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Harm Reduction in the Social Work Practice

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by

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The Clinical Research Project is a graduation requirement for the MSW students at ST. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conduction within a none-month time frame to demonstrate facility with basic social research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor dissertation

Abstract

Harm reduction is a technique used to address a variety of behaviors that produce harm and is implemented at micro, mezzo and macro levels. The purpose of this study was to examine the social worker experience of implementing harm reduction techniques with clients that identify as using substances. This study aimed to discover the strengths, limitations, and barriers of implementing harm reduction into the social work practice. This is a qualitative study that used guided interviews to collect data. Eight licensed graduate social workers that identify as using harm reduction techniques with clients that abuse substances were interviewed. Data gathered was analyzed by coding the interview transcripts, and identifying themes that emerged from the data. Data reviewed was linked to previous literature and discussed further in application to social worker practice and policy. The findings showed that social workers view harm reduction as a strength to establishing rapport with clients. In addition the data also showed limitations with legal concerns and marco level policies. These findings coincide with previous research on how harm reduction is used not only in the therapeutic relationship but also from a policy level, and how each level relates to the other.

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Introduction

Harm reduction is a concept that was introduced to social issues dating back to the 1980s as a way to address the HIV epidemic. Harm reduction is now used amongst a variety of health professionals and lobbyists. Although there is no definitive definition of harm reduction, harm reduction is easily described as reducing harm of a risky behavior. The simple yet vague description makes the concept of harm reduction easy to apply but difficult to be consistent, just as human behavior is diverse. The aim of this study will be to explore the limitations and barriers to implementing harm reduction with people experiencing substance abuse.

In order to reduce the harm of a risky behavior, the person taking part in said behavior must want to make that initial change, leaving treatment options to be decided amongst him/her. This fits with the social work framework of meeting the client in their natural environment. However, because the definition of harm reduction is ambiguous, it can create ethical dilemmas pertaining to treatment of the client and letting the client choose their course of treatment. The concept of applying harm reduction techniques has branched from substance abuse treatment settings, to residential and community settings. The diversity in agencies that identify the harm reduction concept has broadened the application, the concept, and the types of interventions related to harm reduction by social workers. As a result, the number of practitioners applying the harm reduction model has increased in both addressing substance abuse and a variety of social issues.

The purpose of this study is to identify limitations and barriers to the harm reduction concept while working with chemically dependent clients. More specifically, it will address the need of having a concept that is concretely defined in assessment,

application and interventions. Social workers will be interviewed in efforts to explore and analyze their experiences with applying the concept of harm reduction to their practice.

Questions will address social workers' perceptions about the limitations and barriers of implementing the concept of harm reduction into their practice with substance abusing clients. Questions will explore the service provider perspective in providing treatment, interventions used, client involvement, and ethics.

Limitations to the study include sample size and process of picking participants. The size of the sample is 8 participants, which limits the number of responses and ability to get a wide look at social workers in the St. Paul, Minnesota metro area. On the other hand, the sample size will allow us to view every set of data individually and more thoroughly which is what the concept of harm reduction aims to do.

Literature Review

The review of literature will identify the history of harm reduction in substance abuse treatment and how it is applied on micro, mezzo, and macro levels. The concept of harm reduction has been identified as a tool in social work practice. It helps to relate with, and better serve substance abusing clients. The literature will explore interventions of harm reduction and how practitioners have implemented hard reduction to better meet their clients' needs. It also looks at limitations that have come from applying the concept of harm reduction.

History

In the 1980s, the United States was grappling after being hit by the largest pandemic in modern history, the spread of the human immunodeficiency virus, commonly known as HIV (Einstein, 2007). Whether people realized it or not, a silver lining emerged amidst the battle to contain the spread of HIV, the harm reduction movement. Although a single definition of reduction cannot be found, it is most often described as a therapeutic approach in reducing the harm of a specific behavior (Castro, 2002, p.89). During the HIV epidemic, two critical patterns were targeted to reduce the risk of contracting HIV: intravenous drug use and sexual intercourse. The HIV virus is transmitted through bodily fluids such as semen and blood; therefore reducing one's contact with semen and blood reduces the risk of contracting HIV (Einstein, 2007). At this time, two courses of action existed in attempt to mitigate the risk of coming in contact with bodily fluids. The first course involved remaining abstinent from drugs and sexual intercourse, while the second course relied on the use of clean needles for drug administration, as well as condoms for sexual activity. The latter rationale incorporates

the idea of the harm reduction concept, which comprises the theory of reducing the inherent risk of behaviors, in this case drug use and sexual activity (Patchen, 2013).

As the concept has developed, harm reduction has branched from drug use to any aspect of one's life that has the risk of harm attached to that behavior. For example, driving in a car can be considered dangerous but wearing a seatbelt reduces the potential harm to oneself if he/she were to get into an accident (Brocato, 2003). That being said, harm reduction has been applied at micro, mezzo and macro social levels through policy and law making.

Harm Reduction Approach

"Harm reduction can be viewed as an umbrella term under which a variety of modalities may be employed" (Seiger, 2003, p. 120). Harm reduction is often paired with a variety of social work theories and concepts; however it is most commonly associated with Motivational Interviewing. Motivational Interviewing is comprised of four stages of change; pre-contemplation, contemplation, action and maintenance. Of these stages, harm reduction is introduced at the first stage, pre-contemplation. Pre-contemplation refers to the beginning stage, in which the problem behavior exists but no decisions or interventions have been made to eliminate the behavior in question. At this stage, practitioners request that their clients reduce the risk of said behavior, such as using a clean needle during intravenous drug use (Miller, 2002).

Although the idea of harm reduction is associated with the well-established theory of Motivational Interviewing, harm reduction does not have an established model for practitioners to abide by. According to Brotcato, harm reduction is identified as "a collection of interventions that have as their objective the reduction of damage"

(Brotcato, 2003, p. 118). Therefore, it is merely a tool used when discussing a client's course of treatment. It serves as a conscious reminder to the client to consider their actions and behaviors; regardless if a behavioral change is actually progressing. The concept provides a gradual course of action for the client and helps to prevent failure due to a client's inability to maintain change without external support.

As noted earlier, harm reduction is a collection of interventions aimed to reduce the damage of a risky behavior. To better understand how a clinician can utilize the harm reduction concept with clients, Brocato and Wagner identify three general interventions that are considered harm reduction approaches pertaining to substance abuse:

1.) Changing the route of administration of a substance.

2.) Providing a safer substance or drug to replace the more harmful substance.

3.) Reducing the frequency or intensity of the target behavior. (2003, p. 119)

As observed, none of the interventions require the client to abstain from a harmful behavior in its entirety; instead the interventions rely on the client's voluntary participation. Risky behaviors are viewed as coping mechanisms to other stressors. If the harm-reduced alternative is eliminated, the client is more likely to engage in an equally, if not more harmful behavior, provided the underlying stress is not addressed. In addition, it does not require the client to identify or address the underlying stressors, preventing additional turmoil that stems from the inadequacy of solving his/her problems (Tatarsky, 2010).

While there is no clear-cut application of harm reduction, five principles can be identified that are usually associated with harm reduction, along with three general application practices (Brocato, 2003). The five main principles consist of: pragmatism,

adoption of humanistic values accorded to clients, prioritizing the amelioration of harms, conceptualizing treatment as collaboration, and lastly, prioritizing immediate and feasible goals (Brocato, 2003). Pragmatism refers to "[the] reasonable and logical way of doing things or of thinking about problems that is based on dealing with specific situations instead of on ideas and theories" (Riley, 1999, p. 14). In practice, it provides a rationalization for a client's behavior, as it is their logical way of problem solving based on the positive result they experienced, despite the negative impact that followed. The second principle, the adoption of humanistic values, accompanies the idea that the client is to follow their values rather than those of another person or treatment modality. Third, the client prioritizes what is most harmful and helpful to their health. From there, the principle of conceptualizing treatment is reached through collaboration of what the client identifies that he/she wants and needs. The fifth and final principle refers to the client's prioritization of immediate and feasible goals. For example, a client could switch to diet soda verses regular soda to reduce sugar intake, so while he/she is still consuming a drink that is considered harmful to one's health, it is their least harmful option (Brocato, 2003).

Harm reduction and meaning making

"Ambivalence plays a central role in resistance to changing problematic substance use and needs to be addressed to facilitate positive change" (Miller & Rollinick, 2002, p. 158). Many substance users have put meaning behind their substance abuse decisions, and often continue to use due to the development of positive meaning that they have experienced compared to other aspects of their lives. As best described from *Journal of Clinical Psychology*:

> Substances may continue to be experienced positively at times, and different aspects of the person may have their own unique relationships to the substance based on how they meet the values, needs, wishes, and interests of that part of the person. (2010, p. 125)

Creating new positive meaning is a necessity for the client in order to reduce the use of substance abuse. This is a key aspect in harm reduction, as people cannot change their behaviors if they are not ready to analyze the meaning behind them (Witikiewitz, 2006). It should also be noted that another key aspect of harm reduction is recognizing that the client may never be ready to have the desire to change.

Understanding meaning making has been a changing attitude amongst chemical dependency treatment professionals in the Midwest. The International Journal of Drug Policy conducted a study in 2003 that performed pre and post tests to treatment professionals after attending a seminar on the concept of harm reduction. The study found that participants were significantly more favorable to the concept of harm reduction after attending the seminar. The seminar covered harm reduction and how change will not occur if the client is not ready. This contradicts the idea of creating or identifying a rock bottom for client to change. When applying harm reduction the client will self-identify their rock bottom. The study found the main outtake is to understand where the client is in their treatment process. Professionals with extended experience in treatment settings that stress high success rates often forget that the program's success may be different than the clients' success (Goddard, 2003).

Three years later, the International Journal of Drug Policy published an article analyzing peer-reviewed articles from 2003-2006. The article identifies harm reduction

as an "orientation and belief system" modeled by practitioners and applied by clients rather than policy or model, which is similar to referring to harm reduction as a concept (Witkiewitz, 2006). Meaning making is still very prevalent, as the research of literature by the authors found more supportive evidence in finding meaning behind behaviors and creating new positive meaning for changes.

Policy

The nation of Spain serves as a testament to the possible efficiency of the harm reduction concept (Torrens, 2012). With an increasingly dire rate of AIDS-related mortality among those who used opioids and other illicit drugs, Spain was one of the first countries to formally address this pandemic through the harm reduction approach. Legislative changes were drafted; this created a policy shift from a drug-free approach, to expanding greater access to opioid agonist maintenance treatment (OAMT). This re-evaluation of policy allowed for treatment centers to dispense pharmaceutical drugs such as methadone, in order to give opioid users a harm-reduced approach to satisfy opioid cravings without the risk of contaminated needles or accidental overdose (Torrens, 2012). In addition to using opioid maintenance treatments, clean needles were also distributed in order to reduce the risk of transmitting diseases.

As a result Spain saw a seventy-two percent decrease of AIDS related deaths from 1992 to 1999. While the decrease in deaths can also be attributed to additional factors, such as advancements in HIV/AIDS treatment, it should also be noted that the number of new HIV infections dropped from roughly 17,000 to less than 2,500 cases (Torrens, 2012, p. 137). In addition, the program received praise from the public, as the opioid agonist maintenance treatment was considered successful in reducing the number of

HIV/AIDS cases and deaths. Through the beginning process of implementing OAMT, "moral concepts and prejudices that hinder legislation and interfere with the implementation of OAMT had been more influential in the treatment of opioid dependence than the scientific evidence." (Torrens, 2012, p. 138).

Although opioid maintenance treatment is available in the United States, it is not nearly as accessible or accustomed as it is in European countries such as Spain. However, policies regarding substance abuse treatment have shifted from the abstinence-only focus on substance use, and instead toward an integration of psychological techniques that focus on the process of substance abuse from how it started and how to overcome it. In 1999 the National Institute on Drug Abuse proposed guidelines for substance abuse programs to administer effective treatment as they were seeing the need for psychological treatment in addition to focusing on abstinence (Futterman, 2005). This transition shifted treatment goals toward observing the wide spectrum of co-occurring disorders and how to treat substance abuse and psychological stressors.

Substance Abuse Treatment

Once the mental health guidelines were created to be a part of treatment, researchers started to look into harm reduction in a treatment setting, meaning clients were allowed to use upon entering treatment and would discontinue using when they were ready. One study in particular followed two groups of clients through an abstinence-based substance abuse treatment and a harm-reduction substance abuse treatment. The study found that participants from the abstinence-based program had a higher short-term success rate, but nine months after treatment the overall success rate was similar (Futterman, 2005).

The same study identified alternate approaches to both the control and variable group. The staff at the facilities felt that it often becomes clear in the early point of treatment that a referral to a different program would better serve the client (Futterman, 2005). This alternative view however may not coincide with the harm reduction concept. If the client does not want to go to a different program and it would increase their use, the ethical dilemma of denying treatment arises.

Social Work and Harm Reduction

"Harm reduction concept, known primarily for its application in the area of substance abuse, reflects the most fundamental and cherished ideals of social work and provides an idea framework for social work practice in a wide variety of settings" (Bigler, p 71, 2005). Social work as a profession is required to abide by the code of ethics from the National Association of Social Workers. The preamble to the National Associations of Social Worker's Code of ethics notes that the primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty (Bigler, 2005)

To reach this mission, there are ethical values and principles laid out by the National Association of Social Workers. The "ethical principles are based on social work's core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence. These principles set forth ideals to which all social workers should aspire" (National Association of Social Workers, 1999). Social workers apply these ideas at micro, mezzo and macro levels of service. The

concept of harm reduction mirrors the ethical values of service, dignity and worth as a person, importance of human relation and competence.

Micro

Social workers work with the distinctive person-in-environment philosophy, meaning social workers meet the client where they are at and address their needs (Bigler, 2005). This also pertains to services and treatment; in order to keep the dignity and worth of a person, social workers do not provide treatment that the client does not want. This concept is in alignment with harm reduction in that pushing treatment on a client who is not ready will not provide positive outcomes, and actually hinders the therapeutic alliance.

Mezzo

Social workers service the oppressed and vulnerable, and they have a keen eye to identify problems within a culture or group which has contributed to the oppression and vulnerability. For example, high schools in the United States have addressed the issue of teen pregnancy by applying the harm reduction concept through the use of contraceptives, such as readily-available condoms, and through educational classes for teen parents. However, there has been backlash of this application, as some parents feel that it supports sexual intercourse among teens. Those in support feel that if teens are going to be sexually active, they should have support and guidance in order to engage with the least amount of risk (Patchen, 2013).

Macro

Policy and legislative efforts help promote the concept of harm reduction on a macro level. These efforts address the “complexities of modern social problems with an

ecological/systems concept of human behavior" (Bigler, 2005, p. 70). Social workers collaborate with policy makers and lobbyist in order to identify problems experienced within the field that can be changed or improved upon. A recent example can be seen through a major policy change that has been applied in 2013. In past years, for woman to receive free or reduced-fee contraceptives, they would often go to a facility such as Planned Parenthood. Although Planned Parenthood has been recognized for providing this reduced-fee care since 1916, it requires young woman to have different medical care facilities, which can hinder efficiency of the healthcare system in general, while also reducing the probability that individuals will take advantage of such external service (Planned Parenthood, 2013). In 2010, the Patient Protection and Affordable Care Act, commonly known as "ObamaCare," made oral contraceptive medication free for all woman, (Planned Parenthood, 2013) making it more accessible through their primary care physician or facility, thus eliminating the need for additional office visits, record transfers, and out-of-pocket insurance deductibles.

Teenage pregnancy prevention is one example of how harm reduction has been applied at micro, mezzo and macro levels. In relation to substance abuse, it has been difficult to make policy changes due to the stigma surrounding the notion that substance abusers will be able to support their continued use.

Harm Reduction and Housing

A study published in the American Journal of Public Health examined the effects of a Housing First program for homeless and mentally ill individuals on "consumer choice, housing stability, substance use, treatment and psychiatric symptoms" (Tsemberis, 2004, p. 651). The 24 month study followed 225 participants through

housing programs that gave the individuals the option to pick housing centered on treatment and sobriety, or to receive immediate housing without treatment. Both are examples of the harm reduction concept, as the first group is entering a treatment based housing facility that monitor substance use, and while the other group does not offer treatment, it offers a place to live which reduces the harm of affiliating with what the article refers to as "street life" and gives the participants a feeling of stability. The study defines street life as life being homeless, unstable, and risky (Tsemberis, 2004, p. 654).

While the study found the program that offered immediate housing without treatment choice had a longer retention rate, it found no significant difference in substance use or psychiatric symptoms. The notion that there exists a correlation between mental illness and residential stability was challenged, and the study proved that a person's psychiatric diagnosis is not related to his or her ability to obtain or maintain independent housing (Tsemberis, 2004). What the study did not examine was the readiness of change identified by participants as well as what they found to be meaningful in regard to their housing retention maintenance of psychotic symptoms.

Stigma and Barriers

Harm reduction has experienced public and professional backlash since its inception. Many individuals view harm reduction as a means to make substance use legal and even promote use. Schools that readily provide condoms to their students have had backlash due to the perception that it promotes sexual activity. One study in particular identified medical viewpoints of methadone treatment and found that it was not fully accepted among the medical community. In the study, primary care doctors found methadone treatment "attitudes leaned more towards disapproval of drug use and

orientation to abstinence rather than maintenance therapy, both of which were associated with lower willingness to prescribe methadone" for opioid treatment programs (Dooley, 2012, p. 20). In effect, the participants felt that providing methadone maintenance programs would allow substance use to subsist and provide little to no effect in changing the behavior of abuse.

Another study, which took place over 15 years in Vietnam, explored the effectiveness of their clean needle exchange and methadone maintenance programs. Police officers were interviewed on their expectation to utilize resources of clean needle exchange, methadone and treatment programs. The research identified that some police officers "were still skeptical about the effects of the program or perceived it as contradictory to their main task of fighting drugs" (Khuat, 2012, p. 8). This contradiction is not uncommon for professionals working with substance abusers, especially law enforcement. They juggle the task of referring drug abusers to needle exchange and methadone programs, while also trying to eliminate drug use overall.

Another obstacle that is often overlooked when addressing substance use amongst communities is the prevalence of the drug trade and why individuals become involved. According to the International Journal of Drug Policy, national and international drug trade policies stand in the way of improving health and welfare. "The criminalization of drugs—and of people who use drugs, farmers, and poor people driven to or coerced into the drug trade—is an obstacle to reducing drug related health and social harms" (Stimson, 2010, p. 93). The social background of the drug trade impacts the effectiveness of any model concerning the treatment of substance use when it is not addressed on a macro level. Often times people, particularly those in a disadvantaged socio-economic climates,

view the drug trade as a convenient and lucrative means to provide for their families, which otherwise would not exist due to lack of privilege and education.

Ethical Dilemmas

Ethical dilemmas arise in a variety of settings that comprise harm reduction, which also mirrors everyday struggles for social workers. As a result of not having any guidelines to implementing the concept of harm reduction, ethical dilemmas arise in how it is applied or used. Issues or morality and values become apart of the discussion of harm reduction and the client's point of view could get lost in the process. Treatment should be client centric and the client needs to be ready for treatment, however the primary goal for the social worker is to address the social problem. This balancing act is under scrutiny when quality of life is at stake, and even more when life or death can be impacted by treatment. While a client may be in a substance abuse program that uses the harm reduction concept, they are still at risk of overdose or death. Substances still have impact on cognitive functioning while also impacting the growth and development of the brain.

The city of Vancouver, Canada has been a strong force in implementing policies on harm reduction and needle exchange programs. Dene Moore analyzed the decrease of drug users and needling sharing and found the following:

> In 1996, almost 40 percent of drug users reported sharing needles, but by 2011, that had dropped to 1.7 percent. About 25 percent of Vancouver's drug users are HIV positive, and nearly 90 percent suffer from Hepatitis C. The overall health of drug users had improved and more people began accessing addictions treatment,

> jumping from 12 percent utilizing methadone treatment in 1996 to 54.5 percent since 2008 (2013, p. 15).

Although the percentage of those sharing needles dropped, the mortality rate amongst illicit drug users had only slightly dropped. The mortality rate of illicit drug users is eight times the general population, which demonstrates the ethical dilemma of allowing monitored use and the danger of not providing treatment (Moore, 2013).

Gaps Within Research

While research exists on the variety of programs that utilize the procedures of harm reduction on micro, mezzo, and macro levels, little has been done in examining why harm reduction does or does not work. In addition, when harm reduction is applied to a program, it is often a blanket approach applied to all clients. The question of whether harm reduction should be applied to all participants within a program and when harm reduction turns into enabling has been looked over.

Social workers observe a client in-environment, while keeping in mind that every person and case is different. Social workers tailor treatment plans to identify client-centered and client-identified goals. That being said, the decision of whether harm reduction as a blanket approach would be the most effective approach should be addressed when looking at treatment interventions. What should also be identified from the practitioner's perspective is if harm reduction is actually a form of treatment, or if it is simply a concept that we use to justify the burnout of limited progress when working with a difficult client. Harm reduction "advocates the recognition that some people may be unwilling or perhaps unable to eliminate risks entirely" (Bigler, 2005, p. 73). This can

be forgotten as a practitioner when one is working with the client to achieve identified goals, as if those goals are not achieved burnout begins and the feeling of failure sets in.

Lastly, as seen with previous studies mentioned the long-term substance abuse rate was not correlated with harm reduction or abstinence only programs, which makes it difficult for policy makers to know how and where to fund treatment programs. On the other hand, harm reduction programs that have been implemented in schools that make condoms available for sexually active teens have seen a reduction in teenage pregnancy. This shows that harm reduction works in some scenarios, but not necessarily in all. Identifying when harm reduction is an appropriate approach is often implied, due to the concept that reducing harm in any way is considered a positive action.

Conclusion

In conclusion, the concept of harm reduction mirrors social work practice and has been applied to a variety of settings as well as levels of service. Social issues have been addressed by using the concept of harm reduction dating back to the 1980s with the HIV outbreak. Harm reduction has been proven to reduce risks of HIV by using prevention of transmission, but the number of drug users has not necessarily decreased. The next step in research is to analyze the different ways the concept of harm reduction has been applied in social work settings.

Conceptual Framework

Harm reduction is a concept that addresses risky behavior. The concept was introduced in mainstream substance abuse treatment in the 1980s and has gained notoriety since. Harm reduction means to "reduce the harm of a risky behavior" (Seiger, 2003, p. 120). This concept has been applied to a wide variety of social issues from teenage pregnancy to substance abuse. The number of social services agencies that identify with following the harm reduction model and applying it to treatment services to all clients has increased greatly since the year 2000 (Goddard, 2003).

Social workers identify with ethical values and principles of the National Association of Social Workers that coincide with harm reduction by providing client centered treatment. On a macro level, social workers use harm reduction as a tool to understand what strengths and limitation the client has, what his or her needs are and identify goals with reducing an unwanted behavior. Harm reduction is often used in conjunction with other models. The model harm reduction is most commonly identified with is motivational interviewing.

On a mezzo level, practitioners use harm reduction as an agency as a whole. This blanket approach gives the clients the option to reduce harm of a risky behavior. The option to reduce the behavior is in the hands of the client, the client still has control over changing the behavior, but the agency can help provide interventions to reduce the risk. The example of this previously was providing free condoms to public school students.

Lastly, harm reduction on a macro level is often seen on a policy level. When harm reduction first became a concept in the 1980s, by creating clean needle exchange centers and methadone treatment programs to help address opioid dependency and the

connection with the HIV epidemic. Social workers have historically been advocates in providing a safer using environment for substance abusers in efforts to reduce harm.

As noted, harm reduction is a concept used by many social workers in working with individuals, groups and large scale cliental. The concept of harm reduction gives clients more options to address risky behaviors that they may or may not want to change when they are ready. Harm reduction is client centered and used in client-directed treatment.

Methods

Research Question

The concept of harm reduction can be ambiguous in application and definition. The research question explored was; what are social worker perceptions about the limitations and barriers to implementing harm reduction with people experiencing substance abuse? Interview questions were formatted as a guide, with open-ended questions regarding type of service, applications used, reduction of harm and areas of uncertainty. The questions addressed how social workers apply harm reduction to their practice and within the therapeutic alliance. Social work practitioners apply harm reduction techniques along side other modalities, therefore how harm reduction coincides with other treatment models was also addressed. This type of sample allows us to be specific with a demographic that identifies with the concept of harm reduction, while looking at the diversity of application.

The application of the concept of harm reduction by social workers was analyzed through collecting narrative data gathered from licensed general social workers. The social workers interviewed identified using the harm reduction concept while providing services to clients that abuse substances. Because harm reduction is a concept which application varies from client to client, semi-qualitative interviews were used to gather rich information on individual experiences rather than generalized responses to survey questions. Since social work's ethical principles and values coincide with the concept of harm reduction, social workers have knowledge on facilitating a client identified treatment plans. Through this type of research we are able to analyze how ambiguity affects practice of social work.

Sample

The target population was eight licensed graduate social workers and/or licensed clinical social workers in the St. Paul, MN metro area. The social workers are case managers that practice with a variety of agencies that service the St. Paul and surrounding metro area. LGSWs and LICSWs were chosen for this study because of their education and training in harm reduction and working with substance abusing clients. Due to the time constraints and nature of incentive-free responses, semi-structured qualitative research is also the most feasible design choice to gather the best look at practitioners working with the harm reduction concept. Using semi-structured interviews allowed for the consistency of following interview guidelines but availability to further explore a participant's response.

Availability and snowball sampling were used to gain participants of the study. A member of the committee who works within the field assisted in identifying appropriate individuals for the sample. The researcher contacted participants that may be available participants. The researcher described the nature of the study along with the risks, benefits, confidentiality, and protection of human subjects. Once those participants consented to the study they were asked to provide contact information for potential candidates.

Although availability sampling is low cost, convenient and accessible there are limitations to the sampling style. Because the researcher utilized pre-established relationships there may have been bias in the participants which the researchers have connections. The same can be said for snowball sampling, biases can occur from the referred social workers as they may share similar views.

Protection of Human Subjects

The research was designed to protect the participants, beginning with an informed consent. A form of consent was reviewed with the respondent prior to data collection. The informed consent was created through a template approved by the St. Catherine University Institutional Review Board (IRB) and given to Rajean Moone, course professor for review and approval (Appendix A). The participants were informed of the level of confidentiality of the interview, noting the data collection process and access to the transcript. The only individuals with access to the transcript during the course of research will be the researcher. In addition the researcher will destroy the transcript on or by June 1, 2014. Data was collected through narrative interviews with the information being recorded. The interview was then be transcribed for coding. Any personal information was not be gathered or coded, therefore it did not damage the integrity of the research or ethical guidelines. The participants were informed that the findings would be presented in an oral report and written report.

In addition to the informed consent, prior to the interview participants were informed of the length of the interview, which lasted about thirty to forty-five minutes. Privacy for the interview was considered and the interview took place in a room with only the participant and researcher. There were no identified risks for benefits associated with the participation in the study. The target population of clinical social workers is characterized as a non-vulnerable population.

Data Collection Instrument and Process

By signing the consent form, the participant agreed to participate in the data collection process, which was be in form of an interview. The interview was guided by questions that were preapproved by Rajean Moone and the St. Catherine University

Institutional Review Board (see appendix B for interview guide). The questions were developed to be as open-ended and as objective as possible to encourage untainted feedback and keep the integrity of the research. The interview guide was formed as a result of questions that came from the literature reviewed and addressed various aspects of harm reduction. First, the interview questions addressed how long the participant has practiced as a social worker, and what type of setting they practice social work. From there questions were asked regarding how the concept of harm reduction is implemented in their practice, what works with harm reduction, what does not work, and their overall experience using harm reduction. The questions were used as a guide to structure the interview but the respondent addressed the questions in a natural manor.

The interview took place in a private setting that was convenient for the participants. Only the researcher and participant were present, which ensured the privacy of the location. Interviews will last thirty to forty-five minutes and were recorded on a password-protected computer. After the interview was complete, it was transcribed and coded by the researcher. To further protect confidentiality the interview and transcript will be destroyed June 1, 2014.

Data Analysis

Data was extracted from the transcript of the interview. This is considered to be Grounded Theory methodology because the researcher compared the explanations with those in current literature (Berg, 2012, p. 330). To ensure reliability the researcher coded concepts and themes that came through the text. Coding the research was done carefully as to not have subjective experiences outweigh the objectivity of the research. The codes and themes were then examined, compared and contrasted with one another in how they

differ. In addition the research committee is comprised of experts in the field of social worker that will provide some triangulation of results.

Strengths and Limitations

Utilizing availability sampling and snowball samplings style had strengths and limitations, yet the strengths outweigh the limitations. One limitation is the size of the sample; the size limits the ability to generalize findings to a large population, especially geographically. Social workers abide by different laws from different areas; therefore generalizing this research to include social workers views to across the country would be unethical.

Qualitative research limits the ability to get clear yes/no answers from the participants, which can create personal biases. Although there may be personal biases from the method of finding participants, the participants have extensive knowledge on harm reduction with substance abuse clients. A major strength is focusing on the identified demographic application of the concept of harm reduction. Having a smaller sample size allows for research to be inclusive to participant experiences, rather than generalized. This type of data collection gives individual responses meaning, which is parallel to creating individual harm reduction interventions for clients.

Findings

The study asked eight social workers to identify strengths and limitations to implementing harm reduction techniques into their practice, while providing services to substance abusing clients. There participants broke down into the following categories: two case managers that provide housing services, three assertive community treatment case managers, two mental health intensive case managers, and one residential treatment coordinator. All participants were licensed graduate level social workers that provide services to substance using adults, and could be considered expects in the field and application of harm reduction techniques. Interviewing participants of this background created a strong voice for social workers, which emphasizes the richness of the sample and data gathered from participants.

The results of this study indicate that social workers identify with applying reduction techniques. All participants defined harm reduction as reduction harm of a behavior or action. In addition, all participates recognized harm reduction as client driven. In application in their practice, participants found harm reduction to be helpful in their therapeutic relationships. However, external barriers to using harm reduction techniques were also identified by participants. The study gathered information at the micro level, and addressed experiences as case-by-cases bases. The data was coded, and themes emerged from the data.

After coding the research, four themes were identified in regards to social worker's perceptions to implementing harm reduction with clients that abuse substances. These themes are: 1. Harm reduction helps to establish rapport, 2. Legal issues, 3. Macro level policies impact harm reduction practices on a micro level, 4. Social worker

implementation of therapeutic modalities. These themes are important when discussing harm reduction because they were pulled from raw data, based on social workers direct experiences with using harm reduction.

Establishing Rapport

Establishing rapport was the strongest theme in how harm reduction was used in social work practice, and how it helped to achieve goals. As one social worker described *"I don't think I could do my job if I didn't use harm reduction. It helps my clients to establish trust in me, and know that I am a safe person"*. Another participant noted, "*When the overall goal is to do something like, keep housing, we focus on keeping the housing and not stopping all substance use. We might still have to address drug use and encourage clients to use off the property so they keep their housing, but when the goal is something not substance use related, it makes it easier to talk about the substance issues"*.

The theme of establishing rapport and meeting clients where they are at, was seen in the response to the question, *Can you give three barriers to implementing harm reduction in your practice? And How have you overcome these barriers*, most participants stated that what they liked about harm reduction is adjusting the intensity of interventions, therefore diminishing the barriers. This is supported by the quote "*harm reduction works because it meets the client at their stage of change. I wouldn't use the same interventions on a client that has not had a drink in three years, with a client that is currently struggling with alcohol use*". Another participant noted, "*I think it is important to let my clients know that I don't hold a relapse against them. Substance use is never their only problem*". In short, the research of this study found that harm reduction is a

helpful tool in establishing rapport with a client, to reach their needs, wants, issues and concerns.

Legal Concerns

Using and abusing substances creates a greater risk of getting into legal troubles. Participants identified that working with clients on probation or in a program that required them to be sober, made it difficult to implement harm reduction interventions. This sometimes hindered the therapeutic relationship. Clients that are involved in the legal system hold information back from the social worker for "*fear they will get into trouble*", as one participant described it. Another way that legal issues get in the way were described as *"using drugs puts a person at risk, period. We can try to reduce the harm of risky behaviors, like clean needle clinics, but that doesn't take away the legal risk of buying and possessing an illegal substance. Harm reduction is a way to protect our clients, but we can't always do that"*. One participant even described the legal barrier to reducing harm from a relapse perspective "*if a client is sober because of legal issues and they decide to use, they might go-all-the-way and use more than normal or do as much as possible to make it worth it, or they don't care since they know it could get them in trouble"*.

Macro Level Impact

Barriers to implementing hard reduction techniques were often described as coming from outside the therapeutic relationship, not occurring between the social worker and client. Meaning harm reduction interventions applied by the social worker were impacted by the service the social worker was providing. This is supported by the experience by one participant that stated "*I have a client that cannot use drugs in their*

apartment otherwise they lose their housing. To keep that service, we safety plan drug use and collaborate on where the safest place to use is, if they are going to use". Another participant stated, "*clients that are going to use, are going to use until they are ready to stop. I focus on keeping services available regardless of drug us*". It is encouraging to compare this theme with what was discovered by Futterman, who found that abstinence-based programs compared to harm reduction programs had similar long-term success rates (2005). Therefore, like our data shows, social workers aim to provide services regardless of drug use, because "*making them stop wont solve all of their problems*".

Therapeutic Strategies

Participants felt that using harm reduction alone without any other therapeutic strategy is a barrier in itself. Participants identified this is a limitation "*because it doesn't get at the core issues. If you use it with CBT, you can help the client change behaviors instead of just saying 'don't do this because it is harmful to you'. I guess that also brings in the clients choice to decide their treatment"*. It is interesting to note that in all eight cases of this study, participants agreed that harm reduction should be used and applied in conjunction with other therapeutic modalities. In fact, one participant recognized that "*as practitioners, we use a variety of models on a daily basis, sometimes without realizing it. I think that when we work with a client, we aren't sticking to one therapeutic model, and we pull from other evidence based practices to create our style of care*". In addition, the results of this study did not show any agreement or indication to the future of harm reduction becoming a structured model. Participants felt that creating a structured model took away from harm reduction being as individual as the person. As quoted from the study "*I think creating a structured model to apply harm reduction, takes away the*

flexibility and the overall goal of harm to reduction, which is to tailor the level of safety to the client".

Discussion

The goal of this study was to assess the limitations and barriers to implementing harm reduction techniques into social work practice. More narrowed, the study analyzed responses of eight social workers providing services to consumers that self-disclose as abusing substances. The study aimed to interview participants in efforts to gather information regarding personal experience. Similarities were found between themes that emerged from the data in this study and information presented through previous research on harm reduction, which was discussed in the literature review. Those similarities were seen on the micro, macro, and mezzo levels of social work.

Although previous research has shown that harm reduction is a full-circle approach to practice, the amount of data from this study that tied into mezzo or macro levels of service is overwhelming. Participants were able to identify ways they used harm reduction interventions, so the client could be illegible for services. As stated previously, participants identified using harm reduction to keep housing for a client, or any funding for a service that required a consumer to be sober.

The four themes identified relate to previous research on harm reduction. Beginning with establishing rapport, the literature reviewed connects harm reduction to how social workers work with their clients. Social workers abide by the National Code of Ethics. Within that code, self-determination is identified as a social work value (National Association of Social Workers, 1999). Harm reduction interventions involve the client to determine their level of use and treatment. Participants felt that letting the client determine their use and the amount they want to focus on substance use helped to establish rapport and build a therapeutic relationship. In addition, social workers

advocate for their clients, which helps to establish rapport by validating their struggles. Using harm reduction "advocates the recognition that some people may be unwilling or perhaps unable to eliminate risks entirely" (Bigler, 2005, p. 73), which further ties the results of this study to previous research. Establishing rapport by utilizing harm reduction techniques can be accomplished in a variety of ways, as seen through both the literature and research.

A major barrier to implementing harm reduction techniques was legal concern. This theme emerged so clearly from the research, that it displays disconnect of the legal system has with harm reduction. Social workers identify as meeting clients where they are at, where as the law upholds citizens to standards. This mirrors the debate on the idea of do no harm verses do less harm. Harm reduction fits the mold of doing less harm, which covers the gray area of ways to treat and acknowledge substance use. The law contradicts this by viewing behaviors as either right or wrong. The act of this struggle has been alive since the idea of harm reduction was first introduced, and contributes to policies in this day (Einstein, 2007). Having a client that needs to meet certain criteria because of the law takes away the flexibility of harm reduction and self-determination.

A similar theme was found, which was the barrier of implementing harm reduction interventions due to macro level policies and laws. This theme notes how macro level policies impact how social workers use harm reduction interventions. Participants felt affected by the impact macro level policies had on their interventions with their clients. Programs, waivers and grants that serve the clients of the participants are created at the macro level through the government. The policies and laws are created to appease the general needs that need to be met, which can be conflicting when harm

reduction is introduced. It is not uncommon to have conflict because harm reduction is tailored to the clients' needs, where as the government implements laws and policies to fit the general need. Participants stated that they understood that allowing substances in government-funded housing could potentially harm the other residents of the building. Yet, it also gives a people the safety of their own home a safer environment to use compared to public options. This back-and-forth struggle is identified through the literature on police officers that were supposed to apply on harm reduction to their police work. The police officers were conflicted with referring substance users to a clean needle exchange, treatment, or jail while also trying to eliminate the drug use problem (Khuat, 2012). Macro level polices impacted response to substance use in both this study and previous research.

Lastly, the theme of therapeutic strategies has a strong connection with data gathered from this study and the previous research. Participants responded that therapeutic approaches are always being applied, and it is difficult to use one model without applying another. For example, research involving the stages of change identified motivational interviewing and harm reduction as a tool to recognize the stage of change someone is in, and helping them to make a change (Miller & Rollinick, 2002). Participants noted that using only harm reduction does not get to the deeper layer to why someone turns to substances and how to mend that process.

Strengths

This study gathered information on a personal level. Since harm reduction varies from the case-to-case basis, it is important to gather information from a diverse population so the data represents responses from a variety of experiences. This could be

considered to be a participant centered way of gathering information, similar to client centered. This approach places the participant in the driver's seat, much like harm reduction does for the consumer. Another strength to this study is that it can represent programs that are being used by substance abusing clients and how the services are impacting their quality of life. It should be noted that interviewing clinical social workers as opposed to policy social workers feeds the richness of the sample. Interviewing social workers that work the policy scope of social work and not in the clinical realm could have diluted the sample size and data received.

Limitations

Information gathered from participants, analyzed and coded in this study supports the research previously identified on harm reduction, but does not give clarity to questions regarding transference/countertransference, ethical dilemmas, and the interpersonal struggle as a practitioner while using the harm reduction model. For example, there was only limited data gathered on ethical impact of using harm reduction techniques, and specific examples of *when harm reduction would not be appropriate*. This caused difficulty to draw conclusions on what the ethical guidelines there are, or should be, when using harm reduction techniques. But what we can draw from the study on this topic, is that agencies identified as using the harm reduction model, but more often than not, participants were unaware of any guidelines that the agency put in place. The participants stated that the consumer was more aware of the guidelines of what services they were receiving, and what the stipulations were to receiving that service verses the company's policy on harm reduction. Although this information was presented through the research the data was not strong enough to draw a concise

conclusion on the topic, leading to the idea that ethical dilemmas within companies should be explored further.

We can contribute the lack of responses to when harm reduction is not appropriate to the impact facilitating face-to-face interviews have on responses. Social workers value and strive to advocate for their clients (Seiger, 2003). Identifying personal strength is the foundation to the core of being a social worker. Therefore social workers as participants may have been more apt to report positive emotions of using harm reduction opposed to negative emotions and finding flaws in the harm reduction model.

Implications for social work practice

Micro

In the micro setting, social workers can continue to provide services on an individual one-on-one basis. The micro level of social work is a best way to understand the person-in-environment and harm reduction, as noted in our data and review of literature. Working on a micro level is the first way to gather data on how systems effect specific population. After understanding a person's needs to addressing a risky behavior, the social work can move to working on a larger scale and advocating for their clients needs. Continuing to study the micro level of social work practice gives personal perspective and data on how programs are working and being applied.

Mezzo

By understanding what the client needs to address a risky behavior, we can look at what mezzo level of interventions can apply to that client. Providing support, groups, and education are three ways to intervene on a mezzo level, while still using harm reduction. Education on harm reduction is important to groups, just like individuals. Harm reduction can't happen without the conversation; therefore having a conversation through educating a larger group of people has a greater impact on addressing risky behaviors. This is supported by this quote from the data "*talking about what the client wants to do, what risk they want to reduce, is the best way to intervene. My agency offers support groups for substance use and mental illness which people attend for support*".

Macro

Social workers are greatly affected by the macro level because of funding for programs. More often than not the type of work a social worker is providing is based on a

program that they are the case manager for. This was represented by our data. In order for macro levels to use harm reduction techniques for consumers that abuse substances, discussion needs to occur on what options are available to meet their needs. In addition, it should be understood that substance use might not be the biggest concern to the client. As represented by the data, using only harm reduction is not how social workers address needs and problems of a client, therefore programs and policies should represent the fact that consumers will use substances regardless, and try to solve the deeper problems. It is difficult to decide what requirements policies and programs should have for consumers, because every person is different. In addition, social work ethics outline the right of self-determination and having policies at a macro level that hinder the self-determination goes against social work values.

Future Research

This research of this study had the strengths of representing social workers perceptions of harm reduction when working with clients, and supported previous research on the topic. The study had difficulty addressing what the personal limitations and barriers to implementing harm reduction existed. To address the lack of specific data on limitations and barriers, future research should include personal bias when using harm reduction, how the therapeutic relationship impacts the harm reduction, and what education should include when addressing harm reduction on a macro level.

Future research should be considered on what education to the consumer looks like, as well as to the general population. Education is one type of harm reduction intervention that can be applied on micro, mezzo and macro levels. Education on harm reduction comes with education of risky behaviors and understanding what leads someone to engage in risky behavior, and what meaning that risky behavior holds to that person. Education on risky behaviors and harm reduction can potentially stop a person from engaging in a risky behavior such a substance use, or help them to stay safe if they are going to engage in the risky behavior. If a person does identify to being addicted to substances, providing education gives them resources to reduce the risk of their behaviors, thus improving their quality of life. Providing education gives options, which also fuels self-determination.

The therapeutic relationship can be phenomenal display of how the client interacts with others in their life. That being said, the discussion of how open social workers are with their clients should be considered while applying harm reduction techniques. Like previously stated in the literature review, identifying emotions that are attached to a

specific behavior can help to understand that behavior, and learn how to change that specific behavior (Witikiewitz, 2006). Working through the emotions related to high-risk behaviors can bring out interpersonal struggles within the therapeutic alliance. Personal bias from the social worker can create hurdles in the therapeutic bond on the practitioner's behalf. Learning how to overcome the interpersonal struggle and bias that one feels from a therapeutic relationship while using harm reduction is an area of future research to discuss.

Harm reduction and how it intertwines with treatment modalities is both simple and complex. As our research showed, participants felt that harm reduction was never used alone, and is tied with other therapeutic strategies. However, funding for programs and services require the social worker to provide specific services to their consumer. If insurance or funding for a service does not cover harm reduction interventions, or requires a consumer to completely abstain from all drugs, then harm reduction cannot be applied. Research on how harm reduction aligns with funding, billing and insurance when used with therapeutic modalities, treatments, and services should be explored and how that impacts the consumers' overall health and wellbeing.

Lastly, social workers provide services in a variety of ways whether it be policy or clinical. Digging into and comparing how different types of social workers identify harm reduction and use harm reduction techniques should be explored. This study looked at social workers that directly provided services in the community. Examining how social workers implement harm reduction in settings such as hospitals, schools, or at the policy level, would give perspective to how harm reduction helps the client and recognize possible limitations and barriers to implementing harm reduction strategies.

In summary, this research supports the previous literature on the topic of harm reduction on micro, mezzo, and macro levels of social work. Research implied that rather than harm reduction being a limitation or barrier itself, the external environment impacts the type of interventions to be used to approach the problem. Gaps in previous research include analyzing the effectiveness of purely harm reduction and what transference/countertransference social workers experience when using harm reduction techniques. Overall, harm reduction is viewed as a positive approach to reducing the harm of a risky behavior.

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Appendix A

CONSENT FORM
ST. CATHERINE UNIVERSITY
GRSW682 RESEARCH PROJECT

Harm Reduction in Social Work Practice

I am conducting a study harm reduction and the application by social workers with substance abusing clients. I invite you to participate in this research. You were selected as a possible participant because of your background as a social worker and direct client contact with substance abusing clients. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Kayla Lessard, a graduate student at the School of Social Work, Catherine University/University of St. Thomas and supervised by Dr. Rajean Moone, a faculty member at the school.

Background Information:
The purpose of this study is: to explore the application of the harm reduction concept in social work settings, specifically how it relates to substance abusing clients.

Procedures:
If you agree to be in this study, I will ask you to do the following things: Participate in one-time in person interview of no more than 90 minutes in length. The interview will be recorded, transcribed and destroyed.

Risks and Benefits of Being in the Study:
The study has minimal risks. Some of the identified potential risks to participants is discussing sensitive subject matter that may be related to their social work practice. The reviewing the proposal and data collection process with committee members will minimalize risks. The committee members will assist in ensuring that risks are addressed appropriately if any should occur throughout this research.

There are no direct benefits to you for participating in this research.

Confidentiality:
The records of this study will be kept confidential. As a classroom protocol, I will not publish any of this material. Research records will be kept in a locked file that only the researcher will have access to. I will also keep the electronic copy of the transcript in a password-protected file on my computer. The audiotape and transcript will be destroyed by June 1, 2014.

Voluntary Nature of the Study:
Your participation in this study is entirely voluntary. You may skip any questions you do not wish to answer and may stop the interview at any time. Your decision whether or not

to participate will not affect your current or future relations with St. Catherine University, the University of St. Thomas, or the School of Social Work. If you decide to participate, you are free to withdraw at any time without penalty. Should you decide to withdraw, data collected about you will not be used.

Contacts and Questions
My name is Kayla Lessard, You may ask any questions you have now. If you have questions later, you may contact me at 651-785-5340 or my faculty research advisor, Dr. Rajean Moone via email moon9451@stthomas.edu.You may also contact the St. Catherine University Institutional Review Board at 651-962-5341 with any questions or concerns.

You will be given a copy of this form to keep for your records.

Statement of Consent:
You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing this form, please know that you may withdraw from the study at any time.

_____

I consent to participate in the study and agree to be audio recorded.

_____
Signature of Participant Date

_____
Signature of Researcher Date

Appendix B

Interview Questions for Qualitative Research Project

What are social worker perceptions about the limitations and barriers to implementing harm reduction with people experiencing substance abuse?

1. What is your role in providing services to individuals that identify as abusing substances?
2. How would you define harm reduction?
3. Can you give me an example of how you use harm reduction in social work practice?
    a. In these situations, why was it appropriate or how did it help achieve goals?
4. Can you give three barriers to implementing harm reduction in your practice?
    a. How have you overcome these barriers?
5. What does your agency policies say or not say about harm reduction?
6. When is a time when using harm reduction would not be appropriate?
    a. How do you determine if the concept of harm reduction is appropriate for a client verses abstinence from substances?
7. What are your thoughts on harm reduction being used in conjunction with other therapeutic modalities?
8. How do you see harm reduction becoming a more structured model?
9. Do you have any other thoughts or comments on harm reduction?