2023

Social Worker Perspectives on Implementation of Harm Reduction into Abstinence-Based Substance Abuse Programs

Susan Woomer
Walden University

Walden University

College of Social and Behavioral Health

This is to certify that the doctoral study by

Susan K Woomer

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Thomas McLaughlin, Committee Chairperson, Social Work Faculty
Dr. Angela Wood, Committee Member, Social Work Faculty
Dr. Kristin Richards, University Reviewer, Social Work Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2023

Abstract

Social Worker Perspectives on Implementation of Harm Reduction into Abstinence-Based Substance Abuse Programs

by

Susan K. Woomer

MSW, Rutgers University, 2016

BA, Fairleigh Dickinson University, 2011

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Social Work

Walden University

May 2023

Abstract

Opioid addiction is a growing epidemic in the United States and was declared a public health emergency by the Department of Health and Human Services in October of 2017. There is a growing recognition that the current treatment for heroin and opioid addiction, abstinence-based treatment programs, is not readily available and has minimal success in addressing the epidemic. Harm reduction therapy is recognized as an effective way to address the opioid epidemic. This study aimed to develop further insight and understanding of how to integrate harm reduction therapy in abstinence-based treatment programs. The theoretical framework for this study was the harm reduction theory. Data were collected from narrative, semistructured interviews with addiction professionals. Purposeful sampling was used to select 13 credentialed addiction professionals in northern New Jersey with at least 2 years of experience. Data analysis was conducted by evaluating transcripts of audio recordings from the interviews. The findings of this study include the following themes: the need to implement harm reduction into abstinence-based treatment, the need for increased supervision to discuss harm reduction techniques, the importance of policies to be introduced to support evidenced based treatment, and the importance of acknowledging the efforts of social workers and addiction counselors to meet the clients they serve. All social work professionals working in the field of substance abuse may benefit from the results of this study, leading to positive social change. The research in this study highlights the benefits of implementing harm-reduction techniques into all substance abuse programs.

Social Worker Perspectives on Implementation of Harm Reduction into Abstinence-Based Substance Abuse Programs

by

Susan K. Woomer

MSW, Rutgers University, 2016

BA, Fairleigh Dickinson University, 2011

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Social Work

Walden University

May 2023

Dedication

I dedicate this research study to all the individuals who are currently struggling or have struggled with addiction. I dedicate this also to the parents and families of love ones lost from the opioid addiction, especially in my home state of New Jersey. You are not alone and there is always hope.

Acknowledgments

First and most importantly I want to thank God for the opportunities I have been presented with in my life in order to achieve my dreams. There were moments in my life where I never would have thought I would be graduating with my DSW, but my faith has brought me here and I am extremely humbled, grateful, and thankful.

I want to thank my parents Fay and Michael, and my grandma Florence, who over the last 33 years sacrificed, prayed, and supported me through all my endeavors. My family has given me faith when I didn't have any, they have encouraged me when I felt hopeless and lost, and they have never given up on my dreams, even when I had moments of doubt.

I want to thank my amazing boyfriend Michael for supporting me through this process, encouraging me to continue pursuing this, and listening to me talk for hours about something that he didn't always understand.

I want to say thank you to my team at Walden University, including Dr. Thomas McLaughlin, Dr. Angela Wood, and Dr. Kristen Richards. They have been supportive of my process from the start and have always gone above and beyond to make sure I stay on track and reach my goals.

Table of Contents

Section 1: Foundation of the Study and Literature Review

Introduction

The United States is facing an opioid epidemic that began in the early 1990s with the pharmaceutical companies' assistance (Kolodny et al., 2015). Pharmaceutical companies ensured medical doctors that OxyContin, an extended-release pain medication manufactured by Purdue Pharma, was not harmful or addictive (Kolodny et al, 2015). Twenty years later, the Department of Health and Human Services (HHS) declared the opioid epidemic in America a public health emergency, and opioid-related deaths are now higher than those attributed to car accidents in the United States. Opioid addiction impacts every American, no matter socioeconomic class, race, religion, or culture (Kolodny et al., 2015). The economic burden of the opioid epidemic costs the United States an estimated $78.5 billion annually, including increased health care and substance abuse treatment costs. The costs associated with the opioid epidemic are primarily funded by public health insurance programs (i.e., Medicare, Medicaid) and through state and local governments (Bipartisanpolicy, 2019). The economic burden of the opioid epidemic not only causes taxes to increase but causes criminal justice fines and healthcare costs to increase as well. The opioid epidemic impacts the addicted individual as well as their family, friends, and community (Kolodny et al., 2015).

Current treatment for opioid use disorder is quick detoxification in an inpatient center, followed by an outpatient program and attendance at 12-step or other recovery support groups (Bailey et al., 2013). Current treatment practice requires more inpatient bed availability, and since more people need treatment than beds available, the current system has failed. The opioid epidemic claims thousands of lives every day, and those

that seek treatment are experiencing relapse rates as high as 63% (Friedmann, 2017). Opioid treatment requires a change, including harm reduction approaches and addressing the various aspects that impact an individual's treatment, including social, economic, and environmental factors (Friedmann, 2017). Detoxification programs are used as an opportunity to explore longer-term treatment options, including outpatient programs and support groups (Bailey et al., 2013). Harm reduction approaches combined with traditional substance abuse treatment allow an addicted individual to successfully recover from opioids (Friedmann, 2017).

This study identified how harm reduction techniques are implemented into traditional abstinence-based substance abuse treatment programs from the perspective of social work professionals working in addictions. This research highlighted the importance of why the integration of harm reduction into traditional substance abuse therapy is necessary with the current opioid epidemic occurring. This research focused on implications for treatment, specifically focusing on integrating harm reduction techniques into substance abuse treatment programs, and the use of medication-assisted treatment (MAT) is also discussed. Using a narrative approach to interview addiction professionals allowed for detailed and open-ended responses that provided a more in-depth insight into the day-to-day work of addiction professionals involved with substance abuse treatment. Although this research took place in New Jersey, the implications are appropriate for all social work practices, including settings outside of substance abuse treatment. This research provides deeper insight into the necessity of harm-reduction therapy approaches for all substance abuse clients. Northern New Jersey was chosen as the focus of this paper because it is an area that is between two major cities—New York and Philadelphia. As a

suburban area, access to MAT is less available; therefore, it shows an important gap in access.

Pharmaceutical Companies and the Opioid Epidemic

Purdue Pharma funded studies that determined OxyContin was only 'physically dependent', which they claimed was different than becoming 'addicted' (Kolodny et al., 2015). Doctors then began prescribing OxyContin at an all-time high (Kolodny et al., 2015). In 2001, Purdue Pharma spent $200 million in marketing OxyContin, resulting in over 6.2 million prescriptions in 2002 (Kolodny et al., 2015). Around the same time that Purdue Pharma marketed OxyContin, the American Pain Society established a campaign to recognize pain as the fifth vital sign (Skolnick, 2018). Vital signs measure how 'well' an individual's body functions; the four signs are blood pressure, body temperature, pulse, and respiratory rate (Medline Plus, 2015). The Veterans Health Administration and the Joint Commission on Accreditation of Healthcare Organizations adopted the American Pain Society's campaign, which focused on addressing and managing patients' pain (Skolnick, 2018). With pain as the recognized fifth vital sign, medical professionals could prescribe pain medication at increased rates to accommodate their patients, which ultimately amplified the availability of opioids (Skolnick, 2018). With high availability, abuse and misuse began, specifically related to crushing and snorting or injecting OxyContin (Skolnick, 2018).

Impact of the Opioid Epidemic

The addicted individual, when compared to the general population of nonaddicted individuals, experiences a diminished quality of life, including sleep disturbances, greater severity of depression, poorer physical health, and increased criminal activity (Kolodny

et al., 2015). Drug addiction causes changes in the addicted individuals' behavior, which can lead them to engage in harmful behaviors (Rahmati et al., 2019). Addiction leads to impulsive negative behavior, overdose, and physical injuries (Rahmati et al., 2019). In addition, the addicted individual suffers from low self-esteem, and poor nutrition, which can lead to various medical conditions such as hepatitis C or HIV (Rahmati et al., 2019). The middle-class mortality rate has increased significantly in the last decade, specifically related to the opioid epidemic; from 2010 to 2015, heroin overdose rates tripled within suburban America (Dasgupta et al., 2018). In addition to increased mortality, opioid-addicted individuals are more likely to be unemployed and have limited access to health insurance. Unemployment can cause other interpersonal issues, including strained relationships with family, increased stress and cardiac issues, and a more significant burden for the community (Dasgupta et al., 2018). There has also been an established connection between criminal activity and opioid addiction, meaning that individuals with criminal records are more likely to face challenges finding adequate employment (Dasgupta et al., 2018).

The addicted individual's loved ones are significantly impacted by an addicted individual's drug use because they are generally in close proximity (Jesuraj, 2012). Opioid use imposes financial burdens on families, disrupts the family routine and communication, especially when children are involved, and causes loved ones to experience increased depression and adverse health effects (Hagemeier, 2018). Children raised in a household with opioid addiction are more likely to have behavioral, cognitive, and interpersonal issues that will impact their ability to perform adequately in school (Horn, et al., 2018). Children from addictive families may suffer emotional problems like

guilt, anxiety, embarrassment, and inability to form close friendships (Jesuraj, 2012). Children may be failing classes, not attending school, lacking friends, and displaying anti-social behavior such as stealing, fighting, or abusing alcohol and drugs themselves (Jesuraj, 2012). Family members who do not seek treatment themselves are at risk for codependency issues, including increased stress-related medical issues (Horn, et al., 2018). Family members can also experience guilt, insomnia, anxiety, and depression. Family members develop unhealthy coping mechanisms to deal with the addicted individual, including bargaining with them, trying to control them, blaming them, becoming angry with them, denying the situation, or becoming preoccupied with them (Jesuraj, 2012). The family system needs to be restructured for everyone to recover and establish healthy communication and boundaries.

Lastly, the community where the addicted individual lives is also impacted. Addiction increases medical costs for the public associated with more frequent emergency room, inpatient, and outpatient visits and increases prevention and research costs (Birnbaum et al., 2011). Healthcare costs in the United States alone accounted for over 60 billion dollars for opioid related costs, and over 70 billion dollars were spent on overdose mortality (Simmons-Duffin, 2019). Addiction increases criminal behavior and criminal activity rates in communities and increases costs associated with unemployment (Hagemeier, 2018). Criminal justice costs are primarily associated with correctional facilities, but there are also costs associated with property loss due to crime (Birnbaum et al., 2011). As mentioned previously, the United States' economic burden of the opioid epidemic is astonishing. Although healthcare costs are the primary burden of the epidemic, the criminal justice system is also a significant contributor to economic costs.

Individuals who commit criminal offenses to obtain money or opioids will increase crime rates in neighborhoods, ultimately reducing the value of a home (Hagemeier, 2018). In 2018, over 10 billion dollars were spent on criminal aspects related to the opioid epidemic (Simmons-Duffin, 2019)

Social workers and addiction professionals provide services in community settings, schools, clinics, hospitals, child welfare agencies, and local, state, and federal agencies. Their knowledge of how the opioid epidemic impacts the individual, the family, and the community provides an opportunity for addiction professionals to be an agent of change. Social workers and addiction professionals provide direct face-to-face interventions. However, they also link individuals, families, and communities to necessary services, which helps to address the gaps in the continuum of care that cause inadequate recovery and ultimately increase relapse rates (Council of Social Work Education, n.d.). Social workers and addiction professionals are trained to tackle the impacts of the opioid epidemic, including unemployment, homelessness, criminal activity, and interpersonal issues. Social workers and addiction professionals can reduce the economic burden of the opioid epidemic by reducing gaps in treatment to ensure that individuals and families are receiving appropriate care (Council of Social Work Education, n.d.). They can support evidence-based practice by being a part of multidisciplinary treatment, and they can continue to provide advocacy and awareness regarding the opioid epidemic to other professionals and the public (Council of Social Work Education, n.d.).

History of Opioid Treatment

Substance dependence is a chronic, relapsing disorder that requires long-term multidisciplinary solutions that include regular monitoring and evidence-based practice (Vogel et al., 2017). Traditional treatment for opioid dependence includes short-term detoxification (detox) in a medically monitored facility (Friedman, 2017). Traditionally, inpatient detoxification requires abstinence, and treatment is geared toward abstinence (Friedmann, 2017). After an individual completes detox, the recommendation might be for continued inpatient or outpatient treatment in an intensive aftercare program, again geared toward abstinence or drug-free treatment (Friedmann, 2017). Inpatient treatment historically encourages individuals to maintain 'medication free' and instills that pharmacotherapy is inconsistent with 'true recovery' (Friedmann, 2017). Inpatient treatment for opioid dependence has been the most used treatment approach, despite much research that reports high rates of relapse post-discharge (Broers et al., 2000). Studies related to relapse rates show that an initial relapse often occurs within the first few weeks after the end of treatment (Broers et al., 2000). Several factors associated with relapse include lack of social support, housing issues, employment problems, or issues related to adequate access to medical care (Broers et al., 2000). Age, gender, and duration of drug use were not associated with treatment success, but outside social, economic, and psychological factors were significant (Broers et al., 2000). Traditional treatment does not often address outside factors because the central belief is that sobriety and abstinence will decrease all problems (Friedmann, 2017). However, research supports that abstinence is not always the answer to achieving long-term success (Broers et al., 2000).

With the traditional treatment option of inpatient detoxification or rehabilitation not often successful, the introduction of harm reduction therapy, including MAT, brought much hope to opioid-addicted individuals. Harm reduction therapy was developed on the principle that flexibility is the key to beginning a therapeutic relationship (Little & Franskoviak, 2010). Harm reduction therapy allows practitioners to build a trusting relationship with addicted individuals, even if they do not stop using substances (Little & Franskoviak, 2010). Harm reduction therapists believe that addiction problems are diverse and treatment should be individualized and provide various options for success (Little & Franskoviak, 2010). MAT is one component of harm reduction therapy and includes using medications combined with behavioral therapies to treat substance abuse disorders (SAMHSA, 2022). The FDA-approved medications used in MAT, include methadone, buprenorphine, and naltrexone (SAMHSA, 2022). These medications provide options for opioid-addicted individuals so they can stop using opiates and achieve long-term success from addiction (Broers et al., 2000). MAT can assist in reducing the overall costs of addiction related to the opioid epidemic by reducing continuous inpatient admissions and reducing the overall societal impact (Broers et al., 2000). According to the National Institute on Drug Abuse (NIDA; 2019), MAT does have long-term effectiveness. According to one of the first long-term studies done on this subject matter, NIDA found that about 50% of people were still abstinent from opioids 18 months after starting MAT, and after 3.5 years, about 61% of people were abstinent from opioids (NIDA, 2019).

Harm Reduction Therapy

Harm reduction treatment is an umbrella term that includes interventions to reduce the problematic effects of behaviors, specifically those associated with substance dependence (Logan & Marlatt, 2010). Harm reduction therapy assists the social worker or addiction professional in working with clients nonjudgmentally, allowing recovery to be viewed in various ways. Harm reduction therapy guides clients toward abstinence, but it does not require it to be successful (Logan & Marlatt, 2010). Harm reduction therapy uses motivational interviewing techniques, including empathy and support for whatever stage of change clients are in (Logan & Marlatt, 2010). Harm reduction therapy does not see using substances during treatment as a relapse but instead focuses on reducing the amount and frequency of use (Vakharia & Little, 2016). Harm reduction therapy allows social workers and addiction professionals to acknowledge clients' autonomy and self-determination while facilitating growth, self-discovery assisting in their decision-making process (Vakharia & Little, 2016). Harm reduction therapy allows social workers and addiction professionals to support clients, no matter what stage of change they are in, and allows them to take the focus away from abstinence (Little & Franskoviak, 2010). According to the National Social Workers' Code of Ethics, social workers are to enhance human well-being and empower vulnerable populations (National Association of Social Workers, 2017); harm reduction therapy can provide an opportunity for social workers to build rapport and trust with clients who are not ready to commit to abstinence. Harm reduction therapy allows social workers and addiction professionals to apply the practice in a variety of settings, including street corners, community drop-in centers, needle exchange programs, and primary care clinics (Little & Franskoviak, 2010).

Problem Statement

This qualitative, narrative study explored how harm reduction is integrated into abstinence-based treatment programs from the perspective of addiction social workers and addiction professionals. The study's overall purpose was to improve treatment protocols to address opioid addiction. The current literature on harm reduction does not focus on integration with abstinence-based treatment, despite research supporting harm reduction for opioid addiction treatment (Friedman, 2017; Little & Franksoviak, 2010). Gaining insight into how the integration of harm reduction is occurring can help determine how to spread awareness to other abstinence-based programs and support programs that want to begin to integrate.

This study researched if the integration of harm reduction techniques has been successful in abstinence-based programs, specifically gaining insight from addiction professionals on ways to integrate. The opioid epidemic has become more deadly in the last decade, despite increasing public knowledge and daily news coverage of opioid-related information (Skolnick, 2018). Overdose deaths due to heroin increased by more than 20% between 2014 and 2015, while overdose deaths related to fentanyl and other synthetics increased by more than 70% (Skolnick, 2018). Not only is the epidemic causing life expectancy to decrease, the financial burden on the United States is astronomical (Johnson, 2018). In 2017, it was estimated that more than $500 billion was spent to address the epidemic, including the cost of health insurance and treatment, and for communities to address the side effects (Johnson, 2018). In addition to the financial burden, an increase in infectious diseases such as hepatitis C and HIV can be linked to the opioid epidemic (Skolnick, 2018). Drug users with little education regarding harm

reduction approaches are more likely to engage in risky behaviors while using (Vashishtha et al., 2017).

Social workers and addiction professionals in almost any setting will face the effects of the opioid epidemic, even if they are not directly working with substance abuse populations. However, addiction professionals who are working specifically with substance abuse populations need to ensure they are properly trained to address the epidemic appropriately and provide evidence-based treatment approaches (Williams & Bisaga, 2016). Many stigmas are associated with harm reduction therapy, including how to integrate with an abstinent-based treatment program since addicted clients do not always remain abstinent (Nadelmann & LaSalle, 2017). Harm reduction therapy can include MAT, which is also stigmatized in many abstinence-based programs (Davis et al., 2017). Harm reduction therapy is often thought of as 'anti-abstinence'; however, harm reduction's end point is usually abstinence but understands that addicted individuals can have various ways of achieving that goal (Marlatt et al., 2001).

Integrating harm reduction into traditional abstinence-based treatment programs can also be challenging for addiction professionals. Research has shown that social workers and addiction professionals are more likely to accept non-abstinent treatment goals when they are associated with marijuana and alcohol versus opioids (Davis et al., 2017). The reasoning for this acceptance is believed to be associated with education, degree, professional experience, and the counselor's history of a substance use disorder (Davis et al., 2017). Research supports that newer addiction professionals may be more accepting of non-abstinence goals versus more seasoned professionals, but overall, even new counselors are not fully accepting of non-abstinence goals (Davis & Lauristen,

2016). Social workers and addiction professionals need to have more understanding of opioid-addicted clients with non-abstinent treatment goals and ensure they are trained on evidence-based practice to assist them toward their recovery goals (David et al., 2017). Addictive behaviors are characterized as chronically relapsing; therefore, it is common for the recovery process to include periods of return to drugs. When addicted individuals return to substance use, professionals who utilize harm reduction will view this as part of the process. In contrast, abstinence-based professionals might view this relapse as a 'failure' (Marlatt et al., 2001).

Addiction social workers who engage in advocacy at a state and federal level need to also understand the importance of harm reduction therapy as an evidence-based practice for opioid addiction. Addiction professionals who are engaging in advocacy need to ensure they are aware of the importance of harm reduction for opioid treatment because they are fighting for funding for treatment, including harm reduction treatment (Williams & Bisaga, 2016). In order to view opioid addiction as a chronic medical condition that requires long-term treatment, there must be structural changes, revision of current regulations, and improved access for marginalized populations (Williams & Bisaga, 2016). MAT programs have demonstrated effectiveness in treating opioid use disorder, yet most insurance companies do not offer coverage for the medications (Saloner & Barry, 2018). In addition, individuals with state insurance have even less access to these medications because they are generally indigent and cannot afford any out-of-pocket costs (Saloner & Barry, 2018). Grant funding from federal and local government programs is required to ensure these medications are available to opioid-addicted individuals. Grant funding can provide medications for treatment programs that

provide harm reduction approaches, while state insurance can assist with coverage for the treatment (Saloner & Barry, 2018).

The lack of access to MAT programs is apparent in northern New Jersey. There are limited MAT programs, long waiting lists for available programs, and even fewer programs that provide treatment for Medicaid clients (Clemans-Cope et al., 2019). According to the New Jersey Department of Health (n.d.), seven harm reduction centers provide access to sterile syringes and other injection equipment, life-saving naloxone, and education on safer use and overdose information. A report on the five major harm reduction centers (Atlantic City, Camden, Newark, Paterson, and Jersey City) notes that they have served around 10,000 drug users (Livio, 2012). According to the New Jersey Department of Health's report (2021), there were over 50,000 admissions for opioid and heroin treatment; therefore, the harm reduction centers are not addressing even one-third of the needed population. According to the same Department of Health Report (2021), only about 41% of treatment centers used MAT. Social workers and addiction professionals that are employed in substance abuse treatment centers are not exposed to harm reduction strategies therefore, they are not able to integrate appropriately when clients are in need.

Purpose Statement and Research Questions

This study aimed to further develop insight and understanding of how to integrate harm reduction therapy in abstinence-based treatment programs, specifically focusing on addiction professionals' personal experiences with integration. The research project is distinct because it focuses on the addiction social workers' perspective on integrating harm reduction therapy within abstinence-based programs. In contrast, the majority of

current and previous research only looks into the actual integration (Davis et al., 2017). This study is critical because it focuses on the professionals and how they may contribute to barriers to harm reduction integration. Research has suggested that addiction social workers are not educated appropriately on the effectiveness on harm reduction for the treatment of opioid use disorders, specifically those professionals working in an abstinence-based program (Fillmore & Hohman, 2015). This study reiterated the effectiveness of harm reduction therapy with opioid treatment and how to better integrates these techniques into practice with opioid-addicted clients.

Research Questions

The research questions for this study provided insight into aspects of harm reduction therapy for opioid-addicted clients and further detailed the effectiveness for this population.

Research Question 1: In what ways are harm-reduction programs being integrated into abstinence-based programs, from an addiction professional's perspective?

Research Question 2: What are social worker's perceptions of integrating harm-reduction therapy with traditional 12-step/abstinence-based therapy?

Key Terms

Several key terms were used throughout this paper that can have multiple meanings. For the purpose of this paper, the following words were used in this context:

Harm reduction: A set of practical strategies and ideas aimed at reducing negative (harms) consequences associated with drug use. Harm reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs (Sam Rolfe (He/Him), 2023).

Medication-assisted treatment (MAT): According to the Substance Abuse and Mental Health Services Administration (SAMHSA), medication-assisted treatment (MAT) is the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a 'whole-patient' approach to the treatment of substance use disorders (SAMHSA, 2022.).

Opioid-use disorder: According to the DSM-5 TR, opioid use disorder is defined as two or more of the following in a 12-month period—using larger amounts of opioids or over a longer period of time than was intended; persistent desire to cut down or unsuccessful efforts to control use; great deal of time spent obtaining, using, or recovering from use; craving, or a strong desire or urge to use substance; failure to fulfill major role obligations at work, school, or home due to recurrent opioid use; continued use despite recurrent or persistent social or interpersonal problems caused or exacerbated by opioid use; giving up or reducing social, occupational, or recreational activities due to opioid use; recurrent opioid use in physically hazardous situations; continued opioid use despite physical or psychological problems caused or exacerbated by its use; tolerance (marked increase in amount; marked decrease in effect); and withdrawal syndrome as manifested by cessation of opioids or use of opioids (or closely related substances) to relieve or avoid withdrawal symptoms (American Psychiatric Association, 2022).

Substance abuse counselor/addiction counselor/social worker: Licensed counselor (LCADC, LCSW, LSW) that provides treatment to addicted patients/clients in any setting.

Nature of the Doctoral Project

This study was qualitative in nature and used narrative interviews to gain data from addiction social workers working in substance abuse programs. Semistructured interviews with open-ended questions allowed participants to provide as much information as possible without direction. Interview questions assisted in identifying components of harm reduction therapy being implemented in treatment programs while eliciting professional thoughts and feelings related to utilizing this type of therapy. Interview questions were the same for each interviewee and pertain to the harm reduction model. I interviewed 13 clinical addiction professionals in northern New Jersey currently employed in substance abuse treatment settings, specifically working with clients with an opioid use disorder. All clinical professionals interviewed for the study were obtained through the professional social media site LinkedIn and from referrals by other participants.

Narrative Research

Narrative research allows researchers to gain a deeper understanding of people's lives while allowing interviewees to tell their stories with no boundaries (Larsson & Sjoblom, 2010). Narrative research is based on the basic human instinct for interaction and communication, allowing people to share their personal feelings on specific topics and understand individual perspectives (Larsson & Sjoblom, 2010). Narrative interviews are critical when attempting to understand addiction social workers' interactions with clients, allowing them to discuss their interactions, while providing understanding into social work practice (Larsson & Sjoblom, 2010). Narrative interviews were helpful for

this research paper because they allowed addiction social workers to detail how they integrated harm reduction techniques with their clients.

Data Analysis

Research notes the importance of transcription as part of qualitative research. Qualitative research includes in-depth interviews, but there has not been a significant focus on the transcription process for the researcher (Weinbaum & Onwuegbuzie, 2016). Transcription needs to remain free from reflexivity—the focus of transcription should always be to ensure the information is clear and accurate (Weinbaum & Onwuegbuzie, 2016). Researchers should always remain ethical, culturally sensitive, and unbiased throughout transcription.

All recorded interviews with participants were transcribed with the assistance of Weloty Academic Transcription Services. A consent form was signed by the company to ensure HIPAA compliance and protection for participants. After transcription was complete, all data collected were reviewed to identify themes regarding the efficacy of harm reduction and MAT therapy, and the availability of these programs for intended populations. In addition, an evaluation was completed to see how addiction social workers were integrating harm reduction therapies into traditional 12-step abstinence-based programs.

Significance of the Study

This research filled the gap in understanding addiction social workers' perspectives regarding integrating harm reduction therapy into traditional abstinence-based treatment programs. It has been found that harm reduction therapy is effective concerning the treatment of addictions, but it is not utilized in every treatment program.

Harm reduction is often met with criticism because it does not equal abstinence. Often, professionals believe abstinence is the only way to achieve recovery (Hawk et al., 2017). The belief is that individuals who are using substances in any form are causing harm to themselves and the community they live; therefore, harm reduction therapy is not always accepted as a form of recovery (Hawk et al., 2017). This research also filled a gap in understanding how addiction social workers can include harm reduction techniques into abstinence-based treatment programs, and identified what barriers existed to implementing. Findings from this research study provided a more profound view of how harm reduction therapy, including MAT, can assist addicted clients in achieving recovery, even if they are in an abstinence-based treatment program (Roberto et al., 2014). Harm reduction therapy provides hope for opioid-addicted individuals; most research focuses on whether a program or medication is effective instead of understanding *how* harm reduction is effective from the addiction social workers' perspective. Addiction social workers who are using harm reduction can provide insight to other addiction professionals in abstinence-based programs on how to improve treatment outcomes for clients (Logan & Marlatt, 2010 & Vashishtha et al., 2017).

This study was unique because it brought in the perspectives and experiences of addiction social workers working with this population. The addiction social worker's belief in the effectiveness and acceptability of this type of therapy is crucial for it to be successful in practice; therefore, gaining an understanding of the addiction social worker's belief is necessary (Logan & Marlatt, 2010). Addiction social workers who are trained in abstinence-based therapies are not going to be adequate in helping a wide variety of clients because they will be focusing on abstinence. Clients who want to

achieve sobriety through various nontraditional paths will need assistance from professionals trained in harm reduction approaches. Most treatment programs do not offer harm reduction options; therefore, clients often end up in abstinence-based programs. Individuals who are in abstinence-based treatment programs still need education on harm reduction; therefore, addiction social workers need to be knowledgeable. Concerning opioid addiction specifically, abstinence is not always achievable or desirable by individuals (Vashishtha et al., 2017). This research provided insight into the effectiveness of harm reduction therapy while providing implications for treatment for addiction professionals that work with opioid-addicted populations.

The United States is currently facing the opioid epidemic head-on, and to order to be successful in bringing about change, understanding effective treatment is necessary. The costs associated with opioid abuse are astronomical, and the U.S. overdose rate is at an all-time high in (Hagemeier, 2018). There has been a significant amount of quantitative research that demonstrates the various medications associated with MAT and their effectiveness in the treatment of opioid addiction. However, funding for harm reduction programs has still been limited (Pitt, et al., 2018). Understanding the effectiveness of MAT and harm reduction therapy firsthand from an addiction social worker is necessary to begin advocating for more accessibility, implementing this type of therapy into abstinence-based programs, and assisting in reducing the impact of the opioid epidemic on our country.

Social Change

Social change is defined as any significant revision of behavior patterns, cultural values or norms, and political patterns (Yob & Brewer, n.d.). Social change occurs over

time, requiring individuals from various backgrounds to assist with bringing about the change (Yob & Brewer, n.d.). Historically, social change has been defined in various ways, specifically including words such as *ethics, global education, oppression, social development, social justice, and equity* (Yob & Brewer, n.d.). Social change can bring justice for vulnerable populations, but it requires involvement from large groups of people and occurs over a period of time (Yob & Brewer, n.d.). Social change can have different meanings within different disciplines, but it remains clear that it requires action alongside advocacy to achieve a result (Yob & Brewer, n.d.).

New Jersey has been impacted by the opioid epidemic considerably. In 2021, there were over 2,800 hundred overdose deaths, over 14,800 Naloxone administrations, and over 3.3 million opioid prescriptions written (NJCARES, 2023). The opioid epidemic has taken children away from their parents and parents away from their children. This epidemic has caused police officers to bring devastating news to families daily, and it has caused heartbreak for millions of Americans across our country with no clear, agreed-upon solution in sight. The only option for reducing overdose deaths is to join together in education and awareness. The stigma needs to be eliminated, and the government needs to be educated regarding harm reduction therapy, including MAT. The entire country needs to be united in addressing this epidemic and bringing real solutions, or nothing will change.

Social workers and addiction professionals have a critical role in supporting, educating, and bringing awareness about harm reduction therapy. Social workers can assist in reducing stigma surrounding harm reduction therapies while continuing to engage clients in a client-centered strength-based approach that allows clients to choose

their path to recovery. This capstone provided implications for social change on an individual, group, and community level through understanding harm reduction therapies on a deeper clinical level. In addition, this capstone helped to understand from a professional's perspective how the integration of harm reduction therapies into abstinence-based programs can provide more treatment opportunities for addicted individuals. On an individual and group level, social workers and other addiction professionals may better understand how to integrate harm reduction therapies into abstinence-based treatment and gain insight into barriers to integration. On a macro level, social workers and other addiction professionals can learn the importance of advocating for policy changes that can affect system changes. Social workers and other addiction professionals can advocate for increased access to harm reduction therapies and learn to provide community education to help reduce stigmas surrounding these approaches.

Theoretical Framework

The theoretical framework for this study is the harm reduction theory. Harm reduction is defined as an attempt to reduce health, social, or economic consequences associated with the use/misuse/abuse of legal or illegal substances without requiring individuals to stay abstinent (Einstein, 2007). The harm reduction philosophy does not disregard or encourage substance abuse but accepts substance use as a regular aspect of all societies (Einstein, 2007). Harm reduction models promote individuality and human rights for substance users while reducing adverse risks associated with illegal and legal drug use (Einstein, 2007). According to the Harm Reduction Coalition (Sam Rolfe, 2023), harm reduction beliefs include understanding that drug use is complex and multifaceted; therefore, recovery looks different for every user. Harm-reduction aims to

minimize death, injury, and disability related to opioid use/misuse/abuse (Salmond & Allread, 2019). Harm reduction is not an alternative to substance abuse treatment but instead a support for opioid users to improve overall health through safer practices (Salmond & Allread, 2019). The harm reduction philosophy supports opioid users outside of traditional abstinence-based treatment and provides professionals with various ways to offer help (Salmond & Allread, 2019).

There are five primary principles of harm reduction theory, including pragmatism, adoption of humanistic values, focus on harms, balancing costs and benefits, and priority of immediate goals (Riley et al., 1999). Pragmatism states that harm reduction accepts the logical response to substance use—it is part of the human experience, and society must accept elimination is not realistic (Riley et al., 1999). The acceptance of humanistic values allows professionals to accept, but not approve, the individual's drug use while not passing judgment. The individual using substances has dignity and respect (Riley et al., 1999). Focusing on harms allows the professional to focus solely on the harms associated with substance use instead of focusing on decreasing the use itself. While addressing the harms, the overall goals are generally related to decreasing use, and often individuals want to achieve long-term abstinence (Riley et al., 1999). Balancing costs and benefits assist individuals and professionals in identifying and understanding the negatives and positives associated with substance use. Understanding how substance use impacts the individual is often recognized during this process (Riley et al., 1999). Lastly, prioritizing immediate goals helps individuals target short- and long-term goals. Harm reduction theory utilizes a hierarchy of goals to assist individuals in addressing their immediate needs, which in turn helps to reduce harm associated with use (Riley et al., 1999).

Traditional substance abuse treatment has been proven ineffective for many opioid users, and non-abstinence-based treatment has increased in substance abuse treatment programs in the last several years (Friedmann, 2017). The goal during inpatient detoxification is to begin long-term abstinence, although this is never achieved (Bailey, et al., 2013). Several studies show that as high as 59% of patients relapse within 1 week after completing an inpatient detoxification program (Bailey, et al., 2013). Traditional treatment programs generally refer patients to outpatient programs but do not discuss harm reduction options, including MAT (Saloner & Barry, 2018). Strong evidence supports that harm reduction approaches provide more support for opioid addiction post inpatient detoxification (Saloner & Barry, 2018). Harm reduction theory allows professionals to work with addicted individuals in various ways, providing the necessary support they need to achieve their own recovery. Abstinence-based treatment programs can still provide the necessary education on harm reduction to addicted individuals. Addiction social workers involved in abstinence-based treatment programs need to be educated on harm reduction to properly inform addicted individuals.

Values and Ethics

The National Association of Social Workers (NASW) Code of Ethics is intended to guide social workers' professional conduct. Social workers promote social justice by empowering vulnerable populations. Social workers bring about change for individuals, families, groups, organizations, and communities (NASW, 2017). According to the Code of Ethics (2017), social workers are to treat clients with dignity and respect while ensuring their right to self-determination. The NASW Code of Ethics (2017), Section 1.02 states that

> Social workers respect and promote the right of clients to self-determination and assist in their efforts to identify and clarify their goals. Social workers may limit clients' right to self-determination when, in the social worker's professional judgment, clients' actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others.

Social workers assist clients in achieving their goals in a supportive and nurturing environment (NASW, 2017). Addiction social workers involved in harm reduction therapy are adhering to the NASW Code of Ethics because they are giving clients the right to self-determination; clients are encouraged to be in charge of their own recovery, including making decisions regarding treatment options that support their level of sobriety and willingness (Lee, 2015). Utilizing harm reduction, motivational interviewing, and other client-centered therapy treatment approaches support a client's right to self-determination (Lee, 2015).

The research conducted in this study can assist addiction professionals engaging in harm reduction therapy to meet their clients' needs better and maintain self-determination. This knowledge may help addiction social workers to engage with their clients better and ensure that treatment goals are developed together. This research outlines the importance of the counselor-client relationship and the importance of providing nonjudgmental, client-centered treatment (Lee, 2015). In addition, this research opens the conversation for integrating harm reduction therapy, including MAT, into abstinence-based treatment programs (see Abraham et al., 2011).

Review of the Professional and Academic Literature

A thorough literature review was conducted. EBSCO, PsycARTICLES, PsycINFO, and SocINDEX databases were used to find peer-reviewed academic journal articles between the years 2014 through 2021. Although the majority of articles were published between those years, a small amount of necessary articles were used from previous years, due to the important information they contained. The following terms were used to find articles for this literature review: *opioid epidemic, harm reduction therapy, medication-assisted treatment, 12-step programs, non-abstinent treatment, addiction treatment, and naltrexone.*

History of Opioids

Since the discovery of the opium poppy in 3400 B.C., people have been using opium to treat pain and achieve euphoria. The plant has an uncertain history; there are theories that state it was derived naturally, and others believe it was cultivated, and there are even theories that believe it was naturally mutated due to climate or altitude change (Booth, 1999). With the discovery of opium poppy came controversy—the British and Chinese fought two 19th-century wars over the drug (Booth, 1999). Post-war poppy cultivation was deemed illegal but the opium from the coast of Cantonese was purchased for trade to Europe and the United States (Booth, 1999). Around that time, Friedrich Serturner isolated the active ingredient inside the poppy (opium), combined it with ammonia, and developed morphine (Mann, 2009). Serturner quickly realized the powerful effects of morphine, and in 1817, in the journal *Annalen der Physik*, he concluded, “I consider it my duty to attract attention to the terrible effects of this new substance in order that calamity may be averted” (Mann, 2009).

Syringes: An Introduction

Despite Serturner's warning regarding the powerful effects of morphine, Dr. Alexander Wood, a Scottish inventor, created the hypodermic needle to reduce addiction. Putting aside Serturner's forewarning, Dr. Wood believed that injecting morphine was not addictive and encouraged medical doctors who were treating Civil War veterans to use the approach (Mann, 2009). Treating Civil War veterans with injectable morphine became standard practice, which left hundreds of thousands of veterans addicted (Mann, 2009). Post-Civil War, medical doctors used injectable morphine to treat everything from inflammation to menstrual pain. Morphine and opium pills did not require prescriptions, and injectable morphine was widely accepted as long as a doctor approved it for treatment (Mann, 2009).

In 1884, yet another debate surrounded morphine; multiple doctors felt that opium and morphine caused great rates of addiction, and they attempted to bring restrictions and regulations for these medications. W.G. Rogers, a doctor from Richmond, VA warned:

> I know persons who have been opium-eaters for some years who now daily consume enough of this poison in the form of morphine to kill a half dozen robust men not used to the poison. I have heard them, with tears in their eyes, say that they wished it had never been prescribed for them… Whilst they know it is killing them, more or less rapidly, the fascination, and power of the drug [are] irresistible, and it's a rare exception if they ever cease to take it as long as it can be obtained until they have poisoned themselves to death. (Macy, 2018, pp. 23).

Bayer and the Discovery of Heroin

Unfortunately, the Virginia General Assembly legislation declined to heed W.G. Rogers' warning, and within 14 years heroin was discovered when Bayer chemist Heinrich Dreser reviewed the pharmaceutical history and recreated the compound as it was originally created by mistake in 1874 (Scott, 1998). Dreser presented heroin as a 'cure' for pneumonia and tuberculosis—since the creation of antibiotics did not exist yet. Heroin was marketed as a nonaddictive alternative to morphine and was even promoted to 'cure' alcoholism and morphine addiction (Scott, 1998). Heroin was marketed toward those suffering from respiratory ailments, and in 1906, the *Journal of the American Medical Association* summarized heroin to be useful for diseases related to breathing, cough, bronchitis, pneumonia, asthma, whooping cough, laryngitis, and hay fever (Courtwright, 2001). Bayer Pharmaceutical Company distributed heroin and promoted the drug specifically for respiratory-related disorders (Courtwright, 2001). Bayer's company doctor sought to provide free samples to doctors through mail distribution and encouraged that the drug was safe and nonaddictive, which helped spread the drug fast (Macy, 2018). Today, opioids such as hydrocodone and codeine are often used in prescription cough medications (Caremark, nd). The FDA is involved, including placing limitations on the use of opioid cough medicine in children, and requires prior authorization for use (Caremark, n.d).

Recognizing the Problem: The Beginning

At the beginning of the 20th century, many doctors began to address the habit-forming properties of heroin and the need to end overprescribing (Macy, 2018). It was not until 1906 when the American Medical Association finally recognized heroin as an

addictive substance and stated, “The habit is readily formed and leads to the most deplorable results” (Courtwright, 2001). This is yet another warning regarding the addictive properties of heroin and opioids. It was evident throughout the 1910s and 1920s that heroin was a problem—admissions to hospitals related to heroin abuse were rising, and in 1914, The Harrison Narcotics Act was passed and restricted the sale and possession of heroin and other narcotic drugs (Courtwright, 2001). It was not until 1924 that the manufacturing of heroin was banned (Courtwright, 2001). Previously, heroin users were prescribed medications from their doctors, but with the drug outlawed, now users were labeled as ‘junkies’ (Macy, 2018).

Developing the Problem: Pain and Hospitals

In the current era of heroin addiction, doctors began writing prescriptions for opioid medication at an alarming rate, which unfortunately led to a social issue that has been overtaking our country one addict at a time. As previously discussed, the introduction of OxyContin by Purdue Pharma brought upon an entirely new era of opioid addiction; since the introduction of OxyContin in the 1990s, opioid addiction has taken the form of an epidemic. The American Pain Society worked together with the American Society of Anesthesiologists to address the supposed undertreatment of pain in the inpatient hospital setting; the introduction of “pain as the fifth vital sign” transpired in 1998 and the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) implemented new pain standards in hospitals in 2001 (Woodard & Van Demark, 2017). Pharmaceutical companies that detailed the consequences of not correctly treating pain distributed reports; with the distribution of this information and the relaxation of laws surrounding prescribing opioids for the treatment of noncancerous

pain, the opioid problem was further developed (Woodard & Van Demark, 2017). Pharmaceutical companies mislead prescribers that narcotic pain medication such as OxyContin would not lead to addiction, which ultimately caused prescribers to increase narcotic prescriptions tenfold (Woodard & Van Demark, 2017).

The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) introduced standards to improve pain for patients; patients identified pain on a 1 through 10 numerical scale, where 10 is the most pain, and 1 is the least pain, and medication was prescribed based on the number (Tompkins, et al., 2017). JCAHO required all healthcare organizations to assess for pain to receive federal healthcare dollars; JCAHO assessed patient satisfaction after discharge, and patients were questioned about how pain was managed while inpatient (Tompkins, et al., 2017). Hospitals and prescribers were encouraged to overprescribe narcotic pain medication to ensure high satisfaction ratings on surveys, ultimately leading to higher reimbursement rates and federal dollars (Tompkins, et al., 2017).

Beginning in 2007 with an article written by a neurologist, JCAHO continued to receive negative feedback regarding pain as the fifth vital sign, especially as the opioid epidemic continues to grow. In June 2016, JCAHO decided to remove pain as the fifth vital sign and continued to advocate for hospital surveys not to question patients about pain, since these surveys ultimately decided reimbursement rates (PAINSproject, 2017). With continued support from advocacy groups, the hospital survey, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), announced that starting October 1, 2019, pain questions were removed from all surveys and reimbursement rates would not be related to pain management (HCAHPS, n.d.). The removal of pain

questions in the HCAHPS assisted in reducing overprescribing of pain medication, which ultimately assisted in reducing the impact of opioids in communities.

The Opioid Epidemic and New Jersey

For the purpose of this paper, the focus is on the state of New Jersey. New Jersey experienced just under twelve thousand drug overdose fatalities from January 2019 to December 2022 (NJ Cares, 2023). Opioid-related overdose deaths in New Jersey are nearly five times more than car crashes. According to the *New Jersey Substance Abuse Overview Report,* in 2022, there were over 88,000 treatment admissions in New Jersey, and out of those admissions, there were over 39,000 admissions for heroin and other opioids. Although 88,000 sounds like a lot of treatment admissions, the report found that there were over 79,000 people who felt they needed treatment and only about 46,000 were able to receive treatment. These statistics do not provide specific information related to heroin and other opioids, but it can be seen that less than half of the people who needed treatment were not able to receive it (NJCARES, 2023). Out of the 88,000 treatment admissions, MAT (methadone, suboxone, and vivitrol) was only planned in treatment 29% of the time, which is only 21,000 people (NJCARES, 2023).

Cost of the Opioid Epidemic

The opioid epidemic has impacted the United States financially; financial impacts include unemployment rates, costs associated with opioid-related deaths, treatment costs, halfway house costs, hospitalizations, and prison costs (NJ Reentry Corporation, 2018). Costs associated with the opioid epidemic were upward of $1.2 million, and it was estimated that over 90% of addiction treatment costs were utilized by individuals who had previous treatment attempts (NJ Reentry Corporation, 2018). An estimated $145

million was spent on incarceration costs for those in prison due to primarily drug-related crimes and an estimated $635 million was spent on inpatient and emergency department overdoses alone (NJ Reentry Corporation, 2018).

Harm Reduction Therapy and the Opioid Epidemic

The opioid epidemic has impacted every state in this country, and deaths related to overdoses continue to grow with almost no sign of decline. Since 2013 overdose deaths have exceeded deaths from car accidents, which makes it the top of preventable deaths in the United States (Vashishtha, et al., 2017). Opioid use is a significant public health issue and causes major financial problems for our country; opioid abuse costs the United States over $78 billion (Custer, 2017). Harm reduction approaches to addressing the opioid epidemic include focusing on reducing risky behaviors associated with opioid use, such as overdose, drug use, and paraphernalia (Vakharia & Little, 2016). Overdose deaths are preventable with education and awareness can be prevented with naloxone—an opioid antagonist (Mitchell & Higgens, 2016). Naloxone reverses the respiratory depressive effects of opioids and can be administered intranasal (Mitchell & Higgens, 2016). Naloxone is highly effective in reversing opioid overdoses and can be used by the layperson, but there is still a stigma associated with its use (Mitchell & Higgens, 2016). Access to naloxone is necessary to reduce the impacts of the opioid epidemic because it provides an immediate, lifesaving intervention while waiting for emergency personnel (Mitchell & Higgens, 2016).

Harm reduction therapy has been integrated into clinical settings to reduce risky behaviors for clients who are addicted to substances; harm reduction therapy has become associated with the opioid epidemic precisely because of the associations with mortality

(Little, 2016). The mortality rates of the opioid epidemic are transparent; therefore, harm reduction is necessary to reduce the rate of deaths associated with the epidemic. Harm reduction therapy allows for individuality while maintaining client-centered, compassionate treatment (Custer, 2017). Since harm reduction therapy does not require abstinence, treatment goals can be modified for each client (Custer, 2017). Harm reduction therapy can be used in inpatient or outpatient treatment settings and helps to reduce the cost of treatment since it does not require the addicted individual to be inpatient (Pitt, et al., 2018). This treatment approach allows addiction social workers to engage in therapy in almost any setting and ultimately change the epidemic by reducing the harms associated with opioid use (Vakharia & Little, 2016).

History of Harm Reduction Therapy

Syringe Programs

In 1981 with the discovery of acquired immunodeficiency syndrome (AIDS), harm reduction therapy became well known for treating substance use disorders, and reducing disease transmission (Des Jarlais, 2017). In the 1980's, the idea of syringe exchange programs was introduced mainly in Europe, where drug users could access clean needles and other paraphernalia to encourage safe drug use; these syringe exchange programs would ultimately reduce the spread of AIDS and hepatitis (Des Jarlais, 2017). In the United States, activists attempted to develop syringe programs, but the community was not accepting. It was not until 1986 in Connecticut, that the first syringe exchange program was developed. After the first program was developed, syringe exchange programs began in primarily urban areas in New York City and the West Coast (Des Jarlais, 2017). Despite the growth of syringe exchange programs in the 1990s and early

2000s, there are still fourteen states in the United States that do not have syringe access programs (Nadelmann & LaSalle, 2017). The syringe access programs that are developed meet only 3 percent of the estimated need in the country, but there is hope that new programs will be developed (Nadelmann & LaSalle, 2017). Elected officials who opposed syringe programs have now embraced them as necessary to combat the spread of diseases and as a tool to address the opioid epidemic. The continued development of syringe access programs will provide access to clean and safe drug paraphernalia while providing an opportunity to educate consumers on opportunities to achieve recovery if they are interested (Nadelmann & LaSalle, 2017).

Current Harm Reduction Trends

Currently, there are two trends regarding harm reduction: how to increase government advocacy and how to implement techniques into clinical treatment. The opioid epidemic has been established as a public health emergency in the United States, which has provided increased funding for treatment from the government. The United States Department of Health and Human Services (HHS) has announced a focus on five major priorities—improving access to treatment and recovery services; promoting use of overdose-reversing drugs; strengthening our understanding of the epidemic through better public health surveillance; providing support for cutting-edge research on pain and addiction; and advancing better practices for pain management (NIDA, 2019). The government secured $6 billion in new funding over a two-year window to fight the opioid epidemic by increasing access to evidence-based treatment programs and to overdose-preventing medication (NIDA, 2019). Social workers and other addiction professionals are on the front lines of the opioid epidemic; with increased funds, there should be an

increase in treatment programs, and social workers can continue to battle the opioid epidemic.

Harm Reduction and Clinical Implications

Although it is still not commonplace, harm reduction therapy has become more established in clinical treatment. Many stigmas are associated with harm reduction therapy, and professionals do not always agree with non-abstinent goals for opioid users (Davis & Nickelsen, 2018). Opioid users that enter traditional treatment programs should have goals linked with abstinence, and 12-step beliefs are often integrated into treatment (Davis & Nickelsen, 2018). According to the National Treatment Center Study in 2004, almost 60 percent of publicly funded treatment centers used a 12-step approach, and almost 75 percent of privately funded programs also used a 12-step approach (Lee, et al., 2011). Many treatment programs do include other approaches, such as cognitive-behavioral therapy, although the primary treatment goal is abstinence-based (Lee, et al., 2011).

Twelve-Step Programs

Twelve-step recovery is a non-professional, mutual-aid group to address alcohol and drug dependence with a global attendance. Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) provide support and recovery for those struggling with dependence, but they are based on abstinence (Monico, et al., 2015). Twelve-step programs are not considered professional treatment because they are non-professional and peer-run. They are open to anyone who wants to stop drinking or using substances, and offer fellowship and sponsorship to members through regularly scheduled, peer-facilitated meetings (Lee, et al., 2011). A significant aspect of 12-step programs involves

a spiritual quality; the 12-steps include recognizing powerlessness over alcohol or drugs and then building a relationship with God (as understood by the individual) to assist in maintaining sobriety (Lee, et al., 2011). The spiritual aspect of 12-step programs is the key component that separates them from other treatment approaches. Substance abuse treatment programs often encourage clients to attend 12-step meetings, but they are considered two separate entities.

Twelve-step programs are often integrated into traditional substance abuse programs. At a national level, about 74% of substance use treatment programs integrate some aspect of 12-step programs (Dennis, Roland, & Loneck, 2017). 12-step approaches are often known as the generic follow-up for addicted individuals when they are discharged inpatient or outpatient (Dennis, et al., 2017). Clinicians that are in recovery themselves might have a personal experience with 12-step programs, but there are still many professionals who are not aware of the specifics of 12-step programs (Dennis, et al., 2017). Many inpatient treatment programs allow outside 12-step members to speak with patients in hopes of transitioning to the community 12-step meeting easier. In addition, outpatient programs often provide 12-step meetings to come to their facility and speak with clients regarding meeting attendance (Donovan, et al., 2013). The integration of 12-step programs with harm reduction models can be challenging because they have opposing beliefs, which will be discussed further in this paper.

Harm Reduction and Twelve-Step Integration

Harm reduction approaches seem to have a completely opposite basis for achieving recovery than 12-step programs. Twelve-step programs do not promote the use of alcohol or substances in any way but instead focus on achieving sobriety through

abstinence. At the same time, harm reduction approaches include the acceptance of various forms of recovery and allow for addiction professionals to use a strength-based person-centered approach (Lee, et al., 2011). Integrating harm reduction approaches into historically abstinent-based programs has been difficult due to substance abuse professionals' pushback. Substance abuse counselors have historically been educated on abstinence-only treatment options, which can lead to one belief in a single pathway to recovery (Abraham, et al., 2011). Implementing harm reduction into treatment can allow clients to control their recovery, but counselors need to be supportive in implementing harm reduction techniques (Abraham, et al., 2011). Unfortunately, a small amount of research focuses on how professionals integrate harm reduction into traditional abstinence-based treatment programs. Most research discusses the benefits of harm reduction but does not focus on professionals' perspectives on the integration (Marlatt, et al., 2001). Evidence-based practice has demonstrated that harm reduction has been successful in treating opioid use disorders; therefore, counselors need to include non-abstinent alternatives to treatment for their clients to have all options for success. Harm reduction allows counselors to work from a client-centered approach while providing options for clients to achieve their own perception of recovery.

As previously discussed, 12-step programs traditionally do not support non-abstinent members because it is not in accordance with the twelve steps (Monico et al., 2015). Historically, 12-step programs have viewed individuals utilizing opioid agonist medications as not 'sober', but in recent years this has begun to change (Monico et al., 2015). Since 12-step programs are based on peer support, they are not trained medical professionals and should not determine whether individuals are in recovery (Monico et

al., 2015). How can professionals encourage harm reduction therapy and MAT if they also encourage clients to attend twelve-step programs? Since most treatment programs are abstinence-based programs that encourage 12-step attendance, counselors need to be aware of the pushback from these programs toward individuals on medication. Treatment programs and counselors need to further their education on harm reduction therapy and how to meet better needs of these clients in an abstinence-based program (Abraham et al., 2011). Professionals must ensure they receive continuing education related to the opioid epidemic and harm reduction therapy (Roberto, et al., 2014).

Other Substance Abuse Treatment Models

Other approaches to treating substance abuse addiction besides harm reduction and abstinence include cognitive-behavioral therapy (CBT) and motivational interviewing (MI). CBT was developed initially as a method to prevent relapse when treating problem drinking; CBT has since developed into a practical therapeutic intervention to treat a variety of addictive disorders (Sudhir, 2018). CBT is an evidence-based psychological intervention that is structured and time-limited; CBT focuses on identifying and modifying dysfunctional thoughts to modify negative behaviors and emotions (Sudhir, 2018). Clients can identify maladaptive behavior patterns and learn to correct the problematic behaviors using self-monitoring to identify early signs of problematic behavior. Addiction professionals attempt to enhance clients' self-control by developing coping strategies and skills learned throughout CBT stay with clients after the completion of treatment (Sudhir, 2018.)

Motivational interviewing (MI) is a counseling approach that helps consumers resolve their ambivalence about engaging in treatment and stopping drug use. Motivation

has been identified as one of the most important predictors of clients achieving sobriety and engaging in treatment (DiClemente, et al., 2017). With substance-abuse clients, they are often in 'denial' of their addiction or addictive behaviors, which causes significant issues in treatment. MI eliminates the idea of a client being in "denial;" it views clients as ambivalent about changing behaviors. The addiction social worker helps the client to see that ambivalence toward change is normal and can be resolved by identifying personal motivations and beliefs. Addiction social workers use empathic, nonjudgmental communication and encourage clients to self-direct their treatment, which helps to build a safe and trusting environment (DiClemente, et al., 2017). MI can be defined as a person-centered counseling approach for addressing the common problem of ambivalence about change (Miller & Rollnick, 2013).

Harm reduction therapy and MAT have become more popular since the daily opioid overdose rate has increased significantly in recent years. The facts are presented in the previous sections: opioid addiction is taking over this country one person at a time; the "war on drugs" has failed, and harm reduction therapy, including MAT, has earned keep in the addiction treatment world. Social workers and other addiction professionals have been educated on evidence-based practice, which includes harm reduction techniques, but implementing these techniques is lacking. Social workers and other addiction professionals are required to maintain knowledge of evidence-based practice, but with the controversial subject of harm reduction, there has been a significant lack of implementation (Davis & Nickelsen, 2018). The U.S. Food and Drug Administration issued a press release in August 2018 discussing the importance of expanding MAT to those struggling with opioid use disorder, detailing the acknowledgment of MAT's

success, and the need for expansion and accessibility of these programs (Office of the Commissioner, 2018).

Through an extensive literature review, a gap was found—there is no research that identifies how professionals are integrating harm reduction therapy approaches into abstinence-based programs for opioid-addicted individuals. This paper attempts to reduce that gap by interviewing addiction social workers in abstinence-based treatment programs in Northern New Jersey. The interviews determined how comfortable professionals feel discussing non-abstinent treatment goals with clients and how they can successfully integrate into traditionally abstinence-based programs and provided implications for practice for other addiction social workers. The opioid epidemic is not stopping; therefore, all social workers who are employed in treatment programs must be educated and knowledgeable about harm reduction. Even abstinence-based treatment programs are responsible for educating and informing addicted individuals about other treatment options.

Summary

The history of opioids dates back decades, while the treatment for opioid addiction has been more recent. The current opioid epidemic has a complicated history of efforts by multiple industries to attempt to balance the vital treatment of pain, while managing the misuse and abuse of opioid medications. With the focus of this paper on New Jersey, it is evident that New Jersey opioid overdoses are at an all time high. Treatment admissions for opioid abuse are increasing and there are not enough treatment centers in the state to support the demand. Harm reduction treatment offers an opportunity to meet the demand for treatment without requiring an individual go to an

inpatient center. Harm reduction has been established as evidenced based practice for the treatment of opioid addiction, but implementing the practice across all treatment is not evident. The next section details the research design of this study including, methodology, data collection and analysis and ethical procedures.

Section 2: Research Design and Data Collection

Introduction

Opioid addiction has been established as a social problem in our country and has impacted almost every person in America, whether personally or through someone they know. To adequately address this epidemic, substance abuse professionals need to be properly educated on the success of harm reduction therapy and how to incorporate non-abstinent goals into traditional abstinence-based programs. Professionals can gain the necessary education through continuing education programs and other seminars. The purpose of this capstone research is to understand how to better treat opioid-addicted clients through harm reduction therapy. Professionals may gain insight into the importance of the client-counselor relationship, how to discuss integrating non-abstinence-based goals into therapy, and further address the opioid epidemic through harm-reduction therapy. The research recommendations may also contribute to macro-solutions, including how to reduce the opioid epidemic through harm reduction therapy approaches.

This section begins with a description of the qualitative research design, including the research questions and the study's central concepts. Next, the methodology section includes the data collection methods, recruitment methods, participants of the study, instrumentation, and data analysis. In the concluding section, I will summarize the key points of the section and provide a transition into Section 3.

Research Design

This capstone research study aimed to enhance clinical social work practice by exploring the perceptions of addiction social workers' that use harm reduction treatment

approaches in abstinence-based programs with individuals diagnosed with opioid use disorder. The social work practice problem addressed addiction professionals integrating harm reduction into abstinence-based treatment programs. The integration of harm reduction into traditional treatment programs has been studied, but understanding this integration from an addiction social worker's perspective has not been studied (Williams, et al. 2017). The research questions are:

Research Question 1: How is harm reduction being integrated into abstinence-based programs, from an addiction professional's perspective?

Research Question 2: What are social workers' perceptions of integrating harm-reduction therapy with traditional 12-step/abstinence-based therapy?

This qualitative study gathered participants using purposeful sampling and collected data through semistructured narrative interviews. The semistructured interviews allowed for participants to provide in-depth responses to research questions, while sharing their experiences about harm reduction.

Methodology

Prospective Data

Gathering data through semistructured interviews allows for in-depth responses. Narrative research is very natural for individuals because people tell stories about their lives and reflect on memories (McAlpine, 2016). A narrative approach to gathering qualitative data is helpful because people are inclined to have discussions about topics that interest them, it comes naturally (McAlpine, 2016). One approach to gathering information through a narrative approach is semistructured interviews. Semistructured interviews provide an opportunity for respondents to highlight their professional expertise

and opinion regarding the topic (Jamshed, 2014). Semistructured interviews include questions that have been prepared prior that are focused directly on the topic, but the style allows for flexibility (Jamshed, 2014). Semistructured interviews allow for a large amount of data to be collected with flexibility, and the style is simple enough to be conducted with almost anyone (Jamshed, 2014). There are disadvantages of semistructured interviews, including that there is no way to guarantee the honesty of the information provided, cause and effect cannot always be inferred, and there cannot always be a common theme identified. Although flexibility can provide advantages, it could be a disadvantage because it can lessen the reliability of the information gathered (Jamshed, 2014). Although a narrative approach only captures what the participant is willing to share, it is the best approach for gathering information regarding personal experiences from participants because it allows for a natural flow of conversation, which provides a smooth interview process (McAlpine, 2016).

For this capstone research project semistructured individual interviews were used with addiction social workers currently working in substance abuse treatment programs. Qualitative research generally has a smaller number of participants, allowing for more in-depth interviews. For this capstone research project, 13 addiction social workers were interviewed—ideally, 12 to 15 social workers were pursued.

Participants and Recruitment

For this capstone research study, 13 addiction social workers working in substance abuse treatment programs were interviewed. Semistructured interviews allow for a significant amount of information to be gathered; therefore, 13 social workers provided enough data for the research project. Narrative research provides researchers

with multiple ways of knowing by gathering information from multiple participants (McAlpine, 2016). Qualitative narrative research allows the researcher to document various ways of understanding and can illustrate how multiple views on the same experience can co-exist. A sample size with multiple participants, without being too large, provides a more profound and more credible representation of the lived experience (McAlpine, 2016). Participants were recruited with the professional social media networking site LinkedIn and through referrals from participants. The requirements were that all participants needed to have worked in a substance abuse treatment program, whether inpatient or outpatient, in the northern New Jersey area; participants were addiction social workers with CADC, LCADC, LSW, or LCSW credentials. To ensure quality of data, the participants also had to have at least 2 years of experience working in the addiction field. The flyer was posted on the professional networking site LinkedIn and referrals were received from participants. Participants were provided with a $10 Dunkin Donuts gift card as a token of appreciation for taking time out of their busy schedules. The sampling strategies used will be further detailed in the following section.

Sampling Strategy

Qualitative research designs recruit a small number of participants; therefore, appropriate sampling should be used. Sampling is essential for any research project because the reliability of the findings depends on how well the participants were selected (Luborsky & Rubinstein, 1995). A sample should represent the larger population and include individuals from various backgrounds (Luborsky & Rubinstein, 1995). Purposeful sampling with an option for snow-ball sampling was used to gather participants for this research project; purposeful sampling allows for members to be

selected that are appropriate for the study, while snow-ball sampling allows for respondents to identify other appropriate participants (Luborsky & Rubinstein, 1995). For the purpose of this study, all participants did not come from the same agency, though some overlap did occur. Participants were recruited from various agencies in the Northern New Jersey area.

Instrumentation

In qualitative research, the main instrument often is the researcher themselves; the researcher often records, observes, and takes notes while interviewing participants (Trigueros et al., 2017). The interview guide was used for data collection during face-to-face semistructured interviews. It contained five open-ended questions with prompting questions. Interview guides help to lead the conversation throughout the interview, and the guide helps the interviewer determine what to ask, when to ask it, and what to follow up with (Magnusson & Marecek, 2015). Research questions are not interview questions, so the researcher needs to collect data that is relevant to the research question. The themes that are identified in the literature review help the researcher identify areas of data that need to be collected. Once the researcher develops what data needs to be collected to answer the research questions, interview questions are developed. The interview questions will help the researcher find information relevant to the research questions but also identify themes that will be discussed (Magnusson & Marecek, 2015). The questions gather information on harm reduction therapy and how professionals integrate it into their professional work and inquire about case management techniques for clients. The interview questions were developed with a focus on harm reduction integration. The interview questions asked addiction professionals to identify what harm reduction therapy

means to them and if their agency utilizes the techniques. In addition, the interview questions ask the interviewees to identify their perceptions about harm reduction therapy, if they address the topic during supervision, and if professionals link those in need to outside harm reduction resources.

Before the in-depth interview, demographic questions were gathered to ensure participants met the requirements for the interview and to provide additional information about their clinical background, such as their level of education. The interview questions gathered information relevant to the research questions. Semistructured narrative interviews were used for this research project because of their flexibility and collaborative nature; semistructured interviews allow the researcher to obtain in-depth information by utilizing follow-up questions when needed and keep participants engaged in promoting the collective effort (Trigueros et al., 2017).

Data Analysis

A professional transcription agency transcribed the data collected throughout the interviews. Each narrative interview was recorded with two devices to ensure accuracy and to be prepared for any technological challenges. Precise data analysis is essential because it provides a better understanding of the results to the researcher and provides a deeper meaning and understanding of the material based on the environment where the research is taking place (Akinyode & Khan, 2018). Once data collection occurs, qualitative data analysis includes documenting, organizing, and reviewing data to identify themes and patterns related to the research questions (Akinyode & Khan, 2018). Going through each interview and noting common words related to the study (i.e., MAT, harm reduction, harm reduction therapy) can help identify common statements or words

participants said. The statements or words then become codes, which are later developed into themes. Once themes are identified, they can be directly related to the research, and the researcher can use them to better understand the research (Castleberry & Nolen, 2018).

Determining the validity, transferability, external validity, dependability, reliability, confirmability, objectivity, and trustworthiness were determined throughout the course of this research. Validity, both internal and external, determines if the tools, processes, and data are 'appropriate' for the research study (Amankwaa, 2016). Internal validity determines if the structure of the study is correct; for example, were narrative semistructured interviews the best way to gather data for this study? External validity determines if the conclusions from the study can be applied outside of the study parameters; for example, can the results be transferable to other situations or people (Amankwaa, 2016). For the purpose of this paper, internal validity is addressed through research, explicitly comparing similar studies and how they collected data. External validity is addressed based on the study's results; are the results generalizable to other areas? Reliability refers to replicating the process and obtaining the same results, which can be complicated with qualitative research because there are not always specific ways to determine reliability (Amankwaa, 2016). The overall trustworthiness of a qualitative research study is based on these components in addition the objectivity and dependability of the researcher. The researcher must have an objective and unbiased look at the study. In addition, the researcher must be accurate with gathering and reviewing information to ensure the study is dependable (Amankwaa, 2016). Trustworthiness can also be identified by having interviewees review their transcripts to ensure the correct information. This

capstone interviewed 13 addiction social workers; therefore, the representation of the findings will most likely not be generalizable to all substance abuse treatment programs.

Ethical Procedures

All participants received informed consent before engaging in their interviews; informed consent explained the research study's intentions, goals, procedures, risks, and benefits. Participation was voluntary, and they could withdraw from the study at any time without penalty. All information collected was confidential; information was kept in a locked file cabinet throughout the study and was not shared with anyone. The research study presented minimal risk and all participants were provided an orientation before deciding to participate. If there were any adverse reactions to participation, the researcher would immediately stop the interview and ensure each participant's safety. The orientation included the purpose of the study, methodology, contribution, and the explanation of all risks. Informed consent was discussed with all participants, and they were made aware that they could withdraw any time during the study. All participants were assigned a 'code name' to take the place of their actual name to ensure privacy and confidentiality. Data will be destroyed five years after the researcher completes the doctoral program, and each participant will receive a copy of the results.

Summary

This chapter details the research design and data collection methods to understand the perceptions of social workers engaged in clinical practice with opioid users in a MAT setting. The research questions for the study are:

Research Question 1: How is harm reduction being integrated into abstinence-based programs from an addiction professionals' perspective?

Research Question 2: What are social workers' perceptions of integrating harm-reduction therapy with traditional 12-step/abstinence-based therapy?

The objective of the capstone research project was to identify perceptions from addiction social workers and to improve clinical practice about harm reduction therapy for those individuals who have an opioid use disorder. The qualitative study used narrative semistructured interviews with prepared questions and follow-up questions. The data collected was recorded and later analyzed through a transcription service. All participants were voluntary, and their information will be protected with strict confidentiality. In Chapter 3, data analysis techniques and findings will be detailed.

Section 3: Presentation of the Findings

Introduction

The purpose of this qualitative study was to examine whether harm reduction techniques were being used in abstinence-based substance abuse treatment programs and determine addiction professionals' views on integration. Although harm reduction has been verified as evidence-based practice in the field of substance abuse, there is minimal empirical knowledge of integrating these ideas into an abstinence-based program and even more limited information from an addiction professional's experience. Through interviewing addiction social workers, the goal was to find out if the integration was being done, find out limitations if it is not, and to further identify ways to integrate harm reduction techniques into these abstinent-based programs. In this chapter, an analysis of the data to answer the following research questions is presented.

Research Question 1: In what ways are harm-reduction programs being integrated into abstinence-based programs from an addiction professionals' perspective?

Research Question 2: What are social workers' perceptions of integrating harm-reduction therapy with traditional 12-step/abstinence-based therapy?

Data were collected through semistructured narrative interviews. These interviews allowed addiction professionals to detail their experience. Semistructured interviews allowed participants to detail their experiences in an open-ended format, while the narrative style allowed the participants to be detailed in their responses without having to follow a prompt. This chapter includes an extensive review and explanation of data collection methods, data analysis methods, and the findings from data collection.

Data Analysis Techniques

I recruited participants for this study in two ways. The first approach was using the professional networking site LinkedIn. I posted an initial recruitment flyer to my personal LinkedIn page. Currently, I have 788 connections within my network. The second approach was having participants recommend and/or share my flyer with other addiction professional peers who might have been interested.

I posted the original recruitment flyer to my LinkedIn page in late November 2021 with minimal responses. I mainly attributed the lack of response due to the holidays and many people not being active on their accounts during this time. In early January 2022, I reposted the flyer and received two responses, and interviews were scheduled after screening and the consents were signed. After the initial two responses, two more participants emailed with interest. Those two participants then signed consent and agreed to participate in the study, and interviews were completed in February. I reshared my flyer on my LinkedIn page for the third time, and my previous 4 participants referred other interested addiction professionals. The final sample size was 13 participants, and all interviews were completed by April 2022. After completion of the interviews, audio recordings of the interviews were sent to a professional transcription service (Weloty) to be transcribed. The transcription service then sent a Word document, which was sent to each participant to be reviewed for accuracy.

I obtained a sample size of 13 using a purposeful sampling strategy with an option for snowball sampling. The sample size was determined based on similar qualitative studies on social workers' perspectives on other areas in treatment. The sample size of 13 was set to allow for appropriate data collection for theme analysis and to avoid research

extension (Luborsky & Rubinstein, 1995). Larger sample sizes can cause a study to be overly long and can cause a high level of saturation. Saturation occurs in data collection when new data produces minimal or no new information based on the research questions. Research has noted that saturation can be established within the first 10 interviews (Guest, et al., 2020). Saturation for this study occurred by the fifth interviewee, therefore a sample size of 13 interviewees was sufficient to achieve data saturation.

After receiving written (email) confirmation from prospective participants confirming their interest, I emailed a consent form indicating that they should email back with "I consent" prior to the interview. In addition, they completed a self-administered demographic questionnaire before or during the interview. The participants were given options on the date and time of the interview; all interviewees chose a virtual interview. Each virtual interview took place via Google Meet and was recorded via Google Meet and backed up with a recorder; all interviews included the purpose, procedures, risks and benefits, and contact information. There were no deviations from the protocol outlined in the intended methodology throughout the data collection process. One limitation occurred during the interview with P12, where the Google Meet was interrupted. The participant was able to log back on and continue through their phone. Although technological issues are unavoidable, they can impact the overall interview flow. The individual was accommodating and was able to continue without any issues. There were no other significant issues during data collection.

Demographic Profile of the Participants

The study's 13 participants were all licensed addiction therapists who met the study's inclusion criteria, which included (a) an addiction therapist with one of the

following licenses LCSW, LSW, LCADC, CADC (b) an addiction therapist practicing for at least 2 years in the field of substance abuse (c) must work in an abstinence-based inpatient or outpatient substance abuse treatment center in northern New Jersey. The following is a summary of the participant's profiles:

There were five social workers who were dually credentialed (LCSW, LCADC), two LCSW's, four LSW's, and two LCADC's. The range of experience was from 2 years to 26 years. Ten of the participants were in a supervisor/management role. All participants were employed in inpatient, outpatient, or detox programs.

Data Analysis

After each interview was completed, they were electronically uploaded to a Google Drive between myself and Weloty Academic Transcription Services for transcription. The transcription return was within 1-2 weeks. Weloty services provided a Word document that was shared with each participant so they could review and approve for accuracy. There was one participant, P8, who edited minor transcription errors (wording).

Each interview question was developed in alignment with the research questions to obtain participant perspectives and to serve as a guided script throughout the interviews. As a result, similarities existed between each interview and participant, confirming that the interviews were based on the study's purpose and aligned with the research objectives.

Coding

Each participant answered the same set of predetermined interview questions based on the conceptual framework of the harm reduction model for substance abuse

treatment and the research questions: (a) In what ways are reduction programs being integrated into abstinence-based programs from an addiction professional's perspective? (b) What are social workers' perceptions of integrating harm-reduction therapy with traditional 12-step/abstinence-based therapy?

Codes in qualitative research are most often known as a word or short phrase symbolically associated with a portion of the interview (Williams & Moser, 2018). Open, axial, and selective coding of data allows researchers to understand the data by continuously reading and re-reading the collected data for a theory to evolve (Williams & Moser, 2018). The process is as follows: (a) data collection and analysis (b) open coding (c) axial coding (d) selective coding (e) theory development (f) constructive meaning. Open coding is the first level of coding, where the researcher identifies distinct concepts and themes for categorization. The first level of data is organized by creating broad thematic concepts, where units of classifying are attached to these concepts (Williams & Moser, 2018). For this research, I reviewed the transcripts, identified similar words and phrases, and attached them to larger thematic ideas. Upon review of the transcripts, I identified multiple repetitive phrases and words and initially identified 26 codes that were then analyzed in alignment with the research questions. During the analysis, I used axial coding to identify emergent themes and categorize them into smaller groups (Williams & Moser, 2018). I placed the 26 original codes into five categories: (a) education, (b) client-centered, (c) resistance/relapse, (d) supervision, and (e) judgment/stigma. Those categories became three significant themes, with one subtheme of this research study, client-centered treatment, with a subtheme of judgment/stigma, education, and supervision.

The next stage in the data analysis process was to ensure the research study's validity, credibility, and reliability. In qualitative research, validity notes the appropriate use of the research processes, trustworthiness, data, and instrumentation (Amankwaa, 2016). Validity focuses on the alignment of the research question, the methodology, and if the study's results and conclusions are applicable to the context of the research (Amankwaa, 2016). Credibility in qualitative research notes that the research was conducted in a consistent and trustworthy manner, including disclosing the methods of analysis in detail (Amankwaa, 2016). Reliability in qualitative research focuses on whether the research process and results can be replicated (Amankwaa, 2016). For the purpose of this research, I ensured validity by addressing any biases in sampling, kept a thorough record-keeping of the interview process, and maintained all documents and notes from interviews. Credibility was established with a detailed explanation of the analysis process, including the appropriateness of the research for the study. Lastly, reliability can be determined through other researchers' use of this data while remaining as consistent as possible.

Ethical Procedures

I followed ethical procedures as required by Walden University's Institutional Review Board (IRB) and the ethical values developed by the NASW. My ethical responsibility is to ensure that no physical or mental harm came to the participants who agreed to partake in the study. Informed consent has a detailed description of the research study's purpose, procedures, risks and benefits, payment, and privacy of the study to ensure that each participant has a thorough understanding of their role in the research. No participant information, such as names or other identifying information, was used in the

study. Once the IRB application was approved (#11-18-21-0725314) I began seeking participants by posting my flyer on the professional social media site LinkedIn. Potential participants were able to reach out to me via email, and the informed consent and demographic sheet were sent and completed if they consented. Each interviewee was assigned a number that was used for transcription purposes, so their personal information was not included. In addition, the transcription company signed a confidentiality form. All information collected during the interviews was stored electronically on a password-protected computer; any information that was printed out was stored in a locked file cabinet where I was the only individual with access to the key code. The information collected during the interviews was only shared with committee members and the IRB upon request.

Findings

This qualitative research study aimed to answer the following research questions: (1) In what ways are reduction programs being integrated into abstinence-based programs from an addiction professionals' perspective? (2) What are social workers' perceptions of integrating harm-reduction therapy with traditional 12-step/abstinence-based therapy? The 13 participants of this study shared and discussed their experience with integrating harm reduction into abstinence-based treatment programs, as well as their perspective on that integration. Three primary themes emerged from the collected interview data, which include:

- Theme 1: Client-centered treatment is necessary.
    - Subtheme 1: The impact of stigma/judgment on the relationship.
- Theme 2: Education

- Theme 3: Supervision is necessary to discuss harm reduction integration.

Theme 1: Client-Centered Treatment is Necessary

Throughout the interviews, participants discussed the importance of client-centered treatment. Client-centered treatment was developed by Carl Rogers, and believed that unconditional positive regard, congruence, and empathy produced a change in clients (Velasquez & Montiel, 2018). The foundation of client-centered therapy is that the client and the therapist are in a relationship, and that relationship is the main driving force in producing change within the client (Velasquez & Montiel, 2018). The central idea of the client-centered treatment approach is that the therapist provides unconditional positive regard, which allows the client to recognize their own power in the relationship (Velasquez & Montiel, 2018). Throughout the interview process, multiple participants discussed how the client-centered technique is supportive of harm reduction. Within the harm reduction approach, therapists are supportive of client's goals even if they are not abstinence-based. P2 noted, "All of our treatment is client-directed. The client is the expert on themselves." P2 continued, "If a client tells us they have no intention of abstaining from use, then we just go with that and meet the client where they are and work from there." P7 noted, "Building the rapport, having clients be comfortable enough to be honest."

Throughout almost every interview, each participant mentioned "meeting clients where they are at" in their treatment, which is directly supportive of a client-centered approach because it allows the client to have power in the relationship, and it does not force clients to follow a generic treatment plan. Participants also discussed the importance of the therapeutic relationship and how providing support without judgment

is necessary within the substance abuse realm. Multiple participants noted that "meeting clients where they are at" is essential because it allows the client/counselor relationship to build trust and allows clients to feel safe, which encourages client's honesty.

Subtheme: The Impact of Stigma/Judgment on the Relationship

As mentioned throughout this research paper, judgment impacts the therapeutic relationship, especially when working with substance abuse clients who do not see abstinence as a short- or long-term goal. Interviewers noted that substance abuse clinicians often hold stigmas associated with clients who pursue the harm reduction route. P3 noted, "We have a lot of people who are very conditioned under this idea that if you're using it's an issue immediately no matter what, no matter why." P6 noted, "I think some clinicians who are in recovery, so doing this work, get a little jealous of that [harm reduction], and will continuously try to push them down the road of abstinence." In addition to counselors having stigmas, interviewers also noted clients come to treatment with their own stigmas regarding harm reduction. P7 noted, "Really what I've seen with these clients is the stigma that they put on themselves." P13 noted, "I don't know if they're [clients] even knowledgeable about harm reduction, just because everyone says, abstinence, abstinence, abstinence." Overall, most interviewees recognized a stigma surrounding harm reduction, whether it was from the clinician or the clients themselves.

Theme 2: Education

Individuals who use substances, especially those individuals who inject substances, have been stigmatized for decades. The American Medical Association, the American Society of Addiction Medicine, the US National Institute for Drug Abuse and the US National Institute on Alcohol Abuse and Alcoholism recognizes addiction a

medical condition/disorder, but there is still a stigma that substance/alcohol addiction is a result of moral failing or a choice (Lanzillotta-Rangeley et al, 2021). Although harm-reduction has been prevalent in substance abuse treatment for years, these practices are still not widely accepted. Education is necessary for both treatment providers and clients alike. As previously mentioned, P13 noted that clients are not always aware of harm reduction practices before coming into treatment. P7 also noted, "There's a stigma around harm reduction, not just even so much like the outside group, within the client; they find themselves struggling with it as well." Throughout the interview, every interviewee discussed the importance of education for clients. It has been established that drug users avoid medical services when needed because they feel a stigma from healthcare professionals (Duncan et al, 2022). As professionals who provide substance abuse treatment, it is the ethical responsibility of both social workers and counselors alike to provide non-judgmental and stigma-free care (APCB,n.d., & NASW, 2017).

Regarding substance abuse professionals, there is also an underlying stigma associated with clients who wish to have harm reduction goals. Throughout the interviews, multiple participants mentioned stigma within the field. P1 noted, "There was a lot of staff who, like have been through the NA program to push that and did not support MAT". P6 noted, "So just because abstinence and 12-step works for you, it doesn't mean that that's the only way for everyone." P8 even noted, "There is such a stigma that treatment means abstinence." There has been significant research on counselor's views of harm reduction techniques, including MAT and the general findings support that without education counselors generally view harm reduction techniques negatively. Acceptability of non-abstinence goals has been found to be associated with

substance abuse trained professionals versus those professionals who have been working in the field for many years (Davis & Lauritsen, 2016). The study found that 14%-26% of younger clinicians accepted non-abstinent-based goals versus only 8%-14% of experienced clinicians. Specifically, newer professionals are learning about harm reduction techniques, whereas clinicians who have been in the field for many years are not necessarily learning new evidenced-based practices (Davis & Lauritsen, 2016).

In addition to general negative views on harm reduction from counselors, there is a sub-culture of counselors who are in recovery from substances themselves who also have a negative view. The field of substance abuse is growing, and a significant amount of professionals are in recovery, which can impact the views of harm reduction for clients. Counselors in recovery are less likely to rate harm reduction as effective and acceptable, especially if they achieved sobriety through abstinence (Abraham, et al., 2011). Research supports that although this barrier might be challenging, counselors in recovery require education on harm reduction techniques to reduce their own stigmas (Abraham, et al., 2011).

Theme 3: Supervision is necessary to discuss harm reduction integration.

Supervision in social work is of vital importance for clinicians to grow professionally. According to the NASW (2017), *"*supervision is the relationship between the supervisor and supervisee in which the responsibility and accountability for the development of competence, demeanor, and ethical practice take place." Supervision is necessary for counselors to develop skills, enhance their understanding of subjects, and receive feedback on their performance (NASW, 2017).

Almost all participants noted the importance of discussing harm reduction during supervision to reduce stigma, and for educational purposes. In addition to education, it is necessary for all professional counselors to adhere to their set of codes of ethics regarding non-discrimination, client autonomy, and providing competent services. The NASW supervision guideline notes that it is the responsibility of the supervisor to be aware of the differences between professional ethics and personal beliefs and to help the supervisee distinguish between these while making practice decisions (NASW, 2017). Throughout this study, as previously mentioned, it was noted that supervision is crucial when working with the harm reduction population. P6 referred to discussing harm reduction techniques, "I do it in my clinical supervision sessions, I do it in my administrative supervision sessions." P6 continued, "I make sure everybody is kind of like marching along and being more progressive." P10 noted, "My clinical supervisor always encouraged harm reduction, who was a dually credentialed person, so also clinical and a social worker." P10 continued, "When I am the one providing supervision, I don't want to, for lack of a better word, attack my supervisee when it comes up, because I want to be educational, and I want to be impactful."

A study completed in 2017 with MSW students found that many of these students were unaware of

techniques regarding substance abuse clients (Estreet, et al., 2017). The study detailed the importance of education and found that when students completed a 3-hour training on harm reduction techniques applied in substance abuse, they were more open and favorable to using harm reduction techniques themselves (Estreet, et al., 2017). Another study from 2021 focusing on nursing and harm reduction found that

professionals who believe substance use disorders are a medical illness are more likely to support evidenced-based practice, including harm reduction models (Lanzillotta-Rangeley, et al., 2021). This study noted that professionals who support harm reduction practices are more likely to share that information with their community and peers through education.

Limitations of the Study

There were possible limitations to this study, including the selected method of recruiting participants. For this study, I utilized purposeful sampling with a snowball technique. Researchers use purposeful sampling to find participants that are appropriate for a study, while snowball sampling allows respondents to identify other appropriate participants (Luborsky & Rubinstein, 1995). Although purposeful sampling with a snowball technique is beneficial, it could have selection bias. Purposeful sampling involves identifying participants that are incredibly knowledgeable about a specific topic, but high saturation can occur with this type of sampling. Saturation is when no additional data is collected because the participants share the same ideologies (Palinkas et al., 2015). Snowball sampling, although flexible, also has limitations because it is convenience based. As previously discussed, snowball sampling uses current participants in the study to recommend other participants who meet the criteria; therefore, participants are not necessarily random.

The limitations specific to this study included the limited access to potential participants due to only recruiting through LinkedIn. The flyer was posted on Linkedin, limiting potential participants to those who use this professional networking site. In addition, other participants were recruited using snowball sampling; therefore,

participants referred or recommended qualified individuals to reach out to participate in the study. Lastly, due to the current Covid-19 pandemic, interviews took place via Zoom or Google Meet; therefore in-person body language was not witnessed.

Recommendations for Further Research

This study explored social workers' personal experiences with implementing harm reduction strategies into abstinence-based treatment, specifically in Northern New Jersey. Additionally, this study explored potential bias concerning the implementation of these strategies. Future research should include a larger sample size to explore more abstinence-based treatment centers and to have a wide variation of social workers and addiction counselors. Another recommendation for furthering research would be to separate participants into two categories, clinical social workers and clinical drug and alcohol counselors, to determine if there is a difference in implementation techniques and bias. This research study combined all participants into one category; although the demographics clearly state their professional degree, it would be helpful to have a larger sample size with two clearly defined groups. In addition, this qualitative study was limited to the northern New Jersey area, the study could be researched quantitatively and be expanded to include larger areas to see if the results are different.

Summary

The underutilization of harm reduction therapy in abstinence-based treatment programs is an essential topic in the treatment industry. After analyzing the collected data, I found many addiction professionals struggled to implement any aspect of harm reduction into their treatment—whether that be based off agency policy or misunderstanding of harm reduction treatment itself. In addition, the professionals

interviewed all noted the importance of discussing harm reduction implementation in supervision, but many noted they do not have these discussions with their supervisors. I found that many agencies do not take the necessary steps to address implementing harm reduction into abstinence-based treatment, whether they do not find the importance of doing so or they do not have the adequate training to implement. Section 4 includes applications for professional ethics in social work practice, recommendations for social work practice, and implications for change.

Section 4: Application to Professional Practice and Implications for Social Change

Introduction

This qualitative research study aimed to identify whether harm reduction techniques were being implemented into abstinence-based treatment programs and if professionals had successfully implemented them. Semistructured, narrative interviews were used to explore addiction professionals lived experiences involving the implementation of harm reduction into abstinence-based treatment programs. This method allowed study participants to express their perspectives regarding the implementation, or lack thereof, while answering specific questions based on the research questions.

During data analysis, I identified several themes, including the importance of client-centered treatment, the impact stigma and judgment have on the therapeutic relationship, the importance of education on harm reduction, and the necessity of supervision concerning harm reduction practice and implementation. The success of harm reduction implementation into abstinence-based treatment in the northeastern United States requires addiction professionals to have proper education on the importance of this evidenced-based practice. In addition, insight into how to implement appropriately based on the population and the individual is also necessary.

When conducting social work-focused research, it is crucial to ensure the study's findings extend knowledge in the field of social work. This study involves understanding addiction professionals' lived experiences to improve addiction treatment, specifically with abstinence-based treatment programs. There is not one known study that focuses on the role of addiction professionals, specifically reviewing the implementation of harm

reduction into the abstinence-based treatment realm. This study included the necessary perspectives of addiction professionals and may be beneficial in terms of education for current addiction professionals and social work and addiction students entering the field.

Application for Professional Ethics in Social Work Practice

One main principle from the NASW Code of Ethics is how social workers promote social justice by empowering vulnerable populations. Social workers bring about change for individuals, families, groups, organizations, and communities (NASW, 2017). Social workers must ensure that clients have a right to self-determination, including assisting clients in identifying their goals. Social workers are only allowed to limit self-determination when they feel the actions could cause harm to themselves or others. Addiction professionals have a responsibility to their clients to provide the best treatment that is appropriate for them, including harm reduction. It is necessary for social workers to provide competent services to their clients, but it is crucial for all professionals to ensure they are receiving continuing education to enhance their skills and knowledge.

Findings from this study might have a significant influence on social work practice; these findings are as follows. Social workers and addiction professionals may gain insight into northern New Jersey addiction professionals' current experiences and their view of the presenting problem. With an increase in awareness, northern New Jersey social workers might have an opportunity to advocate for implementation of harm reduction into their treatment programs, continued education on harm reduction, supervision on how to implement, and, more importantly, better understand the stigma that still surrounds harm reduction in the realm of treatment and recovery.

Recommendations for Social Work Practice

Based on study findings, I recommend abstinence-based treatment agencies implement mandatory harm reduction therapy/techniques training or continuing education focusing on addressing how to implement harm reduction techniques into abstinence-based treatment. In addition, there is a need to provide this education and training to all supervisors to ensure lower-level clinicians and interns are educated on this practice as well. Harm reduction has been established as evidenced-based practice (Logan & Marlatt, 2010). Although each treatment center develops their own curriculum, it is necessary to include harm reduction education to clients. Clinicians should use their own professional judgment (and seek supervision as appropriate) to know when to implement these techniques.

In summary, I recommend two action steps for addiction professionals working in abstinence-based treatment centers in the northern New Jersey area. First, all addiction professionals working in abstinence-based treatment centers must attend continuing education on harm reduction therapy and techniques (Abraham et al., 2011). It is the professionals' ethical responsibility to further develop their skills for the welfare of their clients, and understanding an evidenced-based-practice is necessary (NASW, 2017). Second, addiction professionals that are supervising other clinicians and/or interns need to have discussions that include harm reduction, specifically how to approach a client who can benefit from it. Even in abstinence-based programs, clinicians can still provide education on harm reduction when clients complete their program if they choose not to stay abstinent. In addition, professionals at a supervisory level should discuss the

importance of harm reduction with the administration to ensure the education is being understood at a senior level.

Implications for Social Change

There is much potential for positive change at the micro, mezzo, and even macro levels of practice. On the micro-level of practice, social workers and counselors can learn the effectiveness of harm reduction strategies regarding addiction treatment and how to implement these techniques with clients in abstinence-based treatment programs successfully. Harm reduction has been clearly established as evidenced-based practice, but implementing these techniques has not been widespread in abstinence-based treatment. As this study clearly states, the opioid epidemic is highly prevalent, and individuals with substance use disorders need to find recovery, and harm reduction is appealing to many. Substance abuse professionals and clinicians working in an abstinence-based treatment program can request harm reduction techniques be implemented on an individual or group level at their facility. On a mezzo level of practice, it is crucial to help reduce the impact the opioid epidemic has on every community, and social workers can implement harm reduction initiatives in towns, schools, hospitals, and even prison systems. It is essential to implement programs that individuals with substance use disorder feel comfortable with, and harm reduction programs meet that criterion. Social workers that work on a mezzo level can build collaborative relationships with addicted individuals and professionals. Professionals can bring educational discussions to local hospitals, jails, and other areas where addicted individuals frequent; professionals can educate on the effectiveness of harm reduction for those seeking help. On a macro level of practice, developing local and statewide policies

geared toward funding harm reduction treatment is necessary. These policies can directly influence how all social workers and counselors implement harm reduction into treatment, and they can help address the impact of the opioid epidemic on various levels. Substance abuse counselors and clinicians can work with their local government to ensure harm reduction policies are being implemented so addicted individuals can receive adequate treatment. ok

Summary

In the United States, we are currently facing an opioid epidemic that has been occurring for over two decades, with little progress toward a solution (Kolodny et al., 2015). Treatment for opioid addiction has been at a standstill, although significant research supports evidence-based treatment, including harm reduction techniques. This study explored social workers' experiences in implementing harm reduction strategies into abstinence-based treatment programs and studied potential bias surrounding harm reduction. I used a qualitative approach with a semistructured, narrative style interview to identify each participant's experiences. This study identified the need to implement harm reduction into abstinence-based treatment; the need for increased supervision to discuss harm reduction techniques, the importance of policies to be introduced to support evidenced based treatment, including harm reduction, and the importance of acknowledging the efforts of social workers and addiction counselors to meet the needs of clients they serve.

The study findings provided insight into micro, mezzo, and macro-level improvements. Study participants contributed to the importance of implementing evidence-based practice into addiction treatment, specifically in the northern New Jersey

area. More importantly, the study findings informed addiction practice and encouraged social change by increasing awareness of the problem.

References

Abraham, A. J., Rieckmann, T., McNulty, T. L., Kovas, A. E., & Roman, P. M. (2011). Counselor attitudes toward the use of naltrexone in substance abuse treatment: A multi-level modeling approach. *Addictive Behaviors*, *36*(6), 576–583. https://doi.org/10.1016/j.addbeh.2011.01.030

Addiction Professionals Certification Board of New Jersey. (2017b, October 12). *Ethical standards.* Addiction Professionals Certification Board, Inc. https://certbd.org/ethical-standards/

Akinyode, B. F., & Khan, T. H. (2018b). Step by step approach for qualitative data analysis. *International Journal of Built Environment and Sustainability*, *5*(3). https://doi.org/10.11113/ijbes.v5.n3.267

Amankwaa, L. (2015). Creating Protocols for trustworthiness in qualitative research. *Journal of Cultural Diversity*, *23*(3), 121–127.

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

Bailey, G. L., Herman, D. S., & Stein, M. D. (2013). Perceived relapse risk and desire for medication assisted treatment among persons seeking inpatient opiate detoxification. *Journal of Substance Abuse Treatment*, *45*(3), 302–305. https://doi.org/10.1016/j.jsat.2013.04.002

Bipartisan Policy Center (2019). *Tracking federal funding to combat the opioid crisis.* https://bipartisanpolicy.org/wp-content/uploads/2019/03/Tracking-Federal-Funding-to-Combat-the-Opioid-Crisis.pdf

Birnbaum, H. G., White, A., Schiller, M., Waldman, T., Cleveland, J. M., & Roland, C. L. (2011b). Societal costs of prescription opioid abuse, dependence, and misuse in the United States. *Pain Medicine*, *12*(4), 657–667. https://doi.org/10.1111/j.1526-4637.2011.01075.x

Booth, M. (1999). *Opium: A history.* St. Martin's Griffin.

Broers, B., Giner, F., Dumont, P., & Mino, A. (2000). Inpatient opiate detoxification in Geneva: Follow-up at 1 and 6 months. *Drug and Alcohol Dependence*, *58*(1–2), 85–92. https://doi.org/10.1016/s0376-8716(99)00063-0

Caremark. (n.d.) *Opioid cough medications.* https://www.caremark.com/portal/asset/FEP_Rationale_Opioid_Cough_Medications.pdf

Castleberry, A. N., & Nolen, A. L. (2018). Thematic analysis of qualitative research data: Is it as easy as it sounds? *Currents in Pharmacy Teaching and Learning*, *10*(6), 807–815. https://doi.org/10.1016/j.cptl.2018.03.019

Clemans-Cope, L., Epstein, M., & Winiski, E. (2019). *Monitoring patient access to facility-based opioid use disorder treatment in New Jersey.* Urban Institute. *https://www.urban.org/sites/default/files/publication/101033/monitoring_patient_access_to_facility-based_opioid_use_disorder_treatment_in_nj_final.pdf*

Council on Social Work Education. (n.d.) *Social work: A vital workfoce to address the opioid crisis.* https://www.cswe.org/Advocacy-Policy/Policy-Agenda/Articles/Social-Work-and-Opioid-Epidemic-Principles

Courtwright, D. T. (2001). *Dark paradise: A history of opiate addiction in America.* Harvard University Press.

S Custer, W. (2017). The Opioid epidemic and health plans. *Journal of Financial Service Professionals*, *71*(5), 40–42.

Dasgupta, N., Beletsky, L., & Ciccarone, D. (2018). Opioid crisis: No easy fix to its social and economic determinants. *American Journal of Public Health*, *108*(2), 182–186. https://doi.org/10.2105/ajph.2017.304187

Davis, A. K., & Lauritsen, K. J. (2015). Acceptability of non-abstinence goals among students enrolled in addiction studies programs across the United States. *Substance Abuse*, *37*(1), 204–208. https://doi.org/10.1080/08897077.2015.1015702

Davis, A. T., Rosenberg, H., & Rosansky, J. A. (2017). American counselors' acceptance of non-abstinence outcome goals for clients diagnosed with co-occurring substance use and other psychiatric disorders. *Journal of Substance Abuse Treatment*, *82*, 29–33. https://doi.org/10.1016/j.jsat.2017.08.006

Davis, A. T., Nickelsen, T., Zucker, R. A., Bonar, E. E., & Walton, M. A. (2018). Acceptability of nonabstinent treatment outcome goals among addiction treatment providers in Ukraine. *Psychology of Addictive Behaviors*, *32*(4), 485–495. https://doi.org/10.1037/adb0000354

Department of Health, New Jersey (2022). *Substance abuse overview 2021*. https://www.nj.gov/humanservices/dmhas/publications/statistical/Substance%20Abuse%20Overview/2021/statewide.pdf

Department of Health, New Jersey. (n.d.). *Department of Health HIV, STD, and TB services harm reduction centers.* https://www.nj.gov/health/hivstdtb/sap.shtml

Dennis, C. B., Roland, B. D., & Loneck, B. M. (2017). Strengthening the working alliance through a clinician's familiarity with the 12-step approach. *The American Journal of Drug and Alcohol Abuse*, *44*(3), 378–385. https://doi.org/10.1080/00952990.2017.1378892

Des Jarlais, D. C. (2017). Harm reduction in the USA: the research perspective and an archive to David Purchase. *Harm Reduction Journal*, *14*(1). https://doi.org/10.1186/s12954-017-0178-6

DiClemente, C. C., Corno, C. M., Graydon, M. M., Wiprovnick, A. E., & Knoblach, D. J. (2017). Motivational interviewing, enhancement, and brief interventions over the last decade: A review of reviews of efficacy and effectiveness. *Psychology of Addictive Behaviors*, *31*(8), 862–887. https://doi.org/10.1037/adb0000318

Donovan, D. M., Ingalsbe, M. H., Benbow, J., & Daley, D. C. (2013). 12-Step Interventions and Mutual Support Programs for Substance Use Disorders: An Overview. *Social Work in Public Health*, *28*(3–4), 313–332. https://doi.org/10.1080/19371918.2013.774663

Duncan, E., Shufelt, S., Barranco, M., & Udo, T. (2022). Acceptability of supervised injection facilities among persons who inject drugs in upstate New York. *Harm Reduction Journal*, *19*(1). https://doi.org/10.1186/s12954-022-00665-x

Einstein, S. (2007). Harm and Risk Reduction: History, Theories, Issues, and Implications. *Substance Use &Amp; Misuse*, *42*(2–3), 257–265. https://doi.org/10.1080/10826080601141990

Estreet, A., Archibald, P., Tirmazi, M. T., Goodman, S., & Cudjoe, T. (2017). Exploring social work student education: The effect of a harm reduction curriculum on

student knowledge and attitudes regarding opioid use disorders. *Substance Abuse*, *38*(4), 369–375. https://doi.org/10.1080/08897077.2017.1341447

Fillmore, S., & Hohman, M. (2015). Traditional, alternative, and harm reduction approaches: What do social work students think? *Journal of Social Work Practice in the Addictions*. https://doi.org/10.1080/1533256x.2015.1056527

Friedmann, P. D., & Suzuki, J. (2017). More beds are not the answer: transforming detoxification units into medication induction centers to address the opioid epidemic. *Addiction Science &Amp; Clinical Practice*, *12*(1). https://doi.org/10.1186/s13722-017-0092-y

Guest, G., Namey, E., & Chen, M. (2020). A simple method to assess and report thematic saturation in qualitative research. *PLOS ONE*, *15*(5), e0232076. https://doi.org/10.1371/journal.pone.0232076

Hawk, M., Coulter, R. W. S., Egan, J. E., Fisk, S., Reuel Friedman, M., Tula, M., & Kinsky, S. (2017). Harm reduction principles for healthcare settings. *Harm Reduction Journal*, *14*(1). https://doi.org/10.1186/s12954-017-0196-4

Hagemeier, N. E. (2018). Introduction to the opioid epidemic: the economic burden on the healthcare system and impact on quality of life. *The American Journal of Managed Care*, *24*(10 Suppl), S200–S206.

Horn, K. A., Pack, R. P., Trestman, R., & Lawson, G. (2018). Almost everything we need to better serve children of the opioid crisis we learned in the 80s and 90s. *Frontiers in Public Health*, *6*. https://doi.org/10.3389/fpubh.2018.00289

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). (n.d.) CAHPS hospital survey: What's new. https://www.hcahpsonline.org/en/whats-new/

Jamshed, S. (2014). Qualitative research method-interviewing and observation. *Journal of Basic and Clinical Pharmacy*, *5*(4), 87. https://doi.org/10.4103/0976-0105.141942

Jesuraj, M. (2012). Impact of substance abuse on families. *Rajagiri Journal of Social Development, 4*(2), 33-44. Retrieved from Walden University Library

Johnson, A. (2018). Curbing the high cost of opioid abuse treatment. *Benefits Magazine*, *55*(6), 14–19. Retrieved from Walden University Library Database

Kolodny, A., Courtwright, D. T., Hwang, C. S., Kreiner, P., Eadie, J. L., Clark, T. W., & Alexander, G. C. (2015). The prescription opioid and heroin crisis: A public health approach to an epidemic of addiction. *Annual Review of Public Health*, *36*(1), 559–574. https://doi.org/10.1146/annurev-publhealth-031914-122957

Lanzillotta-Rangeley, J., Zeller, T. A., Beachler, T., Litwin, A. H., Clark, A., & Stem, J. (2021). The impact of the disease model of substance use disorder on evidence based practice adoption and stigmatizing attitudes: A comparative analysis. *Pain Management Nursing*, *22*(5), 616–622. https://doi.org/10.1016/j.pmn.2021.03.004

Larsson, S., & Sjöblom, Y. (2010). Perspectives on narrative methods in social work research. *International Journal of Social Welfare*, *19*(3), 272–280. https://doi.org/10.1111/j.1468-2397.2009.00672.x

Lee, H. S. (2015). The ethical dilemma of abstinence-only service delivery in the united states. *Journal of Social Work Values & Ethics*, *12*(1), 61. Retrieved from Walden University Library

Lee, H. S., Engstrom, M., & Petersen, S. R. (2011). Harm reduction and 12 Steps: complementary, oppositional, or something in-between? *Substance Use & Misuse*, *46*(9), 1151–1161. https://doi.org/10.3109/10826084.2010.548435

Little, J., & Franskoviak, P. (2010). So glad you came! Harm reduction therapy in community settings. *Journal of Clinical Psychology*, n/a-n/a. https://doi.org/10.1002/jclp.20673

Livio, S.K. (2012, October 5). *NJ needle exchange program is called a success by officials.* NJ Advance Media for NJ.com

Logan, D. E., & Marlatt, G. A. (2010). Harm reduction therapy: a practice-friendly review of research. *Journal of Clinical Psychology*, n/a-n/a. https://doi.org/10.1002/jclp.20669

Luborsky, M. R., & Rubinstein, R. L. (1995). Sampling in qualitative research. *Research on Aging*, *17*(1), 89–113. https://doi.org/10.1177/0164027595171005

Macy, B. (2018). *Dopesick.* New York, NY: Little, Brown and Company

Magnusson, E. & Marecek, J. (2015). *Doing Interview-Based Qualitative Research: A Learner's Guide*. (2015). Cambridge University Press.

Mann, J. J. (2008). Compare turn on and tune in - Pychedelics, narcotics and euphoriants | Mann, J. John | 9781847559098 | Royal Society of Chemistry. *The Royal Society of Chemistry.*

Marlatt, G. A., Blume, A. W., & Parks, G. A. (2000). Integrating harm reduction Therapy and traditional substance abuse treatment. *Journal of Psychoactive Drugs*, *33*(1), 13–21. https://doi.org/10.1080/02791072.2001.10400463

McAlpine, L. (2016). Why might you use narrative methodology? A story about narrative. *Eesti Haridusteaduste Ajakiri. Estonian Journal of Education*, *4*(1), 32–57. https://doi.org/10.12697/eha.2016.4.1.02b

Medline Plus. (2015, December 22). *Vital signs.* Retrieved from https://medlineplus.gov/vitalsigns.html

Miller, W.R. & Rollnick, S. (2013) *Motivational interviewing: helping people change*. (7th ed.). [Kindle Edition] https://doi.org/9781462507580h

Mitchell, K. D., & Higgins, L. J. (2016). Combating opioid overdose with public access to Naloxone. *Journal of Addictions Nursing*, *27*(3), 160–179. https://doi.org/10.1097/jan.0000000000000132

Monico, L. B., Gryczynski, J., Mitchell, S. G., Schwartz, R. P., O'Grady, K. E., & Jaffe, J. H. (2015). Buprenorphine treatment and 12-step meeting attendance: Conflicts, compatibilities, and patient outcomes. *Journal of Substance Abuse Treatment*, *57*, 89–95. https://doi.org/10.1016/j.jsat.2015.05.005

Nadelmann, E. & LaSalle, L. (2017). Two steps forward, one step back: Current harm reduction policy and politics in the United States. *Harm Reduction Journal, 14*(1), 1-7. https://doi.org/10.1186/s12954-0%607-0157-y

National Association of Social Workers. (2017). *Code of ethics of the National Association of Social Workers.* Washington, DC: NASW Press

National Institute on Drug Abuse (NIDA). (2019, January) *Opioid overdose crisis.* https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis

NIDA (2015, November 30). Long-term follow-up of MAT for addiction to pain relievers yields "cause for optimism". https://archives.drugabuse.gov/news-events/nida-notes/2015/11/long-term-follow-up-medication-assisted-treatment-addiction-to-pain-relievers-yields-cause-optimismon 2020, April 26

NJ CARES. (2023). *The office of the new jersey coordinator for addiction responses and enforcement strategies.* https://www.njcares.gov/

NJ Reentry Corporation. (2018). *Reentry: New jersey opioid addiction report: A modern plague.* http://njreentry.org/wp-content/uploads/2018/09/Published_9_24.pdf

Office of the Commissioner. (2018, August 6). *FDA takes new steps to encourage the development of novel medicines for the treatment of opioid use disorder*. U.S. Food And Drug Administration. https://www.fda.gov/news-events/press-announcements/fda-takes-new-steps-encourage-development-novel-medicines-treatment-opioid-use-disorder

PAINS Project. (2017, January). *An important view on pain as a 5th vital sign* (Issue 8). Lenexa, KS: Author.

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2013b). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health and Mental Health Services Research*, *42*(5), 533–544. https://doi.org/10.1007/s10488-013-0528-y

Pitt, A.L., Humphreys, K., & Brandeau, M.L. (2018). Modeling health benefits and harms of public policy responses to the US opioid epidemic. *AJPH Open-Themed Research, 108*(10), 1394-1400. https://doi.org/10.2015/AJPH.2018.304590

Rahmati, A., Zeraat Herfeh, F., & Hosseini, S. O. (2019). Addicted people's experiences of the consequences of substance abuse on their lives: a phenomenology study. *Journal of Research and Health*, *9*(2), 112–124. https://doi.org/10.29252/jrh.9.2.112

Riley, D., Sawka, E., Conley, P., Hewitt, D., Mitic, W., Poulin, C., Room, R., Single, E., & Topp, J. (1999). Harm reduction: Concepts and practice. A Policy Discussion Paper. *Substance Use &Amp; Misuse*, *34*(1), 9–24. https://doi.org/10.3109/10826089909035632

Roberto, A. J., Shafer, M. S., & Marmo, J. (2014). Predicting substance-abuse treatment providers' communication with clients about medication assisted treatment: A test of the theories of reasoned action and planned behavior. *Journal of Substance Abuse Treatment*, *47*(5), 307–313. https://doi.org/10.1016/j.jsat.2014.06.00

Salmond, S., & Allread, V. (2019). A Population Health Approach to America's Opioid Epidemic. *Orthopaedic Nursing*, *38*(2), 95–108. https://doi.org/10.1097/nor.0000000000000521

Saloner, B., & Barry, C. L. (2018). Ending the opioid epidemic requires a historic investment in medication-assissted treatment. *Journal of Policy Analysis and Management, 37*(2), 431–438. https://doi.org/10.1002/pam.22047

Sam Rolfe,. (2023, February 1). National Harm Reduction Coalition. https://harmreduction.org/

Scott, I. (1998). Heroin: A hundred-year habit. *History Today, 48*(6). http://cbm.msoe.edu/markMyweb/ddtyResources/documents/opioidReceptorHeroin.pdf

Simmons-Duffin, S. (2019, October 24). The real cost of the opioid epidemic: An estimated $179 billion in just 1 year. NPR. https://www.npr.org/sections/health-shots/2019/10/24/773148861/calculating-the-real-costs-of-the-opioid-epidemic

Skolnick, P. (2018). The Opioid epidemic: Crisis and solutions. *Annual Review of Pharmacology and Toxicology, 58*(1), 143–159. https://doi.org/10.1146/annurev-pharmtox-010617-052534

Substance Abuse and Mental Health Services Administration (SAMHSA). (2022). *Harm Reduction.* https://www.samhsa.gov/find-help/harm-reduction

Sudhir, P. M. (2017). Cognitive behavioural interventions in addictive disorders. *Indian Journal of Psychiatry*, *60*(8), 479. https://doi.org/10.4103/psychiatry.indianjpsychiatry_15_18org.ezp.waldenulibrary.org/10.4103/psychiatry.IndianJPsychiatry_15_18

Tompkins, D. A., Hobelmann, J. G., & Compton, P. (2017). Providing chronic pain management in the "Fifth Vital Sign" Era: Historical and treatment perspectives on a modern-day medical dilemma. *Drug and Alcohol Dependence*, *173*, S11–S21. https://doi.org/10.1016/j.drugalcdep.2016.12.002

Trigueros, R., Francisco, J., & Sandoval, H. (2017 May, 28). Qualitative and quantitative research instruments: Research tools. *Research Gate,* https://www.researchgate.net/publication/323014697_QUALITATIVE_AND_QUANTITATIVE_RESEARCH_INSTRUMENTS_Research_tools

Vakharia, S. P., & Little, J. (2016). Starting where the client is: Harm reduction guidelines for clinical social work practice. *Clinical Social Work Journal, 45*(1), 65–76. https://doi.org/10.1007/s10615-016-0584-3

Vashishtha, D., Mittal, M. L., & Werb, D. (2017). The North American opioid epidemic: current challenges and a call for treatment as prevention. *Harm Reduction Journal, 14*(1). https://doi.org/10.1186/s12954-017-0135-4

Velasquez, P. a. E., & Montiel, C. J. (2018b). Reapproaching Rogers: a discursive examination of client-centered therapy. *Person-Centered &Amp; Experiential Psychotherapies, 17*(3), 253–269. https://doi.org/10.1080/14779757.2018.1527243

Vogel, M., Dürsteler, K. M., Walter, M., Herdener, M., & Nordt, C. (2017b). Rethinking retention in treatment of opioid dependence—The eye of the beholder. *International Journal of Drug Policy, 39*, 109–113. https://doi.org/10.1016/j.drugpo.2016.09.003

Weinbaum, R. K., & Onwuegbuzie, A. J. (2016). Getting more out of your interview data: Toward a framework for debriefing the transcriber of interviews. *Journal of Educational Issues, 2*(1), 248. https://doi.org/10.5296/jei.v2i1.9216

Williams, A. R., & Bisaga, A. (2016). From AIDS to opioids — How to combat an epidemic. *New England Journal of Medicine, 375*(9), 813–815. https://doi.org/10.1056/nejmp1604223

Williams, A.M., Hansen, J., Kruetzkamp, A. (2017, May 5). Identifying and lifting barriers to integrating MAT with 12 step modalities. [PowerPoint].

https://www.thenationalcouncil.org/wp-content/uploads/2017/06/MAT-with-12-Steps-slide-deck.pdf

Williams, M., & Moser, T. (2018). The art of coding and thematic exploration in qualitative research. *International Management Review*, *15*(1), 45. https://www.questia.com/library/journal/1P4-2210886420/the-art-of-coding-and-thematic-exploration-in-qualitative

Woodard, D. R., & Van Demark, R. E. (2017). The opioid epidemic in 2017: Are we making progress? *South Dakota Journal of Medicine*, *70*(10), 467–471.

Yob, I. ,& Brewer, P. (n.d.). Working toward the common good: An online university's perspectives on social change, 1-25.

Appendix: Interview Questions

1. How do you define harm reduction therapy?
    a. Prompt question: Does your agency utilize harm reduction therapy day-to-day with clients?
    b. Prompt question: Does your agency utilize harm reduction therapy with clients that have a history of chronic relapse?
    c. Prompt question: Does your agency provide information about harm reduction options during the assessment or first session with new clients?
2. Can you give me an example of a time where you implemented a harm reduction technique?
    a. Prompt question: Does your agency allow clients to be on medication while in the program?
    b. Have you worked with any clients that have been on medication?
    c. Prompt question: Does your program require 12-step program attendance?
        i. Prompt question: If yes, do you provide options for clients who are on medication to attend different meetings? (i.e. Smart Recovery, All Recovery)
3. Do you believe there is a need to implement harm reduction techniques into abstinence-based treatment programs? Why? or Why not?
    a. Prompt question: If not, does your agency provide linkage to harm reduction programs if clients need?
    b. Prompt question: How would you build rapport, with addicted clients, within the harm reduction model?
4. As an addiction professional, are you open to clients who wish to have non-abstinent goals?
    a. Prompt question: If yes, explain why you think non-abstient based goals are important for clients?
    b. Prompt question: Do you use a harm reduction perspective with clients who have a history of chronic relapse?
        i. If yes, explain how you do this.
5. When receiving supervision, whether professional or peer, do you have discussions regarding the positive and negative experiences of implementing harm reduction techniques?
    a. Prompt question: If yes, what discussions have you had, can you provide examples?
    b. Prompt question: If no, would you like to have more discussions regarding this topic?