

Come As You Are: Harm Reduction Drop-In Groups for Multi-Diagnosed Drug Users

Jeannie Little, LCSW
Kimya Hodari, MA
Jamie Lavender, MA
Anna Berg, MSW

ABSTRACT. Harm reduction is a radical new paradigm in substance abuse treatment. It is most noted for its public health interventions, such as syringe exchange, with active drug users in order to reduce the harms associated with alcohol and other drug use. Harm reduction therapy is the treatment approach of the harm reduction movement. Harm reduction therapy, and harm reduction therapy groups, particularly the drop-in groups discussed in this paper, extend a low-threshold welcome to people with unresolved substance abuse problems. Harm reduction groups have been found by the authors of this paper to be an excellent way to engage dually diagnosed individuals in an ongoing treatment process. Members are encouraged to focus on the issues of greatest concern to them, which makes this a truly integrated treatment.

KEYWORDS. Harm reduction therapy, dual diagnosis, substance abuse groups, stages of change, motivational interviewing, drop-in groups

Jeannie Little, LCSW, is Executive Director of the Harm Reduction Therapy Center (HRTC).

Kimya Hodari, MA, is Program Director of the HRTC.

Jamie Lavender, MA, and Anna Berg, MSW, are therapists in the HRTC's community programs.

Address correspondence to: Jeannie Little, HRTC, 423 Gough St., San Francisco, CA, 94102 (E-mail: jeanglitttle@gmail.com).

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INTRODUCTION

The founding principle of harm reduction, a radical new paradigm in the treatment of alcohol and other drug problems, is to begin where the client is. Harm reduction groups, grounded in harm reduction principles and techniques, extend a low-threshold welcome to people with unresolved substance abuse problems. Thus the oft-used expression “Come as you are” (Kurt Cobain, on the Nirvana album *Nevermind*, 1991) and the less common but nonetheless accurate expression in all of the groups illustrated in this and its companion paper, “Stay as long as you need.”

The intent of this article is to introduce drug treatment and mental health providers who work in settings with multidiagnosed or chaotic drug users to a model of group treatment that the authors have found to be highly successful at engaging such drug users in stable, ongoing treatment. The authors share their story of four groups, all drop-in groups for multidiagnosed, low-income, often homeless drug users. Several vignettes appear in the article. The identities and characteristics of the group members have been changed so that, among the hundreds of members of the four groups described, they are unrecognizable.

The model was developed in 1994 by the first author and subsequently successfully implemented by the other authors. The authors all work in community settings that serve people who are poor, often homeless, infected with HIV or hepatitis C, and often involved in the jail, prison, or child protective service systems. Services at these agencies include primary (HIV) medical care; individual therapy; drop-in counseling, also known as “sidewalk therapy” because it can occur indoors or outdoors on the street (Rogers & Ruefli, 2004) or during office visits by appointment; daily groups; psychiatric care; and addiction medicine. Low-threshold enough to welcome the most disorganized of drug users, flexible enough to promote high rates of retention, and sophisticated enough to facilitate change in addictive behavior, harm reduction groups are, in the experience of the authors, a very reliable way to engage complex dually diagnosed individuals in a successful ongoing treatment relationship.

Harm Reduction

Harm reduction provides a new framework for understanding substance use and abuse. Rather than based in the disease model of addiction and recovery, with its assumption of a chronic, progressive, incurable disease only

treatable by lifelong abstinence from psychoactive substances, harm reduction supports the idea that drug use occurs on a continuum from benign to chaotic. Some drug use is harmful, most is not. Whereas most substance use does not qualify as abuse or dependence (Substance Abuse and Mental Health Services Administration (SAMHSA), 2006), harm reductionists identify harms that occur to people who are not addicted, notably drinking and driving and college drinking episodes that lead to alcohol poisoning or death.

Harm reduction asserts that abstinence is not essential to reduce harm. Its interventions aim to reduce drug-related harm to individuals, their families, and their communities without necessarily reducing the consumption of drugs and alcohol. It is the damage done by drug and alcohol use, not necessarily the drug use itself, that is the focus of attention.

Originating in Europe in the early 1980s, harm reduction began as a drug user-driven public health movement to stop the spread HIV and hepatitis among intravenous drug users. It moved to the United States with the dissemination of bleach kits for cleaning dirty needles and then with the first legal needle exchange in 1988, although underground needle exchanges existed prior to that time. Springer (1991) published the first article describing harm reduction counseling for HIV prevention. Marlatt (1998), also in Europe to observe drug treatment strategies, began applying his prodigious research skills and resources to the study of a variety of harm reduction interventions resulting in the first published text on harm reduction. Marlatt's (1996) characterization of harm reduction is that it is "compassionate pragmatism." (p. 779) In other words, we have to accept that people are going to abuse alcohol and other drugs and help them to do so more safely if they are not going to abstain. Much of Marlatt's research on relapse prevention (e.g., 1986), as well as that of the Sobells and others on controlled drinking (Saladin & Santa Ana, 2004) prior to the 1990s was harm reduction oriented, although that term had not yet come into use. Their work was (and is) based on behavioral rather than disease-model conceptions of addiction. Harm reduction is practiced in three arenas in the United States today.

- *Public health:* Syringe exchange programs remain the most recognizable public health intervention. They are joined by other programs designed to save the lives of drug users such as overdose prevention, condom distribution, distribution of safer crack smoking apparatus, as well as efforts to provide comprehensive health care to active drug users.

- *Advocacy*: The United States practices prohibition in its drug policy and applies law enforcement measures in its efforts to control drug use. Harm reduction advocates, most notably the Drug Policy Alliance, are working to end the failed War on Drugs with its demonization of drugs and pointless incarceration of drug “offenders.”
- *Treatment*: Harm reduction therapy (HRT) is the treatment model that incorporates the public health principles of harm reduction with cognitive behavioral interventions for substance abuse and general psychodynamic treatment principles.

Harm Reduction Therapy

HRT (Denning, 2000; Denning, Little, & Glickman, 2004; Tatarsky, 1998, 2002), or harm reduction counseling (Springer, 1991), was developed by these authors in the 1990s especially for active drug users who are either ambivalent about or resistant to giving up or changing their drug use, with a special emphasis on treating dual diagnosis. While not yet researched in its own right, HRT incorporates many evidence-based treatments, most notably motivational interviewing (Miller & Rollnick, 2003). There are many cognitive-behavioral theories and treatments for addiction, some of which are abstinence-oriented, others of which are not. Rotgers, Morgenstern, and Walters (2003) and Miller and Carroll (2006) provide helpful reviews of various models of evidence-based substance abuse treatment. To the extent that any substance abuse treatment does not hold abstinence to be either the condition or goal of treatment, it is considered to belong under the harm reduction umbrella.

The goal of HRT is to assist drug users to do less harm to themselves and others. It is a radically client-centered model that does not prescribe or advocate any particular outcome. It is only interested in helping users to make informed choices about their future use of drugs or other behaviors. Although abstinence is not the goal of harm reduction treatment, it *is* one of the many harm-reducing goals chosen by clients. HRT is a model that promotes gradual change in drug use, change that is realistic and sustainable. It is also a model that allows for other priorities to coexist with, or even to preempt, drug problems as the focus of attention. Each client is encouraged to establish his or her own “hierarchy of needs” at the beginning of treatment and to continue to reassess his or her needs and desires (Denning, 2000; Denning et al., 2004).

HRT integrates accurate information about alcohol and other drugs, cognitive interventions to facilitate change in addictive behavior, and

biological interventions specific to substance dependence (e.g., methadone or buprenorphine) and coexisting mental and emotional disorders (e.g., antidepressants, anxiolytics, or antipsychotics), all within a framework of a long-term psychodynamic treatment relationship. The following evidence-based principles support and inform all HRT:

Not All Drug Use is Abuse

Most people in the United States use some type of drug, and most do not have problems (SAMHSA, 2006). Drug *problems*, however, develop out of a complex interaction between the drug, the person using, and the environmental context within which that use happens, as explained in an evidence-based biopsychosocial model called “drug, set, setting” (Zinberg, 1984).

People Use Drugs for Reasons

Dual diagnosis is the rule, not the exception. More than 50% of people with mental illness will abuse drugs at some point (Drake, Essock, Shaner, 2003; Peele & Brodsky, 1991). The numbers are astounding for people with histories of trauma (see, for example, Center for Substance Abuse Treatment [CSAT]’s TIP on Substance Abuse Treatment for Persons with Child abuse and Neglect Issues, 2000). In his large body of work, Khantzian (1985, 2002) and Khantzian, Halliday, and McAuliffe (1990) propose a “self-medication hypothesis,” which says that drug users suffer from several deficits—difficulty with self-esteem, relationships, and affect regulation—and drugs ameliorate the impact of these deficits.

Incremental Change is Normal

The stage model of change (Prochaska & DiClemente, 1992) explains the process that we go through to make change in addictive behavior and asserts that change is *most* effective if we work through the stages one at a time, thoroughly, in order, and preferably with support.

Client-Authored Motivation is the Most Effective Change Agent. The Therapist Works as a Facilitator, Not a Director of Treatment

Self-Determination Theory (Ryan & Deci, 2000) informs us that client-driven, not externally driven, goals are most highly correlated with intrinsic motivation and therefore with successful behavior change. Motivational interviewing (Miller & Rollnick, 2003), with its primary focus on working

with ambivalence about and resistance to change, makes it the evidence-based cognitive counseling model of choice for harm reduction therapists.

Outcomes are as Varied as the People Seeking Change; This is Not Only Real, it is Desirable

At any point in time, most people in the United States with drug problems are not abstinent (SAMHSA, 2006). To date, treatment has abysmal abstinence outcomes, but much better harm reduction outcomes (i.e., Services Research Outcome Study (SROS), 1998). Controlled drinking, which predates harm reduction but falls squarely under its umbrella, is a common and legitimate outcome of problem drinking (Rotgers & Ruefli, 2004; Saladin & Santa Ana, 2004) Finally, abstinence *is* one of many harm reduction goals: It just isn't the only one (Rotgers, Little, & Denning, 2005)

HARM REDUCTION GROUPS: COME AS YOU ARE

Groups that welcome all drug users regardless of the status of their use and that highlight the differences between members are most therapeutic for individuals with dual disorders (Little, 2002). With the full range of drug-using behavior and motivation to change represented in a group, each member can better clarify his or her own relationship with drugs. Rather than protect members from others who use drugs, harm reduction groups, by exposing members to different points on the continuum of drug use and change, get closer to each member's ambivalence about, and desire to use, drugs. In this way, the group can work with each person's impulses and conflicts. Harm reduction argues that uniqueness and diversity, not identification, are the therapeutic factors in this group treatment.

Groups for Substance Abuse: Abstinence-Oriented

Groups dominate treatment for substance abuse in the United States. Alcoholics Anonymous (AA) and its 12 steps form the basis of 93% of programs in the United States (Peele & Brodsky, 1991). Unfortunately, these groups and programs have had limited capacity to treat people with mental illness, as well as a limited tolerance for people who are actively using drugs, whether they have yet to stop or they have relapsed. Although the message in 12-step groups is "welcome" and although it is not necessary to be "clean and sober" to attend, the message that "the only requirement for membership in AA is a desire to stop drinking" excludes everyone who

does not have a desire to stop drinking (or using), which, in the experience of the authors, describes the vast majority of drug users that we treat. With the exception of detoxification programs, treatment programs do not admit people who are actively using and usually discharge them for relapsing during program. Thankfully, this is changing and providers are becoming more comfortable with retaining “relapsers” in treatment. The focus on abstinence as the goal of treatment or 12-step participation, however, creates homogeneity in the most important domain, that of the person’s relationship with alcohol and other drugs. In other words, in asserting a commitment to abstinence, the complexity of each user’s ambivalence about drugs and motivations to continue to use can get lost in the emphasis on and language of “recovery.”

Groups for Substance Abuse: Not Abstinence-Oriented

There have been exceptions to the abstinence-only focus in group. Khantzian et al. (1990) wrote about modified dynamic group therapy for cocaine abusers in which they assert that dynamic therapy can and should start on the first day of abstinence. People who relapse in this group model are kept in the group, and the relapse and other members’ feelings about it are explored. For years Vannicelli (1997) has run groups based on the belief that “problem drinkers” can learn to moderate their use of alcohol. The self-help program Moderation Management is a research-based program (Rotgers, Kern, & Hoetzel, 2002) that helps people moderate their alcohol use.

Motivational interviewing has been adapted for group treatment by some practitioners. Foote and colleagues (1999) applied the general principles of motivational interviewing and the FRAMES (feedback, responsibility, advice, menu of options, empathy, and self-efficacy) model to create an “autonomy-supportive” (p. 185) environment for a manualized four-session group treatment called group motivational interviewing (GMI). Velasquez, Stephens, and Ingersoll (2006) likewise explicate the application of motivational interviewing in groups. Both sets of authors describe very sensitively the general practice of motivational interviewing in groups and the specific interventions used to facilitate change in addictive behavior. These groups use as a reference point “stopping,” “quitting,” and “recovery.”

The major difference between harm reduction groups and the motivational interviewing groups is that harm reduction groups have no reference point vis-à-vis abstinence, nor do they specifically advocate or train members to practice moderation. Problems are identified by each member (this

is also true of Foote et al.'s [1997] model) and change, *if any*, is suggested by each member, not by the leader. The contribution of this article to the field of substance abuse groups is to provide a comprehensive overview of the application of harm reduction principles and HRT techniques to drop-in groups, which are designed to attract the most chaotic of drug users.

**THE SOBRIETY SUPPORT GROUP: ESTABLISHING A
HARM REDUCTION GROUP CULTURE IN THE FIRST
HARM REDUCTION GROUP (JEANNIE LITTLE)**

“Welcome” is the word that greets everyone who comes to the Sobriety Support Group. This drop-in group, the first harm reduction treatment group in the United States, began in 1994 at the Department of Veteran’s Affairs (VA)’s Comprehensive Homeless Center in San Francisco, a drop-in center that provides social work and medical services to chronically homeless multidisabled veterans. The group was created for dually diagnosed high users of inpatient services whose follow-up in outpatient care was poor or was forbidden because of their complex diagnostic profile or their frequent return to active drug use. It meets Monday, Wednesday, and Friday for an hour in the morning and is joined on the other 2 days of the work week by other groups run by medical staff and nutritionists.

The first goal of the Sobriety Support Group, so-named to identify it as a group that would address drug and alcohol issues (before the author had heard of harm reduction), is to welcome dually diagnosed drinkers and drug users into a bona fide treatment relationship in which they can freely examine their relationship with drugs and begin a process of gradual amelioration of drug-related problems, psychiatric symptoms, and social problems. True to the principles of harm reduction, the group has no conditions for membership—not a minute “clean and sober,” nor a *desire* to be.

The first harm reduction culture-building moment occurred in the second group session. A homeless man, heroin and alcohol dependent with paranoid schizophrenia, was persuaded by his social worker to attend the group. His daily ritual was to come into our center, park his shopping cart, and sleep until we closed. He left his cart in his social worker’s office, came into the group, sat in our circle, and promptly fell asleep with his head hanging at an awkward angle. The other seven group members looked at me expectantly. Some had been in treatment programs where it was prohibited to sleep in group. What was I to do? I focused on his immediate need—to

sleep. If he continued to sleep in this posture, he was going to wake up with a terrible crick in his neck. I stood up, gathered up several jackets, rolled them into a pillow, placed them under his head, then sat back down. The group looked at me incredulously. But since that moment, a caring and gentle culture has prevailed, and many group members have expressed the feeling, “There but for the grace of God go I.” Our culture of respect, unquestioning acceptance, and care was thus started with a bang—or a pillow—and truly embodies the welcome to “come as you are.”

A second key harm reduction group norm established by the Sobriety Support Group is its strong adherence to a drop-in format. Dually diagnosed clients are renowned for not keeping appointments, as are active drug users, particularly those who are also homeless. Moreover, many members of this population cannot sit through an hour, or cannot stay in the room when effect-laden material is discussed. To accommodate these realities people are welcome whenever they come, and they are free to go in and out of the room at any time during the group. Each person is assumed by the group to know what he or she needs. By not demanding abstinence, regular attendance, or that anyone sit through an entire session, the therapist relinquishes control over how each member handles his or her treatment and puts responsibility for developing tolerance for the group in the hands of the client. This flexibility has been remarked upon by members on hundreds of occasions over the years as evidence that the leader “trusts” the group, a trust that is reinforced by the members with supportive comments like “You’re not late; you came in time for the group that *you* need.”

Third, the Sobriety Support Group displays a deep respect for diversity. Because of dramatic differences between members in regard to their drug use, goals for change, and mental health status, one member, who is involved in abstinence-based treatment, might be talking about his strategies for maintaining sobriety while another, a schizophrenic not taking his medications, describes his days of panhandling to maintain a \$100-per-day crack habit, while yet a third inadvertently flings his coffee on his neighbors as he twitches and “tweaks” in the midst of a speed run. The group listens with equal attention, patience, and “sobriety” to each.

Fourth, all conversation in the group is member-driven. Themes for discussion emerge out of a check-in process that is organic and does not demand that people speak if they prefer not to. Typically in harm reduction groups approximately 50% of group time is devoted to talking about drug use and change. Members also talk about emotional issues, struggles to survive, relationships, family, and treatment (e.g., HIV or psychiatric) adherence. Frank, a long-time member of the Sobriety Support Group,

once commented, “I like that there is no agenda in here. I don’t know what I think until I start talking in this group. I learn what is in my mind when I hear myself talk.”

There is only one rule in the Sobriety Support Group: Members (and the leader) must ask permission before offering comments, reactions, or feedback to each other. This rule was created about a year after the group began.

Rashid, a crack smoker with schizoaffective disorder, joined the group and found the free-flowing conversation (“crosstalk”) difficult to tolerate. He became so threatened that he used to shout repeatedly in each group: “YOU DON’T KNOW ME. I’M MY OWN MAN!” while pounding his chest with his fists. I suggested that we might want to institute a rule that we not interrupt or give anyone else feedback until first asking, and being granted, permission.

Asking for permission has become the golden rule of harm reduction groups and will resurface as a theme in the last two vignettes of this article.

The Sobriety Support Group succeeded in creating a treatment environment that has attracted hundreds of members who would ordinarily not attend other treatment programs. Over its 14-year history, this group has enjoyed large attendance and retention rates. Approximately 100 new members “join” the group each year for a total of almost 1,500 over the last 14 years. Of those, 90% return occasionally and 60% attend regularly (at least once a week) for a minimum of 3 months. Some have been regular members for the life of the group. At any given time 50% to 85% are formally dually diagnosed with serious and persistent mental illnesses; 50% are homeless living on the streets; and 50% are currently maintaining or actively pursuing abstinence, some in 12-step programs. Except that most members are veterans and male, this is a very diverse group.

CHOICES: BUILDING A GROUP, BUILDING A CULTURE, BUILDING A PROGRAM (KIMYA HODARI)

I knew we had something going when group members were trying to wake someone in group who was sitting on a metal chair, in the corner of our group room, fast asleep, as if he were in a warm comfortable bed at the Hilton Hotel. With that thought in mind, I went and got a blanket and covered him. The group’s shock opened the door for a discussion about basic needs—shelter, food, and a sense of safety. Our sleeper had one out of three, the group, in which he could safely close his eyes and rest.

The CHOICES Program was developed to help address the growing need for substance abuse treatment at the Grady Health System, Infectious Disease Program (IDP), in Atlanta, Georgia. The IDP is an outpatient facility providing comprehensive medical care and services to consumers living with advanced HIV disease. As a “one-stop shop” comprehensive system of care, IDP services include adult, adolescent and pediatric medical care, oral health services, nutrition services, case management services, Project Open Hand to help with food needs, housing assistance services, and mental health and substance abuse treatment services (MH/SATS). CHOICES, a component of the program’s mental health services, is a long-term outpatient substance abuse treatment program designed to help meet the needs of clients diagnosed with advanced HIV disease and dually diagnosed with mental health and substance use disorders. The CHOICES program is open to all consumers receiving their HIV-related medical care at the IDP.

A New Group

It had become clear that the increase of substance use among our marginalized population with complex biopsychosocial issues was having a major negative impact on adherence to medical care and medication regimens at the IDP. I was asked to join the Mental Health Service with the task of developing and implementing an outpatient substance abuse treatment program. I decided to start with a women’s group, based on the Women’s Renewal Program that I had run for the Department of Family and Children’s Services (DFACS) for 5 years. Though mandated, it was a very successful, popular, and empowering program that focused on self-esteem building rather than powerlessness. I would not have the overseers, the courts, or the (DFACS) mandate treatment in lieu of jail time or losing custody of children. Attendance rates were very low and inconsistent. These women had a choice to attend or not to attend. So, how could I make the choice to attend more attractive without the threat of punishment?

Early in 2000, I was introduced to the harm reduction model while attending a conference that featured Edith Springer. Springer, who had brought harm reduction to the United States in the 1980s, outlined a model of substance abuse treatment that was nonjudgmental, supportive, and welcoming regardless of where one was on the continuum of substance use. It was a revelation that rekindled my motivational and creative juices. I could not wait to return to the IDP and get started. Because harm reduction was not fully understood, not widely accepted, and often challenged as an

effective substance abuse treatment model, I started slowly, without a lot of fanfare. Our first “drop-in” group was advertised with a flier that simply read, “Concerned about health and family issues, substance use or just life issues . . . just drop in and talk about it . . . Mondays at 10 a.m.”

The number and consistency of participants attending were staggering. By the next grant cycle we were able to hire another dual-diagnosis clinician to assist with our Monday “Keeping It Real” drop-in group.

Because of the challenges caused by some of the members’ mental health diagnoses, it was necessary to be very flexible with what is often thought of as “group disruptions.” Those who are unable to sit through the entire group because of an inability to tolerate stimulation or confinement are able to come and go as they need. Those who are actively using are welcome in group as long as they are not disruptive to others’ trying to talk. We believe that if you show up, it is for a reason, even if it is simply to be in a warm, safe room. We respect all reasons for coming.

Expanding the Group Into a Program

In 2001, I attended a 2-day dual diagnosis workshop by Patt Denning and Jeannie Little. Little focused on harm reduction groups for dual diagnosis. Coincidentally, it was time to expand our still unnamed program. We asked our core group of about 12 to 15 participants to tell us what a substance abuse treatment program would look like if they were to develop it. We still follow the basic curriculum designed by group members then. The importance of choice was stressed by the core group over and over until it seemed to be hammered into my being, not just when dealing with addictions, but with life itself. CHOICES would be the program name.

Powerlessness is not a part of the CHOICES program. We believe the only time one is powerless is when one loses the ability to be in control of one’s choices. Monday, we still have the “Keeping It Real” group, where participants check in and have open discussion ranging from family issues to politics to drugs. Our other groups focus on healthy choices, powerfulness, stress management (including meditation training), healthy relationships, and relapse prevention. Sometimes outside speakers come, sometimes group members provide all the information we need. We also have Fun Friday. The first half of the Friday group is for sharing weekend plans to be safe and healthy. The second part of the group is for playing team games, telling jokes, dancing, or karaoke. Teamwork, conflict resolution, learning new ways to have fun, and laughter are the themes for our Friday groups. Fun Fridays have also included field trips to such places as the zoo,

museum, and Botanical Gardens. Two years ago we also started a monthly “Creative Arts Day.”

After our trip to the Botanical Gardens, the group decided they wanted to have their own garden at the IDP. They named it the “Garden of Life.” Group members are responsible for maintaining the garden. The garden represents hope, faith, and living life to the fullest. It has been a way for those involved to connect with self, each other, nature, and even some of their providers in an existential way. They are excited, protective, and proud to be responsible for taking care of another form of life. As they care for and watch their garden grow and blossom, they are able to recognize how self-care impacts their growth and well-being.

How Does the Group Work With Substance Use?

The harm reduction model supports those who are at any stage of behavior change.

Some of the CHOICES group participants, because of ambivalence about making decisions, have taken years to reduce or eliminate drug use. CHOICES participants who are “using successfully,” or who are not ready to stop using, are supported rather than judged or punished. The presence of many active users can be a challenge for some who are maintaining abstinence. Most abstinent members do not feel threatened; the group understands and values each person’s change process.

Wendell has attended CHOICES regularly for the past 3 years and continues to use alcohol. When he joined the group, he was also using cocaine and marijuana at least four times a week. He admitted that cocaine was not his drug of choice, but it had started to cause the most serious consequences (drop in T-cell count due to nonadherence to medical care regimens, as well as loss of employment, which eventually led to homelessness).

The group encouraged Wendell to discuss his dilemma of not wanting to “just stop using everything all at once” on the one hand, but of being pressured by his sister to quit on the other hand. After a year, with much deliberation, frustration, and several relapses, Wendell decided to end his relationship with cocaine. During the next year, he decided to decrease his alcohol and marijuana use to what he called his “weekend thang!” This freed him to move out of the shelter and in with his sister. In order to remain living with his sister he had to get a job, which he did. After a few months, the fear of losing his job because of a positive random drug screen prompted Wendell to discontinue his marijuana use. He now attends groups on his days off, when he has medical appointments, or when he just wants

to check in with his CHOICES family. He shares that he is happy, healthy, enjoying life, and still doing his “weekend thang!” but with alcohol only.

A Group Rule That Went Awry

As with any program development and implementation, the process is open to change. Experience is the best teacher, and not all experiences are good ones. Because of the complex psychosocial issues involved, facilitating these groups can be very difficult. New staff, who are usually more accustomed to going into group prepared with an agenda, become frustrated when issues that come up in group are unrelated to that agenda. Over the years, a growing group of leaders had added more structure and more rules and began confronting and punishing members. One of those rules prohibited members from being in group if they had drugs on their person.

Robert, a long-term group member who was actively using, had recently lost his housing and came to a group obviously inebriated and became disruptive in group. During an interaction with him, it was discovered that he brought crack cocaine to group. The group and its leaders had determined that the consequence for bringing illegal drugs and/or alcohol to group would be a 5-day suspension from group. This consequence was enforced with Robert. Tragically, during that week, he was robbed and murdered on the street.

The group was distraught at their role in taking away his safe place during the day. The rule was amended immediately. If someone is suspended from group for an egregious breach of etiquette and an inability to put it right with the group, the maximum time away is 3 days and during those 3 days they are urged to attend individual counseling at least once and to attend anger management or assertiveness training groups, which are available in our mental health program. Therefore, no one will be totally without CHOICES support unless it is his or her choice. The group continues to process this tragedy.

What Makes This Group Work?

In 2006, CHOICES MH/SATS served 527 individuals for more than 4,000 visits. Statistically our members were 70% male, 30% female, and 3% transgender. Ninety-seven percent fell below the federal poverty level. Most importantly, we have members who have been a part of the CHOICES groups from day one. We even have clients who attend CHOICES groups who do not have a history of substance abuse but are in need of the

unconditional sense of belonging that CHOICES offers and a safe place to share their stories. For some it is the family they never had. For some it is the extended family. For some it is the newly formed family, once their own families abandoned them because of their HIV status or as a consequence of substance use behaviors. Group members often greet each other with “Hi, family,” or when they return after an absence, “Missed you, family.” It is the connection, the intimacy (into-me-see), the similarities, the differences, the ability learn how to care for and be cared for, and the genuine unconditional acceptance modeled by staff that keeps our, at times, “dysfunctional” family united.

CHOICES provides a powerful disclaimer to the notion of using incentives to help maintain group consistency and numbers. When we started in 2000, and group participants received two transportation tokens and a lunch, provided by Project Open Hand. Today, we provide one transportation token and no lunch. Our groups on any given day average between 12 and 18 participants. We have tried to divide the group into two smaller groups. Members would not have it!

Group members, even at their most fragile, have found strength in each other by providing unconditional, nonjudgmental support. Knowing that an abstinent group member had returned to using, several group members went to the crack house where he was and brought him back to group the next day. Nothing about the incident was mentioned by any of the members who went to get him. However, he told the story to the group and thanked those who probably “saved my life . . . I probably would have been too shamed to come back on my own. I love you, family.”

HARM REDUCTION SUPPORT GROUP AT TENDERLOIN HEALTH: FACILITATING RELATIONSHIPS AND WORKING THE DECISIONAL BALANCE (ANNA BERG)

The harm reduction support group at Tenderloin Health began in November 2005 to address the needs of active substance users at a community agency in San Francisco’s unofficial “drug zone.” Located in the Tenderloin district, clients of Tenderloin Health are sex workers and their employers, drug users and sellers, the homeless and marginally housed, and those who are mentally and physically ill; in addition, the neighborhood has the city’s fastest growing rates of HIV infection. At the time the leader began the harm reduction support group, Tenderloin Health offered groups focused

on topics ranging from sexual health to a “Positive Pizza” group for HIV-positive clients. The agency had a strong group culture yet no groups that directly addressed substance use. The harm reduction support group was created to address this need.

The group has been meeting twice weekly, on Wednesday mornings and Thursday afternoons for one-hour sessions, since November of 2005. In that time, between late 2005 and late 2007, more than 250 people have attended the group. In the full reflection of harm reduction principles, group members are welcomed just as they are, in any state of intoxication, mental status, or desire to make changes in their lives (Denning, 2000; Denning et al., 2004; Little, 2006). To allow group members to appropriately “dose” themselves with treatment, members are encouraged to drop in at any time during the group and to take smoke or bathroom breaks or to “take off if you’re just not feeling it.”

The following vignette illustrates not only how a harm reduction group culture allows for the contribution and value of all members but also how specific therapeutic interventions (such as motivational interviewing and decisional balancing) can be used in a drop-in group to help clients explore their relationships to the drugs they use and what they may (or may not) be willing to do about it.

Seven members were present for this Thursday afternoon session. The conversation took off when Jesse checked in:

Jesse: I’ve been off heroin for 3 days now and it’s good so far. This bupe [buprenorphine] stuff is great. (Larry, who was previously nodding out on a combination of opiates and benzodiazapines, looks up.)

Leader: Wow. Three days? What’s it like?

(Group discusses how buprenorphine works and Jesse’s reasons for getting off heroin, which he has been using since he was 16 years old.)

Jesse: Well, it’s not the heroin I’m missing so much. I mean, the medicine really takes care of that. It’s not the heroin, it’s the needle.

Morris: Yeah man, I know what you mean. I used to be into needles too, but then I found out about the virus (Morris is HIV-positive), so now I just do smack (crack).

Chris: I’m getting cravings talking about all this. I mean, I like it when I have to have my labs done. I kinda close my eyes and wait for the needle and then there’s the rush.

Leader: So you're thinking about using speed right now. (The leader was drawing Chris out. Chris had earlier in the session told the group he flushed his antiretroviral medications down the toilet because his doctor told him he shouldn't take them and use speed.)

Chris: Well, I've been thinking about it all day. It just really gives me energy. Otherwise I would never clean or even leave my house.

Leader: So there are some things you like about using speed. You like the energy it gives you. Anything else?

Chris: Well, it makes, um. . . me feel more intimate. I want to be around people more, you know?

Leader: So you have some reasons for using. It helps you feel more sexual and social and gives you energy. Anything you don't like about it? (The leader was trying to flush out potential motivation for change.)

Chris: Well, it's really not good for me, my health. And I sleep for 3 days when I come down. (He was quiet for a minute.) And my connection, well, he trashes the place. Then I have to use all over again to clean up.

Leader: Hmm. So there are some costs to using. In this group, we say feedback is okay as long as it's okay with whoever is talking. Are you open to hearing what others might have to say about reasons for using and not using? (Chris nods and leader invites Sam, Rufus, and Larry, who is still nodding out, to share thoughts)

Sam: Well, I used to do heroin too. But the thing is, you got to control the drugs, you can't let them control you.

Leader: What do you mean by that, Sam?

Sam: Well, you know. I used to just shoot (heroin) and stuff and it got out of control. I didn't have a place to live, I was getting sick and it wasn't fun anymore. Now, I don't mess with hop, but I pay my rent and my bills and then use.

Leader: So I part of controlling your use is that you make sure your bills are paid.

Sam: Yeah, and I use with people in case. I drink a lot and make sure I eat. Actually, my roommate makes sure I eat.

Jesse: What's your drug of choice, man?

Sam: Speed. Marijuana. But I only use speed a couple times a week. Sometimes speedballs. Crack.

Jesse: Do you use needles?

Sam: Naw, I smoke it mostly.

Chris: I make sure I pay my rent, too. And I use speed, too. It's really important to drink a lot of water. I buy milk, too, in case I get too high and need to come down. I used to drink half and half.

Leader: So, paying rent and bills and making sure you drink and sleep are some ways to keep control over your use. How do you tell if things get out of control?

Rufus: (interrupts) I have a message. One, put God first. Two, live the Word. Three—

Leader: (interrupts) Rufus, this sounds like more than one message.

Rufus: (smiling) Three, treat your neighbor as yourself. Four, give it to God.

Morris: Yeah, sometimes God helps.

Leader: So Rufus, are you and Morris are maybe suggesting that for some people faith might help when things get out of control? (The leader was translating for Rufus, who has schizophrenia, which results in other members sometimes having a hard time understanding him.)

Rufus: Yes. (Morris nods.)

Sam: I think things get out of control when all you do is use and think about using.

Jesse: Yeah, man.

Leader: So in this group, we say you can come high or come low and that you don't have to want to be clean to come here. I wonder if we have someone in the room right now who thinks about using all the time. (The leader was referring back to group culture to help keep the space safe for members like Larry, who continues to nod out.)

Moe: (opens door and enters group room) Hello, hello. Slim Shady is here, feeling like 5-below, a little cool. Got any coffee?

(Group welcomes Moe and then resumes checking in with other members.)

What Happened in This Group?

This session highlights the complexities of drug user behavior as well as the importance of group culture to help members contain and explore ambivalence about change. The harm reduction group at Tenderloin Health operates on a drop-in model, where all members are encouraged to join the group at any point during its meeting time, in any state of intoxication, wherever they are at along the continuum of change. This established culture allows the group to welcome Moe when he arrives after group has

begun, and also creates a safe place for Larry, a heroin user of more than 20 years, to nod out while Jesse explores the benefits surrounding his decision to get off heroin by taking buprenorphine. When Rufus, actively psychotic and disorganized, delivers his message from God, he is provided a space where he can participate as he is able, with the leader actively containing and translating his words for the rest of the group. Most important, the leader watches the feedback process carefully and makes sure that members honor the “golden rule,” and the group proceeds smoothly with respect to each person having the room to be themselves.

The chaotic lives of many active users, particularly those who are homeless and mentally ill, mandates that substance abuse treatment be accessible and flexible. Many of those who abuse alcohol or other drugs also have a co-occurring emotional disorder. By offering a space where Moe can get coffee, Rufus can share his prophecies, and Chris can discuss the challenges of sexual intimacy or his cravings, the group not only ensures that all are welcome, but also helps facilitate interpersonal exchange and mediates members’ abilities to acclimate to relational difficulties, excitements, or disappointments. Additionally, when the leader highlights potential resistance to the discussion of wanting to come off drugs (when she wonders if anyone in the group might think about using all the time), not only does the intervention provide a safe space for the intoxicated Larry, but also helps ensure that if Jesse, Chris, or any other member finds their motivation to change wavering, they will be welcome in the group, thus encouraging members to remain active in treatment.

The decisional balance (Miller & Rollnick, 2002) is a useful tool to help group members evaluate the pros and cons of their life decisions. By encouraging members to talk about their reasons for using, exploring potential harms resulting from their use, and exploring their decision making process, group members are encouraged to be their own experts with the power to make decisions about their lives. When the leader focuses on Chris and his cravings for speed, she uses the decisional balance to help Chris identify some of his challenges to letting go of speed (which Chris has previously told the group he prefers to following up with his antiretroviral therapies). By encouraging Chris to explore his reasons for using (and liking) crystal meth, she opens up the idea that he is making choices that affect other aspects of his life. By using the motivational interviewing technique of expressing empathy *before* helping clients explore discrepancies between desires and decision making, the leader helps Chris be more receptive to the leader’s subsequent question about the downside of using speed.

An established value of the group is that it welcomes all members regardless of their desire or nondesire to make changes in their behavior. According to the stage model of change (Prochaska & DiClemente, 1992), gradual movement is a normal part of behavior change and motivation is likely to fluctuate given the complexities of people's lives. In addition, the process of making major behavioral changes has been found to be most effective when the stages are comprehensively worked through with the support of others. Thus, harm reduction groups that welcome people at any stage of change offer an ideal forum to assist participants with their change process. As Chris and Morris explore the complexities of their use and potential conflicts between reasons for using and reasons for wanting to change how they use (if at all), Jesse discusses his decision-making surrounding beginning buprenorphine. Sam reminds the group of an important concept in harm reduction—that a person may have different relationships with different substances—while Rufus offers thoughts to the group not directly related to drug use. Jesse, Chris, and Morris explore their relationship not only to intravenous drugs, but to the needle itself, identifying the importance of ritual and a potential trigger. The leader, by encouraging group members to talk about the reality of their experience with drugs, without a group agenda that mandates members to work on getting clean and sober, provides a forum where members are also able to talk about practical safety measures and identify possible points of intervention in destructive patterns of drug use.

***HARM REDUCTION DROP-IN GROUP AT THE
TENDERLOIN SELF-HELP CENTER: MANAGING
CONFLICT IN A SESSION WHERE MOST MEMBERS
OF THE GROUP ARE PSYCHOTIC (JAMIE LAVENDER)***

In 2005, staff of the Harm Reduction Therapy Center (HRTC) began offering drop-in harm reduction groups at Central City Hospitality House's Self-Help Center. Hospitality House, as it is commonly known, is the oldest homeless drop-in center in San Francisco, located in the heart of San Francisco's poorest, most drug-ridden neighborhood. Self-help accurately describes the program model. Almost all of the staff are former clients of the center and are able to understand and support center participants because of their own personal experiences. HRTC is the first group of professionals to bring services into Hospitality House. It is only because of

its low-threshold acceptance of all people, regardless of their drug-using or other behaviors, that HRTC was invited to come in.

The harm reduction groups at Hospitality House meet four times per week and are facilitated by two different therapists (the latter two are co-authors of this article). Because there is only one individual therapist, who also facilitates two of the groups, and because there are several hundred dually diagnosed clients who come to the center, the need is great and the resources scarce. Both group leaders note high levels of desperation and tension at Hospitality House, which makes the groups more volatile. The vignette below illustrates what happens when the “golden rule” of harm reduction groups is not upheld. The leader in this group struggles to maintain safety and control once a conflict emerges.

Group began with Warren and Sam. Warren (a White, middle-aged gay man from Tennessee, homeless, crack-smoking, and a registered sex offender with borderline personality disorder) was talking about feeling suicidal and about giving HRTC’s addiction medicine physician an ultimatum about writing an order for him to have a medical marijuana card.

Warren: I told him, if you don’t give me a card I’m gonna start smoking crack and stop taking my psych meds. (Warren also said that being abused and raped and not helped when he was a child had made him the way he is, and the way he is society’s fault.) Sam (an African American man, also a crack smoker, and easy to anger) began to give him feedback.

Leader (noticing Warren’s defensiveness): Sam, in this group, we suggest that people ask permission before giving feedback, because sometimes unwanted feedback leads to strong reactions, which can cause conflicts.

Sam agreed and turned to Warren, who gave him permission to speak.

Sam: You can’t blame your situation on anybody else. You gotta take responsibility for yourself.

At this moment, Ronald (an energetic African American man, another crack smoker, with schizoaffective disorder, whose speech is peppered with biblical “fire and brimstone” messages) entered the room very forcefully, pacing, looking around, and then going to the coffeepot, where Warren had gotten up to fix a cup of coffee. Sam paused at this interruption.

Leader: Welcome, Ronald.

Ronald: Like you give a shit.

Leader: Wow. Do you think I don't give a shit about you?

Ronald gave a grunt as he tried to get around Warren to get his own drink.

Warren: Excuse me (not sarcastically) Warren sat down and Ronald got his drink.

Leader (to Ronald): Sam was just checking in.

Sam began to speak again. Warren attempted to interrupt, as did Ronald.

Leader: Hang on, Sam's not finished. Then we can hear Warren and Ronald.

While Sam and Warren conversed about responsibility, Ronald was rocking in his chair, putting up his hand, and trying to interject verbally. Player (a schizophrenic African American musician who takes no psychiatric medications except the ones he prescribes for himself—mostly pot—and who possibly hasn't bathed or changed clothing in many months) came in, sat down and rolled his eyes back in his head. I asked Player if he was having a medical emergency, to which he replied that he was not.

Ronald (becoming frustrated at the continued delay): Okay Jamie (pause)I gotta go for a minute. (He returned holding his bible.)

When Ronald's turn came to talk, he started to preach in a loud voice, with an angry facial expression, while glaring at Warren. As was usual for Ronald, his words consisted of Christian biblical quotes and his interpretations of them: 1 Corinthians 10:23, "All things are lawful for me, but not all things are expedient." I can tell you this, Warren, this is not about a pot card. this is about your relationship to the Almighty Father and praying to Him for guidance and the truth. This emotionally charged and unasked-for delivery stoked the brewing anxiety in the room. As Warren attempted to get a defending word in, and Ronald continued to challenge him, Sam and Player sat in frozen silence. At one point, Sam said "Oh no," in a soft voice.

Leader: I'm going to call time out for a moment. I think Ronald is giving Warren feedback without asking permission. Ronald, would you mind asking Warren if he wants feedback before you continue?

Ronald (pausing for a moment): Sure. But Jamie you know what I'm talking about. We've talked about this before. (Then to Warren, skipping the permission part) Do you know what Satan means? Satan means "the accuser," and I wouldn't accuse you of anything, Warren.

Sam (to the leader): I'm gonna go. (Asked if he was okay) Yeah, I just can't deal with this dude coming in all hostile, I gotta go.

*Ronald (as Sam walked out the door): Hostile? I'll show you hostile.
Sam (opening the door and coming back in): Do you have something to say to me? Cause we can take this out here.*

The two started to exchange threats. The leader got up to close the door, asking Ronald to sit down. He got caught between Sam and Ronald, both pushing toward each other and exchanging threats. He ushered Sam back out, followed him out, closed the door, and asked Sam to cool down and to check in individually later. The leader reentered the group room, sat down and looked at Ronald.

Ronald: I didn't threaten him, Jamie. It's just, some people need to not write a check that their ass can't cash.

Leader: I'm sorry Ronald, but you did say some threatening things. (Player and Warren sat silently watching, though Warren shot a glance at the leader, seeming to say he couldn't believe Ronald was denying threatening Sam.) You're having a hard time respecting our most important rule, and I think you need to leave for today.

Ronald: You might as well ask me to leave for life.

Leader: Ronald, I'm not asking you to leave for life, just for today, and to come see me first before the next group.

Ronald: Jamie, you know I didn't threaten anybody, and you know the spirits are going to get involved with this. (He stood up while saying this, pacing around the room.)

*Leader (sternly): Ronald, I heard you using threatening language, first coming in angry, telling me I don't give a shit, pushing Warren out of the way to get your coffee, then laying into Sam for suggesting that you were being hostile, then standing up. All that kind of stuff is threatening, as we've talked about before in this group. It makes the group unsafe, and I'm charged with maintaining safety in this group.
Ronald(smiling broadly and sitting down): Congratulations, Jamie! I'll humble myself to tell you I'm proud of you, you've got guts, you've got backbone, and I respect that.*

Leader: I appreciate the compliment, but I still have to ask you to leave. We'll have to continue this conversation later.

Ronald: You know the spirits will try to prevent that.

Leader: I'll do my best anyway.

Ronald left.

Warren: I hate when Ronald is in group.

Paul (a tall, White, bearded homeless man in his sixties with schizophrenia, HIV, and problems with alcohol use) entered. The group informed him that a conflict had nearly come to blows and that

Sam and Ronald had left. Paul said he liked Sam and thought he was a mild, nice guy.

Warren: You should have seen Jamie, Paul. He really let Ronald have it. Jamie, I'll never again question whether or not you have guts. And I'll never fire you again. (Warren periodically "fires" Jamie, who is also his individual therapist, for any perceived insult, such as when he is a minute late to sessions.)

Warren then brought Paul up to date with his problem of the day: his seeking a pot card, then threatening to commit suicide or to smoke crack.

Paul: Hey man, don't you know that pot makes you paranoid, and maybe even more suicidal?

Warren: What are you talking about? Pot's the only drug that chills me out.

Leader: This is a great example of how different people experience pot. Paul, are you trying to tell Warren that you are concerned about him?

Paul: Yes, I like him. I like seeing him. I wouldn't like it if he killed himself.

Warren: Thanks, man. I like you too.

Leader (noting that the group is nearing the end of the hour): Player, you haven't said much. How are you doing after all that's happened in this group?

Player: I don't have feelings. Anyway, what is it that Sam has in his personality that Ronald and I do not have? Sam isn't mild, he'd be the kind of person who acts mild and then jumps you with 20 other people. (He pretended to talk like Sam in a mimicking voice.) In fact, I can prove to you that Sam doesn't even exist. Sam is a cartoon. (Pause) That was a joke but nobody laughed. (Chuckling to himself.) At this, the leader closed the group.

What Happened in This Group?

Although it is not typical for members to threaten each other (on only a handful of occasions in 2 years have members been asked to temporarily leave a session), this is a very typical example of a group session at the Self-Help Center. It is a valuable lesson in what happens when a leader missteps in a group of extremely fragile individuals.

The group started out in its usual fashion, with one member "checking in" about his recent experience of trying to get a medical marijuana

card. Warren raised several anxiety-provoking issues, including drug use, suicide, childhood abuse, dependence on and responsiveness of service providers, and the question of responsibility for one's life and choices.

When Sam responded, seemingly handling his own anxious feelings about these issues by telling Warren to be more responsible, the group leader made his first mistake. He did not enforce the feedback rule. The giving of unsolicited feedback is always an opening for conflict and its accompanying anxiety, as it is often experienced as critical, and therefore as a judgment. This seemed to be somewhat resolved by framing Sam's response as feedback, thus communicating the norm of the group that people ask if they can give feedback before giving it. However, when another group member entered ready for a fight, it didn't take much to reignite the tension.

The leader's second error was to not intervene immediately with Ronald's aggression. In attempting to be good-humored about Ronald's initial angry responses ("Like you give a shit," and pushing aside a group member to get coffee), the leader missed the moment in which Ronald's aggression might have been negotiated with less disruption to the group and less harm to the members. A response such as, "Group, we may need to attend to Ronald before we continue with checking in. Something is going on with him. Ronald, what's going on? You seem like you're upset . . ." may have helped contain Ronald before his conflict with Sam erupted, and might have enabled both of them to remain in group for the duration.

Third, the leader missed Sam's escalating anxiety. While some psychotic group members prefer to withdraw as a means of containing their anxiety in a group (such as Player, rolling his eyes back in his head), others rely on the attention of the group for containment. Sam first expresses his anxiety by asking for the leader's help with Player rather than by asking for help with Ronald, whose agitation is more visibly threatening. When the leader attends to Sam's overt request, Ronald leaves in frustration but then returns, bible in hand, ready for battle.

Then, while trying to prevent a fight, the leader "lets Ronald have it," and things spun out of control. Paradoxically, the leader's accidental loss of composure turns out to be an effective intervention, finally offering Ronald the containment that he's been soliciting throughout the session. Is Ronald's smile one of submission or of long-awaited satisfaction, or both? Unfortunately, Ronald is now scapegoated, if only by temporary banishment. The member with the least resources for managing his anxiety and impulses and, aside from Player, the most obviously mentally ill,

Ronald nevertheless was trying to refocus the group on mental health and drug use issues.

Although everyone who came to this group session was a drug user, the only references to drugs occurred at the beginning, with Warren's threat to kill himself if he couldn't get a medical marijuana card, then when Ronald read the Bible verse, and at the end with George's caution about the relationship between pot and paranoia. George's lesson was ironic given that this group session was driven by paranoia and reactivity.

Was this group session helpful to anyone? It's hard to say. It is important to understand that this group session is one in hundreds of sessions in a group that has so far been meeting for 2 1/2 years. The members of this group for the most part know each other well. There are no surprises. The leader made some errors that tipped the balance and that led to a very disruptive session. But all of the members are still coming, and many other discussions have taken place. This group session was one in the life of a group in an already devastated community that is learning to work together about their problems with drugs and their problems with life.

SUMMARY OF INTERVENTIONS UTILIZED IN HARM REDUCTION DROP-IN GROUPS

Drop-in Structure That Is Welcoming of Anyone and Anything Except Violence

Drop-in groups are the lowest threshold form of group treatment. People may attend or not attend as they need or wish. They are thereby able to "dose" themselves with treatment, much as they dose themselves with drugs. Such a model affirms that the client is the expert and knows what he or she needs. This, in turn, lowers resistance by placing authority in the hands of the client. It supports the tenets of self-determination theory (Ryan & Deci, 2000). Finally, it supports client self-efficacy, a key ingredient for motivation to change (Miller & Rollnick, 2003).

Acceptance

The primary challenge to promoting acceptance of drug use as adaptive is the cultural dominance of the disease model of addiction and its insistence that abstinence is the only rational response to out-of-control drug use. This attachment to the culture of "clean and sober" has created challenges to the

harm reduction model. People are not accustomed to talking openly with a therapist about the details of their drug use. Many have experienced being excluded from treatment if they use, or they have internalized the stigma of being an active drug user (so often referred to as “dirty”). The leader must create a culture of acceptance of drug use by constantly reinforcing that people use drugs for reasons, by asking group members to talk about those reasons, and by expressing empathy and respect for each person’s chosen means of coping. The leader does much reframing in order to combat the conventional view that continued drug use represents failure.

Treating Group Members as the Experts

In harm reduction groups, members tell their own story. No one’s relationship with drugs is the same as anyone else’s. By not defining problems from any particular perspective such as the disease model of addiction, harm reduction groups create the conditions that encourage each individual to explore their own experience. This, too, supports self-determination and self-efficacy as group members come to appreciate their own wisdom reflected in their choices. As members of the Sobriety Support Group often say, “each of us knows what we need, including whether to be here or not. No one else can tell us what we need.”

Members Talk About Whatever They Choose

To reinforce that group members are the experts, the leader of a harm reduction group must not set an agenda. In other words, it is not for the leader to decide what is important. Group members can decide in advance what topics are of interest to them so that the group leader, or a designated member, can come prepared with information on those topics. Or the group can be structured in such a way that topics of interest are arrived at spontaneously during the course of a check-in.

No Screening for Drugs

It would be pointless to invite active users into a group, only to then screen their urine for drugs. We take responsibility for creating a culture that is sufficiently welcoming that members will eventually feel comfortable telling us what they are using, how often, and how much. This is a much more productive way to enter into a treatment relationship than the practice of policing people’s urine. We find that people move very quickly to telling us what they are using. They become curious or challenging about what we

might have to offer, but we do not offer too quickly. We explore whether they are ready for new information, thereby giving ourselves and our clients the opportunity to assess motivation for change.

WORKING THROUGH AMBIVALENCE, OR THE CONTEMPLATION STAGE OF CHANGE (PROCHASKA, DICLEMENTE, & NORCROSS, 1992)

The contemplation stage of change is the pivotal stage, ruled by ambivalence, in which unconscious conflicts must be made conscious, thus allowing decisions to be made and implemented. Miller and Rollnick (2002) recommend the “decisional balance,” a cost-benefit analysis, to bring ambivalence to light and help the client resolve it and make decisions. The pros and cons of change are compared to the pros and cons of maintaining the same behavior. In decisional balance work it is the relative *weight or importance* of each item that is important, rather than the length of the pros and cons lists.

The Therapist Having No Agenda as to the Outcome of Treatment for Each Individual

The therapist must remain neutral in the decisional balance. The client’s own feelings about each issue give the therapist plenty to explore. The beauty of doing decisional balance work in a group is that the group itself will demonstrate multiple layers of ambivalence. Each time it appears that a decision to *do* something has been made, a well-trained group will say “But, what about that great sex?” Some will proceed to tell stories about their own drug-sex associations, helping to flesh out the dilemmas and challenges opposing the determination to change. The therapist need only ask the group if the member in question has fully explored all sides of her ambivalence. Decisional balance work makes the movement toward changing one’s relationship with drugs as complex as it really is.

Respecting Resistance

People have a right not to change. They might incur consequences for not doing so but, as in the title of a powerful 1970s play about a patient’s right to die, whose life is it anyway (Clark, 1972)? “Rolling with resistance” is one of the four principles of motivational interviewing

(Miller and Rollnick, 2003). This refers to the practice of backing off when we meet with resistance to our ideas.

Minimizing Conflict

Whereas difference is to be welcomed and highlighted, conflict has not been found helpful in the settings where, or with the populations with whom, the authors work (Little, 2002). Although group members are quite capable of aggression, particularly when intoxicated, the strong affect of aggression seems more often to frighten our group members. Khantzian (1985, 2004) and Khantzian et al (1990), in their vast body of work, asserts that affect regulation is the major deficit of drug users. If the leaders of harm reduction groups intervene to contain and divert potential conflicts, space is then created for group members to work together productively. This also means that encouraging confrontation is absolutely not a part of harm reduction group work.

Support for Facilitators

For these low-threshold, heterogeneous, medically fragile, psychosocially complex, dual diagnosis harm reduction groups to work, the burden of maintaining a therapeutic and ordered (but not controlled) environment is placed on the facilitators, not the members. A risk is the temptation on the part of group leaders to “over-rule” the group. Supervision is essential. Ideally, the supervisor has an open door policy. Staff can and should come immediately to discuss any group incidents that might lead them to react adversely in the group. It is also essential that co-facilitators process before and after groups to manage any feelings that arise in response to group members and incidents. A high value is placed on group supervision by the authors of this article, as is the importance of self-care strategies for staff.

CONCLUSION

Most members of the four groups described above have expressed deep appreciation for, and have protected the culture of, diversity and inclusion. A feeling often expressed by group members, grateful that they are not punished by either the group or the leader, perhaps an existential factor common to members of any stigmatized subculture, is “There but for the grace of God go I.” In the Sobriety Support Group and CHOICES, the

culture of harm reduction groups has evolved over many years, with an unfortunate tragedy along the way in CHOICES.

The two groups in the Tenderloin highlight the most important group rule (the golden rule) of harm reduction groups, that members and leaders should ask permission before offering feedback to one another. It is a premise of this article that asking permission to give feedback helps to maintain the safety and harmony necessary for members of harm reduction groups, who can represent extreme polarities in regard to their drug use patterns and motivations to change. There are many concerns expressed about harm reduction by members of the drug treatment community. Common complaints are that harm reduction “enables” drug use; that harm reductionists, in their efforts to reduce global harms like HIV transmission, are ignoring the individual’s problems with addiction; that harm reduction is about diminished expectations of people we have given up on; and even that harm reduction is a cover for drug legalization. Those concerns are compounded when drug treatment professionals hear about harm reduction groups where orderly, task-oriented conversations are somewhat rare. On every occasion over the years when the leader of the Sobriety Support Group asked the abstinent members why they would come to such a group, they have offered such replies as, “It keeps me humble to see where I was. I come to learn not to teach,” “I come to this group because we can talk about whatever we want. It doesn’t always have to be about drugs or recovery,” or “This is my therapy group.”

Three of the groups described in this article take place in low-threshold drop-in settings: one homeless center with almost no clinical services and two homeless centers with a full array of medical and psychiatric services. The fourth takes place in a hospital-based outpatient HIV care center that typically serves low-income patients. Three of the leaders run other harm reduction groups, two of them in other settings: a mandated program in the criminal justice system, a private practice, and a group focused on living with HIV. The principles and customs of the drop-in groups apply because they are grounded in the fundamentals of self-determination and motivational interviewing.

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