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Counselor Attitudes Toward the Harm Reduction Approach in Substance Abuse Treatment

Nicole Marie Kyser
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**Counselor Attitudes Toward the Harm Reduction Approach
in Substance Abuse Treatment**

by

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A Dissertation Submitted to the Faculty of
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This dissertation is dedicated to the one most influential man I believe I will ever have in my life- my Dad, Joseph S. Rachmaciej.

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ABSTRACT

In the United States, the preferred method for treating alcohol and drug addictions is the abstinence based approach. While most American mental health professionals use this approach, studies over time have demonstrated that relapse rates remain high. In Europe, the harm reduction approach, in which the primary goal is to decrease the harms associated with substance use, is beginning to be implemented as an additional approach to abstinence. Although the outcomes of the harm reduction approach are not yet clear, countries that utilize harm reduction have seen a decrease in crime, wages lost, and hospitalizations due to alcohol and drug addictions.

This study examined counselors' attitudes toward harm reduction and explored whether their attitudes toward harm reduction were associated with their personal characteristics. Goddard's (2003) Harm Reduction Assessment Scale, Howden's (1992) Spirituality Assessment Scale, and a brief personal information form were utilized to measure the variables. The population for this study was professional members of the *American Counseling Association* who held a master's degree or higher in counseling. A multiple regression was conducted to analyze the data. Results showed that counselors had a slightly positive attitude toward the concept of using a harm reduction approach to treating substance abuse issues. This was a significant finding because treatment for substance abuse in the United States is primarily abstinence based. Data analyses determined that counselors' attitudes toward harm reduction were predicted by three variables (living in an urban setting, having a close relationship with someone with a substance abuse problem, and years of substance abuse counseling experience). It was determined that counselors who lived in urban areas are more favorable to harm

reduction as a treatment method than those who lived in rural or suburban areas, that those who had a close relationship with individuals with substance abuse problems had favorable attitudes toward harm reduction, and that the more years of substance abuse counseling experience counselors had, the more favorable were their attitudes toward harm reduction. Implications of the results of this study for counselors, counselor educators, and future researchers are discussed.

CHAPTER I

INTRODUCTION

Background

In the United States, the goal of most substance abuse counseling programs is the elimination of clients' use of illegal and illicit substances, in other words--total abstinence (MacMaster, 2004). The abstinence approach in substance abuse treatment began in the 19th century. Between the years 1785 and 1835, ideas and conceptions about alcohol use went from the belief that alcohol use was medicinal to the belief that the use of alcohol was the work of the devil (Levine, 1984). The Temperance movement demonized alcohol, actually referring to it as a *demonic* substance, and the Temperance cause became the longest lasting middle-class mass movement in the 20th century (Levine). The Temperance movement helped shape the current method of treating substance abuse in the United States, which is the abstinence model.

In contrast, harm reduction, a relatively new approach to treating people with substance abuse addictions, is being utilized in Europe. Despite the acceptance of the harm reduction approach in Europe, it is an underutilized concept in the world of substance abuse treatment in the U.S. Harm reduction focuses on taking small steps to reduce substance use and to reduce harm to oneself and others, with abstinence being a possible goal (Marlatt, Blume, & Parks, 2001). Harm reduction is a public health option to the moral, criminal, and disease models of drug use and addiction (Marlatt, 1996). Instead of blaming the individual for his or her substance abuse, placing the individual in jail, or labeling a person as having a disease, harm reduction is being used in substance abuse treatment by inviting the community to assist those with substance abuse problems. This is an alternative to the abstinence based approach which dominates the substance

abuse treatment field in the United States.

There are five main characteristics or principles of harm reduction (Bigler, 2005; Riley et al., 1999). The characteristics or principles are *pragmatism*, *humanistic values*, *focus on harms*, *balancing costs and benefits*, and *priority of immediate goals*. *Pragmatism* is about accepting that the use of substances is a part of the human experience. *Humanistic values* involve not making any moralistic judgments and accepting a person's decision to continue to use substances. *Focus on harms* is centering attention on reducing negative consequences of drug or alcohol use to the user and others. *Balancing costs and benefits* involves assessing the costs and benefits of any intervention that may be used in order to focus resources on priority issues. *Priority of immediate goals* involves focusing attention on a person's most pressing issues. These characteristics or principles help make up the holistic treatment approach that is taken when using the harm reduction method of substance abuse treatment.

The beginnings of the harm reduction approach to substance abuse treatment began in the Netherlands in 1972 (Marlatt, 1998). In the Netherlands at that time, heroin became widely available (Marlatt). The Narcotics Working Party published a document that described the risks involved in drug use (Marlatt). This led to the adoption of the Dutch Opium Act of 1976 which made the distinction between drugs of high risk such as heroin, cocaine, LSD, and drugs of low risk such as marijuana (Marlatt).

In England, in the 1980s, two men had been developing ideas for the New Model for Public Health: John Ashton who was from the Department of Public Health and later Mersey Regional Director of Public Health, and Howard Seymour, who was the Head of the Health Promotion of the Mersey Regional Health Authority (O'Hare, 2007). For the

development of the New Model, they brought together old ideas of environmental change, prevention, and therapeutic interventions. They went a step further and realized there was a need to include social aspects of health problems which are caused by lifestyles (O'Hare). In this way, the social aspect tries to take the approach of blaming lifestyles instead of blaming the individual. This approach is further discussed in chapter 2.

The first international conference on harm reduction was held in Liverpool, England in 1990 (Marlatt, 1996). From this conference, the *medicalization* approach was emphasized. The medicalization approach entails being able to prescribe drugs such as heroin and cocaine on a maintenance basis. This started the approach to substance abuse treatment that we know today as the harm reduction approach.

In the United States, the harm reduction movement is slowly gaining credibility for being considered as a public health alternative to both the moral and medical models of treatment. One of the earliest instances of implementation of the harm reduction approach in the United States occurred in 1972 (Duncan, Nicholson, Clifford, Hawkins, & Petosa, 1994). This early harm reduction program included an educational program in an urban, Southwestern drug abuse treatment center that was confronting an epidemic of *huffing*. *Huffing* involves draining cans of spray paint into plastic bags and inhaling the fumes to get high. When people learned young adolescents were dying from this practice, it was decided to place a priority on preventing deaths. Education on how to huff without killing oneself was taught. As a result of the education, no further deaths occurred and crisis calls relating to huffing declined sharply. It appears as though after that instance, the concept of harm reduction was not practiced. However, because of the

history with drugs and alcohol in the United States, it is easy to see why some might object to teaching young people how to use drugs without killing themselves, rather than challenging them to stop drug use altogether.

Most abstinence based substance abuse treatment programs incorporate the 12-step approach, which has a spiritual component (Levine, 1984). In this study, I explored whether counselors were receptive to the use of harm reduction as a treatment option for substance abuse. I examined whether or not counselors' level of spirituality had an association with their acceptance of harm reduction. Wiggins-Frame (2005) defined spirituality as "one's beliefs, awareness, values, subjective experience, sense of purpose and mission, and an attempt to reach toward something greater than oneself. It may or may not include a deity" (p. 13). Spirituality is defined as individualistic. The meaning of spirituality is derived according to one's own beliefs, awareness, and personal values, in spite of any outside influences. Wiggins-Frame defined religion as "a set of beliefs and practices of an organized religious institution" (p. 13). With religion, the beliefs one holds is not his or her own; rather the beliefs stem from an organized institution.

Significance of Study

This study was important because more needs to be known regarding the acceptance or rejection of the harm reduction model among counselors in the United States. With relapse rates ranging from 40%-60% in programs using the abstinence model, there appears to be a need for additional approaches to the abstinence approach for the treatment of people with substance abuse problems (McLellan, Lewis, O'Brien, & Kleber, 2000). There have been vast costs to society because of substance abuse problems in terms of health care, employability, decrease in work behavior, institutional

support, crime, incarceration, drug and alcohol related accidents, health care costs for family members, and other factors (Keller & Dermatis, 1999). Abstinence-based treatment programs have been the main accepted approach to substance abuse treatment in the United States.

Proponents of the harm reduction approach to the treatment of individuals with substance abuse problems claim that costs to society, communities, and individuals can be decreased (Bigler, 2005; Duncan & Nicholson, 1997; DuPont, 1996; Marlatt, 1996). One possible way to justify a decrease in overall costs is shown by example in bars. For example, individuals who become inebriated in bars may cause harm to themselves or others. However, training bar staff in responsible serving may help decrease the risk of intoxication (of individuals). Giving staff the skills to prevent accidents (in communities) may decrease the incidents of driving under the influence of alcohol or drugs (in society). Drunk driving laws, the provision of public transportation, and designated driver programs reduce risks of injury and fatality by separating drinking from driving (International Harm Reduction Association, 2006). Hence, the costs to individuals, communities, and society have the potential to decrease.

As stated above, the harm reduction approach to substance abuse treatment is slowly being introduced in the United States. Because abstinence only programs are so wide spread in the United States and substance abuse treatment professionals who work in such programs are taught that abstinence is the main way (or perhaps the only way) to treat individuals who abuse drugs or alcohol (Marlatt, 1998), it is important to gain an understanding of whether counselors are receptive to the harm reduction model of substance abuse treatment.

Purpose of Study

The purpose of this study was to assess the receptivity of counselors' attitudes toward harm reduction as an additional treatment model in substance abuse. This study was also conducted to determine if receptivity to the harm reduction approach to treating substance abuse problems is associated with personal characteristics including spirituality, length of practice, type of license or credential held, employment setting, location of environment in which they live (rural, urban, or suburban), and personal experience with substance abuse and substance abuse counseling. Currently, there is no research on receptivity toward harm reduction based on a person's level of spirituality and other personal characteristics of counselors that were explored in this study.

Research Question

The general research question explored was: Are counselors' attitudes toward the use of harm reduction rather than total abstinence in substance abuse treatment associated with their level of spirituality, length of practice, employment setting, location of environment in which they live (rural, urban, suburban), and personal experience with substance abuse?

Definitions

12-Step Program: a spirituality based fellowship that supports the development and maintenance of abstinence for those who want it and offers steps for sobriety and lifelong character development (van Wormer & Davis, 2008).

Abstinence: the elimination of non-medical substances (MacMaster, 2004).

Alcohol: distilled liquid from fermented fruits, grains, and vegetables (SEMCA, 2009).

Alcohol or drug abuse: either alcohol or drug use that is excessive and detrimental. In this study, the terms *substance abuse* and *alcohol or drug abuse* are used interchangeably.

Drugs: substances deemed illegal for use according to the U.S. Department of Drug Enforcement.

Harm reduction: a treatment approach which aims to reduce harmful consequences associated with substance use, provide an option to abstinence approaches by incorporating substance use goals (abstinence or moderation) that are meeting the client where they are regarding substance use, and promoting access to services by offering low-threshold alternatives to traditional alcohol prevention and treatment (Marlatt & Witkiewitz, 2002).

Religion: an adherence to beliefs and practices of an organized church or religious institution (Shafranske & Maloney, 1990).

Spirituality: one's beliefs, awareness, values, subjective experience, sense of purpose and mission, and an attempt to reach toward something greater than oneself. It may or may not include a deity (Wiggins-Frame, 2005).

Substance abuse: either alcohol or drug use that is excessive and detrimental. In this study, the terms *substance abuse* and *alcohol or drug abuse* are used interchangeably.

CHAPTER II

REVIEW OF THE LITERATURE

History of Alcohol Use and Abuse in the United States

Temperance

In the 17th and 18th centuries, “alcoholic beverages, and especially rum, were highly esteemed and universally valued and were in no way stigmatized or regarded as tainted or evil. Most liquor was regarded as good and healthy; alcohol was tonic, medicine, stimulant, and relaxant” (Levine, 1984, p. 110). Alcohol was used in many ways; it was socially and culturally accepted by most people.

Shortly after the Revolutionary War from 1785 to 1835, ideas and conceptions about alcohol began to transform (Levine, 1984). “Record consumption of distilled spirits about 1830 worried many Americans who noticed that alcohol in large amounts did not seem to match the claims for it” (Musto, 1989, p. 6). At the end of this period, the Temperance movement which “demonized alcohol, literally referring to it as a ‘demonic’ substance, became the largest enduring middle-class mass movement of the 19th century” (Levine, p. 110). Benjamin Rush, a physician in the Revolutionary Army, began the Temperance movement (Fehlandt, 1904). During this movement, temperance groups began to form which required members to pledge to give up drinking alcohol, attend temperance meetings, and assist in a campaign of public education regarding the evils of alcohol marked by speeches, meetings, and publications (Onni, 2006).

Prohibition

There were three waves of Prohibition between the years of 1850-1890. The first two waves did not make as much of an indelible impression as the third wave did. The third wave of Prohibition began with the Anti-Saloon League. The Anti-Saloon League

(ASL) defined itself as a stringently impartial association and to some extent developed modern lobbying and pressure politics tactics (Levine, 1984). The ASL wanted Prohibition passed, so with the power they had, they influenced politicians to sway their way. The 19th century Temperance movement saw Prohibition being achieved as part as an extensive moral restoration of American Society and not merely as the result of pressuring for specific laws (Levine). In the early 20th century, under the leadership of the ASL, Prohibition took precedence to all other activities (Levine, 1978). Prohibition laws were passed and came into effect in 1919 (Levine, 1984).

For 13 years, between 1920 and 1933, liquor stores were scarce in the United States (Jantzen, 1978). Although there were barely any liquor stores, Prohibition was massively and openly violated and alcohol was readily available in most of the U.S. (Levine, 1984). In 1926, the Association Against the Prohibition Amendment (AAPA) argued that repeal would “provide jobs, stimulate the economy, increase tax revenue, and reduce the ‘lawlessness’ stimulated by and characteristic of the illegal liquor industry” (Levine & Reinerman, 1991, p. 464). This helped to speed the process of repeal. In December of 1933, Prohibition was repealed (Jantzen).

Less than 100 years ago, Americans took a strong stand that alcohol should not be consumed in any form, and should even be illegal. Even though Prohibition was repealed, those who were against any use of alcohol were able to pass laws making it illegal in the U.S. for a 13 year period. It is not surprising then that Americans adopted a treatment model for alcohol abuse that included abstinence. Abstinence based treatment models hold that the only way to help an individual who abuses alcohol is to require that person to avoid all use of alcohol in the future.

History of Drug Use and Abuse in the United States

In the United States, drugs were available and used in similar ways to the use of alcohol (Brecher, 1972). Attitudes toward drug use turned in the same direction as did attitudes toward alcohol use in that drug use was at first accepted, and then later banned (King, 1989). Immigrants who came to the U.S. in the early 20th century, brought not only their culture to the U.S., they also brought their attitudes toward the use of drugs (Brecher). In China, railroad and mineworkers openly smoked opium; and when they immigrated to the U.S., they still smoked opium openly (Brecher). The U.S. passed the Harrison Narcotic Act of 1914 to impede opium usage (Brecher). The Harrison Act forced all those who made, traded, or administered opium to register with the Internal Revenue Services (IRS) so they could be taxed (King). In the shadow of the Temperance movement with alcohol, laws were passed to make possession of drugs illegal (King). Federal law mandated prison terms from two years to life for anyone caught using heroin (Levine, 1984). In spite of this, heroin became frequently used for substance abusers in the 1950's. Drugs were beginning to get out of control and were having a negative effect on the lives of many people (Levine).

“In 1969, President Nixon coined the term, *War on Drugs*” (Dowling, 2004, ¶ 12). President Nixon created the Drug Enforcement Administration (DEA) in 1973 to declare the global *War on Drugs* (Suddath, 2009). It was not until this point that the term *War on Drugs* became widely used. As of 2006, the U.S. has spent 32 billion dollars on the *War on Drugs*, with small rates of effectiveness (Dowling). When the *War on Drugs* first started, 3-5% of the U.S. population was estimated to have an addiction (Dowling). According to Dowling, the estimate of the U.S. population with an addiction remains to

be 3-5%, even after all the ways the government has attempted to regulate alcohol and drugs. Although these drug policies are unsuccessful, they are still in being enforced.

History of Alcohol Use in Europe

Temperance

The American Temperance movement led to the establishment of temperance societies in Europe (Knight, 2009). The beginnings of an organized Temperance movement in Europe can be traced to groups in Sweden that were organized in 1819 by a man named Per Wieselgren (Knight). Members of these Swedish groups pledged themselves to abstain from all harmful spirituous beverages (Knight). By the 1830s, temperance societies were established in Ireland, Scotland, and England (Knight). As in the United States, alcohol was seen as a prime cause of poverty and suffering among the working class because some spent their paychecks on alcohol (Hauge, 1999). Alcohol was believed to be responsible for crime in the lower social classes because crimes were being committed both under its influence and in an attempt to fund alcohol consumption (Hauge). At that point, alcohol was interfering with lives among many social classes (Hauge). Temperance groups formed and as in the U.S., they traveled around talking about harm that all consumers of alcohol could potentially incur (Hauge).

Prohibition

In the early 1900s, most Protestant nations had come to consider drinking a social evil, and the Prohibition movement was being hurried by the circumstances of World War I (WWI; *Prohibition*, 2006). During WWI, England was fighting against Germany and Austria, however, a huge domestic fight was taking place against alcohol. Soon the British government restricted the sale of alcohol to a few hours in the early evening

(Prohibition). In Scotland, the general public had the right through voting to ban drinking establishments after 1920. In Norway in 1919, voters banned the sale of drinks with alcohol content of more than 12% by referendum (*Prohibition*). That same year, the Finnish government banned the sale of any drink that contained more than 2% alcohol (*Prohibition*). By 1932, many European nations had repealed their laws on alcohol (*Prohibition*). However, since the 1980s, Europe has begun to take a public health perspective which entails involving the community to assist with substance abuse problems. Taking a public health perspective has led to a major change in the thought process involved in creating the alcohol policy in Europe (Hauge, 1999).

History of Drug Use in Europe

As in the United States, European nations at one time employed drug policies which were geared towards abstinence. However, with the failure of the *War on Drugs* in the European countries, the drug policy has evolved toward an *acceptance paradigm*, which has continued for the past 20 years (Böllinger, 2002). The *acceptance paradigm* recognizes there cannot be a drug free society, recreational and self-gratifying drug consumption has to be accepted to some degree, and it is possible to distinguish between non-harmful drug use, and risky use (Böllinger). To further explain, the acceptance paradigm may mean that small amounts of drugs may be acceptable, while risky and harmful amounts of drugs are not acceptable. By technical criminal law, nearly all the European Union member states have reduced punishment for obtaining and possessing small amounts of all illicit drugs (Böllinger). In fact, some European states have been proactive about the acceptance approach to drug use. In 1992, needle exchange programs

were legalized in Germany and have been running smoothly. In the year 2000 in Norway, heroin dispensing programs and safe injection rooms were legalized (Böllinger).

In reviewing the literature, one can see that Europe has become accepting of the fact that people are going to use substances regardless of whether they are illegal. Since people will use drugs, European nations have decided to take an approach which makes using substances safer, and assists people in obtaining treatment if needed, rather than incarcerating them.

Theoretical Models of Substance Use

Temperance

One of the first models to be created in response to alcohol abuse was the temperance model. Between 1825 and 1836, concern about the rise in alcohol consumption grew from an influential cause to a mass movement of a broad section of the American middle-class (Levine, 1984). The pledging to give up alcohol, attend temperance meetings, and assist in campaigns of public education formed the model used in practice (Onni, 2006). Temperance groups were found in the U.S. and members were adamant about doing away with the *demons* of alcohol (Levine). These groups were adamant because they wanted to enforce temperance issues of protecting middle-class homes, women and children, assist with personal success and health, and decrease crime and poverty (Levine).

Disease

In the U.S. during the 1930s and 1940s, the disease model of substance abuse emerged (Miller & Kurtz, 1994). The disease model began with a man named Benjamin Rush. Rush was a medical doctor who served in the Revolutionary Army, a member of

the Continental Congress of 1776, and one of the signers of the Declaration of Independence (Fehlandt, 1904). Rush was adamant in his belief that alcoholism was a disease (Miller & Chappel, 1991). Being a physician, Rush published pamphlets declaring that alcoholism was a disease. Shortly after, many other people followed suit and accepted the concept that alcoholism was a disease. According to the disease model, people who misuse or abuse substances are seen as ill and needing treatment (Marlatt, Blumes, & Parks, 2001). The disease model also states that people who misuse or abuse substances are sufferers of a disease that they are defenseless to have power over. With this approach, alcoholics are seen to bear no responsibility for the development or continuation of their problems. They are viewed as inept in making coherent decisions, calling for social interventions to force them into treatment and into abstinence (Miller & Kurtz).

The disease model states that people with substance abuse problems cannot be left to themselves to make good, appropriate judgments (Miller & Kurtz, 1994). The disease model sees addiction as a biological/genetic pathology and related behaviors such as cravings and drug seeking as signs and symptoms of the disease (Garlitz, 2007). The disease model supports reduction as the most important goal of prevention and abstinence as the only acceptable goal of treatment (Marlatt, 1996). The disease model of substance abuse treatment stresses that addiction is a major disease characterized by loss of control and denial, and is only treatable by immediate abstinence (Denning, 2005). At present, the disease model is used almost exclusively in drug treatment programs in the United States.

One downfall of the disease model is that it fosters dependency (Brickman et al., 1982). Dependency is fostered by the disease models' philosophy that those who have substance problems are incapable of making their own decisions about substance use because their decisions will not be rational. Hence, those who are caring for a person with a substance abuse problem must take away the person's right to make his or her own choices about substance use until abstinence is reached.

Moral

In general, the moral model of substance abuse treatment is based on the belief that those who do not conform to what the majority of society deems as proper cannot be good moral people and cannot be productive providers to the family and community (Garlitz, 2007). With the moral model, drinking is seen as an indication of weak disposition (Brickman et al., 1982). From the viewpoint of the moral perspective, substance abuse is seen as a violation of societal rules by the abuser. Those engaged in harmful substance use are given a warning to take control of their lives, stop abusing substances, and act in a socially acceptable (morally correct) way (Marlatt, Blumes & Parks, 2001). Moral judgment is passed on those with substance problems based on understanding that drunkenness is a choice and that people become inebriated by their own willful behaviors (Miller & Kurtz, 1994). For example, the *War on Drugs* mindset includes beliefs consistent with the moral model of addiction which recognizes substance use as a societal evil rather than a public health issue (Marlatt, Blumes, & Parks).

According to the moral model, possible causal factors for the deficit in character are lack of spirituality and conscious choice (addiction-rehabilitation.com, 2006). From the moral model perspective, causal factors of substance abuse lead to possible courses of

treatment which include spiritual guidance, moral persuasion, imprisonment, social consequences (addiction-rehabilitation.com), or implementation of willpower to gain control of themselves in order to return to sobriety and respectability (Brickman et al., 1982).

Society keeps the moral model intact by having the justice system implement consequences for substance related crimes. Civil and criminal courts presently still demonstrate blaming defendants for behaviors committed under the influence (Miller & Kurtz, 1994). The moral model views people who misuse or abuse drugs as criminals who should be prosecuted (Marlatt, Blumes, & Parks, 2001). Continuing with this theme, American drug control policy has deemed that illegal substance use or distribution of such substances is a crime justifiable of punishment. The assumption behind punishing illegal substance users and distributors is that illicit drug use is morally wrong (Marlatt, 1996). Proponents of this model feel it is a punishable crime and the individual who commits the crime is responsible for his or her choices. Hence, as of 2004, there were approximately 333,000 people in the United States incarcerated for illegal substance use (Mumola & Karberg, 2006).

Biopsychosocial

Under the Biopsychosocial model, emphasis is placed on the biological, psychological, and social aspects that sway and sustain alcohol and drug treatment (Wiltsek, 2004). This model emphasizes the importance of all three domains when attempting to understand the etiology and treatment issues of substance use problems (Wiltsek). This model takes into consideration more than just the psychological, social, and medical dimensions of a person. By utilizing the three domains, those working with

clients with substance problems may be able to help the client in a more holistic way (Wiltsek). For example, with substance abuse problems, bio-chemical, psychological, family, cultural, and social aspects are equally taken into consideration. In general, those who adhere to this model challenge the assumptions of other models and believe there may be several reasons for substance abuse which may differ from individual to individual (Wiltsek). In addition, acknowledging the diversity of alcohol problems, based on genetic tolerance, metabolism, and brain sensitivity are possible factors to explore. Furthermore, recognition of social and environmental factors may play a role in substance use and the role of endorsement and accessibility may also be considered (Wiltsek). For example, in the early 20th century, popular fiction, theater, and new movies hardly ever characterized drinking in positive conditions and consistently portrayed drinkers as flawed characters. Most family magazines and many daily newspapers discarded liquor ads (Blocker, 2006). However, presently, the message of substance use is conflicting considering that advertisements for alcohol are seen where they had once been banned and alcohol is associated with enhanced quality of life in movies. Today, the biopsychosocial model is utilized in many treatment centers, and many clinicians and addiction specialists alike, work under the assumptions included in that model (Wiltsek).

Models Compared

Each model of substance abuse prevention or treatment views substance use differently. The Temperance model states that the drug itself is addictive and destructive (addiction-rehabilitation.com, 2006). According to the Moral model, the substance abuser is in violation of societal rules and must be punished for not conforming to the

majority of society (Marlatt, Blumes, & Parks, 2001). The Disease model states that there is a loss of control over the use of substances and there is a preoccupation with acquiring and using the substance (Miller & Chappel, 1991). The Biopsychosocial model addresses the biological, psychological, and social part of a problem at the same time (van Wormer & Davis, 2008).

Even though the all of the models discussed above have differences, they are also related. For example, the Temperance and Moral models are similar in that morals play a role with people from the Temperance movement calling alcohol *demonic*; this insinuates alcohol is *bad* or *wrong*. With alcohol being *bad* or *wrong*, people who consume it are seen as immoral; people who drink alcohol are bad.

The Disease model stems from the temperance model; the term *disease* originated from a man who was one of the pioneers of the Temperance movement. The disease model states substance use is uncontrollable to the individual, it is an illness that takes over the body. This way of thinking is an extension of the Temperance model. The biopsychosocial model incorporates parts of each model into one (Margolis & Zweben, 1998), and takes it a step further by individualizing treatment for those who seek it. The biopsychosocial model overlaps with the disease model when dealing with the biological aspect of substance use. The biopsychosocial model also taps into the moral model when taking into account an individuals' social, cultural, and family life. For example, issues pertaining to a substance abusers' interaction with society and his or her family and how people view the substance abuser may be explored.

Models of Treatment

A.A./N.A.

The beginning of self-help groups to assist those who abuse substances was born from the Washingtonian Movement in 1840. The group that started this movement consisted of *sick* intemperate persons who developed their own resources and techniques of self-help (Miller & Chappel, 1991). This group paved the way for Alcoholics Anonymous (A.A.). A.A. was started in the 1930s by two middle class habitual drunkards, Bill Wilson, a stockbroker, and Robert Smith, a physician (Levine, 1984). A.A. and Narcotics Anonymous (N.A.) are nonprofit comradeships or groups of men and women for whom substances have become a major problem in their lives (Narcotics Anonymous, 2008).

The most commonly used type of addiction treatment is referred to as the *12 step* abstinence based or *A.A. method*. The A.A. program is based on the concept that alcoholism is an addiction to alcohol, and as such is an autonomous disease or disorder (Levine, 1984). Wilson and Smith believed that individuals who became alcoholics had a disease; they had something wrong with their bodies which ultimately made them powerless to control their drinking (Levine). The first recognized treatment center to utilize this method was established in Center City, Minnesota in the 1950s and the form of treatment using A.A. as a foundation has come to be known as the *Minnesota Model* (Miller, 1995). Today, A.A. meetings are held in almost every city in the United States.

Alcoholics Anonymous is a self-help network of recovered and recovering alcoholics who assist each other in abstaining from alcohol and approach other alcoholics offering them assistance to maintain sobriety and improve their lives. This is all done

anonymously (Levine, 1984). A.A. draws a firm line between normal drinkers, who can keep their drinking within the limits of moderation, and obsessive drinkers, who cannot keep their drinking under control (Blocker, 2006). The primary requirements of A.A. and N.A. programs are that individuals become involved with the process of recovery by attending meetings, being sponsored and sponsoring, having service promises, and fellowshiping (Friedman-Gell, 2006).

A.A. is fundamentally a spiritual program. Although A.A. is considered a form of treatment, it is also a way of living and being (Miller & Kurtz, 1994). One feature of A.A.'s claim to be spiritual rather than religious is that it does not impose faith or dogma (Miller & Kurtz). The way of living and being is contained within the 12 steps. Interestingly, only the first of A.A.'s 12 steps names alcohol. The remaining are concerned with spiritual processes: familiarity of and relationship with "God or a Higher Power, self-searching, confession, openness to being changed, amends, prayer, seeking God's will and carrying the message to others" (Miller & Kurtz, p. 161). Applying the 12 steps conveys a recovery portrayed by progress in character qualities such as integrity, humbleness, and patience. Because of A.A.'s spiritual focus, A.A. is by nature broad rather than restricted (Miller & Kurtz). Miller and Kurtz sum up the 12 steps: steps one through three involve admitting being powerless over the addiction; in the fourth through seventh steps, participants purposely take accountability for exploring their past lives, and becoming acquainted with and admitting their limitations; in the eighth and ninth steps, this accountability is extended to making penitence for past mistakes. A.A.'s last three steps are often known as the *maintenance steps*. These steps presume doing away with the garbage of the past, not disregarding or denying it (Miller & Kurtz). At first

A.A. was *only* for alcoholics and extended *only* to people whose drinking appeared to be unrestrained (Levine). However, the influence of Alcoholics Anonymous on treatment has spread out to such treatment groups as Narcotics Anonymous and Cocaine Anonymous (Havranek & Stewart, 2006).

Outcome Studies

Outcome studies have been conducted to evaluate the effectiveness of A.A and N.A.. Gossop, Stewart, and Marsden (2007) studied the relationship between how many times individuals attended N.A. and A.A. meetings and substance use results after residential treatment of drug dependence. Criterion for participation in the study was that participants had to have a drug and/or alcohol problem, but not just an alcohol problem. They found that clients who went to N.A./A.A. after treatment were more likely to be abstinent from opiates at follow up (1, 2, and 4-5 years) than those who did not attend. While there was no change overall in rates of alcohol abstinence before and after treatment, participants who attended N.A./A.A. were more likely to be abstinent from alcohol at all follow-up points than those who did not attend N.A./A.A.. More frequent N.A./A.A. attendees were more likely to be abstinent from opiates and alcohol when compared both to non-attendees and to occasional (less than weekly) attendees.

Barbosa Terra et al. (2008) examined whether A.A. groups were effective post-hospitalization. The population studied consisted of 300 Brazilian alcohol dependents who were hospitalized in a mental facility. Six months after discharge, follow up interviews took place in the individuals' homes. Results of the interviews demonstrated that there was less than 20% adherence to A.A. Some of the reasons given by the participants for the low adherence included relapse, lack of need, and lack of credibility.

Sanchez-Craig, Annis, Bornet, and MacDonald (1984) compared abstinence to controlled drinking approaches to treatment. They examined 70 early stage problem drinkers and randomly assigned them to a goal of either abstinence or controlled drinking. Both groups received about six individual weekly counseling sessions, both groups were taught to identify risk conditions and existing competencies, both groups developed cognitive and behavioral coping skills, and both groups objectively assessed their progress. The difference between the groups was that the controlled drinking group was taught procedures for moderate drinking. However, six months after treatment, drinking had been reduced for both groups from an average of 51 drinks per week to 13, and this reduction was maintained throughout the second year for both groups. Over the two year follow up, no significant differences were found. Although the outcomes of the groups were similar, controlled drinking was considered to be a more suitable goal; it was more acceptable to the majority of the participants, and most of those assigned to abstinence developed moderate drinking on their own.

Kaskutas (2009) reviewed studies reporting negative results for A.A. in abstinence treatment based on six criteria for establishing causation. Studies that had positive results for A.A. and several 12-step facilitation studies with mixed results were intentionally excluded from the review. The six criteria were (1) magnitude of effect; (2) dose response effect (how often participant went to A.A.); (3) consistent effect (did participant go weekly or near weekly); (4) temporally accurate effects; (5) specific effects; and (6) plausibility. Results showed that for criterion one, rates of abstinence were approximately twice as high for those who attended A.A. following treatment. For criterion two, the more a person went to 12-step meetings, the more the person was

abstinent from alcohol and drugs. Results of criterion three demonstrated that approximately 50% of participants who attended A.A. or 12-step meetings only were abstinent at one, three, and eight years. Results of criterion four showed all but one study did not meet this criterion. The one study that did meet the criterion reported that frequency of A.A. meetings attended as well as overall A.A. involvement in one to six months significantly predicted the percentage of days of being abstinent during months seven to 12. Results for criterion five (specific effects) were that two studies found a positive effect for A.A., one study found a negative effect, and one study found a null effect. Results of the last criterion found a positive relationship between A.A. involvement and abstinence has been shown to be explained by psychological and spiritual means, social influences, and social learning and behavioral means.

In summary, there are mixed results as to how effective A.A. is. When A.A. is measured by itself, results show attending such a group helps lessen the number of those who use substances (Gossop, Stewart, & Marsden, 2007), granted the number of those who attend on a consistent basis are relatively low. When practicing abstinence is compared with other methods such as controlled drinking, controlled drinking appears to be a more attainable goal than adhering to an A.A. program.

Other Models of Treatment

Although the 12-step model is most commonly used with the substance abuse population, there are two other models that are deserving of mention: Cognitive-Behavioral (C-B) and Motivational Interviewing. Both of these interventions differ from the traditional 12-step approach.

The C-B approach to substance abuse treatment was born from social learning theory and clinical research (Ouimette, Finney, & Moos, 1997). A basic supposition of the C-B model is that substance abuse is a learned, maladaptive behavior. C-B involvement usually aims to have an impact in two areas: altering distorted thinking about abused substances and escalating adaptive coping reactions (Ouimette, Finney, & Moos). Ouimette, Finney, and Moos conducted a study involving 3,018 patients from 15 programs at U.S. Department of Veterans Affairs Medical Centers. They compared the effectiveness of the 12-step and cognitive-behavioral models of substance abuse treatment. Results after one year of treatment discharge demonstrated that patients in 12-step programs were more likely to be abstinent and although patients in 12-step and C-B programs had somewhat better rates of employment at 1 year, 12-step, mixed 12-step/C-B, and C-B programs were otherwise equally successful in lessening patients' substance use and psychological symptoms, and increasing the quantity of patients who steered clear of legal problems and who were not imprisoned or homeless.

Magill and Ray (2009) conducted a meta-analysis with 53 randomized controlled trials of C-B treatment with adults having a primary diagnosis of a substance use disorder. C-B treatment could have been provided in group or individually and delivered alone or in combination with one or more treatments including medication. Results of this meta-analysis showed that C-B treatment had a small but statistically significant effect versus comparison conditions which were either discussion groups, control groups, motivational interviewing (M.I.), pharmacology, or educational sessions.

Motivational interviewing (M.I.) is a direct, client-centered counseling approach for bringing out behavior change by assisting clients to discover and resolve ambivalence

(Wagner & Connors, 2001). When contrasted with nondirective counseling, M.I. is more focused and goal-directed. The assessment and resolution of ambivalence is its essential function, and the counselor is deliberately directive in shadowing this goal (Wagner & Connors). M.I. is applied in treatment in a systematic manner. Motivation to change is brought out from the client, and not forced. The task of the client, rather than the counselor, is to express and resolve his or her own conflicting emotions and thoughts. The counseling manner is commonly a calm and eliciting one. Readiness to change is not a client characteristic; it is an unpredictable result of interpersonal communication. The therapeutic relationship is more like a partnership than the expert/recipient role. The counselor respects the client's independence and liberty of choice (and costs) in relation to his or her own behavior. Counseling sessions take place in an interpersonal manner, not at all limited to prescribed counseling settings. The session is a balance of directive and client-centered mechanisms created by a leading philosophy and understanding of what activates change.

A meta-analysis conducted by Burke, Arkowitz, and Menchola (2003) examined 30 studies that implemented motivational interviewing principles on an individual face to face, controlled clinical trial. Half of the studies examined M.I. for alcohol problems, two for smoking cessation, five for drug addiction, two for HIV risk behaviors, four for diet and exercise problems, one for treatment adherence, and one for eating disorders. In 26 studies, M.I. was compared with control groups and in nine studies, it was compared with treatments such as C-B interventions, client centered counseling, and 12-step groups. They found M.I. was better than no treatment at all and just as effective when compared to other treatments.

Harm Reduction

Definition

In the United States, there appears to be a hesitation to embrace harm reduction as a treatment option in substance abuse because the philosophy of harm reduction treatment is clearly in conflict with the abstinence model. In the harm reduction approach to substance abuse treatment, abstinence is the desired goal only if the client wants to become abstinent. In abstinence based substance abuse programs abstinence is required.

Persons with substance abuse problems face many difficulties reaching and maintaining abstinence from alcohol and other drugs (Mancini, Linhorst, Broderick, & Bayliff, 2008). Achieving abstinence may appear impossible to someone with a substance abuse problem. The harm reduction approach does not call for individuals to decrease or give up drug or alcohol use; rather it attempts to alleviate the negative consequences of drug use (Christie, Groarke, & Sweet, 2008). Harm reduction provides an alternative to the moralistic, social, and medical models of drug and alcohol treatment, acknowledging that some individuals may be unable or unwilling to refrain from use (Hobden & Cunningham, 2006). Although the most preferable outcome in harm reduction programs is the termination of use (i.e., abstinence), programs that use harm reduction differ from traditional abstinence only programs in that these programs do not make abstinence or the desire to achieve abstinence the only treatment goal or a precondition to receiving services (Mancini, et al). Marlatt, Blume, and Parks (2001) have said harm reduction therapy views treatment as involving all parts of a person's life, not just the substance use or mental health arena. Similar to the biopsychosocial model, harm reduction takes a holistic approach to treatment which benefits the client. Harm

reduction provides low threshold, easy access, non-stigmatizing, and flexible treatment options with a variety of goals and approaches catered to the needs of each individual patient (Marlatt & Witkiewitz, 2002).

There are five principles of harm reduction: *pragmatism*, *humanistic values*, *focus on harms*, *balancing costs and benefits*, and *priority of immediate goals* (Riley et al., 1999). *Pragmatism* is accepting that the use of mind altering substances is a common feature of the human experience. *Humanistic values* involve imparting no moralistic judgment of condemning or supporting the use of drugs; the dignity and rights of the drug user are respected. *Focus on harms* is honing in on decreasing the negative consequences of drug or alcohol use to the user and others, as opposed to focusing on decreasing the drug or alcohol use itself. *Balancing costs and benefits* refers to indentifying, measuring, and assessing the relative significance of drug or alcohol use related problems, and their associated harms. The costs and benefits of intervention are assessed in order to focus resources on priority issues. *Priority of immediate goals* refers to focusing and addressing a person's most pressing needs.

MacMaster (2004) has stated that abstinence may not be a reasonable approach for everyone who abuses alcohol and other substances. Relapse is seen as a natural and expected occurrence in all traditional substance abuse treatment programs and models. It is the rule rather than the exception for a person with substance abuse problems to prolong use, even after entering treatment (MacMaster). Although relapse is viewed as a natural and expected occurrence, in abstinence based programs, relapse is seen as a weakness, the individual is viewed as a failure when he or she relapses (Brickman, et al., 1982). However, with harm reduction, the concept of relapse as used in traditional

abstinence models of substance abuse treatment, does not apply since individuals dictate their own treatment goals. With harm reduction, relapse may be understood in terms of substance abusers not being able to meet their treatment goals as originally planned, leading to a modification of clients' treatment goals to best fit their immediate needs. The harm reduction approach embraces the principle of non-judgment, which is very important to treatment.

Models used in Europe

There are two well-known models of substance abuse treatment which are employed in Europe. In Amsterdam, the Dutch Model is based on a matter of health and social well-being. Engelsman (1998) has said the Dutch are sober and pragmatic people; they have opted for a sensible and realistic approach to drug and alcohol problems rather than for a moralistic or over-dramatized one. The drug abuse problem should not be primarily seen as a difficulty of the police and courts (Engelsman). Visitors to Amsterdam and other major cities in the Netherlands can find special *coffee shops* that sell marijuana and hashish, which can be consumed in the shop or taken home. In the red light districts, prices for sexual services are fixed and condom use is mandatory (Marlatt, 1996). These special coffee shops and moderated sex services are examples of taking a public health approach to treatment. The Dutch policy *normalizes* the drug problem; hence the person with a drug abuse problem more resembles someone who is unemployed rather than a menace to society (Engelsman).

The second model of substance abuse treatment in Europe is the Merseyside Model which was created in the United Kingdom (U.K.). In the early to mid-1980s, John Ashton of the Department of Public Health developed ideas for the New Model for Public

Health (O'Hare, 2007). The objectives were to reduce the following: sharing of injection equipment, injecting drug use, street drug use, and drug use, and if possible increase abstinence (O'Hare). By the late 1980s, the Merseyside Harm Reduction Model was created. The foundation of this model is rooted in U.K.'s history. Marlatt stated that since the 1920s, the U.K. was the forerunner of the *medicalization* approach, in which drug abusers can be prescribed drugs such as heroin and cocaine on an as needed basis (1998). The basis of the Merseyside Model is the prescribing of mainly methadone along with needle exchanging and community outreach (O'Hare). The Merseyside Model reinforces categorizing the issue of substance abuse as a societal problem. Police play an important part in helping to enforce this model. On a regular basis, police refer arrested drug offenders to treatment services and provide public support for needle exchange programs (Marlatt), whereas in the United States, drug offenders may volunteer to receive treatment services (Substance Abuse Treatment FAQ, 2009). The Merseyside Model demonstrates that society and communities play a role in helping those with substance abuse problems.

Currently, police stations in Amsterdam supply clean syringes on an exchange basis. Throughout many European and Australian cities, automated syringe exchange machines are available 24 hours a day (van Wormer & Davis, 2008). In many parts of Europe one can find general practitioners as well as clinics providing methadone--it is even made available from *methadone buses* (van Wormer & Davis). Germany has become a model for other European countries by offering mobile vans for needle exchange services and counseling, needle exchange in city pharmacies, four crisis centers for medical care, and rooms where addicts can inject drugs safely (Marlatt, 1998). In

Canada, pharmacists participate in the syringe exchange program as well (van Wormer & Davis).

Harm Reduction- United States

According to Mancini, Linhorst, Broderick, and Bayliff (2008) harm reduction is seen as a controversial approach in the United States due to a long policy history of drug prohibition that has largely viewed drug use as a moral and legal issue rather than a health issue. For harm reduction advocates, U.S. policies rely too readily on prohibition and criminalization and disregard the health and social issues involved in drug use (Sorge, 1991). Hence, there is a conflict between those who are open to harm reduction and those who support abstinence only approaches to drug abuse treatment in the United States. Although there is controversy about harm reduction, some agencies in the United States do utilize a harm reduction approach to drug and alcohol abuse treatment. Harm reduction is utilized in the form of methadone distribution programs. Methadone programs were designed to lessen an individual's use of illicit drugs and problems with the law while increasing a substance abuser's ability to be employed and otherwise function in society (Sorge). Although methadone programs have been around for many years, they were not seen as a harm reduction approach, although in essence they are. Sorge states there is a delay in receiving services for drug use and it is based not on medical evidence or public health policy, but mostly on ideological justification that does not take a realistic explanation of the foundation of and answer to drug-related harm. As a result, there is the argument about the benefits of harm reduction and the principles of how we use it.

Although the U.S. practiced harm reduction briefly in the past, only two studies have been conducted that assess attitudes toward harm reduction. Goddard (2003) measured treatment professionals' attitudes toward harm reduction before and after a two-hour education presentation on harm reduction. These participants were from southern Ohio and central Kentucky who had a mean of 10.13 years experience treating substance abuse issues. Forty- three percent of participants had a master's degree while 42% held a doctoral degree. Goddard created and used the Harm Reduction Acceptability Scale to measure attitudes pre and post educational session. She found participants' attitudes were significantly more favorable after the presentation than before. The study may suggest education is a missing factor to being open to the concept of harm reduction.

The second study conducted by Havranek and Stewart (2006) measured rehabilitation counselors' attitudes toward harm reduction using a 10 item variation of Goddard's Harm Reduction Acceptability Scale. They found that most respondents believed the harm reduction approach in treatment is good, but more believed that all illegal drug use should be avoided. They also found that males in general tended to agree more with harm reduction than females, and participants 50 years and older favored harm reduction more than those under 50 years old. In addition, Havranek and Stewart found that participants with a religious affiliation were more likely to disfavor harm reduction than those who denied a religious affiliation. The researchers also discovered that the more years rehabilitation counselors had spent in their professional career, the less they accepted harm reduction.

Critic of the harm reduction approach

Although there has been criticism of the abstinence only approach to substance use, there has also been criticism of the harm reduction approach. One criticism is that harm reduction is not value-neutral, but rather expresses and promotes values that are so widely accepted that they are not subject to debate (Keane, 2003). Being open to the idea of value neutral would be a difficult concept to grasp considering we are a nation whose morals are based on abstinence; we have not been very open to other approaches of helping substance users. Erickson (1999) has expressed the belief that harm reduction is viewed as too practical, concerned only with the harms of drug use and not as concerned with the negative consequences of prohibition.

More criticisms of harm reduction include the following: (1) it promotes drug use, (2) it sends a mixed message, and (3) it fails to get people to abstain (Christie, Groarke, & Sweet, 2008). Since American attitudes are rooted in the belief that abstinence is the *only way*, it can be difficult to imagine there may be different ways to approaching the same problem. The definition of harm reduction can become easily misconstrued to those who are not open to the idea of harm reduction or do not have a basic understanding of what harm reduction is about. Harm reduction does not promote drug use; harm reduction *accepts* that the use of substances is part of the human experience. People will use drugs and alcohol; harm reduction emphasizes how to use them safely. Unlike the abstinence model, harm reduction does not require abstinence in order for people to receive services or to remain in treatment. Abstinence would be a goal if a client so chooses it; otherwise, enforcing abstinence would not provide the opportunity for someone with a substance use problem to make his or her own choices and determine what he or she wants. To date,

there are very few studies (Emmanuelli & Desenclos, 2005; Hawks & Lenton, 1995; Hoben & Cunningham, 2006) that demonstrate that the harm reduction approach to substance abuse treatment is as effective as or more effective than the abstinence model.

Benefits

Harm reduction is exclusively intended to meet an individual where he or she is regarding the use of drugs or alcohol and develop treatment strategies based on the motivation, strengths, and limitations of each person (Witkiewitz, 2005). This contrasts from M.I. in that with M.I., the counselor is intentionally directive. Hobden and Cunningham (2006) found that harm reduction strategies such as needle exchange and methadone maintenance have resulted in reductions in drug use, disease, crime, unsafe injection behaviors, drug related deaths, and improvements in employment and interpersonal relationships among IV drug users. Small interventions that affect people on an individual level, such as training someone how to inject safely or giving them clean needles, can create a domino effect, affecting larger social, administrative, and bureaucratic systems: legal, judicial, health, child welfare, and social services of all kinds (Sorge, 1991). For example, teaching IV drug users how to inject safely has the potential to reduce needle sharing (social), reduce government involvement of controlling IV drug users (administrative), and reduce the spreading of HIV (bureaucratic/health). As explained, small interventions have the potential to create a safer society for all.

In 1985, Australia adopted the National Drug Strategy which incorporated demand reduction and supply reduction initiatives to reduce drug related harm (Hawks & Lenton, 1995). Hawks and Lenton reviewed literature pertaining to the National Drug Strategy. They demonstrated how the National Drug Strategy has assisted in reducing

drug-related harms in the country. In terms of alcohol, Australia introduced random breath testing in all states and territories and the progressive reduction of permissible blood alcohol level when driving. While the United States practices random breath testing, the U.S. has not reduced permissible blood alcohol level when driving. These measures appear to have helped in reducing harm (i.e., accidents). Part of the National Drug Strategy involves utilizing needle exchanges and other HIV prevention campaigns. In the early 1980s, Australia was ranked in the top four of 24 countries in terms of AIDS cases per capital. Since the inception of the National Drug Strategy, Australia has ranked lower on the list. In 1988, Australia ranked sixth, and in 1991, Australia ranked eighth (Hawks & Lenton).

Putting Harm Reduction into Practice

In 2002, Scotland created the Scottish Plan for Action on Alcohol Problems which aims to reduce harm with communities and works with young adults between the ages of 16 and 24 (O'Donnell, 2006). The Plan for Action uses prevention and education, protection and controls, and provision of services and tries to incorporate them into the Scottish culture. A couple of ways in which Scotland is trying to implement this approach is through mass media and licensing legislation (O'Donnell). Posters displayed in the general public and in washrooms demonstrate comparisons between perceived *good* and *bad* nights out and accentuate the negative consequences of a bad night. Leaflets are also produced and given out during group settings involving youths. On the legislative side, there are talks of considering selling alcohol 24 hours a day versus keeping a time restriction. The aim is to move away from the rapid drinking seen in bars to a café culture where there is no need to drink quickly. There are also plans to abolish

the advertisement of happy hour and drink all you can promotions (O'Donnell). Included in the legislation is server training. Servers will deny already intoxicated customers the right to purchase more alcohol.

France put two strategies in to place in 1997: they improved access to sterile syringes for intravenous drug users and made access widespread to substitution treatments in order to lessen intravenous drug use. Emmanuelli and Desenclos (2005) followed those strategies between the years of 1996-2003. They analyzed syringe sales and prescribed substitution treatments as indicators of success of harm reduction. Results of the analysis showed from 1988-1998 needle sharing decreased from 48% to 20% and needle re-use from 75% to 45%. Since 1996, AIDS cases among those who use needles have regularly decreased, making up 11.4% of all HIV cases diagnosed in 2003. Sales for substitution treatments such as methadone and high dosage buprenorphine increased throughout France from 1996-2003. These results suggest that drug users are making an effort to use drugs in a safe way.

In the United States, 222 substance abuse treatment agencies were surveyed on their acceptability and availability of harm reduction interventions for drug abuse using the Harm Reduction Attitudes Questionnaire. Eight percent of participants had five or less years of experience with substance abuse treatment, 22% had six to 10 years experience, 44% had 11- 20 years experience and 26% had more than 20 years experience. Rosenberg and Phillips (2003) found that at least 50% of the participants were somewhat or completely acceptable of different non-pharmacological and pharmacological interventions used to reduce drug related harm. When it came to non-

abstinence being a final outcome goal, participants did not think that was acceptable; however, non-abstinence as an intermediate goal was more acceptable.

Spirituality/Religion

Definitions

Although spirituality is an important part of most abstinence-based substance abuse treatment programs and is becoming more prevalent in other forms of substance abuse treatment, there is ambiguity surrounding the definition of spirituality (Mathew, Georgi, Wilson, & Mathew, 1996). One of the complexities in the meaning of spirituality is its relationship with religion. For example, the Fetzer Institute has published that while religions try to encourage and nurture the spiritual life, it is possible to accept the external forms of religious worship and principle without having a strong relationship to the transcendent (2003). The Fetzer Institute also has held that spirituality is at times a significant part of religious involvement. Another way of explaining the relationship between religion and spirituality is that religion and spirituality go hand in hand.

Wiggins-Frame (2005) has said that religion is a form of spirituality. For instance, she has written that some religious individuals find that religious association, doctrine, practice, programs, and community are ways through which their spirituality is practiced and grown.

From a different perspective, Stanard, Sandhu, and Painter (2000) have stated that spirituality is a widespread experience with lesser restrictions than religion. While a few may believe that spirituality and religion are the same, others think religiousness has explicit behavioral, social, doctrinal, and denominational uniqueness because it occupies a structure of worship and doctrine that is mutual within a group (Fetzer Institute, 2003).

Knight et al. (2007) have defined religion and spirituality as separate constructs. They have said that religiousness commonly relates to beliefs, practices, and behaviors connected with organized religious groups, such as church association and presence at religious services. They have held that spirituality usually refers to more individual and theoretical beliefs and practices, such as knowledge of the divine in every day life or communication with a transcendent power, which may or may not be connected with structured religious practices. Wiggins-Frame (2005) has made a clear distinction between spirituality and religion. She has stated that spirituality consists of one's beliefs, attentiveness, values, subjective experience, sense of purpose and mission, and an attempt to reach toward something greater than oneself. An individuals' spirituality may or may not include a God. Religion refers to a set of beliefs and practices of an organized religious institution and tends to be expressed in ways that are denominational, external, cognitive, behavioral, ritualistic, and communal.

Professionals' Attitudes toward Religion/Spirituality

Findings from studies in which helping professionals were asked about religion and spirituality can help in understanding the differences in the two constructs. Researchers have studied whether a helping professionals' religiousness or spirituality may affect the outcome of treatment for his or her clients.

Schaler (1996) examined 295 U.S. addiction treatment providers on spiritual thinking which was based on the A.A. philosophy. Most of the participants were Caucasian (94.9%). In terms of education, 28% reported they had some college, 39% reported having a bachelor degree, 73.9% had a graduate degree and 2% had a medical degree. He found that those participants who were spiritual thinkers believed in the

disease model of addiction, were members of A.A., and were Catholic or Protestant. Those who were not spiritual thinkers viewed addiction as a purposeful behavior, were not members of A.A., and tended to be Jewish, agnostic, or atheistic.

Curlin et al. (2009) examined 1,200 U.S. physicians' (600 general internists and 600 rheumatologists) and 1,200 Complementary and Alternative Medicines (CAM) providers' (600 acupuncturists and 600 naturopaths) attitudes toward CAM and the likelihood of them to practice it. Predictors of practicing CAM included age, gender, religious affiliation, region of the U.S. in which practitioners lived, and self-perceived level of spirituality. The researchers found that naturopaths were significantly younger than internists, rheumatologists, and acupuncturists, most of the CAM providers were women, and CAM providers were mostly located in the West while rheumatologists were mostly located in the South and Northeast, and internists were located almost evenly in all regions. CAM providers were three times more likely than physicians to report having no religious affiliation; however, they were twice as likely to perceive themselves as "very spiritual." In terms of attitudes toward CAM and the likelihood to practice it, researchers found that physicians reported lower levels of attitudes toward and personal use of practicing CAM, suggesting those who reported being more spiritual were more open to the use of CAM.

Day, Lopez-Gaston, Furlong, Murali, and Copello (2005) examined 346 United Kingdom professional substance misuse treatment workers' attitudes toward A.A./N.A. groups and the likelihood of referring clients to such groups to supplement their treatment. The researchers were interested in personal characteristics such as perceived knowledge of about A.A./N.A. groups, place of work, and perceived level of spirituality.

Results showed that 88% of participants said they had average or above average knowledge about A.A./N.A., with approximately 32% rating themselves as having high or very high knowledge about A.A./N.A. Thirty-nine percent of participants stated their attitude was positive or very positive toward A.A./N.A., with 55% of participants rating themselves as neutral. Participants who were positive or very positive toward A.A./N.A. scored statistically significantly higher as being spiritual as did those who were likely or very likely to recommend someone to A.A./N.A. Although more participants had a neutral attitude toward A.A./N.A., those who had a positive attitude were more likely to be spiritual and would refer clients to such groups. These results are in contrast to the results in the Curlin, et al. study in that those who were more spiritual were more open to practicing alternative medicine, whereas in this study, those more spiritual favored the traditional way of treating substance use.

In this study, I define religion and spirituality in the same vein in which Wiggins-Frame (2005) has defined the two terms. Religion differs from spirituality in that religion involves a set of beliefs and practices of an organized religious institution. Spirituality does not involve a set of beliefs or practices of an organized religious institution. In this study, spirituality will be defined as an individual's beliefs, attentiveness, values, subjective experience, sense of purpose and mission, and an attempt to reach toward something greater than oneself. An individual's spirituality may or may not include a God. Religion is defined as a set of beliefs and practices of an organized religious institution that tend to be expressed in ways that are denominational, external, cognitive, behavioral, ritualistic, and communal and involve a God.

Summary

The history of substance use and abuse in the United States and Europe has been summarized along with models of substance use, models of treatment, and harm reduction. The literature in the United States has shown that historically, abstinence is the main method of treating substance abuse addictions. However in Europe, harm reduction has been more accepted as another option for treatment.

In the United States, the abstinence-based model of treatment for alcohol and drug abuse is generally the most practiced method. Studies have shown that A.A./N.A. may work for some people, but not all. Studies have also shown that controlled drinking, Cognitive-Behavioral, and Motivational Interviewing approaches have worked as well. In Europe, substance abuse programs are more often taking a harm reduction approach which in essence teaches people how to use substances safer if people do not want to practice abstinence. In some of the European countries discussed, this approach appears to be achieving desirable effects.

The concepts of spirituality and religion, especially in relation to substance abuse treatment, have been reviewed and defined as the terms are defined in this study. Studies have shown that those in the United States who consider themselves spiritual are likely to be more open to practicing additional methods of treatment whereas those in the United Kingdom who consider themselves spiritual, favor the 12-step approach (Day et al., 2005).

The review of the literature revealed only two studies that examined attitudes toward harm reduction. Goddard (2003) conducted a pre and post test of treatment professionals and found participants had a more favorable attitude toward harm reduction

after an educational presentation on harm reduction, suggesting there may be a lack of education about harm reduction. Havranek and Stewart (2006) measured rehabilitation counselors' attitude towards harm reduction. Among variables examined, they found that those with a religious affiliation were more likely to not be receptive to harm reduction compared to those who denied a religious affiliation. For counselors, there is an importance to be flexible and open to different approaches to assisting their clients. However, counselors in the United States treat clients with substance abuse in one way, the abstinence approach.

This study seeks to examine personal characteristics that may be correlated with attitudes toward harm reduction. To date, no studies have measured mental health professionals' attitudes toward harm reduction and investigated if their level of spirituality was related to their openness to this approach to substance use.

CHAPTER III METHODOLOGY

Purpose

The purpose of this study was to examine attitudes of counselors who were professional members of the *American Counseling Association* regarding harm reduction and to determine whether their attitudes regarding harm reduction were related to their level of spirituality or personal characteristics. The Harm Reduction Assessment Scale (HRAS; Goddard, 2003) and the Spirituality Assessment Scale (SAS; Howden, 1992) were administered to participants in this study. The HRAS measured treatment professionals' attitudes toward harm reduction. Permission to use this instrument was requested and granted by the instrument's author. The SAS was intended to measure participants' level of spirituality. Permission to use this instrument was also requested and granted by the instrument's author.

Variables

Variables of interest that were considered in this study were counselors' self-reported level of spirituality, years of experience as a counselor, the location of environment in which participants lived (urban, rural, or suburban), primary work setting, personal experience with substance abuse and substance abuse counseling, and credentials held by counselors. Research has shown the following: those who perceive themselves as spiritual may be more open to additional methods of helping people (Curlin et al., 2009) and those who have been in the field longer may be less receptive to alternative treatment (Haverank & Stewart, 2006). I was interested in knowing if there is a difference of attitudes toward harm reduction depending on the location of environment in which participants live (rural, urban, suburban). There have not been any studies to

date that have surveyed various types of counselors on their attitudes toward harm reduction. This will be beneficial to examine attitudes counselors in general hold regarding harm reduction. Since research states there is a spiritual component to the traditional way of treating substance abuse (Miller & Kurtz, 1994), it would be of interest to see if those who have personal experience with substance abuse and substance abuse counseling have a receptive attitude towards harm reduction. Lastly there is an interest to examine credentials held by counselors to see if there is any correlation among those who hold, for example, a Certified Rehabilitation Counselor (CRC) credential, versus a Licensed Professional Counselor (LPC) license, or a combination of licenses and certifications.

The criterion variable that was examined in this study was counselor attitudes toward harm reduction. Attitudes toward harm reduction were measured by the HRAS (Goddard, 2003). This questionnaire was designed to measure treatment professionals' attitudes toward harm reduction. The questionnaire consisted of 25 items in which participants were asked to choose the degree to which they agree or disagree with each item.

Spirituality was measured by the SAS (Howden, 1992). This questionnaire was designed to measure a person's level of spirituality. The questionnaire contained 28 items in which participants were asked to choose the degree to which they agree or disagree with each statement. The SAS consists of four subscales: Purpose and Meaning in Life, Innerness or Inner Resources, Unifying Interconnectedness, and Transcendence. Overall scores were compared to scores of participants' attitudes toward harm reduction.

Research Design

The research design used in this study was a quantitative, non-experimental survey of professional counselors. A randomly selected sample of professional counselors from the *American Counseling Association (ACA)* was asked to complete and return surveys via email.

General Research Question

Are counselors' attitudes toward the use of harm reduction rather than total abstinence in substance abuse treatment associated with their level of spirituality, length of practice as a counselor, primary employment setting, location of environment in which they live, and personal experience with substance abuse?

Specific Research Questions

1. Is there a relationship between counselors' attitudes toward harm reduction and spirituality?
2. Is there a relationship between where counselors work (primary work setting) and their attitudes toward harm reduction?
3. Is there a relationship between counselors' years of experience counseling and their attitudes toward harm reduction?
4. Is there a relationship between location of environment in which counselors live (urban/suburban/rural) and their attitudes toward harm reduction?
5. Is there a relationship between counselors' personal experience with substance abuse and substance abuse counseling and their attitudes toward harm reduction?
6. Is there a relationship between credentials counselors hold and their attitudes toward harm reduction?

Method

Participants

The participants in this study consisted of professional counselors from the *American Counseling Association*. According to the *American Counseling Association* (2009), members with *Professional* status hold a master's degree or higher in counseling or a closely related field from a college or university that was accredited when the degree was awarded by one of the regional accrediting bodies recognized by the Council for Higher Education Accreditation. ACA has approximately 40,000 members. Only Professional members who have addresses in the United States and who have provided their email addresses were asked to complete the questionnaires. Using Cohen (1992) as a guideline, assuming medium effect size of a 0.15, $\alpha = .05$, a minimum of 107 participants were needed for this study. Anticipating a return rate of 5-30%, a total of 2,000 Professional members of ACA were asked to complete surveys. ACA was asked to send email addresses to this researcher of 2,000 Professional members who have addresses in the United States and have been selected randomly or systematically (for example, every 23rd person from an alphabetical list). Gender and ethnicity from those who completed the questionnaires were compared to the profile of all United States Professional ACA members to determine whether a representative sample of ACA professional members participated in the study.

Study Context/Setting

This study took place online utilizing Inquisit, an online survey builder. Inquisit contained an introduction and consent to participate page and the questionnaires. The questionnaires included the personal information page, the Harm Reduction Acceptability

Scale, and the Spirituality Assessment Scale. Participants were able to complete the survey at their convenience.

Instrumentation

Two questionnaires were utilized in this research study. The first was Goddard's (2003) *Harm Reduction Acceptability Scale* (HRAS). This questionnaire measured treatment professionals' attitude toward harm reduction. The questionnaire contained 25 items and participants were asked to indicate their level of agreement for each item on a scale of 1 to 5 in which 1= strongly agree; 2= agree; 3= neither agree nor disagree; 4= disagree; and 5= strongly disagree. Items 1, 2, 4, 6, 9, 11, 13, 15, 18, 21 23, and 25 are reversed scored. A mean score of less than 3 suggests a favorable attitude toward harm reduction, while a mean score higher than 3 suggests a favorable attitude towards abstinence. Reliability includes moderately high internal consistency and moderate 3-week test-retest reliability with Cronbach's alphas ranging from .89 (pre) to .93 (post), $r = .83$ (Goddard). The HRAS was significantly correlated with Burt and Roney's (1994) Temperance Mentality Questionnaire to reflect validity (Goddard). Cronbach's alpha for this study was .88. This questionnaire takes approximately 5 minutes to complete.

The second questionnaire was the Spirituality Assessment Scale (SAS; Howden, 1992). This questionnaire measured a person's level of spirituality. The questionnaire contained 28 items in which participants were asked to indicate their level of agreement with each item on a scale in which SA= strongly agree; A= agree; AM= Agree more than Disagree; DM= Disagree more than Agree; D= Disagree; and SD= Strongly Disagree. When scoring, points were assigned to each choice: 1= Strongly Disagree, 2= Disagree, 3= Disagree more than agree, 4= Agree more than Disagree, 5= Agree, and 6= Strongly

Agree. No items on the SAS were reversed scored. A higher score on the SAS is considered to represent a higher level of spirituality. The possible total SAS scores may range from 28 to 168. Howden determined the score ranges would represent spirituality as follows: 113-168 would represent strong, positive spirituality; 57-112 would represent fair, or mixed positive and negative spirituality; and 28-56 would represent weak or negative spirituality.

There are four subscales to the SAS: Purpose and Meaning of Life (4 items), Innerness or Inner Resources (9 items), Unifying Interconnectedness (9 items), and Transcendence (6 items). Survey items 18, 20, 22, and 28 make up the Purpose and Meaning subscale. Survey items 8, 10, 12, 14, 16, 17, 23, 24, and 27 make up the Innerness or Inner Resources subscale. Survey items 1, 2, 4, 6, 7, 9, 19, 25, and 26 make up the Unifying Interconnectedness subscale. Survey items 3, 5, 11, 13, 15, and 21 make up the Transcendence subscale. Indicators of Purpose and Meaning of Life are the process of searching for or discovering events or relationships that provide a sense of worth, hope, or reason for living. Indicators of Innerness or Inner Resources are the process of striving for or discovering wholeness, identity, and a sense of empowerment. Innerness or inner resources are manifested in feelings of strength in times of crisis, calmness, or serenity in dealing with uncertainty in life, guidance in living, being at peace with one's self and the world, and feelings of ability. Indicators of Unifying Interconnectedness are feelings of relatedness or attachment to others, a sense of relationship to all of life, feelings of harmony with one's self and others, and feelings of oneness with the universe or a universal element or Universal Being. Indicators of Transcendence include the ability to reach or go beyond the limits of usual experience;

the capacity, willingness, or experience of rising above or overcoming bodily or psychic conditions; or the capacity for reaching wellness. The following are Cronbach alpha levels for the subscales: Purpose and Meaning of Life (.91), Innerness or Inner Resources (.79), Unifying Interconnectedness (.80), and Transcendence (.71).

Content validity of the scale was evaluated by six experts in the area of spirituality and spiritual health and subjected to a pilot test to assess readability, reliability, and validity. In a study of 189 subjects, the SAS was found to have high internal consistency, $\alpha = 0.92$. To evaluate for construct validity, each item was evaluated as to its loading on a factor. Factor loadings of .40 or higher on at least three items for a factor was considered support for the factor and the keeping of those items. Loadings for the items were fairly well correlated, with most loadings well above the .40 criterion (Howden). Cronbach's alpha for this study was .94. This questionnaire takes approximately 5 minutes to complete. Again, for this study, the subscales were not examined, only the scale as a whole was examined as a variable.

A personal information form was created for this study. Items included on the form are as follows: gender, ethnicity, primary work setting, location of environment participants live (rural, urban, suburban), years of experience as a counselor, type of license/credential held, and personal experience with substance abuse and substance abuse counseling. This questionnaire takes approximately 2 minutes to complete.

Procedures

The on-line research packet contained the following: introduction to the study and consent page, a personal information form, the HRAS, and the SAS. Researcher contact information was given in an e-mail message to the participants.

E-mail addresses were obtained from the *American Counseling Association*. E-mails messages were sent with a hyperlink attached asking participants to click on the link to the survey instrument if they would like to participate.

Timeline

Participants were given approximately two weeks to complete the survey instrument. The link to the questionnaires was open from January 25, 2010 to February 9, 2010.

Data Analysis

The data analysis statistical test that was used was a multiple regression. This was done using the computer statistical software, *Statistical Package for the Social Sciences* (SPSS) version 15. This study determined whether several variables of interest had a relationship with participants' attitudes toward harm reduction.

Validity Threats

Some threats affected the validity of this research study. It was assumed that the instruments used in this study validly measured the two constructs of attitudes toward the harm reduction model of substance abuse treatment and spirituality. External validity threats were related to the procedures used in this study. This study was conducted via e-mail; hence participants took the survey whenever they checked their e-mail. Some participants may have taken the survey in a hurry, not quite paying attention to what was being asked. This may have skewed the data. Social desirability may have played a role in this study. Participants may have felt obligated to fill out the questionnaires based on what is socially viewed as *correct*, even though they were assured of confidentiality and anonymity. Also, since participants were counseling professionals, they may have

completed the instruments based on how they believed a counseling professional should think, feel, and behave, rather than based on how they actually think and feel about harm reduction. Since participants included only Professional members of ACA who reside in the United States, the results were generalized only to that population.

Assumptions of the Study

It was assumed participants in the study were representative of the population of ACA members who were Professional members who lived in the United States. It was also assumed that those who participated in the study responded openly and honestly. It was assumed that participants in this study understood what it is they were being asked to do. It was assumed that the instrumentation used in this study accurately measured what it was intended to measure.

Limitations

One limitation was social desirability. Participants may not have responded to the questionnaire items according to how they truly think and feel. They may have responded to how they think the researcher or society may have wanted them to respond. There was no procedure in the study to determine the attitudes of those who were invited but did not respond. There was no guarantee all participants understood all the items of the questionnaires. As a result, some items may have been skipped or did not reflect accurate perceptions.

Delimitation

A delimitation of this study was the population that was chosen to participate. For this study, only Professional members of the *American Counseling Association* who resided in the United States were asked to participate.

CHAPTER IV

RESULTS

The purpose of this study was to examine the attitudes of counselors who were professional members of the *American Counseling Association* regarding harm reduction and to determine whether their attitudes regarding harm reduction were related to their level of spirituality and personal characteristics. The questionnaires used in this study were the Harm Reduction Acceptability Scale (HRAS; Goddard, 2003) which is included in Appendix B, the Spirituality Assessment Scale (SAS; Howden, 1992) which is included in Appendix C, and a Personal Information questionnaire, which was created for the purpose of this study and is included in Appendix D. The HRAS measured participants' receptivity to harm reduction by asking them to rate whether they agreed or disagreed with statements in the questionnaires. The SAS measured participants' level of spirituality by asking them to rate whether they agreed or disagreed with statements in the instrument. The personal information page asked participants to indicate their gender, race/ethnicity, type of degree held, type of license/certification held, years experience as a counselor, personal experience with substance abuse, and years of experience with substance abuse counseling. The participants for this study were 176 professional members of the *American Counseling Association* (ACA) who resided in the United States.

Surveys were sent via e-mail to a sample of 2,000 professional members of ACA. Two hundred and thirty participants opened the questionnaires. Of those 230 individuals, 176 completed and returned the survey instruments. Fifty-three e-mail messages came back as undeliverable. Fifty-two participants did not complete the questionnaire or only

partially completed it and two questionnaires were not used because participants reported having residences outside the United States. By computing the number of usable surveys (176) and dividing that number by the total number of deliverable e-mails sent (1,947), a response rate of 11% was determined.

Participant Demographics

Table 1 includes a summary of the characteristics of the 176 individuals who were professional members of the *American Counseling Association* who completed the survey instruments in this study.

Table 1

Characteristics of Participants

| Type of Demographic | <i>N</i> | % | Did not respond (<i>N</i>) |
|----------------------|----------|------|------------------------------|
| Gender | | | |
| Male | 54 | 30.7 | |
| Female | 122 | 69.3 | |
| Ethnicity | | | |
| African-American | 8 | 4.5 | |
| White | 153 | 86.9 | |
| Hispanic/Latino | 5 | 2.8 | |
| Native American | 2 | 1.1 | |
| Multiracial | 4 | 2.3 | |
| Other | 4 | 2.3 | |
| Area | | | |
| Rural | 44 | 25.0 | 1 |
| Suburban | 90 | 51.1 | |
| Urban | 41 | 23.3 | |
| Degree held | | | |
| Master's | 125 | 71.0 | 2 |
| Education Specialist | 6 | 3.4 | |
| Doctorate | 40 | 22.7 | |

| | | | |
|---|-----|------|----|
| Other | 3 | 1.7 | |
| Primary Work Setting | | | 3 |
| Community Agency | 29 | 16.5 | |
| School | 29 | 16.5 | |
| Private Practice | 64 | 36.4 | |
| Other | 51 | 29.0 | |
| Years of Experience Counseling | | | 24 |
| 1-5 years | 41 | 23.3 | |
| 6-10 years | 37 | 21.0 | |
| 11-21 years | 39 | 22.2 | |
| 22-45 years | 35 | 19.9 | |
| Combination of Lic./Cert. | | | |
| State License alone | 59 | 33.5 | |
| State License & one or more other credentials | 50 | 28.4 | |
| CRC alone & one or more other credentials | 8 | 4.5 | |
| CADC alone & one or more other credentials | 13 | 7.4 | |
| School alone & one or more other credentials | 19 | 10.8 | |
| Other credentials or no credentials | 27 | 15.3 | |
| Years of Exp. with Sub. Abuse Coun. | | | 22 |
| 0-2 years | 45 | 25.6 | |
| 3- 6 years | 45 | 25.6 | |
| 7-15 years | 38 | 21.6 | |
| 16-36 years | 26 | 14.8 | |
| Personally have had Sub. abuse problem | | | 1 |
| Yes | 31 | 17.6 | |
| No | 144 | 81.8 | |
| Know someone w/sub. abuse problem | | | 1 |
| Yes | 155 | 88.1 | |
| No | 20 | 11.4 | |

n= 176.

Of the 176 professional members of the *American Counseling Association* who completed the survey in this study, all resided in the United States and 69.3% ($n = 122$) were female and 30.7% ($n = 54$) were male. On the demographic question regarding ethnicity, 86.9% ($n = 153$) identified themselves as Caucasian/White, 4.5% ($n = 8$) identified themselves as African American, 2.8% ($n = 5$) identified themselves as Hispanic/Latino, 2.3% ($n = 4$) identified themselves as Multiracial, 2.3% ($n = 4$) identified themselves as other, and 1.1% ($n = 2$) identified themselves as Native American. Regarding the area in which they lived, 51.1% ($n = 90$) participants reported they lived in a suburban area, 25% ($n = 44$) reported they lived in a rural area, and 23.3% ($n = 41$) reported they lived in an urban area. 0.6% ($n = 1$) participant did not answer this question. In terms of type of degree held, 71% ($n = 125$) reported they had a Master's degree, 22.7% ($n = 40$) reported they had a Doctoral degree, 3.4% ($n = 6$) reported they had an Educational Specialists' degree, and 1.7% ($n = 3$) reported they had an "other" type of degree. 1.1% ($n = 2$) participants did not answer this question.

When asked about type of licenses or certifications they held, 33.5% ($n = 59$) participants indicated they held a state counseling license only, 28.4% ($n = 50$) participants held a state counseling license and one or more other credentials (other than school certification, CADC, and CRC), 15.3% ($n = 27$) participants held other credentials or no credentials, 10.8% ($n = 19$) participants held a school certification alone or with one or more other credentials, 7.4% ($n = 13$) participants held a CADC alone or with one or more other credentials, and 4.5% ($n = 8$) participants held a CRC alone or with one or more other credentials. Examples of other credentials participants listed were

Psychologist, Licensed Clinical Social Worker, Registered Nurse, and Certified Advanced Traumatic Incident Facilitator.

In terms of where participants worked, 36.4% ($n = 64$) reported working in private practice, 29% ($n = 51$) reported working in an “other” setting, 16.5% ($n = 29$) reported working in a school, and 16.5% ($n = 29$) reported working in a community agency which included hospitals, state agencies, rehabilitation facilities, substance abuse facilities, and veteran’s affairs agencies. Examples of “other” work settings participants listed included a county jail, nursing home, police department, and residential eating disorder center. 1.7% ($n = 3$) participants did not answer this question.

In regards to the question of how many years experience participants had as a counselor, participants were able to type in the number of years. In order to create categories in which there were almost equal numbers, the frequency of responses were counted and divided by four to obtain the following categories: one to five years experience, six to 10 years experience, 11 to 21 years experience, and 22 to 45 years experience. When asked how many years of experience they had as a counselor, 23.3% ($n = 41$) participants reported having one to five years of experience as a counselor, 21% ($n = 37$) participants had six to 10 years experience as a counselor, 22.2% ($n = 39$) participants had 11 to 21 years experience as a counselor, and 19.9% ($n = 35$) participants had 22 to 45 years experience as a counselor. A total of 13.6% ($n = 24$) participants did not answer this question.

When participants were asked if they themselves had ever had a substance abuse problem, 81.8% ($n = 144$) reported no, and 17.6% ($n = 31$) reported yes. 0.6% ($n = 1$) participant did not answer this question. When participants were asked if they knew

anyone personally (a friend, spouse, relative) who had a substance abuse problem, 88.1% ($n = 155$) reported yes and 11.3% ($n = 20$) reported no. 0.6% ($n = 1$) participant did not answer this question.

When responding to the question of how many years experience participants had counseling persons with substance abuse issues, participants were able to type in the number of years. To create categories in which there were almost equal numbers, the frequency of responses were counted and divided by four to obtain the following categories: zero to two years of experience, three to six years of experience, seven to 15 years experience, and 16 to 36 years experience. When asked approximately how many years participants had counseling persons with substance abuse issues, 25.6% ($n = 45$) reported having no experience to two years of experience, 25.6% ($n = 45$) reported having from three to six years experience, 21.6% ($n = 38$) reported having seven to 15 years experience, and 14.8% ($n = 26$) reported having 16 to 36 years of experience. A total of 12.5% ($n = 22$) participants did not answer this question.

To determine whether the sample of ACA professional members who responded to this survey was a representative sample of the overall population of ACA professional members, some of the characteristics of the sample were compared to the population.

According to ACA (personal communication, March 16, 2010), at the time the survey was distributed, there were 21,352 active professional members who resided in the United States, but 10,471 did not provide information related to their gender. Of the 10,881 who did indicate their gender, there were 72.1% ($n = 7,844$) females and 27.9% ($n = 3,037$) males. In the sample that completed survey instruments for this study, 69.3% were female and 30.7% were male. These findings that the percentage of females and

males were almost the same in the study sample as the population suggest that the sample was representative of the population related to gender.

According to ACA (personal communication, March 16, 2010), at the time the survey was distributed, there were 21,352 active professional members who resided in the United States, but 11,056 did not provide information related to type of degree held. Of the 10,296 who did indicate type of degree they held, 76.4% ($n = 7,865$) members reported having a Master's degree while 23.6% ($n = 2,431$) reported having a Doctorate degree. In the sample that completed questionnaire instruments for this study, 71% held a Master's degree and 22.7% held a doctorate degree. These findings that the percentage of type of degree held were almost the same in the sample as the population suggests that the sample was representative of the population related to type of degree held.

Information regarding race/ethnicity of ACA professional members was not known and therefore could not be compared the race/ethnicity of the study participants.

Participants' Scores on the Harm Reduction Acceptability Scale (HRAS)

The HRAS (Appendix B) measures a person's acceptability of harm reduction as an alternative means of treating individuals with substance abuse problems. Most substance abuse treatment programs in the United States follow a total abstinence model. In the harm reduction model, the goal is to help a person with a substance abuse problem reduce the harm substances cause, rather than requiring those in treatment to abstain altogether from continued use of a substance or substances.

On the HRAS, a mean score of less than three indicates a favorable attitude toward harm reduction. A mean score of more than three indicates a non-favorable attitude toward harm reduction. Participants were asked to indicate whether they agreed

or disagreed with statements related to harm reduction with 1= strongly agree and 5= strongly disagree. The 176 ACA professional members who participated in this study obtained an overall mean of 2.69. Goddard (2003), who created the HRAS, measured 137 treatment professionals' attitudes toward harm reduction before and after a two-hour education presentation on harm reduction. The treatment professionals were from Kentucky and southern Ohio. The population sample had a mean of 10.13 years of experience treating alcohol/drug problems, 43% had a master's degree, and 42% had a doctoral degree. She found participants' attitudes were significantly more favorable after the presentation than before. Goddard conducted a pre-post comparison study, and the pre-test mean was 2.55; the post test mean was 2.16, indicating that the educational program increased participants' favorable attitudes toward harm reduction. Participants in this study ($M = 2.69$) found harm reduction less acceptable than pre-test individuals in Goddard's study ($M = 2.55$). Table 2 includes a summary of means and standard deviations for this study sample and Goddard's pre-test sample.

Table 2

Summary of Means and Standard Deviations for Harm Reduction Acceptability Scale

| Type of Study | <i>M</i> | <i>SD</i> | <i>n</i> |
|----------------------------|----------|-----------|----------|
| Goddard's Study (pre-test) | 2.55 | .50 | 137 |
| Current Study | 2.69 | .48 | 176 |

A t-test was computed to determine whether there was a significant difference between the scores of this study sample and Goddard's sample. Goddard had a pre-test

mean of 2.55 ($SD = .50$), and participants in this study had a mean of 2.69 ($SD = .48$). To determine whether there was a significant difference between the scores of this study sample and Goddard's sample, a t-obtained and a t-critical value were obtained. The t-obtained value was 3.5 and the t-critical value was 1.98. The t-obtained value was larger than the t-critical value which means there was a significant difference between the sample means. This result suggests that professional members of ACA were less favorable to harm reduction than the participants in the study conducted by Goddard.

Preliminary Analyses and Data Screening

A preliminary univariate data screening was conducted. This included obtaining descriptive statistics on all the variables such as the mean and checking for skewness. Upon completing a frequency check, the means and standard deviations (respectively) of the following continuous variables were found: Years of experience as a counselor ($M = 13.29$, $SD = 9.68$) and Approximate number of years of experience counseling persons with substance abuse issues ($M = 8.15$, $SD = 8.21$). Although the skewness values of the two continuous variables were slightly over the ± 1 skewness values (1.01 and 1.27, respectively), it was determined they were not high enough to transform.

Next, bivariate diagnostics were performed to assess linearity. This assessment was completed by viewing a scatterplot (see Figure 1). A scatterplot examining the variables HRAS and *Years of experience as a counselor* with a $R^2 = .004$ indicated a non-significant relationship between the HRAS scores and experience as a counselor. A scatterplot examining the HRAS scores and *Years of experience with substance abuse counseling* with a $R^2 = 0.05$ indicated a non-significant relationship between the HRAS scores and years of experience with substance abuse counseling (see Figure 2).

Assumptions of multicollinearity and homoscedasticity were examined and met with a

tolerance value greater than .01 and a Durbin-Watson value of 2.11, indicating the errors of prediction were independent of each other.

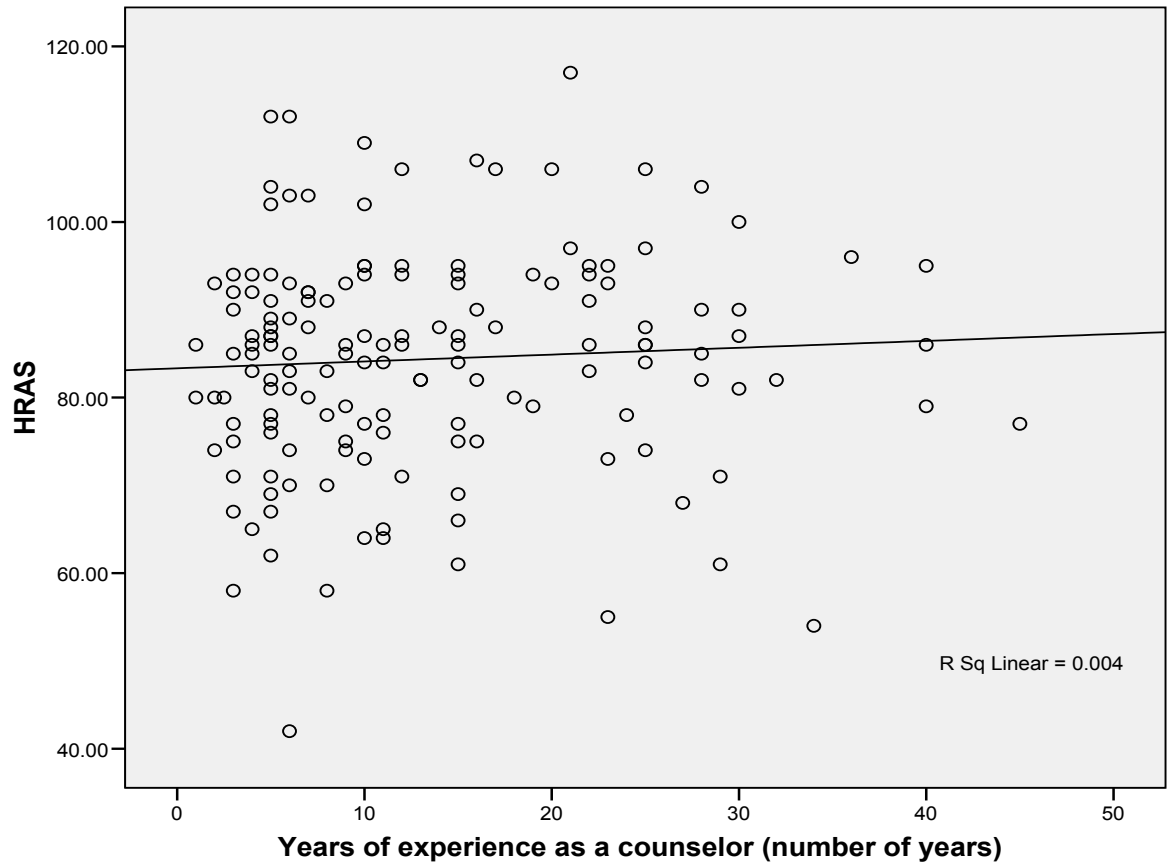


Figure 1. Correlation between Harm Reduction Acceptability Scale and Years Exp.

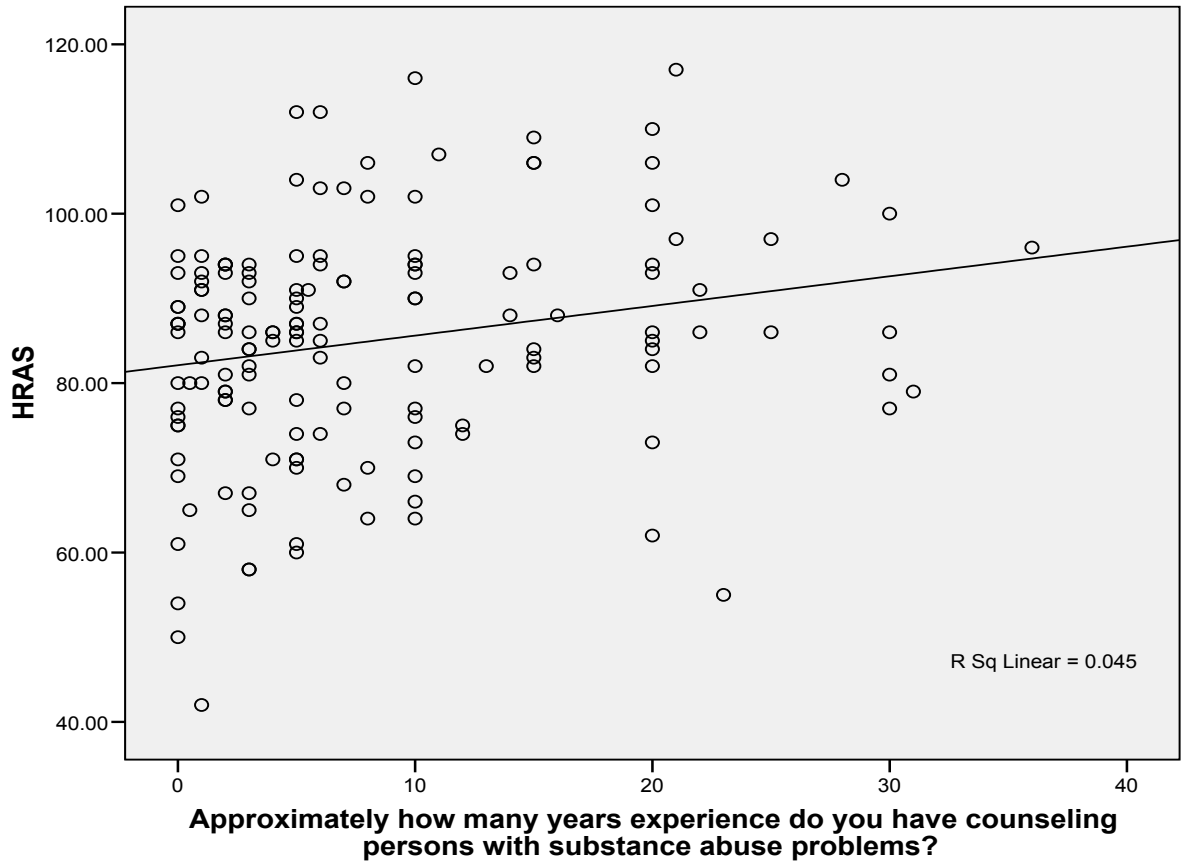


Figure 2. Correlation between HRAS and Years Exp. Substance Abuse Counseling

The following nominal variables were dummy coded because they had two or more levels: primary work setting, area in which participants lived (rural, urban, suburban), and combination of licenses/certifications. The following categorical variables were dummy coded to indicate a presence of a reference group: *personal experience with substance abuse* and *relationship with someone with substance abuse issues*. Because participants were able to check all that applied, the variable Type of license/certification held was recoded to include all possible combination types and was renamed “Combination of license.” There were six possible combination types of license and certifications.

The multiple regression equation used for this study was $HRAS\ Scores = a + (b_1)(Rural) + (b_2)(Urban) + (b_3)(SAS) + (b_4)(Personal\ experience\ substance\ abuse) + (b_5)(Community\ Agency) + (b_6)(School) + (b_7)(Private\ Practice) + (b_8)(State\ License\ and\ one\ or\ more\ other\ credentials) + (b_9)(Years\ of\ counseling\ experience) + (b_{10})(Years\ of\ substance\ abuse\ counseling\ experience) + (b_{11})(CRC\ alone\ or\ with\ one\ or\ more\ other\ credentials) + (b_{12})(CADC\ alone\ or\ with\ one\ or\ more\ other\ credentials) + (b_{13})(School\ alone\ or\ with\ one\ or\ more\ other\ credentials) + (b_{14})(Other\ credentials\ or\ no\ credentials) + (b_{15})(Relationship\ with\ someone\ with\ substance\ abuse\ issues)$. Tables 3 and 4 include a summary of the betas of the individual predictor variables.

Table 3

Multiple Regression Analysis with Included Variables

| Predictor Variables | Beta | <i>t</i> | <i>p</i> |
|---|------|----------|----------|
| Relationship w/someone with substance abuse issues | .23 | 2.85 | .01 |
| Years exp. substance abuse coun. | .18 | 2.21 | .03 |
| Urban | .17 | 2.16 | .03 |

n = 176.

Table 4

Multiple Regression Analysis with Excluded Variables

| Predictor Variables | Beta | <i>t</i> | <i>p</i> |
|---|------|----------|----------|
| Rural | .11 | 1.35 | .18 |
| Spirituality Assessment Scores | -.01 | -.09 | .93 |
| Years counseling experience | -.10 | -.92 | .36 |
| Personal Exp. w/ sub. abuse | .09 | 1.07 | .29 |
| State License & one or more other credentials | .13 | 1.55 | .12 |
| CRC alone & one or more other credentials | .04 | .55 | .59 |
| CADC alone & one or more other credentials | -.01 | -.14 | .89 |
| School alone & one or more other credentials | -.06 | -.76 | .45 |
| Other credentials or no credentials | .05 | .55 | .59 |
| Community Agency | .05 | .59 | .56 |
| School | .03 | .34 | .74 |
| Other work setting | .02 | .30 | .76 |

n = 176.

General Research Question

Are counselors' attitudes toward the use of harm reduction rather than total abstinence in substance abuse treatment associated with their level of spirituality, length of practice, employment setting, area in which they live, type of credential held, and personal experience with substance abuse?

A multiple regression was used to analyze the data. A multiple regression is used to predict the difference in a dependent variable, based on linear combinations of interval, dichotomous, or dummy independent variables. A multiple regression can determine if a set of independent variables explains a proportion of the difference in a dependent variable at a significant level and can establish the relative predictive importance of the independent variables (Garson, 2009).

A stepwise multiple regression analysis was conducted to evaluate how well personal characteristics of participants predicted attitudes toward harm reduction. In a stepwise multiple regression, the predictor variable best correlated with the dependent variable is entered into the equation first, then the next best predictor variable goes in and so forth until adding the remaining predictor variables do not increase the R^2 by a significant amount (Garson, 2009). The predictors were spirituality, primary work setting, years of counseling experience, type of environment in which participants lived (urban, rural, suburban), personal experience with substance abuse, knowing someone close who had a substance abuse issue, years of experience counseling those with substance abuse issues, and credentials participants held, while the criterion variable was attitudes toward harm reduction. The stepwise combination of three personal characteristics (living in an urban setting, years of substance abuse counseling

experience, and having a close relationship with someone with a substance abuse problem) were significantly related to attitudes toward harm reduction, $F(3, 136) = 6.49$, $p < .05$. The multiple correlation coefficient was .35, indicating that approximately 13% of the variance of the attitude toward harm reduction in the sample can be accounted for by the linear combination of personal characteristics. This means that the personal characteristics explain 13% of the difference in the attitudes toward harm reduction. This also means that someone who lives in an urban environment who also has a close relationship with someone who has a substance abuse problem, and more years of experience counseling those with substance abuse problems, will report having a favorable attitude toward harm reduction.

Research Questions

Table 5 includes a summary of the means and standard deviations of the HRAS and the variables of interest.

Table 5

Mean Scores on the Harm Reduction Acceptability Scale

| | <i>N</i> | <i>M</i> | <i>SD</i> |
|---|----------|----------|-----------|
| Level of Spirituality | | | |
| Weak | 2 | 2.70 | .25 |
| Fair | 173 | 2.70 | .48 |
| Personal Experience w/substance abuse | | | |
| Yes | 31 | 2.58 | .54 |
| No | 144 | 2.72 | .46 |
| Close relation w/someone with substance abuse | | | |
| Yes | 155 | 2.67 | .47 |
| No | 20 | 2.89 | .53 |
| Work Setting | | | |
| Community Agencies | 29 | 2.69 | .43 |
| School | 29 | 2.68 | .44 |

| | | | | |
|--|--|-----|------|-----|
| | Private Practice | 64 | 2.73 | .56 |
| | Other | 51 | 2.67 | .42 |
| Area | | | | |
| | Rural | 44 | 2.63 | .53 |
| | Urban | 41 | 2.54 | .43 |
| | Suburban | 90 | 2.79 | .46 |
| Type of Degree Held | | | | |
| | Master's, Ed. Spec. & Other | 134 | 2.71 | .50 |
| | Doctorate | 40 | 2.61 | .40 |
| License/Certification Combination | | | | |
| | State License alone | 59 | 2.77 | .54 |
| | State License & one or more other credentials | 50 | 2.60 | .35 |
| | CRC alone or with one or more other credentials | 8 | 2.80 | .58 |
| | CADC alone or with one or more other credentials | 13 | 2.52 | .63 |
| | School alone or with one or more other credentials | 19 | 2.84 | .44 |
| | Other credentials or no credentials | 27 | 2.62 | .43 |
| Years Experience as a Counselor | | | | |
| | 1-5 years | 41 | 2.78 | .43 |
| | 6-10 years | 37 | 2.69 | .51 |
| | 11-21 years | 39 | 2.66 | .48 |
| | 22-45 years | 35 | 2.71 | .45 |
| Years Experience with Substance Abuse Counseling | | | | |
| | 0-2 years | 45 | 2.81 | .47 |
| | 3-6 years | 45 | 2.74 | .48 |
| | 7-15 years | 38 | 2.59 | .52 |
| | 16-36 years | 26 | 2.53 | .50 |

n= 176.

There are 25 items on the HRAS and scores for each question range from 1= Strongly Agree to 5= Strongly Disagree. Mean scores on the scale can range from 1 to 5. A mean score less than 3 indicates a higher level of acceptability to harm reduction as a

possible treatment for substance abuse whereas a mean score higher than 3 indicates a lower level of acceptability to harm reduction. For sake of clarity with the results, the HRAS scale was reversed so that a mean score of less than three indicated a lower level of acceptability to harm reduction and a mean score higher than three indicated a higher level of acceptability. This was done to conduct the multiple regression only.

Research Question One

Is there a relationship between mental health professionals' attitudes toward harm reduction and spirituality?

The results of the multiple regression shown in Table 4 answered this research question. Participants' level of spirituality did not predict attitudes toward harm reduction, $Beta = -.01$, $t = -.09$, $p = .93$.

This question was further investigated using descriptive statistics (e.g., central tendency such as mean and range of scores, and variability measures such as standard deviation). One hundred and seventy six participants responded to this question. On the Spirituality Assessment Scale, participants having a score between 28-56 are considered to have a weak level of spirituality, those having a score between 57-112 are considered to have a fair level of spirituality, and those having a score between 113-168 are considered to have a strong level of spirituality (Howden, 1992). Of the 176 participants, 173 reported having a fair level of spirituality. Those reporting a fair level of spirituality had a mean score of 2.69 ($SD = .48$) on the HRAS with mean scores ranging from 1.48 to 4.24. The two participants who reported having a weak level of spirituality had a mean score of 2.70 ($SD = .25$) with mean scores ranging from 2.52 to 2.88. One participant reported having a strong level of spirituality mean score of 2.44. The means on the

HRAS of these groups were almost identical, further confirming the finding in the regression that participants' spirituality score was not associated with their HRAS score.

Research Question Two

Is there a relationship between where counselors work (primary work setting) and their attitudes toward harm reduction?

The results of the multiple regression shown in Table 4 answered this research question. In terms of participants primary work setting, with private practice being the reference variable, there was no significance with attitudes toward harm reduction if they worked at a Community Agency (Beta = .05, $t = .59$, $p = .56$), School (Beta = .03, $t = .34$, $p = .74$), or other work setting (Beta = .02, $t = .30$, $p = .76$).

This question was further investigated using descriptive statistics (e.g., central tendency such as mean and range of scores and variability measures such as standard deviation). One hundred and seventy three participants responded to this question. Sixty four participants worked in private practice and had a mean score of 2.73 ($SD = .56$) with mean scores ranging from 1.48 to 4.24. Fifty one participants reported working in an "other" type of setting and had a mean score of 2.67 ($SD = .42$) with mean scores ranging from 1.52 to 3.64. Twenty nine participants worked in a community agency and had a mean score of 2.69 ($SD = .43$) with mean scores ranging from 1.68 to 3.60. Twenty nine participants reported working in a school and had a mean score of 2.68 ($SD = .44$) with mean scores ranging from 1.84 to 3.84. The means on the HRAS of these four groups were almost identical, further confirming the finding in the regression that participants' primary work setting was not associated with their HRAS score.

Research Question Three

Is there a relationship between counselors' years of experience counseling and their attitudes toward harm reduction?

There are 25 items on the HRAS and scores for each question ranged from 1= Strongly Agree to 5= Strongly Disagree.

The results of the multiple regression shown in Table 4 answered this research question. Years of experience as a counselor did not predict attitude toward harm reduction, $Beta = -.10$, $t = -.92$, $p = .36$.

This question was also investigated using descriptive statistics (e.g., central tendency such as mean and range of scores and variability measures such as standard deviation). One hundred and fifty two participants responded to this question. Forty one participants reported having one to five years experience as a counselor and had a mean score of 2.78 ($SD = .43$) with mean scores ranging from 1.68 to 3.60. Thirty seven participants reported having six to 10 years counseling experience and had a mean score of 2.69 ($SD = .51$) with mean scores ranging from 1.68 to 4.24. Thirty nine participants reported having 11 to 21 years counseling experience and had a mean score of 2.66 ($SD = .48$) with mean scores ranging from 1.48 to 3.64. Thirty five participants reported having 22 to 45 years counseling experience with a mean score of 2.71 ($SD = .21$) with mean scores ranging from 1.84 to 3.84. The means on the HRAS of these four groups were very similar further confirming the finding in the regression that participants' years of experience as a counselor were not associated with their HRAS score.

Research Question Four

Is there a relationship between type of environment in which counselors live (urban/suburban/rural) and their attitudes toward harm reduction?

There are 25 items on the HRAS and scores for each question ranged from 1= Strongly Agree to 5= Strongly Disagree.

The results of the multiple regression shown in Tables 3 and 4 answered this research question. Participants who lived in a rural area did not significantly predict attitudes toward harm reduction, $Beta = .11, t = 1.35, p = .18$. However, participants who lived in an urban area significantly predicted attitudes toward harm reduction, $Beta = .17, t = 2.16, p = .03$. Those who live in an urban setting have favorable attitudes toward harm reduction.

This question was further investigated using descriptive statistics (e.g., central tendency such as mean and range of scores and variability measures such as standard deviation). One hundred and seventy five participants responded to this question. Forty four participants reported living in a rural area and had a mean score of 2.63 ($SD = .53$) with mean scores ranging from 1.52 to 4.24. Ninety participants reported living in a suburban area and had a mean score of 2.79 ($SD = .46$) with mean scores ranging from 1.68 to 4.00. Forty one participants reported living in an urban area and had a mean score of 2.54 ($SD = .43$) with mean scores ranging from 1.48 to 3.64. The means on the HRAS of these three groups varied, confirming the finding in the regression that type of environment participants live was associated with their HRAS score. Participants living in an urban area (mean score of 2.54) had more positive attitudes toward harm reduction

than participants who lived in a rural area (mean score of 2.63) and participants who lived in a suburban area (mean score of 2.79).

Research Question Five

Is there a relationship between counselors' personal experience with substance abuse and substance abuse counseling and their attitudes toward harm reduction?

There are 25 items on the HRAS and scores for each question ranged from 1= Strongly Agree to 5= Strongly Disagree.

Personal experience with substance abuse was assessed by asking participants if they ever had a substance abuse problem, if they had a close relationship with someone with a substance abuse problem, and how many years experience they have counseling those with substance abuse problems. The results of the multiple regression shown in Tables 3 and 4 answered this research question.

Participants who personally had substance abuse issues did not predict attitudes toward harm reduction, $Beta = .09$, $t = 1.07$, $p = .29$. This question was further investigated using descriptive statistics (e.g., central tendency such as mean and range of scores and variability measures such as standard deviation). One hundred and seventy five participants responded to the question of if they ever had a problem with substance abuse. Thirty one participants reported they had a substance abuse problem and had a mean score of 2.58 ($SD = .54$) with mean scores ranging from 1.48 to 3.64. One hundred and forty four participants reported they did not have a substance abuse problem and had a mean score of 2.72 ($SD = .46$) with mean scores ranging from 1.52 to 4.24.

Participants who had a close relationship with someone who had a substance abuse problem did predict attitudes toward harm reduction, $Beta = .23$, $t = 2.85$, $p = .01$.

Those who have a close relationship with someone with a substance abuse problem have more favorable attitudes toward harm reduction. This question was further investigated using descriptive statistics (e.g., central tendency such as mean and range of scores and variability measures such as standard deviation). One hundred and seventy five participants responded to the question of if they had a close relationship with someone who had a substance abuse problem. One hundred and fifty five participants reported they did have a close relationship with someone who had a substance abuse problem and had a mean score of 2.67 ($SD = .47$), with mean scores ranging from 1.48 to 4.24. Twenty participants reported they did not have a close relationship with someone with a substance abuse problem and had a mean score of 2.89 ($SD = .53$) with mean scores ranging from 1.52 to 3.64.

Participants were asked approximately how many years of experience they have counseling those with substance abuse problems. The more years of experience participants had with substance abuse counseling, the more favorable their attitudes toward harm reduction, $Beta = .18$, $t = 2.21$, $p = .03$. This question was further investigated using descriptive statistics (e.g., central tendency such as mean and range of scores and variability measures such as standard deviation). One hundred and fifty four participants responded to this question. Forty five participants reported having none to two years experience counseling those with substance abuse problems and had a mean score of 2.81 ($SD = .47$) with mean scores ranging from 2.08 to 4.24. Forty five participants reported having three to six years of experience counseling those with substance abuse problems and had a mean score of 2.74 ($SD = .48$) with mean scores ranging from 1.68 to 3.34. Thirty eight participants reported having seven to 15 years of

experience counseling those with substance abuse problems and had a mean score of 2.59 ($SD = .52$) with mean scores ranging from 1.52 to 3.52. Twenty six participants reported having 16 to 36 years experience counseling those with substance abuse problems and had a mean score of 2.53 ($SD = .50$) with mean scores ranging from 1.48 to 3.64. The means on the HRAS of these four groups decreased as counselors had more substance abuse counseling experience, further confirming the finding in the regression that years of experience with substance abuse counseling was associated with their HRAS score.

Research Question Six

Is there a relationship between credentials counselors hold and their attitudes toward harm reduction?

There are 25 items on the HRAS and scores for each question ranged from 1= Strongly Agree to 5= Strongly Disagree.

The results of the multiple regression shown in Table 3 answers this research question. There was no significance of having a State license alone and one or more other credentials (Beta = .13, $t = 1.55$, $p = .12$), CRC alone and one or more other credentials (Beta = .04, $t = .55$, $p = .59$), or school alone and one or more other credentials (Beta = -.06, $t = -.76$, $p = .45$), or CADC alone and one or more other credentials (Beta = -.01, $t = -.14$, $p = .89$), or other/no credentials (Beta = .05, $t = .55$, $p = .59$) and attitudes toward harm reduction.

This question was further investigated using descriptive statistics (e.g., central tendency such as mean and range of scores and variability measures such as standard deviation). One hundred and seventy six participants responded to this question. Fifty nine participants reported having a state license only and had a mean score of 2.77 ($SD =$

.54) with mean scores ranging from 1.68 to 4.24. Fifty participants reported having a state license and one or more other credentials (other than school certification, CADC or CRC) and had a mean score of 2.60 ($SD = .35$) with mean scores ranging from 1.68 to 3.60. Eight participants reported having a CRC alone or with one or more other credentials and had a mean score of 2.81 ($SD = .58$) with mean scores ranging from 1.92 to 4.00. Thirteen participants reported having a CADC alone or with one or more other credentials and had a mean score of 2.52 ($SD = .63$) with mean scores ranging from 1.48 to 3.64. Nineteen participants reported having a School credential alone or with one or more other credentials and had a mean score of 2.84 ($SD = .44$) with mean scores ranging from 2.32 to 3.84. Twenty seven participants reported having other credentials or no credentials and had a mean score of 2.62 ($SD = .43$) with mean scores ranging from 1.84 to 3.40. The means on the HRAS of these six groups are very similar, further confirming the finding in the regression that type of license/certification participants held were not associated with their HRAS score.

CHAPTER V

DISCUSSION

The purpose of this study was to assess counselors' attitudes toward harm reduction as an additional treatment model in substance abuse. Generally, in the United States, substance abuse clients must adhere to total abstinence in order to participate in treatment programs (Marlatt, 1998). This study was also conducted to determine if receptivity to the harm reduction approach to treating substance abuse problems was associated with personal characteristics including spirituality, length of experience, type of license or credential held, employment setting, type of environment in which they live (rural, urban, or suburban), and personal experience with substance abuse and substance abuse counseling. Prior to this study, no research had been completed on receptivity toward harm reduction based on a person's level of spirituality and other personal characteristics of counselors.

Attitudes toward harm reduction were measured by the Harm Reduction Assessment Scale (HRAS; Goddard, 2003). This questionnaire measured counselors' attitudes toward harm reduction. Spirituality was measured by the Spirituality Assessment Scale (SAS; Howden, 1992). The SAS was designed to measure a person's level of spirituality. Also, a personal information questionnaire was created. Internal consistency reliability for the HRAS and the SAS were established by calculating a Cronbach's alpha for each. The alpha for the HRAS was .88. The alpha for the SAS was .94.

The research design used in this study was a survey of professional members of the American Counseling Association (ACA). Email addresses of 2,000 professional

members were selected by ACA. Members of the sample were asked to complete and return surveys via email. Only professional members who had mailing addresses in the United States and who had provided their email addresses were asked to complete the questionnaires. One hundred and seventy-six usable surveys were returned.

Discussion of Findings

ACA Professional Members had Favorable Attitude toward Harm Reduction

Overall, ACA professional members leaned more toward having a favorable attitude toward harm reduction than having a neutral or negative attitude toward harm reduction. Mean scores on the HRAS below 3.00 indicate a more positive attitude toward harm reduction and mean scores above 3.00 indicate a more negative attitude toward harm reduction. The professional members of the American Counseling Association who participated in this study had an overall average score of 2.69, indicating they leaned toward having favorable attitudes toward harm reduction. The results of this study suggest that perhaps counselors are open to considering harm reduction as an alternative method of intervention for treating individuals with substance abuse, rather than the current practice in the United States of offering almost exclusively abstinence based treatment programs.

Two studies (Goddard, 2003 & Havranek & Stewart, 2006) have examined counselors' attitudes toward harm reduction, and in both studies results indicated that counselors may be open to the idea of using harm reduction methods in treating individuals with substance abuse. The study conducted by Goddard (2003) in which the HRAS was used, counselors in Kentucky and Ohio, before being taught about harm reduction, had a mean score of 2.55. The other study conducted by Havranek and

Stewart (2006) measured rehabilitation counselors' attitudes toward harm reduction using a 10 item survey that was modeled after the HRAS and found that participants believed the harm reduction approach in treatment was good, but they also believed all illegal drug use should be avoided.

The step-wise multiple regression model results showed that 13% of the variance was accounted for by the significant variables (living in an urban environment, more years of experience with substance abuse counseling, and having a close relationship with someone who has a substance abuse problem). This means that someone who lives in an urban environment, who also has a close relationship with someone who has a substance abuse problem, and more years of experience counseling those with substance abuse problems, will report having a favorable attitude toward harm reduction. This finding is significant in that participants who live in an urban environment who also have a close relationship with someone who has a substance abuse problem and more years of experience with substance abuse counseling see that there may be promise toward the harm reduction approach to substance abuse treatment.

Spirituality and Attitude toward Harm Reduction

Results of the multiple regression showed that participants' level of spirituality did not predict their attitude toward harm reduction ($p = .74$). This is in contrast to the study conducted by Curlin et al. (2009) that found that participants who perceived themselves to be very spiritual practiced Complementary and Alternative Medicines (CAM). The Curlin et al. study appeared to demonstrate that practitioners who were very spiritual were more receptive to alternative types of professional practices. However, in this study, there was very little variance of level of spirituality. Approximately 99% of

the participants scored in the “fair” level of spirituality. It was not surprising to find that 99% of the participants scoring within the fair level of spirituality on the SAS, did not predict attitudes toward harm reduction. If an instrument had been used that yielded more variance in spirituality of counselors, perhaps spirituality would have predicted attitudes toward harm reduction.

Years of Experience and Attitude toward Harm Reduction

Results of the multiple regression showed that years of experience as a counselor did not predict attitude toward harm reduction, however years of experience counseling those with substance abuse problems did. In this study, the participants had an average of 8.15 years of experience counseling those with substance abuse problems. One hundred and fifty four participants responded to this question. Forty five participants reported having none to two years experience counseling those with substance abuse problems and had a mean score of 2.81. Forty five participants reported having three to six years of experience counseling those with substance abuse problems and had a mean score of 2.74. Thirty eight participants reported having seven to 15 years of experience counseling those with substance abuse problems and had a mean score of 2.59. Twenty six participants reported having 16 to 36 years experience counseling those with substance abuse problems and had a mean score of 2.53.

The abstinence based model is almost the exclusive model used in treating substance abuse in the United States (Levine, 1984). The finding in this study may suggest as participants counsel those with substance abuse problems over a longer period of time, they begin to see a need for additional forms of treatment beyond the abstinence model. Also, these results may suggest that counselors with little or no experience

counseling individuals with substance abuse problems may need to be educated on harm reduction as an additional model of treatment.

When the *War on Drugs* was first initiated, the estimated rate of the population in the U.S. who had a substance abuse problem was 3% to 5%. Forty-one years and over a trillion dollars later, the estimated percentage of the U.S. population who had a substance abuse problem continued to be 3% to 5% (Office of National Drug Control Policy, 2008). In addition, with relapse rates ranging from 40%-60% in programs using the abstinence model, there appears to be a need for additional approaches to the abstinence approach for the treatment of people with substance abuse problems (McLellan, Lewis, O'Brien, & Kleber, 2000). Participants who have many years experience counseling those with substance abuse problems may be seeing the need to have another model of treating substance abuse problems.

Participants had an average of 13.29 years of experience as a counselor. An examination of the participants' years of experience compared to their mean scores on the HRAS indicated their attitudes toward harm reduction did not reveal any trends in either direction regarding their attitudes toward harm reduction. Participants with one to five years experience had a mean score of 2.78, participants with six to 10 years experience had a mean score of 2.69, participants with 11 to 21 years experience had a mean score of 2.66, and participants with 22 to 45 years experience had a mean score of 2.71. This is in contrast to what Havranek and Stewart (2006) found with rehabilitation counselors in terms of years of experience. They found that the more years rehabilitation counselors spent in their professional careers, the less they accepted harm reduction.

Personal Experience with Substance Abuse and Attitude toward Harm Reduction

Personal experience with substance abuse partially predicted attitude toward harm reduction. In this study, 17.6% of the participants reported having personal experience with substance abuse while 81.8% of participants reported not having any personal experience with substance abuse and this did not predict attitude toward harm reduction. This may be because most participants have not personally experienced a substance abuse problem that would have them seek treatment. However, most of the participants in this study (88.1%) had a close relationship with someone who had a substance abuse issue, while 11.4% did not and this predicted attitude toward harm reduction. This finding supports the need to have an additional method to treating substance abuse issues because the method may not work for everyone.

The costs of substance abuse to the individual, family and society is well documented (Bigler, 2005; Duncan & Nicholson, 1997; Dupont, 1996; Keller & Dermatis, 1999; & Marlatt, 1996). Although most participants in this study did not have a substance abuse problem themselves, most did have a close relationship with someone who did. Participants may feel there needs to be an additional approach to substance abuse treatment because they may have experienced how substance abuse affects not only the person using, but also the family and society.

Other Personal Characteristics and Attitude toward Harm Reduction

Primary work setting did not predict attitude toward harm reduction. There has not been any research prior to this study conducted regarding work setting and counselor attitudes toward harm reduction. Apparently, counselors in this study had the same attitudes toward harm reduction, no matter where they worked. For example, school

counselors' attitudes were about the same as those of counselors in private practice. This study did not inquire about the percentage of clients the participants counseled who had substance abuse problems. If a variable like experience counseling substance abuse clients had been investigated, perhaps differences would have been found.

The combination of credentials participants held was examined in this study in relation to their attitudes toward harm reduction. Of the combination credential types, none predicted attitudes toward harm reduction. These results lead to the finding that the credentials counselors hold do not predict their attitudes toward harm reduction.

Type of environment in which participants lived (rural, suburban, or urban) did predict attitudes toward harm reduction. Participants who lived in an urban environment held a more favorable attitude towards harm reduction. In 2008, the rate of current illicit drug use among persons aged 12 or older was higher in urban areas than in non-urban areas. The rates were 8.5% in large urban counties, 8.1% in small urban counties, and 6.3% in non-urban counties as a group (SAMHSA, 2009). Participants who lived in an urban environment may have had a more favorable attitude than those who lived in a suburban or rural environment because substance abuse issues may be more prevalent in an urban area or perhaps counselors who live in urban environments are more open to new ideas. With substance abuse being more prevalent in an urban area, there may need to be additional approaches to treating substance abuse issues.

Limitations

One limitation of this study was the effect that social desirability may have had on the way in which participants responded to items on the survey instruments. Harm reduction is seen as a controversial approach to substance abuse treatment in the United

States possibly due to a long policy history of drug prohibition that has largely viewed drug use as a moral and legal issue rather than a health issue (Mancini, Linhorst, Broderick, & Bayliff, 2008). While the mean score was under three in this study, the mean score was still close to three, which may suggest participants had a “neither agree nor disagree” attitude toward harm reduction. This may suggest that although participants agreed with some of the question items on the HRAS, there were other items that participants either did not agree with, or were not sure how to respond.

Participants may not have responded to the questionnaire items according to how they truly thought or felt. Instead, they may have responded to how they thought other counselors or society may have wanted them to respond. Another limitation was that there was no procedure in the study to determine the attitudes of those who were invited to participate but did not respond.

In addition, there was no guarantee that all participants understood all the items of the questionnaires. As a result, some items may have been skipped or may not have reflected accurate perceptions of the participants. Participants may have completed the HRAS thinking the approaches may be a good idea, but not have a basic understanding of what harm reduction is completely about. Participants may not have had any prior knowledge about what harm reduction is.

Conclusions

In the United States, the goal of most substance abuse counseling programs is the elimination of clients’ use of illegal and illicit substances, in other words- total abstinence (MacMaster, 2004). However, some countries in Europe are currently practicing harm reduction as a viable approach to treating individuals who have alcohol or drug problems.

Because the professional literature has shown that abstinence programs of substance abuse do not help all people with substance abuse issues (Office of National Drug Control Policy, 2008; Barbosa Terra et al, 2008; & Sanchez-Craig, Annis, Bernet & MacDonald, 1984), there appears to be a need for investigating additional approaches to substance abuse treatment.

This was a preliminary study that sought to gauge the attitudes toward harm reduction of various counselor types. Participants' attitudes toward harm reduction was studied in relation to their personal characteristics including spirituality, years of experience as a counselor, type of environment in which they lived, years of experience with substance abuse counseling, personal experience with substance abuse, and type of credentials held. There was no relationship between personal characteristics of counselors and attitudes towards harm reduction with the exception of those who live in an urban area, those who have a close relationship with someone with a substance abuse problem, and years of experience with substance abuse counseling.

Results of this study suggest that ACA professional counselors had slightly favorable rather than neutral attitude toward harm reduction. This shows some possible slight acceptance of counselors to additional treatment models to the abstinence model of substance abuse treatment which is almost the exclusive model of treatment for substance abuse in the United States. Because there is a high rate of ineffectiveness of the current substance abuse treatment model, there is a need to explore other models of substance abuse treatment (Barbosa Terra, et al., 2008; Gossop, Marsden, & Stewart, 2007). The harm reduction approach has been found to be effective in Europe and should be considered in the United States as well.

Goddard's (2003) study surveyed counselors in Ohio and Kentucky before and after a two hour education session on harm reduction. She found that participants were more receptive toward harm reduction after the education session. Her pre-test mean was 2.55, while the mean of participants in this study was 2.69, suggesting that harm reduction may be viewed more favorably by treatment professionals if they are educated about the approach.

Despite the findings in this study that suggest that counselors are neutral or slightly favorable toward the idea of harm reduction, there is value in continuing to study harm reduction as an addition to the abstinence based model of substance abuse in the United States. Studies have shown that the abstinence approach is not effective for many, so other additional approaches, including harm reduction, need to be introduced and their effectiveness studied in the United States (Marlatt, 1998).

Implications for Counselors

Counselors are often told to check their biases before entering a counseling relationship with clients. They are also told to make sure they do not impose their own beliefs on clients. With the results of this study, attitudes toward harm reduction are very important as literature has shown that the current approaches counselors have with working with those with substance abuse issues do not help everyone. There appears to be a need to have other approaches to substance abuse treatment. When the *War on Drugs* was first initiated in 1969, the estimated rate of the population in the U.S. who had a substance abuse problem was 3% to 5%. Today the estimated percentage of the U.S. population who had a substance abuse problem continues to be 3% to 5% (Office of National Drug Control Policy, 2008). The percentage of people in the U.S. who have a

substance abuse problem may be the same, but the actual number of individuals dealing with this problem has increased. Therefore, there seems to be a need for additional approaches to substance abuse treatment. Clinicians should be aware of all possible approaches when working with people with substance abuse problems, not just approaches they are comfortable using.

Implications for Counselor Educators

Although very little research has been completed in the United States regarding attitudes toward and the practice of harm reduction, countries in Europe have put harm reduction into practice (Emmanuelli & Desenclos, 2005; O'Donnell, 2006; O'Hare, 2007). Counselor educators should learn from counselors who practice harm reduction in Europe and share what they learn with their students. Counselors can learn about harm reduction in the classroom and at professional conferences. I believe examining the models that have come out of Europe will provide a sound foundation for what we might be able to do in the United States for people who cannot follow the abstinence model of substance abuse treatment.

Counselor educators can also become advocates for harm reduction by citing the research completed in Europe and asking policy makers to support the development and study of harm reduction based programs and encourage their students to do the same. By doing this, there may be a possibility of having the government support harm reduction programs in the future which would ultimately benefit clients who are not ready to practice abstinence.

Implications for Future Studies

There are many ways in which this study can provide groundwork for future studies. For example, a future study could be a controlled study where there are an almost equal number of males and members of other races/ethnicities as there were for females and those who were Caucasian. Assessing how much people know and what they know about harm reduction may aid in a better comparison of attitude towards harm reduction in general and with personal characteristics in terms of gender and race/ethnicity. Because religion seems to have a more concrete definition and spirituality is more loosely defined, perhaps exploring ones' religiosity and attitudes toward harm reduction may have some significance.

Instead of exploring various counseling disciplines as was done in this study, perhaps counselor professionals whose main focus is the substance abuse population should be surveyed. Those who are experienced in substance abuse treatment may provide more fruitful results in that they may be able to offer a better picture of attitudes towards harm reduction and possibly provide reasons why they feel or do not feel receptive toward harm reduction.

A qualitative study that explores the attitudes of policy makers and counselors who are strongly committed to the abstinence model of substance abuse treatment or strongly opposed to the model might provide insight into why harm reduction is not as an accepted model of treatment in the United States as it is in Europe. Also exploring their depth of knowledge about the effectiveness of harm reduction in other countries and the reasons they are committed or opposed to the abstinence model of treatment may provide insight as to why harm reduction is not as accepted in the United States as it is in Europe.

Official governmental policies that support only abstinence based substance abuse treatment programs and the reason these policies are so strong should be studied to provide a better understanding of why harm reduction is not being practiced in the United States even though it has been found to be effective in Europe. Steps that can be taken to practice harm reduction in the United States may also be explored.

CHAPTER VI

JOURNAL ARTICLE

To be Submitted to the Journal of Addictions & Offender Counseling

Counselors' Attitudes toward Harm Reduction in Substance Abuse Treatment

This study investigated personal characteristics of counselors' and their attitudes toward harm reduction. Results showed that counselors with master's degrees who belong to the American Counseling Association lean toward a favorable attitude toward harm reduction overall. Implications for further research are discussed.

In the United States, the goal of most substance abuse counseling programs is the elimination of clients' use of illegal and illicit substances, in other words- total abstinence (MacMaster, 2004). The abstinence approach in substance abuse treatment began in the 19th century. Between the years 1785 and 1835, ideas and conceptions about alcohol use went from the belief that alcohol use was medicinal to the belief that the use of alcohol was the work of the devil (Levine, 1984). The Temperance movement demonized alcohol, actually referring to it as a *demonic* substance, and the Temperance cause became the longest lasting middle-class mass movement in the 20th century (Levine). The Temperance movement helped shape the current method of treating substance abuse in the United States, which is the abstinence model.

In contrast, harm reduction, a relatively new approach to treating people with substance abuse problems, is being utilized in Europe. Despite the acceptance of the harm reduction approach in Europe, it is an underutilized concept in the world of substance abuse treatment in the U.S. Harm reduction focuses on taking small steps to reduce substance use and to reduce harm to oneself and others, with abstinence being a possible goal, but not necessary (Marlatt, Blume, & Parks, 2001). Harm reduction is a public health option to the moral, criminal, and disease models of drug use and addiction

(Marlatt, 1996). Instead of blaming the individual for his or her substance abuse, placing the individual in jail or labeling a person as having a disease, harm reduction is being used in substance abuse treatment by inviting the community to assist those with substance abuse problems. Harm reduction is an alternative to the abstinence based approach which dominates the substance abuse treatment field in the United States.

There are five main characteristics or principles of harm reduction (Bigler, 2005; Riley et al., 1999). The characteristics or principles are *pragmatism*, *humanistic values*, *focus on harms*, *balancing costs and benefits*, and *priority of immediate goals*. *Pragmatism* is about accepting that the use of substances is a part of the human experience. *Humanistic values* involves not making any moralistic judgments and accepting a person's decision to continue to use substances. *Focus on harms* is centering attention on reducing negative consequences of drug or alcohol use to the user and others. *Balancing costs and benefits* involves assessing the costs and benefits of any intervention that may be used in order to focus resources on priority issues. *Priority of immediate goals* involves focusing attention on a person's most pressing issues. These characteristics or principles help make up the holistic treatment approach that is taken when using the harm reduction method of substance abuse treatment.

The beginnings of the harm reduction approach to substance abuse treatment began in the Netherlands in 1972 (Marlatt, 1998). In the Netherlands at that time, heroin became widely available. The Narcotics Working Party published a document that described the risks involved in drug use. This led to the adoption of the Dutch Opium Act of 1976 which made the distinction between drugs of high risk such as heroin, cocaine, LSD, and drugs of low risk such as marijuana (Marlatt).

In England, in the 1980s, two men had been developing ideas for the New Model for Public Health: John Ashton and Howard Seymour (O'Hare, 2007). For the development of the New Model, they brought together old ideas of environmental change, prevention, and therapeutic interventions. They went a step further and realized there was a need to include social aspects of health problems which are caused by lifestyles (O'Hare). In this way, the social aspect tries to take the approach of blaming lifestyles instead of blaming the individual.

In the United States, the harm reduction movement is slowly gaining credibility for being considered as a public health alternative to both the moral and medical models of treatment. One of the earliest instances of implementing the harm reduction approach in the United States occurred in 1972 (Duncan, Nicholson, Clifford, Hawkins, & Petosa, 1994). This early harm reduction program included an educational program in an urban, Southwestern drug abuse treatment center that was confronting an epidemic of *huffing*. When people learned young adolescents were dying from this practice, it was decided to place a priority on preventing deaths. Education on how to huff without killing oneself was taught. As a result of the education, no further deaths occurred and crisis calls relating to huffing declined sharply. It appears as though after that instance, the concept of harm reduction was not practiced. However, because of the history with drugs and alcohol in the United States, it is easy to see why some might object to teaching young people how to use drugs without killing themselves, rather than demanding that they stop the drug use altogether.

Most abstinence substance abuse treatment programs incorporate the 12-step program, which has a spiritual component (Levine, 1984). In this study, I explored

whether counselors were receptive to the use of harm reduction as a treatment option for substance abuse. I examined whether counselors' level of spirituality had an association with their acceptance of harm reduction. Wiggins-Frame (2005) defined spirituality as "one's beliefs, awareness, values, subjective experience, sense of purpose and mission, and an attempt to reach toward something greater than oneself. It may or may not include a deity" (p. 13). Spirituality is defined as individualistic. The meaning of spirituality is derived according to one's own beliefs, awareness, and personal values, in spite of any outside influences. Wiggins-Frame defined religion as "a set of beliefs and practices of an organized religious institution" (p. 13). With religion, the beliefs one holds is not his or her own; rather the beliefs stem from an organized institution.

With relapse rates ranging from 40%-60% in programs using the abstinence model, there appears to be a need for additional approaches to the abstinence approach for the treatment of people with substance abuse issues (McLellan, Lewis, O'Brien, & Kleber, 2000). There have been vast costs to society because of substance abuse problems in terms of health care, employability, decrease in work behavior, institutional support, crime, incarceration, drug and alcohol related accidents, health care costs for family members, and other factors (Keller & Dermatis, 1999). Abstinence-based treatment programs have been the main accepted approach to substance abuse treatment in the United States.

Proponents of the harm reduction approach to the treatment of individuals with substance abuse problems claim that costs to society, communities, and individuals can be decreased (Bigler, 2005; Duncan & Nicholson, 1997; DuPont, 1996; Marlatt, 1996). One possible way to justify a decrease in costs all around is shown in bars. For example,

individuals who become inebriated in bars may cause harm to themselves or others. However, training bar staff in responsible serving may help decrease the risk of intoxication (of individuals). Giving staff the skills to prevent accidents (in communities) may decrease the incidents of driving under the influence of alcohol or drugs (in society). Drunk driving laws, the provision of public transportation, and designated driver programs reduce risks of injury and fatality by separating drinking from driving (International Harm Reduction Association, 2006). Hence, the costs to individuals, communities, and society have the potential to decrease.

The harm reduction approach to substance abuse treatment is slowly being introduced in the United States. Because abstinence only programs are so widespread in the United States and substance abuse treatment professionals who work in such programs are taught that abstinence is the main way to treat individuals who abuse drugs or alcohol (Marlatt, 1998), it is important to gain an understanding of whether counselors are receptive to the harm reduction model of substance abuse treatment.

Although the U.S. practiced harm reduction briefly in the past, only two studies have been conducted that assess attitudes toward harm reduction. Goddard (2003) measured treatment professionals' attitudes toward harm reduction before and after a two-hour education presentation on harm reduction in Ohio and Kentucky. To conduct the study, she constructed the Harm Reduction Acceptability Scale (HRAS). She found participants' attitudes were significantly more favorable after the presentation ($M = 2.16$) than before ($M = 2.55$). Goddard's study suggests education may be a missing factor to being open to the concept of harm reduction.

The second study conducted by Havranek and Stewart (2006) measured

rehabilitation counselors' attitudes toward harm reduction using a 10 item survey that was modeled after the HRAS. They found that most respondents believed the harm reduction approach in treatment is good, but more believed that all illegal drug use should be avoided. They also found that males in general tended to agree more with harm reduction than females, and participants 50 years and older favored harm reduction more than those under 50 years old. In addition, Havranek and Stewart found that participants with a religious affiliation were more likely to disfavor harm reduction than those who denied a religious affiliation. The researchers also discovered that the more years rehabilitation counselors had spent in their professional career, the less they accepted harm reduction.

Curlin et al. (2009) examined 1,200 U.S. physicians' (600 general internists and 600 rheumatologists) and 1,200 Complementary and Alternative Medicine (CAM) providers (600 acupuncturists and 600 naturopaths) and their attitude towards CAM and the likelihood of them to practice it. Predictors of practicing CAM included age, gender, religious affiliation, region in which practitioners lived, and self-perceived level of spirituality. The researchers found that naturopaths were significantly younger than internists, rheumatologists, and acupuncturists, most of the CAM providers were women, and CAM providers were mostly located in the West while rheumatologists were mostly located in the South and Northeast, and internists were located almost evenly in all regions. CAM providers were three times more likely than physicians to report having no religious affiliation; however, they were twice as likely to perceive themselves as *very spiritual*. In terms of attitudes toward CAM and the likelihood to practice it, researchers found that physicians reported less positive attitudes toward and personal use of

practicing CAM, suggesting those who reported being more spiritual were more open to the use of CAM.

The purpose of this study was to assess the receptivity of counselors' attitudes toward harm reduction as an additional treatment model in substance abuse. This study was also conducted to determine if receptivity to the harm reduction approach to treating substance abuse issues was associated with personal characteristics including spirituality, length of practice, type of license or credential held, employment setting, location of environment in which they live (rural, urban, or suburban), and personal experience with substance abuse and substance abuse counseling. The general research question explored was: Are counselors' attitudes toward the use of harm reduction rather than total abstinence in substance abuse treatment associated with their level of spirituality, length of practice as a counselor, employment setting, location of environment in which they live (rural, urban, suburban), and personal experience with substance abuse?

Method

Participants

The participants in this study consisted of counselors from the *American Counseling Association*. According to the *American Counseling Association* (2009), members with *Professional* status hold a master's degree or higher in counseling or a closely related field from a college or university that was accredited when the degree was awarded by one of the regional accrediting bodies recognized by the Council for Higher Education Accreditation. ACA has approximately 40,000 members. Only Professional members who have addresses in the United States and who have provided their email addresses were asked to complete the questionnaires. Using Cohen (1992) as a guideline, assuming

medium effect size of a 0.15, $\alpha = .05$, a minimum of 107 participants were needed for this study. A total of 2,000 Professional members of ACA were asked to complete surveys. ACA provided email addresses of a random sample of 2,000 Professional members who had addresses in the United States. An e-mail was sent to all 2,000 professional members. This study took place online utilizing Inquisit, an online survey builder. Gender and ethnicity from those who completed the questionnaires were compared to the profile of all United States Professional ACA members to determine whether a representative sample of ACA members participated in the study. ACA's professional members in general, consisted of 72.1 % females and 76.4% have a Master's degree. Participants in this study consisted of 69.3% females and 71% held a Master's degree. The profile of the participants in this study was representative of the professional members of ACA who have physical addresses in the U.S. There were 176 participants in this study.

Measures

Two questionnaires were utilized in this research study. The first was Goddard's (2003) Harm Reduction Acceptability Scale (HRAS). This questionnaire measured treatment professionals' attitudes toward harm reduction. The questionnaire contained 25 items and participants were asked to indicate their level of agreement for each item on a scale of 1 to 5 in which 1= strongly agree; 2= agree; 3= neither agree nor disagree; 4= disagree; and 5= strongly disagree. A mean score of less than 3 suggests a favorable attitude toward a harm reduction approach to substance abuse treatment, while a mean score higher than 3 suggests a favorable attitude toward an abstinence approach. Reliability includes moderately high internal consistency and moderate 3-week test-retest reliability

with Cronbach's alphas ranging from .89 (pre) to .93 (post), $r = .83$ (Goddard). The HRAS was significantly correlated with Burt and Roney's (1994) Temperance Mentality Questionnaire to reflect validity (Goddard). Cronbach's alpha for this study was .88.

The second questionnaire was the Spirituality Assessment Scale (SAS; Howden, 1992). This questionnaire measured a person's level of spirituality. The questionnaire contained 28 items in which participants were asked to indicate their level of agreement with each item on a scale in which SA= strongly agree; A= agree; AM= Agree more than Disagree; DM= Disagree more than Agree; D= Disagree; and SD= Strongly Disagree. When scoring, points were assigned to each choice: 1= Strongly Disagree, 2= Disagree, 3= Disagree more than agree, 4= Agree more than Disagree, 5= Agree, and 6= Strongly Agree. A higher score on the SAS is considered to represent a higher degree of spirituality. The possible total SAS scores may range from 28 to 168. Howden determined the score ranges would represent spirituality as follows: 113-168 would represent strong, positive spirituality; 57-112 would represent fair, or mixed positive and negative spirituality; and 28-56 would represent weak or negative spirituality. There are four subscales; however total scores were of interest, not scores of the subscales. Content validity of the scale was evaluated by six experts in the area of spirituality and spiritual health and subjected to a pilot test to assess readability, reliability, and validity. In a study of 189 subjects, the SAS was found to have high internal consistency, $\alpha = 0.92$. To evaluate for construct validity, each item was evaluated as to its loading on a factor. Factor loadings of .40 or higher on at least three items for a factor was considered support for the factor and the keeping of those items. Loadings for the items were fairly well correlated, with most loadings well above the .40 criterion (Howden). Cronbach's alpha

for this study was .94.

A personal information form was created for this study. Items included on the form were as follows: gender, ethnicity, primary work setting, location of environment participants live (rural, urban, suburban), years of counseling experience, type of license/credential held, and personal experience with substance abuse and substance abuse counseling.

Data Analysis

The data analysis statistical test that was used was a step wise multiple regression. This was completed using the computer statistical software, *Statistical Package for the Social Sciences* (SPSS) version 15. This study determined whether several variables of interest had a relationship with participants' attitudes toward harm reduction. Descriptive statistics, a t-test, and a multiple regression were used to summarize and analyze the data.

Results

Overall, ACA professional members leaned toward having a favorable attitude toward harm reduction rather than having a neutral or negative attitude toward harm reduction. Participants in this study had a mean score of 2.69. A mean of score of 3.0 indicates neutrality and scores of less than 3.0 indicate a positive attitude toward harm reduction. Although participants' attitudes were not strongly in favor of harm reduction, they were more positive than negative about that approach to treating substance abuse clients. Participants in this study had a less favorable attitude toward harm reduction ($M = 2.69$) than the pre-test participants ($M = 2.55$) in the study conducted by Goddard (2003).

A t-test was computed to determine whether there was a significant difference between the scores of this study sample and Goddard's sample. Goddard had a pre-test

mean of 2.55 ($SD = .50$), and participants in this study had a mean of 2.69 ($SD = .48$). The t-obtained value was 3.5 and the t-critical value was 1.98. The t-obtained value was larger than the t-critical value which means there was a significant difference between the sample means. This result suggests that professional members of ACA were less favorable to harm reduction than the participants in the study conducted by Goddard.

Table 1 includes a summary of the characteristics of the 176 individuals who were professional members of the *American Counseling Association* who completed the questionnaires in this study. As shown in Table 1, participants were mostly White females who held a Master's degree.

A step wise multiple regression analysis was conducted to evaluate how well personal characteristics of participants predicted attitudes toward harm reduction. For sake of clarity with the results, the HRAS scale was reversed so that a mean score of less than three indicated a lower level of acceptability to harm reduction and a mean score higher than three indicated a higher level of acceptability. This was done to conduct the multiple regression only. The predictor variables were spirituality, primary work setting, years of counseling experience, location of environment in which participants lived (urban, rural, suburban), personal experience with substance abuse, having a close relationship with someone who had a substance abuse problem, years of experience counseling those with substance abuse problems, and credentials participants held, while the criterion variable was attitude toward harm reduction. The stepwise combination of three personal characteristics were significantly related to attitudes toward harm reduction, $F(3, 136) = 6.49, p < .05$. The multiple correlation coefficient was .35, indicating that approximately 13% of the variance of the attitude toward harm reduction

in the sample can be accounted for by the linear combination of personal characteristics. This means that the personal characteristics explain 13% of the difference in the attitudes toward harm reduction. A professional counselor who lives in an urban environment, who also has a close relationship with someone who has a substance abuse problem, and more years of experience counseling those with substance abuse problems, will report having a favorable attitude toward harm reduction. Table 2 includes a summary of the betas of the individual predictor variables.

As shown in Table 2, there was no significance between attitudes toward harm reduction and counselor's personal characteristics with the exception of living in an urban setting, years of experience counseling those with substance abuse issues, and having a relationship with someone with substance abuse issues. Descriptive statistics were also used to analyze the data. Table 3 includes a summary of the means and standard deviations of the HRAS and the variables of interest. Mean scores were just under 3.0 for all predictor variables which indicated that counselors in this study leaned toward having a slightly favorable attitude toward harm reduction.

Discussion

The step-wise multiple regression model results showed that 13% of the variance was accounted for by the significant variables (living in an urban environment, more years of experience with substance abuse counseling, and having a close relationship with someone who has a substance abuse problem). This means that someone who lives in an urban environment, who also has a close relationship with someone who has a substance abuse problem, and more years of experience counseling those with substance abuse problems, will report having a favorable attitude toward harm reduction. This finding is

significant in that participants who live in an urban environment who also have a close relationship with someone who has a substance abuse issue and more years of experience with substance abuse counseling see that there is receptivity toward the harm reduction approach to substance abuse treatment.

The most important findings of this study were that participants who lived in an urban setting, and those who had a close relationship with someone with a substance abuse issue were significant predictors of attitude toward harm reduction, and as years of experience with substance abuse counseling increased, the more favorable the attitude toward harm reduction. This finding was surprising because almost all substance abuse treatment programs in the United States are abstinence based. Abstinence and the 12-step program are the only approaches of substance abuse treatment currently taught in the United States. It is interesting that practicing counselors are open to the idea of a harm reduction approach to substance abuse treatment given that approach is not as well known in the United States.

It was discovered in this study that participants had a less favorable attitude toward harm reduction ($M = 2.69$) than the pre-test participants ($M = 2.55$) in the study conducted by Goddard (2003). The primary differences between the population in this study and Goddard's study was that this study included various types of counselors throughout the United States while Goddard's study surveyed treatment professionals in only two states (Kentucky and Ohio). Perhaps harm reduction is viewed more favorably by treatment professionals in those two states than counselors from throughout the United States.

This was a preliminary study that sought to gage the attitudes toward harm

reduction of various counselor types. Participants' attitudes toward harm reduction was studied in relation to their personal characteristics including spirituality, years of experience as a counselor, location of environment in which they lived, years of experience with substance abuse counseling, personal experience with substance abuse, and type of credentials held. There was a relationship between those who lived in an urban setting, who had a close relationship with someone with a substance abuse problem, and years of experience with substance abuse counseling and attitudes towards harm reduction.

In 2008, the rate of current illicit drug use among persons aged 12 or older was higher in urban areas than in non-urban areas. The rates were 8.5% in large urban counties, 8.1% in small urban counties, and 6.3% in non-urban counties as a group (SAMHSA, 2009). Participants who lived in an urban environment may have had a more favorable attitude than those who lived in a suburban or rural environment because substance abuse issues may be more prevalent in an urban area or perhaps counselors who live in urban environments are more open to new ideas. With substance abuse being more prevalent in an urban area, there may need to be additional approaches to treating substance abuse issues.

Personal experience with substance abuse partially predicted attitude toward harm reduction. In this study, 17.6% of the participants reported having personal experience with substance abuse while 81.8% of participants reported not having any personal experience with substance abuse and this did not predict attitude toward harm reduction. This may be because most participants have not personally experienced a substance abuse problem that would have them seek treatment. However, most of the participants in this

study (88.1%) had a close relationship with someone who had a substance abuse issue, while 11.4% did not and this predicted attitude toward harm reduction. This finding supports the need to have an additional method to treating substance abuse issues because the method we do have may not work for everyone.

The costs of substance abuse to the individual, family and society is well documented (Bigler, 2005; Duncan & Nicholson, 1997; Dupont, 1996; Keller & Dermatis, 1999; Marlatt, 1996). Although most participants in this study did not have a substance abuse problem themselves, most did have a close relationship with someone who did. Participants may feel there needs to be an additional approach to substance abuse treatment because they may have experienced how substance abuse affects not only the person using, but also the family and society.

The abstinence based model is almost the exclusive model used in treating substance abuse in the United States. The finding in this study may suggest as participants counsel those with substance abuse problems over a longer period of time, they begin to see a need for additional forms of treatment beyond the abstinence model. Also, these results may suggest that counselors with little or no experience counseling individuals with substance abuse problems may need to be educated on harm reduction as an additional model of treatment. Most counselors are taught that abstinence is the only acceptable model for treating substance abuse.

Also, when the *War on Drugs* was first initiated, the estimated rate of the population in the U.S. who had a substance abuse problem was 3% to 5%. Forty-one years and over a trillion dollars later, the estimated percentage of the U.S. population who had a substance abuse problem continued to be 3% to 5% (Office of National Drug

Control Policy, 2008). In addition, with relapse rates ranging from 40%-60% in programs using the abstinence model, there appears to be a need for additional approaches to the abstinence approach for the treatment of people with substance abuse problems (McLellan, Lewis, O'Brien, & Kleber, 2000). Participants who have many years experience counseling those with substance abuse problems may be seeing the need to have another model of treating substance abuse problems.

Results of this study suggest that ACA professional counselors had slightly favorable rather than neutral or negative attitudes toward harm reduction. This shows some slight acceptance of counselors to a treatment model different from the abstinence model of substance abuse treatment which is almost the exclusive model of treatment for substance abuse in the United States. Because there is a high rate of ineffectiveness of the current substance abuse abstinence treatment model, there is a need to explore other models of substance abuse treatment. The harm reduction approach has been found to be effective in Europe and should be considered in the United States as well.

Harm reduction is seen as a controversial approach to substance abuse treatment in the United States possibly due to a long policy history of drug prohibition that has largely viewed drug use as a moral and legal issue rather than a health issue (Mancini, Linhorst, Broderick, & Bayliff, 2008). Participants may have been conflicted as to how to answer the question items. Social desirability may have played a part in how the participants responded to the HRAS. While the mean score was under three, the mean score was still closer to three which may suggest participants had a "neither agree nor disagree" attitude toward harm reduction. This may suggest that although participants agreed with some of the question items on the HRAS, there were other items that

participants either did not agree with, or were not sure how to respond.

Havranek and Stewart (2006) measured rehabilitation counselors' attitudes toward harm reduction using a 10 item survey that was modeled after the HRAS and found that participants believed the harm reduction approach in treatment was good, but they also believed all illegal drug use should be avoided. Participants in this study possibly may have responded to the question items with the thinking that although some of the approaches were good, it would be best if participants did not use drugs or alcohol at all.

Results of the multiple regression showed that participants' level of spirituality did not predict their attitude toward harm reduction ($p = .93$). This is in contrast to the study conducted by Curlin et al. (2009) that found that participants who perceived themselves to be very spiritual practiced Complementary and Alternative Medicines (CAM). The CAM study appeared to demonstrate that practitioners who were very spiritual were more receptive to alternative types of medicinal practices. However, in this study, there was very little variance of level of spirituality; approximately 99% of the participants scored in the "fair" level of spirituality. With most participants falling under one level of spirituality, it was not surprising to find that level of spirituality in this study did not predict attitude toward harm reduction. If an instrument had been used that yielded more variance in spirituality of counselors, perhaps level of spirituality might have predicted attitudes toward harm reduction.

Implications for Counselors

Counselors are often told to check their biases before entering a counseling relationship with our clients. Counselors are also told to make sure they do not impose their own beliefs on their clients. With the results of this study, attitudes toward harm reduction are

very important as literature has shown that the current approaches we have with working with those with substance abuse issues does not help everyone. There appears to be a need to have other approaches to substance abuse treatment. When the *War on Drugs* was first initiated in 1969, the estimated rate of the population in the U.S. who had a substance abuse problem was 3% to 5%. Today the estimated percentage of the U.S. population who had a substance abuse problem continues to be 3% to 5% (Office of National Drug Control Policy, 2008). The percentage of people in the U.S. who have a substance abuse problem may be the same but the actual number of individuals dealing with this problem has increased. Therefore, there seems to be a need for additional approaches to substance abuse treatment. Clinicians should be aware of all possible approaches when working with people with substance abuse problems, not just approaches they are comfortable using.

Limitations

One limitation of this study was the effect that social desirability may have had on the way in which participants responded to items on the survey instruments. Participants may not have responded to the questionnaire items according to how they truly thought or felt. Instead, they may have responded to how they thought other counselors or society may have wanted them to respond. Another limitation was that there was no procedure in the study to determine the attitudes of those who were invited to participate but did not respond.

In addition, there was no guarantee that all participants understood all the items of the questionnaires. As a result, some items may have been skipped or may not have reflected accurate perceptions of the participants. Participants may have completed the

HRAS thinking the approaches may be a good idea, but not have a basic understanding of what harm reduction is completely about. Participants may not have had any prior knowledge about harm reduction as an alternative treatment in substance abuse.

Directions for Future Research

There are many ways in which this study can provide groundwork for future studies. Researchers may want to assess how much people know about harm reduction. Because religion seems to have a more concrete definition and spirituality is more loosely defined, perhaps exploring counselors' religiosity and attitudes toward harm reduction may have some significance.

Instead of asking counselors from a variety of settings about their attitudes toward harm reduction as was done in this study, perhaps counselor professionals whose main focus is the substance abuse population should be surveyed. Those who are experienced in substance abuse treatment may provide more fruitful results in that they may be able to offer a better picture of attitudes towards harm reduction and possibly provide reasons why they feel or do not feel receptive toward harm reduction.

A qualitative study that explores the attitudes of policy makers and counselors who are strongly committed to the abstinence model of substance abuse treatment or strongly opposed to it might provide insight into why harm reduction is not as an accepted model of treatment in the United States as it is in Europe. Also exploring their depth of knowledge about the effectiveness of harm reduction in other countries and the reasons they are committed or opposed to the abstinence model of treatment may provide insight as to why harm reduction is not as accepted in the United States as it is in Europe.

Official governmental policies that support only abstinence based substance abuse

treatment programs and the reason these policies are so strong should be studied to provide a better understanding of why harm reduction is not being practiced in the United States even though it has been found to be effective in Europe.

Table 1
Characteristics of Participants

| Type of Demographic | N | % | Did not respond (N) |
|---------------------------------------|-----|------|---------------------|
| Gender | | | |
| Male | 54 | 30.7 | |
| Female | 122 | 69.3 | |
| Ethnicity | | | |
| African-American | 8 | 4.5 | |
| White | 153 | 86.9 | |
| Hispanic/Latino | 5 | 2.8 | |
| Native American | 2 | 1.1 | |
| Multiracial | 4 | 2.3 | |
| Other | 4 | 2.3 | |
| Area | | | |
| Rural | 44 | 25.0 | 1 |
| Suburban | 90 | 51.1 | |
| Urban | 41 | 23.3 | |
| Degree held | | | |
| Master's | 125 | 71.0 | 2 |
| Education Specialist | 6 | 3.4 | |
| Doctorate | 40 | 22.7 | |
| Other | 3 | 1.7 | |
| Primary Work Setting | | | |
| Community Agency | 29 | 16.5 | 3 |
| School | 29 | 16.5 | |
| Private Practice | 64 | 36.4 | |
| Other | 51 | 29.0 | |
| Years of Experience Counseling | | | |
| 1-5 years | 41 | 23.3 | 24 |
| 6-10 years | 37 | 21.0 | |
| 11-21 years | 39 | 22.2 | |

| | | | |
|---|-----|------|----|
| 22-45 years | 35 | 19.9 | |
| Combination of Lic./Cert. | | | |
| State License alone | 59 | 33.5 | |
| State License & one or 50 more other credentials | | 28.4 | |
| CRC alone & one or more other credentials | 8 | 4.5 | |
| CADC alone & one or more other credentials | 13 | 7.4 | |
| School alone & one or more other credentials | 19 | 10.8 | |
| Other credentials or no credentials | 27 | 15.3 | |
| Years of Exp. with Sub. Abuse Coun. | | | 22 |
| 0-2 years | 45 | 25.6 | |
| 3- 6 years | 45 | 25.6 | |
| 7-15 years | 38 | 21.6 | |
| 16-36 years | 26 | 14.8 | |
| Personally have had Sub. abuse problem | | | 1 |
| Yes | 31 | 17.6 | |
| No | 144 | 81.8 | |
| Know someone w/sub. abuse problem | | | 1 |
| Yes | 155 | 88.1 | |
| No | 20 | 11.4 | |

n = 176.

Table 2
Multiple Regression Analysis with Dependent Variable Attitude towards Harm Reduction

| Predictor Variables | Beta | <i>t</i> | <i>p</i> |
|--|------|----------|----------|
| Rural | .11 | 1.35 | .18 |
| Urban | .17 | 2.16 | .03* |
| Personal Exp. w/ sub. abuse | .09 | 1.07 | .29 |
| Relationship w/someone with substance abuse issues | .23 | 2.85 | .01* |
| Years counseling experience | -.10 | -.92 | .36 |
| Years exp. substance abuse coun. | .18 | 2.21 | .03* |
| Spirituality Assessment Scores | -.01 | -.09 | .93 |
| Community Agency | .05 | .59 | .56 |
| School | .03 | .34 | .74 |
| Other work setting | .02 | .30 | .76 |
| State License & one or more other credentials | .13 | 1.55 | .12 |
| CRC alone & one or more other credentials | .04 | .55 | .59 |
| CADC alone & one or more other credentials | -.01 | -.14 | .89 |
| School alone & one or more other credentials | -.06 | -.76 | .45 |
| Other credentials or no credentials | .05 | .55 | .59 |

* $p < .05$

Table 3
Mean Scores on the Harm Reduction Acceptability Scale

| | <i>N</i> | <i>M</i> | <i>SD</i> |
|--|----------|----------|-----------|
| Level of Spirituality | | | |
| Weak | 2 | 2.70 | .25 |
| Fair | 173 | 2.70 | .48 |
| Personal Experience w/substance abuse | | | |
| Yes | 31 | 2.58 | .54 |
| No | 144 | 2.72 | .46 |
| Close relation w/someone with substance abuse | | | |
| Yes | 155 | 2.67 | .47 |
| No | 20 | 2.89 | .53 |
| Work Setting | | | |
| Community Agencies | 29 | 2.69 | .43 |
| School | 29 | 2.68 | .44 |
| Private Practice | 64 | 2.73 | .56 |
| Other | 51 | 2.67 | .42 |
| Area | | | |
| Rural | 44 | 2.63 | .53 |
| Urban | 41 | 2.54 | .43 |
| Suburban | 90 | 2.79 | .46 |
| Type of Degree Held | | | |
| Master's, Ed. | 134 | 2.71 | .50 |
| Spec. & Other | | | |
| Doctorate | 40 | 2.61 | .40 |
| License/Certification Combination | | | |
| State License alone | 59 | 2.77 | .54 |
| State License or one or more other credentials | 50 | 2.60 | .35 |
| CRC alone or with one or more other credentials | 8 | 2.80 | .58 |
| CADC alone or with one or more other credentials | 13 | 2.52 | .63 |
| School alone or with one or more other credentials | 19 | 2.84 | .44 |
| Other credentials or no credentials | 27 | 2.62 | .43 |

| | | | |
|---------------------------------|----|------|-----|
| Years Experience as a Counselor | | | |
| 1-5 years | 41 | 2.78 | .43 |
| 6-10 years | 37 | 2.69 | .51 |
| 11-21 years | 39 | 2.66 | .48 |
| 22-45 years | 35 | 2.71 | .45 |

| | | | |
|--|----|------|-----|
| Years Experience with Substance Abuse Counseling | | | |
| 0-2 years | 45 | 2.81 | .47 |
| 3-6 years | 45 | 2.74 | .48 |
| 7-15 years | 38 | 2.59 | .52 |
| 16-36 years | 26 | 2.53 | .50 |

n = 176

REFERENCES

- American Counseling Association. (2009). *Join ACA Today!* Retrieved September 23, 2009 from <http://www.counseling.org/Counselors/MemberJoin.aspx>
- Bigler, M. O. (2005). Harm reduction as a practice and prevention model for social work. *The Journal of Baccalaureate Social Work, 10*(2), 69-86.
- Cohen, J. (1992). A power primer. *Psychological Bulletin, 112*(1), 155-159.
- Curlin, F. A., Rasinski, K. A., Kaptchuk, T. J., Emanuel, E. J., Miller, F. G., & Tilburt, J. C. (2009). Religion, clinicians, and the integration of complementary and alternative medicines. *The Journal of Alternative and Complementary Medicine, 15*, 987-994.
- Duncan, D. F., Nicholson, T., Clifford, P., Hawkins, W., & Petosa, R. (1994). Harm reduction: An emerging new paradigm for drug education. *Journal of Drug Education, 24*, 281-290.
- DuPont, R. L. (1996). Harm reduction and decriminalization in the United States: A personal perspective. *Substance Use & Misuse, 31*, 1929-1945.
- Goddard, P. (2003). Changing attitudes towards harm reduction amongst treatment professionals: A report from the American Midwest. *International Journal of Drug Policy, 14*, 257-260.
- Havranek, J. E., & Stewart, J. R. (2006). Rehabilitation counselors' attitudes toward harm reduction measures. *Journal of Applied Rehabilitation Counseling, 37*, 38-44.
- Howden, J. (1993). Development and psychometric characteristics of the spirituality assessment scale. *Dissertation Abstracts International, 54*(1). (UMI No. 9312917)
- International Harm Reduction Association. (2006). *What is harm reduction?* Retrieved on April 21, 2009 from <http://www.ihra.net/Barcelona/WhatisHarmReduction>
- Keller, D. S., & Dermatis, H. (1999). Current status of professional training in the addictions. *Substance Abuse, 20*, 123-144.
- Levine, H. G. (1984). The alcohol problem in America: From temperance to alcoholism. *British Journal of Addiction, 79*, 109-119.

- MacMaster, S. A. (2004). Harm reduction: A new perspective on substance abuse services. *Social Work, 49*, 356-363.
- Mancini, M. A., Linhorst, D. M., Broderick, F., & Bayliff, S. (2008). Challenges to implementing the harm reduction approach. *Journal of Social Work Practice in the Addictions, 8*, 380-408.
- Marlatt, G. A. (1996). Harm reduction: Come as you are. *Addictive Behaviors, 27*, 779-788.
- Marlatt, G. A. (1998). *Harm reduction pragmatic strategies for managing high-risk behaviors*. New York: Guilford Press.
- Marlatt, G. A., Blume, A. W., & Parks, G. A. (2001). Integrating harm reduction therapy and traditional substance abuse treatment. *Journal of Psychoactive Drugs, 33*, 13-21.
- McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness. Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association, 284*, 1689-1695.
- O'Hare, P. (2007). Merseyside, the first harm reduction conferences, and the early history of harm reduction. *International Journal of Drug Policy, 18*, 141-144.
- Office of National Drug Control Policy. (2008). *National drug control strategy*. Retrieved on April 11, 2009 from <http://www.whitehousedrugpolicy.gov/publications/policy/09budget/index.html>
- 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 and Misuse, 34*, 9-24.
- SAMHSA. (2009). *Results from the 2008 national survey on drug use and health: national findings*. Retrieved on May 15, 2010 from <http://www.oas.samhsa.gov/nsduh/2k8nsduh/2k8Results.cfm#2.11>
- Suddath, C. (2009, March 25). The war on drugs. *Time Magazine*. Retrieved from <http://www.time.com/time/world/article/0,8599,1887488,00.html>

Wiggins-Frame, M. (2005). Spirituality and religion: Similarities and differences. In C. S. Cashwell, & J. S. Scott (Eds.), *Integrating spirituality and religion into counseling: A guide to competent practice* (11-30). Alexandria, VA: American Counseling Association.

REFERENCES

- Addiction-Rehabilitation.com. (2006). *Models of drug addiction and treatment*. Retrieved July 20, 2009 from <http://www.addiction-rehabilitation.com/models.html>
- American Counseling Association. (2009). *Join ACA Today!* Retrieved September 23, 2009 from <http://www.counseling.org/Counselors/MemberJoin.aspx>
- Barbosa Terra, M., Tannhauser Barros, H. M., Tetelbom Stein, A., Figueira, I., Palmero, L. H., Dias Athayde, L., de Souza Goncalves, M., & da Silveira, D. X. (2008). Do alcoholics anonymous groups really work? Factors of adherence in a Brazilian sample of hospitalized alcohol dependents. *The American Journal on Addictions, 17*, 48-53.
- Bigler, M. O. (2005). Harm reduction as a practice and prevention model for social work. *The Journal of Baccalaureate Social Work, 10*(2), 69-86.
- Blocker, J. S. (2006). Did prohibition really work? Alcohol prohibition as a public health innovation. *American Journal of Public Health, 96*, 233-243.
- Böllinger, L. (2002). Recent developments regarding drug law and policy in Germany and the European Community: The evolution of drug control in Europe. *Journal of Drug Issues, 32*, 363-378.
- Brecher, E. (1972). *Licit and illicit drugs, the consumers union report on narcotics, stimulants, depressants, inhalants, hallucinogens, and marijuana*. Boston: Brown and Company.
- Brickman, P., Rabinowitz, V. C., Karuza, Jr., J., Coates, D., Cohen, E., & Kidder, L. (1982). Models of helping and coping. *American Psychologist, 37*, 368-384.
- Burke, B. L., Arkowitz, H., & Menchola, M. (2003). The efficacy of motivational interviewing: A meta-analysis of controlled clinical trials. *Journal of Consulting and Clinical Psychology, 71*, 843-861.
- Burt, G., & Roney, C. (1994). The "temperance mentality": A survey of students at a Canadian university. *Contemporary Drug Problems, 21*, 301-327.

- Christie, T., Groarke, L., & Sweet, W. (2008). Virtue ethics as an alternative to deontological and consequential reasoning in the harm reduction debate. *International Journal of Drug Policy, 19*, 52-58.
- Cohen, J. (1992). A power primer. *Psychological Bulletin, 112*(1), 155-159.
- Curlin, F. A., Rasinski, K. A., Kaptchuk, T. J., Emanuel, E. J., Miller, F. G., & Tilburt, J. C. (2009). Religion, clinicians, and the integration of complementary and alternative medicines. *The Journal of Alternative and Complementary Medicine, 15*, 987-994.
- Day, E., Lopez-Gaston, R., Furlong, E., Murali, V., & Copello, A. (2005). United Kingdom substance misuse treatment workers' attitudes toward 12-step self-help groups. *Journal of Substance Abuse Treatment, 29*, 321-327.
- Denning, P. (2005). Harm reduction tools and programs. In L. Erlbaum (Ed.), *Addiction counseling review: Preparing for comprehensive, certification, and licensing examinations* (487-509). Mahwah, N. J.: Taylor & Francis.
- Dowling, J. (2004). *Law enforcement against prohibition*. Retrieved on April 11, 2009 from <http://www.joycedowling.com/Against-Drug-Prohibition.htm>
- Duncan, D. F., & Nicholson, T. (1997). Dutch drug policy: A model for America? *Journal of Health & Social Policy, 8*, 1-14.
- Duncan, D. F., Nicholson, T., Clifford, P., Hawkins, W., & Petosa, R. (1994). Harm reduction: An emerging new paradigm for drug education. *Journal of Drug Education, 24*, 281-290.
- DuPont, R. L. (1996). Harm reduction and decriminalization in the United States: A personal perspective. *Substance Use & Misuse, 31*, 1929-1945.
- Emmanuelli, J., & Desenclos, J. C. (2005). Harm reduction interventions, behaviours and associated health outcomes in France, 1996-2003. *Addiction, 100*, 1690-1700.
- Engelsman, E. M. (1989). Dutch policy on the management of drug-related problems. *British Journal of Addiction, 84*, 211-218.
- Erickson, P. G. (1999). Introduction: The three phases of harm reduction. An examination of emerging concepts, methodologies, and critiques. *Substance Use and Misuse, 34*, 1-7.
- Federal Bureau of Prisons. (2009). *Substance abuse treatment FAQ's*. Retrieved on December 20, 2009 from http://www.bop.gov/inmate_programs/substanceabuse_faqs.jsp

- Fehlandt, A. F. (1904). *Century of drink reform in the U.S.* Cincinnati: Jennings and Graham.
- Fetzer Institute. (2003). *Multidimensional measurement of religiousness/spirituality for use in health research*. Retrieved on July 15, 2009 from http://www.fetzer.org/PDF/Total_Fetzer_Book.pdf
- Friedman-Gell, L. (2006). Narcotics anonymous: Promotion of change and growth in spiritual health, quality of life, and attachment dimensions of avoidance and anxiety in relation to program involvement and time clean. *Dissertation Abstracts International*, 67(10-B). (UMI No. 3239040)
- Funk & Wagnalls New Encyclopedia. (2006). *Prohibition*. Retrieved on July 25, 2009 from <http://www.history.com/encyclopedia.do?articleId=219884>
- Garlitz, D. M. (2007). College students' attitudes toward drug addiction: Disease model versus moral model. *Dissertation Abstracts International*, 68(3-B). (UMI No. 3257963)
- Garson, G. D. (2009). *Multiple regression*. Retrieved on March 2, 2010 from <http://faculty.chass.ncsu.edu/garson/PA765/regress.htm>
- Goddard, P. (2003). Changing attitudes towards harm reduction amongst treatment professionals: A report from the American Midwest. *International Journal of Drug Policy*, 14, 257-260.
- Gossop, M., Stewart, D., & Marsden, J. (2007). Attendance at narcotics anonymous and alcoholics anonymous meetings, frequency of attendance, and substance use outcomes after residential treatment for drug dependence: A 5- year follow up study. *Addiction*, 103, 119-125.
- Hauge, R. (1999). The public health perspective and the transformation of Norwegian alcohol policy. *Contemporary Drug Problems*, 26, 193-207.
- Havranek, J. E., & Stewart, J. R. (2006). Rehabilitation counselors' attitudes toward harm reduction measures. *Journal of Applied Rehabilitation Counseling*, 37, 38-44.
- Hawks, D., & Lenton, S. (1995). Harm reduction in Australia: Has it worked? A review. *Drug and Alcohol Review*, 14, 291-304.
- Hobden, K. L. & Cunningham, J. A. (2006). Barriers to the dissemination of four harm reduction strategies: A survey of addiction treatment providers in Ontario. *Harm Reduction Journal*, 3(35). Retrieved July 8, 2008, from <http://www.harmreductionjournal.com/articles/browse.asp?date=12-2006>

- Howden, J. (1993). Development and psychometric characteristics of the spirituality assessment scale. *Dissertation Abstracts International*, 54(1). (UMI No. 9312917)
- International Harm Reduction Association. (2006). *What is harm reduction?* Retrieved on April 21, 2009 from <http://www.ihra.net/Barcelona/WhatisHarmReduction>
- Jantzen, S. (1978). Prohibition: The “noble experiment” that failed. *Senior Scholastic*, 16, 11-13.
- Kaskutas, L. A. (2009). Alcoholics anonymous effectiveness: Faith meets science. *Journal of Addictive Diseases*, 28, 145-157.
- Keane, H. (2003). Critiques of harm reduction, morality and the promise of human rights. *International Journal of Drug Policy*, 14, 227-232.
- Keller, D. S. & Dermatis, H. (1999). Current status of professional training in the addictions. *Substance Abuse*, 20, 123-144.
- King, R. (1989). *The drug hang up: Americas fifty-year folly*. New York: Norton.
- Knight, K. (2009). *Temperance movements*. Retrieved on July 15, 2009 from <http://www.newadvent.org/cathen/14482a.htm>
- Knight, J. R., Sherritt, L., Harris, S. K., Holder, D. W., Kulig, J., Shrier, L. A., Gabrielli, J., & Chang, G. (2007). Alcohol use and religiousness/spirituality among adolescents. *Southern Medical Journal*, 100, 349-355.
- Levine, H. G. (1978). The discovery of addiction. *Journal of Studies on Alcohol*, 39, 143-174.
- Levine, H. G. (1984). The alcohol problem in America: From temperance to alcoholism. *British Journal of Addiction*, 79, 109-119.
- Levine, H. G., & Reinarman, C. (1991). From prohibition to regulation: Lessons from alcohol policy for drug policy. *The Milbank Quarterly*, 69, 461-494.
- MacMaster, S. A. (2004). Harm reduction: A new perspective on substance abuse services. *Social Work*, 49, 356-363.
- Magill, M., & Ray, L. A. (2009). Cognitive-behavioral treatment with adult alcohol and illicit drug users: A meta-analysis of randomized controlled trials. *Journal of Studies on Alcohol and Drugs*, 70, 516-527.

- Mancini, M. A., Linhorst, D. M., Broderick, F., & Bayliff, S. (2008). Challenges to implementing the harm reduction approach. *Journal of Social Work Practice in the Addictions, 8*, 380-408.
- Margolis, R. D., & Zweben J. E. (1998). *Treating patients with alcohol and other drug problems: An integrated approach*. Washington: American Psychological Association.
- Marlatt, G. A. (1996). Harm reduction: Come as you are. *Addictive Behaviors, 27*, 779-788.
- Marlatt, G. A. (1998). *Harm reduction pragmatic strategies for managing high-risk behaviors*. New York: Guilford Press.
- Marlatt, G. A., Blume, A. W., & Parks, G. A. (2001). Integrating harm reduction therapy and traditional substance abuse treatment. *Journal of Psychoactive Drugs, 33*, 13-21.
- Marlatt, G. A., & Witkiewitz, K. (2002). Harm reduction approaches to alcohol use: Health promotion, prevention, and treatment. *Addictive Behaviors, 27*, 867-886.
- Mathew, R. J., Georgi, J., Wilson, W. H., & Mathew, V. G. (1996). A retrospective study of the concept of spirituality as understood by recovering individuals. *Journal of Substance Abuse Treatment, 13*, 67-73.
- McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness. Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association, 284*, 1689-1695.
- Miller, N. S. (1995). History and review of contemporary addiction treatment. *Alcoholism Treatment Quarterly, 12*(2), 1-22.
- Miller, N. S., & Chappel, J. N. (1991). History of the disease concept. *Psychiatric Annals, 21*, 196-205.
- Miller, W. R., & Kurtz, E. (1994). Models of alcoholism used in treatment: Contrasting AA and other perspectives with which it is often confused. *Journal of Studies on Alcohol, 55*, 159-166.
- Mumola, C. J., & Karberg, J. C. (2006). Drug use and dependence, state and federal prisoners, 2004 (special report). *Bureau of Justice Statistics*, 1-12. Retrieved October 17, 2009 from <http://www.ojp.usdoj.gov/bjs/pub/pdf/dudsfp04.pdf>
- Musto, D. F. (1989). Evolution of attitudes toward substance abuse. *Annals of the New York Academy of Sciences, 562*, 3-7.

- NA World Services. (2008). *Narcotics Anonymous- Basic Text*. Retrieved on June 22, 2009 from <http://www.na.org/?ID=ips-eng-index>
- O'Donnell, B. A. (2006). Reducing harm and changing culture: Scotland's national plan for action on alcohol problems. *International Journal of Drug Policy*, 17, 367-372.
- O'Hare, P. (2007). Merseyside, the first harm reduction conferences, and the early history of harm reduction. *International Journal of Drug Policy*, 18, 141-144.
- Office of National Drug Control Policy. (2008). *National drug control strategy*. Retrieved on April 11, 2009 from <http://www.whitehousedrugpolicy.gov/publications/policy/09budget/index.html>
- Onni, A. G. (2006). A cross-national outcome study of post-treatment alcoholics: Their abstinence and relapse. *Dissertation Abstracts International*, 65(3-A). (UMI No. 1434766)
- Ouimette, P. C., Finney, J. W., & Moos, R. H. (1997). Twelve-step and cognitive-behavioral treatment for substance abuse: A comparison of treatment effectiveness. *Journal of Consulting and Clinical Psychology*, 65, 230-240.
- 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 and Misuse*, 34, 9-24.
- Rosenberg, H., & Phillips, K. T. (2003). Acceptability and availability of harm-reduction interventions for drug abuse in American substance abuse treatment agencies. *Psychology of Addictive Behaviors*, 17, 203-210.
- SAMHSA. (2009). *Results from the 2008 national survey on drug use and health: national findings*. Retrieved on May 15, 2010 from <http://www.oas.samhsa.gov/nsduh/2k8nsduh/2k8Results.cfm#2.11>
- Sanchez-Craig, M., Annis, H. M., Bornet, A. R., & MacDonald, K. R. (1984). Random assignment to abstinence and controlled drinking: Evaluation of a cognitive-behavioral program for problem drinkers. *Journal of Consulting and Clinical Psychology*, 52, 390-403.
- Schaler, J. A. (1996). Spiritual thinking in addiction-treatment providers: The spiritual belief scale. *Alcoholism Treatment Quarterly*, 14(3), 7-33.
- SEMCA. (2009). *Know the facts about alcohol*. Retrieved on June 22, 2009 from <http://www.semcaprevention.org/alcohol.html>

- Shafranske, E. P., & Maloney, H. N. (1990). Clinical psychologists' religious and spiritual orientations and their practice of psychotherapy. *Psychotherapy, 27*, 72-78.
- Sorge, R. (1991). Harm reduction a new approach to drug services. *Health/PAC Bulletin, 21*(4), 22-27.
- Stanard, R. P., Sandhu, D. S., & Painter, L. C. (2000). Assessment of spirituality in counseling. *Journal of Counseling and Development, 78*, 204-210.
- U.S. Department of Census, (2009). *United States Census*. Retrieved on April 29, 2009 from <http://www.census.gov/popest/estbygeo.html>
- van Wormer, K., & Davis, D. R. (2008). *Addiction treatment: A strengths perspective* (2nd ed.). California: Thompson Brooks/Cole.
- Wagner, C., & Connors, W. (2001). *What is MI?* Retrieved on July 16, 2009 from <http://www.motivationalinterview.org/clinical/whatismi.html>
- Wiggins-Frame, M. (2005). Spirituality and religion: Similarities and differences. In C. S. Cashwell, & J. S. Scott (Eds.), *Integrating spirituality and religion into counseling: A guide to competent practice* (11-30). Alexandria, VA: American Counseling Association.
- Witkiewitz, K. (2005). Defining relapse from a harm reduction perspective. *Addiction, Assessment, and Treatment with Adolescents, Adults, and Families, 2*, 191-206.
- Wiltsek, S. D. (2004). Assessing practicing psychologists' alcohol/substance use and their treatment attitudes with alcohol using clients: Abstinence vs. harm reduction. *Dissertation Abstracts International, 65*(3-B). (UMI No. 3125042)

APPENDIX A

IRB PERMISSION

DARDEN COLLEGE OF EDUCATION

OFFICE OF THE DEAN

NORFOLK, VIRGINIA 23529-0156

PHONE-: (757) 683-3938

FAX: (757) 683-5083

November 30, 2009

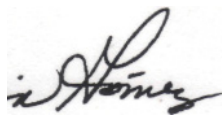
Proposal Number 200901043

Dr. Remley:

Your proposal submission titled, "**Counselor Attitudes towards Harm Reduction**" has been deemed EXEMPT by the Human Subjects Review Committee of the Darden College of Education. If any changes occur, especially methodological, notify the Chair of the DCOE HSRC, and supply any required addenda requested of you by the Chair. You may begin your research.

PRIOR TO THE START OF YOUR STUDY, you must send a signed and dated hardcopy of your exemption application submission to the address below.

Thank you.



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APPENDIX B

Harm Reduction Assessment Scale

DIRECTIONS: Indicate the number that corresponds to your personal attitude.

| | | | | |
|----------------|-------|---------------------------|----------|-------------------|
| 1 | 2 | 3 | 4 | 5 |
| Strongly agree | Agree | Neither agree or disagree | Disagree | Strongly disagree |

1. People with alcohol or drug problems who will not accept abstinence as their treatment goal are in denial.
2. It is not acceptable to teach injecting drug users how to use bleach to sterilize their injecting equipment.
3. A choice of treatment outcome goals (for example, abstinence, reduced use of drugs or alcohol, safer use of drugs or alcohol) should be discussed with all people seeking help for drug or alcohol problems.
4. People who live in government-funded housing must be drug and alcohol free.
5. Doctors should be permitted to prescribe heroin and similar drugs to treat drug addiction as long as doing so reduces problems such as crime and health risks.
6. Even if their drug use is stable, women who use illicit drugs cannot be good mothers to infants and young children.
7. Drug users should be given honest information about how illicit drugs may be used more safely (for example, how overdose or related health hazards may be avoided).
8. People with drug or alcohol problems who are not willing to accept abstinence as their treatment outcome goal should be offered treatment that aims to reduce the harm associated with their continued drug or alcohol use.
9. In most cases, nothing can be done to motivate clients in denial except to wait for them to “hit bottom”.
10. It is acceptable to prescribe substitute drugs such as methadone in order to reduce crime and other social problems associated with illicit drug use.
11. Prisons should not provide sterilizing tablets or bleach in order for inmates to clean their drug injecting equipment.

12. As long as clients are making progress towards their treatment goals, methadone maintenance programs should not kick clients out of treatment for using street drugs.
13. Measures designed to reduce the harm associated with drug or alcohol use are acceptable only if they eventually lead clients to pursue abstinence.
14. People with drug and alcohol problems may be more likely to seek professional help if they are offered at least some treatment options that do not focus on abstinence.
15. The prescription of substitute drugs such as methadone should be forbidden.
16. People whose drug use is stable should be trained to teach other drug users how to use drugs more safely (for example, how to inject safely).
17. Making clean injecting equipment available to injecting drug users is likely to reduce the rate of HIV infection.
18. Abstinence is the only acceptable treatment option for people who are physically dependent on alcohol.
19. It is possible to use drugs without necessarily misusing or abusing drugs.
20. Pamphlets for educating drug users about safer drug use and safer sex should be detailed and explicit, even if these pamphlets would be offensive to some people.
21. Opiate users should only be prescribed methadone for a limited period of time.
22. Drug injectors who are not willing to accept abstinence as a treatment goal at the beginning of treatment should be given easy access to clean injecting equipment to reduce the spread of HIV and other blood-borne diseases.
23. Women who use illicit drugs during pregnancy should automatically lose custody of their babies.
24. People with alcohol or drug problems should be praised for making changes such as cutting down on their alcohol consumption or switching from injectable drugs to oral drugs.
25. Abstinence is the only acceptable treatment goal for people who use illicit drugs.

APPENDIX C

Spirituality Assessment Scale

DIRECTIONS: Please indicate your response by circling the appropriate letters indicating how you respond to the statement.

MARK:

“SA” if you STRONGLY AGREE

“ A ” if you AGREE

“AM” if you AGREE MORE than DISAGREE

“DM” if you DISAGREE MORE than AGREE

“ D ” if you DISAGREE

“SD” if you STRONGLY DISAGREE

There is no “right” or “wrong” answer. Please respond to what you think or how you feel at this point in time.

- | | | | | | | | |
|-----|--|----|---|----|----|---|----|
| 1. | I have a general sense of belonging. | SA | A | AM | DM | D | SD |
| 2. | I am able to forgive people who have done wrong to me. | SA | A | AM | DM | D | SD |
| 3. | I have the ability to rise above or go beyond a physical or psychological condition. | SA | A | AM | DM | D | SD |
| 4. | I am concerned about destruction of the environment. | SA | A | AM | DM | D | SD |
| 5. | I have experienced moments of peace in a devastating event. | SA | A | AM | DM | D | SD |
| 6. | I feel a kinship to other people. | SA | A | AM | DM | D | SD |
| 7. | I feel a connection to all of life. | SA | A | AM | DM | D | SD |
| 8. | I rely on an inner strength in hard times. | SA | A | AM | DM | D | SD |
| 9. | I enjoy being of service to others. | SA | A | AM | DM | D | SD |
| 10. | I can go to a spiritual dimension within myself for guidance. | SA | A | AM | DM | D | SD |
| 11. | I have the ability to rise above or go beyond a body change or body loss. | SA | A | AM | DM | D | SD |
| 12. | I have a sense of harmony or inner peace. | SA | A | AM | DM | D | SD |

| | | | | | | | |
|-----|---|----|---|----|----|---|----|
| 13. | I have the ability for self-healing. | SA | A | AM | DM | D | SD |
| 14. | I have an inner strength. | SA | A | AM | DM | D | SD |
| 15. | The boundaries of my universe extend beyond usual ideas of what space and time are thought to be. | SA | A | AM | DM | D | SD |
| 16. | I feel good about myself. | SA | A | AM | DM | D | SD |
| 17. | I have a sense of balance in my life. | SA | A | AM | DM | D | SD |
| 18. | There is fulfillment in my life. | SA | A | AM | DM | D | SD |
| 19. | I feel a responsibility to preserve the planet. | SA | A | AM | DM | D | SD |
| 20. | The meaning I have found for my life provides a sense of peace. | SA | A | AM | DM | D | SD |
| 21. | Even when I feel discouraged, I trust that life is good. | SA | A | AM | DM | D | SD |
| 22. | My life has meaning and purpose. | SA | A | AM | DM | D | SD |
| 23. | My innerness or an inner resource helps me deal with uncertainty in life. | SA | A | AM | DM | D | SD |
| 24. | I have discovered my own strength in time of struggle. | SA | A | AM | DM | D | SD |
| 25. | Reconciling relationships is important to me. | SA | A | AM | DM | D | SD |
| 26. | I feel a part of the community in which I live. | SA | A | AM | DM | D | SD |
| 27. | My inner strength is related to a belief in a Higher Power or Supreme Being. | SA | A | AM | DM | D | SD |
| 28. | I have goals and aims for my life. | SA | A | AM | DM | D | SD |

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APPENDIX D

Personal Information Form

Directions: Please place a "X" in the blank that best describes you or fill in the blank.

1. Gender: Male: _____ Female: _____

2. Race/Ethnicity: African American: _____
Asian: _____
White/Caucasian: _____
Hispanic/ Latino: _____
Pacific Islander: _____
Native American: _____
Multiracial: _____
Other: _____

3. Please indicate which state you live in: _____ (please spell out)

4. Which best describes the area in which you live: Rural _____
Suburban _____
Urban _____

5. What is your highest degree held? Master's: _____
Education Specialist: _____
Doctorate: _____
Other: (please specify) _____

6. Primary work setting: State Agency: _____
Veteran's Affairs: _____
School: _____
Hospital: _____
Substance Abuse/Addiction Agency: _____
Rehabilitation Facility: _____
Private Practice: _____
Other: _____ (please specify)

7. Years of experience as a counselor: _____ (number of years)

8. Which licenses/certifications do you currently hold? (check all that apply)
State Counselor License (LPC/LMHC/LCPC, etc.) _____
NCC (National Certified Counselor) _____
CRC (Certified Rehabilitation Counselor) _____
CADC or state issued certificate or license as a substance abuse counselor _____
LMFT (Licensed Marriage and Family Therapist) _____
Certified or Licensed School Counselor _____
Other _____ (please specify)

9. Have you ever had a substance abuse problem? Yes _____
No _____

10. Have you had a close relationship with anyone (a friend, family member) who has had a substance abuse problem? Yes _____
No _____

11. Approximately how many years experience do you have counseling persons with substance abuse problems? _____ (number of years)

APPENDIX E

Nicole Marie Kyser earned a Bachelor's of Arts degree in Psychology in 2005 and a Master's of Arts degree in Rehabilitation Counseling in 2007, both from Northeastern Illinois University in Chicago, Illinois. She is a Licensed Professional Counselor and a Certified Rehabilitation Counselor.

Nicole is currently working for Disability Services at Old Dominion University. In addition, she specializes in dealing with transition and adjustment issues for returning Veterans and conducting vocational assessments.

Nicole is a member of the American Counseling Association, National Rehabilitation Counseling Association, and Chi Sigma Iota.