PROFESSIONALS’ PERSPECTIVES ON KNOWLEDGE AND CHALLENGES TO HARM REDUCTION AS AN APPROACH IN STABLE HOUSING AMONG CLIENTS WITH DUAL DIAGNOSIS

A Thesis

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by

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Houston Edward Wyllie

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Division of Social Work
Abstract

of

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This study explores the perspectives of professionals who work with clients in permanent supportive housing, on harm reduction as an approach to working with dual diagnosis clients particularly in ensuring stable housing. The study used secondary data from a single human services agency in the greater Sacramento area that offered to the researchers the data they collected from 75 professionals who work in their agency. Housing individuals with co-occurring disorders such as mental illness and substance use is problematic due to the complexities of individual symptoms. This has created a circular pattern of chronic homelessness among dully-diagnosed adults. Two prevalent models currently exist which try to address chronic homelessness within this stigmatized population; the abstinence model and the harm reduction model of substance use tolerance. The study findings indicate that the majority of respondents support harm reduction as an efficient model of recovery that ensures stable housing options. Their perspectives reinforce the literature review themes that harm reduction is not
counterproductive to recovery and stable maintenance of an acceptable standard of living. Recommendations for openness to innovative and practical modalities for the treatment and rehabilitation of the dual diagnosis population are included from the harm reduction and integration framework.

________________________, Committee Chair
Jude Antonyappan, Ph.D

________________________
Date
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Chapter 1

STATEMENT OF THE PROBLEM

Sacramento county Department of Health and Human Services reported in their report on the homeless population, that there are roughly 1,595 individuals who are chronically homeless due to substance use and severe mental illness (Schatz & Halcom, 2011). The National Association of Social Workers identifies adults who are homeless and have co-occurring disorders, such as substance use and mental illness, as an extremely vulnerable population (Sun & An-Pyng, 2012). In order to create an environment for individuals who often fail in high threshold abstinence housing programs, a harm reduction model of supportive housing was created (Tiderington, et al, 2011). The concept of creating a harm reduction environment based on research findings suggests that when interventions are designed to help homeless individuals transition from excessive use of substances into a supportive living environment that encourages a reduction of substances based on a therapeutic alliance between a provider and consumer (Little & Frankskoviak, 2010). However, the treatment goal of harm reduction conflicts with a more prevalent treatment goal of abstinence (VanWormer, 2009).

Mancini, (2008) demonstrated that practitioners in a housing program for people with psychiatric disabilities and substance use disorders, perceived the harm reduction approach favorably. Practitioners favored the approach of harm reduction, but were frustrated by its perceived ambiguity regarding long-term outcomes and client expectations (Mancini et al, 2008). This study seeks to expand this research and examine the attitudes of providers who work in supportive housing environments in the
Sacramento region. The study intends to test the notion that, provider views about abstinence influence practices as they relate to harm reduction being an effective treatment modality. This study also intends to discern if practitioners are knowledgeable about the practice of harm reduction and if practitioners feel that they are adequately trained in implementing harm reduction in the supportive housing environments in which they work.

Traditional approaches to substance abuse treatment prescribe abstinence as the only goal (Lee, et al, 2011). Early housing programs required individuals to maintain abstinence as a mandatory requirement to keep their housing. This mandate was enforced regardless of any co-occurring disorder and resulted in creating a vast population of homeless individuals who suffered from both mental illness and substance related challenges (MacMaster, 2004). HR was introduced to supportive housing with the purpose of providing a stable environment in which personal growth and recovery could organically take place in a community based setting (Van Wormer, 2009). However, the change from abstinence only programs to HR supportive programs has caused some providers to develop some resistance to HR being implemented (Lee et al, 2011).

**Background of the Problem**

Successfully housing individuals with psychiatric disabilities has been problematic since the mid 1960’s when significant rights were given to individuals, who had previously been confined to psychiatric treatment hospitals. These rights coupled with deinstitutionalization of thousands of individuals who suffer with psychiatric disabilities created a population which had little access to appropriate housing and
services (Tschopp, et al, 2009). Early housing models consisted of little more than food and shelter. Even more problematic, these housing programs had a zero tolerance policy for substance use, which often resulted in individuals being unable to retain permanent housing. In response to an overwhelming jump in widespread chronic homelessness among the mentally ill, the federal government intervened with subsidies provided by FHA or the Federal Housing Administration to reduce chronic homelessness (Nelson, 2010). This helped create the “housing first” approach where consumers get to choose and keep their housing without having to prove abstinence first.

The “housing first” model has become widely popular as a way to retain and treat individuals who suffer for severe psychiatric disabilities, but it has created some misconceptions about its outcomes (Rosen, 2007). The primary goal of “housing first” is to keep an individual housed and off the street, thereby reducing homelessness among those who suffer from psychiatric disabilities. The secondary goal is to offer non-mandated supportive services once the individual has stabilized to the permanence of their housing. The largest criticism from the public and professionals comes from the ability of individuals who are housed in these environments, and who choose to use and abuse substances. To many, these “housing first” programs are simply creating an ‘enabling’ environment in which individuals can live in subsidized housing and participate in uncontrolled drug use (Duff, 2010).

The homeless population in the Sacramento region is culturally diverse and in a 2013 homeless count it discovered that the population consists of 53.0% White/Caucasian, 16.8%, Black/African American, 4.3%, American Indian/Alaskan...
Native, 0.4%, 1, 3%, Asian, Pacific Islander, .9 % Hawaiian, 10.8 % Multiple Races, 4.7% Hispanic/Latino/Mexican (Schatz & Halcom, 2013). It is estimated that of the 1,194 individuals, counted 17% are chronically homeless and 27% are living with a severe mental illness (Schatz & Halcom, 2013). These individuals will eventually seek some kind of supportive housing and treatment modality. Many of these individuals will find that the housing agency that they have sought out for service will be using the Assertive Community Treatment (ACT) approach to treatment and rehabilitation.

ACT is often utilized because it brings rehabilitative psychiatric services directly to the consumer rather than having services provided in a restrictive hospital setting. A key component to the success of the ACT model is the built in design of assigning a case manager (Rosen, et al. 2007). The case manager becomes a critical part of the recovery process for the individual, because the case manager has intimate daily contact with them. It is vital that research is conducted to examine this relationship because the therapist’s interpersonal skills, ideologies, and abilities to meet the client where they are at in their recovery will directly influence client outcomes. It is important to note that ACT is considered an evidence-based psychiatric rehabilitation practice and has proponents as well as critics. Critics argue, “ACT is contradictory to the philosophy of empowerment due to the use of interventions that could be considered coercive” (Tschopp, et al., p. 408). Proponents argue that when ACT is administered properly it helps individuals with psychiatric disabilities participate fully in their community, which is a vital part of recovery-oriented practice (Kidd et al. 2008).
A factor that influences the client/case manager relationship is the amount of time spent in a working alliance that exists between the two individuals. There have been few studies that have examined how working alliance is created and perpetuated in these intimate relationships. A study was conducted by (Hopkins & Ramsundar, 2006) which the authors found the importance of clinicians understanding that their first impression of their client can directly affect the working alliance. The same study found that stable housing and working alliance played a large role in changes in community functioning for the client. In all of these cases, the ability for the client to choose the type of services and housing that meets their perceived needs is vital for successful outcomes related to housing permanence and a reduction in debilitating mental health symptoms.

Case managers enter the field with their own expectations and biases as it relates to working with clients. Some may have had many of the same challenges with mental health and substance use. Ideologies that have been developed by case managers with this type of lived experience can sometimes become problematic if their beliefs and agency beliefs do not coincided with one another. One such belief that would be counter to the HR model of treatment in supportive housing would be the belief that abstinence is the only goal to recover from substance abuse. These beliefs are often a large part of many AA or NA support groups (Lee et al. 2011) and could become problematic for a case manager working in an HR environment where a tolerance of continued use is accepted without exception.
Statement of the Research Problem

A strong working alliance between providers and consumers who live in supportive housing can be adversely affected by individual provider views of harm reduction as a sole intervention. HR polices are ambiguous and are often viewed as enabling clients to continue illicit drug use while enjoying free housing subsidies from local and federal sources. Little research has been conducted to examine professional provider views about the conflicting nature between HR and the lack of abstinence in supportive living environments.

Study purpose. The purpose of this study is to explore the perspectives on knowledge and challenges to harm reduction as an approach in stable housing among clients with dual diagnosis.

Theoretical framework. The task centered model was developed by William Reid and Laura Epstein in the 1960’s as an alternative to costly and often lengthy psychodynamic theory (Tolson, 2003). The Task center model focuses on a problem the client feels they have (Roberts, 2002). Issues the clinician may feel need to be talked about are put aside for what the client feels is most important and relevant to their needs (Roberts, 2002). The task-centered model is appropriate for the harm reduction due to the ability for the consumers to discuss what challenges them. Consumers in harm reduction have had many individuals of authority tell them what is wrong with them, but very few have asked them what help they need with. This is exactly what the task centered model is designed to do.
Practitioners who implement this theory focus on problems the client’s wants to work on. A practitioner using this model focuses both on a collaborative and caring relationship with an emphasis being placed on the importance of transparency (Roberts, 2002). In this model, clients are seen as active participants in their change by working through interventions and developing problem solving abilities that can be applied outside of sessions. Primary change in this theory is brought about by problem solving tasks that are to be completed in between sessions with the clinician. The main function of the sessions with the client is to lay the framework and a structured plan for problem solving tasks to be completed prior to the next session. The task centered approach is very similar to the behavioral model, problem solving approach and learning theory in that is focuses on changing behavior by completing tasks and not on emotion.

The task-centered model can be broken down into three phases, the first being the initial phase, in this phase discussion focuses on the reason for referral and processing the clients understanding of their current challenges. Within this phase contracts and goals are set with the client as well as an explanation of the process of the therapy is discussed (Roberts, 2002). The second phase is the middle phase in which problems and challenges discussed and reviewed to understand progress made by the client with their problem. In this phase, tasks are reviewed and for those tasks that may be too difficult for the client to complete alternative are developed. A crucial aspect of this phase is the task planning and implementation sequence in which tasks are selected and implemented. The final phase in is the Termination phase in which challenges are reviewed to show the client the strides that have been accomplished and that can be continued after sessions are complete.
Concentration in is placed on how the client can maintain the gains that have been made as well as developing better communication skills.

Carl Rodger’s personality theory is an important aspect to consider when examining the provider/consumer relationship because it can help the provider move towards natural empathy. Rodgers viewed an effective helping relationship to be collaborative and person-centered. Thus, the role of the therapist in the helping relationship focuses on understanding how the individual constructed their thoughts about themselves and why (Anderson, 2001). The therapy session becomes a vehicle for the individual to explore their feelings about why a problem exists and what steps they can take to understand it and change it if necessary. Rodgers theory relies heavily on the relationship between client and therapist. It requires three core valves that the therapist must believe in order to create an environment conducive to competence and growth. Roger’s characteristics for creating a climate of change in a helping relationship are genuineness, unconditional positive regard, empathetic understanding and recognizing the spiritual of transcendental characteristic (Anderson, 2001).

Anderson (2001) in her article, *Postmodern collaborative and person-centered therapies: what would Carl Rogers say?* describes the use of the clients story as a philosophical stance because the relationship between the client and the therapist becomes more mutual and egalitarian (Anderson, 2001). The therapist becomes the learner in the relationship and maintains a stance of not knowing thus the clients story and the way they choose to tell it becomes center stage. This is helpful to the client because the story becomes new to the client and the therapist can examine the constructs
of the story and ask for clarifications during the narrative. Anderson argues that maintaining a stance of not knowing is an ethical position because it is not the job of the therapist to use knowledge to direct a client in a particular way but to promote dialogue in which possibilities can emerge (Anderson, 2001). This is a way of being with individuals that respects the power in the relationship and recognizes the humanity and the journey of both the therapist and the client. This way of being also creates a natural collaborative, because it is the way anyone would want to be addressed and that is with respect, love, and willingness to authentically be present with another human being that is suffering. The last argument that Anderson makes is that “therapy from a postmodern collaborative perspective becomes less hierarchical and less dualistic; it becomes more like the everyday ordinary relationships and conversations most of us prefer” (Anderson, 2001).

**Definitions of terms.** The following terms will be used throughout this thesis and are relevant to explaining the Harm Reduction and Abstinence based models and forms of treatment. Their definitions are listed below:

- **Supportive Housing** or the housing first model is a non-custodial approach, in which individuals who are struggling with psychiatric disabilities and substance abuse challenges are provided housing (Nelson, 2010).

- **Assertive Community Treatment** is a evidenced based practice model in which community based organizations provide comprehensive individualized treatment, rehabilitation, and supportive services to people with psychiatric disabilities (Tschopp, et al, 2009; Bond et al. 2004)
Treatment First model is that of requiring detoxification and sobriety prior to entering a treatment facility.

Case Management as defined in this context is the combination of all systems services required to meet the consumers needs (Rosen et. al, 2007). These services will be provided while the individual is living in the community and may continue while the individual is hospitalized (Rosen et. al, 2007).

Case Manager is an individual who plans and coordinates services for a consumer within their own organization as well as brokers services within the community of their clients.

Abstinence is a view that adheres to the disease model understanding of addiction (Escamilla and Mancera, 2008; Margolis and Zebbwen, 1998). Abstinence requires individuals to abstain from illegal drugs; i.e. marijuana, heroin, crack, methamphetamine, alcoholic beverages and the abuse of prescription medication; i.e. benzos and opiates (Escamilla & Mancera, 2008). In this ideology individuals who struggle with challenges of addiction must abstain from drug use in order to be cured (Collins et. al., 2011).

Alcoholics Anonymous is a form of open group therapy with no direct leader in which individuals struggling with alcohol may discuss their challenges.

Narcotics Anonymous is a form of open group therapy no direct leader in which individuals struggling with narcotics may discuss their challenges.

Harm Reduction is a conceptual framework in which individuals struggling with substance abuse challenges are provided services regardless of their drug use (MacMasters, 2004). The primary goal of harm reduction is to help reduce negative consequences of an individual’s high risk behaviors. This conceptual framework
identifies that an individual’s relationship with drugs plays an intricate role in their life and moves to gradually modify this behavior to one of a low level of risk. Although abstinence is a goal of this form of treatment it is not the primary goal (Mancini et. al., 2008).

Duel Diagnosis can be described individual suffering from psychiatric disabilities as well as a substance abuse disorders. Severe Mental Illness is defined as a individual who suffers from severe mental health symptoms causing great distress in regards to their normal functioning, in daily life. These individuals often have difficulty with psychosis in which they may lose touch with reality. Many may have difficulty suffering with severe debilitating delusions, hallucinations and mood regulation which may also affect them negatively. Commonly these individuals may be diagnosed with Schizophrenia and Bio-Polar disorder. Homelessness can be defined as an individual who lacks constant housing. Chronic homelessness as defined by the Department of Housing and Urban Development is an individual who has been homeless for a year or longer or has been homeless four times in the last three years and has a disability (National Alliance to End Homelessness, 2013).

**Assumptions.** The assumptions of this research are grounded in the following notions: a) Case manager relationships with their clients are influenced by many factors but personal beliefs about substance use can be detrimental to client outcomes. b) HR use in supportive housing environments offer the ability for the client to choose services and contemplate a reduction in illicit drug use all while maintaining safe and stable housing.
c) Educating case managers and support staff about the primary function of HR in supportive housing can improve client outcomes. d) The uses of HR in supportive housing environments help reduce chronic homelessness among client with duel diagnosis. e) The use of HR in supportive housing environment reduces jail visits, emergency room visits, and mental health hospitalization.

**Social work justification.** The researchers hope to examine popular beliefs among professional providers as it relates to the practice of HR in supportive housing with individuals with co-occurring disorders. The National Association of Social Workers (NASW, 2008) “Social workers understand that relationships between and among people are an important vehicle for change” (para. 22). This change includes tolerance for behaviors that sometimes conflict with personal beliefs. By examining the complex interactions between professionals and clients tools for educating future practitioners can be created to improve client outcomes. Establishing awareness of the primary goals of HR within the professional community is likely to lead to a better understanding among the public.

**Study limitations.** Non-random sampling methods were used by the agency that collected the data. Hence, the results cannot be generalized to the population from which the sample was chosen. Despite this limitation, the researchers devised the questionnaire in a way to capture a cross sectional demographic that is similar to the population. Threats to internal validity are not addressed.

**Statement of Collaboration.** The researchers, Kacee Clark and Houston Wyllie, worked in collaboration to develop and complete this Master’s thesis. The researchers
generally met multiple times a month for numerous hours to collaborate on this thesis.

The researchers worked collaboratively to develop the research tool that was provided to the agency and formulated the chapters of this document. Both researchers were responsible for the analysis of the data, interpretation of the findings, writing the thesis, and the completion of the required formatting for the thesis as prescribed by the division of social work and graduate studies of the university.
Chapter 2

REVIEW OF THE LITERATURE

The authors of this literature review present themes that emerged from reviewing scholarly literature on professional’s perspectives on knowledge about and challenges to harm reduction as an approach in stable housing among clients with a dual diagnosis. The themes presented in this chapter are: the history and creation of supportive housing programs, assertive community treatment, the abstinence approach to supportive housing, benefits and challenges of harm reduction, harm reduction in dual diagnosis, and the role of harm reduction in supportive housing. These themes offer the rationale for the need for conducting the study from the perspectives of the professionals.

History and Creation of Supportive Housing Programs

In 1967 California passed the Lanterman-Petris-Short Act, with the sole purpose to abolish inappropriate indefinite commitment of individuals with mental illness who refused voluntary treatment (Lenell, 1977). In the 1960’s and 70’s individuals with mental illness spent their lives in psychiatric treatment hospitals, but with the closure of these treatment facilities in the early 1980’s these individuals became deinstitutionalized and mental health services became fragmented (Tschopp, et al, 2009).

Deinstitutionalization created a population that was not accompanied by community based supports, such as housing and treatment (Nelson, 2010). Nelson argues that there has been an evolution of housing approaches from the early custodial approach to a more supportive approach in use today. The custodial approach offered little to the individual in relation to active rehabilitation and the care consisted of meals and
medication (Nelson, 2010). The supportive housing or housing first approach was introduced by Paul Carling in 1995 and offered consumers a “choose, get, and keep” approach to housing.

Sacramento’s supportive housing programs practice a model that combines housing first, harm reduction and peer support models to help reduce the number of mentally ill homeless in the region. Proponents of this blended model argue that this blended approach is successful because it improves outcomes (Bean, et al, 2013). These outcomes are based on reduced risk of hospitalization, chronic homelessness, and fewer days spent in county jails. There is some argument about what supportive housing actually is. Recent research indicates that core dimensions of supportive housing are, housing choice, separation of housing and services, and service choice (Rosen, 2007). Wong, Filoromo, and Tennille (2007) in their comprehensive study of supportive housing further extrapolate that the core domains of supportive housing are, consumer choice, typical and normalized housing, resource accessibility, consumer control, and individualized and flexible support.

In order to further understand what supportive housing is and the evolution of harm reduction as a part of it, it is necessary to recognize the difference between “integrated” or “parallel” housing. Integrated housing combines housing, resources, and supportive case managers in a central location such as an apartment housing complex. The parallel housing model provides independent housing with supportive services elsewhere in the community. In an 18 month study McHugo et al. (2004) found that those in integrated housing reported more stable housing, life satisfaction, and a reduction in
psychiatric symptoms than those in parallel housing (Nelson, 2010). Nelson argues few studies have been completed in regards to supportive housing and caution should be taken about making definitive statements about outcomes related to these programs.

The shift from the custodial approach of housing to the supportive model has created some misconceptions about why supportive housing is needed. These misconceptions center around ideas that mentally ill individuals are dangerous, unable to make their own decisions and need more care than a community based program can offer (Rosen, 2007). There also seems to be a class and racial issue involved in the formation of public opinion about supportive housing programs. The largest factor that contributes to this misconception is the racial diversity within the mentally ill homeless population (Stergiopoulos, et al, 2012). One study found that 45% of participants identified as non-white and 22% identified as Black (Stergiopoulos, et al). These factors coupled with a decrease in federal and state funding for supportive housing programs has lead to an erosion of public policy for housing (Nelson, 2010).

**Assertive Community Treatment**

Assertive Community Treatment (ACT) is a comprehensive individual approach to treatment and rehabilitation of people with psychiatric disabilities (Tschopp, et al, 2009). ACT is considered an evidence-based psychiatric rehabilitation practice (Bond et al. 2004). ACT is best delivered in an integrated model of supportive housing because it involves the presence of a treatment team in all aspects of a consumer’s life (Tschopp, et al, 2009). It emerged in the US in the 1970s as an effort to replace state hospital treatment (Cupitt, 2011). The efficacy of ACT is strong and studies have found that compared with
usual mental health care ACT decreased hospital-based mental health care, improved outcomes, and reduced symptoms and increased housing stability (Rosen, et al. 2007). Rosen argues that most economic analyses found that ACT reduces treatment costs by reducing hospital bed days (Rosen, et al, 2007), but cautioned that as mental health systems rely less on hospitals over time the cost advantages of ACT will be harder to justify and will need to be based more on its clinical benefits.

The key component that ACT employs is the use of a case manager in the treatment process. Rosen argues that as care shifted from hospitals to the community mental health services became fragmented and difficult to navigate for the mentally ill, therefore creating the need for case management (Rosen, et al. 2007). Rosen defines case management, as “the role of combining into one coherent system all the services required in meeting the consumer’s needs” (Rosen, et al.). This is in relation to the supportive housing model because supportive housing creates the system in which to provide services to consumers. Rosen argues that the important issues for ACT do not lie in the efficacy/effectiveness debate, but rather in the newly emerging supportive environments in which it is delivered (Rosen, et al. 2007).

**History and Description of Abstinence**

Escamilla & Mancera (2008) cite Margolis and Zebbwen (1998) and state that the United States currently adheres to the disease model in its view of addiction. This model is often viewed as the medical model as well as the 12-step program (Escamilla & Mancera). In which addiction is viewed as a disease that has a high rate of relapse and can only be decreased by abstinence (Collins et. al., 2011). The goals of these programs
are to bring about change through complete abstinence from nonmedical drugs (MacMaster, 2004).

Participants who adhere to these types of programs are to abstain from all substances, to remain an active member and in some cases are required to abstain prior to entering treatment (Mancini et. al., 2008). If participants are unable to fulfill their obligation through these processes often, they are removed from the treatment (Mancini et. al., 2008). Participants who are duel diagnosed with both addiction as well as a diagnosed mental illness have more difficulty within these very highly structured systems (Mancini et. al. 2008). Often these participants do not possess the cognitive and behavioral skills and external resources necessary to maintain abstinence within treatment (Mancini et. al., 2008). Due to strict procedures and policies within this type of treatment nearly 76% remove themselves from treatment before completion (Mancini et. al.).

According to MacMaster the view of addiction in the disease model has shaped the framework of the criminal justice systems in the United States into one of prohibition and abstinence (2004). The United States criminal justice policies have focused on “zero tolerance” (MacMaster, 2008) of drug use and place a moral blame on individuals who are addicted to illegal substances (Tiderington et. al., 2011). A common component being encouraged by the court is to have probationers attend twelve-step meetings such as alcoholics anonymous (AA), or narcotics anonymous (NA), as part of their recovery plan. AA was founded by two alcoholics, Bill Wilson and Dr. Bob Smith and is based on 12-steps of recovery (Escamilla & Mancera 2008, cite Inada & Cohen, 2000). According to
Denning & Little 2008 more than 90% of alcohol and drug treatment programs are based on the twelve steps of AA.

The twelve step of AA are discussed in “The Big Book” and the steps are as follows:

1. We admitted that we were powerless over our addiction, that our lives had become unmanageable.
2. We came to believe that a power greater than ourselves could restore us to sanity.
3. We made a decision to turn our will and our lives over to the care of God as we understood Him.
4. We made a searching and fearless moral inventory of ourselves.
5. We admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. We were entirely ready to have God remove all these defects of character.
7. We humbly asked Him to remove our shortcomings.
8. We made a list of all persons we had harmed, and became willing to make amends to them all.
9. We made direct amends to such people wherever possible, except when to do so would injure them or others.
10. We continued to take personal inventory, and when we were wrong promptly admitted it.
11. We sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will for us, and the power to carry that out.

12. Having had a spiritual awakening as a result of those steps, we tried to carry this message to addicts and to practice these principles in all our affairs (Inaba & Cohen, p. 403).

Traditional approaches to substance abuse treatment called for complete abstinence as a prerequisite to enter and remain in a program (Mancini et. al., 2008). A study was done to examine the parallels between harm reduction and the 12 Steps tradition. The study suggests that the presence of 12 steps in treatment programs across the United States is much higher than 60 to 75% and that many individuals involved in harm reduction are simultaneously involved in 12-step programs (Lee, et al, 2011). Lee argues that contrary to popular belief harm reduction and 12-step programs do not differ significantly from one another. The only requirement to participate in an AA program is the desire to stop drinking and the latter is true for NA programs as well, thus creating tolerance for controlled substance use (Lee, et al, 2011). This is significant because Lee also argues that a dichotomous paradigm exists between professional views about harm reduction and public misconception. These misconceptions include that harm reduction enables increased substance use, advocates drug legalization, and that it fosters stagnation (Lee et al, 2011).
History and Description of Harm Reduction

Harm reduction was originally suggested in the 1920 in the United Kingdom under the Rolleston Committee’s recommendations for drug policy changes (MacMaster; Scavuzzo, 1996). Harm reduction has been used in the Netherlands for over 30 years as well as having been utilized in both Germany and Switzerland as part of their substance abuse policy (MacMaster; Van Laar et. al., 1996; UNIDCP, 1997). This approach became prominent in the early 1980’s as a response to the spread of HIV/AIDS and hepatitis among intravenous drug users throughout the world (Scavuzzo, 1996, Mancini et. al.; Inciardi & Harrison, 2000) Recently, The United States prevention of HIV/AIDS has taken priority over prevention of drug use (MacMaster, 2004). The preventable harm of HIV/AIDS far outweighs the need to focus on the abstinence as the only treatment for drug use (MacMaster, 1996). As MacMaster cites Vail & Stokes saying (1999) “dead addicts don’t recover”.

MacMaster states that harm reduction is a conceptual framework that provides clients with limited services regardless of drug use. The goal of harm reduction is to limit preventable negative consequences of drug use rather than only focusing on abstinence as a way of treatment (Tiderington et. al.2011). Although abstinence is a goal of this form of treatment it is not the primary goal (Mancini et. al., 2008). Collins et. al. (2011) cites Denning (2000) and Marlatt (1996) and state that consumers who take part in harm reduction treatment are “accepted where they’re at”. Treatment is giving in the form of education, in safer drug use practice, protected sexual practices, maintaining secure housing, receiving adequate nutrition, and developing support networks (Mancini et. al.).
Tiderington et. al. (2011) cites Lee & Petersen (2009) and states that harm reduction treatment reaches high-risk populations by “normalizes” and “destigmatizing” their behaviors rather than limiting their ability to continue treatment as found in drug abstinence programs. This behavioral change is incremental and is based on the idea that consumers are more likely to change their behavior if they feel they have power to shape their goals and enact them (Roger & Ruefli, 2004).

The principles of harm reduction as recognized, by the Harm Reduction Coalition which is a national advocacy and capacity-building organization that promotes the health and dignity of individuals and communities impacted by drug use are as follows:

- Accepts, for better and or worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects, rather than simply ignore or condemn them.
- Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.
- Establishes quality of individual and community life and well-being—not necessarily cessation of all drug use—as the criteria for successful interventions and policies.
- Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.
- Ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.
- Affirms drugs users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies which meet their actual conditions of use.
- Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people’s vulnerability to and capacity for effectively dealing with drug-related harm.
- Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use. (Harm Reduction Coalition, 1996)

**Benefits of Harm Reduction**

It has been indicated that harm reduction goals exist on a continuum that include “staying alive,” “maintaining health,” and “getting better” “(Lee, et al, 2011). Consumers of harm reduction practices state that they are looking for common ground, “feeling know, “the importance of talk” And feeling like somebody” (Tiderington et. al. 2011). Above all harm reduction is considered a client centered practice that does not impose expectations or goals on the client (Denning & Little, 2012). A study was done to examine what drug users are looking for when they contact drug treatment services: abstinence or harm reduction and it was discovered that most individuals cited a desire to reduce drug use (Denning & Little, 2012, Mckeganey et al, 2004). Lastly it has been indicated that harm reduction based treatment challenges the “one-size-fits-all” approach to assisting people with substance use problems (Lee, et al, 2011).
According to Denning and Little (2012) harm reduction is prevalent in three major areas in the United States which include public health, advocacy and treatment. Denning and Little argue that this is creating a shift in public policy that is changing drug policy and the belief that drug and alcohol concerns are health matters not issues to be addressed by the criminal justice system. However, Denning and Little continue to argue that American attitudes about drug and alcohol use are based on misinformation and biases and this has led to a zero tolerance in relation to substance abuse thus leaving no room for non-abstinence based models such as harm reduction. According to Duff (2009) stresses that all drug use behaviors are mediated by diverse social, political and economic processes. Illustrating these ecological forces Denning and Little state that people who are unemployed are three times more likely to use drugs than those who are employed full time. Given the complexities of harm reduction, it is vital to understand the most common assumptions. MacMaster (2004) cites Des Jarlais(1995), Drucker (1995), Harm Reduction Coalition (1996), Scavuzzo (1996), Springer (1991) (1996), van Laar, de Zwart, & Mensink (1996) in implementing five assumptions of harm reduction:

1. Substance use has and will be part of our world; accepting this reality leads to a focus on reducing drug-related harm rather than reducing drug use.
2. Abstinence from substances is clearly effective in reducing substance-related harm, but it is only one of many possible objectives of services to substance users.
3. Substance use inherently causes harm; however, many of the most harmful consequences of substance use (HIV/AIDS, hepatitis C, overdoses, automobile accidents, and so forth) can be eliminated without complete abstinence.
4. Services to substance users must be relevant and user friendly if they are to be effective in helping people minimize their substance-related harm.

5. Substance use must be understood from a broad perspective and not solely as an individual act; accepting this idea moves interventions from coercion and criminal justice solutions to a public health and social work perspective.

It has been indicated that harm reduction is congruent with social work values because the primary responsibility of social workers’ is to promote the well-being of clients (Mac Masters, 2004). Further the NASW Code of Ethics contains no ethical obligations for social workers to require their clients to remain abstinent to obtain services (NASW, 2008). According to Duff (2010) the primary action of harm reduction is to offer hope to individuals who suffer from substance use as well prime an individual for change. Further an ethical factor of social work is to enhance clients’ capacity and opportunity to change and to address their own needs (NASW, 2008). One question that remains unanswered about the application of harm reduction practices is whether harm reduction interventions perpetuate or enable clients to maintain actions that pose a serious, foreseeable, and imminent risk to themselves or others (Mac Masters, 2004).

Some current treatment options that are based on the principle of harm reduction are as follows:

*Methadone treatment.*

- Methadone maintenance reduces and/or eliminates the use of heroin, reduces the death rates and criminality associated with heroin use, and allows patients to improve their health and social productivity.
Enrollment in methadone maintenance has the potential to reduce the transmission of infectious diseases associated with heroin injection, such as hepatitis and HIV.

*Use of less harmful drugs for more harmful ones.*

- For example, replacing methamphetamine (meth) use with tobacco use would be beneficial in that tobacco is a substance that is not as mind altering as meth. Tobacco use is also legal and, therefore, would lead to less social problems such as incarceration in comparison to meth use.

*Testing illegal drugs for users.*

- It is important for the user to know if a substance that they purchase is pure or has been altered with other substances that may be life threatening. For example, a person who injects methamphetamine into their blood stream would be at higher risk of fatality if meth was laced with another illegal substance.

*Drug decriminalization/legalization through legislation.*

- Instead, of punishing individuals for using illegal substances by incarceration, they should be required to participate in a treatment program tailored to their individual needs. In addition, substances, such as marijuana, which are beneficial to some individuals for medical reasons should be legalized in U.S. counties.

*Controlled drinking/drug use though behavior modification.*

- Motivational interviewing is one example of an intervention that uses behavior modification. This intervention recognizes the stages of change model, which
accepts that change in behavior is incremental and that treatment should be modified depending on the stage of change that the individual is in. (Escamilla & Mancera, 2008 cites Inaba & Cohen, 2000, p.382).

**Challenges to Harm Reduction**

One of the largest challenges to the harm reduction model is the ambiguity about the practice (Mancini et. al., 2008). Mancini argues that harm reduction is an atheoretical approach informed by a public health model that has no universal definition (Mancini et. al., 2008). Further complicating the appearance of harm reduction are the interventions that are applied to different populations. Mancini et. al., 2008 cites Denning (2001), Erickson (1995), & Marlatt (1996) and states that harm reduction is best described as a constellation of interventions. These constellations look very different when applied to HIV/AIDS, supportive housing, and alcohol and drug use and could be misconstrued as enabling poor behavior (Duff, 2010).

Professionals who work in harm reduction environments are often faced with ambiguity in accepting non-abstinence based model of substance use treatment (Mancini et. al., 2008). Largely because harm reduction moves away from traditional abstinence-only models. Mancini (2008) argues that providers must be able to practice flexibility and accept a reduction of harmful behaviors as a legitimate outcome for clients. Further that these views can become problematic for staff that actively participate in their own recovery and are asked to tolerate substance use behaviors thereby leaving the clients caught between two opposing views (Mancini et. al., 2008). Lee (2011) argues that more
research is needed to advance understanding of the ways in which providers are responding to the emergence of the harm reduction model.

**Harm Reduction in Dual Diagnosis**

The National Association of Social Workers identifies adults who are homeless and have co-occurring disorders such as substance use and mental illness as an extremely vulnerable population (Sun & An-Pyng, 2012). In order to create an environment for individuals who often fail in high threshold abstinence housing programs a harm reduction model of supportive housing was created (Tiderington, et al, 2011). This environment was designed to help homeless individuals transitioning from active use of substances into a supportive living environment that encourages a reduction of substances based on a therapeutic alliance between a provider and consumer (Little & Frankskoviak, 2010). There are key challenges that face individuals with dual diagnosis’s who access these types of services, such as psychiatric, legal, and health problems that inhibit recovery (Mancini et. al., (2008); Drake et al., 2003; Rach Beisel, Scott & Dixon, 1999).

According to Denning & Little (2012) 29 % of the population with a mental disorder will also have an alcohol or drug disorder as well. A study was done which revealed that individuals with a dual disorder often have a longer more serious course of illness and are vulnerable to homelessness and victimization (Denning & Little 2008). Given these factors Mancini et al 2008 argues that continuous engagement in high-quality comprehensive services integrated with substance abuse treatment are vital for clients with dual disorders. Other problems that complicate treatment of individuals with co-occurring disorders is they often do not possess the behavioral and cognitive skills
necessary to be successful in highly rule laden environments (Mancini, 2008). This is where the conceptual framework and philosophy of service and treatment styles reinforce practitioners placing abstinence at the far end of acceptable outcomes for clients (Mancini, 2008).

Permanent supported housing has been identified as a central approach to reducing homelessness among individuals with psychiatric and/or substance use problems (O’Connell, 2013). A recent study was done among veterans to examine subgroups of abstinent and nonabstinent individuals who live in supportive housing and it was discovered that active substance users at the time of housing were able to retain their housing as well as abstinent clients (O’Connell, 2013). According to Duff (2010), enabling environments help increase individual function, promote health and creates a conduit for resource delivery. Housing-first approaches theorize that by providing active substance users with housing with no requirement of sobriety will help the individual successfully exit homelessness and reduce their substance use (O’Connell, 2013).

Conclusion

This literature review presented the emergence of harm reduction and its widespread use among diverse populations and treatment modalities. The primary themes address the role of abstinence and non-abstinence based approaches to treatment with clients who present conditions of dual diagnosis. It explained the challenges and benefits of harm reduction and the role that harm reduction plays in reducing homelessness among adults with psychiatric disabilities and substance use disorders. It is evident from the literature review that understanding the challenges to supportive housing from the
perspectives of professionals who employ the dimensions of integrated, abstinence and harm reduction approaches in their practice, is necessary to strengthen the service delivery to the homeless individuals who present dual diagnosis and mental health issues.
Chapter 3

METHODS

This chapter presents the methods used to conduct the study; process of data collection, and Human Subjects protocol. The purpose of this study was to interpret how professional perspectives about harm reduction influence the implementation of this practice with dually diagnosed adults who live in supportive housing. Some professionals embrace an abstinence only approach while other professionals understand that tolerance about substance use may lead to housing retention and recovery. It is the existence of these two vastly different philosophies held by case managers and support persons that make it critical for researchers to examine these ideologies and these impacts in supportive housing.

Study Objectives

Do conflicting ideologies about harm reduction held by case managers and support staff create difficulties in the implementation of harm reduction in supportive housing environments? This question was explored through secondary data offered by the agency that surveyed case managers and support persons who have direct contact with dual diagnosed individuals who live in supportive housing. The questions centered on their beliefs about harm reduction and abstinence only approaches.

Sampling Procedures

This study used secondary data from a study conducted by the agency in which sample constituted case managers and support staff from a community based mental
health provider. The subjects of the study sample constituted four different educational backgrounds who responded to the questionnaire: those who had finished high school, those who had an undergraduate degree, those who had a graduate degree, and those with a doctoral degree. The respondents ranged in age from 18 to 65 or older and self-identified as Latino, Black or African American, Asian, Hawaiian or Other Pacific Islander, and Caucasian. All respondents identified as either male or female and had experience in human services ranging from 0 to 10 years or more. The secondary research question was to explore the amount of training professionals received about harm reduction.

**Study Design**

The design of the study is quantitative secondary data analysis utilizing survey research. The tool used by the agency for this data collection used questionnaire containing Likert scale type questions along with three open-ended questions. Quantitative data makes it easier to aggregate, compare, and summarize data and the use of secondary data analysis created an efficient medium for researchers to facilitate timely research. Qualitative data is employed to add a richer meaning to open-ended questions because the depth in meaning would be lost in quantitative calculation (Babbie, 2004). The combinations of these two types of data in a single study are widely accepted among professional researchers today (Babbie, 2004).

**Data Collection Procedures**

A questionnaire was used to gather data for this study (Appendix A). The questionnaire consisted of 33 questions, which were designed to elicit responses about
harm reduction and its use in permanent supportive housing. The first three questions consisted of gathering demographic information such as age, gender, and race. The following two questions identified respondent’s educational level and length of employment in human services. The following 28 questions dealt with perceptions and attitudes towards harm reduction and the abstinence only approach. The last two questions provided respondents an opportunity to provide researchers with suggestions to improve harm reduction and a chance to comment on what they felt the questionnaire did not cover.

The questionnaire was adapted from a study Dr. Michael A. Mancini, St. Louis University School of Social Work did on the Challenges to Implementing the Harm Reduction Approach in 2008. The researchers of this current study added demographic questions, and open-ended questions to help quantify and qualify the answers given by the respondents. The 28 questions related to attitude and perception asked the participants to rate their agreement with each statement by choosing one of five responses: strongly agree, agree, unsure, disagree, and strongly disagree. These questions were designed to elicit respondent’s ideology between abstinence only and the harm reduction approach. The last two open-ended questions were used by the researches in the hope that given the vast diversity and wealth of available knowledge by the respondents would generate possibilities about harm reduction and abstinence that the researches had not considered. It also created a vehicle in which respondents could freely express the thoughts and concerns about harm reduction and abstinence.
Process Data Collection

A community based mental health provider’s research specialist e-mailed the questionnaire to the study subjects via Survey Monkey. The CSUS researchers were involved in the creation of the questionnaire because of their expert knowledge in the harm reduction approaches. But the agency was responsible for collecting the data. The researchers were given permission to utilize the data for the purposes of the completion of their Master’s project. There was no identifying information about the participants in the data provided by the agency.

Data Analysis

Once the questionnaires were completed, the researchers utilized descriptive statistics to analyze the data. For all the nominal variables about demographics, frequencies, summaries and cross tabulations were run. For all ordinal variables such as agreement of supportive staff, that were measured on the likert scale, associations and other estimations were used. Interval level variables were analyzed using the scores on the scale in relation to support for supportive housing and perceptions about supportive housing. T – Tests were conducted to examine differences between group categories and perceptions regarding harm reduction.

Protection of Human Subjects

The protocol for the Protection of Human Subjects was submitted and approved on September 26, 2013 by the Division of Social Work as Approved as Exempt 13-14-004. The community-based organization administers surveys routinely and follows its own approved protocol for doing so within the state guidelines of human subject’s
protection. There was no identifying information about the participants in the data provided by the agency. The agency’s researchers followed all protocols of ethical research (Sacramento County) which includes voluntary participation and informed consent. The agency has access to the data and the data was provided to the researchers for the purpose of analysis. All data was stored in a locked cabinet. Once the researchers completed analyzing the data it was returned to the agency. The agency follows a strict protocol for maintaining its data.
Chapter 4

STUDY FINDINGS AND DISCUSSION

In this chapter the author presents the findings from the study on helping professionals’ perspectives on knowledge and challenges to harm reduction as an approach in stable housing among clients of dual diagnosis. It is organized into demographics, and overall findings and specific findings. The participants in the study were employed by a community-based human services agency in the greater Sacramento area. Ethnic backgrounds of the respondents included Latino, American Indian, Alaska Native, Native Hawaiian, Other Pacific Islander, Asian, Black or African American, and White. The age of respondents ranged from 18 to 65 or older. The respondents reported educational backgrounds from GED to PhD, and reported years worked in human services from under one year to ten years or more.

Figure 1

Age of respondents in years
Overall Findings

Table 4.1

<table>
<thead>
<tr>
<th>Can you please state your gender?</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete abstinence is the only goal of treatment for alcohol and substance abuse.</td>
<td>female</td>
<td>60</td>
<td>3.8000</td>
<td>1.20451</td>
</tr>
<tr>
<td>male</td>
<td>15</td>
<td>3.7333</td>
<td>1.16292</td>
<td>.30026</td>
</tr>
</tbody>
</table>

Researchers conducted an independent samples t-test to infer the statistical significance of the differences in the mean scores on agreement with the statement, “Complete abstinence is the only goal of treatment for alcohol and substance abuse” on a scale of 1-5 between male and female professionals who offer services to clients with mental health needs. The analysis indicated that although there is no statistical significance due to the very small mean difference between the scores of the two group's professionals on their agreement with statements that are counter indicative of harm reduction’s applicability. The small difference between the two groups (.066) could be attributed to the difference in the size of the groups with 60 females and 15 males. This is non random sample and therefore the data has limited internal and external validity as well.
When researchers estimated a correlation matrix between the variables relevant to understanding the professionals’ perceptions regarding harm reduction and its relevance for meeting life’s challenges among the mental health clients, there were statistically significant relationships observed.

### Table 4.2
Bivariate Correlations between professionals’ perceptions on harm reduction

<table>
<thead>
<tr>
<th></th>
<th>Abstinence is a achievable goal</th>
<th>Acceptance of substance use has no place in treatment</th>
<th>You cannot help a person with addictions if you tolerate the use of substances</th>
<th>Recovery means complete abstinence from drugs and alcohol</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pearson Correlation</strong></td>
<td>1</td>
<td>-.121</td>
<td>-.269*</td>
<td>-.665**</td>
</tr>
<tr>
<td><strong>Sig. (2-tailed)</strong></td>
<td></td>
<td>.300</td>
<td>.020</td>
<td>.000</td>
</tr>
<tr>
<td><strong>N</strong></td>
<td>75</td>
<td>75</td>
<td>75</td>
<td>75</td>
</tr>
<tr>
<td><strong>Acceptance of substance use has no place in treatment</strong></td>
<td><strong>Pearson Correlation</strong></td>
<td>-.121</td>
<td>1</td>
<td>.389**</td>
</tr>
<tr>
<td><strong>Sig. (2-tailed)</strong></td>
<td>.300</td>
<td></td>
<td>.001</td>
<td>.015</td>
</tr>
<tr>
<td><strong>N</strong></td>
<td>75</td>
<td>75</td>
<td>75</td>
<td>75</td>
</tr>
<tr>
<td><strong>You cannot help a person with addictions if you tolerate the use of substances.</strong></td>
<td><strong>Pearson Correlation</strong></td>
<td>-.269*</td>
<td>.389**</td>
<td>1</td>
</tr>
<tr>
<td><strong>Sig. (2-tailed)</strong></td>
<td>.020</td>
<td>.001</td>
<td></td>
<td>.000</td>
</tr>
<tr>
<td><strong>N</strong></td>
<td>75</td>
<td>75</td>
<td>75</td>
<td>75</td>
</tr>
<tr>
<td><strong>Recovery from substance abuse means complete abstinence from drugs and alcohol.</strong></td>
<td><strong>Pearson Correlation</strong></td>
<td>-.665**</td>
<td>.280*</td>
<td>.464**</td>
</tr>
<tr>
<td><strong>Sig. (2-tailed)</strong></td>
<td>.000</td>
<td>.015</td>
<td>.000</td>
<td></td>
</tr>
<tr>
<td><strong>N</strong></td>
<td>75</td>
<td>75</td>
<td>75</td>
<td>75</td>
</tr>
</tbody>
</table>

* Correlation is significant at the 0.05 level (2-tailed).
** Correlation is significant at the 0.01 level (2-tailed).
significant correlations as listed below. There was a strong ( -.665), negative, statistically significant p<(.001) correlation between the responses to the following statements: You cannot help a person with addictions if you tolerate the use of substances and Abstinence is a reasonable and achievable goal for all people. Null hypothesis: There is no relationship between education and adherence to the harm reduction’s implementation in serving clients with dual diagnosis. Research hypothesis ( H1) Education of the professionals and scores on the scale that measures the adherence to harm reduction philosophy are related.

Table 4.3

Mean difference on adherence to harm reduction scores between groups with different educational levels.

<table>
<thead>
<tr>
<th>Equal variances assumed</th>
<th>Levene's Test for Equality of Variances</th>
<th>t-test for Equality of Means</th>
<th>95% Confidence Interval of the Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F  Sig.</td>
<td>t  df  Sig.</td>
<td>Mean</td>
</tr>
<tr>
<td>Equal variances assumed</td>
<td>.0  .891</td>
<td>1. 62  .109</td>
<td>-7.47246</td>
</tr>
<tr>
<td>Equal variances not assumed</td>
<td>2. 60.282</td>
<td>.015</td>
<td>-7.47246</td>
</tr>
</tbody>
</table>
In other words, higher the education, higher the scores on the scale that measures adherence to harm reduction principles in practice. When researchers divided the respondents into two groups of those with educational levels of Bachelor’s degree and those with Master’s and doctoral degrees into two groups and estimated the difference in the mean scores on the harm reduction scale between these two groups, it was established that when one tailed estimation rule was used, there was statistical significance at (p= .05).

<table>
<thead>
<tr>
<th>Race1</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00</td>
<td>Minorities</td>
<td>46</td>
<td>50.1522</td>
<td>20.40367</td>
</tr>
<tr>
<td>2.00</td>
<td>Caucasian</td>
<td>28</td>
<td>45.3929</td>
<td>6.10003</td>
</tr>
</tbody>
</table>

When the researchers estimated mean score differences between professionals who identified themselves as belonging to Caucasian groups and those who identified themselves as African American, Asian, Latino, Native Hawaiian or Pacific Islander, American Indian or Alaska Native, and White there was a mean difference of 4.75 in the score on harm reduction scale with the maximum score (99). Furthermore, despite the lack of statistical significance the difference may be attributed to education, years of experience or general orientation to practice and abstinence as a method for success in drug treatment. This relationship may be indicative of the need for impact of culture in the professionals’ approach to treatment modalities.
<table>
<thead>
<tr>
<th>Statement</th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstinence is an achievable goal for all people.</td>
<td>75</td>
<td>1.00</td>
<td>5.00</td>
<td>2.6400</td>
<td>1.12274</td>
</tr>
<tr>
<td>Acceptance of substance use has no place in treatment.</td>
<td>75</td>
<td>1.00</td>
<td>5.00</td>
<td>4.2000</td>
<td>.85424</td>
</tr>
<tr>
<td>You cannot help a person with addictions if you tolerate the use of substances.</td>
<td>75</td>
<td>1.00</td>
<td>5.00</td>
<td>3.9333</td>
<td>.97722</td>
</tr>
<tr>
<td>Recovery from substance abuse means complete abstinence from drugs and alcohol.</td>
<td>75</td>
<td>1.00</td>
<td>5.00</td>
<td>3.3067</td>
<td>1.20778</td>
</tr>
<tr>
<td>Relapse is a natural phase of the treatment process.</td>
<td>75</td>
<td>1.00</td>
<td>5.00</td>
<td>3.9600</td>
<td>.96479</td>
</tr>
<tr>
<td>A legitimate goal of treatment is to help people reduce their substance use to a level that allows them to function effectively in society.</td>
<td>75</td>
<td>2.00</td>
<td>5.00</td>
<td>4.1600</td>
<td>.54624</td>
</tr>
<tr>
<td>Harm Reduction is not an effective approach for substance abuse.</td>
<td>75</td>
<td>1.00</td>
<td>5.00</td>
<td>4.2933</td>
<td>.85065</td>
</tr>
<tr>
<td>The harm reduction approach is dangerous.</td>
<td>75</td>
<td>1.00</td>
<td>5.00</td>
<td>4.0400</td>
<td>.77877</td>
</tr>
<tr>
<td>Harm reduction strategies encourage drug and alcohol use.</td>
<td>75</td>
<td>1.00</td>
<td>5.00</td>
<td>4.0000</td>
<td>.75337</td>
</tr>
<tr>
<td>People diagnosed with psychiatric disabilities and addictions can benefit from harm reduction approach.</td>
<td>75</td>
<td>1.00</td>
<td>4.00</td>
<td>3.2400</td>
<td>.56569</td>
</tr>
<tr>
<td>The harm reduction approach is effective in retaining individuals in treatment.</td>
<td>75</td>
<td>1.00</td>
<td>5.00</td>
<td>3.9200</td>
<td>.71206</td>
</tr>
<tr>
<td>Valid N (listwise)</td>
<td>75</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Specific Findings

Table 4.5

<table>
<thead>
<tr>
<th></th>
<th>legitimate</th>
<th>effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>legitimate</td>
<td>Pearson Correlation</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.001</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>75</td>
</tr>
<tr>
<td>effective</td>
<td>Pearson Correlation</td>
<td>.363**</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.001</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>75</td>
</tr>
</tbody>
</table>

**. Correlation is significant at the 0.01 level (2-tailed).

A statistically significant (p<.01) moderate (.363) positive correlation between the scores was found on the following statements: A legitimate goal of treatment is to help people reduce their substance use to a level that allows them to function effectively in society and Harm reduction is not an effective approach for substance abuse. This may be indicative of the emergence of supportive housing environments, changes in treatment modalities such as strengths based approach and widespread acceptance of the mental health recovery model.
Recovery from substance abuse means complete abstinence from drugs and alcohol.

Secondary data analysis indicates that a majority of professionals in this study have moved away from traditional beliefs that recovery can only mean complete abstinence from drugs and alcohol. This is in sharp contrast to the 12 Steps tradition which calls for an abstinence only approach to treatment and recovery. Further complicating this is the abundance 12 step programs dominating the treatment paradigm at a perspective 60 to 75% (Lee, et al, 2011). This is further illustrated in table 4.7 which shows a tolerance of substance use among treatment professionals.
The chief complaint about harm reduction is that that harm reduction enables increased substance use, advocates drug legalization, and that it fosters stagnation (Lee et al, 2011). If this were true about harm reduction then the logical conclusion would be to expect to see treatment professional having a view that harm as dangerous. The secondary data indicates that only a few participants hold a view that the approach is dangerous. Further the data indicates that a majority of participants hold the view that harm reduction is an effective approach for substance abuse as illustrated in table 4.8. This is in contrast to the study conducted by Mancini et. Al in 2008 which suggested that professionals who work in harm reduction environments are often faced with ambiguity in accepting non-abstinence based model of substance use treatment because harm reduction moves away from traditional abstinence-only models.
Figure 4

Harm reduction is not an effective approach for substance abuse.

The majority of participants disagreed with the statement that you cannot help a person with addictions if you tolerate the use of substances. In a review of the literature researchers discovered that professionals who are actively participating in their own recovery can often become caught between two opposing views in relation to tolerance. Understandably, a professional participating in an abstinence only 12-step approach to their own recovery would develop a measure of dissonance while being asked to tolerate the substance use of their clients. Lee (2011) argues that more research is needed to advance understanding of the ways in which providers are responding to the emergence of the harm reduction model. The secondary data from this study indicates that there is greater tolerance than intolerance among professionals in the greater Sacramento area.
I believe that housing services should NOT be contingent upon abstinence.

Data from the study illustrated that among professionals who were surveyed there was a greater dispersion as in related to the belief that housing services should not be contingent upon abstinence. This is counter to previous research indicating that enabling environments help increase individual function, promote health and creates a conduit for resource delivery (Duff, 2010). Table 5.1 illustrates the further ambiguity that exists among professionals as it relates to the effectiveness of harm reduction in retaining individuals in treatment.

Summary

Data indicates that participants struggled with housing services being contingent upon abstinence but agreed overwhelmingly that the harm reduction approach was effective in retaining individuals in treatment. O’Connell argued in 2013 that housing-
first approaches theorize that by providing active substance users with housing with no requirement of sobriety will help the individual successfully exit homelessness and reduce their substance use. This study has highlighted the value of harm reduction from the perspectives of service providers who work with the population of clients diagnosed with both mental illness and substance abuse.
Chapter 5
CONCLUSIONS AND RECOMMENDATIONS

This study was designed to elicit professional perspectives about the use of harm reduction in permanent supportive housing with adults having a dual diagnosis. A local human services agency sent out surveys as a part of their data collection. The agency had seventy-five professionals participate in the study form the Sacramento area. The agency provides counseling and support services to homeless and formerly homeless individuals. A survey consisting of twenty-five likert scale and two opened ended questions were designed to elicit information about their professional perspectives as it related to their experience working directly with individuals in supportive housing environments. The design of the study was descriptive secondary data analysis utilizing survey research and the conclusions of this study are limited due to a small sample size and having secondary data from only one agency.

Summary of Study

The major findings of this study indicate that most participants supported the use of harm reduction as an approach that was effective in retaining individuals in treatment. A majority of the professions surveyed believed that tolerance of substance use was a part of the helping process and most believed that harm reduction was an effective approach for managing, treating and preventing substance abuse. There was a lack of congruence among professionals about whether recovery from substance abuse meant complete abstinence from drugs and alcohol. Despite this incongruence there was agreement among professionals that the harm reduction approach was not counterproductive or
delayed the progress of recovery. Many participants felt that more training about harm reduction was needed. Others felt that harm reduction was not a treatment but a way to keep individuals in supportive housing environments. Lastly there was no statistical significance between male and female professional views of the statement “Complete abstinence is the only goal of treatment for alcohol and substance abuse,” but the level of education and professional adherence to the harm reduction philosophy were related.

It was expected that trained professionals working in human services would have a tolerance towards substance use in supportive housing environments because that is how these environments were designed to function. Equally important is the distinction between professionals who see abstinence as a goal and those who see abstinence as a requirement of recovery. A major assumption of the study was, “case manager relationships with their clients are influenced by many factors but personal beliefs about substance use can be detrimental to client outcomes.” The data collected does not support this assumption but the data seems to show that there is some ambivalence between professionals who embrace a 12-step model of recovery and those who embrace tolerance of substance use as a bridge towards recovery. It is apparent that these two belief systems held by professionals are present in supportive housing but the research indicates that there is little impact to the clients. This is supported by the majority of the professionals that agreed that harm reduction is not counterproductive or that harm reduction delays recovery.

The second major assumption of the study was that, “educating case managers and support staff about the primary function of harm reduction in supportive housing can
improve client outcomes.” Participants in the study responding to the question, “Can you please provide the researchers with your suggestions about improving harm reduction” provided significant feedback related to education about harm reduction. One participant stated, “Offering harm reduction oriented classes and supportive meetings for clients at housing sites would be helpful so that there is an alternative to strict recovery programs like AA and NA.” Another responded, “The harm reduction approach needs to be demystified for line staff and consumers alike. Specific training about what the aims and techniques of this approach entail would be most useful.” Many more of the participants called for more training and education related to the aspects of harm reduction. One respondent seemed to embrace both the 12-step model and harm reduction by stating, “I think increased training in harm reduction would be beneficial as I have observed positive behavioral changes in the life of a client with dual diagnosis who would not have made gains with complete abstinence due to delusions. There are some clients who would benefit from complete abstinence due to the inability to comprehend the content in the programs offered at drug treatment. Harm reduction has more flexibility and I suggest more education for the providers, clients, and within the community.”

Overall, the participants in the study were accepting of the harm reduction model but many felt that more work is needed to educate professionals and the public about why harm reduction is necessary. A major question that was left unanswered by the study was “What is the agreed upon definition of “recovery” when applied to individuals recovering from both a substance use issue and a mental health challenge.” It is clear the word
“recovery” is highly subjective and carries different meanings for both clients and professionals.

**Recommendations**

Based on these findings, the researchers recommend harm reduction be addressed in the following ways; develop ways to address the apparent lack of knowledge about harm reduction among professionals and encourage non-profits serving adults in supportive housing to partner with the Substance Abuse & Mental Health Services Administration (SAMHSA) to create an awareness campaign designed to educate the general public about the practice of harm reduction thereby reducing the stigma associated with the practice. By addressing these two factors, the researchers believe that harm reduction can evolve into an acceptable practice embraced by professionals and the public.

At the micro level of social work practice, it is imperative that professionals accept the harm reduction is about little steps made by the client that lead to a quality of life that most individuals have not enjoyed due to chronic homelessness. Harm reduction is a strengths approach that has been empirically tested and is evidence based. Harm reduction is a model that can be applied to other populations including individuals suffering from trauma, veterans, and those suffering from eating disorders. At the Mezzo, level of social work practice a client’s family needs to be integrated into the process of recovery. Housing is only the first step for clients working towards recovery. Often individuals who have been chronically homeless have lost contact with family members due to aggressive symptoms of mental health and substance abuse. Social workers need
to educate family members about the disease of addiction and provide psycho education about the client’s mental health diagnosis thereby reducing stigma.

At the Micro level of social work practice, more research needs to be done about the outcomes of individuals who participate in supportive housing environments. There is an apparent lack of longitudinal research being done in these environments because goals for participants are centered on retaining housing and reducing the homeless population. Current supportive programs contribute to stagnation of clients because the housing environment becomes more of a containment center for homelessness rather than offering a way out of supportive housing. Many programs have rules in place that prevent community members from taking more than six units at local colleges. The explanation for this policy is that housing providers want to discourage individuals at supportive housing sites from using this environment as a college dormitory. Programs need to be developed to encourage graduating from supportive housing back into independent living.

Researches suggest that a three-tier program be developed and implemented in supportive housing sites. Tier-one residents would be the entry level as supportive housing is designed currently. Tier-two residents would have sought out significant progress in controlling substance use and managing their psychiatric challenges. Graduates to this level would be offered smaller housing communities, intensive case management, and be encouraged to seek out educational opportunities. These graduates would become per-mentors for residents in tier-one housing. Tier-three residents would be offered individual town homes in the community and ultimately graduate form
supportive housing all together. Tier-three residents would act as peer counselors to residents in both tier-one and tier-two.

Training programs about harm reduction should be put in place for all workers that choose to work in supportive housing sites. Providers that have a clear understanding about the goals and the purpose of harm reduction are more likely to collaborate with clients and create clearer and more attainable goals. The egalitarian nature of a relationship by a professional who can fully embrace harm reduction will ameliorate inherent power struggles because the professional can accept tolerance about substance use as an acceptable part of recovery.

**Implications for Social Work**

Based on this study the researchers have identified the following implications for social work practice. The National Association of Social Workers (NASW) states in its ethical responsibilities to clients that “Social workers’ primary responsibility is to promote the wellbeing of clients” (NASW, 2008). Regardless of personal beliefs it is up to an ethical social worker to “promote clients’ socially responsible self-determination” (NASW, 2008). In this case, harm reduction allows the client to engage in his or her own decision-making process. Social workers embracing the Strengths Perspective as part of their practice underpin supporting a client’s ability to make choices thereby validating the recovery process.

The major principle of the Strengths Based approach in supportive housing environments is that it reduces the power and authority barrier between client and case manager by placing the case manager in the role of partner or guide. This reduces the
perceived parental role the client may have about their case manager. A secondary benefit of the Strengths Based approach is reducing the stigma for a client participating in supportive housing programs. Many of the participants in supportive housing programs have struggled with oppression and shaming due to their diagnoses. An ethical case manager can reduce the amount of shame and stigma a client endures by supporting their decision to engage client centered services or not. Recovery is a choice in these supportive environments not a requirement.

By conducting this research on harm reduction, the researchers have identified the following social work competencies. The Council on Social Work Education (2008) states in Educational Policy 2.1.4 that “social workers understand how diversity characterizes and shapes the human experience and is critical to the formation of identity.” The research shows that individuals in supportive housing environments have been subject to chronic homelessness and have been denied basic experiences that bolster self-esteem and self-worth and it is critical that these individuals encounter professionals that can demonstrate empathy and recognize how chronic homelessness has impacted their lives. The Educational Policy goes on to state “Social workers recognize the extent to which a culture’s structures and values may oppress, marginalize, alienate, or create or enhance privilege and power” (CSWE, 2008). The research in this study construes that a culture of homelessness, addiction, and poverty exists among individuals who seek out supportive housing environments thus creating a vast power differential between provider and client. It is important that social workers acknowledge this perceived imbalance
because not doing so creates opportunities to further stigmatize and oppress this venerable population.

**Conclusion**

The purpose of this study was to explore professionals’ perspectives about the use of harm reduction in permanent supportive housing environments. In particular, this study looked at how professionals view abstinence and its role in recovery. Largely, the participants agreed that harm reduction is a necessary component in supportive housing, but some professionals struggled with the meaning of recovery. Some professionals embraced the abstinence only approach as the only true meaning of recovery while other professionals embraced tolerance of substance use. Overall, the participants felt that more education about harm reduction and its role in supportive housing should be implemented. Areas for further study include longitudinal research as it relates to client success and considering a change to how supportive housing is structured.
APPENDIX A

Questionnaire

1. Can you please state your gender?
   ○ 1. Female
   ○ 2. Male
   ○ 3. Transgender
   ○ 4. Decline to state

2. Can you please select an age range?
   ○ 18 to 24
   ○ 25 to 34
   ○ 35 to 44
   ○ 45 to 54
   ○ 55 to 64
   ○ 65 to 74
   ○ 75 or older

3. Can you please state you race? Mark one or more.
   ○ White
   ○ Black or African American
   ○ Asian
   ○ Native Hawaiian or Other Pacific Islander
   ○ American Indian or Alaska Native
   ○ Latino
   ○ Other

4. How many years have you worked in human services?
5. What is your educational background?
   - GED
   - High School
   - Some college
   - A.A. Degree
   - Bachelors
   - Masters
   - PhD

6. Complete abstinence is the only goal of treatment for alcohol and substance abuse.
   
   Strongly agree   Agree   Unsure   Disagree   Strongly disagree

7. Abstinence is a reasonable and achievable goal for all people.
   
   Strongly agree   Agree   Unsure   Disagree   Strongly disagree

8. Acceptance of substance use has no place in treatment.
   
   Strongly agree   Agree   Unsure   Disagree   Strongly disagree

9. You cannot help a person with addictions if you tolerate the use of substances.
10. Recovery from substance abuse means complete abstinence from drugs and alcohol.

11. You can't help someone recover by tolerating drug use in any way.

12. Relapse is a natural phase of the treatment process.

13. A legitimate goal of treatment is to help people reduce their substance use to a level that allows them to function effectively in society.

14. Harm reduction is not an effective approach for substance abuse

15. The harm reduction approach is dangerous.

16. The harm reduction approach is an effective form of treatment.
17. Harm reduction strategies encourage drug and alcohol use.

Strongly agree  Agree  Unsure  Disagree  Strongly disagree

18. People diagnosed with psychiatric disabilities and addictions can benefit from harm reduction approach.

Strongly agree  Agree  Unsure  Disagree  Strongly disagree

19. People diagnosed with serious psychiatric disabilities and addictions can benefit from harm reduction approach.

Strongly agree  Agree  Unsure  Disagree  Strongly disagree

20. I believe that housing services should NOT be contingent upon abstinence.

Strongly agree  Agree  Unsure  Disagree  Strongly disagree

21. The harm reduction approach is effective in retaining individuals in treatment.

Strongly agree  Agree  Unsure  Disagree  Strongly disagree

22. The harm reduction approach is a valid and useful treatment modality.

Strongly agree  Agree  Unsure  Disagree  Strongly disagree

23. The harm reduction approach doesn't make people accountable for their behavior.

Strongly agree  Agree  Unsure  Disagree  Strongly disagree
24. The harm reduction approach supports drug use.

Strongly agree    Agree    Unsure    Disagree    Strongly disagree

25. I believe that permanent supportive housing should be reserved for those willing to achieve/maintain abstinence.

Strongly agree    Agree    Unsure    Disagree    Strongly disagree

26. I feel that I am adequately trained in the harm reduction approach.

Strongly agree    Agree    Unsure    Disagree    Strongly disagree

27. I feel that I fully understand the harm reduction approach.

Strongly agree    Agree    Unsure    Disagree    Strongly disagree

28. I need more training in the harm reduction approach.

Strongly agree    Agree    Unsure    Disagree    Strongly disagree

29. I have serious concerns about the level of training I have received to work effectively with this population.

Strongly agree    Agree    Unsure    Disagree    Strongly disagree

30. I have personally witnessed positive life changing effects of the harm reduction being used in permanent supportive housing.

Strongly agree    Agree    Unsure    Disagree    Strongly disagree
31. My contact with client's that live in supportive housing sites which practice the use of harm reduction is

☐ I do not have direct contact with client's
☐ I have limited contact with client's
☐ I supervise those who have direct contact with client's
☐ I have daily contact with client's

32. Can you please provide the researchers with your suggestions about improving harm reduction?

33. Please provide any recommendations or feedback about harm reduction that you feel has not been covered.
References


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doi:10.1080/10428230903301394