

COME AS YOU ARE: THE ACCEPTABILITY OF HARM REDUCTION APPROACHES
FOR OPIOID USE DISORDER AMONG PROFESSIONAL COUNSELORS

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ABSTRACT

Over the last two decades, the Opioid Epidemic has caused immense harm to communities nationwide. Over 400,000 fatal opioid overdoses occurred in the United States between 1999 and 2017 (CDC, 2019). Professional counselors are among the front-line treatment providers addressing substance use, including Opioid Use Disorders. Professional counselors have a unique professional identity that is built upon humanistic values, a commitment to social justice, and client empowerment. These values align closely with contemporary approaches to substance use treatment, including harm reduction strategies. Harm reduction is an approach to substance use treatment that involves mitigating risks and improving the quality of life of individuals, regardless of their willingness or ability to stop using substances. There are several harm reduction strategies that reduce the risk of fatal opioid overdose or secondary harms of opioid use specifically, including medication-assisted treatment and the distribution of naloxone for overdose reversal. This study examined the acceptability of harm reduction strategies for Opioid Use Disorder among addiction treatment professionals, with a focus on professional counselors. In addition to measuring the level of acceptance of harm reduction for Opioid Use Disorder among professional counselors, counselors were also compared to other professionals who treat substance use. Predictors of acceptability of harm reduction for Opioid Use Disorder were examined based on overlapping components of professional counseling identity and harm reduction philosophy among professional counselors as well.

The results of this study provided a baseline for the level of harm reduction acceptance among counselors who treat substance use. Counselors did not have higher levels of harm reduction acceptance for OUD compared to social workers with advanced degrees or bachelor's level substance use treatment providers. Social justice attitudes and empathy were statistically significant predictors of acceptance among counselors. This research indicates that these two factors are key components of counselor identity that explain harm reduction acceptance. The findings of this study highlight a need for more research about harm reduction acceptance for OUD among counselors, including further examination of provider factors that influence acceptance and examination of a broader array of professionals. This research contributed to the understanding of how professional counselors perceive novel approaches for addressing Opioid Epidemic.

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GENERAL AUDIENCE ABSTRACT

The Opioid Epidemic is a public health crisis that has led to hundreds of thousands of overdose deaths over the last two decades. Counselors are among the treatment professionals addressing substance use in the United States, including responding to the Opioid Epidemic. Harm reduction is a unique approach to substance use treatment that focuses on keeping people who use substances alive and healthy, regardless of their ability or intent to stop using substances. The current study sought to explore the perceptions of harm reduction strategies for people who use opioids among counselors, including comparing their attitudes to other professionals and exploring the impact of their professional identity. Counselors were not found to be more accepting of harm reduction than other professionals who treat substance use and social justice and empathy were key aspects of counselor professional identity that predicted accepting attitudes towards harm reduction. More research is needed to understand how counselor identity affects harm reduction perceptions.

DEDICATIONS

For Leslie, Parker, and Owen

I cannot imagine this journey without you. Thank you for believing in me, making me laugh, and reminding me what matters most. I love you all to the heart.

I also want to dedicate this work to the millions of people affected by the Opioid Epidemic, especially those who have died from overdose, as well as those who have lost a loved one.

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CHAPTER ONE: INTRODUCTION

The Opioid Epidemic in the United States has caused devastating harm to communities nationwide, including contributing to over 400,000 overdose deaths over the last 20 years and major social consequences (CDC, 2018). Professional counselors throughout the United States are working alongside other front-line treatment professionals to treat individuals who are at-risk of harm due to opioid use. Harm reduction approaches for the treatment of individuals with symptoms of Opioid Use Disorder (OUD) include Motivational Interviewing, medication-assisted treatment, the distribution of Naloxone for overdose reversal (and education about overdose prevention), needle exchange programs, educating users about safe drug use practices, housing first programs, distributing Fentanyl testing kits, safe consumption sites, and supporting client goals that do not include abstinence from opioids (Collins et al., 2011; Moro & Burson, 2018). Professional counselors are among the front-line providers in the field of addictions treatment and have a professional identity that includes parallels to harm reduction philosophy, such as humanistic and social justice values. These professional values align well with the use of co-constructed harm reduction goals for clients with OUD. There is an urgency to reduce the harms of the Opioid Epidemic, given the staggering loss of life attributed to these addictions, as well as the ripple effects caused by opioid addiction in families and communities nationwide. Simply put, no one who dies from a fatal opioid overdose will have the opportunity to recover and live a full, productive life. This study was designed to improve our understanding about how professional counselors who treat addictions perceive strategies for addressing the Opioid Epidemic, including their perceptions of efficacious harm reduction strategies.

Context for Study

The Opioid Epidemic

The Opioid Epidemic is currently a major focus of drug policy in the United States, as Americans are now more likely to die due to an opioid overdose than injuries sustained in a car crash (National Safety Council, 2019). While this public health crisis has emerged during the last two decades due to the proliferation of prescription opioids (Ruhm, 2019), there is now an impetus to find ways to save lives and reduce the harm to users, their families, and society. Opioid use and fatal opioid overdoses are an epidemic and a public health crisis in the United States due to the number of lives lost and immense harm to society (Centers for Disease Control and Prevention [CDC], 2018). In 2017, 47,600 people died via fatal opioid overdose, contributing to a total of over 400,000 fatal opioid overdoses in the United States between 1999 and 2017 (CDC, 2018). Researchers are now seeing a shift from prescription opioid misuse towards illicit heroin and Fentanyl use (Seth, Rudd, Noonan, & Heagerich, 2018), which is related to tightening regulations around the prescribing of opioid medications (Pitt, Humphreys, & Brandeau, 2018). Despite policies aimed at reducing the number of prescriptions written for opioids and increasing access to OUD treatment, fatal opioid overdose rates have continued to rise each year for two decades (CDC, 2018). Fatal opioid overdoses and the societal harms of the Opioid Epidemic are motivators for finding effective treatment strategies and ensuring that providers are engaging in evidence-based practices.

Each fatal opioid overdose is more than a statistic, as it represents a person who had relationships with friends, family members, and communities that were impacted by their death. Individuals who die from opioid overdoses will never have the chance to recover from OUD. There are also secondary harms of the Opioid Epidemic to communities that include drug-related crimes involving users and sellers, loss of employment by users, harm to pregnant mothers with

OUD and their children, family strain and child-parent separation caused by addiction, the societal costs of incarceration due to illegality of opioid use without a prescription, and the cost of treatment episodes for people with OUD (Denning & Little, 2012). Costly treatments for OUD include outpatient therapies, intensive community-based programs, and residential treatment that often involves detoxification (Denning & Little, 2012). The dramatic impact the Opioid Epidemic is having on American society motivates professionals who treat addiction to consider the full array of efficacious treatment options that can be individually tailored for each person struggling with opioid use.

Professional Identity and the Role of Counselors in Addressing the Opioid Epidemic

Professional counselors are trained to provide services to clients with addictions and are seeing high numbers of clients with substance use disorders (Lee, 2014). Many masters-level counseling programs now require a course in addictions and substance use interventions for their students (Lee, 2014). Prioritizing addictions treatment curriculums is driven by the Council for Accreditation of Counseling and Related Programs (CACREP) criteria for addiction and substance use knowledge and training for counselors-in-training in clinical mental health counseling programs (2.F.3.d., 5.C.1.d, 5.C.2.e.; 2016). CACREP has also developed specific standards for programs certified with Addictions Counseling specialization (5.A.; 2016). Additionally, many states offer licensure or certification in addictions counseling, as well as national organizations offering credentials for professional counselors focused on addictions treatment (Astramovich & Hoskins, 2013). There are currently 343 CACREP-accredited Clinical Mental Health Counseling programs and 10 accredited Addictions Counseling programs (CACREP, 2019). Counselors work alongside allied professionals in addressing addictions via psychotherapeutic interventions, including social workers and psychologists (Vakharia & Little,

2017; W.R. Miller & Brown, 1997), as well as bachelors level providers and peer recovery specialists (Hagedorn, Culbreth, & Cashwell, 2012). Each of these professions has a unique role to play in substance use treatment. Counselors working within this spectrum of substance use professionals have a unique professional identity grounded in humanism and empathy, with an emphasis on social justice advocacy.

Humanistic Foundations and Empathic Understanding

Professional counseling has developed an identity that is built upon humanistic principles (Hansen, Speciale, & Lemberger, 2014) and multiple scholars have described the unique professional identity of counselors among mental health professionals (Grazzola & Smith, 2007; Cureton, Davis, & Giegerich, 2019; Mellin, Hunt, & Nichols, 2011; Ronnestad & Skovholt, 2003). Moss, Gibson, and Dollarhide (2014) found that counselor professional identity development is facilitated via training programs, supervision, and interactions with clients. In another study, Mellin et al. (2011) described professional counselors as distinguishing their identity from social workers and psychologists, with counseling being a “unified profession” with a “developmental, prevention, and wellness orientation toward helping” (p. 144-145). Related to addictions counseling, Simons, Haas, Massella, Young, and Toth (2017) explored a sample of certified alcohol and drug counselors in Pennsylvania, finding that nearly half of the providers had a professional identity that superseded the identity associated with their certification. Simons et al. (2017) noted that providers with addictions counseling certifications likely have other professional identities stemming from their training discipline. These studies illuminate that the substance use treatment field is made up of a diverse array of professionals who often have professional identities that are aligned, yet separate, from their role in substance use treatment systems.

A humanistic philosophy of healing in psychotherapy can be traced back to the work of Carl Rogers, who developed the process of client-centered therapy (1951). Rogers described three “necessary and sufficient conditions” for therapeutic change: accurate empathy, authenticity, and unconditional positive regard (1957). Rogers consistently reinforced the importance of empathic understanding between the therapist and the client, pointing to empathy as an essential precursor for client change in therapy (1975). Rogers’ idea of an empathic way of being facilitating strong therapeutic alliance and fostering positive outcomes for clients has been supported by research over the past few decades (Norcross & Wampold, 2011). Given that empathic relationships with clients are a key component of the humanistic foundations of professional counseling, it is worthwhile to explore how counselor’s empathic responding traits influence acceptance of harm reduction approaches for treating OUD.

Professional counselors working in the addiction treatment field have been trained in a discipline that has humanistic epistemological foundations. Vereen, Hill, Sosa, and Kress (2014) described the relationship between humanism and counseling as “synonymic”, highlighting that this congruence “emerges from the emphasis counselors place on relationality, development, empowerment, wellness, and social justice” (p. 192). Indeed, professional counseling emerged as a distinct discipline in the late 20th century, paralleling the arrival of humanism as the “third force” in psychotherapy (Hansen et al., 2014). Dollarhide and Oliver (2014) further clarified that counselors are humanistic in that they focus on empathy, treat clients as the experts about their own lives and change process, respect their clients’ individuality, and empower clients to take action in their lives. The emphasis on empathy is important to highlight, as there is evidence that this quality in counselors has a large impact on outcomes and reduces resistance to change among clients (Moyers & W.R. Miller, 2013; Norcross & Wampold, 2011). Empathy and

authentic, mutual connection in the counseling relationship are also seen as key components of humanistic approaches. These two defining features of humanistic counseling have influenced the evolution of approaches related to Rogers' Person-Centered Counseling, including Relational-Cultural Theory/Therapy (Jordan, 2010), the existential approach to psychotherapy (Yalom, 1980), and Motivational Interviewing (W.R. Miller & Rollnick, 2013). Humanism as a distinct component of counselor identity informs the use of specific interventions with clients who struggle with substance use, including using empathy as a tool for positive change.

The humanistic foundations of the counseling profession influence the way these counselors support clients struggling with addictions. By aligning treatment approaches with clients' desires for change, counselors show respect to their clients and forge a unified path towards positive outcomes (Sommers-Flannagan, 2015). Counselors are important providers within the addiction treatment field, working alongside social workers and psychologists in providing psychotherapy. Counselors treating substance use problems collaborate with physicians treating substance use with medications (Roy & M. Miller, 2012) and peer recovery professionals (White, 2004; Hagedorn et al., 2012), as well as community organizations that provide access to healthcare, housing, and other resources. Although the counseling profession is grounded in humanistic principles, counselors working with people with substance use disorders often integrate cognitive-behavioral approaches, Twelve Step philosophy, and confrontational strategies (Quinn, Bodenhamer-Davis, & Koch, 2004). While empathy may be a component of developing therapeutic alliance with other approaches, interventions based on humanism value empathic connection between counselor and client as the keystone of the therapeutic process. This study sought to explore how counselors perceive approaches designed to facilitate growth

and the change process for clients with OUD, including reducing the risk of serious harm or fatal opioid overdose.

Social Justice

Social justice is relevant for counselors treating people who use substances, including those with OUD, given that opioids and other substances are criminalized, with many users facing severe consequences of use, possession, or distribution. Drug laws have historically been enforced unevenly, with minorities, including Black and Brown Americans, being more likely to be arrested and facing harsher sentences than White drug users (Fellner, 2009). Additionally, the criminalization of the use of certain substances is a social justice issue in itself, as the choice to use substances could be addressed via a public health approach. A public health approach would reduce the secondary harm of criminal penalties and lingering social consequences of a criminal record for substance users (Walthers, Weingardt, Witkiewitz, & Martlatt, 2012). A public health approach would treat substance use as a health issue that is not criminalized or moralized, but it would instead focus on connecting users to treatment and support services (Walthers et al., 2012). Counselors working with clients who use substances consider the systemic injustices these individuals face and, if working from a social justice perspective, advocate for changes in the way substance users are treated by society.

Multiculturalism and social justice are considered to be the fourth and fifth forces within the counseling profession (Ratts, 2009), with foci on competence and sensitivity towards diverse populations and advocacy for systemic changes to mitigate the impact of historical injustices, respectively. Beyond counseling, Young (2001) spoke about social justice as a philosophy that supports structural equality in society, emphasizing that it is a worldview that goes beyond specific issues. Social justice must be, instead, a broad view of the need for a just society for all,

according to Young (2001). Social justice is an increasingly prevalent aspect of professional counselor identity, with the American Counseling Association supporting the development of advocacy competencies (Toporek, Lewis, & Crethar, 2009) and competencies for multicultural and social justice counseling (Ratts, Singh, Nassar-McMillan, Butler, & McCollough, 2016). Social justice in counseling involves the awareness of systemic injustices and oppression in society, how those forces impact the well-being of counseling clients, and counselors being called to advocate by taking action to address these injustices on behalf of individuals they serve, in their communities, and in society at-large (Crethar & Winterowd, 2012; Ratts et al., 2016). In describing the humanistic foundations of professional counseling, Vereen et al. (2014) includes social justice as central element of professional counseling identity. While social justice as an aspect of counselor identity has emerged in the last 15 to 20 years, it has become a transformational movement within the counseling profession, as evidenced by the implementation of competencies and influence on professional ethics (Ratts et al., 2016; American Counseling Association, 2014). Humanism and social justice are aspects of professional counselor identity that are aligned with harm reduction philosophy.

Harm Reduction Philosophy

Harm reduction is a pragmatic approach to helping substance users that focuses on improving quality of life, rather than pursuing abstinence from substances as a primary goal (Collins et al., 2011). Tatarsky (2003) described harm reduction as “a paradigm-shifting idea that has the potential to significantly improve the treatment of problem substance users” (p. 249). Collins et al. (2011), as well as Moro and Burson (2018), noted that harm reduction approaches to substance use remain controversial due to concerns about enabling users’ high-risk behaviors. Accessing a nationally representative sample via phone surveys, McGinty et al. (2018) found

that only 29% of Americans support legalizing safe consumption sites, while only 39% support legalizing needle exchange programs. Despite negative societal perceptions of certain harm reduction approaches, the Centers for Disease Control and Prevention (CDC) identifies several harm reduction approaches as evidence-based practice for preventing opioid overdose, including needle exchange, targeted Naloxone distribution for opioid overdose reversal, and medication-assisted treatment (Carroll, Green, & Noonan, 2018). These programs focus on reducing the risk of fatal opioid overdose, health problems related to substance use, and helping individuals meet other needs, such as housing, while acknowledging that many people will continue to engage in high-risk opioid use. Collins et al. (2011) noted that, although harm reduction is seen at odds with abstinence-based treatment programs, these are not dichotomous approaches to change, as abstinence is the appropriate outcome for many substance users for whom sobriety is their chosen goal. The main objective of harm reduction is to improve quality of life and minimize the harm of substance use, even for individuals who cannot or will not stop using substances (Moro & Burson, 2018; Collins et al., 2011). Harm reduction definitions have included components of social justice and advocacy (Harm Reduction Coalition, n.d.), as well as humanism, empathy, and compassion (Collins et al., 2011; Denning, 2001). The harm reduction philosophy is a shift away from a focus on the morality of substance use and is a novel approach to working with people who use substances. Harm reduction philosophy and specific programs are a departure from traditional abstinence-based treatment substance use treatment models (Collins et al., 2011).

Traditional Substance Use Treatment: Twelve Step and Confrontation

Psychotherapeutic interventions for addiction have evolved during the last century, although foundations of the Twelve Step philosophy have remained influential. Developed

during the 1930's, the Twelve Steps are an approach to substance use recovery that emerged from Alcoholics Anonymous, a collection of community-based, peer-led, self-help groups (Alcoholics Anonymous, 2019). From this perspective, people are considered in recovery from addiction if they are now abstinent from substances of abuse. These recovery support groups are rooted in spirituality and the idea that people with addictions must admit that they are powerless over their addiction, before having transformative experiences to achieve sustained abstinence (Le, Ingvarson, & Page, 1995). The Twelve Step approach to recovery has spread widely among the addiction recovery community beyond alcoholism and has been utilized in many addictions' treatment programs during the last century (Quinn et al., 2004). Bristow-Braitman (1995) noted that cognitive-behavioral strategies have been used in conjunction with Twelve Step tenets in many substance use treatment programs. These programs supplement the Twelve Steps' focus on fellowship and surrender with realistic goal setting, craving management strategies, and the development of behavior-oriented relapse prevention plans (Bristow-Braitman, 1995). A central component of the Twelve Step philosophy is the idea that abstinence from all substances of abuse is necessary and the preferred outcome for people with substance use problems (it should be noted that cigarette smoking and caffeine consumption are known to be common occurrences at Alcoholics Anonymous meetings, which may relate to social norms). Twelve Step principles have become foundational components of many drug treatment programs (Quinn et al, 2004), although there are concerns about the effectiveness of using these principles and that this approach is contradictory to key aspects counselor identity (J.C.Miller, 2008). J.C. Miller (2008) writes, "Therapeutic alliance (e.g. Kohlenberg et al. 2004) and unconditional positive regard are considered important and primary predictors of positive therapeutic outcome; yet 12-Step approaches utilize and instill moral culpability, deviance and labeling" (p. 572). Similarly, Le et

al. (1995) suggested that this style of substance use treatment is in conflict with core values of the counseling profession, mainly due to the focus on powerlessness and character flaws.

Emerging approaches to supporting substance users, such as harm reduction, must be contextualized within the historical context of the addiction treatment field.

Confrontation and coercion are common in addictions counseling, partially because many clients are mandated for treatment due to legal issues and face severe consequences if drug use continues (Sullivan et al., 2008). J.C. Miller (2008) argued that Twelve Step principles are antithetical to professional counseling ideals, as these principles support confrontational techniques and a focus on moral shortcomings. White and W.R. Miller (2007) described the historical underpinnings of confrontation as a key strategy in addictions counseling being intertwined with the conceptualization of addiction as a moral deficiency. Further, White and W.R. Miller (2007) pointed to Alcoholics Anonymous and associated confrontational treatment philosophies exacerbating the stigmatization of people with addictions as being dishonest and manipulative. Based on a review of studies, White and W.R. Miller concluded that there is no evidence that these approaches lead to positive outcomes for substance use clients (2007). J.C. Miller (2008) alleged that this approach to changing substance use behaviors involves clinicians asserting authority and power over struggling clients. J.C. Miller's perspective was that this approach is incongruent with empathy, self-efficacy, and empowerment (2008), which are key counseling values. White and W.R. Miller (2007) noted that confrontational approaches are associated with poor outcomes in addiction counseling, including higher rates of dropping out of services, lower self-esteem, and lower abstinence rates. Moyers and W.R. Miller (2013) provided evidence that counselor empathy is closely tied to positive client outcomes in addiction treatment, including increased treatment engagement and higher abstinence or use reduction

rates. The findings of these reviews of studies are consistent with evidence that the therapeutic relationship and counselor empathy, as perceived by the client, are strong predictors of positive counseling outcomes (Norcross & Wampold, 2011). Longshore and Teruya (2005) found that client readiness and resistance were important factors for outcomes of substance use treatment, with resistance potentially being amplified by confrontational treatment program content.

Concerns about alignment between confrontation and counseling identity, as well as the potential for increasing client resistance to change, are relevant as counselors choose intervention strategies for substance use. Confrontational approaches to substance use treatment, associated with the Twelve Steps, contrast with contemporary treatment philosophies focused on enhancing motivation and collaborative goal setting.

Motivational Interviewing and Contemporary Treatment Options

Many counselors who treat substance use are shifting from confrontational approaches to Motivational Interviewing, a more humanistic and collaborative approach to client change. This empirically supported approach is a tailored application of humanistic counseling well-suited for addiction treatment and is taught regularly to counselors-in-training (Miller & Rollnick, 2013). More than a set of strategies, Motivational Interviewing is a way of being with clients that involves collaborative decision-making (Miller & Rollnick, 2013). Developed during the 1990s, Motivational Interviewing could be considered more modern and aligned with the identity of professional counselors when compared to Twelve Step and confrontational approaches. Evidence suggests Motivational Interviewing is effective in treating addictions with an array of substances, populations, and settings (DiClemente, Corno, Graydon, Wiprovnick & Knoblach, 2017). Importantly, Motivational Interviewing is recognized as an evidence-based practice for addictions treatment by SAMHSA (2018). Motivational Interviewing strategies for substance use

counseling do not assume that abstinence from one's drug of choice or all substances is the appropriate outcome for the client, given that treatment outcomes are mutually developed between counselor and client (Denning & Little, 2012). Motivational Interviewing offers counselors an approach to addiction counseling that is non-confrontational and efficacious.

Medication-assisted treatment is an empirically supported intervention for OUD that involves medications (buprenorphine, methadone, and/or naltrexone) in conjunction with counseling. These interventions for OUD are supported by SAMHSA (2018) and the CDC (Carroll et al., 2018) as evidenced-based practices for preventing fatal opioid overdose. Bart (2013) summed up the significant benefits of these medications based on a review of research, stating that medication-assisted treatment "reduces mortality, improves social function, and is associated with decreased drug use and improved quality of life" (p. 218). These medications help manage cravings and, in some cases, curb euphoria if opioids are misused, which helps people with opioid addiction avoid illicit use. There is strong evidence that medication-assisted treatment should be incorporated for clients with Severe OUD, although the use of these medicines is often seen at odds with abstinence-based treatment programs and Twelve Step ideology (Monico et al., 2015). Monico et al. (2015) note that members of Narcotics Anonymous (a Twelve Step support network modeled from Alcoholics Anonymous) who are prescribed methadone for OUD treatment are barred from holding positions within the organization and are not given credit for being sober. Counselors working with physicians prescribing medicines to curb withdrawals and cravings for opioids are intervening in a manner that is consistent with efficacy research for OUD treatment.

Twelve Step and confrontational approaches are seen as traditional treatment strategies in substance use treatment, while Motivational Interviewing and harm reduction are seen as

paradigm shifts in the field (Tatarsky & Kellogg, 2012). Professional counselors inform their work with a variety of counseling theories, but the profession has humanistic foundations that value client empowerment and holistic wellness (Hansen et al., 2014; Kaplan, Tarvydas, & Gladding, 2014), as well as an awareness of social justice issues (Toporek, Lewis, & Crethar, 2009). These ideals and the identity of the counseling profession are compelling reasons to explore counselors' perceptions of novel strategies for responding to the Opioid Epidemic.

The Benefits of Integrating Harm Reduction into OUD Treatment

Motivational Interviewing and medication-assisted treatment are within the spectrum of harm reduction approaches for opioid and other addiction treatment. Denning and Little (2012) situate Motivational Interviewing within the framework of harm reduction psychotherapy.

Counselors working from a harm reduction foundation focus on supporting clients in improving their quality of life and avoiding significant harm, such as overdose death, without abstinence from substances as an expected outcome or prerequisite for treatment (Collins et al., 2011).

While it is possible that medication-assisted treatment providers or practitioners using Motivational Interviewing may prefer abstinence as an end-goal of treatment, their approach is focused on meeting clients with OUD where they are in the change process and reducing harm. In addition to medication-assisted treatment and Motivational Interviewing, harm reduction for OUD includes the distribution of the overdose reversal medication Naloxone to opioid users (and teaching overdose prevention strategies), "housing first" programs that provide housing without requiring abstinence, distributing kits to test illicit opioids for Fentanyl contamination, safe consumption sites for users of these drugs, and needle exchange programs (Moro & Burson, 2018; Collins et al., 2011). Several of these services are recognized by the CDC as evidence-based practices for preventing opioid overdose (Carroll et al., 2018), including needle exchange,

medication-assisted treatment, and Naloxone distribution. These programs have efficacy in improving outcomes for opioid users and can be important tools for counselors working to enhance the quality of life for their clients.

Harm reduction is considered an alternative and controversial approach when compared to traditional, abstinence-based approaches to treating substance use (Moro & Burson, 2018). Denning and Little (2012) pointed to the United States' history of prohibition and stigmatization of drug use as reasons that harm reduction treatment is seen as controversial. Counselors who are not discouraging all drug use when treating addictions may be perceived as condoning drug use and enabling users (Moro & Burson, 2018). Harm reduction is often seen at odds with abstinence-based "success" measures for substance use treatment, although Collins et al. (2011) diminished this dichotomy, pointing to abstinence as appropriate for individuals who chose those goals for themselves. Counseling has been described as a humanistic profession (Hansen et al., 2014), which values client autonomy and co-constructed outcome goals, congruent with harm reduction's focus on improving quality of life based on collaborative goal setting and pragmatism (Collins et al., 2011). Additionally, congruent with social justice counseling values, harm reduction approaches acknowledge systemic and social influences in how substance users are treated based on their use, race, ethnicity, age, gender, and other factors (Harm Reduction Coalition, n.d.). Pursuing alignment with client goals, whether that involves stopping drug use or not, allows counselors to engage clients who might otherwise avoid treatment or remain resistant if mandated (Denning & Little, 2012).

Statement of the Problem

Despite growing evidence regarding the efficacy of harm reduction approaches, there remains a need to understand counselors' perception of these strategies for addressing

problematic opioid use. First and foremost, counselor perceptions are consequential, given that counseling professionals have influence on their clients' utilization of these life-preserving services. Second, counselors may choose to advocate for increased access to these services for clients with OUD if they find these programs as acceptable approaches to care. There is currently a lack of research about attitudes towards harm reduction for opioid use among addiction treatment providers trained as professional counselors. If harm reduction approaches are effective and practical strategies for addressing problematic opioid use, it is important to explore how counselors perceive programs like needle exchange, Naloxone distribution, and medication-assisted treatment, in addition to exploring their willingness to integrate harm reduction principles in psychotherapy (Denning and Little, 2012). This necessity arises from professional counselors' roles as front-line substance use treatment providers during an increasingly harmful epidemic of opioid use and fatal opioid overdoses. As literature increasingly validates the efficacy of these approaches in preserving the lives of opioid users and creating positive change for individuals and communities, researchers will benefit from identifying the attitudes of front-line addiction treatment providers. These attitudes are relevant, as they likely impact if counselors discuss or recommend harm reduction programs to their clients.

What are the Implications of these Perceptions?

Harm reduction utilization and perceptions among professional counselors may influence their approach to client change and the referrals considered for clients. Denning and Little (2012) connected harm reduction psychotherapy to a belief that clients should determine the best outcomes for themselves. Harm reduction is also humanistic, as therapists integrating this philosophy relinquish any authority they have over their clients, ensuring egalitarian collaboration towards treatment goals (Tatarsky & Kellogg, 2012; Denning & Little, 2012).

Denning and Little (2012) encouraged therapists integrating harm reduction in psychotherapy to embrace the fundamental healing power of relationships. These ideals evoke comparison to Rogers' focus on empathy and trust in the client's process towards change (1975), which is noteworthy given Rogers' stature as one of the founders of the humanistic counseling movement (Hansen et al., 2014). Moro and Burson (2018) discussed the offering of harm reduction strategies to substance using clients as "unconditional affirmation", which closely parallels Rogers' description of unconditional positive regard as a necessary condition for client change (1957). Collins et al. (2011) directly linked harm reduction and humanism, stating, "Harm reduction reflects a humanistic perspective: people will make more health-positive choices if they have adequate support, empowerment, and education" (p. 6). Collins et al. (2011) also noted that harm reduction for high risk behaviors, including substance use, draws heavily on social justice frameworks, with a goal of mitigating secondary harms of policies aimed at people who use substances. There is a need to understand how the humanistic focus on empathic responding to clients and the valuing of social justice within the counseling profession influence harm reduction acceptability, as these philosophies seem to have harmonious values. While attempting to explore client-counselor gender and ethnic congruence, Florentine and Hillhouse (1999) found that counselor empathy was a better predictor of client outcomes in a substance use treatment program than shared gender or ethnicity. Given this prior research showing that empathy influences outcomes in substance use treatment, there is a need for further exploration. This study strives to clarify how professional counselors who treat substance use perceive the harm reduction approaches and programs for OUD, including how this aligns with empathic responsiveness and social justice attitudes among counselors.

It is possible that counselors with a strong professional identity, including valuing empathy and social justice in their approach to client change, may be more accepting of harm reduction approaches for problematic opioid use. Goddard (2003) found that addiction treatment professionals scored higher on a measure of harm reduction acceptability after a two-hour presentation on these interventions and approach, regardless of prior treatment philosophy. Moyers and Miller (2013) proposed screening addictions counselors for empathic listening skills to maximize client outcomes, as their analysis of multiple studies suggested that counselor empathy is a “moderately strong predictor of substance abuse treatment outcomes” (p. 880). Moyers and Miller (2013) also described multiple studies that link confrontational or authoritarian approaches with no change or adverse client outcomes. Norcross and Wampold (2011) pointed to empathy, an aspect of therapeutic responsiveness, as having evidence in influencing client change. Clark (2004) described objective empathy developing based on understanding of a reference group, such as a population that shares a diagnosis or cultural heritage. Clark (2004) also described interpersonal empathy developing from direct exposure to another person’s experiences and subjective interpretations. These two dimensions of empathy development in Clark’s model (2004; 2010) of empathy speak to the possibility that counselors who experience more exposure to clients with OUD will have higher levels of empathy for these individuals. Despite the potential for amplified empathic responses with more exposure to a client issue, researchers have documented compassion fatigue as a phenomenon in which more time spent caring for high need individuals leads to less empathy for those individuals (Thompson, Amatea, & Thompson, 2014). Counselor experiences and training, as well as exposure to harm reduction strategies and people with OUD, may have an influence harm reduction acceptability among counselors.

Providing access to the full array of programs that benefit people with OUD is an aspect of social justice values in counseling, as this means removing barriers to health and well-being for opioid users. Harm reduction acknowledges that individuals who use substances are inherently valuable and deserve appropriate care, even if they are “unable or unwilling to stop using substances” (Harm Reduction International, 2019, para. 8; Moro & Burson, 2018). Substance using individuals are likely to experience varying levels of motivation and readiness to make or sustain changes over time, which supports the importance of therapeutic alliance based on trust and mutuality. Recognizing fluctuations of motivation to reduce or avoid substance use is consistent with Motivational Interviewing and fits with the self-deterministic groundings of this approach. Often people with OUD will have intersecting identities (e.g., race, religion, gender identity, age) that may exacerbate distrust of the traditional substance use treatment system or increase marginalization and social stigma. Harm reduction offers these individuals an alternative, low threshold access to services that benefit their well-being, prevent fatal opioid overdose, and address multidimensional wellness needs. Congruent with harm reduction philosophy, counselors working from a social justice perspective would strive to understand the perspectives and worldview of people with OUD who may or may not want to pursue abstinence, offering interventions that match those client needs and perspectives.

A major concern is that addiction counselors who have negative perceptions of harm reduction may not offer the full array of treatment options to a client. These counselors may further stigmatize opioid using clients who are unable or unwilling to pursue abstinence from opioids or all substances. One example was studied in Australia in the early 1990s, as Caplehorn, Lumley, Irwig, and Saunders (1998) found that provider perceptions of methadone treatment did have an impact on client outcomes (this study also focused on the influence of public policy

changes with methadone, which influenced public acceptance of methadone treatment). Misconceptions about harm reduction may inhibit counselors from referring clients to programs, even those deemed evidence-based in preventing fatal opioid overdose by the CDC (Carroll et al., 2018). Working from a harm reduction base allows counselors to provide options that improve users' quality of life, such as needle exchange or a housing first program (providing housing without requiring abstinence from substances). In contrast, an abstinence-focused counselor recommending Narcotics Anonymous or detox to clients who are not wanting abstinence is not likely to lead to client follow through and effective intervention. In this way, harm reduction can facilitate therapeutic alignment with clients who are unable or unwilling to pursue abstinence. This is especially important, as many people who use substances experience changes in motivation for change over time, based on the stages of change model (Prochaska, DiClemente, & Norcross, 1992). By focusing on interventions that sustain therapeutic alliance and match the client's current motivation and goals for change, the counselor avoids stigmatizing the substance using client or pushing them away (Ryan, Lynch, Vansteenkiste, & Deci, 2011). For example, a counselor working from a harm reduction approach would likely refer a heroin-injecting client who is not ready to stop using to needle exchange and encourage the client to carry Naloxone and use in proximity to other users able to administer that medication. The counselor and client would then collaborate in determining what changes the client would like to make to improve their quality of life. This example demonstrates the contrasts between a traditional abstinence-based approach to treating OUD and a harm reduction treatment philosophy. This study built upon prior research of harm reduction perceptions among treatment providers, while providing a specific focus on professional counselors.

Prior Research About Harm Reduction Perceptions

Prior research has explored addiction treatment providers' perceptions of specific harm reduction strategies for working with substance using clients. Rosenberg and Davis (2014) explored a nationwide sample of addiction clinicians' acceptance of non-abstinence goals and found most clinicians were not accepting of these goals. In this study, acceptability of non-abstinence varied based on the substance a client might be using, with more acceptance of moderation with cannabis and alcohol, compared to heroin, cocaine, or other illegal substances. Studies have found similar patterns of non-acceptance of moderation goals among providers treating clients with both mental health and substance use diagnoses (Davis, Rosenberg, & Rosansky, 2017) and among undergraduate and graduate students in programs offering specialization in addiction studies (Davis & Lauritsen, 2016). Henwood, Padgett, and Tiderington (2014) found that front-line providers in housing programs for people with substance use disorders welcomed harm reduction and tolerated ambiguity well, although providers in abstinence-only programs were less aware of harm reduction as an option. This research contributes to the knowledge base of how addiction treatment providers perceive specific harm reduction approaches.

Similar studies have shown that addiction treatment providers' perceptions of harm reduction strategies do not always align with what is accepted as evidence-based practice for OUD. Bonar and Rosenberg (2010) compared attitudes towards harm reduction treatment for injection drug users, including providing clean needles, with abstinence-based approaches among clinicians and program directors of substance use programs. Harm reduction programs were consistently rated as less beneficial than traditional approaches for clients who inject drugs by these professionals. This is an example of research that shows a divide between which treatments are perceived as acceptable by providers and treatment methods for OUD backed by evidence,

given that the CDC lists needle exchange as an evidence-based practice for preventing opioid overdose (Carroll et al., 2018). With a focus on treatment of OUD, Aletaris, Edmond, Paino, Fields, and Roman (2016) explored clinician attitudes towards two opioid treatment medications. They found that buprenorphine was more acceptable to providers than Methadone and that Twelve Step orientations were negatively associated with the acceptability of these medications. Further research is needed to clarify which provider factors influence these perceptions, including exposure to clients with OUD, professional and personal experience, discipline of professional training, and theoretical orientation.

Other studies on harm reduction approaches have focused on perceptions of drug users. A community-participatory study with people who inject drugs in Canada, where there is better access to harm reduction programs than the United States, found that users faced barriers to access these programs (Boucher et al., 2017). The barriers cited by intravenous drug users included stigma from providers and society at-large. Intravenous drug users in this study did utilize personal harm reduction strategies within and outside of structured programs. Personal strategies included moderating use or helping other users to boost self-esteem, while participants also accessed medication-assisted treatment and free health clinics for harm reduction (Boucher et al., 2017). Collins et al. (2015) found that homeless individuals with alcohol dependency set harm reduction goals related to alcohol use, quality of life, and health needs. These participants focused on reducing consumption and avoiding negative consequences of drinking alcohol. Research about substance users' perceptions and utilization of harm reduction strategies reinforce the importance of knowing if providers commonly accept and support these goals.

Each of these studies provides evidence about the current state of harm reduction perceptions among addiction treatment professionals. There is a pattern of providers having

negative views of harm reduction goals and treatment programs (Bonar & Rosenberg, 2010; Davis & Rosenberg, 2014; Davis, Rosenberg, & Rosansky, 2017). Additionally, there is research showing that clients who use substances are utilizing harm reduction programs and use personal strategies for harm reduction. Currently, there is a dearth of research on professional counselors' acceptance of harm reduction and how their professional identity influences their perceptions of these interventions. This study aims to address that gap in the existing literature.

The Lack of Research About Professional Counselors' Perceptions of Harm Reduction

Existing research has focused on the acceptance of harm reduction amongst substance use treatment providers broadly, while there is a gap in research exploring perceptions of harm reduction among professional counselors. For instance, prior studies sampled peer recovery specialists, bachelor's level recovery coaches, master's level social workers and counselors in combination, doctoral level psychologists, and medically trained professionals (Rosenberg & Davis, 2014; Davis et al., 2017; Aletaris et al., 2016). There is a lack of research narrowing the focus to master's level professional counselors' attitudes towards harm reduction approaches for problematic opioid use. Two studies found that professional counselors have somewhat positive views of harm reduction, especially for counselors not ascribing to Twelve Step philosophy and among counselors with eclectic theoretical orientations (Kyser, 2010; Madden, 2016). The counseling profession values a humanistic approach that emphasizes empathic relationships as a core aspect of healing (Hansen et al., 2014; Dollarhide & Oliver, 2014). These values align professional counseling with a harm reduction approach to treatment, including respecting autonomy and co-constructing therapeutic goals with clients (Tatarsky & Kellogg, 2012; Denning & Little, 2012). In addition, professional counseling identity includes social justice competency and awareness of client marginalization (Ratts et al., 2016). Similarly, harm

reduction seeks to diminish barriers to well-being that are exacerbated by the marginalization of drug users, including those with OUD (Denning & Little, 2012). This overlap in values is worth exploring, as prior studies have shown some evidence for differences in acceptability of harm reduction approaches based on level of training (Rosenberg & Davis, 2014) and the theoretical identity of treatment providers (Goddard, 2003; Bonar & Rosenberg, 2010). While some discussion about the acceptability of harm reduction for psychologists (Wryobeck & Rosenberg, 2005) and social workers (Vakharia & Little, 2017) exists in the literature, research focused on professionals trained as counselors is notably lacking. There is also a need for research on perceptions of harm reduction specific to opioid use issues. Professional counselors are often in similar “front line” positions for treating addiction and their perceptions of harm reduction warrant more research.

Another unmet need in current research include studies giving attention to a more complete array of harm reduction strategies for problematic opioid use. The persistence and human toll of this Opioid Epidemic makes the understanding of treatment providers’ views and use of specific approaches for responding to OUD an urgent need. Nadelmann and LaSalle (2017) noted shifting attitudes and increased access to harm reduction resources in response to the Opioid Epidemic, including medication-assisted treatment (Stancliff et al., 2012), overdose reversal medication (Skolnick, 2018), needle exchange programs (Des Jarlais, 2017), and, recently, a push for safe consumption rooms in a few cities in the United States (Nadelmann & LaSalle, 2017). Studies related to harm reduction strategies for OUD among addiction treatment providers have included a focus on medication-assisted treatment (Aletaris et al., 2016), but there is a need to explore these perceptions for the wider range of harm reduction programs. This study

has analyzed data to enhance awareness of the level of acceptance of this wider array of harm reduction strategies for problematic opioid use among professional counselors.

Professional counselors are well-trained clinicians who are treating substance use in communities, including supporting clients affected by opioid use. The identity of professional counselors may influence their acceptance of harm reduction approaches, which could affect how they discuss these strategies and programs with their clients. If harm reduction represents a promising paradigm shift in the treatment of addictions (Tatarsky, 2003), and fatal opioid overdoses are killing thousands of Americans each year (CDC, 2018), it is a worthwhile endeavor to examine how counselors perceive harm reduction practices.

Purpose of the Study

The seriousness of the Opioid Epidemic, combined with the potential of harm reduction as a novel paradigm for supporting positive change for people with OUD, raises the need to explore the level of acceptance of these strategies among addiction professionals. Counselors treating clients who use opioids have the option to refer clients to harm reduction programs, as well as adopting these strategies in their direct counseling practice. While their employer or legal policies may limit their ability to do so, it is likely that substance use providers would not consider these programs if they have negative perceptions. There is a need to explore how counselors perceive the harm reduction approaches and programs for clients with OUD. This study sought to enhance the understanding of counselor perceptions of harm reduction for OUD, including comparing counselors to peer addiction treatment professionals and exploring the influence of key overlapping components of counselor identity and harm reduction philosophy. The overlapping aspects of harm reduction and counselor identity of interest for this study were empathic responsiveness, social justice attitudes and professional counseling values.

This study examined how professional counselors perceive harm reduction strategies for OUD, as well as comparing those perceptions to other addiction treatment professionals and examining the influence of counselor empathy, social justice attitudes, and professional counseling values. The overarching goal is to contribute to the understanding of how counselors are addressing the Opioid Epidemic within the current context of substance use treatment in the United States. By comparing counselors working in substance use treatment to their allied professionals in these settings, this study increases awareness of how counselors' acceptance of harm reduction for OUD relates to professionals with different training. This study also examined how key professional counselor identity factors might influence counselors' harm reduction acceptability, such as empathic responsiveness, social justice attitudes and intentions, and their professional identity as counselors. If these components of counselor professional identity did predict harm reduction acceptance, counselor educators and supervisors may wish to emphasize discussions and activities that challenge counselors-in-training to empathize with substance use clients, understand harm reduction as a social justice issue, and highlight congruence between the identity of counselors and this approach to substance use treatment. Comparisons between professions also helps multidisciplinary treatment programs to be aware of potential differences in approach to treatment among staff members working with clients with OUD. Given the Opioid Epidemic's toll on society in the form of lives lost and social harm, it is urgent that we understand how counselors perceive harm reduction strategies for OUD. The research questions for this study are:

RQ1: What is the acceptability of harm reduction approaches for Opioid Use Disorder among professional counselors?

RQ2: Do professional counselors have higher levels of harm reduction acceptance for Opioid Use Disorder than other professionals treating substance use?

H₁: Professional counselors will have higher levels of acceptance of harm reduction approaches for Opioid Use Disorder than other professionals treating substance use.

H₀: Professional counselors will have similar levels of acceptance of harm reduction approaches for Opioid Use Disorder as other professionals treating substance use.

RQ3: Can professional counselors' acceptance of harm reduction strategies for Opioid Use Disorder be explained by the composite of their level of empathy, social justice attitudes, and their professional identity/values as a counselor?

H₁: Level of empathy, social justice attitudes, and counselor professional identity/values will be statistically significant predictors of acceptance of harm reduction strategies for Opioid Use Disorder among professional counselors.

H₀: Level of empathy, social justice attitudes, and counselor professional identity/values will not be statistically significant predictors of acceptance of harm reduction strategies for Opioid Use Disorder among professional counselors.

Definitions of Terms

Harm Reduction

Harm reduction has become an essential aspect of public health dialogue in the last century, having roots in the response to HIV proliferation in the 1980's and Canadian and

European responses to drug use in recent decades (Collins et al., 2011). Although a multitude of definitions of harm reduction are available, the following descriptions do well in summing up this approach to public policy, treatment, and healing. The following definition is used by Harm Reduction International (2019):

Harm reduction refers to policies, programmes and practices that aim to minimise negative health, social and legal impacts associated with drug use, drug policies and drug laws. Harm reduction is grounded in justice and human rights - it focuses on positive change and on working with people without judgement, coercion, discrimination, or requiring that they stop using drugs as a precondition of support. (para. 2)

Collins et al. (2011) broadened the definition of harm reduction beyond drug use, conceptualizing harm reduction as “a set of compassionate and pragmatic approaches for reducing harm associated with high-risk behaviors and improving quality of life...” which “span various fields, including health policy, prevention, intervention, education, peer support, and advocacy” (p. 5-6). Finally, Riley and O’Hare (2000) provide a definition that clarifies two focuses in conceptualizing harm reduction for substance use, describing it as “both a goal—the reduction of the number of harms associated with drug use—and a strategy—a specific approach that focuses on the negative consequences of drug use rather than on level of use” (p. 19). While some authors have noted controversial aspects of harm reduction, these descriptions capture harm reduction as an approach in the context of this study. These definitions encompass the various implementations of harm reduction philosophy for addressing substance use.

Opioid Use Disorder

The Diagnostic and Statistical Manual of Mental Disorders- Fifth Edition (DSM 5) indicates that:

Opioid Use Disorder includes signs and symptoms that reflect compulsive, prolonged self-administration of opioid substances that are used for no legitimate medical purpose or, if another medical condition is present, that requires opioid treatment, that are used in doses greatly in excess of the amount needed for that medical condition (American Psychiatric Association, 2013, p. 542).

The criteria for OUD include impairment in functioning as a result of opioid use, which may involve struggles with cravings, experiencing withdrawals, and continued use despite interpersonal or social problems as a result of use, among other possible symptoms (American Psychiatric Association, 2013). OUD may be active or in remission, and an individual with OUD may be specified as “on maintenance therapy”, which indicates the individual is prescribed and appropriately using an agonist or partial agonist medication to manage symptoms and avoid illicit use. OUD may be classified as mild, moderate, or severe, based on the number of symptoms indicated.

Empathy

Although many definitions of empathy exist, within the context of counseling, Rogers (1957) offered this definition:

To sense the client's private world as if it were your own, but without ever losing the "as if" quality—this is empathy, and this seems essential to therapy. To sense the client's anger, fear, or confusion as if it were your own, yet without your own anger, fear, or confusion getting bound up in it, is the condition we are endeavoring to describe. (p. 99)

Here, Rogers pointed to the importance of a counselor connecting with a client's experience. In other writings, Rogers discussed the importance of accurately understanding the client's emotions and that empathy is an ongoing, continuously unfolding process within counseling

relationships (1975). Understanding Rogers' conceptualization of empathy is essential in capturing this construct as it relates to the humanistic counseling process. Jordan (2010), one of the founders of another humanistic approach, Relational-Cultural Theory, described empathy as "a complex affective and cognitive capacity that fuels movement (towards authenticity and mutual empowerment)" (p. 4). In counseling, Jordan (2010) conceptualized empathy as a mutual process that fosters growth through connection. Relational-Cultural theorists conceptualize empathy similar to Rogers, while adding a focus on the mutual process of empathy between two people.

Another definition of empathy offered by Elliot, Bohart, Watson, and Greenberg (2011) focuses more on neurobiology, including the presence of mirror neurons activated by empathic interactions. Elliot et al. (2011) highlighted three researched components of empathy: an "*emotional simulation* process that mirrors the emotional elements of" another person's "bodily experience", "a conceptual, *perspective-taking* process", and "an *emotion-regulation* process...making it possible to mobilize compassion and helping behavior" (p. 43). Elliot et al. (2011) went on to delve deeper into the characteristic neurobiological responses involved with empathy between two people. Spreng, McKinnon, Mar, and Levine (2009) pointed to several aspects of empathy that have been researched and measured in other studies, including: perspective taking, sympathy, personal distress (when others are in pain), emotional contagion (experiencing the emotions of another), theory of mind (understanding the emotion state of others; p. 62). It is noteworthy that Spreng et al. (2009) defined the traits of individuals who respond empathically to others, while counseling scholars sometimes see empathic responding being a process that occurs in relationships. To clarify, empathy can be a capacity to relate to another person's experience (a trait), as well as dynamic process occurring in the moment with

another person (a state of empathizing; Nezlek, Schütz, Lopes, & Smith, 2007). Nezlek et al. (2007) note that “an emphasis on trait empathy seems to dominate research on empathy within the context of therapy” (p. 188). Most importantly, empathy definitions coalesce as the ability to connect and understand the emotions of another person, with internal awareness and affective responses occurring in the context of interactions other people.

Social Justice

In the context of professional counseling, Chang, Crethar, and Ratts (2010) offered a comprehensive definition of social justice:

Social justice is both a goal and a process for counseling professionals who believe in a just world. A socially just world is one wherein all people receive equitable opportunities to access resources and participate in policy and law development that affects them, ultimately resulting in a society that embodies harmony between the needs of individuals and the needs of the whole (Crethar, Torres Rivera, & Nash, 2008). The goal of social justice is to ensure that every individual has an opportunity to resources such as health care, employment, and to achieve optimal mental health. The process of achieving social justice should be one that is participatory and one that considers the community in which clients live. This perspective holds that client problems are largely rooted in oppressive environmental factors. (p. 84)

This comprehensive definition encapsulates the perspectives, intentions, and actions involved with a social justice orientation in counseling. Toporek and Williams (2006) shared a similar conceptualization of social justice as a process of being aware of marginalization, collaborating with oppressed groups, and linking social justice with advocacy through direct actions by mental health professionals in communities. These definitions, focused on counseling and related

professions, capture the essence of social justice as a desired outcome for a more equitable society and action-oriented process of pursuing a just society.

Counselor Professional Identity and Values

“Counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals” is the definition of counseling arrived at via a Delphi study completed in response to the *20/20: A Vision for the Future of Counseling* initiative to unify the counseling profession (Kaplan et al., 2014, p.366). This definition was affirmed by vote of 31 counseling organizations, with only two regional or national counseling organizations not voting in favor of this consensus definition in March 2010 (Kaplan et al., 2014). This is the most concise, yet thorough, definition of professional counseling available and is the result of a systemic process involving counseling experts. Woo, Henfield, and Choi (2014), as well as Healy and Hayes (2012), described key aspects of professional counseling philosophy as including a focus on development, prevention, wellness, empowerment, and advocacy. Mellin, Hunt, and Nichols (2011) noted that these philosophical groundings are at odds with the medical model, which focuses on pathology and deficits in treatment. Furthermore, Mellin et al. (2011) found that many counselors see the focus on personal growth (development) and wellness (strengths) as key differences between counselors and peer professions, namely psychologists and social workers. Professional counseling embraces a unique identity and philosophy of healing amongst the behavioral health professions.

Overview of Methods

This study utilized quantitative methods, with descriptive statistics, a one-way analysis of variance (ANOVA), and a simultaneous multiple regression analysis being used to answer the research questions. Descriptive statistics were used to provide a baseline for the level of

acceptance of harm reduction strategies for OUD among professional counselors in the sample. Second, a one-way analysis of variance was used to investigate between-group differences within the sample to differentiate the level of acceptability of harm reduction for OUD among professional counselors from their peer professions. Additionally, because the analysis of variance found a statistically significant difference between groups, a post-hoc analysis was used to examine where the differences between groups exist. This allowed the researcher to determine if counselors are different from their peer professions in their acceptance of harm reduction for OUD. Finally, the multiple regression explored the predictive value of empathic responsiveness, social justice attitudes, and counselor orientation and values for the acceptance of harm reduction strategies for OUD among counselors. The main population of interest was professional counselors who treat clients with substance use disorders throughout the United States. Participants self-identified their primary discipline of training (option that best described their professional identity), which included those identifying themselves as professional counselors. An overall sample of 200 substance use treatment providers was needed to achieve sufficient statistical power for the one-way analysis of variance, with at least four groups. A sample of at least 77 counselors treating substance use was needed to achieve sufficient statistical power for multiple linear regression analysis of the variables of interest. These addiction treatment providers were sampled from sites identified by SAMHSA in their National Directory of Drug and Alcohol Abuse Treatment Facilities (SAMHSA, 2019). That directory included 13,260 at the time of data collection, with the researcher planning to sample every 50th site on the list, once the sites were divided into four regions and each site was given a random number. Facilities included on the directory must meet certain criteria, including providing services that are funded by a state mental health agency or the U.S. Department of Veteran Affairs and be appropriately

licensed by their state (SAMHSA, 2019). The four regions (Northeast, South, Midwest, and West) used for stratified random sampling were defined by the regions used by the U.S. Census Bureau (U.S. Territories were omitted; 2010). Participant acceptability of harm reduction practices for OUD was measured with an adapted version of the Harm Reduction Acceptability Scale-Revised (HRAS-R; Goddard, 2003), with supplemental items added to explore acceptance of harm reduction strategies for clients who use opioids specifically. The predictor variables were measured using the following scales: The Toronto Empathy Questionnaire (Spreng, McKinnon, Mar, & Levine, 2009), The Social Justice Scale- Attitudes Towards Social Justice subscale (Torres-Harding, Siers, & Olson, 2012) and the Professional Orientation and Development Scale for Counselors-Professional Orientation and Values subscale (La Guardia personal communication, September 27, 2019; Healy & Hayes, 2011). These methods allowed for an exploration of counselor acceptability of harm reduction approaches for OUD, including investigating differences in acceptance in comparison to peer professionals, and exploring aspects of professional counselor identity that predict these attitudes.

Document Organization

Following this brief introduction, this study progresses to a chapter dedicated to a more thorough literature review of the topics and constructs highlighted in this section. The third chapter then summarizes the methods of sampling, data collection, and statistical analysis for this quantitative study. The fourth chapter conveys the results of the survey, followed by chapter five, dedicated to discussion of the meaning and implications of the data analysis findings. The final sections of the document include the referenced citations and appendices with figures displaying the results and analysis.

CHAPTER TWO: REVIEW OF LITERATURE

The harm reduction approach to counseling clients who use substances emphasizes a focus on improving quality of life, while not requiring or expecting abstinence as either a precondition of treatment or an outcome goal (Collins et al., 2011). Harm reduction represents a promising and transformative approach for addressing the Opioid Epidemic, given the need to prevent fatal opioid overdoses and support people with Opioid Use Disorder (OUD) in making changes to avoid death or other negative consequences. Harm reduction approaches and programs for OUD include needle exchange programs, Motivational Interviewing, medication-assisted treatment, providing testing kits for Fentanyl contamination, supplying users with Naloxone to reverse opioid overdoses, and safe consumption sites, among a multitude of other strategies (Moro and Burson, 2018; Denning & Little, 2012; Nadelmann & Lasalle, 2017). As front-line treatment providers in addiction treatment programs, professional counselors treat and respond to the epidemic of fatal opioid overdoses in the United States. Professional counseling grounds its professional identity upon humanistic values (Hansen et al., 2014), which align well with the collaborative goal setting that exemplifies a harm reduction approach to addiction treatment and healing. Empathy is considered a key component of humanistic counseling identity (Dollarhide & Oliver, 2014). Social justice, a value of the counseling profession, is considered the “fifth force” of influence in the counseling profession (Ratts, 2009). With approximately 46 Americans dying daily due to fatal opioid overdoses (CDC, 2018), an urgent need exists for front-line providers to embrace and support effective treatment strategies. The loss of individuals who die via fatal opioid overdose deprives them the opportunity to heal and lead full, productive lives. Each fatal overdose also causes ripple effects within family systems and communities. This

study sought to improve understanding of how professional counselors who treat substance use perceive strategies for responding to the Opioid Epidemic. Specifically, this study focused on understanding professional counselors' acceptance of evidence-based harm reduction strategies, as well as the role of empathic responsiveness, attitudes towards social justice, and professional counseling orientation and values in predicting their level of acceptance.

Context for the Study

The Opioid Epidemic

According to the Centers for Disease Control and Prevention (CDC), the average life expectancy of Americans decreased in recent years, a direct result of the increase in fatal opioid overdoses over the last twenty years (2018). Americans are now more likely to die due to a fatal opioid overdose than via motor vehicle collisions (National Safety Council, 2019). The CDC describes three “waves” of fatal overdoses occurring during the Opioid Epidemic, which spans from the late 1990’s through the present (2018). The first wave began in the late 1990’s, as prescriptions for natural and semi-synthetic opioids for pain treatment increased rapidly, coinciding with an increase in fatal opioid overdoses. The second wave began in 2010, as fatal opioid overdoses due to heroin use increased rapidly, presumably due to efforts to curb the prescribing of opioids for pain. The current, third wave of the epidemic began as fatal opioid overdoses via synthetic opioids, especially illicit Fentanyl, skyrocketed. In October 2017, President Donald Trump declared the Opioid Epidemic a “national health emergency”, stating, “Hundreds of thousands of Americans have lost their lives to drug abuse, and it will only get worse unless action is taken” (The White House, 2017, para. 2). The Opioid Epidemic is well known in American society as one of the most imminent public health crises of our time.

Opioids are a class of compounds that bind to opiate receptors in the human brain, generally divided into the subcategories of naturally derived opiates (e.g. morphine), synthetic opioids (e.g. Fentanyl), and semi-synthetic opioids (e.g. heroin; Rosenblum, Marsch, Joseph, & Portenoy, 2008). Opioids derived from the poppy plant have been used to treat pain and other ailments for several millennia in various cultures. These substances have been more strategically used since the early 20th Century as medical treatment for pain (Rosenblum et al., 2008). Because opioids cause relief from pain symptoms through neurochemical mechanisms and cause euphoria for users, a high potential for the misuse of opioid medications exists, as well as a thriving illegal opioid market in the United States (Rosenblum et al., 2008; CDC, 2018). Unfortunately, regular users of these opioids often experience physiological and psychological withdrawal symptoms when deprived of these drugs, which causes significant distress and perpetuate the cycle of ongoing, increasing usage (American Psychiatric Association, 2013; Weigel, Donovan, Krug, & Dixon, 2007). This leads to immense challenges for regular opioid users to reduce or stop using. As a result, many users find themselves addicted to these substances and unable to stop using without therapeutic and medical intervention.

The Diagnostic and Statistical Manual of Mental Disorders- Fifth Edition (DSM-5) highlights that individuals with Opioid Use Disorder (OUD) often experience tolerance, characterized by diminished effect of consuming opioids, and withdrawals, characterized by psychological and physiological symptoms when the person stops using opioids (American Psychiatric Association, 2013). OUD is situated within the Substance-Related and Addictive Disorders section of the DSM-5, along with other substance use disorders. An important aspect of OUD, like other substance use disorders in the DSM-5, is the presence of clinically significant distress, manifesting as a result of problems associated with opioid use. OUD is often associated

with impulsive use of prescription or illicit opioids that inhibit the ability to fulfill important life roles, such as parenting, work, or social functioning, as well as struggles with cravings to use, tolerance, and withdrawals. It is important to note that many people who are prescribed opioids or use them illicitly would not meet criteria for a disorder; however, the CDC highlights that many people who are prescribed opioids do become addicted (2018). Sub-diagnostic, or even prescribed, opioid use can still be problematic, given the impact on personal health and associated legal issues. Individuals with OUD are at increased risk of fatal opioid overdose, as well as other consequences, such as legal consequences, employment instability, and disruptions in social relationships (American Psychiatric Association, 2013).

Fatal opioid overdoses occur when, in response to inhibitory functions these chemicals have on the brain, respiration slows or stops, causing the user to die via lack of oxygen (White & Irvine, 1999). White and Irvine (1999) note that overdose death via hypoxia (lack of oxygen to the brain) can occur in a matter of minutes or gradually over several hours. The risk of fatal overdose is exacerbated when opioids are combined with other central nervous system depressants, such as benzodiazepines (anxiety treating medications) or alcohol. While the nationwide statistics of individuals who die via opioid overdose are staggering, the CDC highlights that “for every drug overdose that results in death, there are many more nonfatal overdoses, each one with its own emotional and economic toll” (para. 1; 2018). Relapse is common among individuals who attempt to quit opioids due to physiological dependence and withdrawal symptoms. Fatal opioid overdoses are more likely to occur during relapse due to decreased tolerance to the substances (Nunes et al., 2018). Many fatal overdoses involve multiple substances and the lack of consistency in toxicology assessments post-mortem make it difficult to estimate rates of fatal opioid overdoses. Despite these confounds, traditional measures of fatal

opioid overdose deaths show a nationwide rise from around 4,000 deaths per year in 1999 to more than 30,000 in 2016 (Seth et al., 2018). Rates of overdose continue to rise, despite efforts to restrict prescribing patterns, as research suggests this may contribute to increased heroin usage (Pitt, Humphreys, & Brandeau, 2018). Deaths via fatal opioid overdose remain a serious threat to Americans affected by OUD, despite awareness of and efforts to curb the Opioid Epidemic in recent years.

The Opioid Epidemic demands an assertive response from policymakers and treatment professionals in the United States. Each life lost to fatal opioid overdose is a call to action to explore approaches that are effective in giving people with OUD the chance to recover and live full lives. The field of addiction treatment, which includes professional counselors, has a responsibility to identify efficacious treatment approaches and implement those services to preserve life and heal communities. Given the consistent rise in fatal opioid overdoses in the last two decades, there is a need to make changes that increase treatment access and engagement, while reducing these deaths and OUD-related social consequences. This includes learning from what works and what is lacking in traditional substance use treatment systems.

The Twelve-Step Approach and Minnesota Model for Addiction Treatment

The number of deaths caused by OUD drives an urgency for addiction treatment professionals and researchers to find what works for saving lives. The field of addictions treatment as it exists today could not have emerged without the enhanced awareness of alcoholism as treatable condition facilitated by the development of Alcoholics Anonymous (AA) in the 1930s (Van Wormer & Davis, 2008). Van Wormer and Davis (2008) credit AA for bringing the issue of alcoholism as a treatable condition into the light, as treatment of addiction had been primitive prior to the 1930s. AA developed a model of change based on the Twelve

Steps, which include an initial step of the person with the addiction admitting they are powerless over alcohol (Alcoholics Anonymous, 2019). The subsequent steps guide members through a process of admitting faults, seeking redemption, and having a spiritual awakening, on the path to sustained abstinence (Alcoholics Anonymous, 2019). AA and the shift towards seeing addiction as a treatable disease helped launch a movement to develop behavioral interventions for problematic substance use.

The Twelve Steps made an impact via mutual support groups throughout the last several decades, in addition to influencing addiction treatment programs. Twelve Step Facilitation Therapy is currently listed as evidenced-based practice for substance use disorders by the National Institute of Health and National Institute on Drug Abuse (McGovern & Carroll, 2003; National Institute on Drug Abuse, 2018a). Quinn et al. (2004) describe the integration of the Twelve Steps with confrontational approaches grounded in cognitive-behavioral therapy emerging as the Minnesota Model, a dominant paradigm of substance use treatment in the second half of the twentieth century. In a dated meta-analysis of studies on the efficacy of the Minnesota Model in treatment programs, Cook (1988) found that these programs offer promise in engaging multidisciplinary treatment teams and elevating the benefits of helpers in recovery themselves, while indicating that there is a concern about dogmatism. Cook (1988) did find that nearly two thirds of patients in these programs report “good” outcomes for their substance recovery. Quinn (2004) describes the importance of substance users accepting and admitting they are addicts and have a problem before treatment can truly begin as a key component of the Minnesota Model. The Twelve Steps and the Minnesota Model continue to make a large impact on the field of addiction treatment, including advancing the idea that people recovering from substance use have an essential role in helping those who are active users (White, 2004).

In a large national study funded by the National Institute on Drug Abuse, the National Institute of Health, and United States Department of Health and Human Services, Gamble and O'Lawrence (2016) found a statistically significant difference in abstinence rates among adult heroin users were higher at one-year and five-year follow-ups for users actively engaging Twelve Step group therapy, with those in the control group more likely to have relapsed. One major issue with this study, which collected data between 1991 and 1999, is that there was a high drop-out rate in the study. The study started with 6,204 participants, with only 1,213 remaining in the study at the one-year follow up, and 598 participants remaining in the five-year follow-up. A more recent longitudinal study found that adolescents participating in Twelve Step Facilitation Therapy combined with a motivational approach had similar outcomes to those participating in modern Motivation Enhancement Therapy combined with Cognitive-Behavioral Therapy (Kelly et al., 2017). This study found that participants in the Twelve Step based program who attended mutual support groups and had fewer behavioral consequences at three, six, and nine-month follow-ups. It must be contextualized that Kelly et al. (2017) performed a small pilot study ($n=59$) with only adolescents (mean age of 16.85), making it difficult to generalize these results. It is noteworthy that the Twelve Step Facilitation Therapy is considered efficacious treatment for OUD and that there is evidence for this approach helping substance users pursue abstinence-based recovery (National Institute on Drug Abuse, 2018a).

In exploring the conflict between the Twelve Steps and the values of the counseling profession, Le et al. (1995) questioned the validity of studies that have found a link between sobriety and attending mutual support Twelve Step groups, pointing to the voluntary component of these groups. Le et al. (1995) also compared the counseling profession's theoretical underpinnings with Alcoholics Anonymous philosophy, including counseling theory focusing on

cultivating strengths and personal responsibility, while Alcoholics Anonymous (Twelve Step philosophy) focuses on personal shortcomings and character defects. In terms of treatment programs integrating this philosophy, a quasi-experimental study (control and treatment groups included), Hayes et al. (2004) found the individuals provided Twelve Step Facilitation Therapy with polysubstance use history in methadone maintenance programs did have decreased opioid use (measured by urinalysis and self-report) at a six-month follow-up compared with those who were treated with methadone alone. This finding is limited by the study's high drop-out rate which may include many participants who returned to drug use and the authors noted that some participants may have had aversion to Twelve Step ideology based on prior experiences (Hayes et al., 2004). This empirical study illuminates that therapeutic interventions utilizing Twelve Step ideology can support changes in use patterns among people with OUD, with a key limitation of not accounting for client perceptions or comparing Twelve Step Facilitation Therapy to a wider array of therapeutic approaches. The literature referenced highlights conflicting evidence for the benefits of incorporating Twelve Step philosophy into treatment programs, despite the notable benefits that mutual self-help support groups like Narcotics Anonymous have for people with OUD and other substance use disorders pursuing abstinence.

It is valuable to explore the origins of substance use treatment programs, given that this study will focus on harm reduction approaches to treatment that represent a shift away from abstinence-based outcome goals for substance users. Research has shown that participation in Twelve Step mutual support groups is associated with sustained abstinence from drugs following treatment (Florentine, 1999). Laudet (2003) found that treatment providers and individuals in treatment for substance use have positive views of Twelve Step mutual support groups, while other scholars have questioned whether this philosophy is congruent with counseling values (Le

et al., 1995) or may be harmful to many clients (J. Miller, 2008). Le et al. (1995) specifically points to philosophical incongruence, while J. Miller (2008) cites client outcome concerns with programs that integrate Twelve Step philosophy. Other researchers have noted that, when assessing the benefits of Twelve Step mutual support groups and treatments that integrate those principles, it is difficult to account for attrition that likely represents substance relapse and negative views towards these principles (Hayes et al., 2004; Kelly et al., 2017; Le et al., 1995). Quinn et al. (2004) also noted that the morality components of Twelve Step programs align treating professionals with societal stigmatization of substance users and the criminal justice system, which likely alienates many people needing substance use treatment. J. Miller (2008) went further in claiming that major studies showing Twelve Step philosophy as an effective approach in treatment have methodological flaws and true “remission” rates are lower than reported. It is also noteworthy that no studies were found that speak to the effectiveness of Twelve Step integrated treatment for OUD, or evidence that Twelve Step programs adapt their processes or the steps based on type of substance use for which a person is seeking treatment. Concerns about retention of clients in substance use treatment has contributed to the development of contemporary approaches that are less prescriptive and based on current motivations (Denning & Little, 2012). Harm reduction and other recent developments in substance use treatment have focused on matching the client’s motivation, regardless of their interest in abstinence.

Contemporary Approaches and OUD

Motivational Interviewing and harm reduction strategies represent a transition towards more individualized and collaborative approaches to treating substance use. Collins et al. (2011) stressed that harm reduction approaches for treating substance use are not at odds with

abstinence-based programs, like those grounded in Twelve Step philosophy, as abstinence is an appropriate goal for clients who chose it. Harm reduction counselors integrate Motivational Interviewing into their work with substance users, as it affirms autonomy, is collaborative, and enhances commitment to treatment (Denning & Little, 2012; Tatarsky & Kellogg, 2012; W. Miller & Rollnick, 2013). While Twelve Step practices encourage a desire to quit substances and admission that one is powerless over substances, Motivational Interviewing starts with an assessment of desire and confidence that change is possible (J. Miller & Rollnick, 2013). Similarly, harm reduction provides services for improving quality of life and mitigating harms of drug use regardless of the person's intention to reduce or stop using (Collins et al., 2011). Contemporary approaches are particularly relevant for the Opioid Epidemic, as people with OUD face high relapse rates, difficulty stopping due to withdrawals, and a risk of fatal opioid overdose (American Psychiatric Association, 2013). These approaches allow counselors to build therapeutic alliances with clients who are not ready to stop using or are averse to abstinence-based programs (Moro & Burson, 2018).

Motivational Interviewing

Developed by William Miller and Stephen Rollnick in the 1990s, Motivational Interviewing represents possibly the most dramatic shift away from the highly influential Twelve Step approach in addiction treatment programs. Motivational Interviewing focuses on facilitating client change through collaboration between the provider and client, as well as evocating intrinsic reasons for change and respecting autonomy (W. Miller & Rollnick, 2013). It is important to note that this approach moves away from a prescriptive model of changing behaviors such as substance use, towards a co-constructed process of goal setting. Moro and Burson (2018) highlight, “the shared philosophy of person-centered treatment found in both

[Harm Reduction] and [Motivational Interviewing] is derived from Rogers core conditions of counseling” (p. 240). Specifically, Motivational Interviewing avoids the assumption that abstinence from substances of abuse is the desired outcome for all substance use clients.

Over the last thirty years, Motivational Interviewing has been found to be efficacious in reducing substance use with a range of populations and a variety of substances (Miller & Rollnick, 2013). Motivational Interviewing is also listed as an evidence-based practice for substance use treatment providers by the CDC (J. Carroll et al., 2018). Despite this evidence, one randomized trials found that substance users receiving Motivational Interviewing during treatment assessments were not more likely to be abstaining from substances, or report less substance use, at follow-up interviews than clients who received “standard treatment” assessments (standard assessments included only orientation to the program and information gathering; K. Carroll et al., 2006). This large study found that clients who received Motivational Interviewing during their initial assessment had higher retention rates. It is notable that most providers in the study were newly trained in Motivational Interviewing, that both treatment conditions had better outcomes than no treatment, and that abstinence and decreased use were the outcome measures of interest (rather than other measures of success and well-being; K. Carroll et al., 2006). In another randomized trial study with adults, W. Miller, Yahne, and Tonigan (2003) also found no effect of a single Motivational Interviewing session at the onset of treatment on outcomes for adult substance use clients. W. Miller et al. (2003) acknowledge multiple confounds in their study, including other aspects of treatment following the single Motivational Interviewing session, as well as the demographics of their sample (low income, mostly male, mostly ethnic minority clients). This study also shows that a single Motivational Interviewing session may be insufficient for effectiveness, as the study references nine prior

randomized trial studies that found Motivational Interviewing to be effective. These studies offer some contrast to a wealth of research supporting the efficacy of Motivational Interviewing in helping substance use clients.

Despite a few studies finding limited benefit of Motivational Interviewing, there is a wealth of evidence for this approach's efficacy with substance use clientele. In a meta-analysis exploring the mechanisms of this approach, Apodaca and Longabaugh (2009) identified causal links matching Motivational Interviewing therapist behaviors with client change-talk and recognition of discrepancy, which was associated with better treatment outcomes. In contrast, Motivational Interviewing inconsistent behaviors on the part of therapists was predictive of worse outcomes (Apodaca & Longabaugh, 2009). Of relevance for treatment of OUD, Saunders, Wilkinson, & Phillips (1995) used randomized trials to explore the benefits of a brief Motivational Interviewing-based intervention with clients receiving methadone treatment, comparing them to an education-based treatment group. Saunders et al. (1995) found the group receiving Motivational Interviewing were more likely to remain in treatment after six months, had better expectancy for change, had fewer problems related to opioid use, and relapsed less quickly. Similar to other studies referenced, there was a relatively high drop-out rate (40%), although clients receiving Motivational Interviewing were more likely to be retained because they stayed in treatment. In a study of thirty older adults receiving pain management treatment, Chang, Compton, Almeter, & Fox (2012) found that patients receiving a four-week Motivational Interviewing intervention had less frequent misuse of their prescription opioids. This study found participants receiving Motivational Interviewing reported higher self-efficacy and satisfaction with their care, although the sample is small and relied on self-report measures. Finally, in a large randomized control design study ($n = 1175$) focused on the benefits of a brief Motivational

Interviewing intervention (45 minute session, with 10 minute follow-up call a week later) at the onset of treatment for people seeking treatment for cocaine and heroin use, Bernstein et al. (2005) found evidence that the intervention was beneficial for heroin users. The results showed that the control group, which received information about self-help and other support programs for addiction, relapsed more frequently and more of those participants actively used heroin at three and six-month follow-up interviews. Despite the positive results, this intervention was very brief and other treatments would usually include providing more than a resource list. These studies offer evidence that Motivational Interviewing is a viable treatment for OUD and supports the proliferation of this approach within the substance use treatment community.

Motivational Interviewing represents a major shift in the treatment of addiction, in that it focuses on change as an evolving process. This approach relies on the idea that professional helpers must match their interventions to the client's current motivations and insight for change (W. Miller & Rollnick, 2013). Because of this shift, Motivational Interviewing differs from the more rigid set of steps expected of people seeking recovery in the Twelve Step process, given that a desire to stop using substances is considered a precursor for change in that approach. Reconceptualizing the change process allows counselors and other substance use treatment professionals to provide interventions that improve clients' quality of life, regardless of a substance users willingness or ability to stop using. Denning and Little (2012) describe Motivational Interviewing as a potential basis for broader harm reduction therapy, with both approaches built upon self-determination and collaboration in goal construction. Medication-assisted treatment, another harm reduction approach for OUD, also lowers the threshold for entering treatment and does not require traditionally defined abstinence.

Medication-Assisted Treatment

In recent decades, medication-assisted treatment emerged as a key new development in the treatment of substance use disorders, especially OUD. Medication-assisted treatment refers to the prescribing of medications that block the effect of or cravings to use opioids, in conjunction with counseling. This approach is considered an evidence-based practice for treating opioid addiction (National Institute on Drug Abuse, 2018a) and preventing overdose (J. Carroll et al., 2018). OUD treatment medications include methadone, buprenorphine, or Naloxone, which are highly effective, but underutilized due to stigma and other barriers (National Institute on Drug Abuse, 2018b). Bart (2012) sums up the significant benefits of these medications based on a review of research, stating that medication-assisted treatment “reduces mortality, improves social function, and is associated with decreased drug use and improved quality of life” (p. 218). In a review of evidence, Connery (2015) concluded that medication-assisted treatment for OUD “significantly augments treatment retention, reduces illicit opioid use, reduces the burden of opioid craving, and, in the case of agonist therapies, provides effective relief of the opioid withdrawal syndrome” (p. 69). Connery’s review summarized the results of many rigorous medical studies of these treatments, which also concluded that abstinence-only OUD treatment was less effective (2015). Medication-assisted treatment has strong efficacy for the treatment of OUD and is part of a contemporary approach to treatment.

Of relevance to the current study and professional counselors, in a nationwide study of 725 counselors working in substance use treatment programs, Aletraris et al. (2016) reported that 71 percent worked at a site that did not provide medication-assisted treatment. Aletraris et al. (2016) also found that over twenty percent of counselors felt they did not know enough about buprenorphine or methadone, which negatively impacts acceptance of these treatments. This research also indicated that increased adherence to Twelve Step orientation was correlated with

less acceptance of buprenorphine and methadone treatment for OUD. This is an important consideration, as medication-assisted treatment can be a compliment to Twelve Step groups (Connery, 2015), but Twelve Step philosophy seemingly puts providers at odds with this efficacious treatment for OUD. Despite evidence that these medications work well regardless of counseling services (Fiellin et al., 2013; Ling, Hillhouse, Ang, Jenkins, & Fahey, 2013), Ripley (2019) explored how clients in group counseling in conjunction with buprenorphine treatment experienced counseling. Client participants in Ripley's study described a multitude of benefits of group counseling in supplementing medication treatment (2019). Themes from Ripley's qualitative study included clients benefitting from a supportive safe space to talk, accountability to their goals, receiving help from others, and experiencing genuine caring in the groups (2019). While this study was qualitative, with a small sample size (10), it adds evidence to the benefits of counseling in medication-assisted treatment programs. Additionally, Moore et al. (2016) found that patients abusing prescription opioids had more days abstinent when medications were paired with therapy, although heroin users showed no better outcomes when behavioral therapy was added. This study included 49 prescription drug users and 91 heroin users in a primary care setting (Moore et al., 2016). It is worth noting that many studies focus on cognitive-behavioral therapy interventions (Fiellen et al., 2013; Moore et al., 2016) were administered by providers who were not professional counselors. This is noteworthy, given the humanistic philosophical groundings noted in the counseling profession. Medication-assisted treatment is expected to include counseling and this approach is part of a contemporary approach to treating OUD. Denning and Little (2012), as well as Kilmer, Cronce, Hunt, and Lee (2011), have described buprenorphine and methadone as part of an integrated, harm reduction approach to treating addiction, including opioid use. Motivational Interviewing and medication-assisted treatment

represent two, well-accepted, components of the comprehensive array of harm reduction programs.

Harm Reduction

Collins et al. (2011) “define and examine harm reduction as a set of compassionate and pragmatic approaches for reducing harm associated with high-risk behaviors and improving quality of life” (p. 5). Harm Reduction International (2019) describes this philosophy and approach as:

policies, programmes and practices that aim to minimise negative health, social and legal impacts associated with drug use, drug policies and drug laws. Harm reduction is grounded in justice and human rights - it focuses on positive change and on working with people without judgement, coercion, discrimination, or requiring that they stop using drugs as a precondition of support. (para. 2)

Moro and Burson (2018) describe harm reduction within the field of addiction counseling as a set of “controversial policies like needle exchange, teaching safe injection practices, distribution of Naloxone kits to reverse opioid overdose in opioid addicts, and the prescribing of methadone and buprenorphine to treat opioid addiction” (p. 235). Tatarsky (2002, as cited in Tatarsky & Kellogg, 2012) describe seven core ideas of harm reduction philosophy: “meeting the client as an individual”, “starting where the patient is”, “assuming the client has strengths that can be supported”, “accepting small incremental changes as steps in the right direction”, “not holding abstinence... as a necessary precondition of therapy...”, “developing a collaborative, empowering relationship with the client”, and “the importance of destigmatizing substance users” (p. 39-40). Harm reduction is a philosophy of treating substance use (and other high-risk behaviors) that focuses on mitigating risks and improving quality of life individuals regardless of

a person's current motivations for change (Collins et al., 2011). Harm reduction practice encompasses previously discussed contemporary approaches, in addition to a spectrum of other approaches, programs, and strategies.

Denning and Little (2012) reference Motivational Interviewing as component of harm reduction psychotherapy practice and credit this approach as “a major contribution to our understanding of motivation and have opened up the possibility of revolutionizing chemical dependency treatment” (p. 34). Kilmer, Cronic, Hunt, and Lee (2011) point to methadone, buprenorphine, and other prescriptions that are used for medication-assisted treatment as important aspects of harm reduction for OUD. Other programs for harm reduction for OUD include: the distribution of Naloxone for overdose reversal (as well as teaching overdose reduction strategies; Skolnick, 2018), syringe exchange programs to reduce infection risks (Des Jarlais, 2017), housing first programs that do not require abstinence (Henwood et al., 2014), and safe consumption rooms not yet available in the United States (Nadelmann & LaSalle, 2017), among other approaches. These therapeutic services primarily focus on reducing the risk of the most serious consequences of opioid use; fatal opioid overdose, harms of drug-related crimes (legal issues or physical harm), and medical complication that lead to death, including infections caused by injection.

Needle exchange programs (also called syringe exchange or syringe servicing) provide sterilized, safe injecting equipment to injection drug users to reduce the probability of transmitting disease by sharing equipment, or getting a bacterial infection due to users sharing or reusing this equipment (J. Carroll et al., 2018). The CDC defines needle exchange programs as evidence-based practice for reducing fatal opioid overdoses (J. Carroll et al., 2018), while highlighting that consumers of these programs are more likely to engage treatment programs for

addiction. J. Carroll et al. (2018) also report that law enforcement “buy in” and policies that do not limit these programs support their effectiveness significantly. The CDC gives three main benefits of these programs: lowering infection transmission (especially for low income users), reducing the stigma people who inject drugs experience, and being a point of referral to other treatment (J. Carroll et al., 2018). The findings of a study of 417 intravenous drug users indicated that users having contact with peers in recovery at needle exchange facilities experienced better outcomes related to health, legal issues, sustaining housing, and overdose risk (Ashford, Curtis, & Brown, 2018). This study focused on the benefits of having a hybrid peer-support community combined with a needle exchange program, with the authors highlighting the benefits of peer recovery support staff engaging substance users in harm reduction facilities. Vidourek, King, Yokey, Becker, and Merianos (2019) completed a comprehensive literature review of studies reporting outcome data for needle exchange programs in the United States between 2007 and 2017, finding consistent results showing that these programs have efficacy in improving health outcomes and reducing infection rates. These services validate the necessity of harm reduction for OUD, as these services acknowledge people are injecting opioids and seek to mitigate the risks of that route of use.

Approved by the Food and Drug Administration in its current form for overdose reversal in 2014, Naloxone is recommended by the World Health Organization and United States Surgeon General as essential medicine for people who use opioids (illegally or prescribed; Skolnick, 2018). The CDC also recommends targeted Naloxone distribution to help reduce the occurrence of fatal opioid overdoses (J. Carroll et al., 2018). J. Carroll et al. (2018) summarize that “Naloxone is an opioid antagonist that can quickly and safely reverse the potentially fatal effects of an opioid overdose. Targeted distribution programs seek to train and equip individuals

who are most likely to encounter or witness an overdose...” (p. 8). A vital component of targeted distribution is ensuring high-risk users and first responders have this medication available and are trained to use it when signs of opioid overdose occur (Skolnick, 2018). One small-scale study at the University of Pittsburgh Medical Center found that training for physicians about opioid overdose and Naloxone, as well as sending letters about Naloxone and providing this drug to 97 patients, led to five reversed overdoses (Han, Hill, Koenig, & Das, 2017). This research shows that knowledge about and access to this medication can save lives. Naloxone is primarily available via pharmacists, with laws about needing a prescription varying by state (Bakhireva et al., 2017). In a qualitative study of pharmacists in New Mexico, Bakhireva et al. (2017) found that pharmacists’ willingness and ability to prescribe this life-saving medication faced multiple barriers, including supply issues, as well as personal and societal stigma towards opioid users. Counselors are treatment providers who have a role in referring clients with OUD to programs that help them access Naloxone. Counselors may also wish to advocate for policies that increase access to Naloxone, while seeking training in using this medication themselves. Naloxone distribution is another key component of the harm reduction approach for OUD, as users are overdosing and saving these individuals gives them a chance to recover. Naloxone may be a crucial harm reduction tool for reducing the rates of fatal opioid overdoses.

According to the CDC, the “third wave” of the Opioid Epidemic began in 2013 with a sharp increase in Fentanyl-related overdoses (2018a). Heroin and other illicit drugs are often adulterated by distributors with Fentanyl to increase the high it offers, as Fentanyl and its analogs provide a significantly more potent effect than other common opioids (e.g. heroin, morphine; McGowan, Harris, Platt, Hope, & Rhodes, 2018). The contamination of heroin and other drugs with illicit Fentanyl makes it difficult for users to assess the risk of their drug supply (McGowan

et al., 2018). Forensic Fentanyl test strips allow users of illicit drugs, including heroin and other opioids, to determine if a substance is contaminated with Fentanyl (Krieger et al., 2018). In a study of young adults who used illicit drugs in the northeastern United States, Krieger et al. (2018) found that most participants used at least one of the 10 Fentanyl test strips they were given to detect contamination of drugs they intended to use. Most participants in the study used those substances with more caution, including using with others around and ingesting smaller doses. While there is initial evidence of benefits and willingness to utilize Fentanyl testing kits among people who use drugs, there is limited amount of research to draw from, making conclusions about effectiveness of this form of harm reduction elusive (Krieger et al., 2018; McGowan et al., 2018). Krieger et al. (2018) note that users would likely prefer to access these kits at other facilities treating OUD via medication-assisted treatment or other harm reduction facilities. The distribution of Fentanyl testing kits represents a harm reduction approach, as the goal is to make the ongoing use of opioids and other substances safer and reduce overdose risk.

Finally, safe consumption sites (also called “safe consumption spaces”, “drug consumption rooms”, or “supervised injection facilities”) are locations in which people can use substances, including opioids, with medical and treatment professionals present (Caulkins, Pardo, & Kilmer, 2019). Despite this harm reduction approach being utilized in Canada for more than 15 years and Europe for over 30 years, no safe consumption sites have opened in the United States due to legal barriers and these sites not encouraging abstinence (Caulkins et al., 2019; Cleiric et al., 2018; McGinty et al., 2018). Safe consumption sites represent harm reduction in a pure form, as the goal is to prevent infections, reverse overdoses that occur, and help drug users, without pressuring them to stop using harmful substances. Furthermore,

treatment professionals have the opportunity to build a relationship with people who use drugs and link them to other treatment programs when they are ready.

Safe consumption sites remain controversial, with McGinty et al. (2018) finding only 29% support for safe consumption sites among a nationally representative sample of all Americans. McGinty et al. (2018) also found that stigmatizing attitudes towards opioid users predicted less acceptance of this form of harm reduction. This study used phone surveys with 1004 adults nationwide in 2017 (McGinty et al., 2018). Despite being controversial, there is evidence of the effectiveness of safe consumption sites in reducing fatal overdoses. In studying the impact of North America's first safe consumption site opened in Vancouver, Canada, Marshall, Milloy, Wood, Montaner, and Kerr (2011) identified a 35% reduction in overdose deaths within 500 meters (about a third of mile) of the facility between 2001 and 2005, with no evidence that injection drug use increased in the surrounding area. Additionally, Park et al. (2019) found that the majority of people who inject drugs sampled in Baltimore, Providence, and Boston would be willing to use a safe consumption site, if it were available. Despite correlational evidence, Caulkins et al. (2019) note that the majority of the available literature on safe consumption sites to date lack experimental controls that allow for causal evidence of effectiveness. Although Caulkins et al. (2019) calls for more rigorous study of the effectiveness of safe consumption sites, especially related to cost and impact on local communities, the authors encouraged readers to consider the urgency to implement strategies to save lives in the face of the Opioid Epidemic. Recently, a decision by a District Court Judge in Philadelphia, Pennsylvania opened the door for an organization to open the first supervised consumption site in the United States, despite previous attempts to block this program by the District Attorney (Allyn, 2019). Unfortunately, this site was not opened due to public backlash from the local

community. While clearly controversial and warranting better research, safe consumption sites represent promising, evidence-based harm reduction for preventing fatal opioid overdoses.

Harm reduction for the Opioid Epidemic encompasses a wide range of strategies that can be implemented or recommended by professional counselors. Counselors treating OUD may work in medication-assisted treatment programs and/or provide motivational interviewing interventions with clients, knowing they are following evidence-based best practice recommendations that respect client autonomy. Also, counselors may consider referring their clients to harm reduction programs aimed at improving quality of life and reducing the risk of illness or fatal overdose risk. Harm reduction referral options include the following: medication-assisted treatment, needle exchange programs, Naloxone distribution, Fentanyl testing kits, and safe consumption sites (outside the United States). Counselors are often front-line treatment providers supporting clients struggling with OUD, making their acceptance harm reduction strategies of interest for counseling and addiction treatment researchers.

Empathy: An Essential Component of Counseling and Harm Reduction

Rogers (1957), in describing empathy as essential to the therapeutic process, defined this trait as the ability “to sense the client's private world as if it were your own... To sense the client's anger, fear, or confusion as if it were your own, yet without your own anger, fear, or confusion getting bound up in it” (p. 99). Rogers stressed the importance accurate empathy and the counselor being able to convey their understanding to the client effectively (1975). Indeed, in a review of counseling outcome research, Wampold and Norcross (2011) highlight that positive outcomes are associated with clients’ perception of their counselor ability to empathize with their struggles and concerns. Although Rogers was a psychologist, his conceptualization of empathy as an essential aspect of therapeutic change helped lay the humanistic foundations of the

counseling profession (Dollarhide & Oliver, 2014). Similarly, Collins et al. (2011) describe harm reduction as a compassionate approach that respects the inherent value and dignity of individuals engaging high-risk behaviors (compassion has been described as prosocial form of empathic response; Singer & Klimecki, 2014). In developing the Toronto Empathy Questionnaire, Spreng, McKinnon, Mar, & Levine (2009) described two components of empathic responding: cognitive empathy, or the ability to comprehend others' emotion states, and affective empathy, or having compassion for others' emotions. Empathy was a trait of interest for the current study due to being a well-defined aspect of effective counseling and a characteristic of harm reduction philosophy.

Within the context of the counseling profession, Clark (2007) offered the following definition of empathy: "attunement with the feelings and meanings of an individual's experience from an immediate or extended perspective" (p. 162). Clark developed his conceptualization of empathy as an extension of Rogers' views, describing an "integration model" involving subjective, interpersonal, and objective ways of knowing in a counseling relationship (2004; 2010). Clark clarifies subjective empathy "relates to a counselor's awareness of his or her sensibilities and internal reactions in response to the experiencing of a client" (2010; p. 349). This subjective piece of empathy involves counselors' ability to use intuition, imagination, and senses to identify with the client. The interpersonal component of empathy involves the counselor relating the client's present emotions and reactions, as well as the contextual factors that influence their perceptions (Clark, 2010). Finally, objective empathy involves counselors understanding the larger context of a client's reference groups, including individuals with similar experiences and culture (Clark, 2004). Clark's integration model offers a comprehensive, modern view of what empathy is within counseling. Clark also suggests that while Rogers' Person-

Centered approach most-clearly emphasizes empathy, this trait allows counselors of various theoretical groundings to properly gauge which interventions and techniques will be most effective (2010).

Norcross and Wampold (2011) identified empathy as a factor that is “demonstrably effective” in producing positive outcomes in counseling. In fact, empathy is considered one of the common factors in successful counseling, regardless of presenting issue or other client or counselor factors (Wampold, 2015). Sommers-Flanagan (2015) affirmed that empathic understanding is an aspect of evidence-based counseling practice, which connects to counseling techniques such as validating feelings, reflection, and paraphrasing. Of relevance to the current study, Moyers and W. Miller (2013) highlight that, although there are varying effect sizes in studies of empathy in substance use counseling, counselors’ empathic responsiveness accounts for a significant amount of variance in outcomes for clients with substance use issues. W. Miller and Moyers (2013) connect the well-established fidelity and effectiveness of Motivational Interviewing to its focus on relational factors emphasized by Rogers, especially empathy. Empathy is a well-established cornerstone of counseling practice, with strong evidence as key common factor for therapeutic change. This remains true in the treatment of substance use, including OUD.

Empathy is also congruent with harm reduction practices for substance use, including responses to the Opioid Epidemic. Collins et al. (2011) highlight compassion as a hallmark of harm reduction philosophy and practice. In describing how treatment providers must approach clients using a Motivational Interviewing and harm reduction philosophy, Denning (2001), a leader in the harm reduction therapy movement, summarizes: “The therapist must display an empathy that not only communicates acceptance, but also ‘I get it,’ meaning that the therapist

does actually understand why this person may have chosen to use drugs” (p. 24). While the word “compassion” is used more frequently in descriptions of harm reduction (Denning & Little, 2012; Collins et al., 2011; Harm Reduction International, 2019), empathic responses to people struggling with substance use is vital ingredient for this treatment philosophy.

Social Justice: A Core Value in Counseling and Harm Reduction

Social justice has been described as the “fifth force” in the counseling profession, following psychoanalytic, behavioral, humanistic, and multicultural movements (Ratts, 2009). Social justice’s importance within the counseling profession is evidenced by the development of Multicultural and Social Justice Counseling Competencies by the American Counseling Association, as well as the establishment of Counselors for Social Justice, a division within the American Counseling Association (Ratts et al., 2016). Pauly (2008) encourages the use of a social justice framework to apply harm reduction in communities by acknowledging and advocating for changes in policy and social structures that create inequity based on substance use and intersecting identities (race, religion, socioeconomic status, gender identity, sexual orientation, and more). Harm Reduction International identifies a commitment to social justice and engaging individual who use substances when developing programs and policies as one of the principles of harm reduction (2019). Social justice and advocacy for underrepresented groups, including substance users and their intersecting identities, encompass shared emphases for the counseling profession and the philosophy of harm reduction.

In defining social justice, Chang et al. (2010) propose:

...The goal of social justice is to ensure that every individual has an opportunity to resources such as health care, employment, and to achieve optimal mental health. The process of achieving social justice should be one that is participatory and one that

considers the community in which clients live. This perspective holds that client problems are largely rooted in oppressive environmental factors... (p. 84)

Ratts et al. (2016) highlighted that social justice emphasis in counseling starts with understanding issues such as oppression, stigma, marginalization, and privilege, in order to strategically take advocacy-oriented action within counseling relationships and in society in general. At a training level, there is an emphasis on experiential learning of social justice and advocacy efforts within the counseling profession, such as participating in legislative advocacy efforts of professional organizations or attending to proposed policy changes (Fickling & Gonzalez, 2016). In a phenomenological study of counselor educators and doctoral students, Dollarhide, Clevenger, Dogan, and Edwards (2016) described four themes of social justice identity development: historical/shaping experiences before becoming a counselor, changes in thoughts, emotions, and behavior related to social justice awareness, internalizing the identity of a social justice advocate, and a feedback loop that increased understanding and identity.

Dollarhide et al. (2016) encourage training programs to use experiential learning to foster an impactful feedback loop that challenges counseling students to think and feel critically related to intersecting identities and justice. In a grounded theory study of 20 mental health professionals-in-training that explored the impact of practicum experiences (experiential learning during graduate training), themes of social justice perspective development included self-awareness and personal growth, honoring the experiences of oneself and others, and taking action by challenging power structures to create positive social change (Hoover and Morrow, 2016). The development and cultivation of social justice orientations has been a priority within the counseling profession for over a decade.

Harm Reduction International (2019) lists a commitment to social justice as one of the principles of the harm reduction approach to healing, stating:

Harm reduction is rooted in a commitment to addressing discrimination and ensuring that nobody is excluded from the health and social services they may need because of their drug use, their race, their gender, their gender identity, their sexual orientation, their choice of work, or their economic status. People should be able to access services without having to overcome unnecessary barriers, including burdensome, discriminatory regulations. Further, the meaningful involvement of people who use drugs in designing, implementing and evaluating programmes and policies that serve them is central to harm reduction. (para. 6)

In a more succinct description, Collins et al. (2011) affirms that Pauly's (2008) social justice framework for harm reduction "aims to identify harms to affected individuals that have been precipitated by the larger social context and seeks to use harm reduction strategies as a means of reducing the associated disparities" (p. 22). In an ethnographic qualitative study related to medication-assisted treatment in Canada, Smye, Brown, Varcoe, and Josewski (2017) found that clients experienced stigma and marginalization due to colonialism, especially based on intersectional identities. This included reinforced stereotypes indicative of racism and stigma for being substance users. This study, which used naturalistic observations and focus group interviews of clients and providers in mental health and addiction treatment programs, led the authors to recommend that harm reduction practitioners ensure that their work is broadened to address systemic issues of inequality and social justice (Smye et al., 2017). Affirming the importance of adapting laws to support harm reduction to reduce stigma and unjust treatment of substance users, Moro and Burson (2018) stated that "[harm reduction] is more closely related

with social policy than any other addiction theory. Expansion and reconceptualization of social policy is crucial for [harm reduction] to be successful” (p. 240). Social justice emphases are a core component of harm reduction philosophy, which includes advocating for these approaches to be embraced by society. Social justice was of interest to this study, given that it is a core principle of professional counseling and harm reduction philosophy.

Counselor Professional Identity and Values

Using Delphi methodology with feedback from a diverse array of counseling professionals, Kaplan et al. (2014) arrived at the following definition of professional counseling, which was endorsed by 29 professional counseling organizations: “Counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals” (p. 366, 368). This definition is an appropriate starting point, as it is the most concise, yet thorough, definition of professional counseling that has been developed based on research. It is noteworthy that the organization for school counselors and Counselors for Social Justice (based on a lack of emphasis on advocacy and acknowledging systemic injustices) declined to endorse this definition (Kaplan et al., 2014). While there has been an inconsistency in how professional counselor identity has been previously defined, Woo, Henfield, and Choi (2014) used a systematic review of literature to distill the following defining components of professional counselor identity:

- (a) knowledge of the profession, (b) philosophy of the profession, (c) expertise required of members and understanding of members’ professional roles, (d) attitudes toward the profession and oneself, (e) behaviors expected of members of the profession, and (f) interactions with other professionals in the field. (p. 6)

The factors described by Woo et al. (2014) encapsulate core focuses of counselor identity, including how professional counselors are unique in comparison to other mental health professions (social work, psychology, and medical fields). This differentiation takes into account that development, prevention, wellness, empowerment, and advocacy are grounding principles of professional counseling philosophy (Gladding & Newsome, 2004, as cited in Woo et al., 2014). In addition, Mellin, Hunt, and Nichols (2011), found that professional counselors they surveyed defined the profession by the types of activities engaged by counselors, the type of training and credentials counselors have, and a healing philosophy focused on wellness and prevention. Scholars have also acknowledged a difficulty establishing a unified professional identity due to counselors often defining their work by their sub-specialties and interests (Kaplan et al., 2014; Mellin et al., 2011). The professional identity of counselors has been a topic that has received a lot of attention in scholarly literature. The definitions offered by Kaplan et al. (2014) and Woo et al., (2014) are appropriate starting points in understanding that identity.

Professional identity is often described as a developmental process (Rønnestad & Skovholt, 2003; Gibson, Dollarhide, & Moss, 2010). Gibson et al. (2010) described counselors being influenced by intra-professional experiences (interactions with fellow students, supervisors, and peer counselors) and interprofessional experiences (interactions with other mental health providers and larger treatment systems) as they internalize the professional identity of counseling. Using focus groups with 43 school counseling and marriage and family counselors-in-training, Gibson et al. (2010) synthesized a developmental process for counselors in which external validation, coursework, and field experiences led to an internalizing of professional values and identity. Rønnestad and Skovholt (2003) described six stages of counselor development: lay helper, the beginning student, the advanced student, the novice

professional, the experienced professional, and the senior professional. Their longitudinal study of 100 counselors and therapists also found many themes of development, which included integrating the self with professional identity, a commitment to learning, professional development as a lifelong process, clients as facilitators of growth, seeing the client as the “hero”, and witnessing suffering leading to appreciation of human vulnerability, among other themes (Rønnestad & Skovholt, 2003). Because early identity development is crucial for counseling students, Reiner, Dobmeier, and Hernandez (2011) suggested that counselor educators have an immense responsibility to instill professional values in trainees, linking those values to professional advocacy efforts. Master’s level training relates to the development of professional counselor identity (Hurt-Avila & Castillo, 2017), including a significant focus on identity development in the CACREP training standards (2016). Hurt-Avila & Castilo (2017) compared the identity development of counselors trained in CACREP programs with those trained in other counseling programs, finding that CACREP graduates scored higher on a measure of counselor professional identity. Additionally, multiple scholars have highlighted graduate training as a component of the developmental process of becoming a professional counselor (Rønnestad & Skovholt, 2003; Healy & D. Hayes, 2012) These studies highlight how the professional identity of counselors emerges due to their training and field experiences, with an internalized philosophy of empowering clients developing over time.

To more clearly situate the identity of professional counseling in comparison to social work and psychology disciplines, Mellin et al. (2011) used qualitative data obtained via questionnaires distributed to 238 professional counselors. The questionnaire focused on professional identity and interprofessional collaboration. Most respondents reported clear discernment of professional counselors compared to these peer professionals. The themes that

emerged related to differences counselors and peer professions included: less focus on case management activities and more attention to individual needs compared to social workers, less focus on assessment and testing compared to psychologists, and more focus on wellness, personal growth, and empowerment than the other professions (Mellin et al., 2011). Healy (2009) also described the counseling profession as having a clear distinction from psychology and social work based on valuing advocacy for clients, empowerment of individuals, and a wellness-oriented approach to change. Healy acknowledged that work expectations of these three types of therapists may be similar, while their approach and philosophies differ (2009). The values and areas of emphasis for counselors is closely tied to their professional identity, which contributes to their unique helping philosophy among mental health professions.

Morgen, Miller, and Stretch (2012) examined licensure and credentialing of addiction counselors and observed mixed messages sent to counselors who treat addiction. Namely, the secondary training requirements beyond what exists in CACREP to achieve credentials for substance use or addiction counseling in multiple states send a message that “standard” counseling training might not prepare counselors to treat addiction. Morgen et al. (2012) call for a recalibration of counselor training and various organizations involved with credentialing professional counselors for addiction work, in which there is more communication and alignment in training standards. Other scholars have documented other unique aspects of counselor identity for counselors providing substance use treatment, given that many addiction counseling credentials do not require masters level training (Laschober, Eby, & Sauer, 2013) and because many addiction treatment providers are in recovery from substance use themselves (Curtis & Eby, 2010). The current study focused on professional counselors with master’s level training in counseling, as they are most likely to embrace the values and philosophy of the wider discipline

of professional counseling, including emphasizing development, wellness, prevention, empowerment, and advocacy (Woo et al., 2014). It is worth considering that the identity and treatment philosophy of counselors treating substance use are also influenced by their organization and personal experiences (Curtis & Eby, 2010).

Counselor professional identity was of interest for the current study, as these professional values may influence perceived benefits and utility of harm reduction approaches for OUD. For instance, empowering individuals on their terms may include offering or recommending services that improve quality of life without prerequisite conditions, such as abstaining from opioids (or other substances) before receiving housing support. Valuing holistic, wellness-based interventions may push counselors to embrace approaches that reduce secondary harms of opioid use, such as infection prevention advanced by needle exchange programs. Also, advocating for the rights of substance users is congruent with social justice values of the counseling profession, as substance users have been marginalized in American society. Although there seems to be overlap between counselor identity and harm reduction philosophy, this has yet to be explored in the literature. Professional counselors' unique values are a variable of interest for the current study, as these professionals are front line providers treating clients affected by OUD.

Linking Harm Reduction and Counseling: Social Justice, Empathy, and Identity

The Opioid Epidemic has caused significant loss of life due to fatal opioid overdoses, as well as systemic harm to communities nationwide. Social justice and empathic responding to individual needs seem to be congruent aspects of harm reduction philosophy and the values of professional counselors. Professional counselors have a unique identity and helping philosophy amongst clinical treatment professions. Harm reduction encompasses a variety of services and approaches, including Motivational Interviewing and medication-assisted treatment. This

contemporary approach to treating substance use differs, yet is not in conflict with, prior abstinence-based models that have been prevalent in the addiction counseling field (Collins et al., 2011). Harm reduction approaches have efficacy and are promising responses to the Opioid Epidemic (J. Carroll et al., 2018; Nadelmann & LeSalle, 2017). At its core, harm reduction seeks to prevent harm, empower individuals who use substances, and improve their quality of life. The current study sought to explore multiple aspects of counselor acceptance of harm reduction strategies for OUD. This included comparing counselors' acceptance of harm reduction for OUD to peer addiction treatment professionals, as well as exploring how professional counseling identity and values, social justice attitudes, and empathic responding traits predict harm reduction acceptance for OUD. Each of these variables was of interest individually, and as a combined model of what may predict harm reduction attitudes for OUD among professional counselors.

Professional counselors are among the front-line treatment providers supporting individuals affected by OUD. In exploring the differences in philosophy between the Twelve Steps and the values of the counseling profession, Le et al. (1995) contrasted counseling's values of empowerment, change, growth, and development with what they describe as a focus on powerlessness, dependence, and humility within the Twelve Step literature. In a grounded theory study of substance use counselors and clients in treatment, Koehn and Cutcliffe (2012) described the instillation of hope in substance use counseling as requiring a therapeutic bond, actively changing of perspectives, and as a co-constructive process. These authors cite research correlating hope with positive outcomes in substance use treatment, recommending interventions that focus on sustaining and reinforcing hopefulness at various stages of change. As described in the previous section, the counseling profession values wellness and empowerment-oriented

interventions (Mellin et al., 2011) and scholars have described the profession as having humanistic roots (Dollarhide & Oliver, 2014; Hansen et al., 2014). These values and foundations of professional counseling are highly congruent with the shift towards Motivational Interviewing and harm reduction in addiction treatment, as these approaches emphasize empowering individuals on their own terms.

The methods of this study allowed for exploration of the relationship between overlapping core components of harm reduction and professional counseling. Professional counselors treating substance use in communities nationwide have valuable perspectives about how to engage the change process of clients with OUD and other substance use struggles. Empathic responsiveness is known to be a core condition of the change process (Norcross & Wampold, 2011) and a value of humanistic approaches, as well as being considered foundational to professional counseling (Hansen et al., 2014). Addiction counselors also have opportunities to influence colleagues, treatment systems, and public policy through social justice focused advocacy, which may include supporting harm reduction programs congruent with a public health approach to addressing substance use issues. Despite values that align well with harm reduction, counselors are also influenced by the addiction treatment systems that embrace abstinence-only or Twelve Step ideologies that have historically been utilized in these programs, which may discourage the embracement of harm reduction. Given the significant loss of life due to fatal overdoses associated with the Opioid Epidemic, it is crucial to understand professional counselors' attitudes towards efficacious harm reduction approaches for OUD.

Statement of the Problem

Given the evidence for harm reduction approaches reducing opioid overdoses and increasing treatment engagement, there is a need to understand how counselors perceive these

interventions for OUD. Professional counseling identity and harm reduction philosophy overlap in emphases, including valuing empathy and compassion for people receiving services and a commitment to social justice. This study explored professional counselors' acceptance of harm reduction approaches to OUD, including how counselors' perceptions differed from other addiction treatment professionals, and the influence of the level of acceptance as predicted by empathic responsiveness, social justice attitudes, and professional counseling values. The primary issue is that no research to date has explored professional counselors' attitudes towards harm reduction for OUD, at a time when thousands of Americans are dying each year due to fatal opioid overdoses (CDC, 2018a). This problem was explored by reviewing relevant literature on perceptions of harm reduction approaches as it relates to OUD treatment.

The Importance of Understanding Addiction Providers' Perceptions

Counselor perceptions of interventions, supervision, and populations have been topic of interest in scholarly literature. Of relevance to the field of addiction counseling, prior studies specifically focused on substance use counselors' perceptions of medication-assisted treatment (Rieckmann, Daly, Fuller, Thomas, & McCarty, 2007; Knudsen, DuCharme, & Roman, 2007; Abraham, Rieckmann, McNulty, Kovas, & Roman, 2011; Kang, Magura, Nwakeze, & Demske, 1998), supervision in addiction treatment (Lachober, de Tormes, & Sauer, 2012), and evidence-based practices in addiction counseling (Bride, Kintzle, Abraham, & Roman, 2012). None of these studies narrow the focus to addiction providers who identify as professional counselors, including those trained in master's-level CACREP or analogous training programs. A review of studies will summarize research exploring the perceptions of differing treatment approaches among addiction providers.

Among reviewed studies of counselor perceptions of medication-assisted treatment, “counselors” were not defined by master’s level training in professional counseling, but rather their role in providing addiction treatment. Rieckmann et al. (2007) found an association between the acceptance of buprenorphine treatment and perceived social norms, as well as more acceptance of buprenorphine among outpatient counselors than those in higher levels of care. In this study, less than half of the 376 “counselors” sampled in Oregon and Massachusetts held a bachelor’s degree or higher, with the authors noting that residential programs (more intensive) employed a higher number of “counselors in recovery” (Rieckmann et al., 2007). Rieckmann et al. (2007) conclude, “[a]s the ‘gate-keepers’ of clinical information and referrals, the attitudes and intentions of substance abuse counselors may affect the use of new medications” (p. 213). Knudsen et al. (2007) found that greater exposure to the use of buprenorphine was associated with acceptance of this treatment for OUD among addiction counselors, even among those with Twelve Step orientations. Similarly, naltrexone acceptance among substance use counselors has been associated with exposure to the use of that treatment (naltrexone is a medication that curbs cravings for opioids; Abraham et al., 2011). Abraham et al. (2011) noted that providers in their study who ascribe to Twelve Step orientation perceived medications for addiction treatment more negatively, recommending required education on these approaches for licensure and certification of substance use counselors. In this study, slightly more than half of the providers were master’s level (53%) and the study focused on the treatment of alcohol use, with a slight majority (53%) endorsing acceptance of naltrexone (Abraham et al., 2011). In a study comparing social workers with other addiction providers, Bride et al. (2012) found that those with a social work background were more likely to have a master’s degree, but did not always have more training in Motivational Interviewing or Contingency Management, which are evidence-based

practices for substance use treatment. Bride et al. (2012) determined there were complicated relationships between professional discipline, recovery status, and ascription to Twelve Step orientation with the use of evidence-based practices. The authors described a statistically significant relationship between colleagues' use of these approaches and acceptance in their sample. These studies of addiction treatment provider perceptions of medication-assisted treatment affirm that acceptance of evidence-based practices varies and may relate to education, exposure, and treatment orientation.

While there seems to be interest in addiction treatment providers' attitudes towards medication-assisted treatment and other evidence-based practices used to treat OUD, there is a lack of research focused on professional counselors. Professional counselors have a minimum of a master's degree and many counselors receive training in programs that meet accreditation standards of CACREP (2016), which has specific criteria for classroom and experiential learning. Lee, Craig, Fetherson, and Simpson (2012) highlight changes in the 2009 CACREP standards, showing an increased emphasis on CACREP-accredited Clinical Mental Health Counseling programs preparing students to work with clients with addictions, changes that remained in the 2016 CACREP standards. Iarussi, Perjessey, and Reed (2013) found that 76.7% of CACREP-accredited Clinical Mental Health Counseling programs had a specific course focused on addictions work. There are also currently 10 CACREP-accredited Addictions Counseling programs (CACREP, 2019) whose training is more specialized for addiction treatment. There is a need to understand how the professional identity of counselors informs their perceptions of addictions treatment interventions, including harm reduction approaches for OUD.

Treatment Providers' Perceptions of Harm Reduction

While research on the impact of provider perceptions in addictions treatment has lacked a focus on professional counselors, studies examining harm reduction acceptance among addiction treatment providers exist in the literature. Studies and literature related to harm reduction acceptance have focused on: non-abstinence goals among providers and students (Rosenberg & Davis, 2014; Davis & Lauritsen, 2016; Davis, Rosenberg, & Rosansky, 2017), harm reduction for intravenous drug users (Bonar & Rosenberg, 2010; Boucher et al., 2017; Vearrier, 2019), provider views of medication-assisted treatment (Aletaris et al., 2016), and low threshold housing programs (Henwood et al., 2014), among other studies. Studies that explored how providers perceive various aspects of harm reduction philosophy (such as accepting non-abstinence) and specific harm reduction approaches (such as needle exchange) will be reviewed.

Provider Perceptions of Non-Abstinence Goals

Use reduction and supporting goals that do not include abstinence define the harm reduction approach to treatment (Collins et al., 2011; Denning & Little, 2012). Rosenberg and Davis (2014) explored the acceptance of non-abstinence goals among a nationwide sample of substance use clinicians affiliated with the Association of Addiction Professionals (NAADAC, based on their prior name, National Association of Alcohol and Drug Abuse Counselors; NAADAC, 2019). The primary finding of this study was that these clinicians were more accepting of moderation goals for clients with less severe diagnoses, as well as those using cannabis or alcohol, compared to other substances. While no relationships with theoretical orientation were reported, the study included 432 clinicians, with 65% identifying a Twelve Step orientation, 64% identifying a motivation enhancement orientation, and 42% identifying a humanistic orientation to treatment (participants could select multiple orientations; Rosenberg & Davis, 2014). 68% of the sample had at least master's level training. Additionally, a qualitative

question at the end of the quantitative survey led to themes that acceptance of non-abstinence goals was associated with education about harm reduction and exposure to clients who successfully moderate substance use. Non-acceptance was associated with Twelve Step ideology and experiences with friends or family members who use substances, as well as exposure to clients unsuccessful with moderation. Rosenberg and Davis (2014) noted that younger clinicians might be more knowledgeable about harm reduction approaches and more accepting, although their sample included only middle-ages clinicians and did not find that years of professional experience predicted harm reduction acceptance. Rosenberg and Davis (2014) also recommend treatment programs embrace more flexible approaches, consistent with endorsing a philosophy of multiple pathways to recovery. The Rosenberg and Davis (2014) study offers insight into client and provider factors that influence the acceptance of harm reduction, but it falls short in identifying the influence of training discipline, level of training, or professional identity.

Similar to the Rosenberg and Davis (2014) study, Davis and Lauritsen (2016) explored how college students taking coursework in addictions and substance use treatment perceive non-abstinence goals, using the same type of survey questions. As with the prior study of practitioners, the authors found that students were generally not accepting of non-abstinence outcome goals, with slightly more students accepting non-abstinence outcomes for individuals with Alcohol and Cannabis Use Disorders, compared to other illicit drugs, such as opioids (Davis & Lauritsen, 2016). Another similarity to the Rosenberg and Davis (2014) study was that these students had slightly more acceptance for non-abstinence as an “intermediate” goal, rather than a long-term outcome goal (Davis & Lauritsen, 2016). Another related study examined acceptance of non-abstinence goals for clients with co-occurring psychiatric and substance use diagnoses (Davis et al., 2017). Exploring the perceptions of 751 credentialed substance use clinicians of

clients using various substances of abuse with co-occurring Posttraumatic Stress Disorder, Major Depression, or Social Phobia, the researchers once again found a low acceptance rate for non-abstinence for substance use clients, regardless of these mental health diagnoses (Davis et al., 2017). Post-hoc analyses in this quantitative study revealed no increase in acceptance based on participants reporting training in harm reduction.

Each of these quantitative studies focused on non-abstinence (Rosenberg & Davis 2014; Davis & Lauritsen, 2016; Davis et al., 2017) employed similar survey questions and found that less than a third of students or trained addiction providers accepted non-abstinence goals for clients. Perhaps the most important limitation of these studies is that the questions failed to offer a clear picture of what outcomes might be desirable in conjunction with moderation or use reduction (such as improved quality of life or functioning). Of relevance to the current study, while questions were asked about level of training (i.e. high school diploma, bachelors, masters or higher, or specific addictions treatment specialization) in these questionnaires, no data were analyzed related to the impact of professional discipline. Different professions have distinct philosophies of healing that may impact acceptance of non-abstinence goals. A notable strength of this collection of studies is that each sample of providers and students came from different convenience populations, adding to the ability to generalize these findings. Each study encouraged more investigation of factors that influence these perspectives, as supporting non-abstinence goals aligns with respect for client autonomy.

Perceptions of Specific Harm Reduction Strategies

Specific harm reduction strategies relevant for responding to the needs of individuals with OUD include Motivational Interviewing, medication-assisted treatment, distribution of Naloxone to users for overdose reversal, distributing Fentanyl testing kits, needle exchange

programs, and safe consumption sites. While studies of addiction treatment provider perspectives on all of these approaches is elusive, relevant research studies will be reviewed in this section.

Medication-assisted treatment is considered the gold standard of care for people with OUD (Bart, 2013). Aletaris et al. (2016) explored the perceptions of medication-assisted treatment among addiction treatment professionals by sampling clinicians at SAMHSA-identified addiction treatment programs. Their investigation found that the medications commonly used in medication-assisted treatment, buprenorphine and methadone, were seen less favorably by treatment professionals than psychosocial approaches (counseling only). This is concerning, given the well-known efficacy of both methadone and buprenorphine in improving outcomes for people with OUD, including improved social functioning, reduced opioid usage, and better treatment retention, which reduces overdose risks (Bart, 2013). Aletaris et al. (2016) found more acceptance buprenorphine treatment was among professionals than methadone and that increased knowledge about medication-assisted treatment correlates with acceptance of that treatment. This research also found a negative association between Twelve Step orientations and acceptance of these interventions, which the authors note may be due to medication-assisted treatment not being perceived as abstinence. The study sampled substance use disorder “counselors” at these sites, although only 47% of the sample held a master’s degree or higher (another example of studies focusing on counselors that would not match the definition of professional counselors of interest for the current study). In contrast, more adaptable orientations were associated with acceptance of medication-assisted treatment in this study (Aletaris et al., 2016). These authors recommended training programs for addiction treatment providers prioritizing education about medication-assisted treatment, as many respondents in their study (20%) felt they did not know enough about the interventions to have an informed opinion.

Overall, Aletaris et al. (2016) support the importance of exploring factors that contribute to acceptance of harm reduction approaches for OUD that are efficacious, given the potential consequences of not offering these options to clients (relapse, fatal opioid overdose). As with other studies, despite Aletaris et al. (2016) finding the higher levels of education were associated with acceptance of medication-assisted treatment, the authors did not examine the influence of professional discipline and values, a focus of the current study.

Kepple, Parker, Whitmore, and Comtois (2019) investigated admission rates to 410 programs providing medication-assisted treatment and found that many clients with OUD face significant barriers in meeting admission criteria and obtaining treatment at these facilities. Because barriers already exist for clients with OUD in receiving this evidence-based treatment, it is essential that there is an understanding of substance use treatment providers' views, given that they could create additional barriers due personal biases and misinformation about these programs. While this is just one component of harm reduction for OUD, medication-assisted treatment was not widely accepted in this sample, despite strong evidence for its efficacy (Bart, 2013), and being identified as evidence-based practice for overdose prevention by the CDC (Carroll et al., 2018).

Another component of harm reduction is providing access to services, such as housing or healthcare, without mandating abstinence from recipients of these supports. Henwood, Padgett, and Tiderington (2014) used qualitative interviews to investigate harm reduction approach perceptions among 41 providers working in homeless intervention programs in New York. The authors' primary conclusion was that providers working in harm reduction programs that did not require abstinence to provide housing had positive views of these services and their work, despite having to navigate difficult situations at times (Henwood et al., 2014). On the contrary,

providers working in programs that required abstinence to receive and maintain low-income housing (described as a “treatment first” approach) were less aware of harm reduction options and endorsed frustration with relapse and denying housing to homeless people because of drug use. Harm reduction providers also tolerated ambiguities of their work better, while abstinence providers struggled with enforcing policies while wanting to be helpful. It is worth noting that harm reduction approaches were only broached by the interviewers when the participants discussed this topic, as the interview more generally explored their work as housing providers. Kennedy, Arku, and Cleave (2017) found similar provider perspectives in a qualitative study of providers working in “housing first” programs in Ontario, Canada. This study involved individual interviews and a focus group with 11 providers working in these programs, all of whom had previous experience with abstinence-based housing programs. Similar to Henwood et al. (2014), Kennedy et al. (2017) found that providers preferred the flexibility of harm reduction programs and saw this approach as more effective in addressing homelessness. Kennedy et al. (2017) did find that providers in “housing first” programs still faced systemic barriers to achieving housing for clients with dual diagnosis (substance use and mental health disorders), but providers found these programs to be more successful and positive experience for providers. While these two studies were small scale and qualitative, they do provide evidence for providers benefiting from flexibility in harm reduction programs, including related to housing. Like other studies of harm reduction provider perceptions, these studies lack a focus on the influence of professional discipline and associated professional values.

Needle exchange programs allow intravenous drug users to receive sterile injection equipment, in addition to education about safer drug use practices, in exchange for used injection equipment, including syringes. These programs are key to the Opioid Epidemic, as they focus on

reducing the transmission of diseases such as HIV and Hepatitis C among opioid users who inject drugs by reducing needle sharing (Vidourek et al., 2019). Additionally, these services help reduce bacterial infections associated with repeat use of the same needle. In a review of articles related to needle exchange programs in the United States, Vidourek et al. (2019) noted limited research on provider views of needle exchange programs. They described two articles that explored pharmacists' perception, with each noting mostly negative views of needle exchange due to biases not based in evidence (worry about violence at these facilities, for instance; Vidourek et al., 2019). Vidourek et al. (2019) highlight the importance of training professionals who provide services to substance users to ensure they have sufficient knowledge to inform their views of harm reduction programs, including needle exchange programs, in order to appropriately advise their clients/patients. In a survey of 24 healthcare workers working in needle exchange programs in Toronto and Vancouver, Canada, O'Leary et al. (2018) found strong support among treatment providers for harm reduction approaches leading to positive client outcomes, while noting concerns about making clients "comfortable" with their drug use. The primary theme that emerged from their qualitative surveys was that providers saw the benefit of building relationships with drug users and that these relationships helped them connect these clients to other needed services (O'Leary et al., 2018). Only six of the 24 participants were master's level social workers or counselors (unclear how many of each) in this study. As with other harm reduction literature cited, there is minimal exploration of professional discipline impacting harm reduction acceptability and no exploration of professional counselors' attitudes towards needle exchange. Given the evidence that needle exchange reduces needle sharing, disease transmission, and improves engagement of drug users in treatment to reduce substance

use (Vidourek et al., 2019), it is important to explore if counselors and other professionals are supportive of these efficacious interventions.

Additional harm reduction approaches to the Opioid Epidemic of interest to this study include the distribution of Naloxone for opioid overdose reversal (only works for opioid overdoses) and Fentanyl testing kits determine adulteration of drugs with this dangerous substance, as well as the proliferation of safe consumption sites. Fentanyl testing strips can be given to opioid users to check their drugs or their urine to determine if their drug supply is contaminated with Fentanyl, which is highly potent and increases the risk of overdose. By knowing if Fentanyl is in their drug supply, drug users can decide to not use that supply or use smaller doses to reduce the risk of a fatal overdose. Krieger et al. (2018) found that this method of increasing safety and reducing Fentanyl overdose risk for illicit opioid injection drug users was accepted and highly utilized by a sample of young adults. Glick et al. (2019) explored stakeholder perspectives of Fentanyl test strip distribution in three cities in the northeastern United States, with many participants in this qualitative study being treatment providers. Glick et al. (2019) noted high demand for Fentanyl testing strips among people who inject drugs in a pilot program in Boston. Glick et al. (2019) also documented that these testing strips are often handed out at needle exchange program sites and other harm reduction facilities (and would be utilized at safe consumption sites, if available). These authors found that providers feel Fentanyl testing strips help reduce harm and risk to users, while helping facilities and providers build trust with users (Glick et al., 2019). The main concern among providers in this study was the legality of helping users test their drug supply and the current delay in policy catching up with this approach to harm reduction. This harm reduction approach is new and more research is needed into

provider acceptance and support, including among professional counselors treating clients with OUD.

Naloxone is a medication that can reverse an opioid overdose quickly by being administered via injection or intranasal solution by a bystander witnessing the event. The distribution of Naloxone to illicit and prescription opioid users is considered a form of harm reduction, as it may allow a person to survive an overdose to seek immediate medical care and, perhaps, long term substance use treatment. Much like an Epipen reverses a potentially fatal allergic reaction, Naloxone can reverse the neurological cause of respiratory depression brought on by an opioid overdose. Naloxone distribution is considered evidence-based practice for reducing fatal opioid overdose (Carroll et al., 2018) and is shown to reduce mortality rates among opioid users who carry a supply of emergency Naloxone (MacDonald & Strang, 2016). Although there are studies that examine Pharmacist prescribing practices with Naloxone (Kwon, Moody, Thigpen, & Gauld, 2019; Mueller, Koester, Glanz, Gardner, & Binswanger, 2017) and the impressions of emergency medical technicians (Bessen et al., 2019), only one study was found that explored a sample that included other substance use treatment providers' attitudes towards this harm reduction intervention (Haug, Bielenberg, Linder, & Lembke, 2016). Haug et al. (2016) used a grounded theory approach to analyze posts on Twitter related to Naloxone distribution among professionals who work with substance users. While it is unclear how many counselors fell into the "other" category of professionals (sample included several professions, but not counselors, specifically), of the 368 professionals who posted online about Naloxone, many reported high levels of burnout and frustration with treatment, although this was reduced among those trained to administer Naloxone (Haug et al., 2016). This study offers little evidence about how providers who treat substance use in therapeutic programs perceive the benefits and

effectiveness of this approach, but it does show that many medical and first responders are overwhelmed by the Opioid Epidemic and looking for answers. Once again, the distribution of Naloxone to opioid users is recommended practice and there is a need to understand the level of support among substance use treatment professionals, including professional counselors.

Safe consumption sites are locations where substance users, including those using opioids, can come to consume substance safely, with sterile equipment, medical staff present to treat infections or overdose, and link clients to appropriate treatment services they are open to engaging. Safe consumption sites may also incorporate other harm reduction services on-site, including exchanging needles, distributing Naloxone, and providing Fentanyl testing kits to users. No studies found in a literature search explored the perceptions of safe consumption sites among substance use treatment professionals in the United States, most likely because there are no legally operating safe consumption sites in the country at this time (although recently, Safehouse, an organization in Philadelphia, Pennsylvania, won a lawsuit to pursue the opening of a safe consumption site; Allyn, 2019). Lange and Bach-Mortensen (2019) reviewed 47 articles that summarized stakeholder perspectives of safe consumption sites in Canada, Australia, England, and other European countries, with stakeholders including drug users, staff at the facilities, law enforcement, health professionals, and the general public, among others. Lange and Bach-Mortensen (2019) distilled a few main themes from their analysis, identifying that providers see the benefit of reducing stigma towards substance users and providing effective education about safe injection practices, while many members of the public and law enforcement worldwide have negative stereotypes related to enabling drug use. These authors believe that more education about drug users and the function of these facilities would increase acceptance. Other issues noted in this review of literature were concerns about finding appropriate locations

for these facilities and the importance of what language is used to describe their function (Lange and Bach-Mortensen, 2019; Barry, Sherman, & McGinty, 2018). Although not focused on providers, a study of 237 drug users receiving services at a needle exchange program in Boston found that injection drug users would be likely to utilize a safe consumption site if it were available (León, Cardoso, Mackin, Bock, & Gaeta, 2018). Lange and Bach-Mortensen's review summarized physical safety of users and positive relations between providers/staff and drug users as primary benefits of functioning safe consumption sites that have been studied (2019). There is a need to explore the perceptions and acceptability of this form of harm reduction among substance use treatment providers in the United States, given the possibility that these facilities may become available in the future. As counselors seek evidence-based responses to the Opioid Epidemic, they will need to clarify their views on this comprehensive form of harm reduction.

Harm Reduction Acceptance among Counselors

Two dissertation studies examined harm reduction acceptance among professional counselors (those trained in master's level graduate counseling programs; Kyser, 2010; Madden, 2016). Kyser (2010) utilized a sample of American Counseling Association (ACA) professional members. The survey was sent to 2,000 ACA professional members, with 176 completing the survey. Kyser (2010) used multiple regression to examine predictive relationships between counselor characteristics and harm reduction acceptance, using the Harm Reduction Acceptability Scale-Revised (HRAS-R; Goddard, Gauspohl, & Breitenbecher, 2004). Kyser found that counselor credentials, work setting (level of care), personal substance use history, and spirituality did not have a statistically significant impact on counselor acceptance of harm reduction. Kyser did find that knowing someone who has a substance use problem, more years of

experience in addiction counseling, and working in urban areas predictors of harm reduction acceptance, based on self-report (2010). Most importantly, Kyser found that ACA professional members were generally accepting of harm reduction strategies (Kyser based this finding on the sample having an average score on the HRAS of 2.69, below the midline score of 3.00).

In another dissertation study that sample ACA members, Madden (2016) used regression analyses to explore counselor characteristics that might be predictors of harm reduction attitudes. Madden used a sample of 100 ACA members nationwide who identified having a specialization in addictions or substance use. The study found that counselor age, personal recovery status, years of experience in addiction counseling, and education level were not statistically significant predictors of harm reduction acceptance. Madden did find that counselor philosophy related to the disease model of addiction and eclecticism were predictors of harm reduction acceptance (2016). Self-reports of disease model orientations predicted higher scores on the HRAS-R, indicative of less acceptance of harm reduction approaches. Similar to the Aletaris et al. (2016) finding that adaptability among providers is associated with acceptance of medication-assisted treatment, Madden's (2016) showed that more eclectic orientations predicted more acceptance of harm reduction. There is some conflict between Kyser's (2010) results and Madden's (2016) results related to the influence of years of experience, but this may be related to different sampling criteria. The major contribution of these two sources of data is that they specifically explored the harm reduction acceptance of professional counselors, while prior studies did not look into this specific population of interest.

These two dissertation studies are closely related to the current investigation; however, they do not address certain gaps in the literature. These studies also have limitations that may be addressed by the proposed methods and topics for this study. Madden (2016) and Kyser (2010)

each sampled ACA members, which represent professional counselors who are involved with that organization. While ACA members are professionally affiliated, they may or may not be representative of all professional counselors treating addiction in the United States. The proposed study will investigate professional counselors working in addiction treatment settings, regardless of affiliation to professional counseling organizations. Additionally, each of these studies focused on harm reduction approaches towards substance use in a general sense, evidenced by the use of the HRAS-R (Goddard et al., 2004), which does not narrow the scope of interest to specific substances. The proposed study narrows the focus to harm reduction for OUD, including specific strategies relevant to the Opioid Epidemic. The current study also strives to investigate overlapping values of the counseling profession and harm reduction philosophy, including emphasis on empathic responsiveness and social justice orientation. While the counselor variables explored by Kyser (2010) and Madden (2016), including career longevity, spirituality, and personal recovery status, are of interest, the current study will explore the influence traits and attitudes that represent important values to the counseling profession, which are congruent with harm reduction philosophy. Given the need to respond effectively to the Opioid Epidemic and the appearance of congruent values in professional counseling and harm reduction, there is a need for an exploration of the proposed research questions.

Harm reduction acceptance for OUD among substance use treatment professionals trained as professional counselors has yet to be studied. The parallels between harm reduction treatment philosophy and professional counseling values include relationship-focused intervention, respecting client autonomy, and empowering individuals to use their strengths to make positive change. These parallels warrant investigation of how professional counselors perceive the harm reduction approach for clients struggling with OUD, including the specific

programs best suited for addressing opioid use. This is especially important given the persistent, devastating loss of life and social harms caused by the Opioid Epidemic nationwide. The current study seeks to fill this need by exploring multiple aspects of counselor acceptance of harm reduction strategies for OUD.

Summarizing the Gap in the Literature

The current study aims to explore multiple aspects of counselor acceptance of harm reduction strategies for OUD. First, this study will examine the level of acceptance of harm reduction strategies among professional counselors. Second, this study will investigate differences in acceptability of harm reduction approaches for OUD between profession counselors and other addiction professional disciplines. Finally, this study will explore the predictive relationships that empathic responsiveness, social justice attitudes, and professional counseling values and orientation have on the acceptance of harm reduction approaches to treating OUD. No prior studies have compared counselor perceptions of harm reduction to peer addiction treatment professionals. Additionally, no prior studies have explored the relationship between professional counselor identity and perceptions of the harm reduction approach. Studies that have examined counselor perceptions of harm reduction have not focused specifically on opioid use, which is highly relevant given that there are many efficacious harm reduction approaches that fit well in addressing OUD and because opioids are responsible for the major increase in fatal overdoses over the last two decades (CDC, 2019). Social justice and advocacy for underprivileged groups are considered an essential component of counselor identity in the last decade (Toporek et al., 2009; Dollarhide et al., 2016), which also aligns with the mission of harm reduction approaches (Harm Reduction International, 2019). Harm reduction aims to reduce the stigmatization and criminalization of substance users through a public health approach

that respects individuals' autonomy related to choosing to use drugs, while working to keep them safe (Walthers et al., 2012). Empathy is also a congruent component of counselor identity and harm reduction, with empathy being described as a core component of the humanistic foundations of the counseling profession (Dollarhide & Oliver, 2014). Compassion and empathy have been described as ideals that inform harm reduction philosophy of treatment as well (Denning, 2001; Collins et al., 2011). The relationship between overlapping aspects of counselor identity and harm reduction treatment philosophy for substance use remain unexplored.

Furthermore, counselors are front line providers in treating individuals affected by OUD and the Opioid Epidemic at-large. Opioid use has several harm reduction strategies that are relevant for treating that addiction or are specific only to those substances (Fentanyl testing, medication-assisted treatment, Naloxone distribution). Given the massive toll the Opioid Epidemic has had on communities throughout the United States, there is an urgent need to explore how addiction treatment providers are treating clients with OUD. Because professional counselors have a unique approach to client care, there is a need to investigate how counselors compare to peer addiction treatment professionals in their acceptance of harm reduction strategies for OUD. Also, there is a need to understand if congruent aspects of counselor identity and harm reduction philosophy, influence the acceptability of harm reduction approaches for OUD among professional counselors who treat substance use.

Counselor training programs are emphasizing the instillation of the unique identity of the counseling profession, as evidenced by criteria for accreditation with CACREP (Section 2; 2016). Woo et al. (2014) described defining characteristics of the philosophy of professional counselors, including emphasizing clients' personal development, prevention, wellness, empowerment, and advocacy (p. 7). There are unique factors that influence the identity of

counselors treating substance use, including differing credentials (Morgen et al., 2012) and the influence of organizations they work for (Curtis & Eby, 2010); however, the professional identity of master's level counselors is a potential influence on their approach to healing and change for this population. Of interest to the current study is the way in which the values of professional counselors influence the acceptance of harm reduction for OUD among professional counselors treating substance use. Harm reduction approaches to opioid use have been shown to be effective (Logan & Martlatt, 2010), despite often being perceived as controversial in the United States (Moro & Burson, 2018). It is essential to explore if counselors, united in their philosophy of social justice, empathy, empowerment, and wellness, see harm reduction approaches as acceptable treatments for clients with OUD, given the loss of life via fatal opioid overdose and societal harm caused by the Opioid Epidemic.

CHAPTER THREE: METHODOLOGY

This chapter includes a description of the methods used to answer the research questions. The researcher describes the design of the study, research questions, and data analysis strategies, in addition to study limitations. These descriptions provide a roadmap for the course of this study, including how data was collected and analyzed to answer the research questions.

Research Design

The current study utilized quantitative research methods to explore professional counselors' acceptance of harm reduction for OUD among counselors who treat substance use, compare professional counselors to other professionals treating substance use, and examine the relationship between key components of professional counselor identity and harm reduction acceptance for OUD. Descriptive statistics were used to explore the levels of acceptance of harm reduction approaches for OUD among professional counselors in the sample. This included identifying the distribution of scores on measures of acceptance of harm reduction approaches for OUD among counselors, to explore the distribution of acceptance levels among counselors. A one-way analysis of variance (ANOVA) was then used to compare professional counselors to other substance use treatment professionals in the sample, in order to identify between group differences in harm reduction acceptability for OUD. Other professionals treating substance use in the sample included social workers, psychologists, peer recovery specialists, medical providers (doctors, nurses, and physician assistants), and treatment staff with bachelor's-level training or less (encompassing individuals that identified counseling, substance/addictions, case management, and other professions as their professional identity). Groups of allied substance use professionals were clustered to reduce the differences in group sizes for the ANOVA. This

resulted in four groups for that analysis: Professional Counselors (with master's level training or higher), Clinical Social Workers (with master's level training or higher), a group for those with master's level Psychology, and a group for treatment providers with a bachelor's degree or less (including those identifying their primary discipline of training as psychology, social work, counseling, substance use/addictions, case management, peer recovery support, and others).

Unfortunately, due to differences in professional identity and concerns about unequal sample sized, some substance use treatment providers with advanced degrees who completed the survey were not included in the analyses, including: Marriage and Family Therapists, Medical professionals (doctors, nurses, and physician assistants), and substance use or addiction counseling training. The rationale for grouping professionals with bachelor's level education or less separate from those with higher degrees (or medical professions) was the assumption that those with master's degrees or higher have training that reinforced their professional identity separate from their work setting or credentials. The ANOVA will allow a comparison of professional counselors treating substance to other professionals working in substance use treatment programs. Finally, a multiple linear regression analysis examined how well empathic responsiveness, social justice attitudes, and professional counseling values predict the acceptance of harm reduction approaches for treating OUD among counselors who provide substance use treatment.

This design and these analyses were selected due to the relative lack of research about how professional counselors, who are often front-line substance use treatment providers, perceive harm reduction strategies for OUD. Harm reduction acceptability has been explored among allied substance use treatment professionals, including being discussed in social work literature (Vakharia & Little, 2017) and studied among psychologists (Wryobeck & Rosenberg,

2005) and physicians (Cleirec et al., 2018). This topic has also been studied more broadly among substance use treating professionals (Goddard, 2003; Bonar & Rosenberg, 2010; Rosenberg & Davis, 2014; Deren, Kang, Mino, & Seewald, 2011), among substance using clients (Boucher et al., 2017), and in studies that included both clients and providers (Cleiric et al., 2018; Glick et al., 2019). Two studies explored harm reduction attitudes among American Counseling Association members presumed to be professional counselors (Kyser, 2010; Madden, 2016). No studies were found that examine treatment professionals' perceptions of harm reduction for opioid use, including among professional counselors specifically. Of relevance to the current study, harm reduction approaches show promise as novel and unique efficacious strategies for addressing the Opioid Epidemic, a public health crisis characterized by the dramatic increase in fatal opioid overdoses during the last two decades. The current study sought to examine the acceptance of harm reduction as an approach to treating OUD and preventing fatal opioid overdose among masters-level professional counselors who treat substance use.

Recruitment

This study focused on exploring the acceptability of harm reduction approaches for OUD among professional counselors who provide treatment to clients who struggle with substance use. A nationwide sample of substance use treatment professionals was obtained via contact with programs identified in SAMHSA's National Directory of Drug and Alcohol Abuse Treatment Facilities (SAMHSA, 2019). Of note, facilities in this directory must meet certain criteria for inclusion, including providing services funded by state mental health programs or the U.S. Department of Veterans' Affairs, and either have staff credentialed for substance use treatment, have authorization to bill substance use or addiction services, or licensure for substance use treatment by the state or national accrediting agency (SAMHSA, 2019). The goal was to obtain a

sufficient number of professional counselors (those with master's level training in CACREP or analogous programs) and a sufficient number of other professionals of various disciplines who also treat substance use for comparison via a one-way analysis of variance. In addition, the sample needed to include enough professional counselors to perform a linear multiple regression analysis with three predictor variables (77 counselors needed for sufficient statistical power). Participants were asked to respond to a screening question for eligibility clarifying that they provide treatment to substance use clients in their current employment role. Sampling addiction treatment professionals who currently work with clients struggling with substance use increased likelihood that these professionals are more familiar with the full array of treatment options for OUD, including harm reduction strategies. Harm reduction is also the most relevant to substance use treatment professionals, compared with the broader mental health field. Participants sampled actively provide services to substance use clients in their employment role, which excluded students, administrators not providing direct services, educators, and retired professionals. Participants confirmed they were 18 years of age or older and indicated that they provide treatment to individuals with substance use disorders.

The researcher obtained a nationwide sample of treatment providers meeting criteria for the study. All treatment programs contacted for participant recruitment were identified via SAMHSA's National Directory of Drug and Alcohol Abuse Treatment Facilities (SAMHSA, 2019), with a stratified sample strategy based on the regions used by the U.S. Census Bureau (2010; Northeast, South, Midwest, and West). The final sample included approximately 22 percent of the sites listed on the directory for each region (that percentage includes the sites that did not have contact information available). First, the researcher divided the list of sites by region. Second, within each region's list of sites, a random number generator was used to assign

a number to each site. Next, every 50th site from each region was sampled, with this process being repeated 11 times to obtain the desired number of participants. For each treatment site identified, research team members explored the program's website to find point-of-contact staff members. The staff members identified on the websites received a recruitment email describing the study and asking that the email be forwarded to substance use treatment providers in that program. The recruitment email can be found in Appendix F. If a website lacked email contact or a "contact us" page, the next site on the list was then sampled (for example, if the 250th treatment site in the South region lacked a website or staff contact information could not be obtain on their website, the 251st site was then included in the sample). Sampling continued until a sufficient number of participants completed the research survey. Statistical power analyses required the recruitment of at least 77 professional counselors (for multiple regression analysis with three predictor variables) and 200 other providers treating substance use (for a one-way ANOVA with four groups). It is also worth noting that data collection occurred between May and September 2020, amidst the COVID pandemic in the United States, which may influence response rates. A description of the demographics of the sample can be found in Chapter 4 of this document.

Instruments

Four instruments and a demographic questionnaire were used to answer the research questions and gain information about the participants: The Harm Reduction Acceptability Scale-Revised (Goddard, 2003), The Toronto Empathy Questionnaire (Spreng, McKinnon, Mar, & Levine, 2009), The Social Justice Scale- Attitudes Towards Social Justice subscale (Torres-Harding, Siers, & Olson, 2012) and the Professional Orientation and Development Scale for Counselors-Professional Orientation and Values subscale (La Guardia, 2019). Below, the

instruments are described in detail and full copies of these instruments can be found in the Appendices.

The Harm Reduction Acceptability Scale-Revised (HRAS-R)

The Harm Reduction Acceptability Scale-Revised (HRAS-R; Goddard, 2003; Appendix A) assesses the acceptance of the harm reduction approach in responding to people who use substances. The HRAS was originally developed by Goddard (1999), and it was revised to be useable with both treatment professionals and other populations of interest (Goddard, Gauspohl, & Breitenbecher, 2004). The HRAS-R includes 25 Likert-scale response items (*1= Strongly Agree, 2=Agree, 3= Neither Agree nor Disagree, 4= Disagree, 5= Strongly Disagree*) in which respondents indicate their level of agreement with statements about harm reduction strategies, substance use, and substance users. The HRAS-R is a reliable measure of harm reduction acceptance with undergraduate Psychology students, based on good internal consistency (Cronbach's $\alpha = .853$), as well as test-retest measures (Cronbach's $\alpha = .846$ at Time 1, $.894$ at Time 2; Goddard et al., 2004). The original HRAS, which is worded slightly differently to focus on treatment providers and was tested with addiction treatment providers, also showed moderately high internal consistency (Cronbach's $\alpha = .877$ to $.929$; based on the test-retest administrations of the instrument) and moderate test-retest reliability ($r = .825$ after three-week interval; Goddard, 2003) with a sample of treatment professionals. The HRAS-R is negatively correlated with the Temperance Mentality Questionnaire (TMQ; Burt et al., 1994), which indicates discriminant validity of the instrument. The HRAS-R takes five to ten minutes to complete.

Lower scores on the HRAS-R are associated with higher levels of acceptance of harm reduction interventions, while higher scores indicate less acceptance (Goddard et al., 2004).

Participant scores on the HRAS-R are obtained by computing the mean across the 25 items, with scores ranging from one to five. Eight items on the HRAS-R are reverse scored (items 1, 4, 9, 13, 18, 21, 23, and 25), as agreement with those items indicate non-acceptance of harm reduction approaches. The HRAS-R does not have any cut-off scores or subscales. It produces a single outcome measurement that can be used for analysis. An additional adaptation of HRAS-R will be made to capture acceptance of harm reduction for OUD based on current treatments available. HRAS-R items that mention methadone programs will have language about buprenorphine added, given the current prevalence of these medications being used in medication-assisted treatment programs. This update is being made due to changes in medication-assisted treatment availability since the development of the HRAS-R in 2004.

Supplemental Harm Reduction Items

In order to capture acceptance of harm reduction strategies that fit well for treating individuals with OUD, the researcher developed 10 supplemental harm reduction items that were included in the survey. These items targeted participants' acceptance of the following harm reduction programs for clients with problematic opioid use: motivational interviewing, medication-assisted treatment, needle exchange programs, Naloxone distribution to opioid users, distribution of testing kits for Fentanyl contamination, housing first, and safe consumption sites. In addition, these items sought more narrow responses about perceptions of the harm reduction approach for direct use with people with problematic opioid use, specifically. Although the HRAS-R contains items related to medication-assisted treatment (methadone only, as buprenorphine was not FDA approved at the time of its development), housing first, and needle exchange, these additional items explicitly examined how participants perceive these programs for people using opioids (Appendix A). These supplemental items use the same Likert-scale

response format and were scored separately from the HRAS-R, to maintain the reliability and validity of that instrument. To maintain validated scoring of the HRAS-R, these supplemental items will have their own score and reliability statistics were calculated for these supplemental items. Descriptive statistics and internal consistency reliability measures allowed the researcher to examine how the supplemental items performed as a group in comparison to the HRAS-R. Based on having similar measures of internal consistency and variance, the 25 HRAS-R items and 10 supplemental harm reduction items were combined to serve as the focal outcome variable of the study (for all three research questions). The researcher utilized feedback from three counselors who fit criteria for inclusion in this study to support clarity of the wording and focuses of these supplemental items. The scores from the HRAS-R and the supplemental items were combined as the outcome variable for the study, which was referred to as “HRAS-R/Supplement Score”.

The Toronto Empathy Questionnaire (TEQ)

The Toronto Empathy Questionnaire (TEQ; Spreng et al., 2009; Appendix B) is a self-report questionnaire designed to measure empathy as a stand-alone construct. The TEQ’s range of items focused on behaviors (responsiveness), sensitivity, and perception make the instrument well-equipped to capture traits that allow for accurate empathy. The TEQ is mainly focused on affective empathy, specifically empathic responding to others. The TEQ is relatively concise, with 16 Likert scale response (*0=Never, 1= Rarely, 2= Sometimes, 3= Often, 4= Always*) items that capture an several subcomponents of empathy. Spreng et al. (2009) found this questionnaire to have high internal consistency (Cronbach’s $\alpha = .85$) and high test-retest reliability ($r = .81, p < .001$), as well as convergent validity with similar measures of affective empathy, including the Empathy Quotient (Baron-Cohen & Wheelwright, 2004) and the Interpersonal Reactivity Index

(Davis, 1983). These reliability statistics were obtained in three separate samples of college students at the University of Toronto (Spreng et al., 2009). Spreng et al. (2009) also found discriminant validity between the TEQ and measures of Autism Spectrum symptoms that indicate difficulty with empathic responding.

Higher scores on the TEQ represent higher levels of affective empathic responding. Items capture empathic responding by measuring “the perception of an emotional state in another that stimulates the same emotion in oneself”, emotion comprehension, behaviors demonstrating emotional sensitivity, “sympathetic physiological arousal”, altruism, and “behaviors engaging higher-order empathic responding” (Spreng et al., 2009, p. 69). Despite having items that were developed to match these specific dimensions of empathic responding, the TEQ does not have subscales. The TEQ provides a single outcome measure used for analysis in this study.

The TEQ has been used to measure empathic responding as a trait in helping professions, including physicians (Pantović-Stefanović et al., 2015), social workers (Greeno, Ting, Pecukonis, Hodorowicz, & Wade, 2017), and counseling students (Ivers, Johnson, Clarke, Newsome, and Berry, 2016). Additionally, the TEQ was utilized to measure empathic responding as a predictor variable with each of these populations. Of relevance to the current study, Ivers Johnson, Clarke, Newsome, and Berry (2016) found acceptable internal consistency (Cronbach’s $\alpha = .76$) in a sample of 199 masters level counseling students. Spreng et al. (2009) also noted the TEQ’s utility as a concise measure of empathy, specifically useful in online survey research.

Empathy is an important predictor of interest in this study, as it captures a key component of the professional identity of counseling. Rogers (1957) identified accurate empathy as a necessary condition for client change in psychotherapy and empathic responding is a key

component of the humanistic roots of the counseling profession (Dollarhide & Oliver, 2014). For the current study, the TEQ measured empathy as a trait among professional counselors working with clients with OUD.

The Social Justice Scale (SJS): *Attitudes Towards Social Justice Subscale*

The Social Justice Scale (SJS; Torres-Harding et al., 2012; Appendix C) is a 24-item scale “developed as a tool to be used by community psychologists to measure favorable attitudes toward intentions to engage in social action” (p. 80). The Attitudes Towards Social Justice is an 11-item subscale within the Social Justice Scale designed as a stand-alone measure (Torres-Harding, personal communication September 25, 2019). Despite the reference to psychologists, other authors utilized this instrument to explore social justice attitudes with related professions, including nurses (Scheffer, Lasater, Atherton, & Kyle, 2019), psychology faculty (Mena & Rogers, 2017), and social workers (Bessaha, Schuler, & Moon, 2017). The SJS contains items that were developed based on community and counseling psychologists’ definitions of social justice (Fietzer & Ponterotto, 2015), while confirmatory factor analysis assessed the appropriateness of the subscales in measuring the intended constructs (Torres-Harding et al., 2012).

The SJS has four subscales: *Attitudes Towards Social Justice*, *Perceived Behavioral Control*, *Subjective Norms*, and *Behavioral Intentions* (Torres-Harding et al., 2012). The Attitudes Towards Social Justice subscale was utilized for this study, as the attitudes of substance use professionals were of interest, rather than the other factors and subscales. Azjen’s social cognitive model of planned behavior was the basis of the constructs for the SJS, which has been applied to other behavioral motivations (Azjen, 1991, as cited in Torres-Harding et al., 2012). Torres-Harding (2012) described the attitudes component of Azjen’s model involving

“general dispositions towards a given behavior”, which, when applied to social justice attitudes, includes “an individual’s acceptance of the social justice ideals and related values, such as the belief that one should act for social justice, or that it is right or fair to promote equality of opportunity for everyone, regardless of background” (p. 79). Validated with a sample of undergraduate and graduate students, Attitudes Towards Social Justice subscale performed with strong internal consistency, including a Cronbach’s α of .95. Inter-scale correlations indicated the subscales were “distinct, yet related” (Torres-Harding et al., 2012, p. 83). Torres-Harding et al. (2012) also used other scales to support convergent and divergent validity. Fietzer & Ponterotto (2015) identified the SJS as the only social justice attitudes measure that has evidence of “invariance across populations”, as Torres-Harding et al. (2012) found no differences in subscale scores within the two samples among different demographic groups (age, gender, race, and ability level). Fietzer and Ponterotto (2015) also praise the SJS for being a “promising tool to predict engagement in social justice behavior from an individual’s attitudes” (p. 31).

Higher scores on the SJS indicate increased awareness of, and willingness to acknowledge, injustices in society, while being less likely to blame disadvantaged peoples for their struggles (Torres-Harding et al., 2012). The scale also assesses intentions to pursue social justice actions, while not being a predictor of actual behavior. The scale’s items prompt respondents to rate their level of agreement on 7-point Likert scale (*1= Disagree Strongly, 4= Neutral, 7= Strongly Agree*). Scores are obtained on the Attitudes Towards Social Justice Subscale by computing the mean of the 11 items, with possible scores on the scale ranging from 1 to 7. Given that the instrument was validated with a four-factor model via confirmatory factor analysis, each subscale, including the Attitudes Towards Social Justice Subscale, produces a valid independent score as well (Torres-Harding et al., 2012). These subscales, including the

Attitudes Towards Social Justice Subscale, are designed to be used independently (Torres-Harding, personal communication September 25, 2019).

Professional Orientation and Development Scale for Counselors: *Professional Orientation and Values Subscale*

The Professional Identity and Values Scale-Revised (PIVS-R; Healy, 2009) was developed based on themes emerging from a qualitative study of female counselors. The PIVS-R has two subscales: Professional Orientation and Values, and Professional Development. The Professional Orientation and Values contains 18 Likert response items, 11 of which focus on professional orientation and seven of which focus on professional values of counselors (Healy & Hays, 2012). The Professional Development Subscale has 14 items, which were not utilized for the current study. Each item includes a response range from 1 (*strong disagreement*) to 6 (*strong agreement*). These 32 items make up the full PIVS-R and were developed based on “consensus team review, evaluation of conceptual research, and external expert review”, as well as a second round of expert review that included assessment of “fit with the operational definition of orientation toward the counseling philosophy, counselor values, and counselor identity development” (Healy & Hays, 2012, p.58). Expert review supports the content validity of this instrument. Item development utilized Principle Factor Analysis, followed by items being rated by 10 experts. The PIVS-R expert evaluation had sufficient inter-rater reliability (Krippendorff’s $\alpha = .606$, confidence interval 95%) and inter-item reliability (Healy, 2009). Exploratory Factor Analysis was used in narrowing to the final item pool. The finalized version of the PIVS-R had an internal consistency of Cronbach’s $\alpha = .81$ (Healy, 2009) with a sample of practicing counselors, counseling students, and counselor educators. Convergent validity for the Professional Orientation and Values subscale of the PIVS-R was established by total score

agreement with the philosophy and beliefs subscale of the Professional Identity and Engagement Scale (Puglia, 2008).

Seven items on the PVIS-R are reverse scored: three on the orientation and values subscale (2, 8, 9) and four on the development subscale (1, 4, 5, and 6; Healy, 2009). The score for the PIVS-R is obtained by summing the responses on each subscale, adding them together, and then dividing by two (Healy, 2009). This scoring method was chosen by recommendation of expert reviewers because “development and agreement with orientation and values would likely influence one another and therefore carried equal weight in determining one's level of professional identity” (Healy, 2009, p. 153). Healy (2009) concluded that based on these reliability and validation measures, the PIVS-R is a “valid and reliable measure for agreement with the counseling philosophy, as defined by professionals in the field, as well as professional development” (p. 193).

Recently, the PIVS-R has been revised to the Professional Orientation and Development Scale for Counselors (Appendix D), and it has been subjected to Confirmatory Factor Analysis (La Guardia, personal communication September 27, 2019). The revised version retains the two subscales, with the Professional Orientation and Values subscale being used for this study (the other being the 11 item Professional Development subscale, which was not used for the current study). The current version of The Professional Orientation and Values subscale has 13 items scored on the same Likert scale as the PIVS-R, with no reverse scored items. The instrument developer recommended that the subscales be scored separately with this version of the instrument, affirming the researchers use of The Professional Orientation and Values subscale as a stand-alone measure (La Guardia personal communication, September 27, 2019). The response choices remain the same as PIVS-R, with each item includes a response range from 1 (*strong*

disagreement) to 6 (*strong agreement*). A cumulative score on the Professional Orientation and Values subscale is obtained by calculating the mean (summing the item response and dividing by 13, the total number of items). La Guardia used a Structural Equation Modeling approach to complete a Confirmatory Factor Analysis of the full updated Professional Orientation and Development Scale for Counselors to compare theory and statistic-based models (personal communication, September 27, 2019). The Confirmatory Factor Analysis led to the elimination of several items and retention of the PIVS two factor model. This version of the PIVS has not yet been published.

Additional Survey Items and Demographic Questionnaire

The demographic questionnaire (Appendix E) provided further description of the sample, including participants' age, ethnicity, gender identity, and their geographic location (state or territory in which they provide treatment, and if that location is urban, suburban, or rural). Screening questions in the demographic questionnaire appeared at the beginning of the survey, including the first question of the survey designed to ensure respondents met criteria for the study. Subsequent questions identified participants' level of education, professional discipline, credentials, and the level of care in which they provide substance use treatment. The digital survey distributed via Qualtrics software utilized skip logic to identify counselors trained in CACREP-accredited masters programs, as that item would not be relevant to other professions, including participants with less than a master's level of education. Other items provided useful data that may be associated with acceptability of harm reduction approaches, including the number of clients diagnosed with OUD that participants have treated in the last month, the participant's status as person in recovery from substance use and years of practice in substance

use treatment. The information gathered in this section provided a richer understanding of the sample of professional counselors and other professionals who treat substance use disorders.

Data Collection Procedures

Research Questions and Data Analysis Procedures

This study was designed to answer the following research questions:

RQ1: What is the acceptability of harm reduction approaches for Opioid Use Disorder among professional counselors?

RQ2: Do professional counselors have higher levels of harm reduction acceptance for Opioid Use Disorder than other professionals treating substance use?

H₁: Professional counselors will have higher levels of acceptance of harm reduction approaches for Opioid Use Disorder than other professionals treating substance use.

H₀: Professional counselors will have similar levels of acceptance of harm reduction approaches for Opioid Use Disorder as other professionals treating substance use.

RQ3: Can professional counselors' acceptance of harm reduction strategies for Opioid Use Disorder be explained by the composite of their level of empathy, social justice attitudes, and their professional identity/values as a counselor?

H₁: Level of empathy, social justice attitudes, and counselor professional identity/values will be statistically significant predictors of acceptance of harm reduction strategies for Opioid Use Disorder among professional counselors.

H₀: Level of empathy, social justice attitudes, and counselor professional identity/values will not be statistically significant predictors of acceptance of

harm reduction strategies for Opioid Use Disorder among professional counselors.

The first research question was answered via descriptive statistics gathered from responses on the HRAS-R and supplemental harm reduction items for professional counselors who completed the survey. The researcher answered this question by reporting the range of scores, measures of central tendency, standard deviation, and statistical variance. These statistics allowed the researcher to speak to the level of acceptance of harm reduction approaches for OUD among professional counselors, including comparing these findings to prior studies of substance use treatment providers and counselors.

The second question was answered using a one-way analysis of variance (ANOVA), in addition to post-hoc analysis to examine between-group differences. A combined score for the HRAS-R and supplemental harm reduction items was obtained by calculating the mean for those 35 items (this was done after internal consistency reliability measures confirmed similar functioning of these two scales and items within the scales). The ANOVA allows for comparison of group mean scores for this combined score measure, which was referred to as “HRAS-R/Supplement Score”. Professional counselors were compared to bachelor’s level treatment providers (only excluding medical providers) and master’s level social workers. Psychologists, marriage and family therapists, and others with advanced degrees were excluded from analysis due to divergent sample sizes and differing professional identities that could not be grouped together. Unequal sample sizes were anticipated with the groups included in the analysis, and a Levene’s Test was used to explore homoscedasticity, to ensure sufficient similarity in variances among groups. The Levene’s test ensures that no group variance is four times higher than

another group and this is a common statistic used to account for unequal sample sizes in ANOVA (Howell, 2009). The one-way analysis of variance produced an F statistic, which allowed the researcher to determine if statistically significant differences in the level of acceptance of harm reduction strategies for OUD existed between groups. A statistically significant difference between group means with the omnibus test (F statistic) led to a post-hoc analysis which clarified specific group differences in mean scores on the HRAS-R/Supplement Score. The researcher utilized a Tukey's Test for post-hoc examination of between group differences, due to its acceptance in comparing more than three group means and ability to minimize type II error inflation (familywise error rate; Howell, 2011). Statistical power and effect size (η^2) were included in reported statistics, with effect size indicating the magnitude of the difference between group means (Howell, 2009). The goal of using the one-way analysis of variance is to identify if professional counselors have a statistically significant higher levels of acceptance of harm reduction strategies for OUD compared with the peer addiction treatment professional disciplines, as measured by the HRAS-R/Supplement Score. The null hypothesis was that professional counselors did not differ from other professionals who treat substance use and the alternate hypothesis is that counselors do have higher levels of harm reduction acceptance for OUD.

Answering the third research question involved a simultaneous multiple linear regression analysis, in which counselors' scores on the HRAS-R/Supplement measure were regressed onto scores on the Toronto Empathy Questionnaire, the Attitudes Towards Social Justice Scale, and Professional Orientation and Values Scale. Harm reduction acceptance, measured by the HRAS-R/Supplement Score acted as the dependent variable, with empathic responding (as measured by the Toronto Empathy Questionnaire), social justice attitudes (as measured by the Social Justice

Scale), and professional identity (as measured by the Professional Identity and Values Scale-Revised) being the predictor, or independent, variables. The null hypothesis states that these predictors will not explain variance in harm reduction acceptance for OUD among counselors, while the alternative hypothesis states that these predictors will be statistically significant predictors of harm reduction acceptance for OUD.

Assumptions

This study utilized descriptive statistics, one-way analysis of variance, and a simultaneous multiple regression analysis to answer the three research questions. Descriptive statistics of professional counselors' scores on harm reduction acceptability measures do not have to abide by any assumptions, but this data helped determine if there was a normal distribution of scores among the sample. Assumptions of analysis of variance procedures include homoscedasticity, normality, and independence of observations (Howell, 2009). A simultaneous multiple linear regression analysis was used to explore the ability of empathy, social justice attitudes, and a measure of professional counseling orientation and values to predict acceptance of harm reduction approaches for OUD among professional counselors who treat substance use. Linear regression analyses also assume homoscedasticity, normality, and independence of observations, but also requires a linear relationship between predictor and outcome variables (Keith, 2015). Multiple regression analysis also requires measures to ensure that independent variables are not overly correlated, an issue called multicollinearity (Keith, 2015). This section will speak to the assumptions that must be met for valid analysis of variance and multiple linear regression analysis statistical procedures.

Linearity

Linear regression analyses require dependent variables to have linear relationship with the independent variable. For the multiple regression analysis, a visual inspection of data must show a linear relationship between the predictor and outcome variables. Linearity will be checked via visual inspection of a scatterplot of observed scores for each predictor variable (TEQ, SJS, and POVS scale scores) plotted onto HRAS/Supplement Score residuals, with a line of best fit added called a loess plot (Keith, 2015). A loess plot will not be a perfect line, but it should approximate a straight line as if drawn by a child (P. 189, Keith, 2015). Residuals are used for loess plots to magnify any departures from observed values (Keith, 2015).

Independence of Observations

Independence of observations requires each measured individual to be independent and not influencing the measures of other participants (Keith, 2015). This is necessary for multiple regression analysis, as well as analysis of variance, procedures. This study sampled substance use treatment providers at various treatment sites across the country. The survey was completed by providers individually, limiting the influence they have on one another. Due to the possibility that some participants may have been employed at the same facility, in addition to being members of the same professional organizations, some influence of their workplace dynamics and training could have occurred, which cannot be controlled for. Despite this concern, each participant completed the survey with confidentiality to enhance independence and accurate variance in responses.

Homogeneity of Variance (Homoscedasticity) and Normality of Residuals

Homoscedasticity refers to a random distribution of residuals (errors) among independent variables, which can be checked via a scatterplot of normalized residuals (Keith, 2015). This technique was used to ensure sufficient homoscedasticity of errors in this study. For ANOVA, a

Levene Statistic and Welch ANOVA were calculated to determine if there was sufficient heterogeneity of variance for that sample and statistical test. These statistics help account for unequal group sizes (Howell, 2009). Testing this assumption was necessary for both the analysis of variance and the simultaneous multiple regression analyses. These assumptions must be checked separately for the ANOVA and the multiple regression, as the ANOVA utilizes the larger sample of practitioners, while the multiple regression only included the professional counselors sampled.

Normality of errors refers to a normal distribution (a “Bell Curve”) of residual variance, which can be checked via a histogram of residuals or visual inspection of a scatterplot standardized errors (standardization makes systemic errors easier to identify in a scatterplot; Keith, 2015). This post-hoc analysis was conducted to ensure this assumption was met for appropriate interpretation of the multiple regression analysis and analysis of variance procedures. The normality of residuals is only an assumptions checked for multiple regression.

Multicollinearity

Multicollinearity refers to the correlations between independent variables, indicating they are measuring overly similar constructs. Multicollinearity was checked for the multiple regression analysis. For this study, to ensure there was sufficient discriminant impact on variance among the independent variables, measures of Variance Inflation Factor and Tolerance were utilized, as recommended by Keith (2015). This statistic allows for exploration of correlations between independent variables, as correlations higher than .8 indicate unacceptable collinearity (Keith, 2015). In addition, a correlation matrix allows for inspection of multicollinearity between dependent variables (empathic responsiveness, social justice attitudes, and counselor professional orientation).

Sample Size

Keith (2015) described a statistical power of .8 to .9 being sufficient for statistical analyses, which indicates an 80% to 90% chance of correctly rejecting a null hypothesis. For this analysis of variance procedure in this study, the null hypothesis was that no differences exist between professional counselors and other addiction treatment professionals on the measure of harm reduction acceptability for OUD. The alternative hypothesis that professional counselors would be more accepting of harm reduction for OUD than other professionals treating substance use. For the simultaneous multiple regression analysis in this study, the null hypothesis was that there is no predictive relationship between the independent variables (empathy, social justice attitudes, and counselor professional values) and harm reduction acceptability for OUD. The alternative hypothesis was that higher levels of empathic responsiveness, more positive social justice attitudes, and stronger professional counseling identity would explain the levels of harm reduction acceptability for OUD among professional counselors. Using an *a priori* power analysis based on having four distinct groups, G*Power statistical software (2014) indicated that a one-way analysis of variance requires an overall sample size of 180, based on $\alpha = .05$, $\eta^2 = .25$ (effect size), and an outcome statistical power of at least .8. This power analysis was based on four groups (Professional Counselors, Social Workers, Psychologists/Medical Providers, and Bachelor's level Professionals), as it was believed that there would be far fewer medical providers and psychologists than other treatment provider groups, due to level of training. If there had been five groups, a sample size of 200 would have been needed.

Using G*Power statistical software (2014), an *a priori* power analysis for the simultaneous multiple regression analysis indicated a desired sample size of 77 professional counselors, based on $\alpha = .05$, Cohen's $d = .15$ (effect size), and an outcome statistical power of at

least .8. The sample size of professional counselors needed for the study is based on having three independent variables in the regression analysis (empathy score on Toronto Empathy Questionnaire, social justice attitudes score on the Social Justice Scale, and professional identity measured by the Professional Orientation and Values Scale). These *a priori* power analyses indicated the number of total providers needed for the group comparison (180, based on having four groups), as well as the number of professional counselors needed (77).

Description of Data Analysis

This study will utilize an appropriate analysis strategy for each research question. Statistical analyses used to answer the research questions were conducted using IBM SPSS software (Ver. 26; SPSS, 2018). Descriptive statistics were computed to answer the first research question, including reporting measures of central tendency (the mean [μ], median, and mode) for professional counselors' level of acceptance of harm reduction for OUD. These measures were compared with prior studies of harm reduction acceptance among substance use treatment providers and counselors. Descriptive statistics provided the distribution of scores among professional counselors, allowing the researcher to report the variance (σ^2), standard deviation (σ), skewness, and kurtosis of the sample of professional counselors (Howell, 2009). Obtaining the distribution of scores allowed for the reporting of percentiles and the interquartile range, as well. This information contributed to examination of level of acceptance harm reduction strategies for OUD among professional counselors.

A one-way analysis of variance procedure was used to answer the second research question, in which professional counselors were compared to two other groups of addiction treatment providers, which included master's level social workers, those with masters or higher training in psychology and bachelor's-level treatment providers (encompassing direct care

providers, peer recovery specialists, case managers, and other disciplines). Marriage and family therapists, psychologists, medical professionals, and other professionals with advanced degrees were not included in the analysis, as these groups were too small and could not be combined in a meaningful way for analysis of the influence of professional identity. The analysis of variance provided an *F* statistic, which allowed the researcher to determine if there was a statistically significant difference between these groups in their level of acceptance of harm reduction approach for OUD. If a statistically significant difference between the groups existed, then the Tukey's post-hoc analysis was performed to determine which groups have significant differences in mean scores on the HRAS/Supplement Measure. Tukey's post-hoc analysis allowed the researcher to determine if professional counselors have higher levels of acceptance of harm reduction strategies for OUD than the other addiction professions sampled.

To answer the third research question, a simultaneous multiple linear regression analysis was performed to explore if professional counselors' level of empathy, social justice attitudes, and professional identity/values explains professional counselors' level of harm reduction acceptance for OUD. As previously discussed, the Toronto Empathy Questionnaire (Spreng et al., 2009) was used to measure empathic responsiveness, the Social Justice Scale (Torres-Harding, 2012) Attitudes Towards Social Justice Subscale measures attitudes towards social justice actions, the Professional Orientation and Values Scale (Healy, 2009) was used to measure professional counseling identity/values, and harm reduction acceptance was measured via the Harm Reduction Acceptability Scale- Revised (Goddard et al., 2004) combined with the 10 supplemental questions focused on harm reduction for OUD specifically (HRAS-R/Supplement Score). A simultaneous linear multiple regression analysis allowed for a full exploration of the impact of these three predictors on harm reduction acceptability for clients with OUD.

The multiple regression model is:

$$Y_{ij}(\text{Harm Reduction Acceptability for OUD}) = b_0(\text{Constant}) + b_1(\text{Empathic Responsiveness}) + b_2(\text{Social Justice Attitudes}) + b_3(\text{Professional Counselor Orientation/Values}) + e$$

Missing Data

Missing data is a commonly overlooked issue in counseling research and most quantitative datasets have some items without responses for a variety of reasons (Cook, 2020). Once data collection was completed, the researcher inspected the data and determined that there were data missing at random, indicative of participants skipping items while taking the survey. The researcher determined that other participants had stopped before completing the full survey, leading to missing data. Scales within the survey were scored to answer a research question if a response set included only one missing value within that scale. If one item on a scale was skipped, the average score from the remaining items on the scale were used as the scale score. The only exception was the HRAS-R, in which participants' scores were calculated if two or less items contained missing values (due to this being a longer scale, at 25 items). If there was more than one missing value on a scale (or more than two missing values on the HRAS-R), a score was not calculated for the scale and that participant's response set was not included in the analysis for that research question. This allowed for scale scores to be included if participants completed 90% or more of the scale and limited the number of participant response-sets not included due to skipping a single item on a scale. Once scales were scored based on these procedures, the scores were calculated and used for analysis. Missing data procedures were informed by recommendations provided by Cook (2020) and Keith (2015).

Summary

The current study aimed to explore multiple aspects of counselor acceptance of harm reduction strategies for OUD. First, this study examined the level of acceptance of harm reduction strategies among professional counselors. Second, this study investigated differences in acceptability of harm reduction approaches for OUD between professional counselors and other disciplines of professionals who treat substance use. Finally, this study examined the explanatory relationships that empathic responsiveness, social justice attitudes, and professional counseling values and orientation had on professional counselors' acceptance of harm reduction approaches to treating OUD. A nationwide sample of substance use treatment professionals was accessed via emails to administrators or point-of-contact staff members of programs listed in SAMHSA's National Directory of Drug and Alcohol Treatment Facilities, asking them to distribute to their employees. To measure the acceptance of harm reduction approaches for OUD, the HRAS-R was used, along with 10 additional items focused on the appropriateness of harm reduction interventions specifically with individuals with OUD. These 35 items led to an outcome measure; HRAS-R/Supplement Score. Descriptive statistics provided baseline measures of the level of acceptance of harm reduction for OUD among professional counselors. The analysis of variance explored the acceptability of harm reduction for OUD among professional counselors in comparison to other professionals who treat substance use. The simultaneous multiple regression analysis examined if key components of professional counselor identity could explain harm reduction acceptance for OUD among professional counselors. The regression model included the following predictor variables: empathic responsiveness, social justice attitudes, and a measure of professional identity/values. These predictors were chosen based on overlaps in defining characteristics of the counseling profession (Kaplan et al., 2014; Woo, Henfield, & Choi, 2014; Toporek et al., 2009; Dollarhide & Oliver, 2014) and essential

components of harm reduction philosophy (Collins et al., 2011). These methods allow for data collection and analysis that will increase the understanding of factors contributing to the acceptance of harm reduction for OUD within the counseling profession.

CHAPTER FOUR

RESULTS

This quantitative study examined professional counselors' acceptance of harm reduction approaches for Opioid Use Disorder (OUD). The aim was to gain a baseline understanding of counselors' acceptance of harm reduction for OUD, compare counselors' level of acceptance to other professional disciplines that treat substance use, and examine the predictive value of core components of counselor professional identity for harm reduction acceptance. This chapter describes the sample of participants obtained for the study, the functioning of the instruments used to collect data, how data were cleaned for analyses, and the results of the analyses. Three research questions guided the methods and analyses utilized in this study:

RQ1: What is the acceptability of harm reduction approaches for Opioid Use Disorder among professional counselors?

RQ2: Do professional counselors have higher levels of harm reduction acceptance for Opioid Use Disorder than other professionals treating substance use?

H₁: Professional counselors will have higher levels of acceptance of harm reduction approaches for Opioid Use Disorder than other professionals treating substance use.

H₀: Professional counselors will have similar levels of acceptance of harm reduction approaches for Opioid Use Disorder as other professionals treating substance use.

RQ3: Can professional counselors' acceptance of harm reduction strategies for Opioid Use Disorder be explained by the composite of their level of empathy, social justice attitudes, and their professional identity/values as a counselor?

H₁: Level of empathy, social justice attitudes, and counselor professional identity/values will be statistically significant predictors of acceptance of harm reduction strategies for Opioid Use Disorder among professional counselors.

H₀: Level of empathy, social justice attitudes, and counselor professional identity/values will not be statistically significant predictors of acceptance of harm reduction strategies for Opioid Use Disorder among professional counselors.

Sampling Process

Following Institutional Research Board approval (IRB; Virginia Tech IRB# 20-350, Appendix G) sample of substance use treatment professionals was obtained from the Substance Abuse and Mental Health Services Administration (SAMHSA) National Directory of Drug and Alcohol Treatment Facilities (2019). A stratified random sample of treatment sites was identified by dividing this list of facilities by United States Census Regions (2010) and selecting every 50th site to receive recruitment emails. This process repeated 11 times, leading to approximately 22% of the sites being sampled from the SAMHSA directory (this 22% includes all sites in the directory, including the treatment sites that lacked website or contact information). Many sites were not included in the sample due to lacking a website to gain email contact info for point-of-contact staff members with that facility/program. In these cases, the next site in the sample was taken based on the assigned random numbers. Each time this occurred, the next site on the directory list was sampled. Research team members identified point-of-contact staff members on websites of sampled treatment facilities. Point-of-contact staff received an email explaining the study and asking the staff member to forward the embedded recruitment email to substance use

treatment providers on staff. The recruitment email (Appendix F) contained a clickable link to the Qualtrics survey.

After having a chance to read the informed consent for the study, 655 participants answered the initial screening question (*Do you provide direct substance use treatment to clients/patients in your current position?*), with 567 participants answering *yes*, making them eligible for the study. 477 participants completed the demographic questionnaire, the Harm Reduction Acceptability Scale-Revised (HRAS-R), and supplemental harm reduction questions. These 477 participants were included in the study, as they responded to at least 23 of 25 HRAS-R items and nine of 10 supplemental harm reduction questions, which allowed each of these subscales to be scored independently and used as a combined measure (HRAS-R/Supplement Score). Four participants were not included in the analysis for Research Question Two due to skipping too many items. Participants were categorized by professional discipline by responding to the following item: *Please indicate your primary discipline of training (option that best describes your professional identity)*. Among these participants, 181 identified their professional discipline as professional counseling and indicated they held a master's degree or higher. Forty-seven participants who identified their professional identity as professional counseling, but these participants did not hold a master's degree or higher. These participants were included in the bachelor's level substance use treatment professionals group for Research Question Two, but were excluded from the other analyses focused only on professional counselors. Based on training requirements, 134 professional counselors were included in the study. One counselor was not included in the analysis for Research Question Three due to skipping more than one item on the TEQ and POVS.

Missing Data

Data were inspected for missing values, with some item responses missing at random (apparently skipped for unknown reasons) and others missing not at random, because participants did not complete the full survey. For each scale, a sufficient number of items must have been completed to obtain a score for analysis. If the full scale or a sufficient number of items on that scale had responses, the scale was scored and included in the analysis. Research questions one and two only required that participants complete the HRAS-R and the Harm Reduction Supplement items to obtain the combined HRAS-R/Supplement Score. If participants responded to 23 of 25 HRAS-R items, that scale was scored and included. For the Supplemental Harm Reduction items, participants had to respond to 9 of 10 items to have their scores included in the study. Research question three required professional counselors to have completed the HRAS-R, Harm Reduction Supplement, Toronto Empathy Questionnaire (TEQ), Social Justice Attitudes Subscale (SJS), and the Professional Orientation and Values Subscale (POVS). For the TEQ, participants needed to respond to 15 of 16 items to receive a score. For the SJS, participants needed to respond to 11 of 12 items to receive a score. For the POVS, participants needed to respond to 13 of 14 items to receive a score. These cut-offs allowed for participant response sets to be included if the participant completed 90% or more of the scale. Because of the novel scoring involved with the HRAS/Supplement Score, no imputation procedures were used, to avoid further threats to the validity of that measure (HRAS/Supplement Score was used in all three analyses). For all scales, the calculated score was the mean of the items with responses, as each scale's score instructions indicated the calculated mean would be the correct scoring for the instrument (Goddard, 2004; Spreng et al., 2009; Torres-Harding, 2012; Healy, 2009). For all participants, if a scale score could not be obtained, a listwise deletion eliminated their response-set from the analyses. The resulting sample sizes for each research question were

slightly reduced due to missing data and listwise deletion of participants who did not have scores on necessary instruments. These details are included in the findings section of this chapter.

Instrumentation

This section discusses the functioning and reliability of each scale used in this study.

Harm Reduction Attitudes Scale-Revised and Harm Reduction for OUD Supplement

The HRAS-R usually is scored to have the lowest scores indicate higher levels of acceptance of harm reduction approaches. For the purpose of this study, the scoring was transformed so that higher scores indicated higher levels of acceptance of harm reduction, in order to be consistent with all other scales used in the study and correctly indicate the direction of correlation relationships. The HRAS-R ($n = 457$; includes all substance use professionals who completed all 25 items) performed with a very high level of internal consistency, with a Cronbach $\alpha = .907$, similar to Goddard's sample of addiction treatment professionals who completed the HRAS before and after a two-hour harm reduction training (Cronbach's $\alpha = .877$ to $.929$; 2003). Item statistics summary for the HRAS-R is included in Table 1.

Table 1

Summary Item Statistics: HRAS-R

	Mean	Minimum	Maximum	Range	Maximum / Minimum	Variance	N of Items
Item Means	3.605	2.090	4.394	2.304	2.103	.384	25
Item Variances	1.076	.628	1.725	1.098	2.749	.093	25
Inter-Item Covariances	.301	.084	.810	.726	9.697	.013	25
Inter-Item Correlations	.286	.091	.715	.624	7.872	.009	25

The Harm Reduction for OUD Supplement items were scored in the same manner as the HRAS-R, with items originally designed so lower scores indicated higher levels of harm reduction acceptance for OUD specifically. As with the HRAS-R, responses were transformed so that higher scores indicated higher levels of acceptance to be congruent with other scales used. The Harm Reduction for OUD Supplement also performed with a high level of internal consistency, with a Cronbach $\alpha = .875$ ($n = 466$; includes all substance use professionals who responded to all 10 items). Item statistics summary is included in Table 2:

Table 2.

Summary Item Statistics: Harm Reduction for OUD Supplement Items

	Mean	Minimum	Maximum	Range	Maximum / Minimum	Variance	N of Items
Item Means	4.039	3.264	4.519	1.255	1.385	.133	10
Item Variances	.817	.504	1.274	.770	2.527	.075	10
Inter-Item Covariances	.337	.062	.734	.672	11.926	.026	10
Inter-Item Correlations	.411	.077	.717	.640	9.345	.024	10

Because the HRAS-R and Harm Reduction supplement functioned similarly, a combined score was calculated and used for analysis. The score was calculated by calculating the sum of the item responses and dividing by the number of items the participant responded to. Participants must have responded to 32 of 35 items on these items to receive a score (HRAS-R/Supplement Score). The HRAS/Supplement Score also had a very high level of internal consistency, with a Cronbach $\alpha = .937$ ($n = 440$). Item statistics summary is included in Table 3. Additionally, Table 4 displays mean and standard deviations for each HRAS-R/Supplement Score item and Table 5

contains descriptive statistics if each item were deleted from the scale. Tables 3, 4, and 5 show item statistics before scores were transformed so that higher scores indicate increased harm reduction acceptance (Tables 17 and 18 are the only other tables in the document that used scores before the transformation). The items for the HRAS-R and Harm Reduction for OUD Supplement have similar ranged of mean scores and standard deviations, as well as similarities in the impact on the scale's score or Cronbach α if items were deleted.

Table 3.

Summary Item Statistics: HRAS/Supplement Score

	Mean	Minimum	Maximum	Range	Maximum / Minimum	Variance	N of Items
Item Means	2.335	1.482	4.077	2.595	2.752	.444	35
Item Variances	1.009	.513	1.745	1.231	3.398	.102	35
Inter-Item Covariances	.239	-.697	.811	1.508	-1.164	.051	35
Inter-Item Correlations	.251	-.506	.717	1.223	-1.417	.045	35

Table 4.

Item Statistics: HRAS-R/Supplement Score

	Mean	Std. Deviation	N
<u>HRAS-R</u>			
People with alcohol or drug problems who want to reduce, but not eliminate, their alcohol or drug use are in denial.	2.6977	1.05950	440
Injecting drug users should be taught how to use bleach to sterilize their injecting equipment.	2.3318	1.12494	440
A choice of treatment goals, including abstinence, reduced use of drugs or alcohol, and safer use of drugs or alcohol should be discussed with all people seeking help for drug or alcohol problems.	1.7682	.97387	440
People who live in government-funded housing should be required to be drug free.	2.8955	1.21980	440
In order to reduce problems such as crime and health risks, doctors should be permitted to treat drug addiction by prescribing heroin and similar drugs.	3.9023	1.10785	440
If their drug use does not interfere with their day-to-day functioning (for example, their ability to work, attend school, or maintain healthy relationships), women who use illegal drugs can be good mothers to infants and young children.	3.1636	1.10519	440
Drug users should be given accurate information about how to use drugs more safely (for example, how to avoid overdose or related health hazards).	1.7864	.91547	440
People with drug or alcohol problems who are not willing to accept abstinence as their treatment goal should be offered alternative treatments that aim to reduce the harm associated with their continued drug or alcohol use.	1.6068	.78566	440

Item Statistics: HRAS-R/Supplement Score

	Mean	Std. Deviation	N
In most cases, nothing can be done to motivate clients who refuse to admit that they have drug or alcohol problems except to wait for them to “hit bottom.”	1.9227	.96094	440
To reduce crime and other social problems associated with illegal drug use, substitute drugs such as methadone and buprenorphine should be prescribed.	2.0659	1.01367	440
Prisons should provide sterilizing tablets or bleach in order for inmates to clean their drug injecting equipment.	3.3818	1.17864	440
As long as clients are making progress toward their treatment goals (for example, holding a job or reducing their involvement in crime), methadone maintenance programs, or buprenorphine programs, should not kick clients out of treatment for using street drugs.	2.7977	1.19318	440
Measures designed to reduce the harm associated with drug or alcohol use are acceptable only if they eventually lead clients to pursue abstinence.	2.5886	1.10140	440
People with drug and alcohol problems may be more likely to seek professional help if they are offered treatment options that don't focus on abstinence.	2.1045	.88417	440
Substitute drugs such as methadone and buprenorphine should be an available treatment option for people addicted to drugs like heroin.	1.6000	.83979	440
People whose drug use does not interfere with their day-to-day functioning should be trained to teach other drug users how to use drugs more safely (for example, how to inject more safely).	3.2023	1.21212	440
Making clean injecting equipment available to injecting drug users is likely to reduce the rate of HIV infection.	1.7023	.82941	440

Item Statistics: HRAS-R/Supplement Score

	Mean	Std. Deviation	N
Abstinence should be the only acceptable treatment option for people who are physically dependent on alcohol.	2.5409	1.21800	440
It is possible to use drugs without necessarily misusing or abusing drugs.	2.2159	.95751	440
Pamphlets that educate drug users about safer drug use should be detailed and explicit, even if those pamphlets are offensive to some people.	1.8909	.84406	440
Substitute drugs such as methadone and buprenorphine should only be prescribed for a limited period of time.	3.0136	1.32087	440
To reduce the spread of HIV and other blood-borne diseases, drug injectors should be given easy access to clean injecting equipment.	1.8114	.85556	440
Women who use illegal drugs during pregnancy should lose custody of their babies.	2.6273	1.04006	440
People with alcohol or drug problems should be praised for making changes such as cutting down on their alcohol/drug consumption or switching from injectable drugs to oral drugs.	2.0182	.88245	440
Abstinence should be the only acceptable treatment goal for people who use illegal drugs.	2.1295	1.10869	440

Harm Reduction for OUD Supplement Items

Motivational Interviewing is an appropriate counseling intervention for clients with moderate or severe opioid use problems.	1.6227	.71650	440
Treatment providers should recommend medication-assisted treatment like methadone or buprenorphine for clients who are chemically dependent on opioids and want to stop using illicitly.	1.8295	.88291	440

Item Statistics: HRAS-R/Supplement Score

	Mean	Std. Deviation	N
Treatment providers should recommend needle exchange programs to opioid users who are using via injection.	1.8773	.92716	440
It is essential for treatment providers to help opioid users access supplies of Naloxone to reverse opioid overdoses that may occur.	1.4818	.75139	440
Fentanyl testing kits that allow users to know if their drug supply is adulterated with this substance are useful tools and should be recommended by treatment providers.	1.9727	.94456	440
Opioid users benefit from having safe, legal spaces where they can consume drugs, sterile injection equipment can be provided, and staff can reverse overdoses that occur.	2.4068	1.13765	440
Opioid users should be referred to comprehensive community programs that provide an array of harm reduction services, such as clean needles, Naloxone supplies, education about safe drug use practices, and where their drugs can be checked for fentanyl.	1.9091	.89845	440
Due to the potential for overdose with opioids, people using these drugs are good candidates for programs seeking to reduce overdose risks without requiring abstinence.	2.0023	.84976	440
Linking opioid users to housing programs that do not require them to stop using drugs is appropriate and should lead to better long-term outcomes for these individuals.	2.7364	1.12885	440
Educating individuals who abuse opioids about strategies of using that reduce overdose, infection, and other risks is an aspect of appropriate treatment.	1.7614	.75455	440

Table 5.

Item-Total Statistics: HRAS-R/Supplement Score

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
<u>HRAS-R</u>					
People with alcohol or drug problems who want to reduce, but not eliminate, their alcohol or drug use are in denial.	76.6682	375.074	.453	.313	.936
Injecting drug users should be taught how to use bleach to sterilize their injecting equipment.	77.0341	375.600	.411	.332	.937
A choice of treatment goals, including abstinence, reduced use of drugs or alcohol, and safer use of drugs or alcohol should be discussed with all people seeking help for drug or alcohol problems.	77.5977	377.312	.437	.334	.936
People who live in government-funded housing should be required to be drug free.	76.4705	367.890	.543	.430	.936
In order to reduce problems such as crime and health risks, doctors should be permitted to treat drug addiction by prescribing heroin and similar drugs.	75.4636	376.122	.406	.335	.937

Item-Total Statistics: HRAS-R/Supplement Score

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
If their drug use does not interfere with their day-to-day functioning (for example, their ability to work, attend school, or maintain healthy relationships), women who use illegal drugs can be good mothers to infants and young children.	76.2023	373.273	.475	.429	.936
Drug users should be given accurate information about how to use drugs more safely (for example, how to avoid overdose or related health hazards).	77.5795	370.540	.664	.592	.934
People with drug or alcohol problems who are not willing to accept abstinence as their treatment goal should be offered alternative treatments that aim to reduce the harm associated with their continued drug or alcohol use.	77.7591	377.596	.542	.467	.936
In most cases, nothing can be done to motivate clients who refuse to admit that they have drug or alcohol problems except to wait for them to "hit bottom."	77.4432	380.311	.361	.262	.937
To reduce crime and other social problems associated with illegal drug use, substitute drugs such as methadone and buprenorphine should be prescribed.	77.3000	373.636	.513	.521	.936

Item-Total Statistics: HRAS-R/Supplement Score

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
Prisons should provide sterilizing tablets or bleach in order for inmates to clean their drug injecting equipment.	75.9841	368.139	.558	.470	.935
As long as clients are making progress toward their treatment goals (for example, holding a job or reducing their involvement in crime), methadone maintenance programs, or buprenorphine programs, should not kick clients out of treatment for using street drugs.	76.5682	369.904	.511	.347	.936
Measures designed to reduce the harm associated with drug or alcohol use are acceptable only if they eventually lead clients to pursue abstinence.	76.7773	371.914	.510	.398	.936
People with drug and alcohol problems may be more likely to seek professional help if they are offered treatment options that don't focus on abstinence.	77.2614	376.758	.502	.364	.936
Substitute drugs such as methadone and buprenorphine should be an available treatment option for people addicted to drugs like heroin.	77.7659	377.938	.494	.534	.936

Item-Total Statistics: HRAS-R/Supplement Score

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
People whose drug use does not interfere with their day-to-day functioning should be trained to teach other drug users how to use drugs more safely (for example, how to inject more safely).	76.1636	365.085	.609	.448	.935
Making clean injecting equipment available to injecting drug users is likely to reduce the rate of HIV infection.	77.6636	373.900	.629	.620	.935
Abstinence should be the only acceptable treatment option for people who are physically dependent on alcohol.	76.8250	369.402	.510	.461	.936
It is possible to use drugs without necessarily misusing or abusing drugs.	77.1500	378.392	.415	.376	.937
Pamphlets that educate drug users about safer drug use should be detailed and explicit, even if those pamphlets are offensive to some people.	77.4750	379.635	.439	.306	.936
Substitute drugs such as methadone and buprenorphine should only be prescribed for a limited period of time.	76.3523	367.422	.506	.478	.936

Item-Total Statistics: HRAS-R/Supplement Score

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
To reduce the spread of HIV and other blood-borne diseases, drug injectors should be given easy access to clean injecting equipment.	77.5545	372.348	.657	.657	.935
Women who use illegal drugs during pregnancy should lose custody of their babies.	76.7386	376.635	.423	.328	.937
People with alcohol or drug problems should be praised for making changes such as cutting down on their alcohol/drug consumption or switching from injectable drugs to oral drugs.	77.3477	373.990	.586	.432	.935
Abstinence should be the only acceptable treatment goal for people who use illegal drugs.	77.2364	364.431	.688	.599	.934

Harm Reduction OUD Supplement

Motivational Interviewing is an appropriate counseling intervention for clients with moderate or severe opioid use problems.	77.7432	388.182	.215	.197	.938
Treatment providers should recommend medication-assisted treatment like methadone or buprenorphine for clients who are chemically dependent on opioids and want to stop using illicitly.	77.5364	377.675	.476	.511	.936

Item-Total Statistics: HRAS-R/Supplement Score

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
Treatment providers should recommend needle exchange programs to opioid users who are using via injection.	77.4886	369.275	.691	.638	.934
It is essential for treatment providers to help opioid users access supplies of Naloxone to reverse opioid overdoses that may occur.	77.8841	378.850	.525	.457	.936
Fentanyl testing kits that allow users to know if their drug supply is adulterated with this substance are useful tools and should be recommended by treatment providers.	77.3932	370.722	.637	.530	.935
Opioid users benefit from having safe, legal spaces where they can consume drugs, sterile injection equipment can be provided, and staff can reverse overdoses that occur.	76.9591	363.101	.701	.672	.934
Opioid users should be referred to comprehensive community programs that provide an array of harm reduction services, such as clean needles, Naloxone supplies, education about safe drug use practices, and where their drugs can be checked for fentanyl.	77.4568	367.871	.757	.714	.934

Item-Total Statistics: HRAS-R/Supplement Score

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
Due to the potential for overdose with opioids, people using these drugs are good candidates for programs seeking to reduce overdose risks without requiring abstinence.	77.3636	372.956	.643	.525	.935
Linking opioid users to housing programs that do not require them to stop using drugs is appropriate and should lead to better long-term outcomes for these individuals.	76.6295	365.386	.651	.540	.934
Educating individuals who abuse opioids about strategies of using that reduce overdose, infection, and other risks is an aspect of appropriate treatment.	77.6045	375.602	.636	.531	.935

Other Scales

The TEQ, SJS, and POVS were used to answer Research Question Three, which only focused on professional counselors in the study. Therefore, internal consistency measures reported only include professional counselors, despite many other participants completing these scales. TEQ functioned with a high level of internal consistency ($n = 112$; only professional counselors who completed all items included), with a Cronbach $\alpha = .839$. This is similar to the internal consistency found with college students sampled for the validation of this instrument ($n = 344$, Cronbach $\alpha = .85$; Spreng et al., 2009).

The SJS Attitudes Towards Social Justice Subscale functioned with a very high level of internal consistency ($n = 117$; only professional counselors who completed all items included), with a Cronbach $\alpha = .916$. This was similar to the internal consistency found with the sample of college students (graduate and undergraduate) used to validate the scale ($n = 115$, Cronbach $\alpha = .95$; Torres-Harding, 2012).

The POVS has undergone revisions since it was originally developed (La Guardia personal communication, September 27, 2019). This version of the scale functioned with high internal consistency ($n = 117$; only professional counselors who completed all items included), with a Cronbach $\alpha = .811$. This is nearly identical to the internal consistency found when this instrument was validated with a sample of practicing counselors, counselor educators, and counseling graduate students ($n = 453$; Cronbach $\alpha = .81$; Healy, 2009).

Sample Description

Of the 655 participants who began the survey, 567 (86.6%) indicated they provide direct substance use treatment to clients in their current position, making them eligible for the study. The majority of the sample identified as White/Caucasian ($n = 415$; 78.2%), with the distribution of ethnic identities included in Table 6. The professional counselors sampled also mostly identified as White/Caucasian ($n = 119$; 88.8%), with the distribution of ethnic identities for professional counselors in the study included in Table 7. The majority of participants and professional counselors sampled identified their gender identity as female, with the full sample gender demographics shown in Table 8, and the gender demographics for professional counselors sampled shown in Table 9. The mean age among participants was 44.93, with a range of 22 to 84 years of age.

Table 6.

Ethnicity: Full Sample

	Frequency	Percent	Valid Percent	Cumulative Percent
Declined to Answer	10	1.8	1.9	1.9
Asian	9	1.6	1.7	3.6
Black or African American	35	6.2	6.6	10.2
Caucasian/White	415	73.2	78.2	88.3
Hawaiian Native or Pacific Islander	3	.5	.6	88.9
Hispanic or Latino	27	4.8	5.1	94.0
Multi-racial/Multiple Ethnicities	14	2.5	2.6	96.6
Native American or American Indian	9	1.6	1.7	98.3
Other	9	1.6	1.7	100.0
Total	531	93.7	100.0	
Stopped Survey before this Question	36	6.3		
Total	567	100.0		

Table 7.

Ethnicity: Professional Counselors

	Frequency	Percent	Valid Percent	Cumulative Percent
No Response	1	.8	.8	.8
Asian	1	.8	.8	1.6
Black or African American	5	4.0	4.0	5.6
Caucasian/White	114	90.5	90.5	96.0
Hawaiian Native or Pacific Islander	1	.8	.8	96.8
Hispanic or Latino	2	1.6	1.6	98.4
Other	2	1.6	1.6	100.0
Total	126	100.0	100.0	

Table 8.

Gender Identity: All Participants

	Frequency	Percent	Valid Percent	Cumulative Percent
Male	117	20.6	22.3	22.3
Female	401	70.7	76.4	98.7
Other	5	.9	1.0	99.6
Prefer Not to Answer	2	.4	.4	100.0
Total	525	92.6	100.0	
No Response	42	7.4		
Total	567	100.0		

Table 9.

Gender: Professional Counselors

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Male	23	18.3	18.3	18.3
Female	103	81.7	81.7	100.0
Total	126	100.0	100.0	

Participants from 44 of 50 states responded to the survey (no participants identified their location of practice as Alabama, Delaware, New Hampshire, New Mexico, Rhode Island, or West Virginia; all other states were represented). Table 10 summarizes the distribution of participants who identify their practice setting as rural, urban, or suburban. A large number of participants resided in each of these types of locations, with slightly more working in urban areas.

Table 10.

How would you describe the location of your primary work setting?

	Frequency	Percent	Valid Percent	Cumulative Percent
No Response	9	1.6	1.7	1.7
Rural	156	27.5	29.4	31.1
Suburban	163	28.7	30.7	61.8
Urban	203	35.8	38.2	100.0
Total	531	93.7	100.0	
Stopped Survey before item	36	6.3		
Total	567	100.0		

Participant estimates of number of clients with OUD served in the last month ranged from 0 to 150 or more (no mean calculated, as 150+ was the highest choice available, which was selected by 10 participants). Only 17 participants estimated they had seen more than 100 clients with OUD in the last month and 26 participants estimated they had seen between 50 and 100 clients with OUD in the last month. The majority of participants indicated they were not in recovery from substance use, with a full summary of responses to that item shown in Table 11. Of note, about 30% of full sample were in recovery from substance use, while less than 15% of professional counselors reported being in recovery. A summary of counselors' responses to this item are displayed in Table 12.

Table 11.

Are you in recovery from addiction to alcohol or drugs?

	Frequency	Percent	Valid Percent	Cumulative Percent
No Response	7	1.2	1.3	1.3
Yes	172	30.3	32.5	33.8
No	328	57.8	61.9	95.7
Prefer not to answer	23	4.1	4.3	100.0
Total	530	93.5	100.0	
Stopped survey before item	37	6.5		
Total	567	100.0		

Table 12.

Are you in recovery from addiction to alcohol or drugs? (Professional Counselors)

	Frequency	Percent	Valid Percent	Cumulative Percent
No Response	1	.7	.7	.7
Yes	17	12.7	12.7	13.4
No	109	81.3	81.3	94.8
Prefer not to answer	7	5.2	5.2	100.0
Total	134	100.0	100.0	

Participants were asked about their professional licenses and certifications related to their work as substance use professionals. The participants could choose as multiple credentials, including two options for writing in additional credentials not listed. The most common responses chosen included: State-level addiction treatment certification or licensure ($n = 206$; 29.5%), Licensed Professional Counselor/Licensed Mental Health Counselor ($n = 113$; 16.7%), Licensed Clinical Social Worker ($n = 70$; 10%), national addiction treatment certification ($n = 43$; 6.2%), and Peer Recovery certification ($n = 36$; 5.2%). All other licenses were selected by less than 1.5% of participants; however, 152 participants (29.5%) selected *Other* and wrote-in a response and 32 participants (4.58%) wrote in a *Second Other* credential. *Other* and *Second*

Other responses included residents in counseling and social work, various types of state and national substance use treatment credentials (unfortunately, not captured in the multiple-choice selections), and certifications in specific therapeutic techniques, such as Eye-Movement Desensitization Therapy and Domestic Violence Counselor. Participants were also asked to report their level of education, with half of the sample having a master's degree or higher. The distribution of levels of education reported are displayed in Table 13.

Table 13.

Please indicate your highest level of education

	Frequency	Percent	Valid Percent	Cumulative Percent
No Response	4	.6	.8	.8
High school graduate	38	5.8	7.2	7.9
Associates Degree	46	7.0	8.7	16.6
Bachelor's Degree	109	16.6	20.5	37.1
Master's Degree	313	47.8	58.9	96.0
Doctorate Degree	21	3.2	4.0	100.0
Total	531	81.1	100.0	
Stopped survey before item	124	18.9		
Total	655	100.0		

An important grouping variable for this study was professional discipline, obtained via the following item: *Please indicate your primary discipline of training (option that best describes your professional identity)*. Response choices for this item included the following: *Marriage and Family Therapy, Medical Doctor, Nursing, Physician Assistant, Professional Counseling, Social Work, Psychology, and Other*. The participants choosing *Other* could write-in their discipline of training in a text box. The highest percentage of participants indicated their

professional identity was professional counseling ($n = 181$; 27.6%), followed by social workers ($n = 136$; 20.8%). Table 14 shows the distribution of responses to this item.

Table 14.

Please indicate your primary discipline of training (option that best describes your professional identity)

	Frequency	Percent	Valid Percent	Cumulative Percent
No Response	6	.9	1.1	1.1
Marriage and Family Therapy	20	3.1	3.8	4.9
Medical Doctor	8	1.2	1.5	6.4
Nursing	16	2.4	3.0	9.4
Physician's Assistant	1	.2	.2	9.6
Professional Counseling	181	27.6	34.1	43.7
Psychology	52	7.9	9.8	53.5
Social Work	136	20.8	25.6	79.1
Other:	111	16.9	20.9	100.0
Total	531	81.1	100.0	
Stopped survey before item	124	18.9		
Total	655	100.0		

Research question two was answered via an ANOVA and for that analysis, professional disciplines were grouped by similarities in professional identity. Also, all three research questions required professional counselors to be grouped for analysis, but 47 participants who identified *Professional Counseling* as their discipline of training were removed from that group due to lacking sufficient training (a master's degree or higher) to meet the definition of a professional counselor used for this study. All participants with a bachelor's level of training were consolidated as a single group (other than medical professionals), due to the assumption that in substance use treatment programs, these professional treatment providers likely lacked a

strong professional identity separated from their work setting and responsibilities; while those with master's degrees or higher (and medical professionals) were consolidated based on their discipline. These final groupings of professionals and defining the subset of professional counselors can be found in Table 15. Due to concerns about unequal group sizes for ANOVA, only professional counselors ($n = 134$), bachelor's level or less professionals ($n = 189$), and social workers with a master's degree or higher ($n = 110$) were compared. Data analyses utilized to answer research questions used these professional groupings, with professional counselors being the focal group.

Table 15.

Final Discipline Groupings

	Frequency	Percent	Valid Percent	Cumulative Percent
Non-Med Bachelors or less Level Professionals	189	28.9	35.6	35.6
Professional Counselors	134	20.5	25.2	60.8
Masters Level Social Workers	110	16.8	20.7	81.5
Marriage and Family Therapists	20	3.1	3.8	85.3
Masters level Psychology	27	4.1	5.1	90.4
Medical Professionals	25	3.8	4.7	95.1
Other	26	4.0	4.9	100.0
Total	531	81.1	100.0	
Stopped survey before item	124	18.9		
Total	655	100.0		

Findings

As previously mentioned, the HRAS-R and Harm Reduction Supplement items were combined to arrive at the HRAS-R/Supplement Score, which was used at the outcome variable for all three analyses. The responses for each item on those 35 items were transformed so that

higher scores indicate higher levels of harm reduction acceptability, rather than lower scores indicating higher levels of harm reduction acceptance, in order to show the proper directionality of relationships between variables (the TEQ, SJS, and POVS are each scored so that higher scores are indicative of higher levels of the variable of interest). Research Question One involved the analysis of HRAS-R/Supplement Scores for professional counselors sampled, with an exploration of descriptive statistics to determine if counselors are generally accepting of harm reduction approaches for OUD. Research Question Two involved the analysis of HRAS-R/Supplement Scores for multiple disciplines sampled. A One-Way Analysis of Variance (ANOVA) was used to compare groups with relatively equal sample sizes, based on their HRAS-R/Supplement Scores. A Tukey's post-hoc analysis determined if professional counselors had higher HRAS-R/Supplement Scores compared to other disciplines. The TEQ, SJS, and POVS scale scores were used to answer Research Question Three, which focused only on professional counselors sampled. Research Question Three involved a simultaneous linear multiple regression analysis using the TEQ, SJS, and POVS scale scores as predictor variables, and the HRAS-R/Supplement Scores as the as the outcome variable. The assumptions and findings of these analyses are detailed in this section.

Research Question One

Research Question One asked:

RQ1: What is the acceptability of harm reduction approaches for Opioid Use Disorder among professional counselors?

Descriptive statistics for professional counselors in the study were analyzed, based on their HRAS/Supplement Scores. For Research Question One, 128 professional counselors were included in the analysis, with one participant being excluded due to skipping three items on the

HRAS-R, and five others being excluded due to completing the HRAS-R, but not completing the Harm Reduction for OUD Supplement scale. Figure 1 shows a histogram of HRAS/Supplement Scores for professional counselors, showing a normal distribution of scores. This normal distribution of HRAS/Supplement Scores is also supported by low skewness and kurtosis statistics. Table 16 shows the descriptive statistics for professional counselors' HRAS/Supplement Scores.

Figure 1.

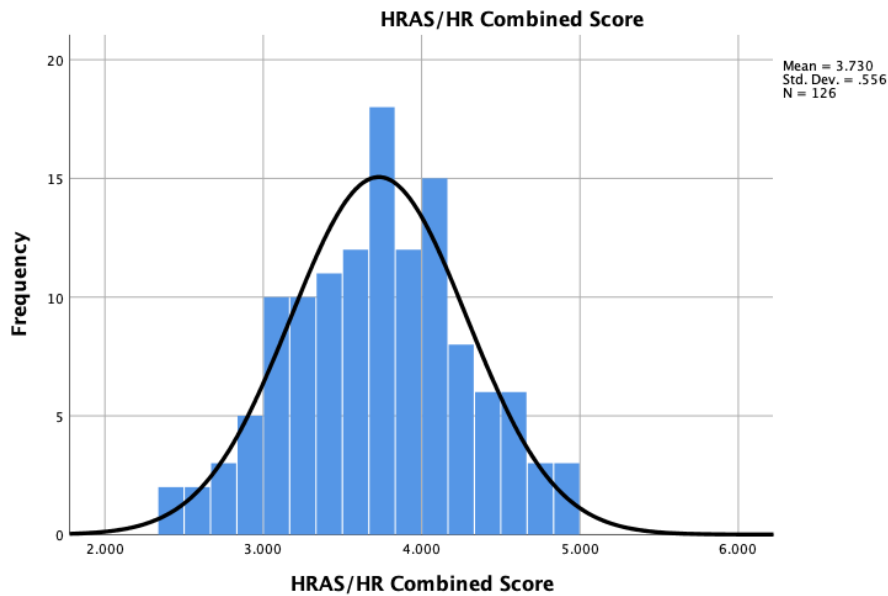


Table 16.

Descriptive Statistics: Professional Counselors' HRAS/Supplement Score

	N	Range	Min.	Max.	Mean	Std. Dev.	Variance	Skewness	Kurtosis		
		Stat.	Statistic	Statistic	Stat.	Stat.	Stat.	Std. Error	Std. Error		
HRAS/ Supplement Score	126	2.657	2.343	5.000	3.730	.556	.309	-.052	.216	-.251	.428
Valid N (listwise)	126										

While the analysis for this question focused on a transformed HRAS-R score combined with the supplemental harm reduction for OUD items (creating the HRAS/Supplement Score), it is worthwhile to compare HRAS-R scores for the current sample with prior samples (using traditional scoring protocols). Note that lower mean scores on the HRAS-R indicate higher levels of acceptance of harm reduction for respondents; however, for the analyses presented in Chapter Four, scores were transformed so higher HRAS-R scores (and HRAS/Supplement Scores) indicated higher levels of acceptance. The descriptive statistics for the HRAS-R only, as traditionally scored, can be seen in Tables 17 (professional counselors only) and 18 (full sample).

Table 17.

Descriptive Statistics: Professional Counselors HRAS-R Scores

	N	Range	Minimum	Maximum	Mean	Std. Deviation	Variance
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic
HRAS Score	128	2.72	1.00	3.72	2.3793	.55723	.311
Valid N (listwise)	128						

Table 18.

Descriptive Statistics: Full Sample HRAS-R Scores

	N	Range	Minimum	Maximum	Mean	Std. Deviation	Variance
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic
HRAS Score	484	3.20	1.00	4.20	2.3964	.57323	.329
Valid N (listwise)	484						

Prior studies were not focused on opioid use, but harm reduction for substance use broadly. In comparing Goddard's sample of treatment professionals used to develop the HRAS (2003) based on their pre-intervention (training) scores ($n = 137$, $M = 2.55$, $S.D. = .50$) to prior samples of counselors, Goddard's sample had slightly higher levels of acceptance than Kyser (2010; $n = 176$, $M = 2.69$, $SD = .48$) and Madden (2016; ($n = 100$, $M = 2.60$; $SD = .43$). The current full sample of practitioners in the current (descriptive statistics shown in Table 28; $n = 484$, $M = 2.3964$, $SD = .57323$), had a higher level of harm reduction acceptance compared to Goddard's pre-test sample (before harm reduction training), based on a two-sample t -test ($t [136] = 2.975$, $p \leq .05$). Additionally, professional counselors in the current study had a higher levels of harm reduction acceptance, as measured by the HRAS-R, compared to Kyser's sample of

counselors (2010; $t [127] = 5.3726, p \leq .05$) and Madden's sample of counselors (2016; $t [99] = 3.605, p \leq .05$). These t statistics show that the current sample of professional counselors had higher levels of acceptance of harm reduction as measured by the HRAS-R compared to the two prior studies that used this measure with counselors. The sample of professional counselors in the current study were identified by their self-reported discipline of training and professional identity, as well as having a master's degree or higher, while Kyser and Madden used samples of ACA members. Also, the current sample only included counselors who treat substance use.

Professional counselors had a mean HRAS/Supplement Score of 3.730 ($n = 126$), with a standard deviation of .556. The lowest possible score was 1.00 and the highest possible score was a 5.00. Further interpretation of these results, as well as discussion of how HRAS-R scores for this sample compare to prior studies, will be discussed in Chapter Five of this document.

Research Question Two

Research question two asked:

RQ2: Do professional counselors have higher levels of harm reduction acceptance for Opioid Use Disorder than other professionals treating substance use?

H₁: Professional counselors will have higher levels of acceptance of harm reduction approaches for Opioid Use Disorder than other professionals treating substance use.

H₀: Professional counselors will have similar levels of acceptance of harm reduction approaches for Opioid Use Disorder as other professionals treating substance use.

This research question was answered via a One-Way Analysis of Variance (ANOVA) in which multiple substance use treatment professional disciplines were compared based on their HRAS/Supplement Scores. For Research Question Two, 134 participants were excluded from the analysis due to not being in one of the three comparison groups. Research Question Two included 389 participants in the analysis. Eight participants were excluded due to lacking an HRAS-R/Supplement Score due to skipping more than two items on the HRAS-R or not completing the Harm Reduction for OUD Supplement scale. Professional disciplines were differentiated with an item used as a grouping variable: *Please indicate your primary discipline of training (option that best describes your professional identity)*. Additionally, level of training was taken into account, given that for professional counseling and other disciplines, post-secondary education enhances the development of professional identity. Despite having a larger sample of professionals included in the study, only three groups were included to maintain similarity in group sizes. Highly unequal sample sizes can diminish the ability of an ANOVA to distinguish the difference between the groups being compared (Shaw & Mitchell-Olds, 1993) and, when groups are very different in size, lead to a violation of the homogeneity of variance assumption (Parra-Futos, 2013).

Assumptions

ANOVA analyses require the data collection process and data collected to meet certain assumptions to be a valid test. First, the independence of observations assumption indicates that each measurement occurred without influencing other measurements (Howell, 2009). In this study, participants completed the survey independently and anonymously, meeting the independence of observations assumption. Second, the normality assumption requires each group to have a normal distribution of errors in measurement around the group mean (Howell, 2009).

The following figures are histogram plots of errors for each discipline, which were inspected for a normal distribution of HRAS/Supplement Scores: Figure 2 is the distribution for bachelor’s level or less substance use professionals ($n = 167$), Figure 3 is the distribution for professional counselors ($n = 126$), and Figure 4 is the distribution for master’s level social workers. Note that each discipline has generally a normal distribution of HRAS/Supplement Score errors, although Master’s level or higher Social Workers’ scores have a slightly negative skew.

Figure 2.

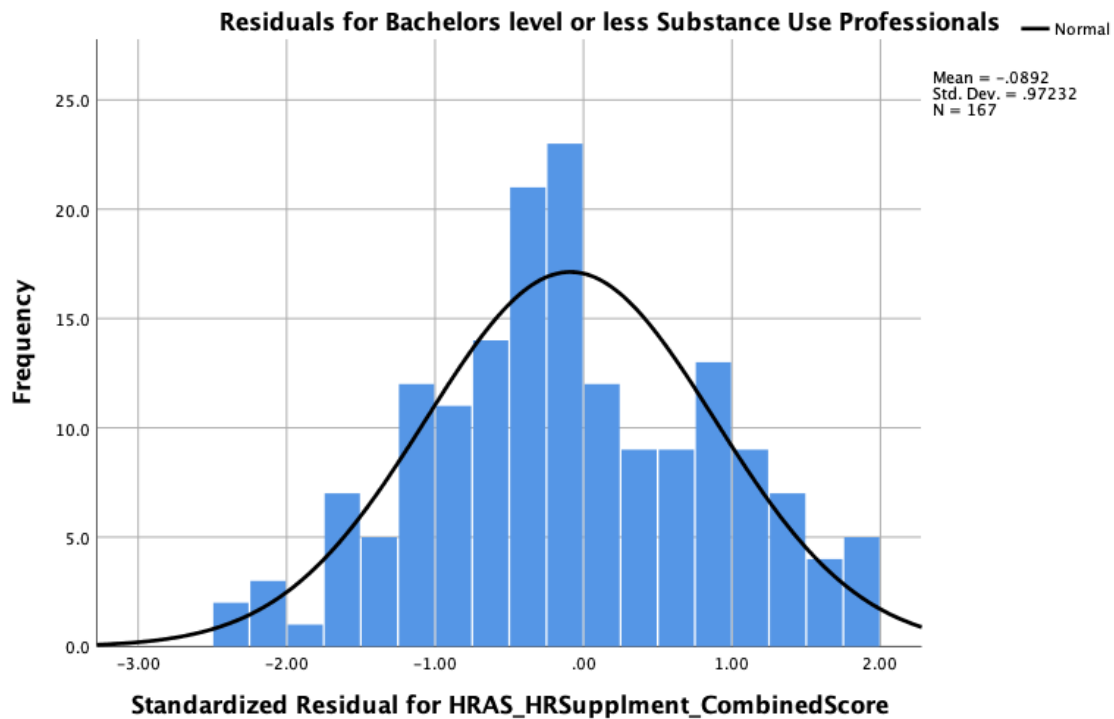


Figure 3.

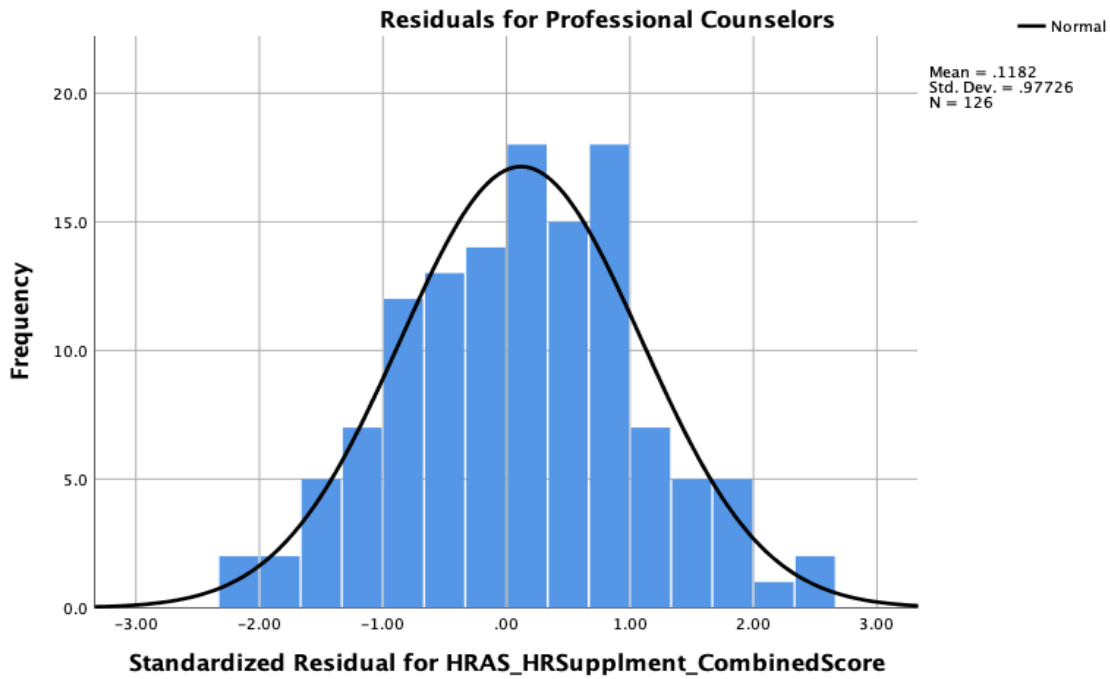
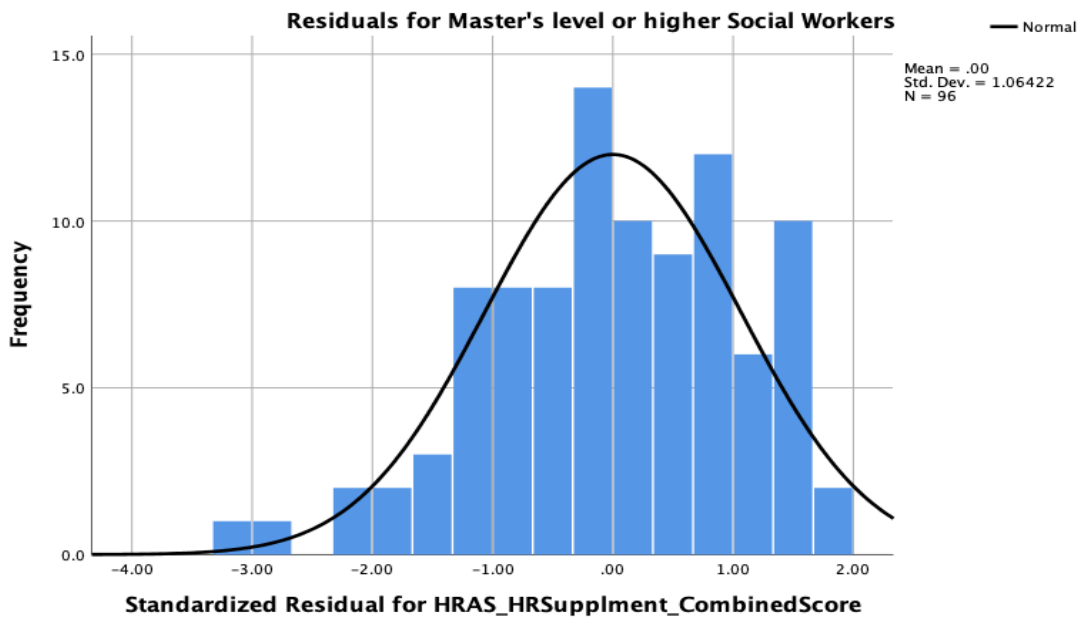


Figure 4.



Finally, the homogeneity of variance (homoscedasticity) assumption indicates that sufficient similarity of variance exists for each group to complete the analysis (Howell, 2009).

This assumption can be checked via the use of Levene statistic, shown in Table 19. Because none of Levene Statistics displayed are statistically significant ($p \leq .05$), the heterogeneity of variance assumption is not violated for this ANOVA grouping. Additionally, Welch's ANOVA was used to confirm that the ANOVA meets this assumption, as this test indicated a low risk of Type I error ($p \leq .05$). Table 20 displays the Welch's ANOVA.

Table 19.

Test of Homogeneity of Variances (ANOVA)

		Levene	df1	df2	Sig.
		Statistic			
HRAS/Supplement Score	Based on Mean	.670	2	386	.512
	Based on Median	.704	2	386	.495
	Based on Median and with adjusted df	.704	2	384.866	.495
	Based on trimmed mean	.649	2	386	.523

Table 20.

Robust Tests of Equality of Means (ANOVA)

HRAS/Supplement Score

	Statistic ^a	df1	df2	Sig.
Welch	6.931	2	225.223	.001

a. Asymptotically F distributed.

Findings

Descriptive statistics for HRAS/Supplement Scores for the disciplines grouped for the ANOVA are shown in Table 21. The ANOVA indicated that statistically significant differences in HRAS/Supplement Scores existed among the three groups compared ($F [2, 386] = 7.362, p \leq$

.05). The ANOVA table is shown in Table 22. The effect size for this analysis was moderately high ($\eta^2 = .201$) and the calculated statistical power was .952.

Table 21.

Descriptive Statistics (ANOVA)

HRAS/Supplement Score

		N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Min.	Max.	Between-Component Variance
						Lower Bound	Upper Bound			
Bachelors or Less Professionals		167	3.61155	.553461	.042828	3.52699	3.69611	2.286	4.800	
Professional Counselors		126	3.72961	.556273	.049557	3.63153	3.82769	2.343	5.000	
Master's Level Social Workers		96	3.88986	.605775	.061827	3.76712	4.01260	2.057	4.943	
Total		389	3.71847	.576908	.029250	3.66096	3.77598	2.057	5.000	
Model	Fixed Effects			.567675	.028782	3.66188	3.77506			
	Random Effects				.080667	3.37139	4.06556			.016219

Table 22.

ANOVA

HRAS/Supplement Score

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	4.745	2	2.372	7.362	.001
Within Groups	124.390	386	.322		
Total	129.135	388			

*Groups: Bachelors Level or Less Professionals, Professional Counselors, and Master’s Level or Higher Social Workers

A Tukey's post-hoc analysis was used to explore where between group differences existed to produce the statistically significant ANOVA result. The Tukey's test revealed no statistically significant differences between professional counselors and master's level or higher social workers or bachelor's level or less substance use professionals. The statistically significant difference in group means existed between social workers and the bachelor's level professionals. The Tukey's test results are detailed in Table 23. Figure 5 is a scatter plot showing that professional counselors sampled had only slightly higher levels of acceptance of harm reduction approaches for OUD than bachelor's level substance use professionals, while having slightly lower levels of harm reduction acceptance than master's level or higher social workers. Neither of these differences were statistically significant.

Table 23.

Multiple Comparisons (ANOVA)

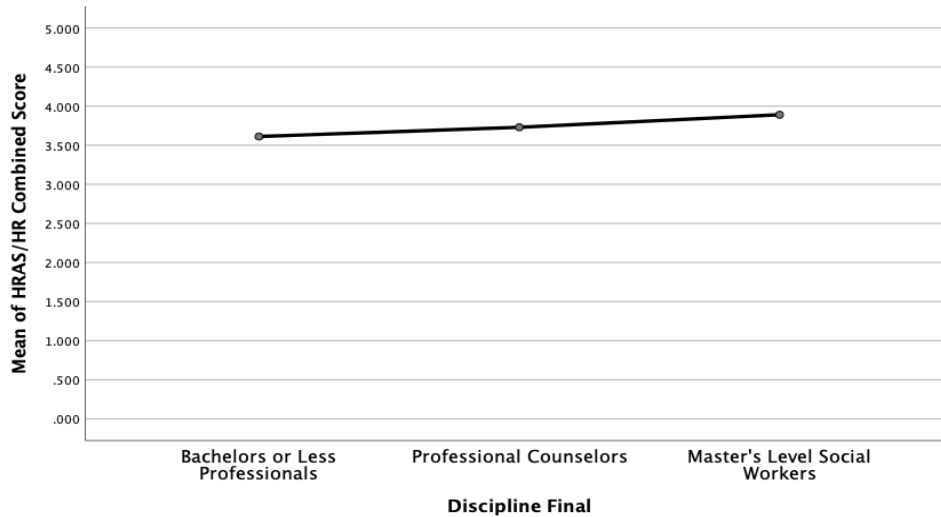
Dependent Variable: HRAS/Supplement Score

Tukey HSD

(I) Discipline Final	(J) Discipline Final	Mean Difference		Sig.	95% Confidence Interval	
		(I-J)	Std. Error		Lower Bound	Upper Bound
Bachelors or Less Professionals	Professional Counselors	-.118055	.066987	.184	-.27566	.03955
	Master's Level Social Workers	-.278312*	.072708	.000	-.44938	-.10724
Professional Counselors	Bachelors or Less Professionals	.118055	.066987	.184	-.03955	.27566
	Master's Level Social Workers	-.160257	.076905	.095	-.34120	.02068
Master's Level Social Workers	Bachelors or Less Professionals	.278312*	.072708	.000	.10724	.44938
	Professional Counselors	.160257	.076905	.095	-.02068	.34120

*. The mean difference is significant at the 0.05 level.

Figure 5.

Scatterplot of Group Means

Based on these results, the researcher fails to reject the null hypothesis, as professional counselors do not have a statistically different level of harm reduction acceptability for OUD compared to bachelor's level substance use treatment professionals or master's level or higher social workers. Further interpretation of this result can be found in Chapter Five of this document.

Research Question Three

Research question three asked:

RQ3: Can professional counselors' acceptance of harm reduction strategies for Opioid Use Disorder be explained by the composite of their level of empathy, social justice attitudes, and their professional identity/values as a counselor?

H₁: Level of empathy, social justice attitudes, and counselor professional identity/values will be statistically significant predictors of acceptance of harm reduction strategies for Opioid Use Disorder among professional counselors.

H₀: Level of empathy, social justice attitudes, and counselor professional identity/values will not be statistically significant predictors of acceptance of harm reduction strategies for Opioid Use Disorder among professional counselors.

This research question was answered via a simultaneous linear multiple regression analysis, in which scores on the TEQ (measuring empathic responsiveness), SJS Attitudes Towards Social Justice subscale, and POVS (measuring the strength of professional counseling orientation and values) were predictors, and HRAS/Supplement Scores were the outcome variable. Research Question Three included only professional counselors included in Research Question One (128); however, an additional six participants were excluded due to skipping more than two items on the HRAS-R or not completing the Harm Reduction for OUD Supplement scale, and one participant being excluded due to skipping multiple items on the SJS and POVS. Only professional counselors were included in this analysis (those who chose *Professional Counseling* as their professional discipline and indicated a master's degree or higher for level of education).

Assumptions

Multiple regression analyses must abide by certain assumptions to be considered a valid statistical test. First, the independence of observations requires that responses from participants sampled are not influenced by one another (Howell, 2009). This study utilized an anonymous survey that participants filled out individually online, making it unlikely their responses were

influenced by other participants. Second, the linearity assumption requires each predictor variable to have a linear relationship with the outcome variable (Howell, 2009). Linearity is the most important assumption, as the assumed linear relationship between predictor and outcome variables is a precursor to other assumptions (Keith, 2015). A loess plot was used to explore linearity for each predictor variable, with residual outcome variables plotted onto observed predictor scores. Figure 6 shows a loess of TEQ scores and HRAS/Supplement residuals, Figure 7 shows a loess plot of SJS Attitudes Towards Social Justice subscale scores and HRAS/Supplement residuals, and Figure 8 shows a loess plot of POVS scores and HRAS/Supplement residuals.

Figure 6.

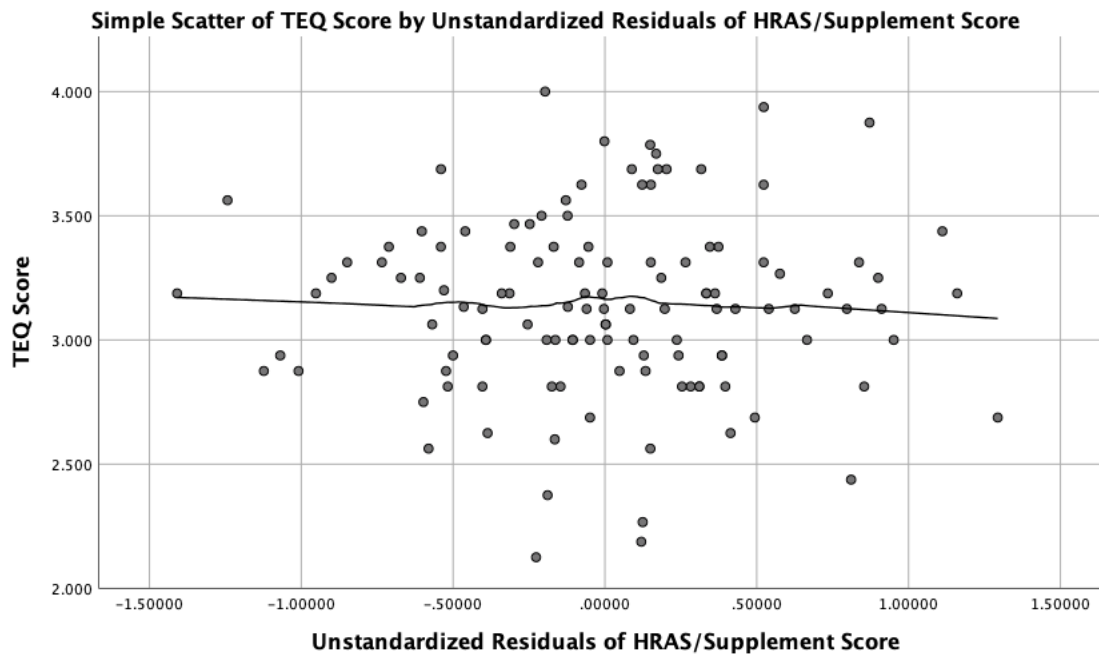


Figure 7.

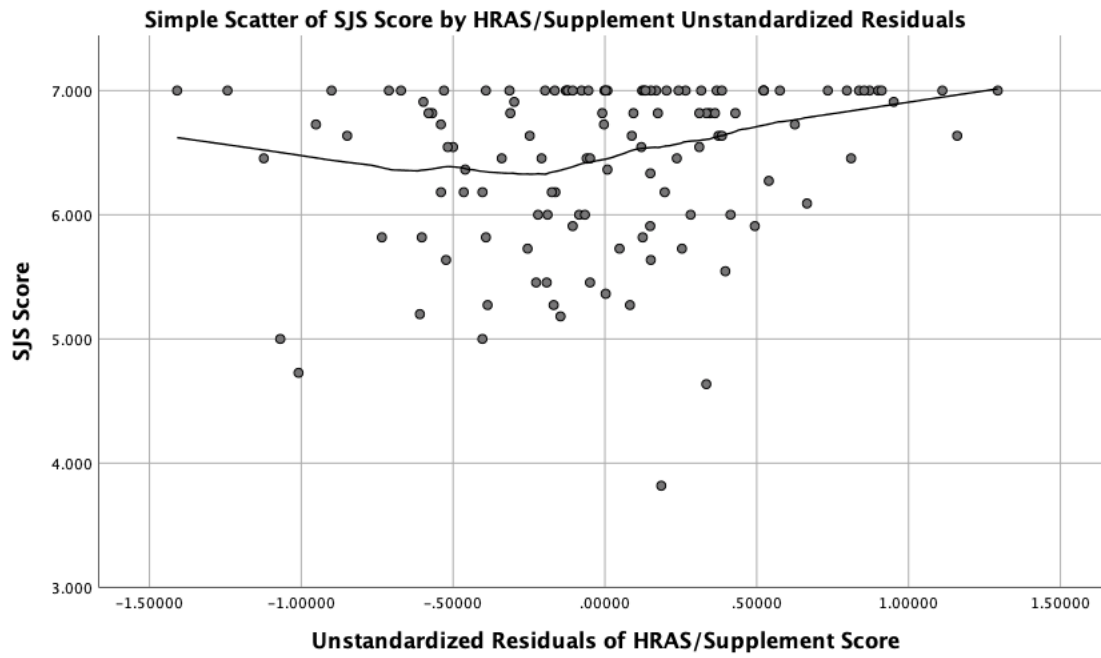
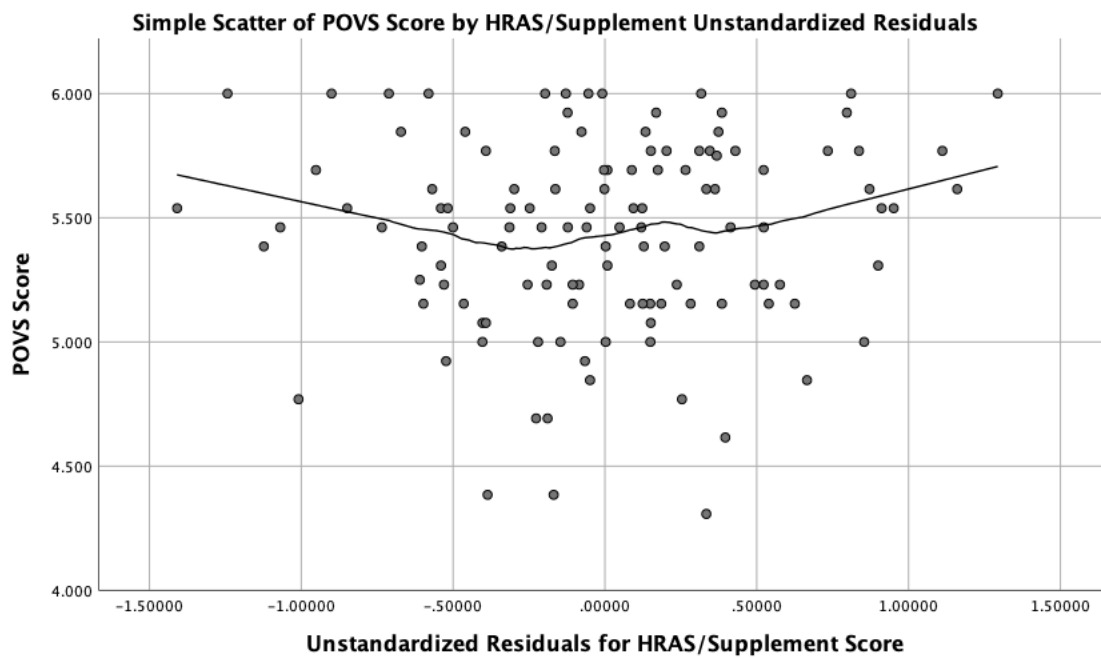
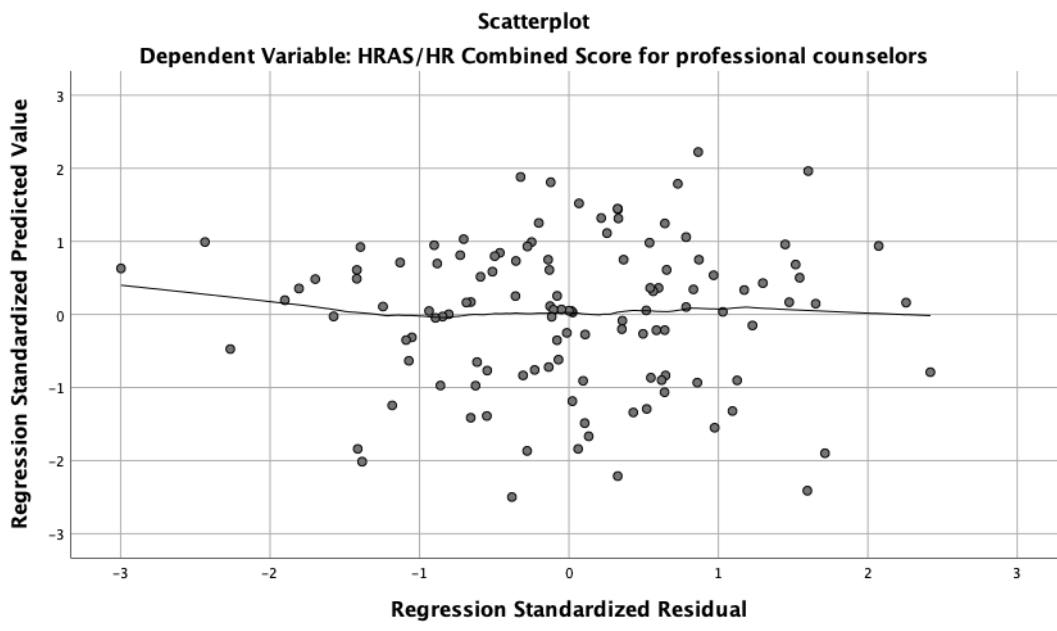


Figure 8.



The third assumption is the homogeneity of variances, which indicates that residual variance is consistently spread across the regression line (Keith, 2015). Figure 9 displays a scatterplot of standardized errors, which indicates a random distribution of residual variance among predictor variables.

Figure 10.



The fourth assumption requires a normal distribution of residual values, which is captured by a p-p plot of residuals (Figure 11) and a histogram of residual values (figure 12).

Figures 11 and 12 confirm a normal distribution of residuals:

Figure 11.

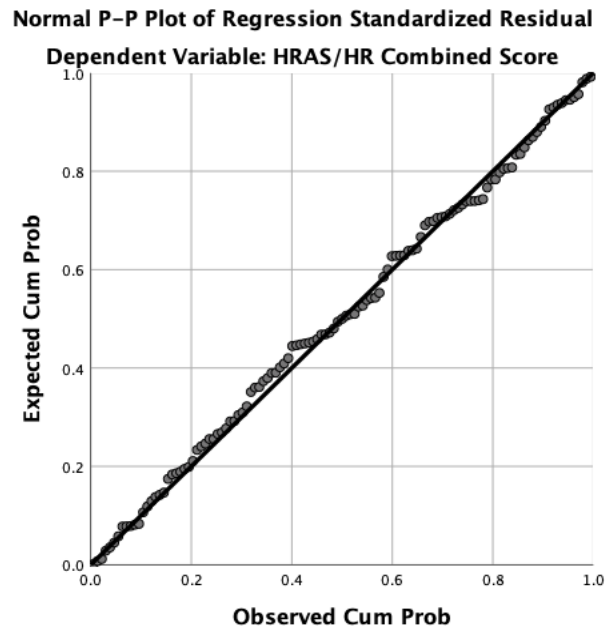
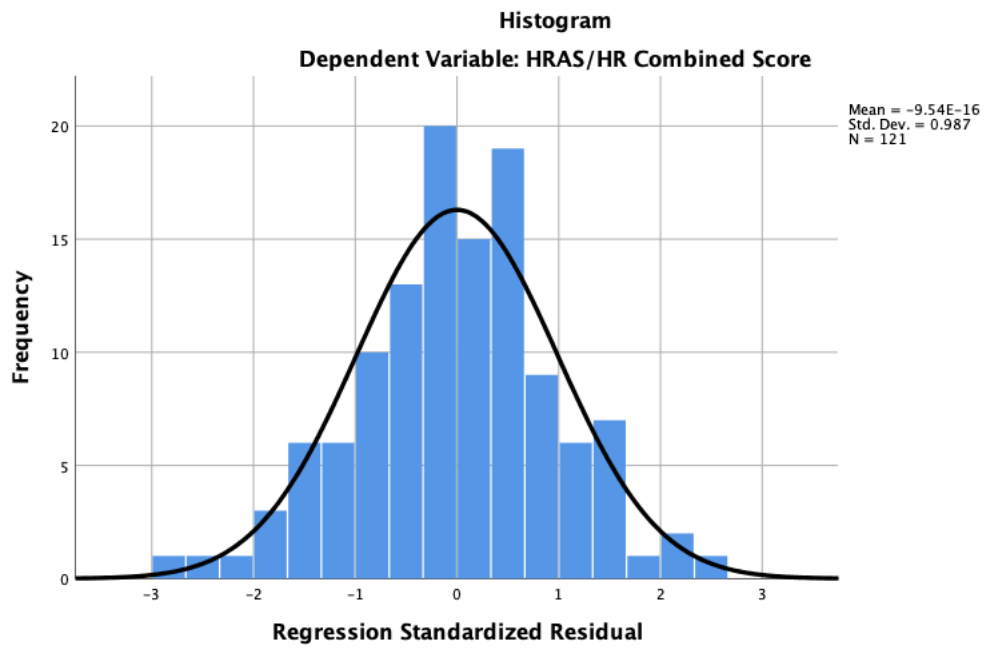


Figure 12.



The final assumption that must be met is the multicollinearity assumption, which requires predictor variables (empathy, social justice attitudes, and counselor professional identity) to not be highly correlated in accounting for the same variability in outcome variable scores (HRAS/Supplement scores). Multicollinearity was ruled out by the Variance Inflation Factor (VIF) and Tolerance statistics (VIF values below 10 and Tolerance values above .25 are generally considered acceptable; Keith, 2015), as shown in Table 24. Based on these regression diagnostics, the multiple regression model met all of the assumptions for analysis.

Table 24.

Collinearity

Model	Collinearity Statistics	
	Tolerance	VIF
1 (Constant)		
TEQ Score	.855	1.170
SJS Score	.522	1.917
POVS Score	.504	1.986

*Dependent Variable: HRAS/HR Combined Score

Findings

Professional counselors who had scores for the TEQ, SJS Social Justice Attitudes Subscale, the POVS, and the HRAS/Supplement Score were included in this analysis ($n = 121$). The predictor variables, TEQ, SJS Social Attitudes Subscale, and POVS scores, were regressed onto the outcome variable, HRAS/Supplement Score, via a simultaneous multiple regression analysis. Descriptive statistics for professional counselors' scores on these instruments are included in Table 25. The simultaneous multiple regression analysis indicated a statistically significant explanatory relationship between the predictors and outcome variable ($F [3, 117] =$

8.464, $p \leq .05$), as shown in the ANOVA table, Table 26. The regression model summary is displayed in Table 27. The regression model reveals a multiple correlation coefficient indicative of a moderate relationship between the predictors and outcome variable ($R = .422$), with nearly 18% of the variance in HRAS/Supplement Scores among professional counselors being accounted for by the predictors ($R^2 = .178$). The effect size for this analysis was moderately high ($f^2 = .217$) and the calculated statistical power was .980.

Table 25.

Descriptive Statistics (Regression)

	Mean	Std. Deviation	N
HRAS/Supplement Score	3.72363	.555408	121
TEQ Score	3.13993	.357765	121
SJS Score	6.43341	.659779	121
POVS Score	5.43357	.383114	121

Table 26.

ANOVA (Regression)

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	6.601	3	2.200	8.464	.000 ^b
	Residual	30.416	117	.260		
	Total	37.017	120			

a. Dependent Variable: HRAS/Supplement Score

b. Predictors: (Constant), POV Score, TEQ Score, SJS Score

Table 27.

Model Summary (Regression)

Model	R	Adjusted R Square	Std. Error of the Estimate	Change Statistics					
				R Square Change	F Change	df1	df2	Sig. F Change	
1	.422 ^a	.178	.509871	.178	8.464	3	117	.000	

The regression coefficients table is displayed in Table 28. The coefficient table shows that TEQ and SJS Social Justice Attitudes Subscale scores had positive linear relationships with HRAS/Supplement Scores, while POVS scores had a negative linear relationship with HRAS/Supplement Scores. Additionally, TEQ and SJS Social Justice Attitudes Subscale scores were statistically significant contributors to the regression model, while POVS scores were not a statistically significant contributor to the regression model. The resulting regression equation is:

$$\text{HRAS/Supplement Score} = 1.672 + .477\text{TEQ} + .258\text{SJS Social Justice Attitudes Subscale} - .204\text{POVS} + e$$

Table 28.

Coefficients (Regression)

Model		Unstandardized Coefficients		Standardized Coefficients		Correlations			
		B	Std. Error	Beta	t	Sig.	Zero-order	Partial	Part
1	(Constant)	1.672	.685		2.440	.016			
	TEQ Score	.477	.141	.308	3.392	.001	.355	.299	.284
	SJS Score	.258	.098	.307	2.643	.009	.310	.237	.222
	POVS Score	-.204	.171	-.141	-1.192	.236	.183	-.110	-.100

a. Dependent Variable: HRAS/Supplement Score

Based on the simultaneous multiple regression analysis, the null hypothesis is rejected, as professional counselors' harm reduction acceptability for OUD can be explained by the

composite of their level of empathy, social justice attitudes, and their professional identity/values as a counselor. This result is based on a statistically significant regression model and the data meeting the assumptions for the analysis. Further interpretation of this result is included in Chapter Five.

Summary

In this chapter, the research questions were reviewed, the assumptions for each analysis were addressed, and the results from each analysis were summarized. The first research question (*What is the acceptability of harm reduction approaches for Opioid Use Disorder among professional counselors?*) was answered via descriptive statistics of professional counselors' HRAS/Supplement Scores. The second research question (*Do professional counselors have higher levels of harm reduction acceptance for Opioid Use Disorder than other professionals treating substance use?*) was answered via the use of a one-way Analysis of Variance and post-hoc Tukey's test. The third research question (*Can professional counselors' acceptance of harm reduction strategies for Opioid Use Disorder be explained by the composite of their level of empathy, social justice attitudes, and their professional identity/values as a counselor?*) was answered via the use of a simultaneous linear multiple regression analysis. These results help clarify professional counselors' acceptance of harm reduction for OUD based on baseline measures, comparison to other substance use treatment professionals, and based on measures of traits essential to the professional identity of counselors.

These results showed that counselors do not differ from social workers with master's level training or higher, or bachelor's-level or lower substance use professionals, in their acceptance of harm reduction for OUD. Additionally, empathic responsiveness and social justice attitudes are significant predictors of harm reduction acceptability for OUD among professional

counselors. Descriptive statistics for the HRAS/Supplement Scores among professional counselors will be contextualized among prior research with counselors and other professionals in Chapter Five. The findings of this study contribute to the understanding of professional counselors' acceptance of harm reduction approaches for OUD. Chapter Five provides interpretation of the meaning of these findings in the context of prior research and implications for practicing substance use counselors, counseling supervisors, counseling students, and counselor educators.

CHAPTER FIVE

DISCUSSION AND IMPLICATIONS

This study sought to explore the acceptability of harm reduction approaches for Opioid Use Disorder (OUD) among professional counselors, including comparing counselors to other professionals who treat substance use and examining the explanatory influence of key components of counselor identity. This chapter begins with an overview of the study, followed by a discussion of the meaning of the findings for each research question and for the study as a whole. This chapter then addresses the implications of the findings for counselors, counselor educators, and substance use treatment programs, as well as the limitations of the study. Finally, the chapter and document closes with proposals for future research based on the outcomes of this study and concluding remarks.

Overview of the Study

Harm reduction approaches for problematic opioid use include motivational interviewing, medication-assisted treatment, needle exchange programs, the distribution of naloxone for overdose reversal, housing first programs, providing fentanyl testing kits to people who use opioids, and safe consumption sites (Denning & Little, 2012; Collins et al., 2011; Moro & Burson, 2018; J. Carroll et al., 2018). Harm reduction approaches do not require abstinence to be an outcome goal for people who use substances and aim to provide services that preserve their health and well-being regardless of their interest in changing use patterns (Collins et al., 2011). Core values of harm reduction appear to align well with essential components of professional counselor identity, including respecting autonomy, cultivating strengths, empowering clients, and emphasizing empathy and social justice (Tatarsky & Kellogg, 2012; Woo et al., 2014; Dollarhide & Oliver, 2014; Ratts et al., 2009). Harm reduction approaches warrant investigation

given that the Opioid Epidemic has contributed to hundreds of thousands of fatal overdose deaths over the last 20 years, with overdose rates increasing consistently during that time period (CDC, 2018a). This study focused on three research questions that investigated the acceptability of harm reduction for OUD among professional counselors nationwide. The first research question established a baseline measurement of acceptance of harm reduction for OUD among counselors via a validated measure of harm reduction acceptance combined with novel items focused on the acceptance of harm reduction for OUD specifically. The second question compared counselors to other professionals who treat substance use utilizing the combined measure of harm reduction acceptance for OUD. The third research question examined if acceptance of harm reduction for OUD among professional counselors can be explained by essential counselor traits, including empathic responsiveness, social justice attitudes, and professional orientation and values.

Research examining the acceptability of harm reduction among substance use treatment providers has not examined professional counselors as a specific group, nor have studies to date focused specifically on harm reduction for people who use opioids. Goddard (2003) developed the Harm Reduction Acceptability Scale (HRAS) with a sample of substance use treatment professionals ($n = 137$), finding that their acceptance of harm reduction approaches increased after a two-hour training on the topic. Additionally, prior research has shown the impact of 12-step treatment orientations on harm reduction acceptance (Rosenberg & Davis, 2014; Aletaris et al., 2016) and that non-abstinence goals for alcohol and cannabis are more acceptable to students and addiction treatment professionals than other illicit drugs, including opioids; (Rosenberg & Davis, 2014; Lauritsen & Davis, 2016; Rosenberg, Grant, & Davis, 2020). The current study built upon these prior findings and uniquely examined the acceptability of harm reduction for opioid use among professional counselors who treat substance use. A lack of research exists

exploring provider perceptions of needle exchange programs (Vidourek et al., 2019) and other forms of harm reduction (safe consumption or the distribution of fentanyl testing strips). The HRAS/Supplement Score measure included items examining acceptance of these varied harm reduction services, including specifically exploring participants' acceptance of these approaches for people who use opioids. Motivational interviewing, medication-assisted treatment, and the distribution of naloxone for overdose reversal, all forms of harm reduction for OUD, are considered evidence-based practices for reducing fatal overdose by the Centers for Disease Control and Prevention (CDC; J. Carroll et al., 2018). This is important, as counselors and other providers who are not accepting of these approaches are dismissing services known to reduce preventable deaths via opioid overdose. No research has investigated the effects of professional discipline on harm reduction acceptance, including comparing professional disciplines. This study sought to fill these gaps in the literature by exploring factors that contribute to professional counselors' acceptance of harm reduction for OUD, as well as comparing counselors' acceptance of these approaches to other substance use treatment professionals.

Limited research has focused on harm reduction acceptability or perceptions among professional counselors. Prior studies of counselors' acceptance of harm reduction did not focus applying these approaches for the Opioid Epidemic, but did find that practicing in an urban areas, years of clinical experience, eclectic treatment orientations, and knowing someone with a substance use struggle increased acceptance of harm reduction among counselors (Kyser, 2010; Madden, 2016). These studies focused on ACA members and utilized the HRAS-R to measure harm reduction acceptability; however, these studies did not focus on applying these approaches with specific client populations or compare ACA members assumed to be counselors to other professionals. Also, the current study sampled professional counselors who treat substance use

via their treatment programs, potentially including many counselors who are not ACA members. A dearth of research investigating the acceptance of harm reduction approaches among professional counselors in the context of the Opioid Epidemic led to the development of research questions for the current study. Given the devastating impacts of the Opioid Epidemic, this study sought to explore the acceptance of harm reduction for problematic opioid use among professional counselors, a topic that has not been explored in prior studies of harm reduction acceptance among counselors.

The following discussion section will contextualize the research findings for this study in relation to prior research. Interpretations of the findings will be presented as relevant to the counseling profession and substance use treatment as a whole. Considerations for the impact of these findings for various systems and counselor training are key aspects of this discussion. Future research ideas are also presented later in this concluding chapter.

Discussion

Research Question One

Research Question One asked:

RQ1: What is the acceptability of harm reduction approaches for Opioid Use Disorder among professional counselors?

Findings indicate that the current sample of professional counselors is more accepting of harm reduction than prior samples of counselors based on HRAS-R scores. There is no cut-off or normed score for the HRAS-R to convey which professionals are “mostly accepting” or “mostly not accepting” of harm reduction. While the HRAS-R does not look specifically at harm reduction for OUD or people who use opioids, several items reference needle cleaning practices (items 2, 11, 17, and 22; Appendix A) and medication-assisted treatment practices (items 10, 12,

15, and 21). Also, items 5 and 15 reference heroin, an illicit opioid, specifically. Furthermore, the descriptive statistics presented in Chapter Four for this research question provide a baseline measure of acceptance of harm reduction for OUD specifically among counselors who treat substance use (HRAS/Supplement Scores; $n = 128$, $M = 2.379$, $SD = .557$).

The higher levels of harm reduction acceptability in the current sample, obtained in between May and September 2020, compared with prior samples of counselors may be related to increased availability for medication-assisted treatment and other forms of harm reduction in recent years (such as the ending of the ban on needle exchange programs). This may also account for the higher levels of harm reduction acceptance among treatment providers in the full sample and Goddard's sample in 2003. It is also possible that the increased awareness of the Opioid Epidemic and the associated loss of life has led newly trained professionals to be more accepting of harm reduction, while professionals who have been in the field for years may have been swayed by the epidemic to expand their acceptance of novel approaches. These possibilities fuel the need for further research about harm reduction acceptability, discussed later in this chapter.

This study also sought to measure harm reduction acceptance for OUD via a combination of the HRAS-R and 10 novel items focused specifically on applying harm reduction for OUD (HRAS/Supplement Score). The descriptive statistics reported in Table 12 for the HRAS/Supplement Scores can be interpreted as the first baseline measure of harm reduction acceptability for OUD among professional counselors. Once again, these statistics are indicative of the HRAS-R and harm reduction supplement items having their scores transformed so that higher scores indicate higher levels of acceptance of harm reduction approaches. The mean score of 3.73 indicates counselors' average item response represented an affirmative attitude towards harm reduction for OUD. Additionally, the minimum HRAS/Supplement Score of 2.34 indicates

that no counselors strongly disagreed with all items on these scales, while two had a score of 5.00, indicating strong agreement with harm reduction on all items (or strong disagreement with negatively worded items on the HRAS-R that were reverse scored). Based on the standard deviation ($SD = .56$), approximately 84% of counselors had an HRAS/Supplement Score of 3.17 or higher. This means the vast majority of counselors agreed with harm reduction approaches more than they disagreed or felt neutral about these practices. Prior research has indicated that harm reduction approaches are seen as less effective than traditional substance use treatment by providers (Bonar & Rosenberg, 2010). Counselors in this sample had higher levels of acceptance than prior samples of providers. Again, this may indicate that harm reduction acceptance has increased over time due to proliferation of these services and approaches, especially needle exchange and medication-assisted treatment. Prior research showed that professionals supported harm reduction approaches for alcohol and cannabis more frequently than harm reduction for opioids or other illegal substance (Rosenberg & Davis, 2014). While the Rosenberg & Davis (2014) study did not focus on counselors, those findings do make it difficult to assume counselors or other professionals would be more accepting of harm reduction for opioid use compared to other substances; however, given the eminence of the Opioid Epidemic and proliferation of harm reduction practices in recent years, higher levels of acceptance for OUD cannot be ruled out. The HRAS/Supplement Scores are difficult to interpret, as no prior study has attempted to quantify harm reduction acceptability for opioid use.

Research Question One focused on establishing a baseline measure of harm reduction acceptability for OUD among professional counselors. Although the descriptive statistics for the HRAS/Supplement Combined Scores for counselors cannot be directly compared to other samples, the HRAS-R scores for counselors sampled indicated more acceptance of harm

reduction approaches compared to prior samples of counselors (Kyser, 2010; Madden, 2016).

The full sample of providers also showed more acceptance of harm reduction approaches compared to the norming sample of providers for the instrument (Goddard, 2003). This information may indicate general increases in acceptance of harm reduction over time or that the current sample of counselors and providers, sampled from substance use treatment programs nationwide, are more accepting than noted samples from previous studies. The item and scale data presented in the results section (Chapter Four; Tables 3, 4, and 5) show that combining the Harm Reduction for OUD Supplemental Items with HRAS-R is appropriate given the similarities in scale functioning, enhancing this study's ability to explore harm reduction acceptance for opioid use specifically.

Research Question One Implications

The higher levels of harm reduction acceptance in this sample compared to prior studies indicates that either this sample is different in some way or harm reduction practices are becoming more acceptable. This contrast was true in comparing counselors to prior samples of ACA members and comparing the full sample to prior samples. The HRAS/Supplement Scores among counselors shows a generally accepting attitude towards harm reduction, reinforcing the postulated alignment between counseling values and harm reduction philosophy. This finding is also encouraging for the potential referral to harm reduction programs and use of harm reduction techniques by practicing counselors, although the acceptance of these strategies does not imply implementation. This baseline data offers a starting point for understanding counselors' attitudes about how to respond to the Opioid Epidemic.

Research Question Two

Research Question Two asked:

RQ2: Do professional counselors have higher levels of harm reduction acceptance for Opioid Use Disorder than other professionals treating substance use?

The alternative and null hypotheses for this question were:

H₁: Professional counselors will have higher levels of acceptance of harm reduction approaches for Opioid Use Disorder than other professionals treating substance use.

H₀: Professional counselors will have similar levels of acceptance of harm reduction approaches for Opioid Use Disorder as other professionals treating substance use.

The null hypothesis was retained, as data shows that counselors did not have a statistically significant difference in acceptance of harm reduction approaches for OUD compared to social workers with advanced degrees or bachelors level professionals. A difficult component of this analysis was the grouping of professionals, as there were large differences in the number of professionals in each discipline. Grouping professions that lacked similarities in identity would have led to a mismeasurement of the impact of professional identity on harm reduction acceptance for OUD. The largest group of survey respondents were professional counselors ($n = 167$), followed by social workers with advanced degrees ($n = 126$). An additional adjustment involved moving participants who identified professional counseling as their professional identity/discipline, while lacking a master's degree or higher, to the "other" category (later grouped as bachelors level providers), as scholars note that counselor professional identity is developed during master's training (Woo, Henfield, & Choi, 2014). The Analysis of Variance (ANOVA) examined group differences professional counselors (with master's level training or

higher), social workers with advanced degrees, and bachelor's level substance use treatment professionals.

The ANOVA indicated an omnibus difference in HRAS/Supplement Scores between bachelor's level substance use treatment professionals, social workers with a master's degree or higher, and professional counselors. Despite the between group differences in the omnibus test, professional counselors did not have a statistically significant difference in HRAS/Supplement Scores compared to the other two groups based on the post hoc analysis. This means counselors are not especially drawn to harm reduction approaches for OUD compared to these allied professionals treating substance use, nor are counselors less accepting of harm reduction for OUD. In comparing counselors to social workers, it may not be surprising that counselors' focus on prevention, wellness, and development (Mellin et al., 2011) does not imply more acceptance of harm reduction than social workers, who focus on empowering vulnerable peoples (Bigler, 2005). Both of these helping professions seem aligned with "compassionate and pragmatic approaches for reducing harm associated with high-risk behaviors..." (p. 5, Collins et al., 2011). and a focus "on positive change and on working with people without judgement, coercion, discrimination, or requiring that they stop using drugs as a precondition of support" (Harm Reduction International, para. 2), which define the harm reduction approach. Counselors were also not statistically different from bachelor's level substance use treatment professionals in their acceptance of harm reduction for OUD, while master's level or higher social workers did have higher levels of harm reduction acceptance compared to that group. Once again, based on these findings, the null hypothesis is retained, as this study did not find that counselors differed from other substance use treatment professionals in their acceptance of harm reduction approaches for OUD. This may imply a need to disseminate information about the efficacy of harm reduction

approaches for OUD to professional counselors, including evidence of the effectiveness of needle exchange programs, naloxone distribution, and medication-assisted treatment in reducing opioid overdose rates (J. Carroll et al., 2018). Based on the comparison of allied professionals to counselors in the ANOVA, counselors do not have higher levels of acceptance of harm reduction for OUD, despite noted alignment in counselor professional identity and harm reduction philosophy.

Given that unequal sample sizes did not allow for this analysis to compare counselors to psychologists, marriage and family therapists, or medical professionals, this study could not explore differences between counselors and these professionals in their acceptance of harm reduction for OUD. Many participants chose “other” for the grouping item (*Please indicate your primary discipline of training [option that best describes your professional identity]*), while several professions had 20 or less participants (doctors, nurses, peer recovery specialists, and marriage and family therapists). Of note, 58 participants identified an “other” identity as *addiction, substance abuse, substance abuse or addiction counselor*, or an addiction counseling certification (or highly similar descriptions). Many of these participants were included as bachelor’s level treatment professionals, based on their level of training. All 11 peer recovery professionals who participated were included in the bachelor’s level professionals’ group, although this role in addiction treatment is unique in requiring lived experiences to support clients in treatment. The dispersion of professional identities/disciplines noted (111 participants chose “other”, while 36 participants chose *professional counseling* as their discipline, despite not having an advanced degree) speaks to variety of backgrounds for substance use treatment providers, as well as tension between discipline identity and certification or treatment program influences noted in prior research (Simons, Haas, Massella, Young, & Toth, 2017; Simons,

Jacobucci, & Houston, 2006). It was not logical to group psychologists with advanced degrees with medical professionals or marriage and family therapists, given differences in training, identity, and therapeutic approach. Also, marriage and family therapists were a small group in the sample ($n= 20$) and are distinct from the reference group for Research Question Two and the study at-large, professional counselors, leading the researcher not to group those participants with professional counselors. While these decisions reduced the number of between group comparisons and reduced the overall number of participants included in the ANOVA, they ensured closer sample sizes that reduced heterogeneity of variance differences, allowing for a more robust comparison between counselors and other key professionals.

It is possible that counselors may differ from medical professionals, psychologists, peer recovery specialists, and marriage and family therapists in their acceptance of harm reduction for OUD; however, future research would need to access a more balanced sample of these professions. Counseling professionals usually receive undergraduate degrees in other disciplines, such as psychology. The professional identity of counselors is solidified in master's degree program. Clinical social workers also develop a distinct professional identity during advanced degree training, including the focus on psychotherapy as a component of their work distinct from undergraduate training (Karpelis, 2014). For these reasons, it was decided that bachelor's professionals represented a distinct group for comparison.

While groupings the ANOVA included trimming some professionals from the analysis, these findings do not support the hypothesis that counselor identity is more aligned with harm reduction philosophy than other professions. Counselors do seem generally accepting of harm reduction, but not at higher levels than social workers with similar levels of training or bachelors level providers. Perhaps counselors embrace or resist harm reduction practices based more on

their work setting influences than identity factors developed during their training. Also, counselor identity may be more closely aligned with social work than anticipated, in the context of substance use treatment philosophy. This analysis provides new evidence about professional discipline's impact on harm reduction acceptance, a topic that has not been investigated previously.

Research Question Two Implications

Perhaps counselors-in-training would benefit from increased exposure to harm reduction strategies in their addictions and other coursework. Harm reduction is a paradigm shift in addictions treatment that shows promise in providing a lower threshold for receiving help that preserves life and wellness of substance users (Tatarsky & Kellogg, 2012), with new approaches gaining momentum regularly. Counselor educators teaching addictions courses in counseling training programs can invest time in exposing students to these approaches, including potentially inviting guest speakers from local harm reduction organizations into the classroom or having practicum or internship students placed in harm reduction programs, where counseling services may be lacking. This is immensely important, as it is common for counseling students to be asked to attend or observe 12 step meetings or participate in an abstinence project, in which the student gives up something they enjoy for a duration of time (Lee, 2013). Covering harm reduction programs would add balance in covering diverse approaches to addiction treatment. Infusing addictions curricula in counseling programs with harm reduction content, projects, and exposure is likely to increase harm reduction acceptance. Goddard (2003) found that substance use treatment professionals who participated in only a two-hour training on harm reduction increased their acceptance of these approaches. Therefore, there is a strong probability that more training on harm reduction in counseling programs would enhance appreciation for these

approaches among developing counselors. This exposure may also mitigate stigmas counselors may have about harm reduction approaches, regardless of their desire to implement these approaches themselves. If research continues to show the efficacy of harm reduction programs for reducing opioid overdoses and improving outcomes for substance users, it is imperative to educate counselors-in-training about these programs and approaches.

Another implication of this analysis is that harm reduction organizations do not have added incentive to collaborate with or hire professional counselors compared with other substance use treatment providers. If counselors are not especially accepting of harm reduction compared to social workers and other allied treatment professionals, harm reduction organizations must evaluate partnerships on a case-by-case basis, rather than seeking out providers trained as counselors. It is unclear if a large number of counseling professionals are motivated to collaborate with harm reduction organizations and programs, but counselors who do support harm reduction can be proactive about engaging dialogues with their fellow counselors about the impacts and benefits of these approaches. Many counselors already provide services to clients who receive medication-assisted treatment from medical professionals and clinics, as well as utilizing motivational interviewing in substance use treatment programs. Counselors and comprehensive harm reduction programs providing needle exchange, safe use education, and distributing naloxone can establish mutually beneficial partnerships, given that many people who use substances have co-occurring mental health struggles; however, counselors need to show that they “buy in” to harm reduction services. While counselors are not uniquely accepting of harm reduction, the entire sample was accepting of these approaches, on average, and harm reduction organizations likely benefit from collaborating with diverse professionals.

There is a push to increase the substance use treatment workforce due to the Opioid Epidemic and programs like the National Health Services Corps Substance Use Disorder Workforce Loan Repayment Program offer incentives for clinicians who work in these substance use treatment programs, including medication-assisted treatment programs (National Health Services Corps, 2020). It seems that counselors have motivation to explore their values around harm reduction programs for OUD, as there may be an expectation that these services are integrated into treatment to satisfy incentive programs like the one offered by the National Health Services Corps.

Overall, the ANOVA for Research Question Two shows that counselors do not differ in perceptions of harm reduction for OUD from other groups sampled, indicating that counselors are not uniquely aligned with these approaches. However, counselors were only compared to social workers with advanced degrees and bachelors level substance use treatment professionals due to small numbers of other professionals completing the survey. Given the large number of counselors treating substance use nationwide, as evidenced by their proportions in this study, the impact of professional discipline on harm reduction acceptance for OUD warrants more research. Harm reduction organizations, the substance use treatment community at-large, and training programs for each discipline will benefit from more study of this topic.

Research Question Three

Research Question Three asked:

RQ3: Can professional counselors' acceptance of harm reduction strategies for Opioid Use Disorder be explained by the composite of their level of empathy, social justice attitudes, and their professional identity/values as a counselor?

The researcher held the following alternative and null hypotheses for this research question:

H₁: Level of empathy, social justice attitudes, and counselor professional identity/values will be statistically significant predictors of acceptance of harm reduction strategies for Opioid Use Disorder among professional counselors.

H₀: Level of empathy, social justice attitudes, and counselor professional identity/values will not be statistically significant predictors of acceptance of harm reduction strategies for Opioid Use Disorder among professional counselors.

The simultaneous linear multiple regression analysis found that the overall regression model was significant, indicating that the predictor variables (empathic responsiveness, social justice attitudes, and counselor professional orientation/values) explain variance in harm reduction acceptability for OUD among professional counselors. In fact, approximately 18% of the variance in harm reduction acceptance for OUD among professional counselors was accounted for by these traits ($r^2 = .178$). Inspecting the data more closely, empathic responsiveness and social justice attitudes were significant predictors that correlated positively with harm reduction acceptance for OUD, while professional counseling orientation and values were not a significant predictor and negatively correlated with harm reduction acceptance for OUD. The moderate effect size supports that these predictors have a relationship with harm reduction acceptability for OUD and that these relationships matter in real world practice. Also, the high level of statistical power indicates a low chance of a type I error, in which a relationship is found that does not exist. These data provide meaningful evidence about the factors that enhance acceptance of these approaches among counselors, which is relevant given the efficacy of harm reduction in reducing overdose deaths amidst the ongoing Opioid Epidemic (J. Carroll et al., 2018).

The regression analysis showing that a measure of counselor professional orientation and values did not contribute significantly to the regression model and was negatively correlated with harm reduction acceptance provides evidence that counselors may not be uniquely oriented towards harm reduction. While empathy and social justice are core components of professional counseling relationships and training, these traits are not necessarily unique aspects of professional counseling training. Social work, as a profession, considers empathy essential for their practice with clients and acknowledge that empathy is associated with positive treatment outcomes (Gerdes & Segal, 2011). Empathy is also a known common factor for positive outcomes in psychotherapy overall (Wampold, 2015), which is not a discipline-specific treatment modality. Marriage and family therapists, clinical social workers, psychologists, and psychiatrists also provide psychotherapy services. Additionally, social justice is a key component of counseling practice, but this is true for social workers as well. The preamble to the National Association of Social Workers Code of Ethics states “Social workers promote social justice and social change with and on behalf of clients (National Association of Social Workers, 2017)”, clearly indicating this a core piece of the identity of that profession. Professional counselors may hold strong social justice values and have high levels of empathy, congruent with these dispositions and traits being documented as aspects of counselor identity (Ratts, 2009; Vereen et al., 2014; Dollarhide & Oliver, 2014), but other professionals treating substance use also shared these values and professional emphases.

Given that social justice is considered a core principle of harm reduction philosophy (Harm Reduction International, 2019) and has even been described as having a social justice framework (Collins et al., 2011), it is not surprising that positive attitudes towards social justice were a predictor of harm reduction acceptance for OUD among counselors. Harm reduction itself

is a form of social justice advocacy, in that it empowers people who use substances by respecting their autonomy, actively working to reduce stigma, and reduces barriers to needed services (Harm Reduction International, 2019). Counselors, too, are advocates for positive social change who seek to empower clients in these ways (Ratts et al., 2016; Toporek et al., 2009). Counselors acknowledge how their power and privilege can be used lift up and support marginalized populations through advocacy (Ratts et al., 2016), which includes people who use substances. The finding that social justice attitudes predict harm reduction acceptance for OUD among counselors provides support to the idea that this is a value alignment between counseling identity and harm reduction philosophy. Counselors advocating for harm reduction approaches are reducing the stigma and discrimination faced by people who use opioids and may wish to highlight this alignment of values with their counseling colleagues treating substance use.

Empathy and compassion are also consistently highlighted as key features of the interactions between providers and clients in harm reduction programs (Denning, 2001; Denning & Little, 2012; Harm Reduction International, 2019). Counselors have focused on empathy as a humanistic profession for many years (Dollarhide & Oliver, 2014), making empathy for clients another clear alignment between counselor professional identity and harm reduction philosophy. Counselors in this sample were more accepting of harm reduction for OUD if they had higher levels of empathic responsiveness to others. Counselors who connect to their clients' lived experiences and respond empathically are likely to save many of these clients' lives if given the opportunity to discuss harm reduction, who may or may not have information about those programs. Counselor empathy is a known common factor for positive client outcomes in counseling (Wampold & Norcross, 2011), making it meaningful that this trait is associated with harm reduction acceptability for clients with OUD among counselors.

The findings of this analysis provide evidence that two key aspects of counselor identity, empathy and social justice values, have a significant predictive relationship with harm reduction acceptability for OUD. The counseling profession now has evidence that counselors who have high levels of empathy and integrate social justice into their identity are more accepting of harm reduction approaches for OUD. These aligned core aspects of counselor identity and harm reduction philosophy warrant attention from practicing counselors and training programs.

Research Question Three Implications

Perhaps counselors' perspectives of how to provide services to clients with OUD or other substance use issues does not relate directly to professional values measured by the POVS, which includes questions about counselor wellness, promoting the profession, and having relationships with fellow counselors. Contrarily, the POVS has items focused on social justice, taking a holistic wellness perspective, client advocacy, and client empowerment, which have noteworthy alignment between harm reduction philosophy and professional counseling identity (Kaplan et al., 2014; Woo et al., 2014; Collins et al., 2011; Tatarsky & Kellogg, 2012). The items on the POVS with a statistically significant positive correlation with HRAS/Supplement scores were items one (*Awareness of social justice issues is an integral part of being a competent counselor; $\alpha = .179, p \leq .05$*), two (*Building a strong relationship with a client is essential to the counseling process; $\alpha = .211, p \leq .05$*), four (*Having a holistic perspective is an essential part of being a counseling professional; $\alpha = .229, p \leq .05$*), and five (*Assisting clients in advocating for their needs is an important component of one's role as a counseling professional; $\alpha = .229, p \leq .01$*). These four items seem to focus on supporting clients through advocacy, a holistic approach to care, and empathic relationships. Each of these items are focused on client needs and

encompass noted overlaps between harm reduction philosophy and professional counseling values.

Despite four out of 13 POVS items having significant positive correlations with the HRAS/Supplement Score, the negative correlation found between the two scales among counselors reveals a potential incongruence between certain counselor values and harm reduction philosophy, which may be captured in the items focused on counselors' self-care, connection to other counselors, and relationship to the counseling profession at-large (items 9, 10, 11, & 13; Appendix D). In fact, POVS items nine (*Community service is valuable for my work as a counseling professional*), 10 (*It is important for counseling professionals to be involved in promoting the counseling profession*), and 13 (*My personal wellness is important to my work as a counseling professional*) were the only items on the scale with a negative correlation with HRAS/Supplement Scores among counselors in the sample (these were not statistically significant negative correlations; only items 1, 2, 4, and 5 had significant correlations with the HRAS/Supplement Scores). Each of these POVS items explored components of professional counseling not focused on direct client care, but instead focus on counselors' needs, service, or engagement with the profession. The harm reduction approach to substance use has been described non-theoretical and pragmatic (Collins et al., 2011). Incongruence seems to exist between harm reduction's pragmatic focus on the needs of people who use substances and aspects of counselor professional identity focused on things that occur outside the counselor-client relationship. This potential conflict raises the issue of how the professional identity is sustained for counselors who employ harm reduction strategies in substance use treatment settings, given that counselors acknowledge a need for professional community and personal

wellness to provide high quality client care. Counselors may struggle to maintain core aspects of their professional identity when they develop a specific specialization (Mellin et al., 2011).

Social justice values and responding empathically are aspects of counselor identity that predict if counselors will embrace a harm reduction approach for OUD. These values do not appear to be unique to substance use professionals trained as counselors and there seem to be aspects of professional counseling identity that mitigate harm reduction acceptance for OUD. Furthermore, counselors included in this study treat people who use substances. This sub-group of counselors may differ in their willingness to embrace or reject harm reduction for OUD compared to other counselors, as they likely have more knowledge about the range of substance use treatment approaches. Prior samples of ACA members presumed to be counselors showed less acceptance of harm reduction compared to the current sample (Kyser, 2010; Madden, 2016), making it plausible that counselors who treat people who use substances are more accepting of harm reduction approaches than other counselors. This valuable evidence underscores the importance of cultivating empathy for substance users among counselors at all phases of their training and career, given that harm reduction approaches reduce overdose risk for users and mitigate social harms. Further research is warranted to examine how working with people who use substances and exposure to harm reduction relate to the identity and approach of counselors.

The findings for Research Question Three also have implications for counselor training and development. Counselor educators, in presenting diverse approaches treating people who use substances, can be intentional in discussing the humanistic and social justice orientation alignment between counseling values and harm reduction in addictions, theory, and multicultural coursework. Counselor educators and supervisors can focus interventions with developing counselors on cultivating empathy and social justice orientations, especially for people who use

substances. Harm reduction researchers and community organizers may find allies in counseling professionals working in addiction treatment programs or counseling students in training programs, given the foundation of empathy and social justice orientations among counselors. Harm reductionists can expand the impact of their work by clearly articulating these approaches to counselors and other professionals, including educating stakeholders and collaborators about the effectiveness of these approaches and associated positive outcomes for consumers of these services. This may include untangling the false dichotomy between harm reduction and abstinence-based recovery programs for people who use substances. The idea that these are diametrically opposed approaches for substance use does a disservice to people seeking treatment for substance use and treatment providers, as both approaches have utility based on individual needs. Research Question Three provides new evidence that harm reduction for OUD is more acceptable for counselors with positive attitudes towards social justice and those who have high levels of empathic responsiveness, while there are other aspects of counselor identity that may mitigate acceptance.

Overall Implications

The sample of substance use treatment professionals studied were generally more accepting of harm reduction approaches than samples used in prior studies. This is encouraging given the benefits of harm reduction in reducing opioid overdose rates and mitigating social harms, despite these approaches being seen as controversial (Moro & Burson, 2018). Based on the findings of this study, professional counselors are not more accepting of harm reduction for OUD than master's level social workers and bachelor's level treatment providers, which indicates that counselors may not be uniquely aligned with harm reduction philosophy compared to these peer professionals. Another main takeaway is that social justice and empathy are traits

among counselors that predict harm reduction acceptance for OUD. The Opioid Epidemic's devastating effect on American society is an urgent motivator for professionals to utilize the full array of efficacious approaches available to reduce fatal opioid overdoses, in addition to mitigating social harms caused by addiction. Social justice attitudes and empathy were statistically significant predictors of acceptance of harm reduction for OUD among counselors, which could be true among all addiction professionals, but is meaningful information for the counseling profession. Many professional counselors are working with clients with OUD in addiction treatment programs, as evidenced by counselors making up approximately 25% of this nationwide sample of substance use treatment professionals. This nationwide sample adds to the literature focused on harm reduction attitudes among substance use treatment providers by specifically focusing on counselors and perceptions of harm reduction for OUD.

Implications for Counselor Educators and Supervisors

Exposure to harm reduction programs could be a key predictor of harm reduction acceptance, including among professional counselors. Prior research has shown the importance of exposure and education for acceptance, including Goddard (2003) finding that a two-hour training on harm reduction increased acceptance and Henwood et al. (2014) finding that many professionals who did not work in housing first harm reduction programs did not consider that approach as an option. Based on that evidence, integrating harm reduction into curriculum in masters training programs, such as counseling programs that often have a specific, semester-long course focused on addictions counseling, could increase harm reduction acceptability as well. CACREP-accredited clinical mental health counseling training programs must include curriculum focused on addictions (CACREP, 2016; 2.F.3.d, 5.C.1.d), although that curriculum may or may not include harm reduction approaches. Exposure to harm reduction programs, such

as inviting personnel from harm reduction programs or visiting these facilities, may be a supplement to abstinence projects and attending 12-step meetings, common aspects of addictions counseling courses in CACREP programs (Lee, 2014). Motivational interviewing and medication-assisted treatment have been established for some time as efficacious treatment for OUD and other addictions (Miller & Rollnick, 2013; Bart, 2013), but it is unclear how consistently information about comprehensive harm reduction programs (needle exchange, distribution of naloxone and fentanyl testing strips, housing first programs, safe consumption sites) is being taught in counseling training programs, which impact the acceptability of these approaches among counseling students. Counselor educators, practicing counselors, and counselors-in-training potential limited exposure to harm reduction is illustrated by the *Journal of Addiction and Offender Counseling*, the ACA journal focused on addictions, lacking any articles with “harm reduction” in the title in its 40-year existence. In short, increased exposure to information about harm reduction, especially for OUD in the context of the current epidemic of fatal overdose deaths, would allow counselors to have better informed opinions about these approaches.

Implications for Treatment Programs and Practicing Counselors

Professional counselors in addiction treatment programs may have their views of harm reduction programs shaped more by their interprofessional experiences and work with clients, compared to their training. Workplace experiences may dilute the impact of professional identity traits developed during training. Counselor training programs and practicing counselors can prioritize sustaining the connection between professional identity and applying empathy and social justice orientations in practice, which would likely increase harm reduction acceptance based on the results of this study. Currently, harm reduction acceptance among counselors may

be mitigated by how these services are embraced by colleagues at their place of employment, as evidenced by prior research on treatment providers' acceptance of housing first programs (Henwood et al., 2014). Data about the types of services offered at treatment sites sampled in this study was not collected, making the influence of program/employer policies for the types of services provided remains unclear based on these results; however, it should be noted that the SAMHSA treatment directory did include Opioid Treatment Programs, which are required to provide medication-assisted treatment to have that designation (SAMHSA, 2019). Collins et al. (2011) noted that harm reduction approaches are philosophically pragmatic, potentially diminishing the impacts of professional identity or philosophy among helping professionals. It is unclear what impact the policies and procedures of employers have on the views of counselors working in substance use treatment, which calls for further investigation.

While questions remain about other factors that may influence counselors' acceptance of harm reduction, this study adds to the understanding that social justice values and empathy are predictors of harm reduction acceptance among counselors who treat substance use. The loss of life and ripple effects of the Opioid Epidemic, combined with the growing evidence of harm reduction programs having efficacy in reducing fatal opioid overdoses, provides motivation for counselor educators, supervisors, and practicing counselors to emphasize social justice and empathy components of their counselor identity. Emphasizing these dispositions could increase harm reduction acceptance for OUD among counselors and potentially lead them to integrate these practices and refer to harm reduction programs. Most importantly, this new evidence supports two key aspects of counselor identity predicting the acceptance of harm reduction approaches for OUD. Limitations of this study and future research possibilities are discussed in the following sections.

Study Limitations

This study was limited in several ways that are key for contextualizing the results and implications. The HRAS/Supplement Score, obtained from the HRAS-R and supplemental items focused on harm reduction for OUD, is a new outcome variable that has not been used with prior samples for comparison. The decision to add supplemental items for scoring was made because the HRAS-R does not focus specifically on harm reduction approaches uniquely suited for OUD and, in fact, has one item specifically focused on alcohol use (item 18). The HRAS-R was also updated so that items that mentioned methadone (items 10, 12, 15, and 21) also included references to buprenorphine, which has become widely accepted medication-assisted treatment for OUD since the development of that instrument. The addition of buprenorphine in these items could impact comparison to prior studies, but it was necessary to update the scale to current treatment norms. The HRAS/Supplement Score is a novel measure to harm reduction acceptance for OUD and will provide a baseline for follow up studies.

Additionally, it is possible that the sample of professional counselors accessed through the SAMHSA treatment facility directory was not be completely representative of all master's level professional counselors throughout the United States. Professional counselors working in SAMHSA-identified substance use programs would likely have more exposure to harm reduction training or practice. This increased exposure to harm reduction approaches would have an impact on participants' perceptions and acceptance. Therefore, results should be generalized to professional counselors who treat substance use only. Also, counselors who have treated clients with OUD may have more knowledge of the range of treatment options for this client population, including harm reduction approaches. Harm reduction was not defined for participants and the survey did not ask about harm reduction broadly, instead focusing on

specific populations and approaches. Other studies have used a vignette to add context for participants (Bonar & Rosenberg, 2010). It is also unclear how SAMHSA's criteria for listing treatment programs in their directory could influence the types of services or orientation of the programs listed. It is very likely that many grassroots harm reduction programs would not be considered "treatment" programs by SAMHSA and professionals working in those programs would not have been included in the study. This could skew the sample towards providers who work in more traditional treatment programs, potentially underrepresenting providers who use and embrace harm reduction. This convenience sample may not be representative of all counselors or all substance use treatment providers; however, this robust sample did offer access to a nationwide population of substance use treatment providers.

Another confound that was not accounted for in this study was the impact of social desirability. It is unclear if respondents would believe that they should be accepting of harm reduction, or if some of these approaches would be disapproved of by colleagues, supervisors, or employers. Social desirability may have affected harm reduction responses, but this confound is also a concern in how professionals responded to items focused on empathic responsiveness and social justice attitudes. Given that these two values are aspects of professional counseling identity, counselors may have felt pressure to respond in ways that align with their profession, rather than based on the personal outlook or perspective. Because there was no control for social desirability in the survey, this is a noted limitation of the study.

This study was also limited by exploring predictors of acceptance of harm reduction for OUD only among counselors in the study, rather than amongst the larger sample of addiction treatment providers sampled. The predictor variables chosen were based on components of counselor professional identity (Kaplan et al., 2014; Woo et al., 2014; Toporek et al., 2009;

Dollarhide & Oliver, 2014), rather than the identity of addiction treatment providers at-large, which informed this research decision. With 18% of variance in harm reduction acceptability for OUD among counselors accounted for by social justice attitudes and empathic responsiveness as a trait, there remains a multitude of other factors not measured in this study that influence acceptance. This includes factors identified by Madden (theoretical orientation; 2016) and Kyser (urban work setting, years working in substance use, and knowing someone with substance use struggles; 2010). Additionally, 98 of the 531 participants who completed the HRAS-R and harm reduction for OUD supplement items were not included in any analyses, reducing statistical power due to the reduction in sample size. These professionals were not included in order to maintain validity of professional discipline comparisons in Research Question Two. While three key professional groups were included in the analysis for Research Question Two, these groups did not encompass the wider array of professionals treating substance use. Groups not represented in the analysis included medical professionals, marriage and family therapists, and psychologists, despite members of each of these disciplines completing the survey.

Another important limitation was the measurement of empathy as a trait via the Toronto Empathy Questionnaire, as empathy can be defined as a trait among people or a dynamic process occurring between individuals. Trait empathy is of relevance as a component of counselor identity and the survey method used for this study could measure that variable. Intentional efforts were made to capture key components of counselor identity that appear to align with harm reduction philosophy, including empathic responding and social justice orientation, in addition to using a scale specially designed to measure professional values among counselors. Despite these efforts, these measures do not fully capture all aspects of counselor professional identity and there can be difficulty narrowing down what truly defines counselor identity (Mellin et al.,

2011). While this study was limited in certain aspects, key variables related to counselor identity were measured in relation to the acceptance harm reduction for OUD and a nationwide sample of substance use treatment providers allowed counselors' acceptance of these approaches to be compared to peer professionals.

A final consideration for contextualizing the findings of this study is the time period of data collection. Data was collected between May and September 2020, amidst the onset of the COVID pandemic in the United States (and globally). It is unclear if the transition of services to online formats and stressors impacting substance use treatment providers affected response rates or responses to specific items/scales. It is possible that providers were experiencing heightened stress that may have increased their empathic responsiveness to others, given the pandemic's indiscriminate disruption of all American lives. It is also plausible that in transitioning to telehealth service delivery methods, providers were checking email more frequently or had more time on their computer to respond to surveys, like the one used in this study. Several organizations did respond to the recruitment email, saying they would not forward it to their staff because staff were already overtaxed amid the pandemic. The influence on the COVID pandemic on American society and treatment programs is important context to consider for this study.

Future Research

This study adds to the literature on harm reduction acceptance among substance use practitioners by focusing specifically on professional counselors' acceptance of harm reduction approaches for OUD. Based on the evidence gathered for the research questions in this study, more questions emerge that could be addressed by future research. Questions about the relationship between counselor identity and harm reduction acceptance remain, as well as the

influence of training and the ongoing Opioid Epidemic on these perspectives. Potential opportunities for future research are identified in this section.

First, future studies may examine the relationship between empathy, social justice, and harm reduction acceptance among a diverse sample of treatment providers. The significance of these predictors in the regression model for counselors' acceptance of harm reduction for OUD needs context, which can be examined by measuring if social justice attitudes and empathic responsiveness explain variance in harm reduction acceptance for OUD with a multidisciplinary sample. For counselors, follow up studies may seek qualitative data to further unpack how counselor identity influences perceptions of harm reduction approaches for problematic opioid use. The influence of other specific counselor identity factors, such as wellness, prevention, and developmental focuses (Woo et al., 2015), on harm reduction acceptance is needed to further answer if counselor professional identity is truly aligned with this approach (as theoretically postulated in this study). Counseling researchers may also benefit from exploring how content covered in addictions coursework influences perceptions of harm reduction and traditional approaches (such as approaches that integrate components of 12 step philosophy). More examination of the key predictors for harm reduction with substance use treatment providers at-large, as well as a closer look at more counselor identity factors, would clarify the unique dynamics between counselor identity and harm reduction acceptance.

Second, research comparing counselors to psychologists, medical professionals, peer recovery specialists, and marriage and family therapists may further clarify where counselors stand in harm reduction acceptance amongst the wider array of substance use treatment professionals. This study sought a broad array of disciplines, but unequal sample sizes inhibited multiple comparisons beyond the three groups including in the analysis for Research Question

Two. There is also a need to investigate factors related to providers' level of education and type of training as it influences harm reduction acceptance, including for OUD, as a prior study of professional counselors showed level of education did not impact harm reduction acceptance, although all counselors sampled had a master's degree or higher (Madden, 2016). In the current study, bachelor's level professionals were grouped given that professional identity for clinical social workers and professional counselors develops during graduate training (Karpētis, 2014; Woo et al., 2015); however, examining level of education as the focus of future research would provide important information about how clinical training received in pursuing an advanced degree for clinical professions influences harm reduction acceptance. The differences between bachelor's level professionals and counselors and social workers with advanced degrees was partially captured in the results for Research Question Two, but further investigation is warranted.

Broader studies focused on acceptance of harm reduction for opioid use among practitioners, people who use substances, and the general public are needed, given that the Opioid Epidemic is a major driver of the increase in fatal overdose deaths in the last few decades (CDC, 2018a). Awareness of the Opioid Epidemic has increased through media attention and direct impacts on communities nationwide, potentially influencing these perspectives and the willingness to consider novel approaches like harm reduction. A need for research also exists exploring how harm reduction perceptions influence the actual implementation of these approaches by counselors and other substance use providers, as well as the influence of employer policies regarding acceptance of these approaches. If counselors and other providers are unable provide harm reduction services and are discouraged from this approach by their employers, it is likely influence their acceptance and perspectives of harm reduction. The Opioid Epidemic has

had a devastating toll on Americans and broader exploration of how this public health crisis has affected harm reduction acceptance is warranted.

Finally, because harm reduction and novel approaches to substance use treatment are often seen as contradicting traditional abstinence-based treatment programs, such as 12 step-oriented programs, there is a need to examine perceptions of both types of programs. For counselors, at least one scholar suggested that 12 step orientations are incongruent with the identity and approach of professional counselors (Le et al., 1995). This calls for new research investigating if counselors are more accepting of 12 step approaches to substance use compared to harm reduction approaches. This may also be explored for counselors who treat substance use in comparison to counselors who do not routinely treat substance use. Future research may also explore the acceptance of diverse approaches using specific client vignettes or situations, rather than asking about these perceptions broadly. There is room for more data to be collected and analyzed to help clarify how counselors perceive these approaches for OUD treatment, and for all people who use substances.

This study provided new evidence about how counselors perceive harm reduction for OUD, which adds to the foundation of knowledge for future studies of harm reduction perceptions. Having evidence that social justice attitudes and empathic responsiveness are key predictors of harm reduction acceptance for OUD for counselors allows researchers to examine if this relationship holds true beyond a sample of counselors or for people who use other substances. Additionally, more study is needed to identify how counselors embrace or reject harm reduction in comparison to other substance use treatment professions, including on the basis of level of education and discipline. Ongoing research benefits harm reduction programs seeking staff and collaborators who will buy into their methods of helping people who use

substances, as well as the counseling profession in understanding how to best contextualize these approaches in training and practice.

Conclusions

This quantitative study aimed to explore multiple aspects of counselor acceptance of harm reduction strategies for OUD. This study was designed to increase awareness of how counselors perceive harm reduction in the context of the Opioid Epidemic, which has led to hundreds of thousands of fatal opioid overdoses over the last twenty years (CDC, 2018a), in addition to immeasurable social harms. Counselors have a unique professional identity that aligns with principles of harm reduction philosophy, including a focus on holistic wellness, empowering individuals being served, and respecting autonomy. This study sought to examine if those overlaps in identity and philosophy lead to increased acceptance of harm reduction for OUD among counselors who treat substance use. This research informs the counseling profession and harm reduction community about where counselors stand in their willingness to embrace harm reduction for people who use opioids.

Three research questions guided this study. First, counselors' acceptance of harm reduction for OUD was measured via the HRAS-R and ten newly developed items focused on harm reduction for individuals who use opioids specifically. This baseline measure, the HRAS/Supplement Score, was used to answer Research Question One, *What is the acceptability of harm reduction approaches for Opioid Use Disorder among professional counselors?* Second, professional counselors' level of acceptance of harm reduction for OUD was compared to other professionals who treat substance use, namely social workers with a master's degree or higher and bachelor's level substance use treatment professionals. An ANOVA and post-hoc analysis (Tukey's Test) using the HRAS/Supplement Scores for these three groups was used to

answer Research Question Two: *Do professional counselors have higher levels of harm reduction acceptance for Opioid Use Disorder than other professionals treating substance use?*. Finally, a simultaneous linear multiple regression analysis was used to examine if empathic responsiveness, social justice attitudes, and professional counseling values could predict harm reduction acceptance for OUD among professional counselors. These variables were measured via the TEQ, SJS Social Justice Attitudes Scale, and the POVS, while HRAS/Supplement Scores were the outcome variable. This regression analysis was used to answer Research Question Three: *Can professional counselors' acceptance of harm reduction strategies for Opioid Use Disorder be explained by the composite of their level of empathy, social justice attitudes, and their professional identity/values as a counselor?*. In total, these research questions, analyses, and interpreted findings contribute to the understanding of professional counselors' perceptions of harm reduction for problematic opioid use.

The findings of Research Question One provided a baseline measure of counselors' acceptance of harm reduction for OUD, given that no prior studies had examined harm reduction acceptance for OUD specifically among substance use treatment providers. Again, this is highly relevant given the harms and loss of life caused by the Opioid Epidemic. The findings of the ANOVA used to answer Research Question Two showed that professional counselors do not have higher levels of acceptance of harm reduction compared to social workers with advanced degrees or bachelors level substance use treatment professionals. This finding led to a retention of the null hypothesis, that counselors do not differ from peer substance use treatment professionals in their acceptance of harm reduction. Finally, the findings of the multiple regression analysis used to answer Research Question Three indicated that, in composite, empathy, social justice attitudes, and counselor professional orientation and values do explain a

significant amount of variance in the acceptance of harm reduction approaches for OUD among counselors. Further examination of the data showed that empathy and social justice attitudes contributed significantly to the regression model, while the measure of counselor professional orientation and values did not. This data indicates that high levels of trait empathy and positive attitudes towards social justice among counselors increases acceptance of harm reduction. This study confirms these key aspects of counselor professional identity align with acceptance of harm reduction for OUD. These findings of the study as a whole fill a gap in the literature by contextualizing counselors' acceptance of harm reduction compared to peer professionals treating substance use, as well as identifying counselor identity factors that contribute to acceptance of harm reduction for OUD.

This study provides evidence that counselors may not be uniquely drawn to harm reduction based on their professional identity, compared with peer professionals who treat substance use. Importantly, social justice attitudes and empathy are values of professional counseling that contribute to harm reduction acceptance for OUD. These values may not be unique to counselors and other values of professional counseling do not acceptance of harm reduction. Given that the Opioid Epidemic has caused immense loss of life and social harms to communities, treatment providers' perceptions of efficacious approaches for addressing OUD are worth investigating. The findings of this study encourage examination of how harm reduction is covered in addiction courses in counselor education programs and the influence of employer policies on harm reduction acceptance among treatment professionals. This study benefitted the counseling profession and harm reduction community by answering key questions about professional counselors' acceptance of harm reduction for OUD. Harm reduction acceptance for OUD is increased for counselors who are highly empathic and have positive attitudes towards

social justice, but counselors do not have higher levels of acceptance than other crucial substance use treatment providers.

The Opioid Epidemic leads to more than 40,000 fatal overdose deaths per year in the United States (CDC, 2018a). Each of these individuals led a life worth saving. Professional counselors made up 25% of this nationwide sample of substance use treatment providers, which speaks to their presence in addiction treatment. Counselors have a strong professional identity that may push them to advocate for harm reduction for clients with OUD, because these professionals value empathy and social justice. No person who dies of an overdose has the opportunity to recover, making it essential that emerging approaches with high levels of efficacy in reducing overdose are supported by professionals treating opioid use. This study provides evidence professional counselors treating substance use are more likely to support efficacious harm reduction approaches if their counselor identity is firmly grounded in empathy and social justice.

References

- Abraham, A. J., Rieckmann, T., McNulty, T., Kovas, A. E., & Roman, P. M. (2011). Counselor attitudes toward the use of naltrexone in substance abuse treatment: A multi-level modeling approach. *Addictive Behaviors, 36*(6), 576-583.
- Alcoholics Anonymous (2019) *Alcoholics Anonymous*. Retrieved from https://www.aa.org/pages/en_US
- Aletraris, L., Edmond, M. B., Paino, M., Fields, D., & Roman, P. M. (2016). Counselor training and attitudes toward pharmacotherapies for opioid use disorder. *Substance Abuse, 37*(1), 47–53.
- Allyn, B. (2019, October 2). Judge rules planned supervised injection site does not violate federal drug laws. *NPR.org (National Public Radio)*. Retrieved from: <https://www.npr.org/2019/10/02/766500743/judge-rules-plan-for-safehouse-drug-injection-site-in-philadelphia-can-go-forwar>
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5th ed.)*. Washington, DC: Author.
- Apodaca, T. R., & Longabaugh, R. (2009). Mechanisms of change in motivational interviewing: A review and preliminary evaluation of the evidence. *Addiction, 104*(5), 705-715.
- Ashford, R. D., Curtis, B., & Brown, A. M. (2018). Peer-delivered harm reduction and recovery support services: initial evaluation from a hybrid recovery community drop-in center and syringe exchange program. *Harm Reduction Journal, 15*(1), 52.
- Astramovich, R. L., & Hoskins, W. J. (2013). Evaluating addictions counseling programs: Promoting best practices, accountability, and advocacy. *Journal of Addictions & Offender Counseling, 34*(2), 114-124.

- Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes*, 50, 179–211.
- Baron-Cohen, S., & Wheelwright, S. (2004). The empathy quotient: an investigation of adults with Asperger syndrome or high functioning autism, and normal sex differences. *Journal of Autism and Developmental Disorders*, 34(2), 163-175.
- Barry, C. L., Sherman, S. G., & McGinty, E. E. (2018). Language Matters in Combatting the Opioid Epidemic: Safe Consumption Sites Versus Overdose Prevention Sites. *American Journal of Public Health*, 108(9), 1157–1159.
- Bart, G. (2012). Maintenance medication for opiate addiction: The foundation of recovery. *Journal of Addictive Disorders* (31)3, 207-225. Doi:10.1080/10550887.2012.694598
- Bessen, S., Metcalf, S. A., Saunders, E. C., Moore, S. K., Meier, A., McLeman, B., ... & Marsch, L. A. (2019). Barriers to naloxone use and acceptance among opioid users, first responders, and emergency department providers in New Hampshire, USA. *International Journal of Drug Policy*, 74, 144-151.
- Bigler, M. O. (2005). Harm reduction as a practice and prevention model for social work. *Journal of Baccalaureate Social Work*, 10(2), 69-86.
- Bonar, E.E., & Rosenberg, H. (2010) Substance abuse professionals' attitudes regarding harm reduction versus traditional interventions for injecting drug users, *Addiction Research & Theory*, 18 (6), 692-707.
- Boucher, L. M., Marshall, Z., Martin, A., Larose-Hébert, K., Flynn, J. V., Lalonde, C., ... Kendall, C. (2017). Expanding conceptualizations of harm reduction: Results from a qualitative community-based participatory research study with people who inject drugs. *Harm Reduction Journal*, 14 (1), 1–18.

- Bride, B. E., Kintzle, S., Abraham, A. J., & Roman, P. M. (2012). Counselor attitudes toward and use of evidence-based practices in private substance use disorder treatment centers: A Comparison of social workers and non-social workers. *Health & Social Work, 37*(3), 135–145.
- Bristow-Braitman, A. (1995). Addiction recovery: 12-step programs and Cognitive-Behavioral psychology. *Journal of Counseling & Development, 73*(4), 414-418.
- Burt, G., Roney, C., Dawes, G., Nijdam, D., Beyerstein, B. L., Van De Wijngaart, G. F., ... & Alexander, B. K. (1994). The “temperance mentality”: A survey of students at a Canadian university. *Contemporary Drug Problems, 21*(2), 301-327.
- Caplehorn, J. R., Lumley, T. S., Irwig, L., & Saunders, J. B. (1998). Changing attitudes and beliefs of staff working in methadone maintenance programs. *Australian and New Zealand Journal of Public Health, 22*(4), 505-508.
- Carroll, K. M., Ball, S. A., Nich, C., Martino, S., Frankforter, T. L., Farentinos, C., ... & Polcin, D. (2006). Motivational interviewing to improve treatment engagement and outcome in individuals seeking treatment for substance abuse: A multisite effectiveness study. *Drug and Alcohol Dependence, 81*(3), 301-312.
- Carroll, J.J., Greene, T.C., & Noonan, R.K. (2018). *Evidence-based strategies for preventing opioid overdose: What’s working in the United States*. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. Retrieved from <https://www.cdc.gov/drugoverdose/pdf/pubs/2018-evidence-based-strategies.pdf>
- Caulkins, J. P., Pardo, B., & Kilmer, B. (2019). Supervised consumption sites: A nuanced assessment of the causal evidence. *Addiction 114*(12), 2109-2115.

- Centers for Disease Control and Prevention (2018a). *Opioid Overdose* [Data file]. Retrieved from <https://www.cdc.gov/drugoverdose/data/index.html>
- Centers for Disease Control and Prevention (2018b). *Nonfatal Drug Overdoses* [Data file]. Retrieved from <https://www.cdc.gov/drugoverdose/data/nonfatal.html>
- Chang, C. Y., Crethar, H. C., & Ratts, M. J. (2010). Social justice: A national imperative for counselor education and supervision. *Counselor Education and Supervision, 50*(2), 82-87.
- Clark, A. J. (2004). Empathy: Implications of three ways of knowing in counseling. *The Journal of Humanistic Counseling, Education and Development, 43*(2), 141-151.
- Clark, A. J. (2007). *Empathy in counseling and psychotherapy: Perspectives and practices*. Mahwah, NJ: Erlbaum.
- Clark, A. J. (2010). Empathy: An integral model in the counseling process. *Journal of Counseling & Development, 88*(3), 348-356.
- Cleirec, G., Fortias, M., Bloch, V., Clergue-Duval, V., Bellivier, F., Dusouchet, T., ... & Vorspan, F. (2018). Opinion of health professionals and drug users before the forthcoming opening of the first drug consumption room in Paris: A quantitative cross-sectional study. *Harm Reduction Journal, 15*(53), 1-11.
- Collins, S.E., Clifasefi, S.L., Logan, D.E., Samples, L.S., Somers, J.M., & Marlatt, G.A. (2011). Current status, historical highlights, and basic principles of harm reduction. In G.A. Marlatt, M.E. Larimer, & K. Witkiewitz (Eds.), *Harm reduction (Second Edition): pragmatic strategies for managing high-risk behaviors* (pp. 3-35) New York, NY: Guilford Press.

- Collins, S. E., Grazioli, V. S., Torres, N. I., Taylor, E. M., Jones, C. B., Hoffman, G. E., ... & Herndon, P. (2015). Qualitatively and quantitatively evaluating harm-reduction goal setting among chronically homeless individuals with alcohol dependence. *Addictive behaviors, 45*, 184-190.
- Connery, H. S. (2015). Medication-assisted treatment of opioid use disorder: review of the evidence and future directions. *Harvard Review of Psychiatry, 23*(2), 63-75.
- Cook, C. C. (1988). The Minnesota model in the management of drug and alcohol dependency: Miracle, method or myth? *British Journal of Addiction, 83*(6), 625-634.
- Cook, R.M. (2020). Addressing missing data in quantitative counseling research. *Counseling Outcome Research and Evaluation, 1-11* DOI: 10.1080/21501378.2019.1711037
- Council for Accreditation of Counseling and Related Educational Programs. (2016). *2016 standards*. Retrieved from <http://www.cacrep.org/wp-content/uploads/2018/05/2016-Standards-with-Glossary-5.3.2018.pdf>
- Council for Accreditation of Counseling and Related Educational Programs (2019). *Find a program*. Retrieved from <https://www.cacrep.org/directory/>
- Crethar, H. C., Torres Rivera, E., & Nash, S. (2008). In search of common threads: Linking multicultural, feminist, and social justice counseling paradigms. *Journal of Counseling & Development, 86*, 269–278.
- Crethar, H. C., & Winterowd, C. L. (2012). Values and social justice in counseling. *Counseling and Values, 57*(1), 3-9.
- Cureton, J. L., Davis, H., & Giegerich, M. A. (2019). Counselor professional identity development: Narratives from a professional event. *The Journal of Counselor Preparation and Supervision, 12*(1), 5.

- Curtis, S. L., & Eby, L. T. (2010). Recovery at work: The relationship between social identity and commitment among substance abuse counselors. *Journal of Substance Abuse Treatment, 39*(3), 248-254.
- Davis, M. H. (1983). Measuring individual differences in empathy: Evidence for a multidimensional approach. *Journal of personality and social psychology, 44*(1), 113-126.
- Davis, A. K., & Lauritsen, K. J. (2016). Acceptability of non-abstinence goals among students enrolled in addiction studies programs across the United States. *Substance abuse, 37*(1), 204-208.
- Davis, A. K., Rosenberg, H., & Rosansky, J. A. (2017). American counselors' acceptance of non-abstinence outcome goals for clients diagnosed with co-occurring substance use and other psychiatric disorders. *Journal of Substance Abuse Treatment, 82*, 29-33.
- Denning, P., & Little, J. (2012). *Practicing harm reduction psychotherapy: An alternative approach to addictions*. Guilford Press: New York.
- Deren, S., Kang, S. Y., Mino, M., & Seewald, R. M. (2011). Attitudes of methadone program staff toward provision of harm reduction and other services. *Journal of Addiction Medicine, 5*(4), 289.
- Des Jarlais, D. C. (2017). Harm reduction in the USA: the research perspective and an archive to David Purchase. *Journal of Harm Reduction, 14*(51), 1-7. <https://doi.org/10.1186/s12954-017-0178-6>
- DiClemente, C. C., Corno, C. M., Graydon, M. M., Wiprovnick, A. E., & Knoblach, D. J. (2017). Motivational interviewing, enhancement, and brief interventions over the last

- decade: A review of reviews of efficacy and effectiveness. *Psychology of Addictive Behaviors*, 31(8), 862-887.
- DiClemente, C. C., Prochaska, J. O., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist*, 47(9), 1102-1114.
- Dispenza, F., & O'Hara, C. (2016). Correlates of transgender and gender nonconforming counseling competencies among psychologists and mental health practitioners. *Psychology of Sexual Orientation and Gender Diversity*, 3(2), 156-164.
- Dollarhide, C. T., & Oliver, K. (2014). Humanistic professional identity: The transtheoretical tie that binds, *Journal of Humanistic Counseling*, 53(3), 203–217.
<https://doi.org/10.1002/j.2161-1939.2014.00057.x>
- Elliott, R., Bohart, A. C., Watson, J. C., & Greenberg, L. S. (2011). Empathy. *Psychotherapy*, 48(1), 43-49.
- Fellner, J. (2009). Race, drugs, and law enforcement in the United States. *Stanford Law & Policy Review*, 20(2), 257–291.
- Fickling, M. J., & González, L. M. (2016). Linking multicultural counseling and social justice through advocacy. *Journal of Counselor Leadership and Advocacy*, 3(2), 85-94.
- Fiellin, D. A., Barry, D. T., Sullivan, L. E., Cutter, C. J., Moore, B. A., O'Connor, P. G., & Schottenfeld, R. S. (2013). A randomized trial of cognitive behavioral therapy in primary care-based buprenorphine. *The American Journal of Medicine*, 126(1), 74.e11- 74.e17.
- Fietzer, A. W., & Ponterotto, J. (2015). A psychometric review of instruments for social justice and advocacy attitudes. *Journal for Social Action in Counseling & Psychology*, 7(1), 19-40.

Fiorentine, R. (1999). After drug treatment: Are 12-step programs effective in maintaining abstinence?. *The American Journal of Drug and Alcohol Abuse*, 25(1), 93-116.

G*Power (Version 3.1) [Computer software]. Germany.

Gamble, J., & O'Lawrence, H. (2016). An overview of the efficacy of the 12-step group therapy for substance abuse treatment. *Journal of Health and Human Services Administration*, 39(1), 142-160.

Gazzola, N., & Smith, J. D. (2007). Who do we think we are? A survey of counsellors in Canada. *International Journal for the Advancement of Counselling*, 29(2), 97-110.

Gerdes, K. E., & Segal, E. (2011). Importance of empathy for social work practice: Integrating new science. *Social work*, 56(2), 141-148.

Gladding, S. T., & Newsome, D. W. (2004). *Community and agency counseling* (2nd ed.). Upper Saddle River, NJ: Merrill/Prentice Hall.

Glick, J. L., Christensen, T., Park, J. N., McKenzie, M., Green, T. C., & Sherman, S. G. (2019). Stakeholder perspectives on implementing fentanyl drug checking: results from a multi-site study. *Drug and Alcohol Dependence*, 194, 527-532.

Goddard, P. (1999). Altering American treatment professionals' attitudes toward harm reduction. *Addiction Biology*, 5, 215-226.

Goddard, P. (2003). Changing attitudes towards harm reduction among treatment professionals: A report from the American Midwest. *International Journal of Drug Policy*, 14(3), 257-260.

Goddard, P., Gauspohl, B., & Breitenbecher, K.H. (2004, April). *Psychometric Properties of the Revised Harm Reduction Acceptability Scale (HRAS-R)*. Poster presented at the annual meeting of the Midwestern Psychological Association, Chicago.

- Hagedorn, W. B., Culbreth, J. R., & Cashwell, C. S. (2012). Addiction Counseling Accreditation: CACREP's Role in Solidifying the Counseling Profession. *Professional Counselor, 2*(2), 124-133.
- Halbur, D., & Halbur, K. V. (2006). *Developing your theoretical orientation in counseling and psychotherapy*. Boston: Pearson.
- Han, J. K., Hill, L. G., Koenig, M. E., & Das, N. (2017). Naloxone Counseling for Harm Reduction and Patient Engagement. *Family medicine, 49*(9), 730-733.
- Hansen, J. T., Speciale, M. and Lemberger, M. E. (2014), Humanism: The foundation and future of professional counseling. *The Journal of Humanistic Counseling, 53* (3), 170-190.
doi:10.1002/j.2161-1939.2014.00055.x
- Harm Reduction Coalition (n.d.) *Principles of harm reduction*. Retrieved from <https://harmreduction.org/about-us/principles-of-harm-reduction/>
- Harm Reduction International (2019) *What is harm reduction?* Retrieved from <https://www.hri.global/what-is-harm-reduction>
- Havranek, J. E., & Stewart, J. R. (2006). Rehabilitation counselors' attitudes toward harm reduction measures. *Journal of Applied Rehabilitation Counseling, 37*, 38-44.
- Haug, N. A., Bielenberg, J., Linder, S. H., & Lembke, A. (2016). Assessment of provider attitudes toward #naloxone on Twitter. *Substance Abuse, 37*(1), 35-41.
- Haug, N. A., Shopshire, M., Tajima, B., Gruber, V., & Guydish, J. (2008). Adoption of evidence-based practices among substance abuse treatment providers. *Journal of Drug Education, 38*(2), 181-192.
- Hayes, S. C., Wilson, K. G., Gifford, E. V., Bissett, R., Piasecki, M., Batten, S. V., ... & Gregg, J. (2004). A preliminary trial of twelve-step facilitation and acceptance and commitment

- therapy with polysubstance-abusing methadone-maintained opiate addicts. *Behavior Therapy*, 35(4), 667-688.
- Healey, A. C. (2009) Female perspectives of professional identity and success in the counseling field (Doctoral dissertation). Retrieved from ProQuest. (UMU No. 3393006)
- Healey, A. C., & Hays, D. G. (2012). A discriminant analysis of gender and counselor professional identity development. *Journal of Counseling & Development*, 90(1), 55-62.
- Henwood, B. F., Padgett, D. K., & Tiderington, E. (2014). Provider views of harm reduction versus abstinence policies within homeless services for dually diagnosed adults. *Journal of Behavioral Health Services & Research*, 41(1), 80–89.
- Howell, D. C. (2009). *Statistical methods for psychology*. Cengage Learning: Belmont, CA.
- Hurt-Avila, K. M., & Castillo, J. (2017). Accreditation, professional identity development, and professional competence: a discriminant analysis. *Journal of Counselor Leadership and Advocacy*, 4(1), 39-51.
- Iarussi, M. M., Perjessy, C. C., & Reed, S. W. (2013). Addiction-Specific CACREP Standards in Clinical Mental Health Counseling Programs: How Are They Met?. *Journal of Addictions & Offender Counseling*, 34(2), 99-113.
- Ivers, N. N., Johnson, D. A., Clarke, P. B., Newsome, D. W., & Berry, R. A. (2016). The relationship between mindfulness and multicultural counseling competence. *Journal of Counseling & Development*, 94(1), 72-82.
- Jordan, J. V. (2010). *Relational-Cultural Therapy* (E. Welsh Ed.). Washington DC: American Psychological Association (pp. 1-32).
- Kang, S. Y., Magura, S., Nwakeze, P., & Demsky, S. (1998). Counselor attitudes in methadone maintenance. *Journal of Maintenance in the Addictions*, 1(2), 41-58.

- Kaplan, D. M., Tarvydas, V. M., & Gladding, S. T. (2014). 20/20: A vision for the future of counseling: The new consensus definition of counseling. *Journal of Counseling & Development, 92*(3), 366-372.
- Karpetis, G. (2014). Advocating the Clinical Social Work Professional Identity: A Biographical Study. *Journal of Social Work Practice, 28*(1), 23–41. <https://doi-org.ezproxy.lib.vt.edu/10.1080/02650533.2013.806888>
- Keith, T. Z. (2015). *Multiple regression and beyond: An introduction to multiple regression and structural equation modeling*. New York: Routledge.
- Kelly, J. F., Kaminer, Y., Kahler, C. W., Hoepfner, B., Yeterian, J., Cristello, J. V., & Timko, C. (2017). A pilot randomized clinical trial testing integrated 12-Step facilitation (iTSP) treatment for adolescent substance use disorder. *Addiction, 112*(12), 2155-2166.
- Kennedy, J., Arku, G., & Cleave, E. (2017). The experiences of front-line service providers of Housing First programme delivery in three communities in Ontario, Canada. *International Journal of Housing Policy, 17*(3), 396-416.
- Kepple, N. J., Parker, A., Whitmore, S., & Comtois, M. (2019). Nowhere to go? Examining facility acceptance levels for serving individuals using medications for opioid use disorder. *Journal of Substance Abuse Treatment, 104*, 42-50.
- Kilmer, J. R., Cronce, J. M., Hunt, S. B., & Lee, C. M. (2011). Reducing harm associated with illicit drug use: Opiates, amphetamines, cocaine, steroids, and other substances. In G.A. Marlatt, M.E. Larimer, & K. Witkiewitz (Eds.), *Harm reduction (Second Edition): pragmatic strategies for managing high-risk behaviors* (pp. 170-200) New York, NY: Guilford Press.

- Knudsen, H. K., Ducharme, L. J., & Roman, P. M. (2007). Research network involvement and addiction treatment center staff: Counselor attitudes toward buprenorphine. *American Journal on Addictions, 16*(5), 365-371.
- Krieger, M. S., Goedel, W. C., Buxton, J. A., Lysyshyn, M., Bernstein, E., Sherman, S. G., ... & Marshall, B. D. (2018). Use of rapid fentanyl test strips among young adults who use drugs. *International Journal of Drug Policy, 61*, 52-58.
- Kwon, M., Moody, A. E., Thigpen, J., & Gauld, A. (2019). Implementation and Evaluation of an Opioid Overdose and Naloxone Distribution Training in a Pharmacist Laboratory. *American Journal of Pharmaceutical Education, ajpe7179*.
- Kyser, N. M. (2010). Counselor attitudes toward the harm reduction approach in substance abuse treatment (Doctoral Dissertation). Available from ProQuest Dissertations and Theses database. (UMI No. 3428817).
- La Guardia, A. (2019). Professional Orientation and Development Scale for Counselors [provided via personal correspondence]. Unpublished instrument, updated from previously published Professional Identity and Values Scale for Counselors (Healy, A., 2009).
- Laschober, T. C., de Tormes Eby, L. T., & Sauer, J. B. (2012). Clinical supervisor and counselor perceptions of clinical supervision in addiction treatment. *Journal of Addictive Diseases, 31*(4), 382-388.
- Laudet, A. B. (2003). Attitudes and beliefs about 12-step groups among addiction treatment clients and clinicians: Toward identifying obstacles to participation. *Substance Use & Misuse, 38*(14), 2017-2047.

- Le, C., Ingvarson, E. P., & Page, R. C. (1995). Alcoholics Anonymous and the counseling profession: Philosophies in conflict. *Journal of Counseling & Development, 73*(6), 603-609.
- Lee, T. K. (2014). Addiction education and training for counselors: A qualitative study of five experts. *Journal of Addiction and Offender Counseling, 35*(2), 67–80.
<https://doi.org/10.1002/j.2161-1874.2014.00027.x>
- León, C., Cardoso, L., Mackin, S., Bock, B., & Gaeta, J. M. (2018). The willingness of people who inject drugs in Boston to use a supervised injection facility. *Substance Abuse, 39*(1), 95-101.
- Ling, W., Hillhouse, M., Ang, A., Jenkins, J., & Fahey, J. (2013). Comparison of behavioral treatment conditions in buprenorphine maintenance. *Addiction, 108*(10), 1788-1798.
- Longshore, D., & Teruya, C. (2006). Treatment motivation in drug users: A theory-based analysis. *Drug and Alcohol Dependence, 81*(2), 179–188.
- McDonald, R., & Strang, J. (2016). Are take-home naloxone programmes effective? Systematic review utilizing application of the Bradford Hill criteria. *Addiction, 111*(7), 1177-1187.
- Madden, T. (2016). Factors associated with harm reduction model use among substance abuse counselors (Doctoral Dissertation). Retrieved from
<http://scholarworks.waldenu.edu/cgi/viewcontent.cgi?article=3234&context=dissertations>
- Marshall, B. D., Milloy, M. J., Wood, E., Montaner, J. S., & Kerr, T. (2011). Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: a retrospective population-based study. *The Lancet, 377*(9775), 1429-1437.

- McGinty, E. E., Barry, C. L., Stone, E. M., Niederdeppe, J., Kennedy-Hendricks, A., Linden, S., & Sherman, S. G. (2018). Public support for safe consumption sites and syringe services programs to combat the opioid epidemic. *Preventive medicine, 111*, 73-77.
- McGovern, M.P., & Carroll, K.M. (2003). Evidence-based practices for substance use disorders. *Psychiatric Clinic of North America, 26* (4), 991–1010.
- McGowan, C. R., Harris, M., Platt, L., Hope, V., & Rhodes, T. (2018). Fentanyl self-testing outside supervised injection settings to prevent opioid overdose: Do we know enough to promote it?. *International Journal of Drug Policy, 58*, 31-36.
- Mellin, E. A., Hunt, B., & Nichols, L. M. (2011). Counselor professional identity: Findings and implications for counseling and interprofessional collaboration. *Journal of Counseling & Development, 89*(2), 140-147.
- Mena, J. A., & Rogers, M. R. (2017). Factors associated with multicultural teaching competence: Social justice orientation and multicultural environment. *Training and Education in Professional Psychology, 11*(2), 61-68.
- Miller, J. C. (2008). 12-Step treatment for alcohol and substance abuse revisited: Best available evidence suggests lack of effectiveness or harm. *International Journal of Mental Health and Addiction, 6*(4), 568-576.
- Miller, W. R., & Brown, S. A. (1997). Why psychologists should treat alcohol and drug problems. *American Psychologist, 52*(12), 33-55.
- Miller, W. R., & Moyers, T. B. (2017). Motivational interviewing and the clinical science of Carl Rogers. *Journal of consulting and clinical psychology, 85*(8), 757-766.
- Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change (3rd ed.)*. New York, NY: Guilford Press.

- Miller, W. R., Yahne, C. E., & Tonigan, J. S. (2003). Motivational interviewing in drug abuse services: A randomized trial. *Journal of Consulting and Clinical Psychology, 71*(4), 754-763.
- Monico, L. B., Gryczynski, J., Mitchell, S. G., Schwartz, R. P., O'Grady, K. E., & Jaffe, J. H. (2015). Buprenorphine treatment and 12-step meeting attendance: Conflicts, compatibilities, and patient outcomes. *Journal of Substance Abuse Treatment, 57*, 89-95.
- Moore, B. A., Fiellin, D. A., Cutter, C. J., Buono, F. D., Barry, D. T., Fiellin, L. E., ... & Schottenfeld, R. S. (2016). Cognitive behavioral therapy improves treatment outcomes for prescription opioid users in primary care buprenorphine treatment. *Journal of Substance Abuse Treatment, 71*, 54-57.
- Morgen, K., Miller, G., & Stretch, L. S. (2012). Addiction counseling licensure issues for licensed professional counselors. *The Professional Counselor, 2*(1), 58-65.
- Moro, R. R., & Burson, J. (2018). Harm-reduction: Meeting clients where they are. In P. Lassiter & J. Culbreth (Eds.), *Addiction Theory and Practice* (pp. 235-257). Thousand Oaks, CA: Sage.
- Moss, J. M., Gibson, D. M., & Dollarhide, C. T. (2014). Professional identity development: A grounded theory of transformational tasks of counselors. *Journal of Counseling & Development, 92*(1), 3-12.
- Moyers, T. B., & Miller, W. R. (2013). Is low therapist empathy toxic?. *Psychology of Addictive Behaviors, 27*(3), 878-884.
- Mueller, S. R., Koester, S., Glanz, J. M., Gardner, E. M., & Binswanger, I. A. (2017). Attitudes toward naloxone prescribing in clinical settings: a qualitative study of patients prescribed

high dose opioids for chronic non-cancer pain. *Journal of general internal medicine*, 32(3), 277-283.

NAADAC: The Association of Addiction Professionals (2019). *About*. Retrieved from <https://www.naadac.org/about>

Nadelmann, E., & Lasalle, L. (2017). Two steps forward, one step back: Current harm reduction policy and politics in the United States. *Harm Reduction Journal*, 14 (37), 1–7.
<https://doi.org/10.1186/s12954-017-0157-y>

National Association of Social Workers. (2017). NASW code of ethics. Retrieved November 5, 2020, from <https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English>

National Health Services Corps (2020). *NHSC Substance Use Disorder workforce loan repayment program*. Retrieved from <https://nhsc.hrsa.gov/loan-repayment/nhsc-sud-workforce-loan-repayment-program.html>

National Institute on Drug Abuse (2018q). *Principles of drug addiction treatment: A research-based guide (third edition)*. Retrieved from <https://www.drugabuse.gov/node/pdf/675/principles-of-drug-addiction-treatment-a-research-based-guide-third-edition>

National Institute on Drug Abuse (2018b, June). *Medications to Treat Opioid Use Disorder*. Retrieved from <https://www.drugabuse.gov/node/pdf/21349/medications-to-treat-opioid-use-disorder>

National Safety Council (2019). *Injury facts; All injuries; Preventable death; Odds of dying*. Retrieved from <https://injuryfacts.nsc.org/all-injuries/preventable-death-overview/odds-of-dying>

- Nezlek, J. B., Schutz, A., Lopes, P., & Smith, C. V. (2007). Naturally occurring variability in state empathy. *Empathy in mental illness*, 187-200.
- Norcross, J. C., & Wampold, B. E. (2011). Evidence-based therapy relationships: Research conclusions and clinical practices. In J. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed., pp. 423–430). New York, NY: Oxford University Press.
- Nunes, E. V., Gordon, M., Friedmann, P. D., Fishman, M. J., Lee, J. D., Chen, D. T., ... & O'Brien, C. P. (2018). Relapse to opioid use disorder after inpatient treatment: Protective effect of injection naltrexone. *Journal of Substance Abuse Treatment*, 85, 49-55.
- O'Leary, B., Strike, C., Rohailla, S., Barnes, M., McDougall, P., Baltzer Turje, R., ... & Chan Carusone, S. (2018). Perspectives of healthcare workers about the delivery and evaluation of harm reduction services for people living with HIV who use substances. *Cogent Medicine*, 5(1), 1-10.
- Pantović-Stefanović, M., Dunjić-Kostić, B., Gligorić, M., Lačković, M., Damjanović, A., & Ivković, M. (2015). Empathy predicting career choice in future physicians. *Engrami*, 37(1), 37-48.
- Parra-Frutos, I. (2013). Testing homogeneity of variances with unequal sample sizes. *Computational Statistics*, 28(3), 1269-1297.
- Park, J. N., Sherman, S. G., Rouhani, S., Morales, K. B., McKenzie, M., Allen, S. T., ... & Green, T. C. (2019). Willingness to use safe consumption spaces among opioid users at high risk of fentanyl overdose in Baltimore, Providence, and Boston. *Journal of urban health*, 53, 353-366.

- Paulhus, D. L. (1988). Assessing self-deception and impression management in self-reports: The Balanced Inventory of Desirable Responding. Unpublished manuscript, University of British Columbia.
- Pauly, B. (2008). Harm reduction through a social justice lens. *International Journal of Drug Policy, 19*, 4– 10.
- Pitt, A. L., Humphreys, K., & Brandeau, M. L. (2018). Modeling health benefits and harms of public policy responses to the US opioid epidemic. *American Journal of Public Health, 108*(10), 1394-1400. <https://doi.org/10.2105/AJPH.2018.304590>
- Poznanski, J. J., & McLennan, J. (1995). Conceptualizing and measuring counselors' theoretical orientation. *Journal of Counseling Psychology, 42*(4), 411-422.
- Puglia, B. (2008). *The professional identity of counseling students in master's level CACREP accredited programs* (Doctoral dissertation, Old Dominion University). Available from ProQuest Dissertations and Theses database. Retrieved from <https://ezproxy.shsu.edu/login?url=http://search.proquest.com/docview/304412126?accountid=7065>
- Quinn, J. F., Bodenhamer-Davis, E., & Koch, D. S. (2004). Ideology and the stagnation of AODA treatment modalities in America. *Deviant Behavior, 25*(2), 109-131.
- Ratts, M. J. (2009). Social justice counseling: Toward the development of a fifth force among counseling paradigms. *The Journal of Humanistic Counseling, Education and Development, 48*(2), 160-172.
- Ratts, M. J., Singh, A. A., Nassar, M. S., Butler, S. K., & McCullough, J. R. (2016). Multicultural and social justice counseling competencies: Guidelines for the counseling

- profession. *Journal of Multicultural Counseling & Development*, 44(1), 28–48.
<https://doi-org.ezproxy.lib.vt.edu/10.1002/jmcd.12035>
- Reiner, S. M., Dobmeier, R. A., & Hernández, T. J. (2013). Perceived impact of professional counselor identity: An exploratory study. *Journal of Counseling & Development*, 91(2), 174-183.
- Rieckmann, T., Daley, M., Fuller, B. E., Thomas, C. P., & McCarty, D. (2007). Client and counselor attitudes toward the use of medications for treatment of opioid dependence. *Journal of Substance Abuse Treatment*, 32(2), 207-215.
- Ripley, D. M. (2019). *Counseling interventions with buprenorphine for treatment of opioid use disorders* (Doctoral dissertation, Virginia Tech).
- Rogers, C.R. (1951). *Client-centered therapy: Its practice, implications, and theory*. Boston: Houghton Mifflin Company.
- Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21, 95-103.
- Rogers, C. R. (1975). Empathic: An unappreciated way of being. *The Counseling Psychologist*, 5(2), 2-10.
- Rønnestad, M. H., & Skovholt, T. M. (2003). The journey of the counselor and therapist: Research findings and perspectives on professional development. *Journal of career development*, 30(1), 5-44.
- Rosenberg, H., Grant, J., & Davis, A. K. (2020). Acceptance of non-abstinence as an outcome goal for individuals diagnosed with substance use disorders: A narrative review of published research. *Journal of Studies on Alcohol and Drugs*, 81(4), 405-415.

- Rosenberg, H., & Davis, A. K. (2014). Differences in the acceptability of non-abstinence goals by type of drug among American substance abuse clinicians. *Journal of Substance Abuse Treatment, 46*, 214–218.
- Rosenblum, A., Marsch, L. A., Joseph, H., & Portenoy, R. K. (2008). Opioids and the treatment of chronic pain: Controversies, current status, and future directions. *Experimental and Clinical Psychopharmacology, 16*(5), 405-416.
- Roy III, A. K., & Miller, M. (2012). The medicalization of addiction treatment professionals. *Journal of Psychoactive Drugs, 44*(2), 107–118. <https://doi-org.ezproxy.lib.vt.edu/10.1080/02791072.2012.684618>
- Ruhm, C. J. (2019). Drivers of the fatal drug epidemic. *Journal of Health Economics, 64*, 25–42. <https://doi.org/10.1016/j.jhealeco.2019.01.001>
- Ryan, R. M., Lynch, M. F., Vansteenkiste, M., & Deci, E. L. (2011). Motivation and autonomy in counseling, psychotherapy, and behavior change: A look at theory and practice. *The Counseling Psychologist, 39*(2), 193-260.
- Scheffer, M. M., Lasater, K., Atherton, I. M., & Kyle, R. G. (2019). Student nurses' attitudes to social justice and poverty: An international comparison. *Nurse Education Today, 80*, 59-66.
- Seth, P., Rudd, R. A., Noonan, R. K., & Haegerich, T. M. (2018). Quantifying the epidemic of prescription Opioid overdose deaths. *American Journal of Public Health, 108*(4), 500–502. <https://doi.org/10.2105/AJPH.2017.304265>
- Shaw, R. G., & Mitchell-Olds, T. (1993). ANOVA for unbalanced data: An overview. *Ecology, 74*(6), 1638-1645.

- Simons, L., Haas, D., Massella, J., Young, J., & Toth, P. (2017). The value of certification in the era of licensure: An exploratory study of professional identity development in alcohol and drug professionals. *Alcoholism Treatment Quarterly*, *35*(2), 130-150.
- Simons, L., Jacobucci, R., & Houston, H. (2006). Novice, seasoned and veteran counselors' views of addiction treatment manuals: The influence of counselor characteristics on manual usefulness. *Journal of psychoactive drugs*, *38*(4), 483-491.
- Singer, T., & Klimecki, O. M. (2014). Empathy and compassion. *Current Biology*, *24*(18), R875-R878.
- Skolnick, P. (2018). On the front lines of the opioid epidemic: Rescue by naloxone. *European Journal of Pharmacology*, *835*, 147–153. <https://doi.org/10.1016/j.ejphar.2018.08.004>
- Smye, V., Browne, A. J., Varcoe, C., & Josewski, V. (2011). Harm reduction, methadone maintenance treatment and the root causes of health and social inequities: An intersectional lens in the Canadian context. *Harm Reduction Journal*, *8*(1), 17.
- Sommers-Flanagan, J. (2015). Evidence-based relationship practice: Enhancing counselor competence. *Journal of Mental Health Counseling*, *37*(2), 95-108.
- Spreng, R. N., McKinnon, M. C., Mar, R. A., & Levine, B. (2009). The Toronto Empathy Questionnaire: Scale development and initial validation of a factor-analytic solution to multiple empathy measures. *Journal of personality assessment*, *91*(1), 62-71.
- SPSS (Version 26) [Computer software] (2018). Armonk, NY: IBM Corp.

- Stancliff, S., Joseph, H., Fong, C., Furst, T., Comer, S. D., & Roux, P. (2012). Opioid maintenance treatment as a harm reduction tool for opioid-dependent individuals in New York City: The need to expand access to buprenorphine/naloxone in marginalized populations. *Journal of Addictive Diseases, 31*(3), 278-87.
<https://doi.org/10.1080/10550887.2012.694603>
- Substance Abuse and Mental Health Services Administration (2018). *Evidence-based practices resource center*. Retrieved from <https://www.samhsa.gov/ebp-resource-center>
- Substance Abuse and Mental Health Services Administration (2019). *National directory of drug and alcohol treatment facilities*. Retrieved from https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/National_Directory_SA_facilities_2019.pdf
- Sullivan, M. A., Birkmayer, F., Boyarsky, B. K., Frances, R. J., Fromson, J. A., Galanter, M., ... & Tamerin, J. S. (2008). Uses of coercion in addiction treatment: clinical aspects. *American Journal on Addictions, 17*(1), 36-47.
- Tatarsky, A. (2002). *Harm reduction psychotherapy*. Northvale, NJ: Aronson.
- Tatarsky, A. (2003). Harm reduction psychotherapy: Extending the reach of traditional substance use treatment. *Journal of Substance Abuse Treatment, 25*(4), 249-256.
- Tatarsky, A., & Kellogg, S. (2012). Harm reduction psychotherapy. In G.A. Marlatt, M.E. Larimer, & K. Witkiewitz (Eds.), *Harm Reduction (Second Edition): Pragmatic Strategies for Managing High-Risk Behaviors*, pp. 36-60 New York, NY: Guilford Press.

- Thompson, I. A., Amatea, E. S., & Thompson, E. S. (2014). Personal and contextual predictors of mental health counselors' compassion fatigue and burnout. *Journal of Mental Health Counseling, 36*(1), 58-77.
- Toporek, R. L., Lewis, J. A., & Crethar, H. C. (2009). Promoting systemic change through the ACA Advocacy Competencies. *Journal of Counseling & Development, 87*(3), 260–268. <https://doi-org.ezproxy.lib.vt.edu/10.1002/j.1556-6678.2009.tb00105.x>
- Toporek, R. L., & Williams, R. (2006). Ethics and professional issues related to the practice of social justice in counseling psychology. In R. L. Toporek, L. H. Gerstein, N. A. Fouad, G. Roysircar, & T. Israel (Eds.), *Handbook for social justice in counseling psychology: Leadership, vision, and action* (pp. 17–34). Thousand Oaks, CA: Sage Publications, Inc.
- Torres-Harding, S. R., Siers, B., & Olson, B. D. (2012). Development and psychometric evaluation of the Social Justice Scale (SJS). *American Journal of Community Psychology, 50*, 77-88. doi: 10.1007/s10464-011-9478-2
- United States Census Bureau (2010). *Census Regions and Divisions of the United States*. https://www2.census.gov/geo/pdfs/maps-data/maps/reference/us_regdiv.pdf
- Van Wormer, K., & Davis, D. R. (2008). *Addiction treatment: A strengths based perspective (second edition)*. Canada: Brooks/Cole, Cengage Learning.
- Vakharia, S. P., & Little, J. (2017). Starting where the client is: Harm reduction guidelines for clinical social work practice. *Clinical Social Work Journal, 45*(1), 65-76.
- Vearrier, L. (2019). The value of harm reduction for injection drug use: A clinical and public health ethics analysis. *Disease-a-Month, 65*(5), 119-141.

- Vereen, L. G., Hill, N. R., Sosa, G. A. & Kress, V. (2014), The synonymic nature of professional counseling and humanism: Presuppositions that guide our identities. *The Journal of Humanistic Counseling*, 53 (3), 191-202. doi:10.1002/j.2161-1939.2014.00056.x
- Vidourek, R. A., King, K. A., Yockey, R. A., Becker, K. & Merianos, A. L. (2019) Straight to the point: A review of the literature on needle exchange programs in the United States. *Journal of Behavioral Health*, 8 (3), 111-121. doi:10.5455/jbh.20181023074620
- Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry*, 14(3), 270-277.
- Walthers, J., Weingardt, K.R., Witkeiwitz, K., & Martlatt, G.A. (2012). Harm reduction and public policy. In G.A. Martlatt, M.E. Larimer, & K. Witkiewitz (Eds.), *Harm reduction (Second Edition): pragmatic strategies for managing high-risk behaviors* (pp. 339-379) New York, NY: Guilford Press.
- Weigel, D. J., Donovan, K. A., Krug, K. S., & Dixon, W. A. (2007). Prescription opioid abuse and dependence: Assessment strategies for counselors. *Journal of Counseling & Development*, 85(2), 211-215.
- Weinstein, C. M., Parker, J., & Archer Jr, J. (2002). College counselor attitudes toward spiritual and religious issues and practices in counseling. *Journal of College Counseling*, 5(2), 164-174.
- White, J. M., & Irvine, R. J. (1999). Mechanisms of fatal opioid overdose. *Addiction*, 94(7), 961-972.
- White, W. (2004). The historical essence of addiction counseling. *The Counselor*, 5(3), 43-48.
- White, W. L., & Miller, W. R. (2007). The use of confrontation in addiction treatment: History, science and time for change. *The Counselor*, 8(4), 12-30.

- White House (2017, October 26). President Donald J. Trump is taking action on drug addiction and the opioid crisis. Retrieved from <https://www.whitehouse.gov/briefings-statements/president-donald-j-trump-taking-action-drug-addiction-opioid-crisis/>
- Woo, H., Henfield, M. S., & Choi, N. (2014). Developing a unified professional identity in counseling: A review of the literature. *Journal of Counselor Leadership and Advocacy, 1*(1), 1-15.
- Wryobeck, J. M., & Rosenberg, H. (2005). The association of client characteristics and acceptance of harm reduction: A policy-capturing study of psychologists. *Addiction Research & Theory, 13*(5), 461-476.
- Yalom, I. D. (1980). *Existential psychotherapy*. New York: Basic Books.
- Young, I. M. (2001). Equality of whom? Social groups and judgments of injustice. *Journal of Political Philosophy, 9*(1), 1-18.

Appendix A**Harm Reduction Acceptability Scale-Revised**

Redacted for ETD. See Goddard (2003) and contact author for updated version of the scale for more detail:

Goddard, P. (2003). Changing attitudes towards harm reduction among treatment professionals:

A report from the American Midwest. *International Journal of Drug Policy*, 14(3), 257-260.

Harm Reduction for Opioid Use Disorder Supplemental Questions

Developed by Justin Jordan (2021)

1	2	3	4	5
Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

(26) Motivational Interviewing is an appropriate counseling intervention for clients with moderate or severe opioid use problems.

1	2	3	4	5
---	---	---	---	---

(27) Treatment providers should recommend Medication-Assisted Treatment like Methadone or Buprenorphine for clients who are chemically dependent on opioids and want to stop using illicitly.

1	2	3	4	5
---	---	---	---	---

(28) Treatment providers should recommend needle exchange programs to opioid users who are using via injection.

1	2	3	4	5
---	---	---	---	---

(29) It is essential for treatment providers to help opioid users access supplies of Naloxone to reverse opioid overdoses that may occur.

1	2	3	4	5
---	---	---	---	---

(30) Fentanyl testing kits that allow users to know if their drug supply is adulterated with this substance are useful tools and should be recommended by treatment providers.

1	2	3	4	5
---	---	---	---	---

(31) Opioid users benefit from having safe, legal spaces where they can consume drugs, sterile injection equipment can be provided, and staff can reverse overdoses that occur.

1	2	3	4	5
---	---	---	---	---

(32) Opioid users should be referred to comprehensive community programs that provide an array of harm reduction services, such as clean needles, Naloxone supplies, education about safe drug use practices, and where their drugs can be checked for fentanyl.

1	2	3	4	5
---	---	---	---	---

(33) Due to the potential for overdose with opioids, people using these drugs are good candidates for programs seeking to reduce overdose risks without requiring abstinence.

1 2 3 4 5

(34) Linking opioid users to housing programs that do not require them to stop using drugs is appropriate and should lead to better long-term outcomes for these individuals.

1 2 3 4 5

(35) Educating individuals who abuse opioids about strategies of using that reduce overdose, infection, and other risks is an aspect of appropriate treatment.

1 2 3 4 5

Developed by Justin Jordan (2021).

Appendix B

Toronto Empathy Questionnaire: A Brief Self-Report Measure of Empathy

Redacted for ETD. See Spreng, McKinnon, Mar, & Levine (2009), for more detail:

Spreng, R. N., McKinnon, M. C., Mar, R. A., & Levine, B. (2009). The Toronto Empathy Questionnaire: Scale development and initial validation of a factor-analytic solution to multiple empathy measures. *Journal of personality assessment, 91*(1), 62-71.

Appendix C**Social Justice Scale: Attitudes Towards Social Justice Subscale**

Redacted for ETD. See Torres-Harding, Siers, & Olson (2012), for more detail:

Torres-Harding, S. R., Siers, B., & Olson, B. D. (2012). Development and psychometric evaluation of the Social Justice Scale (SJS). *American Journal of Community Psychology, 50*, 77-88. doi: 10.1007/s10464-011-9478-2

Appendix D

Professional Orientation and Development Scale for Counselors: Professional Orientation and Values Subscale

Redacted for ETD. See Healy and Hays (2012) and contact author for updated version of the scale for more detail:

Healey, A. C., & Hays, D. G. (2012). A discriminant analysis of gender and counselor professional identity development. *Journal of Counseling & Development, 90*(1), 55-62.

Appendix E**Demographic Questionnaire**

1. Do you provide direct substance use treatment to clients/patients in your current position?

Yes

No

2. Please indicate your highest level of education:

Less than high school diploma

High school graduate

Associates Degree

Bachelor's Degree

Master's Degree

Doctorate Degree

3. Graduation Date for highest degree earned: _____ (drop down list of years)

4. Please indicate your discipline of training:

Marriage and Family Therapy

Medical Doctor

Nursing

Physician's Assistant

Professional Counseling

Psychology

Social Work

Other: _____

5. Please choose the option that best describes your current position as a substance use treatment provider:

Clinician (provides therapeutic services to clients/patients)

Direct Service Provider (not a clinician)

Medical Provider

Peer Recovery Specialist/Professional

Other: _____

6. Please indicate any licenses or certifications you have (select all that apply):

Certified Nurse Assistant

Doctor of Medicine or Doctor of Osteopathic Medicine

Licensed Clinical Psychologist

Licensed Clinical Social Worker

- Licensed Marriage and Family Therapist
- Licensed Practical Nurse or Licensed Vocational Nurse
- Licensed Professional Counselor/Licensed Mental Health Counselor
- National addiction treatment certification
- Nurse Practitioner
- Peer Recovery Certification
- Physician's Assistant
- Registered Nurse
- State-level addiction treatment certification or licensure
- Other: _____
- Second Other: _____

7. Gender Identity

- Male
- Female
- Other Identity: _____
- Decline to Answer

8. How would you describe the location of your work setting:

- Urban
- Suburban
- Rural

9. Age: _____ (drop down menu from 18 to 110).

10. Ethnicity (pick the option which best describes your identity)

- Asian
- Black or African American
- Caucasian/White
- Hawaiian Native or Pacific Islander
- Hispanic or Latino
- Multi-racial/Multiple Ethnicities
- Native American or American Indian
- Other _____

11. State/territory where you practice substance use treatment (select the state in which you work the majority of your weekly work hours): _____ (Drop down of all 50 states and US territories)

12. Please estimate the number of clients with Opioid Use Disorder you have treated during the last month as a substance use treatment provider: _____ (drop down number list 0-150+)

13. *Did you graduate from a CACREP-accredited counselor training program?
Yes/No/Unsure

14. Are you in recovery from an addiction to alcohol or drugs?
Yes/No/Prefer not to answer

15. In which level of care do you primarily provide treatment for substance use?

Prevention

Outpatient

Intensive Outpatient

Partial Hospitalization/ Day Treatment

Inpatient

Medical Detox

Other: _____

*Note: Items 12 and 13 are specific to professional counselors sampled. "Skip logic" will be used in Qualtrics so that only individuals who indicate Professional Counseling or Marriage and Family Therapy as their master's level training discipline will answer these items.

Appendix F

Recruitment Materials

Email to Point-Of-Contact Staff Members for Recruitment

SUBJECT: Invitation to Participate in Research Survey Focused on Substance Use Treatment Providers

Hello,

I am a doctoral student in Counselor Education and Supervision at Virginia Tech. I am conducting a research study to explore how different treatment options for Opioid Use Disorder are perceived by substance use treatment professionals (Virginia Tech IRB# 20-350). I am recruiting participants from sites identified in SAMHSA's National Directory of Drug and Alcohol Abuse Treatment Facilities.

I am requesting that you forward this recruitment email to staff members in your program. The responses to the survey will be anonymous and no information about programs or facilities will be collected. The email includes a link to the online survey. As a token of my appreciation for your time, staff members who complete the survey will be provided with training materials related to the Opioid Epidemic and the treatment of opioid use at the completion of the survey. Provider participation is essential in helping researchers understand how professionals are responding to the Opioid Epidemic and participation in this study will help bridge the gap between practitioners and researchers. Participants will have the option of entering a drawing for one of four \$50 Amazon gift cards and receive access to a training video about treatments for opioid use. Thank you and please feel free to respond with any questions you have.

Sincerely,

Justin Jordan LPC CSAC
Doctoral Candidate
Virginia Tech- Counselor Education and Supervision

SUBJECT: Invitation to Participate in Research Survey Focused on Substance Use Treatment Providers' Perceptions of Opioid Treatment Approaches

Dear Substance Use Treatment Professional,

I am requesting your participation in this research study (Virginia Tech IRB# 20-350), which involves completing the online survey at the link provided. The survey takes about 20-25 minutes. Your participation is completely voluntary. Participants have the option of providing their email address to be entered into a drawing for one of four \$50 Amazon gift cards, as well as being offered a training video focused on treatments for opioid use. Your responses are

anonymous, as your name or other identifying information will not be collected, nor will the survey ask any information about your employer.

The risks of this study are minimal and are described in the Informed Consent in the attached document. The potential benefits include contributing to the field of substance use treatment by enhancing the understanding of which types of interventions for Opioid Use Disorder that are seen as beneficial among providers.

If you have concerns or questions about this research study, please contact me at jjordan3@vt.edu or by calling me at 540-838-5326. Thank you.

Survey link: https://virginiatech.qualtrics.com/jfe/form/SV_0TIHuu1X0ozse3z

Sincerely,

Justin Jordan LPC CSAC
Doctoral Candidate
Virginia Tech- Counselor Education and Supervision

Appendix G

IRB Document



Division of Scholarly Integrity and
Research Compliance
Institutional Review Board
North End Center, Suite 4120 (MC 0497)
300 Turner Street NW
Blacksburg, Virginia 24061
540/231-3732
irb@vt.edu
<http://www.research.vt.edu/sirc/hrpp>

MEMORANDUM

DATE: June 10, 2020

TO: Laura Everhart Welfare, Justin Richard Jordan, Matthew C Fullen

FROM: Virginia Tech Institutional Review Board (FWA00000572, expires October 29, 2024)

PROTOCOL TITLE: Provider Perceptions of Treatment Options for Opioid Use Disorder

IRB NUMBER: 20-350

Effective June 10, 2020, the Virginia Tech Human Research Protection Program (HRPP) determined that this protocol meets the criteria for exemption from IRB review under 45 CFR 46.104(d) category (ies) 2(i),2(ii).

Ongoing IRB review and approval by this organization is not required. This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these activities impact the exempt determination, please submit an amendment to the HRPP for a determination.

This exempt determination does not apply to any collaborating institution(s). The Virginia Tech HRPP and IRB cannot provide an exemption that overrides the jurisdiction of a local IRB or other institutional mechanism for determining exemptions.

All investigators (listed above) are required to comply with the researcher requirements outlined at:

<https://secure.research.vt.edu/external/irb/responsibilities.htm>

(Please review responsibilities before beginning your research.)

PROTOCOL INFORMATION:

Determined As: **Exempt, under 45 CFR 46.104(d) category(ies) 2(i),2(ii)**
Protocol Determination Date: **May 1, 2020**

ASSOCIATED FUNDING:

The table on the following page indicates whether grant proposals are related to this protocol, and which of the listed proposals, if any, have been compared to this protocol, if required.

SPECIAL INSTRUCTIONS:

***Please note that your study has not yet received permission to resume in-person human subjects research (HSR) activities. When you are ready to resume, please submit the template found at https://www.research.vt.edu/content/dam/research_vt_edu/covid-19/sirc/covid-19-resumption-of-hsr-template.docx Do not resume in-person HSR activities until you receive notification from the HRPP that you may implement your plan.

This amendment, submitted May 28, 2020, updates research protocol to add "Two follow up emails will be sent to each of these point-of-contact staff members, totaling 3 emails. The follow-up emails will be the same recruitment email with no changes in either the body or subject line of the email."

Date*	OSP Number	Sponsor	Grant Comparison Conducted?

* Date this proposal number was compared, assessed as not requiring comparison, or comparison information was revised.

If this protocol is to cover any other grant proposals, please contact the HRPP office (irb@vt.edu) immediately.