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Clinical Social Workers' Beliefs Towards Harm Reduction When Working with  
Substance Using Clients

Submitted by Rachel Hofschulte  
May 11, 2012

MSW Clinical Research Paper

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

School of Social Work  
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### **Abstract**

This study explored social workers' beliefs towards harm reduction. Specifically, it explored clinical social workers' beliefs towards harm reduction principles, characteristics of substance users, and beliefs regarding substance abuse treatment options. It also investigated if professional or demographic variables were related to clinical social workers' beliefs towards harm reduction. Using a quantitative design, 24 clinical social workers were surveyed using the Substance Abuse Treatment Survey (SATS) (Housenbold Seiger, 2005). Data was analyzed using descriptive and basic inferential statistics. The findings indicated that chemical dependency or substance abuse training, perceptions of chemical dependency training sufficiency, and previous employment in the chemical dependency field positively impact clinical social workers' beliefs towards harm reduction principles. In addition, training in chemical dependency or substance abuse also positively impacted clinical social workers' beliefs towards harm reduction types of substance abuse treatment options. These findings overlap with the preexisting literature. The impact training has on clinical social workers is profound. Continued training is important so clinical social workers can effectively work with the substance using population.

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## **Introduction**

Practicing from a harm reduction approach, when working with substance users, is a newer concept to the therapeutic and social work community. Social workers come in contact with substance abuse issues in almost every practice setting (MacMaster, 2004). Therefore, it is important that social workers are aware of different types of approaches to effectively work with their substance using clients. Harm reduction is an evidence-based practice (World Health Organization, 2011) but often conflicts with the current mainstream abstinent-only approach in chemical dependency treatment options.

Davis (2011) explains that “harm reduction is a helping strategy that attempts to alleviate the social, legal, and medical consequences associated to unmanaged addiction, and in doing so, limit the harms, such as infectious disease (HIV, hepatitis), violence, criminal activity, and early death, without necessarily attempting to ‘cure’ the addiction”. Furthermore, to understand the concept of harm reduction, Marlatt (1998) describes that there are central assumptions, principles and values of harm reduction that must be understood.

The first is that harm reduction is a public health approach which views substance use differently than criminal or disease models. The second is that harm reduction values abstinence and identifies that abstinence is the best outcome but also accepts different approaches to substance use, as they reduce associated harm. The third is that harm reduction is an approach that has come from the bottom up and has focused on substance use advocacy, rather than a top down approach to policy. The fourth is that harm reduction often is identified as a low threshold approach to services compared to the traditional abstinent based programs which are high threshold. A low threshold services

approach reduces stigma and is more appealing which increases engagement (Marlatt, 1998). Harm reduction assumptions are unique and very different from the mainstream abstinence-only approach.

The United States has proven that mainstream abstinence-only approaches to substance abuse treatment is ineffective and expensive (Lemanski, 2001). Drug abuse costs the United States over a half a trillion dollars annually. This includes costs related to health, crime-related costs, and losses and productivity (Volkow, 2007). The United States does not support all methods to treat substance abuse. It only supports the mainstream abstinence-only treatment models which have proven to be ineffective (Lemanski, 2001). A harm reduction approach towards substance abuse treatment allows for more substance users to receive assistance with their substance use without necessarily stopping the use and also focuses on reducing the harm associated with the substance use (Marlatt 1998) that is often costly to the United States.

Social workers traditionally did not work with alcohol or substance using clients. When they did, they defaulted to the mainstream abstinence-only approach, such as the 12 step approach (Lemanski, 2001). Social workers now work with substance use issues on a regular basis. Smith and colleagues (2006) conducted a study on social workers from the National Association of Social Workers and found that 71 percent of social workers reported that they have worked with substance-misusing clients during the last year. Of those social workers 53 percent reported they received no training regarding substance use during the same time period.

The research shows that social workers are not adequately trained to work with substance using clients (Amodeo & Fassler, 2000; Duxbury et al, 1982; Hall et al, 2000,

Loughran et al, 2010; Peyton et al, 1980). Due to the lack of education and training available to social workers, it is assumed that social workers automatically default to the mainstream abstinent-only approach when working with their substance abusing clients, as discussed earlier by Lemanski (2001). Specifically, lack of harm reduction training in the field of social work is also concerning. Social workers who have not received training specifically in harm reduction are more likely to default to the abstinent-only model (Housenbold Seiger, 2005).

Substance use is a major concern in the United States and substance use treatment is a necessity. According to the United States Substance Abuse and Mental Health Services Administration's (SAMHSA) 2008 National Survey on drug use and health, 23.1 million people, 12 or older, needed treatment for an illicit drug or alcohol use problem. Unfortunately, 20.8 million of the people who needed treatment did not receive it. Combined findings from SAMHSA's 2005 through 2008 surveys concluded that almost 30 percent of people reported that the reason why they did not receive treatment, even though they needed it and wanted it was because they were not ready to stop using. It is unfortunate that people who need treatment and want treatment cannot receive it because they are not ready to quit using.

This study explored social workers' beliefs towards harm reduction. Specifically, it explored clinical social workers' beliefs towards harm reduction principles, characteristics of substance users, and beliefs regarding substance abuse treatment options. It also investigated if professional or demographic variables were related to clinical social workers' beliefs towards harm reduction. Social workers serve substance

using clients in many practice settings and it is important that they are trained effectively to work with the population they are serving.

### **Literature Review**

The literature review will explore harm reduction's connection with the public health model and theoretical approaches in which it overlaps. It also discusses implications to how social work values, ethics and norms support harm reduction concepts. Literature exploring social workers and other professional's views on substance users, perceptions towards harm reduction, social workers and lack of substance use education, and substance user's perceptions on harm reduction treatment models will also be discussed.

### **Harm Reduction**

Harm reduction is a philosophy which is based on a few assumptions: first is that drug use is sometimes inevitable, second is all drug use, both illegal and legal drugs, are equally problematic, third is that problems are viewed as a public health issue rather than a criminal justice issue and the fourth assumption is that users are unwilling to volunteer for treatment and services under the traditional, abstinence based policy system (McNeece, 2003). Harm reduction is a philosophy and set of interventions that aim to reduce the harm associated with substance use and other risky behaviors that typically coincide with substance use without requiring abstinence (Marlatt, 1998). "Harm reduction is defined as a constellation of interventions that have as their own objective, the reduction of damage related to drug taking without requiring abstinence at the initiation of treatment, total abstinence during and following treatment, or both" (Brocato & Wagner, 2003, p.118).

**Public Health Model**

The United States has chosen to look at substance abuse criminally, which is evident by reviewing the United States current drug policies. McNeece (2003) explains that harm reduction promotes a public health approach over the mainstream criminal view of substance use. A public health approach with harm reduction offers a different view of the substance user. It emphasizes the idea that the user is a person rather than a criminal who is breaking the law. The public health approach and harm reduction originally started with needle exchange programs for intravenous drug users. These were initially implemented to stop the spread of diseases and prevent overdoses, abscesses and other medical consequences of drug use (Little, 2006).

Harm reduction allows substance users to take responsibly for their substance use while also providing an opportunity for substance users to make gains in other areas of their health (Koutrolis, 2000). Harm reduction reduces the harm associated with substance use and connects substance users to services which they otherwise might not receive. Harm reduction, when looking through a public health lens, assumes that substance use is a reality of human nature and needs to be accepted as fact (Housenbold Seiger, 2003).

**Social Work Values, Ethics and Harm Reduction**

Social work is driven by the values developed by its profession (MacMaster, 2004). Our current drug policy has been thought of as an intrusion on social justice and human rights which are important to social workers (Brocado & Wagner, 2003). The core values of social work are consistent with harm reduction, as they both uphold respect and dignity for clients in spite of their self-destructive behavior (Housenbold Seiger, 2003).

Social justice and human rights is heavily weighed within the profession of social work. Commitment to clients and self-determination, which come from the Code of Ethics of the National Association of Social Workers, support harm reduction principles. Harm reduction interventions reduce negative consequences related to the substance use which upholds the well-being of the client. Harm reduction principles and social work ethics state that clients should be met where they are at and not where the social worker believes they should be (MacMaster, 2004).

Burke and Clapp (1997) measured the differences between social work managers' and nonsocial work managers' views towards substance abuse programs to determine if there are differences in beliefs based on those who have a social work education and those who do not. It was found that managers with all types of educational backgrounds were overall less strong in their support for a harm reduction approach, but social work managers were more supportive towards harm reduction than nonsocial work managers. Social work managers also did not feel as strongly as nonsocial work managers that clients must maintain sobriety while participating in treatment. This suggests that social work managers might have a different view of relapse and recovery compared to nonsocial worker managers. Burke and Clapp's (1997) findings seem to support the idea that social workers, based off their values, should accept the idea of harm reduction.

MacMaster (2004) explains that the concept of reducing harm is consistent with social work practice when working with people who use drugs and alcohol and when working with people who do not use drugs and alcohol. Social workers have a role to facilitate positive change and reducing harm is part of that facilitation. Burke & Clapp's (1996) results seem to correspond with McMaster's (2004) theory. It seems that social

work managers are more inclined to accept relapse as part of a client's recovery process and will allow that client to stay in treatment if a relapse occurs (Burke and Clapp, 1996).

Mancini and colleagues (2008) focused on views and perceptions towards harm reduction. The study specifically focused on clinical staff perceptions who are employed in a housing program called Place for People Inc. A mixed-method study was used to assess perceptions using a questionnaire and a one-time focus group. The findings from the focus-group parallel with the foundation values of social work.

The focus group expressed two main aspects of harm reduction that respondents felt were positive; 1) that harm reduction is relationship-oriented and 2) that it is non-judgmental and empowerment-focused. When respondents discussed harm reduction and how it is relationship-oriented, respondents indicated that harm reduction places importance on engagement and developing good relationships (Mancini et al, 2008). This helps engage clients, as relapse is not viewed as a failure but as an expected part of recovery. Acceptance of relapse by using the harm reduction approach strengthens relationships as the client is not shamed or seen as a failure. When respondents discussed harm reduction and how it is non-judgmental and empowerment-focused, respondents indicated that using a harm reduction approach heightened their ability to accept their clients and emphasized a client-centered approach. Furthermore, harm reduction focuses on allowing the clients to develop realistic goals which permit them to move forward in recovery at their own pace while also maintaining their dignity (Mancini et al, 2008).

What happens when the clinician is working from a harm reduction framework but the client is making the goal of sobriety when participating in a harm reduction treatment setting? Koutroulis (2000) raised the dilemma concerning clinician's confusion

with what to do when a client has a goal of working towards abstinence but that goal undermines the current harm reduction treatment in which they are participating.

Koutroulis' (2000) sampled clinicians employed in a treatment center where the client must engage in a withdrawal program once entering treatment. The withdrawal program is a series of appointments, counseling sessions and medication management. Medication management is used to assist with the client's withdrawal symptoms for substances. The clinicians are responsible for the treatment planning and addressing the client's concerns. "These might include sleep, cravings, nutrition, relaxation, blood-borne virus testing and other topics of discussion under the rubric of harm reduction" (Koutroulis, 2000, p.92).

Clinicians perceived a difficulty accommodating the client's goal of abstinence while practicing within a harm reduction framework (Koutroulis, 2000). There seems to be a gray area regarding how clinicians can respect a client's goal and also give helpful information regarding potential future substance use. Little (2006) explains when practicing harm reduction "starting where the client is, respecting client choice and autonomy throughout treatment, and accepting that there are many ways to reduce drug-related harm helps clinicians break away from the abstinence vs. non-abstinence dichotomy" (Little, 2006, p.5).

The harm reduction goal of the withdrawal program that Koutroulis (2000) researched was to teach about safe drug use, overdose prevention, blood-borne virus transmission, and future risk and safety concerns. There were varied responses when discussing the dilemma clinicians encounter on how to work with clients that desired sobriety, but the treatment program did not support that goal. Some clinicians identified

that they believe that harm reduction was anything but sobriety and should only be used when it works for that client (Koutroulis, 2000). One clinician felt that by not teaching harm reduction information, the clinician could be contributing to the client's death or overdose, regardless if the client wants the information or not. Another clinician felt that it was important to provide harm reduction information; because many clients are most likely going to continue to use; therefore the client should know how to use safely (Koutroulis, 2000). This clinician's reasoning for wanting to give harm reduction information coincides with McNeece's (2003) assumptions of harm reduction. As stated earlier, a main assumption of harm reduction is substance abuse is sometimes inevitable (McNeece, 2003).

The most important aspect of harm reduction is safety and making sure substance users have the tools to be safe (Koutroulis, 2000). Harm reduction assumptions and social work values, such as a client's right to self-determination and working from a client-centered approach, can sometimes conflict with each other. It is not always about abstinence goals or harm reduction techniques; it is about giving substance users the tools they need to minimize the risk involved with their drug use in case they continue to use substances in the future. By giving substance users the tools they need to be safe, social workers are not prohibiting the goal of sobriety but instead are ensuring safety.

### **Stages of Change**

Little (2006) explains that a therapist must let go of their own agenda to practice harm reduction which is supported by the self-determination theory of Deci and Ryan (2000). This theory explains how motivation is healthiest when it is self-generated. Self-generated motivation is healthier when compared to motivation that is forced externally

through rewards and punishment. When motivation is self-generated, the person is intrinsically motivated because they want to change to help themselves (Little, 2006).

All substance users are in a current stage of change. This stage of change reflects where they are currently at in wanting to make changes with their substance use. The Stages of Change Model states that substance users are either in the pre-contemplation, contemplation, preparation, action, or maintenance stage. The pre-contemplation and contemplation stages are where problems are recognized. The preparation stage is where preparations to make changes are completed. The action stage is when the substance user actively makes the changes, and the maintenance stage is the stage where the user is maintaining their positive actions over an extended period of time (Prochaska, DiClement & Norcross, 1992).

Little (2006) explains the stages of change in greater detail. The pre-contemplation stage is when a person does not believe that their drug use is a problem and there is no need to change. When a client is in the contemplation stage they are aware that the drug use might be a problem, but is not necessarily ready to stop using. The preparation stage is in place when the person has decided to make a change and starts to make a plan towards changing their substance use. The action stage is when the person actually makes the change within their drug use and starts to put structures in place which will support their change. The last stage of change, the maintenance stage, is when a client has made the change and is working at sustaining these changes in their drug use (2005). A social workers' approach will look different when working with people that are in different stages of change.

Some substance abuse treatment agencies require a client to be sober to attend treatment. When using the Stages of Change Model, this would require a client to be at the action stage of change. This then excludes substance users at the pre-contemplation, contemplation and preparation stages. MacMaster (2004) explains how the Stages of Change Model advocates for the idea that abstinence is not always the initial expectation or goal for most substance users who are starting treatment. Therefore, it is important that services should target the stage of change that the client is currently experiencing. Harm reduction approaches tend to gear interventions towards people that are not in the action stage, as they might still be using substances.

Harm reduction therapists accept the client's drug use by supporting the client's possible chance of change within their choice to use drugs, regardless if the drug use causes negative consequences (Little, 2006). Tatarsky and Kellogg (2010) explored what exactly harm reduction looks like during psychotherapy by reviewing case studies. It was found that a harm reduction approach can positively attract and retain active substance users in therapy. This facilitates change for the substance user and to resolve other complex issues related to their substance use and maybe eventually start to make goals related to decreasing the substance use itself.

### **Social Workers and Substance Abuse Education**

The mainstream abstinence-only perspective works for many but it is also questionable, as it has not worked for many substance users in the United States. The idea of harm reduction in chemical dependency services and other social services is critical for social workers. Social workers come in contact with substance abuse issues in almost every practice setting (MacMaster, 2004). McNeece (2003) suspects that social workers

tend to be wary of working with people who use substances because they are seen as being difficult and also the stigmatized perspective that people who use substances are criminals. Several studies have explored this in greater depth.

Peyton and colleagues (1980) researched attitudes of graduate social work students at the University of Texas at Arlington regarding their willingness to treat alcoholics. Students were asked various questions, both direct and indirect, to measure their willingness to treat alcoholics. First year and second year graduate students were sampled to see if more education effectively impacted student's perceptions of alcoholics and their willingness to work with this population. Duxbury (1982) replicated the previous study with graduate students from University of Wisconsin- Madison.

Peyton and colleagues (1980) found that graduate social work students had a significant bias against alcoholics when using an indirect measurement. Duxbury (1982) found that when using the indirect measure there was only a slight trend towards a negative bias against alcoholic clients. Peyton and colleagues (1980) found when using the direct measurement only 36 percent of students would be willing to treat an alcoholic and Duxbury (1982) found that 58 percent of graduate social work students were willing to work with alcoholics. The two studies validate each other's findings, although Duxbury's (1982) findings were more optimistic.

Peyton and colleagues (1980) concluded since second year students were no more willing than first year students to work with alcoholics, it could possibly mean that education did not impact student's decisions regarding alcoholics or that alcoholism was not addressed within graduate school as it is not a mandatory topic of study. Duxbury (1982) discussed that respondents believed they did not seem to have the appropriate

skills needed to work with alcoholics which could have impacted the student's willingness to work the population as well.

Hall and colleagues (2000) conducted a needs assessment study. Hall and colleagues were interested in social workers that worked within licensed substance abuse treatment facilities to get a better understanding of their previous training experience, access to training, and need for training. Surprisingly, four percent of social workers reported that they had no prior training related to substance abuse even though they currently work within a substance abuse treatment facility. Almost 45 percent stated that they have never participated in clinical supervision related to substance abuse; about 65 percent reported that they had not participated in in-service training during the previous year and less than half of the respondents had ever participated in continuing education. Seventy one percent of social workers believed that they had at least a moderate need for training and less than two percent indicated no need for training. Almost 80 percent of social workers feel that additional training would increase their effectiveness at least moderately. Hall and colleagues' (2000) study concludes that substance abuse treatment training is lacking for social workers.

It is especially alarming that almost half of the social workers that responded did not have access to clinical supervision regarding substance abuse. The social work profession has always stressed the importance of clinical supervision; therefore one could conclude that because it is not as accessible in substance abuse settings, social workers who work in substance abuse settings are professionally disadvantaged compared to their social work colleagues who do not work in substance abuse settings (Hall et al., 2000).

Amodeo and Fassler (2000) compared two groups of master level social workers and were interested in on how substance abuse training would impact the social workers ability to work more efficiently with substance abusing clients. One group of master level social workers completed an intense nine month training on substance abuse and the comparison group did not receive the training. To measure the trainee social workers and the comparison group of social workers each were given a self-rated competency assessment and their case load compositions were considered.

Amodeo and Fassler (2000) found that social workers who completed the training worked with over double the amount of clients with substance abuse only and dual diagnosed clients compared to the comparison group. The trainee group also self-rated themselves as more competent in treatment and assessment across all types of substance abuse diagnosis. The trainees self-rated themselves as significantly more competent with their intervention abilities with substance abuse only clients. When looking specifically at caseload composition, the cases were all very complex. “This suggests that MSWs need training that will provide them with the expertise to deal with both legal and illegal drugs, poly drug abuse, the combination of drug abuse and psychiatric illness, and the integrated treatment of drug abuse and multiple psychiatric diagnosis” (Amodeo & Fassler, 2000, p. 639).

Loughran and colleagues (2010) researched social workers’ perceptions of their own role adequacy and role legitimacy when working with substance using clients. Loughran and colleagues (2010) describe role adequacy as feeling knowledgeable about one’s work. Role legitimacy is described as believing one has the right to address clients

on particular issues. These two constructs have been key theoretical concepts to why many professionals are unenthusiastic to work with this population.

Loughran and colleagues (2010) also examined if demographic and professional variables were related to the social workers' perception of role adequacy and role legitimacy. There were two hundred respondents to the web-based survey. Loughran and colleagues (2010) found that not even one fourth of the social workers surveyed reported having little or no training in identifying alcohol and other drug (AOD) difficulties and a little over one third reported none to a little training in regards to AOD intervention. Social workers who had more contact with substance abusing clients and more AOD identification and intervention training were more likely to feel legitimate in their role and also more adequate in their work when working with substance using clients.

Professional variables related to having role legitimacy and role adequacy were having a master's degree and also completion of an AOD licensure test. Social workers who reported working in substance abuse settings reported having more role adequacy as well, but the same was not found in role legitimacy. Also, social workers with more experience tended to feel more adequate and legitimate in their work with substance abusing clients (Loughran et al, 2010). This study supports the idea that training and education is a critical piece for social workers to feel competent in their work with substance users.

Most social workers are not trained appropriately to work with this population. Out of 420 accredited baccalaureate programs and 140 accredited master's programs in social work there is not an agreement on a minimum training essential for practice in the area of substance abuse (McNeece, 2003). Yet, 71 percent of social workers report that

they had dealt with clients that have substance abuse disorders in the past year (O'Neill, 2001). Social Workers have been thought to be less effective than other providers providing chemical dependency services. Social workers believe they do not have the skills and training necessary to provide appropriate interventions within the chemical dependency field. Schools of social work should also better prepare social workers by providing course work related to substance abuse (Brocato & Wagner, 2003).

### **Other Professionals' Views Towards Substance Users**

There are also several studies which address other professionals' views on substance abusers that indicate that education is vital in understanding substance abuse. Several studies explored primary care physicians' opinions on substance abusers and substance abuse. Johnson and colleagues (2005) sampled 648 telephone interviews with primary care physicians regarding their beliefs about substance misuse and treatment. Abed and Munzo (1990) sampled 203 general practitioners regarding their attitudes towards various aspects of addictions treatment. Johnson and colleagues (2005) explain that physicians felt comfortable diagnosing and identifying substance abuse issues yet more than a third of the physicians also reported difficulty discussing substance abuse with their patients. Physicians gave several responses to why they did not address substance abuse with their patients. The most common responses were, "patients often do not tell the truth about their substance use," "time constraints," "questioning the patient's integrity," and "not wanting to frighten or anger the patient" (Johnson et al, 2005, p. 1077). Abed and Munzo (1990) found that 83 percent of general practitioners felt that there was an urgent need for a drug clinic staffed with people who specialize in working with substance abusers. This would imply that these general practitioners felt

uncomfortable with or inadequate when working this specific population. Abed and Munzo found that general practitioners' attitudes toward substance abusers were that they were unreliable patients, that addicts were the cause of their problems, and that drug addiction was not a medical issue (1990).

Both Johnson and colleagues (2005) and Abed and Munzo (1990) explored perceptions towards substance abuse treatment. Johnson and colleagues (2005) found that primary care physicians believed that methods available in the U.S. for treating substance misuse are far less effective compared to treatment effectiveness for other medical conditions. Less than 10 percent of physicians felt that available treatment for substance abuse was "very effective" and that a large amount of physicians actually felt that available treatments were "not too effective" or "not at all effective" (Johnson et al, 2005). Abed and Munzo (1990) found that general practitioners felt that treatment, in regards to prescribing, should be left to the specialist. General Practitioners who have been in practice longer felt more comfortable with managing the drug abusers addiction by treating withdrawal symptoms and medical conditions. Abed and Munzo (1990) also concluded that younger general practitioners had more positive attitudes toward drug abusers. It is unknown why younger general practitioners had more positive attitudes but Abed and Munzo felt that it could have been due to more comprehensive training.

Johnson and colleagues (2005) and Abed and Munzo (1990) both found interesting conclusions from their studies. They both concluded that the doctors in these studies could use more training regarding substance abuse to better effectively work with this substance abuse population and learn how to address substance abuse concerns.

Macdonald and Erickson (1999) measured 89 judges' attitudes towards harm reduction. They found that increased knowledge of substances resulted in an increased likelihood of favoring harm reduction approaches. Hence, education and an understanding seem to be imperative when working with people that struggle with substance abuse.

### **Substances Users and Harm Reduction Interventions**

There are several types of harm reduction interventions; one of the most well known is methadone maintenance programs. People addicted to heroin or other opiates can be prescribed methadone to help ease withdrawal symptoms and assist with cravings. Al-Tayyib and Koester (2011) were specifically interested in client perceptions of the harm reduction modeled treatment for methadone maintenance. While Poel and colleagues (2006) studied client's perceptions of different types of harm reduction services they were receiving. The harm reduction services were placed into two groups. The treatment group included interventions such as methadone maintenance. The care group included services such as day and night shelters for substance abusers, and drug consumption rooms (Poel et al, 2006).

The most popular reasons for clients participating in a methadone maintenance program were to quit using, prevent becoming sick from withdrawal, and to obtain stability and be functional (Al-Tayyib & Koester, 2011). Poel and colleagues (2006) found that almost half of the clients receiving a harm reduction treatment, such as methadone maintenance, wanted more assistance becoming sober or controlling their drug use. About a third even wanted help resolving issues other than their drug use which shows that entering harm reduction treatment for reasons not related to their drug use is

common. Almost 75 percent of clients felt that methadone maintenance was effective with assisting them getting off the opiates (2006). Seeking out assistance, regardless of the reason, is a step in the right direction, as they are making small behavior changes (Poel et al, 2006).

Methadone maintenance is a harm reduction approach which seems to be guided by the clients. Even though sobriety is not the main goal for many participating in methadone maintenance, reducing harm is the goal. This is seen by the client reports on reasons why they choose to take methadone. Some simply need assistance with the sickness associated with withdrawal or just simply to function better and achieve stability (Poel et al, 2006).

Harm reduction is interested in reducing risks directly associated with drug use but also indirectly related to reducing harm in regards to the risky behaviors that tend to coincide with drug use (Marlatt, 1998). Marsch (1998) was interested in the effectiveness of methadone maintenance by measuring client's illicit opiate use, HIV risk behaviors, and criminal involvement while participating in a methadone maintenance program. Marsch (1998) found that clients participating in methadone maintenance reduced their involvement with illicit opiate use. She also found that involvement with methadone maintenance treatment reduced HIV risk behaviors. Methadone maintenance treatment had a small to medium effect on reducing criminal activity, but the majority of criminal activity that was reduced was drug-related criminal activity.

### **Professionals' views towards Harm Reduction Interventions**

Rosenberg and colleagues (2002) were interested in Brittan's substance use treatment agencies' acceptance of clients when they are using pharmacological harm

reduction interventions for substance misuse. Rosenberg and Phillips (2003) were interested in United States substance abuse treatment agencies' acceptance of pharmacological and non-pharmacological harm reduction interventions for substance misuse. Pharmacological interventions include all drug replacement therapies, opiate detoxification interventions, and relapse and overdose prevention. Non-pharmacological interventions include drop in centers for drug users, needle exchange centers, education, and other type of harm reduction therapies that do not involve pharmacological interventions (Rosenberg & Phillips, 2003).

Different substance abuse agencies have different admission guidelines and different substance use providers have different perceptions. During the study in Brittan, Rosenberg and colleagues (2002) found that six percent of the agencies sampled rated none of the pharmacological interventions acceptable. Some agencies accepted a range of some to all interventions as acceptable. The most accepted interventions in both Brittan and the United States was short or long term use of methadone maintenance to treat opiate dependence and dexamphetamine for amphetamine dependence. Many other harm reduction interventions were not found to be acceptable (Rosenberg et al, 2000 & Rosenberg & Phillips, 2003). Rosenberg and Phillips (2003) found that half of the agencies sampled reported somewhat or complete acceptability of a variety of the harm reducing pharmacological and non-pharmacological interventions. Harm reduction therapies range from detoxification, abstinence facilitation, and relapse prevention to needle exchange overdose prevention, and substitute prescribing.

Bonar and Rosenberg (2010) were interested in substance abuse professional's attitudes regarding harm reduction interventions versus traditional interventions for

injecting drug users. Bonar and Rosenberg (2010) found that substance abuse providers rated traditional treatment more much more beneficial than harm reduction interventions. On average, harm reduction interventions were rated neither harmful nor beneficial.

Interestingly enough harm reduction interventions which prevented the spread of blood borne diseases were rated moderately beneficial, but harm reduction interventions that worked toward preventing deaths caused from overdose as more harmful than beneficial (Bonar & Rosenberg, 2010). It is important to note that this study supplied providers with vignettes and had the providers' rate how beneficial different harm reduction interventions could be on that specific vignette.

Goddard (2003) assessed the effectiveness that an educational presentation had on changing professional's attitudes towards harm reduction. This study sampled 137 professionals in the mid-west region after they heard a two hour presentation on harm reduction. A pre and post-test was given to compare the effectiveness that the presentation had on changing attitudes towards harm reduction. Goddard (2003) found that the presentation had an overall significant impact on attitude changes towards harm reduction, as 21 out of the 25 items scored greater acceptance of harm reduction approaches after the presentation.

Hobden and Cunningham (2006) were interested in service providers' attitudes towards anticipated barriers and anticipated benefits of four harm reduction strategies: needle exchange programs, moderate drinking goals, methadone maintenance, and provision of free condoms. Service providers were also asked to define harm reduction, list important aspects of it, and describe what they find troubling but also appealing about harm reduction. Hobden and Cunningham (2006) specifically investigated providers

working in substance abuse agencies in Ontario Canada. Telephone interviews were conducted and recorded and semi-structured surveys were also administered, with a total of 67 respondents.

Perceived and actual barriers of harm reduction were common concerns for providers. Most respondents were not providing needle exchange services or methadone maintenance programs. When asked about implementing these programs, community resistance was the largest perceived barrier. Over 50 percent of the respondents stated that they were concerned with community resistance regarding needle exchange services and almost 60 percent regarding methadone maintenance. About 20 percent of the agencies also thought that needle exchange programs would be seen by the community as promoting drug use. When asked about moderate drinking goals, 95 percent of respondents allowed for moderate drinking outcomes already. When respondents were asked about moderate drinking goals, respondents explained that resistance had been encountered. Respondents reported that they had encountered resistance from other agencies, the alcohol anonymous (AA) community, and even from other staff in their own agency (Hobden & Cunningham, 2006).

Respondents also reported expected and actual benefits of these harm reduction strategies. When asked about expected benefits of needle exchange programs, about 60 percent indicated that it would reduce the spread of HIV and other STDS and almost 30 percent indicated that it could encourage IV drug users to seek therapy. When asked about expected benefits of methadone maintenance programs, about 30 percent indicated that this program improves health and reduces disease of IV drug users, almost 30 percent reported it is an effective way to get heroin addicts off heroin, about 25 percent

reported it would result in decreased criminal activity, and 13 percent thought it could engage IV users to counseling services (Hobden & Cunningham, 2006). When asked about benefits of moderate drinking goals, almost 20 percent of respondents reported that these types of goals were introduced due to client demand, almost 40 percent of respondents reported that was appropriate for some clients and almost 20 percent of respondents reported that abstinence was an unrealistic goal.

Hobden and Cunningham (2006) also found that there was little agreement concerning the definition of harm reduction. Only 23 percent defined harm reduction as reducing harm associated with the substance use. Over half of the respondents fell into the “other” category.

Hobden and Cunningham (2006) also researched important elements and troubling aspects of harm reduction. The most important elements of harm reduction indicated by the respondents were increasing client awareness and education and client choice. The most appealing aspects were: it gives client choice, it is client centered, and it’s non-judgmental. The most troubling aspects found were that harm reduction is not in the best interest of the client and harm reduction is often misunderstood and misapplied.

Mancini and colleagues (2008) focused on views and perceptions towards harm reduction. The study specifically focused on clinical staff views employed in a housing program, Place for People Inc. A mixed-method study was used to assess views and perceptions using a questionnaire and a one-time focus group. Positive views of harm reduction were found. The survey found that over 80 percent of participants agreed that harm reduction was an effective form of treatment and that “a legitimate goal of treatment is to help people reduce their substance use to a level that allows them to

function effectively in society” (Mancini et al, p.395, 2008). Correspondingly, 90 percent disagreed that abstinence is the only goal for substance use (Mancini et al, 2008).

The focus groups also expressed negative aspects of harm reduction. The two main negative aspects found were lack of consequences or enabling and ambiguity of the approach. When discussing how harm reduction could be enabling it was reported that while clients continue to use substances, practicing harm reduction can shield them from natural consequences. When ambiguity of the approach was discussed, “several participants noted that the harm reduction approach lacked concrete methods of implementation and were frustrated with its ambiguity regarding long-term outcomes” (Mancini et al, p.400, 2008).

### **Conceptual Framework**

Harm reduction in chemical dependency services is a newer concept to the social services field. “Harm reduction is a conceptual framework that provides for individuals willing to be engaged in services, but not immediately seeking abstinence” (MacMaster, p.358, 2004). Mainstream abstinent-only treatment services demand that clients be sober and are immediately ready to change their negative behaviors at the time they come into treatment or engage with services. Practicing from a harm reduction model allows clients to engage in services no matter what stage of change they are in.

There are five stages of change that a client could be in depending on the behavior they are attempting to change. For substance abusers, clients are seeking to change behaviors that are related to their substance abuse. Prochaska and Prochaska developed the stages of change theory. The stages of change according to Prochaska and Prochaska are: pre-contemplation, contemplation, preparation, action, maintenance and termination (Prochaska & Prochaska, 2009).

When clients are in the pre-contemplative stage of change, they do not accept that there is a problem. Therefore, they have no reason to believe change is necessary. At the contemplative stage, clients want to take action eventually, but they are not yet dedicated to change. They are also aware that a problem exists. The preparation stage is when clients start to prepare for changes and intend to take action soon. The action stage is when people are actively making positive changes. This stage typically lasts about six months. After the six months, clients are typically in the Maintenance stage. At this point clients do not need to work as hard towards the changes but instead are focused on maintaining the changes they have already made (Prochaska & Prochaska, 2009).

Harm reduction allows for clients to engage in services no matter what stage of change they are in. When traditional abstinence-based treatment models are used, clients are expected to be in the action stage or preparation stage of change, as they need to be abstinent from all substances. Clients that are at a pre-contemplative or contemplative stage do not have the option to engage in services and go through the appropriate stages of change.

Once clients are engaged they can start to think about their substance use as a problem and explore what it would be like to make changes to reduce their drug use or end their drug use. A way that service providers guide clients through the process of change is through Motivational Interviewing.

Motivational interviewing seems to work well with the substance abusing populations and overlaps well in harm reduction treatment settings. It is a change from the traditional abstinent-only approach. Using motivational interviewing and practicing from a harm reduction approach allows substance users to be unsure of how they feel about changing their negative behaviors and explore what change could look like (Wagner, 2008).

There are five main principles of motivational interviewing, as described by Miller and Rollnick (2002). Those principles are conveying empathy, developing discrepancy, avoiding argumentation, rolling with resistance, and supporting self-efficacy. These principles of motivational interviewing are what make the concept unique. Unlike traditional treatment models, motivational interviewing does not confront problems directly. It works with the person by exploring if and what problems exist in their lives and how to overcome ambivalence about changing negative behavior. In

substance abuse settings, the clients explore ambivalence about reducing substance use or reducing harm related to their substance use (Miller and Rollnick, 2002).

According to Rollnick and Miller (1995) there are several key components to motivational interviewing. Motivation to change must be obtained from the client. Resolving ambivalence is the client's task, not the counselor's. Direct persuasion is not helpful when the client is attempting to resolve ambivalence. The style of counseling is soft and eliciting the counselor is directive, not confrontational. When helping the client explore their ambivalence, readiness to change is a changing product of interpersonal interaction, not a client trait. Lastly, the therapeutic relationship is like a partnership. Motivational interviewing starts working with the client at where they are in their stage of change (Wagner, 2008).

Meeting the client where they are is a social work norm that parallels with the harm reduction model. Carl Rogers founded client-centered therapy. This therapy, along with motivational interviewing, does not confront or lead the client during their process of change. It allows the client to lead their treatment, as Rogers felt that clients have an innate motivation to change and find meanings within their lives. According to this theory, if therapists are genuine and authentic, have unconditional positive regard, and have an empathetic understanding towards their clients, growth and positive change will naturally occur (Wade, 2009).

The stages of change theory, principles and components of motivational interviewing, and the core concepts of client-centered therapy overlap with harm reduction principles. Harm reduction philosophy is much different than the mainstream

abstinent-based treatment model by allowing for more options. It is people's right to make informed choices and be provided with options.

## **Methods**

### **Research Question**

This study examined clinical social workers' beliefs towards harm reduction in regard to substance use. The study was interested in clinical social workers' beliefs about harm reduction, beliefs about characteristics of substance users, and beliefs about substance use treatment options. By using the Substance Abuse Treatment Survey (SATS) (Housenbold Sieger, 2005) clinical social workers' beliefs were measured. The study was also interested in any impact that demographic or professional variables might have with beliefs towards harm reduction. The following section includes: a description of who was surveyed, how participants were protected, how participants were surveyed, what measurement tool was used, and how the results were analyzed.

### **Sample**

The target population of this study was clinical social workers. A sample was taken of licensed independent clinical social workers (LICSW) and licensed graduate social workers (LGSW). A mixed-method sampling was used, consisting of convenience and snowball sampling.

The convenience sampling was used by contacting clinical social workers in rural and urban settings in which relationships are already established. Once clinical social workers in both settings agreed to participate in the survey, snowball sampling was used. Clinical social workers were asked to provide e-mail or mailing addresses for other potential candidates.

This convenience sampling has limitations. In this study, only clinical social workers were contacted where pre-existing relationship was established, as it was

convenient and accessible. Snowball sampling also has its limitations. A bias could have occurred, as the referred social worker might have had similar views as the social worker who did the referring. This sample was not intending to represent all clinical social workers and was also a limitation of the study.

This study has the ability to somewhat generalize clinical social workers' views towards harm reduction, as many different types of social workers were sampled. Clinical social workers in both rural and urban settings were chosen to be sampled for a more accurate portrayal of clinical social workers in Minnesota. Even though the sampling methods may have had potential biases, clinical social workers have differences in training, education, and personal experiences which impact beliefs towards treatment models.

### **Research Design**

This study examined clinical social workers' beliefs towards harm reduction. Survey research was conducted to gather information. A cross sectional self-administered questionnaire was e-mailed to clinical social workers. It will be preferred that e-mail surveys were used, but if e-mail was not an option for some of the clinical social workers, a mailed copy was available but not utilized. Accompanying the survey was a letter introducing the survey along with a statement of informed consent (Appendix B) which explained the survey and the purpose.

### **Protection of Participants**

The research was designed to protect its participants. Participants were provided with an explanation of informed consent at the beginning of the survey (Appendix B). The study was conducted on-line through Qualtrics. Qualtrics is a web-based survey

software which is available through the School of Social Work at St. Catherine University and the University of St. Thomas.

The e-mail survey was anonymous and conducted through Qualtrics. There was no way to connect a response from a survey to a specific respondent. No names or locations were provided to protect the anonymity of the respondents.

There were no identified risks or benefits associated with the participation in the study. The target population was clinical social workers which are not a vulnerable population. The study was proposed and granted approval by the University of St. Thomas Institutional Review Board.

### **Measurement**

To measure social workers' beliefs about harm reduction, this study used items on the pre-existing tool, The Substance Abuse Treatment Survey (SATS). The SATS was developed to specifically measure attitudes towards harm reduction in the treatment of substance abusers by Housenbold Seiger (2005). The SATS developed out of a previous survey which was also created by Housenbold Seiger, the Staff Attitudes and Awareness of Harm Reduction survey (SAHHR). Housenbold Seiger (2005) explains that, "The SATS is a more manageable and concise version of the original SAAHR survey, which comprised 54 attitudinal items, a series of demographic items, and clinical case vignette with six questions" (p.52). The SAAHR was developed to measure hospital employees' attitudes toward principles of harm reduction, therefore it needed to be renovated to measure therapists' attitudes. Harm reduction is a newer concept to the clinical community and there was no existing tool that measured attitudes of harm reduction principles and use of harm reduction (Housenbold Seiger, 2005).

When Housenbold Seiger created the SAAHR, which the SATS grew out of, Caplehorn and colleagues' (1996) tool, the Substance Abuse Attitudes Survey, was taken into consideration during the development of the SAAHR. Caplehorn's et al tool measured attitudes and beliefs about methadone maintenance. Methadone maintenance is an example of a harm reduction strategy; therefore items addressing the strategy on this tool were adapted for the use of the SAAHR (Housenbold Seiger, 2005).

The Staff Attitudes and Awareness of Harm Reduction survey (SAHHR) was reviewed by a harm reduction panel of experts. The panel reviewed accuracy and ease of reading and understandability (Housenbold Seiger, 2005). As discussed earlier, the original SAHHR was developed to measure hospital employees' attitudes therefore, when the SAAHR was redesigned to measure therapists' attitudes, Housenbold Seiger conducted trial runs on social workers. Two pre-tests were completed to measure bachelor level social workers and social workers working in the substance abuse treatment field. Feedback was taken from the pre-tests to develop an appropriate tool to measure therapist's attitudes on harm reduction, the SATS. After the SATS was developed, a pilot study was conducted. The pilot study was given to twenty master level social work students to confirm its reliability and validity. Feedback from the pilot study was addressed which created the final version of the SATS (Housenbold Seiger, 2005).

The SATS measures three main constructs as described by Housenbold Seiger. The constructs are: Beliefs about Harm Reduction (BHR), Beliefs About Characteristics of Substance Users (BCU), and Substance Abuse Treatment Beliefs (SATB). Each subscale was carefully defined by Housenbold Seiger. The Beliefs about Harm Reduction (BHR) subscale is measured by 13 items in the SATS. Housenbold Seiger (2005)

describes this subscale as, "...techniques therapists can use to help abusing client's reduce the use and harm of substance abuse while not being totally abstinent" p. 55.

Examples of these items include: "reducing substance use is a legitimate goal for individuals who are not ready to become abstinent" and "teaching intravenous drug users to inject safely is negligent."

The Beliefs About Characteristics of Users (BCU) subscale is measured by 11 items on the SATS. This subscale is defined as, "...therapists beliefs about the characteristics, habits, and attributes of substance-abusing individuals" (Housenbold Seiger, 2005, p. 55). Examples of these items include: "substance abusers always have a psychiatric disorder" and "for substance users, one drink or drug leads to relapse."

The Substance Abuse Treatment Beliefs (SATB) subscale is measured by 11 items on the SATS. It is defined as, "...therapist's or treatment staff's beliefs about the treatment of substance-abusing individuals" (Housenbold Seiger, 2005, p. 56). Examples of these items include: "relapsing individuals should be allowed to remain in treatment" and "the primary goal of treatment is abstaining from all substances"(pg #).

There are a total of 35 items on the SATS and 3 clinical vignettes. The 35 attitudinal items are measured by a likert scale ranging from strongly agree to strongly disagree. The clinical vignettes were designed to further explore therapist's attitudes in a different way (Housenbold Seiger, 2004). This study used a total of 9 items, 3 items in each subscale. This study will not be using any of the clinical vignettes. Permission from Belinda Housenbold Seiger was achieved before the use of the SATS was utilized for this study.

The main research questions include: First, what are social workers' beliefs about harm reduction principles? Second, what are social workers' beliefs about substance users? Third, what are social workers' beliefs about harm reduction treatment options? Three questions on the SATS will be used to measure each sub-question.

To measure social workers' beliefs about substance use harm reduction principles (BHR), items 4, 7 and 27 on the SATS were used. Those items are: "reducing substance use is a legitimate treatment goal for individuals who are not ready to become abstinent," "reducing the harmful consequences of substance abuse is as important as achieving abstinence," and "psychotherapy for individuals actively using drugs, enables continuing use" (Housenbold Seiger, 2004). The items recoded on the survey created for this study (Appendix C) were 12- 2, 12-4, and 12-9.

To measure social workers' beliefs about substance users (BCU), items 6, 22, and 24 on the SATS were used. Those items are: "substance-abusing individuals who believe they quit on their own are in denial," "some individuals can use drugs recreationally without becoming dependent," and "some drug users manage their use so well that there are no perceived problems" (Housenbold Seiger, 2004). The items recoded on the survey created for this study (Appendix C) were 12-3, 12-6, and 12-7.

To measure social workers' beliefs about substance abuse treatment options (SATB), items 2, 8 and 25 were used. Those items include: "controlling drinking is an effective treatment for some binge drinkers," "the primary goal of treatment should be abstaining from all substances," and "relapsing individuals should be allowed to remain in treatment for substance abuse" (Housenbold Seiger, 2004). The items recoded on the survey created for this study (Appendix C) were 12-1, 12-5, and 12-8.

### Findings

This study examined clinical social workers' beliefs towards harm reduction when working with substance using clients. Based on the conceptual model, professional and demographic variables were used as the independent variable and clinical social workers' beliefs toward harm reduction principles, beliefs about characteristics of substance users, and beliefs about harm reduction treatment options were used as the dependent variable. Statistical Package for the Social Sciences (SPSS 19.0) was used for to analyze descriptive an inferential statistics.

As shown in Table 1, the respondent's gender was measured on a nominal scale and classified as male or female (1). The findings in Table 1 show that nine respondents (37.5%) are male and 15 respondents (62.5%) are female. These findings show that the majority of the sample is female. The respondent's number of years of experience was measured on an ordinal scale and classified as four years or less, five to nine years, 10 to 19 years or 20 years or more (2). Results indicate that eight respondents (33.3%) have four years or less years of experience, six respondents (25%) have five to nine years of experience, six respondents (25%) have 10 to 19 years of experience and four respondents (20%) have 20 years or more of experience.

Type of profession was measured and coded as clinician or therapist, supervisor, substance abuse counselor, social worker, case manager, or other (3). Ten respondents (41.7%) identified themselves as clinicians or therapists, seven respondents (29.2%) as social workers, three respondents (12.5%) as supervisors, one (4.2%) respondent as a substance use counselor, one respondent (4.2%) as a case manager, and two respondents (6.7%) responded as other.

The type of employment setting was measured as outpatient mental health, outpatient dual diagnosis, halfway house, hospital or clinic, school, or other (4). Twelve respondents (50%) are employed in an outpatient mental health setting, three respondents (12.5%) were employed in an outpatient dual diagnosis setting, one respondent (4.2%) was employed in a halfway house, one respondent (4.2%) was employed in a hospital or clinic, two respondents (8.3%) were employed in a school and five respondents (20.8%) responded as other. These findings show a wide range of employment settings and that half of the respondents are employed in an outpatient mental health setting.

The respondents' employment region was measured using a nominal scale (5). The response options were: yes, I am employed in the twin cities seven-county metro, Rochester, St. Cloud or Duluth (urban) or no, I am not employed in the twin cities seven-county metro, Rochester, St. Cloud, or Duluth (rural). Table 1 shows that 11 respondents (45.8%) were employed in an urban area and 13 respondents (54.2%) were employed in a rural area.

Respondents' previous employment experience in the chemical dependency field was measured on a nominal scale and classified as yes or no (6). This variable measures how many respondents have ever or have never worked in the chemical dependency field in this sample. Nine respondents (39.1%) have worked in the chemical dependency field and 14 respondents (60.9%) have never worked in the chemical dependency field.

Previous training in chemical dependency or substance abuse was measured on a nominal scale (7). The response options were: yes, I have had training or no, I have not had training. This question measures how many respondents have had training in chemical dependency or substance abuse in this sample. Sixteen respondents (66.7%)

have had training in chemical dependency while eight respondents (33.3%) have not had training in this area.

Previous training in harm reduction was measured on a nominal scale and measured as: yes, I have had training in harm reduction or no, I have not had training in harm reduction (8). Table 1 shows that 13 respondents (54.2%) have had training in harm reduction and 11 respondents (45.8%) have not had training in harm reduction.

Respondents' level of awareness of harm reduction was measured on an ordinal scale (9). The response options included: not at all aware, somewhat aware, and very well aware. Four respondents (16.7%) were not at all aware, 15 respondents (62.5%) were somewhat aware and five respondents (20.8%) are very well aware. These findings show a large majority have at least some awareness of harm reduction.

The respondents' feelings toward sufficient training in chemical dependency was measured on a nominal scale and classified as: yes or no (10). This question measured how many respondents felt the training received in chemical dependency or substance abuse was sufficient. Nine respondents (37.5%) felt that their training has been sufficient and 15 respondents (62.5%) felt that their training has not been sufficient.

The last variable measured was nominal and was interested in if respondents' social work education has been sufficient. The response options were: yes, it has been sufficient or no, it has not been sufficient (11). This question measured how many respondents felt that their social work education was sufficient or not sufficient. Table 1 shows that 10 respondents (41.7%) felt their education was sufficient and 14 respondents (58.3%) felt that their education was not sufficient.

Table 1. *Descriptive Analysis*

Variable		N	%
Gender	Male	9	37.5
	Female	15	62.5
Years of Experience	4 years	8	33.3
	5 to 9 years	6	25
	10 to 19 years	6	25
	20 years or more	4	16.7
Type of Profession	Clinician or therapist	10	41.7
	Social work or clinical supervisor	3	12.5
	Substance Abuse Counselor	1	4.2
	Social worker	7	29.2
	Case manager	1	4.2
	Other	2	8.3
Employment Setting	Outpatient mental health	12	50
	Outpatient dual diagnosis	3	12.5
	Halfway house	1	4.2
	Hospital or clinic	1	4.2
	School	2	8.3
	Others <sup>1</sup>	5	20.8
Employment Region	Urban <sup>2</sup>	11	45.8
	Rural	13	54.2
Work History in the CD/SA	Yes	9	39.1
	No	14	60.9
Previous Training in CD/SA	Yes	16	66.7
	No	8	33.3
Training in Harm Reduction	Yes	13	54.2
	No	11	45.8
Awareness of Harm Reduction	Not at all aware	4	16.7
	Somewhat aware	15	62.5
	Very well aware	5	20.8
Sufficient Training in CD/SA	Yes	9	37.5
	No	15	62.5
Sufficient Education in Social Work	Yes	10	41.7
	No	14	58.3

*Note 1.* Others include college, community mental health center, home-based mental health services, intensive community rehabilitation, non-profit disease organization; *2.* Urban region includes 7 county metro, Rochester, St. Cloud, and Duluth.

### **Inferential Analysis**

**Beliefs towards Harm Reduction Principles (BHR).** This study measures clinical social workers' beliefs towards harm reduction principles (BHR) as a three-item scale. This scale is operationalized with the items: "Reducing substance use is a legitimate treatment goal for individuals"; "Reducing the harmful consequences of substance abuse is as important as achieving abstinence"; and "Psychotherapy for individuals actively using drugs enables continued use". The possible options range from 1 "Strongly Disagree" to 4 "Strongly Agree". This study investigates if professional or demographic variables are related to clinical social workers' beliefs towards harm reduction.

One of the research questions for this study is: Is a respondent's gender related to their beliefs towards harm reduction principles (BHR)? The research hypothesis for this study is: Gender is related to respondents' beliefs towards harm reduction principles. The null hypothesis for this study is: There is no relation between a respondent's gender and their beliefs towards harm reduction principles (BHR).

Table 2 shows the results of the t-test comparing the mean scores of respondents' BHR by gender. Male respondents have higher levels of BHR (Mean Score=10.00) than female respondents (Mean Score=9.78). The mean difference between the two groups is .21. The t-value is .37 with the p-value of .71. Since the p-value is greater than .05, the null hypothesis is accepted. Therefore, there is no statistically significant difference found between the respondents' gender and their belief's towards harm reduction principles (BHR) in this dataset.

An additional research question for this study is: Is a respondent's profession related to their beliefs towards harm reduction principles (BHR)? The research hypothesis for this question is: Profession is related to respondents' beliefs towards harm reduction principles. The null hypothesis for this study is: There is no relation between a respondent's professional identity and their beliefs towards harm reduction principles (BHR).

Table 2 shows the results of the t-test comparing the mean scores of respondents' BHR by professional identity. Respondents who identified professionally as a clinical social worker or clinical supervisor have higher levels of BHR (Mean score=9.92) than other respondents (Mean Score=9.82). The mean difference between the two groups is .10. The t-value is .17 with the p-value of .86. Since the p-value is greater than .05, the null hypothesis is accepted. Therefore, there is no statistically significant difference found between respondents' professional identity and their beliefs towards harm reduction principles (BHR) in this dataset.

Another research question for this study is: Is a respondent's employment region related to their beliefs towards harm reduction principles? The research hypothesis for this question is: Employment region is related to respondents' beliefs toward harm reduction principles. The null hypothesis is: There is no relation between a respondent's employment region and their beliefs toward harm reduction principles (BHR).

Table 2 shows the results of the t-test comparing the mean scores of respondents' BHR by employment region. Respondents employed in an urban area have higher levels of BHR (Mean Score=10.10) than respondents employed in a rural setting (Mean Score=9.70). The mean difference between the two groups is .40. The t-value is .72 with

the p-value of .48. Since the p-value is greater than .05, the null hypothesis is accepted. Therefore, there is no statistically significance difference found between respondents' employment region and their beliefs towards harm reduction principles (BHR) in this dataset.

Another research question for this study is: Is a respondent's employment history related to their beliefs towards harm reduction principles? The research hypothesis for this question is: Employment history is related to respondents' beliefs towards harm reduction principles. The null hypothesis is: There is no relation between a respondent's employment history and their beliefs toward harm reduction principles (BHR).

Table 2 shows the results of the t-test comparing mean scores of respondents' BHR by employment history. Respondents who have had experience working in the chemical dependency or substance abuse field have higher levels of BHR (Mean Score=10.67) than respondents who have not had experience working in the chemical dependency or substance abuse field (Mean Score=9.38). The mean difference between the two groups is 1.29. The t-value is 2.45 with the p-value of .02. Since the p-value is less than .05, the null hypothesis is rejected. Therefore, there is a statistically significant difference found between respondents' employment history and their beliefs towards harm reduction principles (BHR) in this dataset.

Another research question for this study is: Is a respondent's training history related to their beliefs towards harm reduction? The research hypothesis for this question is: Training history is related to respondents' beliefs toward harm reduction principles. The null hypothesis is: There is no relation between the respondent's employment history and their beliefs towards harm reduction principles (BHR).

Table 2 shows the results of the t-test comparing the means of respondents' BHR by training history. Respondents who have had training in the chemical dependency or substance abuse field have higher levels of BHR (Mean Score=10.31) than respondents who have not had training in chemical dependency or substance abuse (Mean Score=8.86). The mean difference between the two groups is 1.45. The t-value is 2.77 with the p-value of .01. Since the p-value is less than .05, the null hypothesis is rejected. Therefore, there is a statistically significant difference between respondents' training history and their beliefs towards harm reduction principles (BHR) in this dataset.

Another research question for this study is: Is a respondent's perception of their training sufficiency related to their beliefs toward harm reduction principles? The research hypothesis is: A respondent's perception of their training sufficiency in chemical dependency or substance abuse is related to their beliefs toward harm reduction principles. The null hypothesis is: There is no relation between a respondent's perception of their training sufficiency and their beliefs towards harm reduction principles (BHR).

Table 2 shows the results of the t-test comparing the means of respondents' BHR by perception of their training sufficiency in chemical dependency or substance abuse. Respondents who feel their training in the chemical dependency or substance abuse was sufficient have higher levels of BHR (Mean Score=10.56) than respondent's who felt their training was not sufficient (Mean Score=9.43). The mean difference between the two groups is 1.13. The t-value is 2.15 with the p-value of .04. Since the p-value is less than .05, the null hypothesis is rejected. Therefore, there is a statistically significant difference between respondents' perceived training sufficiency in chemical dependency

and substance abuse and their beliefs towards harm reduction principles (BHR) in this dataset.

Table 2. *T-Test Results for BHR by Variables*

Variable	Value	Mean Score	T-value	P
Gender	Male	10.00	.371	.71
	Female	9.76		
Profession	Clinical social worker	9.92	.17	.86
	Other	9.82		
Employment region	Urban	10.10	.72	.48
	Rural	9.70		
History working in CD/SA	Yes	10.67	2.45	.024
	No	9.38		
Previous training in CD/SA	Yes	10.31	2.77	.012
	No	8.86		
Sufficient training in CD /SA	Yes	10.56	2.15	.043
	No	9.43		

\* $p < .05$

**Beliefs About Characteristics of Users (BCU).** This study measures the participant's beliefs towards substance users (BCU) as a three-item scale. This scale is operationalized with the items: "Substance-abusing individuals who believe they can quit on their own are in denial"; "Some individuals can use drugs recreationally without becoming dependent"; and "Some drug users manage their drug use so well that there are no perceived problems". The possible options range from 1 "Strongly Disagree" to 4 "Strongly Agree". This study investigates if professional or demographic variables are related to clinical social workers' beliefs towards substance users.

One of the research questions for this study is: Is a respondent's gender related to their beliefs towards substance users (BCU)? The research hypothesis for this study is: Gender is related to respondents' beliefs towards substance users. The null hypothesis for

this study is: There is no relation between a respondent's gender and their beliefs towards substance users (BCU).

Table 3 shows the results of the t-test comparing the mean scores of respondents' BCU by gender. Male respondents have higher levels of BCU (Mean Score = 9.11) than female respondents (Mean Score = 8.57). The mean difference between the two groups is .54. The t-value is 1.43 with the p-value of 1.67. Since the p-value is greater than .05, the null hypothesis is accepted. Therefore, there is no statistically significant difference found between respondents' gender and their belief's towards substance users (BCU) in this dataset.

Another research question for this study is: Is a respondent's profession related to their beliefs towards substance users (BCU)? The research hypothesis for this question is: Profession is related to respondents' beliefs towards substance users. The null hypothesis for this study is: There is no relation between a respondent's professional identity and their beliefs towards substance users (BCU).

Table 3 shows the results of the t-test comparing the mean scores of respondents' BCU by professional identity. Respondents who identified professionally as a clinical social worker or clinical supervisor have lower levels of BCU (Mean score=8.67) than other respondents (Mean Score=8.91). The mean difference between the two groups is .24. The t-value is -.64 with the p-value of .53. Since the p-value is greater than .05, the null hypothesis is accepted. Therefore, there is no statistically significant difference found between respondents' professional identity and their beliefs towards substance users (BCU) in this dataset.

Another research question for this study is: Is a respondent's employment region related to their beliefs towards substance users (BCU)? The research hypothesis for this question is: Employment region is related to respondents' beliefs towards substance users. The null hypothesis is: There is no relation between a respondent's employment region and their beliefs toward substance users (BCU).

Table 3 shows the results of the t-test comparing the mean scores of respondents' BCU by employment region. Respondents employed in an urban area have lower levels of BCU (Mean Score=8.50) than respondents employed in a rural setting (Mean Score=9.00). The mean difference between the two groups is .50. The t-value is -1.34 with the p-value of .19. Since the p-value is greater than .05, the null hypothesis is accepted. Therefore, there is no statistically significance difference found between respondents' employment region and their beliefs substance users (BCU) in this dataset.

Another research questions for this study is: Is a respondent's employment history related to their beliefs towards substance users (BCU)? The research hypothesis for this question is: Employment history is related to respondents'' beliefs towards substance users. The null hypothesis is: There is no relation between a respondent's employment history and their beliefs toward substance users (BCU).

Table 3 shows the results of the t-test comparing mean scores of respondents' BCU by employment history. Respondents who have had experience working in the chemical dependency or substance abuse field have lower levels of BCU (Mean Score=8.67) than respondents who have not had experience working in the chemical dependency or substance abuse field (Mean Score=8.92). The mean difference between the two groups is .25. The t-value is -.64 with the p-value of .53. Since the p-value is

greater than .05, the null hypothesis is accepted. Therefore, there is no statistically significant difference found between respondents' employment history and their beliefs towards substance users (BCU) in this dataset.

Another research question for this study is: Is a respondent's training history related to their beliefs towards substance users (BCU)? The research hypothesis for this question is: Training history is related to respondents' beliefs towards substance users. The null hypothesis is: There is no relation between the respondent's training history and their beliefs towards substance users (BCU).

Table 3 shows the results of the t-test comparing the means of respondents' BCU by training history. Respondents who have had training in the chemical dependency or substance abuse field have higher levels of BCU (Mean Score=8.88) than respondents who have not had training in chemical dependency or substance abuse (Mean Score=8.57). The mean difference between the two groups is .31. The t-value is .74 with the p-value of .47. Since the p-value is greater than .05, the null hypothesis is accepted. Therefore, there is no statistically significant difference between respondents' training history and their towards beliefs substance users (BCU) in this dataset.

Another research question for this study is: Is a respondent's perception of their training sufficiency related to their beliefs towards substance users (BCU)? The research hypothesis is: A respondent's perception of their training sufficiency in chemical dependency or substance abuse is related to their beliefs toward substance users. The null hypothesis is: There is no relation between respondents' perceptions of their training sufficiency and their beliefs towards substance users (BCU).

Table 3 shows the results of the t-test comparing the means of respondents' BCU by respondents' perception of their training sufficiency in chemical dependency or substance abuse. Respondents who feel their training in the chemical dependency or substance abuse was sufficient have higher levels of BHR (Mean Score=9.11) than respondents who felt their training was not sufficient (Mean Score=8.57). The mean difference between the two groups is .54. The t-value is 1.43 with the p-value of 1.70. Since the p-value is greater than .05, the null hypothesis is accepted. Therefore, there is no statistically significant difference between respondents' perceived training sufficiency in chemical dependency and substance abuse and their beliefs towards substance abusers (BCU) in this dataset.

Table 3. *T-Test Results for BCU by Variables*

Variable	Value	Mean Score	T-value	P
Gender	Male	9.11	1.43	.16
	Female	8.57		
Profession	Clinical social worker	8.67	-.64	.53
	Other	8.91		
Employment region	Urban	8.50	-1.34	.19
	Rural	9.00		
History working in CD/ SA	Yes	8.67	-.64	.53
	No	8.92		
Previous training in CD/ SA	Yes	8.88	.74	.47
	No	8.57		
Sufficient training in CD/SA	Yes	9.11	1.43	.17
	No	8.57		

**Substance Abuse Treatment Beliefs (SATB).** This study also measures clinical social workers' beliefs towards substance abuse treatment options (SATB) as a three-item scale. This scale is operationalized with the items: "Controlling drinking is an effective

treatment for some binge drinkers”; “The primary goal of treatment should be abstaining from all substances”; and “Relapsing individuals should be allowed to remain in treatment for substance abuse”. The possible options range from 1 “Strongly Disagree” to 4 “Strongly Agree”. This study investigates if professional or demographic variables are related to clinical social workers’ beliefs towards substance abuse treatment options.

One of the research questions for this study is: Is a respondent’s gender related to their beliefs towards substance abuse treatment options (SATB)? The research hypothesis for this study is: Gender is related to respondents’ beliefs towards substance abuse treatment options. The null hypothesis for this study is: There is no relation between a respondent’s gender and their beliefs towards substance abuse treatment options (SATB).

Table 4 shows the results of the t-test comparing the mean scores of respondents’ SATB by gender. Male respondents have higher levels of SATB (Mean Score = 9.22) than female respondents (Mean Score = 8.79). The mean difference between the two groups is .43. The t-value is .69 with the p-value of .50. Since the p-value is greater than .05, the null hypothesis is accepted. Therefore, there is no statistically significant difference found between respondents’ gender and their beliefs towards substance abuse treatment options (SATB) in this dataset.

Another research question for this study is: Is a respondent’s profession related to their beliefs towards substance abuse treatment options (SATB)? The research hypothesis for this question is: Profession is related to respondents’ beliefs towards substance abuse treatment options. The null hypothesis for this study is: There is no relation between a respondent’s professional identity and their beliefs towards substance abuse treatment options (SATB).

Table 4 shows the results of the t-test comparing the mean scores of respondents' SATB by professional identity. Respondents who identified professionally as a clinical social worker or clinical supervisor have higher levels of SATB (Mean score=9.33) than other respondents (Mean Score=8.55). The mean difference between the two groups is .78. The t-value is 1.31 with the p-value of .20. Since the p-value is greater than .05, the null hypothesis is accepted. Therefore, there is no statistically significant difference found between respondents' professional identity and their beliefs towards substance abuse treatment options (SATB) in this dataset.

Another research question for this study is: Is a respondent's employment region related to their beliefs towards substance abuse treatment options? The research hypothesis for this question is: Employment region is related to respondents' beliefs towards substance abuse treatment options. The null hypothesis is: There is no relation between a respondent's employment region and their beliefs toward substance abuse treatment options (SATB).

Table 4 shows the results of the t-test comparing the mean scores of respondents' SATB by employment region. Respondents employed in an urban area have lower levels of SATB (Mean Score=8.80) than respondents employed in a rural setting (Mean Score=9.08). The mean difference between the two groups is .28. The t-value is -.442 with the p-value of .66. Since the p-value is greater than .05, the null hypothesis is accepted. Therefore, there is no statistically significance difference found between respondents' employment region and their beliefs substance abuse treatment options (SATB) in this dataset.

Another research questions for this study is: Is a respondent's employment history related to their beliefs towards substance treatment options? The research hypothesis for this question is: Employment history is related to respondents' belief towards substance abuse treatment options. The null hypothesis is: There is no relation between a respondent's employment history and their beliefs toward substance abuse treatment options (SATB).

Table 4 shows the results of the t-test comparing mean scores of respondents' SATB by employment history. Respondents who have had experience working in the chemical dependency or substance abuse field have higher levels of SATB (Mean Score=9.22) than respondents who have not had experience working in the chemical dependency or substance abuse field (Mean Score=8.77). The mean difference between the two groups is .45. The t-value is .69 with the p-value of .50. Since the p-value is greater than .05, the null hypothesis is accepted. Therefore, there is no statistically significant difference found between respondents' employment history and their beliefs towards substance treatment options (SATB) in this dataset.

Another research question for this study is: Is a respondent's training history related to their beliefs towards substance abuse treatment options? The research hypothesis for this question is: Training history is related to respondents' beliefs toward substance abuse treatment options. The null hypothesis is: There is no relation between a respondent's employment history and their beliefs substance abuse treatment options (SATB).

Table 4 shows the results of the t-test comparing the means of respondents' SATB by training history. Respondents who have had training in the chemical dependency or

substance abuse field have higher levels of SATB (Mean Score=9.44) than respondents who have not had training in chemical dependency or substance abuse (Mean Score=7.86). The mean difference between the two groups is 1.58. The t-value is 2.71 with the p-value of .01. Since the p-value is less than .05, the null hypothesis is rejected. Therefore, there is a statistically significant difference between the respondents' training history and their beliefs towards substance abuse treatment options (SATB) in this dataset.

Another research question for this study is: Is a respondent's perception of their training sufficiency related to their beliefs towards substance abuse treatment options? The research hypothesis is: A respondent's perception of their training sufficiency in chemical dependency or substance abuse is related to their beliefs toward substance abuse treatment options. The null hypothesis is: There is no relation between a respondent's perception of their training sufficiency and their beliefs towards substance treatment options (SATB).

Table 4 shows the results of the t-test comparing the means of respondents' SATB by respondent's perception of their training sufficiency in chemical dependency or substance abuse. Respondents who feel their training in the chemical dependency or substance abuse was sufficient have higher levels of BHR (Mean Score=9.22) than respondent's who felt their training was not sufficient (Mean Score=8.79). The mean difference between the two groups is .43. The t-value is .69 with the p-value of .50. Since the p-value is greater than .05, the null hypothesis is accepted. Therefore, there is no statistically significant difference between the respondent's training sufficiency in

chemical dependency and substance abuse and their beliefs towards substance abuse treatment options (SATB) in this dataset.

Table 4. *T-Tests for SATB by Variables*

Variable	Value	Mean Score	T/F	P
Gender	Male	9.22	.69	.50
	Female	8.79		
Profession	Clinical social worker	9.33	1.31	.20
	Other	8.54		
Employment region	Urban	8.80	-.44	.66
	Rural	9.08		
History working in CD or SA field	Yes	9.22	.69	.50
	No	8.78		
Previous training in CD or SA	Yes	9.44	2.71	.013
	No	7.86		
Sufficient training in CD or SA	Yes	9.22	.69	.50
	No	8.79		

\* $p < .05$

### **Discussion**

This study concludes that some professional and demographic variables are connected to clinical social workers' beliefs towards harm reduction. The variables that had a statistically significant difference include: employment history, training history, and training sufficiency.

According to this study there are several key findings. Clinical social workers who have been employed in the chemical dependency field favor harm reduction principles (BHR) over clinical social workers who have not been employed in the chemical dependency field. Clinical social workers who have training in chemical dependency or substance abuse favor harm reduction principles (BHR) and harm reduction treatment options (SATB) over clinical social workers who have not had training in chemical dependency or substance abuse. Lastly, clinical social workers who feel their training in chemical dependency or substance abuse has been sufficient favor harm reduction principles (BHR) over clinical social workers who do not feel their training has been sufficient. All the significant findings are connected to variables that are related to training and experience within the chemical dependency or substance field.

This study's findings coincide with some of the previous literature. Training and training efficacy was a common theme found in both this study and the preexisting literature. Lemanski (2001) discussed that due to the lack of education and training available, social workers tend to default to mainstream abstinent-only approaches when working with their substance using clients. This study supports Lemanski's (2001) statement, as this study found that clinical social workers that have had training in chemical dependency or substance abuse favor harm reduction treatment options over

clinical social workers who have not had training in chemical dependency or substance abuse.

Amodeo and Fassler (2001) found that chemical dependency training positively impacted social workers' practice with their substance using clients. Social workers who completed a training worked with more substance abusing clients, self-rated themselves as more competent to work with the substance using population, and more competent with their intervention abilities when serving substance abusing clients. Amodeo and Fassler findings suggest that MSWs need training in the substance abuse field to provide the appropriate expertise needed to work with this population (2001). Amodeo and Fassler's study emphasized this study's findings on the impact that sufficient substance use training has on service providers.

Loughran and colleagues (2010) found that one fourth of social workers surveyed reported having little to or no training in identifying alcohol or other drug difficulties and over one third reported none to a little training in alcohol or other drug interventions. Loughran et al's study indicated that social workers' training in chemical dependency is a deficit. This study seems to correspond with Loughran and colleagues' (2010) study, as over half of the respondents' in this study felt that training they have received in chemical dependency or substance abuse has not been sufficient.

Education was a common discussion point in the existing literature. Although education efficacy was not found as a variable that impacted clinical social workers' views towards harm reduction principles in this study, 58 percent of respondents' felt that their education through their social work program was not sufficient. Like this study, Duxbury's (1982) study found that graduate social work students did not believe they had

the skills necessary to work with alcoholics implying that their social work education was not sufficient in the area of chemical dependency or substance abuse. McNeece (2003) explained that out of 420 accredited baccalaureate programs and 140 accredited masters programs in social work there is no agreement on a minimum training needed for practice in the area of substance abuse. Schools of social work could better prepare social workers by providing coursework related to substance abuse (Brocado and Wagner, 2003). These statements are supported by the respondent's in this study, as over half of the respondents' felt their education was not sufficient.

### **Implications**

This research study used a small sample size of only 24 respondents and only explored beliefs of clinical social workers residing in Minnesota. This study can somewhat generalize the beliefs of clinical social workers, as wide range of types of professions and years of experience were gathered. Also, social workers working in both rural and urban Minnesota were sampled.

This study has implications on social work policy, practice and research. Findings emphasized the importance of training and education. These findings suggest that chemical dependency education within the schools of social work does not seem to be adequate. It is astounding that there is currently no educational mandate of required hours within accredited graduate social work programs in the area of chemical dependency or substance abuse. This seems to be an appropriate area for a policy change so social workers are prepared to work effectively with this population.

Training provided to social workers in the area of substance abuse seems to be a key factor in social workers' ability to make informed decision regarding treatment

options. It is surprising that this study found that 30 percent of social workers reported that they have not had any training in chemical dependency or substance abuse and less than that have had training in harm reduction. It is critical that social workers take it upon themselves to seek out training regarding chemical dependency and substance abuse so they are able to adequately work with their substance using clients.

It is important that further research explores this topic so clinical social workers can use the best evidence based practices with every population they serve. Research could continue to shine light on the benefits of using a harm reduction approach when working with substance using clients. Future studies could also further emphasize the need for proper education and training for all clinical social workers.

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Appendix A  
Permission to Use Scale

From: Belinda Joy Housenbold Seiger  
Sent: Monday, November 7, 2011 12:26 PM  
To: Hofschulte, Rachel A.;

Rachel,

Thank you for your interest in utilizing the SATS, I would be honored to have you utilize it. Please send me the results of your work when you are done as I would like to use it to validate the SATS further.

Best of luck,

Belinda Seiger, PhD, LCSW

On Mon, Nov 7, 2011 at 12:17 PM, Hofschulte, Rachel A. <hofs6825@stthomas.edu> wrote:

Dear Belinda Housenbold Seiger,

My name is Rachel Hofschulte and I am currently attending St. Catherine University and the University of St. Thomas, Masters in Clinical Social Work Program. I am currently working on my first clinical research project. My study is interested in clinical social workers' views towards harm reduction regarding chemical dependency.

I would like to ask your permission to use your Substance Abuse Treatment Survey, SATS, as part of my study. Your dissertation, an exploratory study of social workers' attitudes toward harm reduction with substance abusing individuals utilizing the Substance Abuse Treatment Survey (SATS), was wonderful and I believe the survey would work great for my project.

I look forward to hearing from you.

Sincerely,

Rachel Hofschulte

Appendix B  
Letter of Informed Consent

Dear Social Work Colleague,

My name is Rachel Hofschulte and I am currently attending St. Catherine University and the University of St. Thomas, Masters in Clinical Social Work Program. I am conducting research on clinical social workers' beliefs towards harm reduction when working with substance using clients. This research project is under the supervision of Evan Choi, MSW, and PhD.

I am requesting your participation in this research study because you are either a licensed clinical social worker or a licensed graduate social worker. If you agree to be in this study, please follow the link at the bottom of this page to complete the survey.

Completion of the study will take approximately 5 minutes. Please complete the survey by February 4th 2012.

There are no anticipated risks or benefits to your participation in this study. The records of this study will be kept confidential. Your participation in this study is also completely anonymous, confidential and voluntary. If you do not wish to continue with this survey you can end now by simply deleting this e-mail. If you wish to opt out of the survey once it has been started you can end at that time by simply exiting the webpage. If you do not feel comfortable answering any questions, please feel free to skip them.

You may contact me at (612) 760-6521 or via email at hofs6825@stthomas.edu. You may also contact my instructor, Evan Choi at (507) 205-2077 or the University of St. Thomas Institutional Review Board at (651) 962-4869 with questions or concerns.

**Request for potential participants: Please contact me directly with any LGSW or LICSW's e-mail or mailing address that you feel would be a good potential candidate or feel free to forward this e-mail on.**

**Statement of Consent:**

By completing the survey you indicate your consent to participate in this research.

Please follow this link to take the on-line survey:

[https://atrial.qualtrics.com/SE/?SID=SV\\_8FTwHU1ApG4so4Y](https://atrial.qualtrics.com/SE/?SID=SV_8FTwHU1ApG4so4Y)

Thank you,

Rachel Hofschulte

Appendix C  
Survey

The following questions are about your demographic and professional information. Please circle the appropriate response.

1. Gender     \_\_\_ Male     \_\_\_ Female

2. Years of experience in the social work field?

\_\_\_ 4 years or less

\_\_\_ 5 to 9 years

\_\_\_ 10 to 19 years

\_\_\_ 20 years or more

3. I view myself professionally as:

\_\_\_ Clinician or therapist

\_\_\_ Social work or clinical supervisor

\_\_\_ Substance abuse counselor

\_\_\_ Social worker

\_\_\_ Case manager

\_\_\_ Other (specify: \_\_\_\_\_)

4. I am employed in this type of setting:

\_\_\_ Outpatient mental health

\_\_\_ Outpatient substance use

\_\_\_ Outpatient dual diagnosis

\_\_\_ Inpatient mental health

\_\_\_ Inpatient substance use

\_\_\_ County

\_\_\_ Intensive residential treatment (IRTS)

\_\_\_ Halfway house

\_\_\_ Hospital or clinic

\_\_\_ School

\_\_\_ Other (specify: \_\_\_\_\_)

5. Are you employed in the twin cities seven county metro, Rochester, St. Cloud or Duluth?

\_\_\_ Yes

\_\_\_ No

6. Have you ever worked in the chemical dependency or substance abuse field?

Yes                       No

7. Have you had training in chemical dependency or substance abuse?

Yes                       No

8. Have you had training specifically in harm reduction?

Yes                       No

9. How would you rate your level of awareness of harm reduction interventions as it relates to substance use?

Not at all  
Aware

Somewhat  
Aware

Very well  
Aware

10. Do you feel the training you have received in chemical dependency or substance abuse has been sufficient?

Yes                       No

11. Do you feel the education you have received through your social work program at college has been sufficient?

Yes                       No

12. Please read the following statements carefully and answer how much you agree or disagree with each statement.

	Strongly Disagree	Disagree	Agree	Strongly Agree
1) Controlling drinking is an effective treatment for some binge drinkers.	1	2	3	4
2) Reducing substance use is a legitimate treatment goal for individuals.	1	2	3	4
3) Substance-abusing individuals who believe they can quit on their own are in denial.	1	2	3	4
4) Reducing the harmful consequences of substance abuse is as important of achieving abstinence.	1	2	3	4
5) The primary goal of treatment should be abstaining from all substances.	1	2	3	4
6) Some individuals can use drugs recreationally without becoming dependent.	1	2	3	4
7) Some drug users manage their drug use so well that there are no perceived problems.	1	2	3	4
8) Relapsing individuals should be allowed to remain in treatment for substance abuse.	1	2	3	4
9) Psychotherapy for individuals actively using drugs enables continues use.	1	2	3	4