programs exist in silos, physically and culturally isolated from one another, prevents such exchanges unless there is a framework (e.g., the systems transformation planning process) for them to occur. Third, DBHIDS data that programs that had historically had a difficult time retaining individuals who were homeless were effectively engaging, treating and moving these individuals into supportive housing via integrated AATR/HR initiatives changed the attitudes of many of the people who initially resisted such integration.

Relationships matter. The cross-fertilization of AATR and HR principles and practices is not possible without enhancing relationships across the AATR and HR barrier. Both AATR and HR have existed as closed systems—in part because of the culture stigma each faced. For collaboration and cross-fertilization to occur, these systems must be opened via increased boundary transactions—the movement of people, ideas, and materials from one system to the other system. It was our experience that, by

involving people from AATR and HR in system transformation and related planning processes, more respectful and personal relationships were formed between AATR and HR advocates. These relationships were in turn critical to opening both systems up to nuances of change that would not have been otherwise possible.

Money and public/professional recognition matter. The acrimonious debates that had long flourished between HR and AATR advocates involved a competition of ideas, but they also involved a competition for funding and for public/professional recognition. At a national level, extreme shifts toward or away from AATR or HR could reallocate billions of dollars of funding and profoundly influence the fates of community economies, individual organizations, and professional careers. Recognizing this, efforts were made within the transformation process to assuage fears about loss of funding and to bring additional resources into the system that benefited both HR and AATR organizations. Efforts were similarly made to involve and recognize both HR and AATR representatives at key events (e.g., the Mayor’s Annual Making a Difference Dinner Awards).

HR and AATR collaborations can be a win/win process. In our review of the scientific literature and our experience of the past decade, we believe there are a number of things that AATR organizations can learn from HR organizations that could enhance AATR effectiveness. The first of these lessons is how to identify and engage those individuals and families with greatest problem severity/complexity and lowest recovery capital who do not currently seek addiction treatment and who are continuing to use drugs in a manner posing risk to themselves and others.¹⁰⁵

AATR programs have not historically focused on how to support incremental change in active users, including how to reduce harm to and by those who are at present unwilling or unable to achieve abstinence. HR programs have refined a number of “low threshold,” strengths-based approaches to service engagement that are worthy of emulation.¹⁰⁶ New AATR service models could similarly be developed by shifting from an exclusively “abstinence only” stance to an “abstinence eventually” stance, with service gradations supporting transitions across multiple stages of change.¹⁰⁷ Of particular importance could be integrating what HR programs have learned about the roles access to stable housing, primary health care, mental health care, and social support can play as precursors to subsequent changes in AOD use.¹⁰⁸ HR programs have also included the voices of active drug users in service design feedback in ways never attempted by AATR organizations.¹⁰⁹ Further, discussions of expanding the goal of addiction treatment to include reducing long-term harm to person, family, and community even for those who choose to continue drug use¹¹⁰ could extend the AATR’s traditionally narrow focus on

¹⁰⁵ Marlatt, G. A., Blume, A. W., & Parks, G. A. (2001). Integrating harm reduction therapy and traditional substance abuse treatment. *Journal of Psychoactive Drugs*, 33(1), 13-21. doi:10.1080/02791072.2001.10400463

¹⁰⁶ McQuie, H. (2010). Integrating the spectrum of harm reduction and recovery. Retrieved March 8, 2013 from www.recoverytoday.net/articles/226-harm-reduction-spectrum

¹⁰⁷ Kellogg, S. H. (2003). On “gradualism” and the building of the harm reduction—abstinence continuum. *Journal of Substance Abuse Treatment*, 25, 241-247. doi:10.1016/S0740-5472(03)00068-0

¹⁰⁸ McQuie, H. (2010). Integrating the spectrum of harm reduction and recovery. Retrieved March 8, 2013 from www.recoverytoday.net/articles/226-harm-reduction-spectrum

¹⁰⁹ Crofts, N., & Kerkt, D. (1995). A history of peer-based drug-user groups in Australia. *Journal of Drug Issues*, 25, 599-616. Marlatt, G. A. (1996). Harm reduction: Come as you are. *Addictive Behaviors*, 21(6), 779-788. doi:10.1016/0306-4603(96)00042-1; Marlatt, G. A., Blume, A. W., & Parks, G. A. (2001). Integrating harm reduction therapy and traditional substance abuse treatment. *Journal of Psychoactive Drugs*, 33(1), 13-21. doi:10.1080/02791072.2001.10400463

¹¹⁰ Marlatt, G. A., Blume, A. W., & Parks, G. A. (2001). Integrating harm reduction therapy and traditional substance abuse treatment. *Journal of Psychoactive Drugs*, 33(1), 13-21. doi:10.1080/02791072.2001.10400463

drug use to address multiple high-risk behaviors.¹¹¹ There is much AATR organizations could learn from HR organizations' philosophy of personal choice as a service value¹¹²—something that has only recently been considered as an AATR principle.¹¹³

There are similarly many things HR organizations can learn from AATR organizations, including the recognition of how choice can be neurologically compromised in the most severe and chronic patterns of addiction, the potential for transformative (sudden, unplanned, positive, permanent) rather than incremental change, and methods for biopsychosocial restabilization after substance use disorder recurrence. AATR organizations could also assist HR organizations in knowledge of indigenous recovery support resources, assertive linkage, and person-group matching procedures to mutual aid groups and other recovery support institutions. Also of potential import would be a greater appreciation of the potential for and processes of recovery as an HR outcome.

HR and AATR are not either/or options. HR services are sometimes castigated for postponing help-seeking and prolonging addiction careers via their perceived “enabling” and thus encouraging drug use and preventing entry into AATR, but such suppositions have not been supported by our experience in Philadelphia or the scientific research. (Also, studies of needle and syringe exchange programs document their capacity to reduce risks at personal and community levels without increasing initiation of drug injecting, increasing the frequency of injecting, or prolonging drug injecting careers.)¹¹⁴ In Philadelphia, most people engaged through HR services (via assertive outreach, Housing First programs, MMT and NSP) have had past exposure to AATR—often multiple episodes of such involvement over a period of years—or have rejected AATR service and support options. Some studies have shown that providing housing without sobriety as a condition does not increase alcohol and drug use when compared to control groups where such a condition is imposed, and they also show that stable housing can serve as a platform for recovery initiation.¹¹⁵ There are many people in recovery within the City of Philadelphia who entered recovery through HR portals.

Alcohol and drug dependence takes an inordinate toll in terms of personal morbidity and mortality. Keeping drug dependent individuals alive and preventing or reducing the burden of damage to self and others during periods of active drug use is an important goal even in the presence of other longer term goals (e.g., sustained recovery from a substance use disorder).¹¹⁶ As one HR/AATR integration advocate bluntly explained to the authors, “Dead people don’t recover.”

Drug users may be viewed as “incompetent and pathological” and thus only “objects of intervention” or as “allies and participants in their own individual and

¹¹¹ Marlatt, G. A. (1996). Harm reduction: Come as you are. *Addictive Behaviors*, 21(6), 779-788. doi:10.1016/0306-4603(96)00042-1

¹¹² Lenton, S., & Single, E. (1998). The definition of harm reduction. *Drug & Alcohol Review*, 17, 213-220. doi:10.1080/09595239800187011; Denning, P. (2001). Strategies for implementation of harm reduction in treatment settings. *Journal of Psychoactive Drugs*, 33(1), 23-26. doi:10.1080/02791072.2001.10400464

¹¹³ White, W. (2008). Toward a philosophy of choice: A new era of addiction treatment. *Counselor*, 9(1), 38-43.

¹¹⁴ Wodak, A., & McLeod, L. (2008). The role of harm reduction in controlling HIV among injecting drug users. *Aids*, 22(suppl 2), S81-S92. doi:10.1097/01.aids.0000327439.20914.33

¹¹⁵ Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health*, 94(4), 651-656.

¹¹⁶ Harm Reduction International. (2013). What is harm reduction? Retrieved March 16, 2013 from <http://www.ihra.net/what-is-harm-reduction>; Wodak, A. (1994). Olympian ideas or pragmatism. *Addiction*, 89, 803-814. doi:10.1111/j.1360-0443.1994.tb00975.x

collective health.”¹¹⁷ Active drug users, even in a state of drug dependence, can alter patterns of use to reduce risks (e.g., HBV, HCV, HIV infection; death from overdose) related to use.¹¹⁸ People who are cycling in and out of recovery face special risks and are in need of elevated supports.¹¹⁹ Addiction treatment can be coerced by all manner of external pressure but recovery cannot; recovery can only flow from personal choice.¹²⁰

Recovery initiation is as much about the experience of hope as it is about the accumulation of pain. HR programs have been viewed as antithetical to recovery in part from the perception that they prolong addiction careers by preventing or delaying the experience of “hitting bottom”—an experience viewed by many AATR advocates as a critical catalyst of recovery initiation. But HR programs may provide a different form of catalyst via increases in self-efficacy and recovery capital.

*We reject the notion that people have to “hit bottom” to move from addiction to recovery. Such bottoms are as likely to result in prolonged disability or death as positive transformation. Our position is that hope and growing aspirations for a better life can be a catalyst to recovery as much as a desire to escape addiction-related pain. Our intent is to affirm the recovery option in every encounter with individuals and families experiencing AOD problems and to provide the support that makes this movement toward health possible—either as a sudden dramatic leap or a process involving incremental steps over time. This welcoming doorway of hope must always be open.*¹²¹

Working to prevent immediate harm does not preclude those working in NSPs and other HR programs from also serving as recovery carriers via the transmission of hope for long-term recovery.

AATR and HR are the products of heterogeneous social movements made up of constituency groups with widely varying philosophies and service practices, all of whom cannot be expected to approve of or participate in processes of collaboration. Each movement has a radical wing that views any form of AATR and HR collaboration as ideologically unacceptable. That said, the mainstream of each movement seems to be moving from viewing AATR and HR as binary choices to viewing AATR and HR as complementary. In this emerging view, AATR and HR exist on a continuum of choices available to people who use drugs or wish to cease such use. Anyone presently proposing blending of AATR and HR philosophies and practices can expect criticism from the radical wings of both movements even as the trend toward hybrid models of AATR and HR leave these radical wings increasingly isolated.

HR and AATR integration must be bi-directional. Integration is not one side winning the ideological or service design battle but both sides developing mutual respect

¹¹⁷ Friedman, S. R., de Jong, W., Rossi, D., Touze, G., Rockwell, R., Des Jarlais, D. C., & Elovich, R. (2007). Harm reduction theory: Users culture, micor-social indigenous harm reduction, and the self-organization and outside-organizing of users’ groups. *International Journal of Drug Policy*, 18(2), 107-117. doi:10.1016/j.drugpo.2006.11.006

¹¹⁸ Friedman, S. R., de Jong, W., Rossi, D., Touze, G., Rockwell, R., Des Jarlais, D. C., & Elovich, R. (2007). Harm reduction theory: Users culture, micor-social indigenous harm reduction, and the self-organization and outside-organizing of users’ groups. *International Journal of Drug Policy*, 18(2), 107-117. doi:10.1016/j.drugpo.2006.11.006

¹¹⁹ Wisely, C. (2013). The logic of recovery and injection drug use. *Journal of Substance Use*, 18, 56-64. doi: 10.3109/14659891.2013.761024.

¹²⁰ Wisely, C. (2013). The logic of recovery and injection drug use. *Journal of Substance Use*, 18, 56-64. doi: 10.3109/14659891.2013.761024.

¹²¹ Personal Communication, Dr. Arthur Evans, Jr. March 20, 2013

and a commitment to explore common ground and the potential for new approaches to protecting and promoting the health and safety of individuals, families, and communities not historically included within either perspective.

Conclusion

Harm reduction and abstinence approaches for the management and resolution of AOD problems have often been presented as binary choices within what have often been vitriolic debates within the AOD problems arena. At a policy level, there has similarly been a tendency for governments to focus on one or the other of these strategies while marginalizing the alternative. What we have attempted to explore in this article is how such approaches might be more effectively integrated to achieve greater balance at both social policy and service practice levels.

Spurred on by a philosophy that holds long-term recovery as the ultimate goal for all individuals with AOD problems, considerable efforts have been exerted by the City of Philadelphia to achieve integration of AATR and HR approaches. However, many questions remain about the desirability, mechanics, and outcomes of such integration. What is clear is that the chasm between HR and AATR principles and practices is being bridged with hybrid approaches that integrate public health and clinical perspectives. Such integration may well constitute the future for the management of the most severe, complex, and chronic AOD problems.

Public health and medical models of intervention into AOD problems can each result in a depersonalization of the very people they are intended to serve.¹²² Resilience and recovery perspectives may offer a way to humanize both approaches while retaining their most valuable elements. Hybrid models that blend elements of HR and AATR may be particularly well-suited for individuals and families who have been difficult to reach, engage, treat, and reintegrate into mainstream community life through traditional service programs.

There is a question we continue to confront locally, nationally, and internationally. That question is whether existing social institutions competing for cultural and financial ownership of AOD problems can transcend their ideological divisions to forge new collaborative, integrated models of intervention that address the whole spectrum of AOD problems. The fate of these institutions and the health of nations may well rest on the outcome of this question.

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About the Authors: Arthur. C. Evans, Jr., PhD, (Arthur.C.Evans@phila.gov) is Commissioner of the Philadelphia Department of Behavioral Health and Intellectual disAbilities Services (DBHIDS). William White (bwhite@chestnut.org) is Emeritus

¹²² Miller, P. G. (2001). A critical review of the harm minimization ideology in Australia. *Critical Public Health*, 11(2), 167-178. doi:10.1080/09581590110039865

Senior Research Consultant at Chestnut Health Systems and a consultant to DBHIDS.
Roland Lamb (Roland.Lamb@phila.gov) is Director of the Office of Addiction Services,
DBHDIDS.