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Harm Reduction in Psychotherapy

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Abstract

With approximately 22 people dying due to opiate-related harms every day in Canada (Government of Canada, 2023), there is a great need to offer low-barrier, evidence-based services for people who use substances across various disciplines, including healthcare, social services, and psychotherapy. This qualitative study examined the experiences of Canadian social justice-informed counsellors who work with clients who use substances from harm reduction frameworks of care. Seven counsellors were interviewed on their personal experiences implementing harm reduction in psychotherapy. Through a reflexive thematic analysis, five themes surfaced: axiology of harm reduction work, development of therapist surrounding harm reduction, main focuses of harm reduction work, external influences, and barriers to care. This research highlights various facets of working with clients who use substances amidst the current Canadian sociopolitical climate surrounding harm reduction and substance use and discusses potential gaps and implications surrounding the provision of socially just care to people who use substances.

Keywords: harm reduction, counselling, psychotherapy, substance use, social justice

Lay Audience Summary

With approximately 22 people dying due to opiate-related harms every day in Canada (Government of Canada, 2023), it is evident that there is a great need to offer low-barrier, evidence-based services for people who use substances. Harm reduction offers an avenue to provide care to people who use substances non-coercively and while upholding their basic rights to autonomy and dignity, regardless of where they may be in their journey with substance use. Harm reduction strategies also offer a treatment alternative to abstinence-only care, which can act as a barrier for those not ready or able to cease their substance use altogether (Singer, 2018). The responsibility to mitigate the consequences of Canada's opioid crisis exists across various disciplines, including healthcare, social services, and psychotherapy. This qualitative study examined the experiences of Canadian social justice-informed counsellors who work with clients who use substances from harm reduction frameworks of care. Seven counsellors were interviewed on their personal experiences implementing harm reduction in psychotherapy. Through a reflexive thematic analysis, five themes surfaced: axiology of harm reduction work, development of therapist surrounding harm reduction, main focuses of harm reduction work, external influences, and barriers to care. This research highlights various facets of working with clients who use substances amidst the current Canadian sociopolitical climate surrounding harm reduction and substance use and discusses potential gaps and implications surrounding the provision of socially just care to people who use substances.

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Table of Contents

Abstract	i
Lay Audience Summary	ii
Acknowledgments	iii
Table of Contents	iv
Chapter 1: Introduction	1
Chapter 2: Literature Review	2
Chapter 3: Method	19
Chapter 4: Results	27
Chapter 5: Discussion	47
Chapter 6: Conclusion	64
References	66
Appendix A - Ethics Approval	75
Appendix B - Recruitment Email	76
Appendix C - Letter of Information and Consent	77
Appendix D - Interview Guide	81

Chapter 1: Introduction

Canada's opioid epidemic has been an ongoing societal concern since the 1990s, and the complex array of consequences that accompany addiction have only been aggravated since the COVID-19 pandemic. Canadian health censuses indicate that death due to opioid toxicity and overdose rose by 91% since the onset of COVID-19 in March 2020 (Government of Canada, 2023). In 2023, 3,970 deaths were recorded between January and June that have been attributed to apparent opioid toxicity, which equates to approximately 22 deaths per day (Government of Canada, 2023). Indeed, people who inject drugs have a mortality risk eight times that of the general population (Ng et al., 2017). These statistics are staggering and highlight the urgency to remedy the harms caused to individuals, families, and society more broadly occurring as a result of opioid use. Society's primary conceptualization of addiction and substance use include messages that abstinence is the only method of success (Brown & Stewart, 2020). This conclusion is rooted in the etiology that addiction is a brain disease that operates without a rational basis underlying behaviour (Marlatt & Witkiewitz, 2010; Pickard, 2020). However, between 40-60% of individuals who graduate from a rehabilitation program for substance use end up relapsing and thus not maintaining absolute abstinence (National Institute on Drug Abuse, 2022b). The requirement of abstinence as the sole trajectory for success not only leads to a sense of failure if these standards and treatment goals are not followed, but also restricts the agency and choices of an already marginalized population (Brown & Stewart, 2020). As well, these standards promote secrecy and inaccurate reporting of use to the helping professionals coordinating treatment. This calls for alternative approaches for those who are not ready or

willing to quit using substances, something many individuals facing such challenges see as a necessary step for improved support as well (McQuaid et al., 2017).

Chapter 2: Literature Review

Etiologies of Addiction

Several different modalities exist to help us conceptualize the nature of addiction. The Moral Model believes that addiction represents some sort of moral failing within the individual affected (Kelly, 2015), and that these individuals possess character flaws that led them to their addiction, such as hedonism (Pickard, 2020). This etiology understands addiction as a personal choice and believes a lack of willpower causes people to remain stuck in the cycle of addiction. Not only does the Moral Model place a heavy degree of personal responsibility on the individuals affected, but it also believes them and what they represent to be contrary to the preferred social order (Kelly, 2015). Thus, the Moral Model sees punishment as the most appropriate course of action, and often resorts to incarceration to force those impacted by addiction to give up substances (Marlatt & Witkiewitz, 2010).

As neuroscience progressed throughout the 20th century, and for the sake of countering the aforementioned Moral Model, the Disease Model of addiction emerged (Pickard, 2020). This etiology is focused on the biological facets underlying addiction and represents it as beyond the control of the individual affected. As with the majority of physical illnesses and diseases, it is seen as a brain sickness that will only progressively get worse without adequate treatment (Kelly, 2015; Marlatt & Witkiewitz, 2010; Pickard, 2020). Although the Disease Model does not believe addiction is curable, abstinence is viewed as the only solution to keep the individual from

spiraling further. This approach shows movement towards a more compassionate direction when compared to the Moral Model, as rather than stigmatize and place blame on the individual, it sees the drugs as where the problem lies (Pickard, 2020). However, this viewpoint still carries several problematic assumptions when it comes to empowering those struggling with addiction. The Disease Model continues to push the narrative that those struggling with addiction are fundamentally different from those who are not addicted to substances. As well, because the behaviours associated with their substance consumption are considered to be compulsively occurring and not rationally motivated, they can be perceived as a group to be feared due to their unpredictability (Pickard, 2020). It is no wonder, then, that belief in the Disease Model of addiction has been correlated with high levels of stigma towards people who use drugs (PWUD) among Canadians (Wild et al., 2021). These attitudes and underlying beliefs lead to increased social ostracization and feelings of hopelessness for those struggling (Pickard, 2020). The Disease Model of addiction is still highly influential today, and although it does begin to shed light on the biological component of addiction and substance usage, it is arguably incomplete.

As an alternative to both the moral and disease models, the Biopsychosocial Model was first proposed in the 1970s and aims to recognize the complex array of factors that influence substance use (Kelly, 2015). This etiology recognizes that individuals carry with them a blend of risk factors and protective factors unique to their own lives, and seeks to uncover effective ways to better cope with the risks and vulnerabilities people are up against rather than condemning their substance use (Kelly, 2015; Marlatt & Witkiewitz, 2010). Within this model, individuals are believed to use substances for reasons that are important to understand, as opposed to their behaviour being merely the result of compulsion (Foundations Recovery Network, 2020; Kelly, 2015). The Biopsychosocial Model also sees addiction as something that is treatable, and it does

not see abstinence as the only pathway towards successful treatment (Marlatt & Witkiewitz, 2010). Indeed, this school of thought believes that mitigating the harms associated with substance use, and using in moderation, can still indicate progress and accomplishment. These premises place the Biopsychosocial Model as the etiology of addiction most closely aligned with the principles of harm reduction.

Harm Reduction and its Effectiveness

Harm reduction has been implemented as an alternative to abstinence-based approaches to treatment in Canada since the 1980s (Cavalieri & Riley, 2012), and has merit as a treatment option for individuals not ready or able to completely prohibit their substance use. Harm reduction principles are rooted in the notions of nonjudgmental and destigmatized access to care and seeks to mitigate the harms associated with recreational drug use without the prerequisite of abstinence as a barrier or caveat to care (Singer, 2018). It has been termed ‘compassionate pragmatism,’ illustrating the understanding that the aim of ceasing all drug use is often idealistic and unattainable (Foundations Recovery Network, 2020). Helping professionals who treat addiction tend to lose sight of the dignity that people who use substances possess when they forget this, sacrificing their own compassion for the unrealistic pursuit of abstinence in their clients. Common harm reduction programs currently being implemented across Canada include opioid agonist treatments (OAT), via methadone clinics or administration of suboxone injections, and overdose prevention strategies, such as the distribution of naloxone kits and development of supervised injection sites (Milaney et al., 2022). These efforts often involve case management and a treatment team, wherein a collective of medical professionals, community support workers,

psychotherapists, as well as culturally significant healers (ex. Indigenous elders) work together to provide sufficient wrap-around care for the individual using substances.

Harm reduction's effectiveness has been well-documented in the existing literature. Interventions in line with harm reduction philosophies have led to reduced reuse of needles and more consistent condom use during casual sex (Perminiene & Fatkulina, 2020), and have been shown to contribute to reductions in preventable disease transmission, fewer calls to emergency services, shorter stays in hospital, and reduced rates of overdose and drug-related preventable death (Ng et al., 2017). Harm reduction and its merits have also been well-documented in Western Europe, particularly in Portugal. Since the implementation of a harm reduction approach to tackle the country's opioid crisis in 2001, Portugal has reduced its overall rate of HIV/AIDS transmission, overall rate of drug use, and number of overdose deaths, particularly through decriminalization and better access to education and treatment for PWUD (Greenwald, 2009).

Harm Reduction and Drug Policy in Canada

Canada possesses a long, complex history relative to drug use, gatekeeping, and prohibition of substances. This includes a variety of political approaches implemented to mitigate the impacts drug-related harms have had on broader society. Much like in the United States, Canada instilled a period of drug prohibition in the early 20th century, which continues to shape current perceptions surrounding the morality of substance use (Cavalieri & Riley, 2012). Many of these prohibitionist attitudes were rooted in racist views against minority groups, such as the bans placed on opium targeting Chinese newcomers in North America (Canadian Drug Policy Coalition, n.d.; Denning & Little, 2011). In the 1960s and 1970s, rates of drug

consumption soared, as drug experimentation became embedded in North American youth culture (Cavalieri & Riley, 2012; Aikins, 2015). This rise in experimentation placed a heavy burden on Canada's court system due to high rates of drug-related incarcerations, mainly for young people (Cavalieri & Riley, 2012).

In 1969, the De Lain Commission was formed to research the most appropriate and effective means of dealing with this growing societal concern surrounding drugs, and results led to several recommendations in favour of decriminalization and drug treatment options; however, these suggestions were never implemented (Canadian Drug Policy Coalition, n.d.; Cavalieri & Riley, 2012). Likely heavily influenced by the War on Drugs occurring in the United States, Prime Minister Brian Mulroney instilled Canada's National Drug Strategy in 1987, who declared drug use in Canada as an epidemic undermining Canadian society (Jensen & Gerber, 1993). Although this new drug policy was presented to the public as focused on compassionately allocating resources towards drug treatment options, the majority of efforts were directed towards drug criminalization and punitive measures to control substance use. Furthermore, the Controlled Drugs and Substance Act of 1997 continued to propel the narrative popularized by the War on Drugs, and heavily served to stigmatize and demonize PWUD as individuals in need of punishment rather than humane treatment (Canadian Drug Policy Coalition, n.d.; Cavalieri & Riley, 2012).

Harm reduction initiatives began in Canada's major cities in the 1980s as controlled drinking programs and needle exchange services, in response to the growing rate of HIV infections among injecting drug users (Cavalieri & Riley, 2012). By the late 1980s and early 1990s, nonprofit organizations began advocacy and education workshops dedicated towards harm reduction, and OAT programs became more common across Canada. The 1990s saw a

heightened number of drug overdoses and blood-borne disease infections, particularly in inner cities, and a public health emergency was announced in 1997 due to a swift climb in rates of HIV/AIDS infections among injection drug users in Vancouver's Downtown East Side (Canadian Drug Policy Coalition, n.d.; Cavalieri & Riley, 2012). At this time, approximately 1 in 3 injection drug users in inner-city Vancouver were estimated to be living with HIV, which were considered the highest rates of infection among PWUD in the Western world (Cavalieri & Riley, 2012). Activists began protesting, demanding change and better conditions for PWUD, and unofficial safe injection sites opened as a means of creating safe spaces for at-risk individuals, in spite of their illegality (Canadian Drug Policy Coalition, n.d.). Canada's first nonprofit drug user's union, the Vancouver Area Network of Drug Users (VANDU), was founded in 1997 in response to the lack of care and regard for safety towards PWUD. The organization and its dedication towards advocacy helped to pave the way for harm reduction to become a valid and respected approach towards mitigating drug-related harms facing Vancouver, and in 2003, North America's first legal supervised injection site was opened (Canadian Drug Policy Coalition, n.d.).

Despite these incredible strides towards normalizing harm reduction as an appropriate and effective measure against drug-related harms, these progressive changes were certainly met with resistance. The Harper government tried to eradicate the strides made in favour of harm reduction by promoting criminalization of drugs and made efforts to shut down Vancouver's safe injection site (Canadian Drug Policy Coalition, n.d.; Cavalieri & Riley, 2012). By comparison, the Trudeau government has made more positive strides to re-instill harm reduction measures as reputable, such as the legalization of cannabis in 2018, but attitudes towards PWUD rooted in stigma and stereotypes continue to persist across Canada, and acceptance of harm reduction as a

viable strategy to manage Canada's opioid epidemic is still considered controversial. Certain communities, such as Vancouver, appear to be liberal-minded in their approach to harm reduction, with initiatives such as naloxone distribution and low-barrier services uniquely catered to women and expecting mothers who are actively using drugs (Cavalieri & Riley, 2012). On the opposing end of the spectrum, we see communities and organizations still operating within the discourses popularized by the War on Drugs, with Alberta notably holding more conservative views regarding harm reduction (Cavalieri & Riley, 2012).

Social Determinants of Health, Intersectionality, and Substance Use

When discussing the risks factors that contribute to the likelihood of engagement in unsafe substance use, one cannot ignore the impact of social determinants of health and must mindfully take note of the intersections disproportionately impacted by substance use and how this is connected to structural power and privilege. Social determinants of health refer to the economic and social circumstances that contribute to overall health outcomes, and include variables such as income, community safety, housing, education, access to healthcare as well as nutritious food and clean water (Centers for Disease Control and Prevention, 2022; World Health Organization, n.d.). Social determinants of health such as exposure to discrimination and/or violence, social connectedness and inclusion, and access to resources are particularly pertinent in their relation to substance use and one's vulnerability to use, and must be understood as part of the complex interplay of risk factors underlying addiction and substance use from a biopsychosocial perspective (Canadian Mental Health Association Ontario, n.d.)

In relation to this notion, statistics show that Canadians from equity deserving groups are being impacted by substance use-related harms and the opioid crisis to a greater extent. For

instance, Indigenous Canadians who use drugs are more likely to suffer from drug-related preventable diseases such as HIV, experience or even die due to drug overdose, and are less likely to receive appropriate services or treatment, as was observed throughout British Columbia (Urbanoski, 2017). Men have been documented to experience higher rates of illicit drug use and drug-related deaths, but women also have unique challenges related to substance use concerns, such as a lack of evidence-based treatments being tested with women populations prior to being prescribed or utilized and potentially a greater likelihood of relapse (National Institute on Drug Abuse, 2022a). In addition, research suggests that people from LGBTQ+ identities are more likely to struggle with substance use concerns and to need substance use-related treatment compared to their heterosexual counterparts (Medley et al., 2016). It is important to recognize not only populations more likely to engage in substance use, but to also consider those who are disproportionately affected by drug-related harms to garner a nuanced understanding of the unique barriers that equity-deserving groups are facing amidst the Canadian climate surrounding drugs today.

Substance Use and Stigma

Stigma surrounding substance use is reported as a key factor in why PWUD choose to partake in drug consumption alone, which raises the risk of overdose and drug-related death (Papamihali et al., 2020). Perceived stigma has also been associated with greater levels of anxiety and depression, and negatively correlates with self-esteem and quality of sleep among those who use substances (Birtel et al., 2017). Internalization of societal stigma may keep people who use substances from accessing treatment, as they are taught to think of themselves as undeserving of a better life characterized by greater levels of safety and happiness (Evans, 2019).

Stigma is also reported as a common barrier to care for PWUD in accessing appropriate healthcare treatments, particularly among Indigenous communities (University of British Columbia Applied Science, 2022). Because substance use carries with it certain health and medical risks, access to healthcare is an important component to wellness. However, individuals who use substances appear to possess distrust in the healthcare system, and often perceive the medical professionals providing care as possessing stigma towards them and treating them as less valuable patients (Cockroft et al., 2019; Garpenhag & Dahlman, 2021).

On top of the initial layer of stigma experienced by all individuals who use substances, communities that already face additional degrees of societal oppression and disadvantage seem to experience an added layer of stigma, also known as ‘double stigma,’ when they are also engaging in substance use (Scott & Wahl, 2011). We see this additional degree of discrimination and stigma perceived by racialized men who use substances, which leads to increased levels of social avoidance (Scott & Wahl, 2011). Stigma surrounding substance use also appears to be experienced disproportionately by women, as well as being reported as a barrier to substance abuse treatment more often by women than men, potentially indicating the effects of double stigma (Meyers et al., 2021; Stringer & Baker, 2018). This double stigma may also be experienced within the communities that individuals who use substances belong to, such as increased discrimination towards intravenous drug users rather than those who consume drugs using other methods (Evans, 2019). These studies further point to the need for an anti-oppressive and agency promoting approach to care for people who use substances, a characteristic key to the harm reduction philosophy. With the efficacy of harm reduction approaches well established, and with treatments offering interdisciplinary care from various professional perspectives being a key

component of harm reduction strategies, one is left to wonder what role psychotherapists play when working with people who use substances in the counselling space.

Harm Reduction in Psychotherapy

The existing research on how harm reduction is implemented in the context of psychotherapy specifically is limited but does exist. Dr. Andrew Tatarsky created Integrative Harm Reduction Psychotherapy, which views substance use as biopsychosocial in origin, highly multifaceted and individualized (Foundations Recovery Network, 2020). This approach to addictions treatment combines psychodynamic, cognitive-behavioural, humanistic, and biological approaches to support and facilitate positive change in the client's life (Tatarsky & Kellogg, 2010). The goal is to mitigate the harms associated with problematic substance use, rather than to prioritize abstinence for all clients regardless of their context. With harm reduction psychotherapy, there is also no prerequisite for the client to abstain from use before they are allowed to access treatment (Denning, 2002), and it becomes possible to analyze the cognitive or psychological motivations and pain underlying one's substance use, something not considered relevant with a Disease Model of addiction (Vakharia & Little, 2016). As one would expect, further research into likelihood of substance abuse counsellors implementing harm reduction approaches to treatment correlates negatively with adherence to and belief in the Disease Model of addiction (Madden, 2016). In opposition to the disease conceptualization of substance use, harm reduction-based therapies aim to combat societal stigma towards people who use substances, empower clients, and uphold human rights throughout psychotherapeutic treatment, no matter where a client may be in their personal walk with addiction.

Because harm reduction psychotherapy actively embraces the idea of tailoring treatment based on the client's unique profile of strengths and needs, there is no universal method of incorporating harm reduction into the counselling space (Denning & Little, 2011; National Harm Reduction Coalition, n.d.; Tatarsky & Kellogg, 2010). However, there appear to be certain strategies commonly equipped to provide adequate service. One of these includes facilitating access to harm reduction services in the broader community, such as needle exchange programs and OATs, which requires networking and an awareness of the community resources that are available (Tatarsky & Kellogg, 2010). Resistance to change, and ambivalence towards abstinence is not viewed as a lack of client participation, but as an important and natural step in the change processes that lay ahead of them. As well, collaboration and a facilitative therapeutic relationship between the counselor and client is seen as crucial to success in creating sustainable and realistic changes that suit the unique needs of the individual receiving treatment (Tatarsky & Kellogg, 2010; Foundations Recovery Network, 2020). This emphasis on client-centered practice steers away from the authoritarian relationship between client and therapist that focuses on controlling the former's behaviour, as is often the inevitable result in Disease Model treatments where the counselor is highly directive of the client's goals (Denning & Little, 2011). Instead, harm reduction-focused therapy highlights the importance of working with the client on their own terms, and rightfully restores and promotes client agency (Tatarsky & Kellogg, 2010). Indeed, the importance of the therapeutic alliance cannot be understated within the context of harm reduction-focused psychotherapy, as a positive therapeutic relationship can serve a healing purpose in itself by restructuring narratives surrounding the client's relationships to others, regardless of their substance use (Foundations Recovery Network, 2020).

A strategy commonly implemented by psychotherapists adopting a harm reduction approach is motivational interviewing, wherein the therapist meets the client where they are at in terms of changing their substance use as opposed to forcing change upon them (Logan & Marlatt, 2010). Together, the therapist and client explore the impacts of the client's substance use and/or addictive behaviours on their lives, and what advantages and disadvantages might come with making changes to these patterns. Of course, when using motivational interviewing, it is important that harm reduction strategies are appropriately implemented based on the client's stage of change (Mancini & Linhorst, 2010). Harm reduction techniques are often a great method to kickstart progress for clients in the contemplative and precontemplative stages of treatment when motivation to change is still low or non-existent. This strategy offers a non-coercive pathway for the therapist to begin making healthy changes with the client regarding their substance use.

When utilizing a harm reduction framework, therapeutic progress is viewed and measured by different standards compared to an abstinence-based treatment (Logan & Marlatt, 2010). Whereas abstinence-based treatments might see somebody only reducing their consumption rather than completely refraining from substance use as a failure, and potentially even grounds for removal from treatment, harm reduction-based services would see any movement towards reducing consumption, or reducing risks associated with consumption, as an indication of progress. Not only do harm reduction approaches to therapy offer a low-barrier treatment option, but they can also be applied to a diverse client base. Although harm reduction is traditionally thought of as an applicable treatment option for PWUD, it can also be implemented to serve clients struggling with a variety of addictive or potentially harmful

behaviours, such as excessive alcohol consumption, engagement in unsafe sex, binge eating, and self-harm (Logan & Marlatt, 2010; James et al., 2017).

Counsellor Attitudes and Education Surrounding Harm Reduction

Counsellors' personal opinions on harm reduction treatment options may make them more or less likely to implement harm reduction strategies with clients. The majority of psychotherapists appear to view harm reduction positively and seem to possess similar opinions and acceptance towards harm reduction when compared to helping professionals of different fields, such as social workers or those specializing in substance abuse treatment (Jordan, 2021). Ultimately, counsellors who possess an orientation towards social justice and higher levels of empathy for their clients seem to be more in favour of harm reduction as a treatment option (Jordan, 2021). Support for harm reduction has also been shown to positively correlate with more experience working with people who use substances, living in a city or more urban area, and experience with those close to them having had substance use problems (Kyser, 2010). Access to adequate clinical supervision and guidance or having the opportunity to consult with other members of a treatment team may also be an important contributor to a counselor's willingness and confidence in implementing harm reduction, as was the case for professionals working in community mental health settings (Mancini & Linhorst, 2010).

Counsellors also appear to view harm reduction more positively under certain conditions rather than others. For example, psychotherapists and addictions treatment professionals in the Netherlands were more likely to view controlled use as an appropriate goal for clients who struggle with use of certain substances, such as alcohol, but were less likely to endorse controlled use for clients struggling with use of illicit drugs, such as cannabis and cocaine (Schippers &

Nelissen, 2009). This viewpoint appears to be consistently held by American students in addictions services training, although controlled use of cannabis was seen as a more acceptable treatment modality in comparison (Davis & Lauritsen, 2016). This may indicate a spectrum of acceptability in terms of harm reduction endorsement, wherein controlled use of normalized or legalized substances is viewed more favourably than non-abstinence treatment approaches for illicit, more socially stigmatized drugs. There also appears to be a trend in harm reduction's acceptability regarding goal finality and client progress. Professionals and students alike appear to view moderated substance use as an appropriate midway goal for clients on a journey towards eventual abstinence, but less favourably as a final goal in and of itself (Rosenberg et al., 2020). This could potentially indicate a discomfort and hesitancy that psychotherapists and those pursuing addictions services training possess with regards to embracing harm reduction as a viable and reputable strategy of mitigating harms associated with substance use on its own terms, without an expectation of eventual abstinence. Harm reduction approaches may also be implemented more frequently when the client's substance use and its impact is determined to be less severe (Rosenberg et al., 2020). Research also indicates a slight variance in harm reduction's acceptability regarding controlled use approaches across cultures, likely based on regional norms surrounding drug use and its social acceptability. For example, Canadian professionals who work with individuals who use substances appear to view harm reduction more favourably than their American equivalents but are more hesitant about it than addictions professionals from Europe and Australia (Rosenberg et al., 2022).

Another critical matter is whether psychotherapists are receiving adequate education or professional development opportunities that allow them to feel competent in implementing harm reduction approaches with their clients. One study showcased that psychotherapists and social

workers practicing harm reduction psychotherapy largely recall being formally educated and trained in the 12-step or abstinence-based model when learning to treat clients who struggle with substance use (Milet et al., 2021). Counsellors in training have stated that their early educational experiences, including drug prevention programs targeted at youth, instilled fear and stigmatizing beliefs surrounding drugs, addiction, and the individuals who are struggling with it, that have contributed to difficulties in empathizing with clients who use drugs (Buser et al., 2022). In the past, therapist training surrounding substance use treatments seemed to be largely reliant on referrals to abstinence-focused programs, such as Alcoholics Anonymous or Narcotics Anonymous, which may not cater to the individualized needs of a diverse client base (Denning & Little, 2011). Further, counsellors receive a certain narrative that substance use is a complex issue requiring treatment in privatized, specialized facilities, and may feel as though they cannot alleviate suffering or make positive changes for their clients as general practitioners (Denning & Little, 2011). In addition, research suggests that mental health professionals, by and large, only come to adopt the harm reduction approach through their own frustrations regarding addictions treatments and the traditional narratives surrounding substance use, rather than due to any formal training (Milet et al., 2021). This may indicate a relevant gap in the training offered to those practicing psychotherapy and could potentially highlight a major barrier to harm reduction's utilization in the counselling space.

Despite these concerns, research also suggests that certain strategies may be helpful in increasing psychotherapists' comfort in working with people who use substances. A study of counsellors in training showcased that greater exposure to and interaction with individuals experiencing addiction allowed them to re-evaluate their pre-existing thoughts and beliefs surrounding addiction and substance use (Buser et al., 2022). This research may offer potential

solutions to mediate practitioner discomfort and reservations surrounding service provision for PWUD, and thus create lower barrier services for this population.

The Present Study

It has been established that harm reduction is an effective and anti-oppressive alternative to abstinence-only treatments for people who struggle with substance use, that Canada has been implementing harm reduction initiatives and strategies since as early as the 1980s to combat the Canadian drug crisis, and that harm reduction can and has been adapted to fit the psychotherapeutic context. Despite this, there is very little research on whether and how today's Canadian psychotherapists implement harm reduction techniques, knowledge, and philosophies when working with people who use substances in the counselling context. More research is needed to uncover what the core experiences are of psychotherapists implementing counselling for clients who use substances during this critical paradigm shift in Canadian society, wherein harm reduction approaches are proving themselves as a low-barrier and effective manner of mitigating harms relevant to substance use. Despite its documented efficacy in the available literature, Canada still approaches the topic of harm reduction as a divisive issue, with sociopolitical attitudes varying widely between cities and provinces (Cavalieri & Riley, 2012). Therefore, one is left to wonder how psychotherapists have been taught to conceptualize and treat substance use, and the degree of training and professional development available to them for the purpose of education on harm reduction philosophies, skills, and strategies. Based on all of these variables highlighting the research gap of harm reduction psychotherapy in a Canadian context, the present study seeks to address and explore the following question: what is it like for

social-justice informed counsellors to work with people who use substances from a harm reduction framework of care?

Conceptual Overview

The purpose of the present study is to gain insight and understanding from the perspective of Canadian professionals who practice psychotherapy, as well as students training to practice psychotherapy, who are members of the Canadian Counselling and Psychotherapy Association (CCPA)'s Social Justice Chapter or adjacent to members. This specific sample was chosen for the purpose of increasing the likelihood of hearing from those who are cognizant of harm reduction strategies when treating substance use. The hope is for social-justice-driven professionals to present practice-based evidence concerning what works and what does not when adapting harm reduction principles to psychotherapy, as well as their own thoughts, feelings, and perceptions on harm reductions in terms of its efficacy of care. Although current research and theoretical frameworks suggest that an integrative approach to psychotherapy best reflects the philosophies surrounding harm reduction, the present study adopts a bottom-up approach towards gaining insight on what strategies and theoretical perspectives today's therapists have found effective in promoting harm reduction through their own experience in practice. The theoretical framework aligning with this research and its conceptualization towards drug use is anti-oppressive in nature, wherein addiction is viewed as influenced by not only biological and psychological vulnerabilities, but also social determinants of health, structural oppression, and the inequitable distribution of power and resources (Brown, 2019). Trauma and violence-informed frameworks also serve to guide this research. Within the context of client-centered harm reduction approaches to substance use treatment, trauma and violence-informed care

(TVIC) can be defined as an awareness and recognition of the impact trauma has had on the lives of clients, which includes their substance use, and making conscious efforts to avoid re-traumatization (Marchand et al., 2019; Vakharia & Little, 2016). Retraumatization at the hands of a clinician or helping professional might appear as inappropriately exercising one's authority, using language meant to stigmatize or shame the client, and being excessively intrusive towards the client. As well, the person seeking help feeling as though they have agency and expertise over their own life is a crucial component to anti-oppressive and trauma-informed care. By adopting an anti-oppressive and trauma-informed view of substance use, this research is representing the problem as lying within a multifaceted interplay of influences that impact individuals, families, and society more broadly, rather than placing blame strictly on the individual or problematizing the substances themselves, which would further perpetuate the stigma experienced by this population.

Chapter 3: Method

Because the present study seeks to understand the experiences of its participants in great depth as its chief aim, the research method is primarily qualitative in nature (Hammarberg et al., 2016). Specifically, the present study seeks to help researchers understand the key experiences of psychotherapists who work with people who use substances within the context of Canada and its current political and social climate surrounding drug use and harm reduction. Due to the priority of understanding and encapsulating the lived experiences of the participants, this study fits best within the framework of phenomenology (Creswell et al., 2007). Phenomenology aims to specify the commonalities possessed by a small group of individuals who share familiarity with and/or

expertise regarding a certain experience or phenomena and aims to highlight the key thematic qualities that best describe these identified similarities across participants, for the purpose of best capturing what that experience is truly like. Specifically, this study adopts a hermeneutic phenomenological approach, which assumes that individuals assign personalized interpretations to their experiences (Neubauer et al., 2019); this includes the researcher conducting the study, and thus the hermeneutic model acknowledges that the observer is not without bias when engaging with the research process and will always play an active role in the data collection and analysis processes. Rather than seeing it as a limitation, hermeneutic phenomenology chooses to acknowledge the value of the researcher's own interpretations and views, as this prior subjective knowledge ultimately informs and empowers them to engage in their inquiry to begin with. The hermeneutic phenomenological approach to research aligns most appropriately with the constructivist research paradigm, wherein reality is believed to largely be socially constructed and dependent on one's subjective understanding within their context (Western University, 2022).

One approach utilized by the researcher in order to remain conscious of their own biases, assumptions, thoughts, and feelings was engaging in frequent reflection regarding these experiences when conducting, analyzing, or otherwise engaging with their research, which was done through a reflexive journaling process (Ramsook, 2018). Not only was this process meant to differentiate between the interpretative experiences of the researcher and the participant, but to assist in maintaining the researcher's immersion within their work to enhance access to thematic elements and essential components that reflect more nuanced understandings of the subject matter.

Researcher Positionality

In tandem with the hermeneutical phenomenological approach, wherein the researcher's views and positionality are inherently tied to their understanding and interpretation of their research, I would like to reflect on my own identities and experiences as a researcher and psychotherapist-in-training to provide context to this study. I am a Métis and white settler cisgender female and current student in my final year of the MA Counselling Psychology program at Western University. I am currently training as a psychotherapist through an internship at a post-secondary counselling centre, with a background working in social services for two years with vulnerable adults transitioning out of homelessness in London, Ontario, many of whom were either formerly or currently using substances.

I first became acquainted to the concept of harm reduction through a professional development opportunity as a Peer Support Counselling volunteer when I was an undergraduate student, and continued to learn about harm reduction through my aforementioned work experience in non-profit agencies aimed at alleviating homelessness and its impacts on those who experience it. Through my work experience, I met and created meaningful bonds with many people who faced extensive oppression, discrimination, and stigma due to their substance use, and became aware of the barriers faced at both an individual and organizational level regarding the advocacy of rights for people who use substances and their acceptance in society. I became angry and discouraged that, despite the urgency of Canada's opioid crisis, I continued to observe injustices in my communities directed towards people who used substances and saw them continuously denied care and compassion. Throughout my work experience, I unfortunately lost many people I had once known due to opioid-related deaths such as overdose, and I continue to mourn and remember them as I engage in my research.

I was inspired to engage in this study through the informal and experiential learning I underwent, and the transformative relationships I formed during this time. I have reflected on my own intersections, background, and privileges, and the opportunity I have been granted as a Masters student to engage in meaningful research that could potentially benefit some of the most vulnerable members of our society. I believe that the opioid epidemic Canada is facing is a collective responsibility to alleviate, and that each of us can take action to mitigate the harms experienced by people who use drugs and other substances as we navigate our way through it.

Trustworthiness

As part of the process of conducting research using reflexive thematic analysis, the researcher took several steps to demonstrate their commitment to upholding the integrity of their research and their credibility as a researcher. A reflexive journal was kept to process thoughts, feelings, and reactions the researcher has following each interview with participants, and the data was thoroughly engaged with during collection and review prior to and during analysis. This was maintained through reading manually transcribed data several times over and listening to audio recordings of interviews in order to promote a sense of familiarity between the researcher and the data set. Supervision was consulted when questions and concerns arose, as well as for review and feedback on themes identified by the researcher within the data. All of these actions are examples of the promotion of credibility, as is outlined by Nowell et al. in their recommendations surrounding trustworthiness in research (2017). An audit trail or maintenance of records and documents demonstrating how and why the researcher reached the conclusions they did throughout their engagement with and analysis of the data was also maintained to promote reflexivity and thoughtfulness throughout the research process.

Participants

All study procedures were approved by Western University's Research Ethics Board (Appendix A) before participant recruitment commenced. To promote the research, a mass email (Appendix B) was sent to all members of the Canadian Counselling and Psychotherapy Association's Social Justice Chapter. Eligibility was restricted to either members of the Social Justice Chapter, or adjacents to members who were interested in contributing to the study granted its topic and if they felt they could provide their expertise on the subject matter; this purposive sampling approach, wherein individuals were intentionally chosen to participate based on their level of expertise regarding, or experience with, the subject matter (Ramsook, 2018) was selected in order to increase the likelihood of interviewing counsellors that are cognizant of anti-oppressive and trauma-and-violence-informed-care (TVIC) within the context of psychotherapy, and the importance of these approaches when working with clients facing heavy societal stigma and prejudice, such as individuals who use substances. Chapter members were informed that they could relay study information to their adjacents as well as the researcher's contact information. Those interested in participating contacted the researcher through email and were sent the Letter of Information and Consent Form (Appendix C). Once this was signed and sent to the researcher, an interview was scheduled and participants received the Interview Guide (Appendix D) to prepare for the aforementioned interview. Participants were given the opportunity to ask the researcher questions regarding the study before the interview commenced and gave verbal consent once more to move forward. Participants were compensated with \$10 Tim Hortons electronic gift cards for contributing to this research. Aside from one's status as a professional that practices psychotherapy (or is qualifying to practice psychotherapy), having

experience working with people who use substances within the context of work as a counsellor or psychotherapist, and either their membership in CCPA and its Social Justice Chapter or being adjacent to a Chapter member and interested in social justice motivated research, there was no exclusionary criteria.

The sample consisted of seven mental health professionals who practice psychotherapy (or are qualifying to practice psychotherapy). Participants were recruited over the course of four months, after which additional interest in the study could not be garnered. Table 1 for participant demographics. See Table 2 for career-specific participant demographics.

Table 1

*Demographic Characteristics of Participants**

Participant ID	Age Range	Gender Identity	Ethnic Identity	Racial Identity	Class Identity	Religious Identity	Disability
Participant One	20-30	Cis Male	Irish and Italian	White	Upper Middle Class	None	Yes, ADHD
Participant Two	30-40	Cis Male	Canadian	White	Upper Middle Class	Athiest	No
Participant Three	30-40	Female	Caucasian	White	Middle Class	Spiritual	No
Participant Four	20-30	Female	White Settler	White	Middle Class	Spiritual	Unsure; possible neurodiversity
Participant Five	50-60	Cis Female	Canadian	White	Upper Middle Class	Christian	No

Participant Six	20-30	Female	Irish and British	White	Middle Class	Agnostic	No
Participant Seven	60-70	Cis Female	Caucasian	White	Upper Middle Class	Agnostic	No

Note: one participant was not included in final analysis due to lack of counselling experience (demographic information not included)

Table 2

*Career-Specific Demographic Information of Participants**

Participant ID	Employment Setting	Number of Years since Registration	Registration Status	Highest Degree Attained
Participant One	Private Practice	1	RPQ with CRPO	Masters
Participant Two	Private Practice	4	CCC with CCPA, RCT with Nova Scotia College	Masters
Participant Three	Private Practice, past experience in Public Sector	4-5	RP with CRPO (Ontario), RCT with Nova Scotia College	Masters
Participant Four	Community Counselling Agency	<1	RPQ with CRPO	Masters
Participant Five	Private Practice	5	OCSWSSW, MSW	Masters
Participant Six	Community Mental Health Agency	1	RSW	Masters
Participant Seven	Higher Education, Private Practice	23	Cpsych	PhD

Note: one participant was not included in final analysis due to lack of counselling experience (demographic information not included)

Data Collection

Data was obtained through seven semi-structured interviews. Interviews were conducted electronically through Zoom and lasted approximately 20 to 60 minutes. The interview consisted of nine open-ended questions, and focused on uncovering what helps or hinders participants' implementation of harm reduction strategies when facilitating treatment for people who use substances, what beliefs and values surround their conceptualizations of harm reduction as a philosophy of care, what thoughts, feelings, and situations tend to arise when a harm reduction approach is pursued, and how the current political and social climate of Canadian society regarding drug use and harm reduction policies influences their likelihood, capacity, or ability to engage in harm reduction-based work with their clients. See Appendix D for interview questions. Interviews were recorded for the purpose of subsequent transcription and further analysis.

Data Analysis

As per the hermeneutical phenomenological approach, reflexive thematic analysis was the primary tool utilized during data analysis in order to facilitate thoughtful engagement with the interview data. Specifically, the six-step model of thematic analysis as outlined by Braun and Clarke (2021) was employed to guide the analysis process through its appropriate stages. The initial stage of analysis, known as familiarization, involved transcribing the audio-recorded interviews and reading through the transcripts several times to become acquainted with the data and gain a base-level understanding (Maguire & Delahunt, 2017; Braun and Clarke, 2021). Once familiarity was established, step two could begin, wherein an open coding process took place

wherein codes were generated and revised upon repeated engagement with the data. This initial organization of the data through the coding procedure lead to the beginnings of emergent, broad themes, which were identified by grouping together salient codes and characterizing their overarching meaning and significance, which were then defined and outlined; this was the third stage of analysis as per the Braun and Clarke model. For the next step, themes were re-examined and discussed with supervisors to promote insight and receive feedback. Sub-themes were also identified and included in order to highlight various key facets underlying each theme that emerged within the data. Themes and subthemes were selected based on their distinction and prevalence within the data, and whether or not they helped to encapsulate the core experience participants reported on (Braun and Clarke, 2021). Microsoft Word software was equipped to assist the researcher in the coding processes necessary throughout analysis. Themes were then formally defined and outlined, followed by the summarization process, or narrating the results within structured writing (steps five and six).

Chapter 4: Results

This study seeks to understand the experiences of social justice-informed counsellors when working with clients who use substances from harm-reduction frameworks of care. Through a thematic analysis of the seven participant's interview data, five overarching themes were identified: axiology of harm reduction work, development of therapist surrounding harm reduction, main focuses of harm reduction work, external influences, and barriers to care.

Theme 1: Axiology of Harm Reduction Work

Social justice-informed counsellors approach their practice from harm reduction frameworks based on the beliefs and values they hold towards the importance harm reduction holds in the therapeutic space. Additionally, the philosophical orientations and therapeutic approaches they adopt to guide their orientation to practice help to inform their use of harm reduction approaches and strategies. Subthemes identified include social justice and trauma-informed practice, pragmatism, and harm reduction as a general counselling principle.

Subtheme 1.1: Social Justice and Trauma-Informed Practice

Six out of seven participants discussed how harm reduction is an approach that offers a humane approach to working with people who use substances, particularly in comparison to models of substance use treatment that strictly require or demand abstinence of clients.

Participant Two spoke about how harm reduction ideologies reject certain dichotomies that may encourage negative beliefs about people who use substances perpetuated by more conservative, abstinence-only attitudes and approaches:

Also I think, in my theoretical framework, it gives people messages about them being okay. It doesn't mock them up in opposition to what is good. It doesn't position them as the black, the dark, the bad in a black-and-white, good-and-bad dichotomy.

Others explained how harm reduction frameworks help to uphold the human rights of dignity, agency, and self-determination of people who use substances as they undergo counselling. Participant Five spoke about how harm reduction helps to facilitate and honour client autonomy, which historically and currently is much more restricted in traditional approaches to addressing substance use:

I think it allows people with substance use issues to have a voice in the creation of their treatment goals, and a lot of the time, individuals don't. They're told what to do and how to do it because the rest of society believes that that's the correct way, or normal way, to live.

Others discussed their awareness of the vulnerability of people who use substances, and awareness of the power psychotherapists and other professionals hold over their clients.

Participant Seven explained how her implementation of harm reduction is guided by this trauma-informed recognition:

I think it is imperative that we take a harm reduction approach. People who use drugs do so because of what's happened to them and what might still be happening to them. So as communities, as societies who wield power over people's lives, we need to take responsibility for that.

Subtheme 1.2: Pragmatism

All seven participants explained how their use of harm reduction approaches is guided in part by the evidence basis for its effectiveness, and the realistic lens it offers regarding substance use as part of our society that requires acceptance of its existence. Participant One spoke about the escalating state of substance use in society as informing his pragmatic understanding of a harm reduction approach to care:

[Harm reduction means] recognition that it's there and it's not going anywhere clearly, it's only gotten more intense I feel as the years have gone on.

Others spoke about the practicality of a harm reduction framework as a means of addressing substance use concerns in their clients. Participant Two discussed that a harm reduction approach is a more effective tool for people who use substances, particularly those that are not sufficiently helped by models of treatment that refuse to acknowledge the realities of their current use:

I think it's probably the only thing that works in a lot of situations... so I think, from the practical side, there are a lot of people not so much helped by messaging that doesn't meet them where they are, by help from professionals that is more about what you should be doing and not about what you are doing. So from a practical standpoint I go, 'in a lot of situations I think it's not just ideologically right, it's the only useful tool.'

Participant Four shared a similar sentiment regarding the rationality of harm reduction models offering a realistic framework to address substance use concerns and foster client well-being:

I think that maximizing safety and well-being should be our goal for everything, and we need to think realistically about the best way of doing that. I think that's a piece too is it's also logical. It's all these other lovely things that I think of but for me it's also rational and logical in terms of being realistic about our goals.

Participant Five acknowledged how harm reduction ideologies simultaneously accepts harsh realities of substance use and the potential clients have for transformative and positive change:

I think it's more of a realistic view of addiction, while still acknowledging the client's ability to change for the better.

Others mentioned that their use of and beliefs surrounding harm reduction approaches is guided by the empirical evidence supporting its implementation with clients. Participant Three expressed how harm reduction frameworks and some of its practical applications have shown promise on both individual and societal levels:

Personal beliefs aside, we know that safer supply, harm reduction saves lives. It can reduce crime in our society, and especially right now when you look at places like Southwestern Ontario where people are dying every week, we need to provide harm reduction to save lives.

Subtheme 1.3: Harm Reduction as a General Counselling Principle

Two participants explored harm reduction approaches as a philosophy that can be applied beyond the scope of substance use to help inform practitioner responses to other potentially harmful behaviours and situations discussed in the therapeutic space. Participant Two spoke about harm reduction ideologies as useful in approaching certain behavioural concerns clients may struggle with:

I have a particular way of thinking about it when it's addictions and substances, and then also I think it's a useful concept in a lot of places, especially when thinking about behavioural stuff? I'm thinking about self-harm or things that people do but then want to not do but find themselves doing. I think harm reduction can show up in those places in similar ways.

Participant Four discussed how the general notion of harm reduction comes to mind across various situations encountered in practice, particularly surrounding safety concerns and crisis situations:

When I think of harm reduction I do think of substance use, but I also think a lot about risk assessment, suicide risk... I think about self-harm, I think about assessing risk around the safety of children and CAS involvement. I think about all of those things that come to mind for me too because I think for me, harm reduction relates to those areas as well, and I think I use a harm reduction approach in my suicide risk assessment and crisis assessment, for example.

Theme 2: Development of Therapist Surrounding Harm Reduction

Social-justice informed counsellors appear to undergo professional and personal development as they learn and reflect on the importance and place harm reduction holds in their practice. Analysis of learned and internalized narratives surrounding addiction and people who use substances, and the purpose of harm reduction approaches helps to foster competence and knowledge in facilitating counselling for clients with relevant concerns. Subthemes identified include knowledge acquisition, reflexive self-analysis, and feelings experienced by practitioners.

Subtheme 2.1: Knowledge Acquisition

All seven participants discussed their process of becoming educated, knowledgeable, and well-read regarding harm reduction through a variety of means. Some mentioned how their formal education included discussion on harm reduction, which helped to facilitate their knowledge. Participant Six speaks about how a certain course she took during her Master's program encouraged the inclusion of harm reduction as part of case conceptualization:

We incorporated harm reduction into our clinical assessments. We had a class about systems of oppression, and so the impact of substances and how that intersects with other systems of oppression, and so I would say that [harm reduction] was brought up in that course a lot.

Participant One also spoke about how certain courses throughout his post-secondary degrees helped to facilitate his knowledge on harm reduction and substance use:

I would say that most of my training would've been within my university courses, so learning about different things, courses about drugs and behaviour... some of the stuff I learned while in my [Master's] program.

Most participants spoke about their knowledge on harm reduction as informally gathered. This tended to occur either through prior work experiences and influences from other disciplines such as field social work, social services, corrections, and healthcare, from consultation and discussion with colleagues or family, friends, and partners, or acquired through self-initiated learning and research. Participant Three expressed criticism towards the lack of harm reduction education and training she received throughout her formal schooling, and explained how her partner's expertise, in tandem with self-directed learning, has helped to facilitate her understanding of harm reduction:

When I think about my Master's program, as much as I loved the program, there wasn't any education about it. I signed up for emails from different training organizations and I never see any emails come out about trainings about harm reduction... mine is all through just seeking it out personally. My partner is a social worker who used to work exclusively in harm reduction and doing street outreach so they're a wealth of knowledge, and whenever I come across something that I didn't have education on in the past, they're someone that I can always go to just to find out what's happening.

Participant Seven explained that independent learning was how she primarily acquired knowledge on harm reduction, as well as through meaningful relationships throughout her practice:

All the learning I've done has been post-degree. Some of it's been formal, much of it has been self-initiated; reading, thinking, watching. The biggest teachers have been my colleagues and my clients.

Participant Two explained how his prior work experiences contributed to his knowledge base on harm reduction, and the potential gap that exists regarding harm reduction discourse in counselling education and training:

[My education and training] comes from other professions basically. I did youth work for a while and then I did some education work building curricula around health. And so, on that side of things, harm reduction is so clear. It's like, this is best practice, this is how the world works, when you're talking to experts this is what they're talking about. And in counselling, there's basically no talk about it. Or in my training in counselling there's basically no talk about it.

Subtheme 2.2: Reflexive Self-Analysis

Four out of seven participants explained how engagement in critical analysis to promote self-awareness and increased understanding of the nuances and complexities embedded in addressing substance use concerns was relevant to their growth and learning as practitioners.

Participant Four explained her own experience with this process of reflecting on her internalized feelings and potential biases surrounding substance use disclosures in psychotherapy:

I think in general it's super important to interrogate and be critical of our own reactions to substance use and our beliefs about certain substances and how... thinking before getting into that situation with a client, how are you going to feel if a client says to you that they're using one substance or another? And so I think for me what's become clear since working with clients is that in my experience, I don't have this intense feeling of needing to respond in a certain way when a client shares with me that they're using a substance.

Participant Five explained how her internalized narratives surrounding appropriate goals in psychotherapy when treating substance use have transformed as she gained further knowledge and experience:

I think when I first started I was thinking that abstinence was always the goal, but what I forgot, and what I realized when I started working with these individuals is that there are relapses and those aren't mistakes, that's just realistic. Everyone's going to have a relapse at some point in their lives and that's okay. The thing is is that you come back from it, and you recognize what you did, and you move forward.

Participant Seven reflected on her growth as a practitioner, and explained that as a new graduate, the institutions she learned and practiced within encouraged dismissive treatment towards people who use substances, but the awareness and realizations brought about through her experiences with clients inspired her to break away from the frameworks perpetuated by the system at the time:

It wasn't until a few years in [to practice] when I started to really understand and listen to clients about the conditions they were faced with in their lives, but I began to read widely and to forge my own way of working that was different from the systems in which I had worked, and cast aside the exclusionary policies that I'd been told about, and it was a really important place of learning and growth for me.

Subtheme 2.3: Feelings Experienced by Practitioners

Five out of seven participants reflected on their personal feelings experienced when working with clients who use substances from harm reduction frameworks. Complex feelings characterized by ambivalence and conflicting emotions were commonly reported, as was a sense of anger triggered by systemic injustice or feelings of helplessness concerning the client's circumstances. Participant One spoke about both the positive and negative feelings he experiences during his practice:

Care and compassion, and a bit of concern whether or not this could go south or badly in terms of suicidal ideation or overdose, or the negative implications of substance use, as well as being intoxicated and then out in public and then interacting with the police or having something negative happen there.

Participant Two describes his experience working with a client struggling with substance use and consulting supervision to debrief on his personal feelings:

I remember a conversation I had with my supervisor once, I forget what I said but it was just something about how I was feeling about this work with someone who was really struggling. And I must've said "man it's just scary" or something like that and I think he said "yeah, and frequently heartbreaking." And I was like 'oh fuck, that's so true' yeah, scary and frequently heartbreaking is pretty right on. On the one side you're like, oh man this is so consequential, this is life and death stuff, in some cases, in the cases I'm thinking of. And you just wish so frequently that stuff would go differently than it does.

Participant Three expressed her frustration regarding systemic injustice for people who use substances:

I just feel angry at the world and how little emphasis we put on saving people's lives who are street involved and using substances.

Theme 3: Main Focuses of Harm Reduction Work

The transference of axiology and knowledge to tangible concepts and subject matter discussed throughout the therapeutic space with clients characterize what harm reduction actually looks like in counselling for social justice-informed practitioners. Subthemes include client-centered approach, safety, functionality of use, and tools and interventions.

Subtheme 3.1: Client-Centered Approach

Six out of seven participants spoke about how a person-centered approach in counselling when working with clients who use substances is a key component of harm reduction in their practice. Allowing the client to create individualized goals surrounding their use, therapist-client collaboration, acceptance of the client as a multifaceted human being with unique strengths and weaknesses, and a focus on relationship and building rapport were some of the facets discussed that characterize this component of their therapeutic process. Participant Two explored how he believes harm reduction shows up in his practice more so through this general attitude or stance rather than any specific tools or intervention techniques:

The stuff that comes forward really is more the person-centered kind of work, the nonjudgment, 'showing up for how people are' stance. It's less about technique and

explicit tools, and more about stance. If in the way that we're working together when we're talking about anything then it's all fine and it's all 'you're okay no matter what you're doing,' then I think harm reduction is almost like an emergent property from that.

Similarly, Participant Five spoke about how she believes harm reduction is intertwined with a client-centered perspective and a focus on supporting clients with their chosen treatment goals, whatever those goals may look like:

I think it's allowing an individual to make an individual choice, their choice. They're the expert in their life, they know what they want, and supporting them with whatever that treatment goal is.

While discussing her growth processes as she gained experience as a practitioner, Participant Six brought attention to the important fact that not every client may choose a gradual approach to substance use treatment and may see abstinence as a better fit for themselves, and that suitable recovery options exist across this broad spectrum of choices:

I'm surprised that some individuals really swear by stopping all together, and they jump to abstaining from drugs when they're ready instead of more of a step-ladder approach. I think I've been surprised that some individuals work well with 'taking a step down, taking a step down' reducing their use, and I've been surprised maybe it isn't the best for everybody and some people prefer and feel better when they jump to abstaining from drugs. So I would say that just has opened my eyes to the wide variety of recovery options for people, and that not everyone wants to engage in some of the harm reduction approaches, so naloxone... the other drugs that [local addictions clinic] offers, for different reasons, and they're just waiting to jump. So again, emphasizing to meet people where they're at, that's really been a shift for me.

Participant Seven discussed the importance of the therapeutic relationship and client acceptance to facilitate meaningful and authentic exchanges during session, as well as the recognition that it takes great courage for a client to be candid with a professional regarding their substance use:

I think it's really important to accept people for who they are and build that relationship that they can count on that is non-judgmental, and that is accepting and really puts dignity

at the front. I feel like sometimes I am trying to repair past breaches of dignity, past experience that they've had where they weren't respected or where they were harmed with other encounters with therapists or programs. It takes a lot for a person to trust that I'm not going to judge them harshly for using, right? And it takes a lot for them to trust that my first reaction to hearing about them using is not going to be calling CAS.

Subtheme 3.2: Safety

Four out of seven participants discussed safety as a key pillar of harm reduction work. For some, this meant placing emphasis on discussing strategies to promote safety with their clients, and for others, they explored their approach of conceptualizing substance use as occurring across a spectrum of risk, wherein some substance use is deemed less harmful than other use. When asked about his personal beliefs on harm reduction, Participant One rejected the notion that all substance use is equally harmful, and that there are safer ways of consuming substances that do not inherently mean one's life is negatively impacted:

There's all these ways of doing things which made it safer and made it more acceptable and you can still participate in it without being absorbed by it or giving yourself entirely to this and having nothing else in your life.

Participant Four discussed how the focus of risk assessment when a client is using substances should be focused less on abstinence and more on prioritizing well-being:

Having [risk assessment] be more framed around 'how can we increase safety as much as possible if the behaviour needs to continue?' Because understandably, very often it's a coping tool, it's a way of managing everything that's going on.

Participant Seven explained how prioritizing the safety of her clients who use substances is incorporated into her practice:

The first thing is safety of the client. So when we talk about substance use, we talk about safe use; where they are, who they're with, if they're confident in at least their own ability to manage their safety when they're using.

Subtheme 3.3: Functionality of Use

Six out of seven participants spoke about the reasons underlying the substance use behaviour exhibited by their clients as a key component of case conceptualization from a harm reduction framework. Participant One explained how recognition of substance use as a coping tool is tied to his understanding of harm reduction:

It represents more of a way of accepting that they're using for perhaps pretty good reasons in terms of coping with what they're going through in their lives

Participant Four explained how she communicates empathy to her clients when they choose to discuss substance use in session, through the awareness of the function it may be serving in terms of coping through adversity:

When this is coming across from the client I also emphasize and validate how often it's a tool for someone in managing overwhelm and managing everything they might be dealing with.

Participant Five discussed how clients may be driven by complex personal histories that contribute to their current substance use, rather than an inability or unwillingness to abstain:

People make choices, and they're making decisions based on the information that they have, whether it's trauma, incarceration, a toxic drug supply...

Participant Six explained the connection between mental health, interpersonal relationships, and substance use in her clients, and the measures she takes to contribute to her client's wellness holistically when recounting her experience with clients who use:

Addressing anxiety symptom management, depression symptom management, healthy relationship education, as problems in mental health and relationships show an increase in their substance use

Subtheme 3.4: Tools and Interventions

Four out of seven participants discussed some of the explicit tools or psychological interventions they may implement with clients who use substances when taking a harm reduction

approach to care. This includes counselling strategies such as psychoeducation, motivational interviewing to assess their client's readiness for change and to promote client change, as well as the construction of maintenance plans to sustain positive changes in substance use patterns.

Participant Two shared that he has used motivational interviewing as a technique in the therapeutic space when addressing substance use concerns:

I think about motivational interviewing and stages of change stuff too in that space. There are explicit tools to draw on there and I found myself in some cases being pretty explicit about using them where I'm like 'you know this school of therapy has this way of thinking about it, where would that position you?' especially stages of change stuff, where I think that could be sometimes a pretty useful tool.

Participant Four explained how psychoeducation on the neuroscience surrounding substance use has been utilized in her work with clients:

I think even just the framing of the neuroscience of it all and what we understand about that and what's going on in the brain. Some clients are super into that side of things, so being able to go there if people want to go there.

Participant Six stated that she incorporates a variety of specific tools and intervention strategies when working through substance use concerns with her clients:

In counselling we work on safety planning and education on the impact of substances, so a lot of psychoeducation on the impact of alcohol and drugs on the brain and body, as well as supporting people in creating a maintenance plan

Theme 4: External Influences

The systemic context in which a social justice-informed therapist operates will inevitably be relevant to their practice and their clients. Several practitioners spoke about how macro-level factors surrounding their therapeutic work impact their experience working with clients from harm reduction frameworks. Subthemes include systemic factors and workplace setting.

Subtheme 4.1: Systemic Factors

Five out of seven participants discussed the impact that broader society has on their experience as practitioners. This included an acknowledgement and recognition of the broader systemic context surrounding substance use and harm reduction in Canadian society today, awareness on the dire status of the current climate surrounding substance use and the opioid crisis in Canada, and awareness of the controversy and divisive opinions surrounding harm reduction's implementation with people who use substances. Also recognized was the need for systemic cohesion and service collaboration to provide sufficient wrap-around care and address multifaceted client concerns. Participant One acknowledged the differing opinions surrounding harm reduction as a substance use treatment approach:

It's more implemented in a lot of communities but there's still a lot of that whole 'Not in My Backyard' mentality

Participant Four similarly shared that she has noticed the controversy surrounding harm reduction in the media surrounding discussions of community-based harm reduction intervention strategies:

A lot of the conversations I've seen are around safe injection sites, and I think it's amazing that there is more push for that, but also difficult in that then as we've seen more of that, we've seen increased pushback and controversy

Participant Three discussed that she has observed increased risk in Canadian society surrounding substance use following the COVID-19 pandemic, particularly impacting street-level substance users:

It's not necessarily my experience working with people that's changed my views but just watching what's happening in the world and what's happening with our substances out on the streets. And I think we really saw that with COVID where there was that disruption in supply chain and substances on the street became more toxic as a result.

Participant Five discussed the need for greater collaboration between service providers in order to sufficiently address the complexity of co-occurring substance use and mental health concerns:

There needs to be more of an integrated approach to mental health and substance use treatment. Right now, we're starting to do that which is really great, but there needs to be more done towards that. I was also a social worker at a hospital, and one of the things I found interesting was that my perspective was that substance use is part of the mental health issue that this person has, and that often they're using a substance to cope with whatever they're experiencing. But from a psychiatric point of view, addiction isn't treated, it's only the mental health disorder or issue. So harm reduction is treating, or not necessarily treating but it's assisting and combining the mental health that's going on for these individuals as well as the addiction because they need to be treated at the same time in order to be successful, I think

Participant Six, on the other hand, spoke about her satisfaction with the joint provision of services when working in tandem with other community counselling agencies to best support her clients:

I would say that CMHA and other local mental health and addiction support providers are on the same page. And so because other community agencies are also teaching harm reduction, then it's a consistent message. A lot of my clients, since I'm not a substance use counselor, I send them to CMHA for specific counselling for their substance misuse, but I still keep them on for mental health, and then they're getting the same messaging about harm reduction, so I'd say that's a positive

Subtheme 4.2: Workplace Setting

Three out of seven participants discussed the nature of their workplace setting as a factor that influences their ability to work from harm reduction-based frameworks. This ranged from differences in private versus public sector psychotherapy regarding characteristics and needs of client base, capacity for a certain workplace setting to service clients, to differences in freedom of therapists to exercise professional judgment versus abiding by agency standards. Participant

Two explained that work in private practice grants the counselor certain privileges surrounding independence:

I guess in solo practitioner private practice I don't run into anybody telling me what I can and can't do very much

Participant Three illustrated how her client base's needs profile shifted as she transitioned from public sector to private practice counselling:

I don't see it now in private practice in the same way, just because being in private practice I see individuals who are generally quite privileged. I do offer a very generous sliding scale because ethically speaking that's very important to me. But even still, I'll have occasional people who are struggling with substance use, but they're generally quite high functioning. When I was at a non-profit in an agency, that was more when I was working with people who were using substances and it was everything from people who are using suboxone, methadone to... I did have a couple clients who did require safe supply.

Participant Six praised her workplace setting for its willingness to accept clients with diverse needs and systemic vulnerabilities that may result in denial of services by other community-based practices:

Our agency really prides ourselves in supporting people where they're at, and we accept clients for counselling who otherwise may be turned away from other counselling agencies. So for example, the criminal charges, some counselling agencies will turn them down. But also, we don't automatically reject somebody because they're actively using, we come up with a plan and do an assessment on how they're coping and whether or not we can engage in counselling depending on their use, but we're willing to. Our agency's policies don't limit us, and so that's facilitating us supporting people

Theme 5: Barriers to Care

Hurdles to providing proper support for clients who use substances from harm reduction frameworks of care were discussed extensively by social justice-informed psychotherapists.

Complicating factors when implementing harm reduction in the counselling space appear to exist at the practitioner, client, and systemic levels, all of which must be understood in order to ease

the facilitation of necessary treatment processes. Subthemes include barriers for practitioners, barriers for clients, and external barriers.

Subtheme 5.1: Barriers for Practitioners

Six out of seven participants spoke about certain obstacles they have encountered regarding their training and implementation of harm reduction-based practice. Most often this focused on competency concerns or recognizing a gap in their formal education and professional training surrounding harm reduction, but also included apprehensions surrounding practitioner liability when working with clients who use substances. Participant Two explained not only the lack of specific knowledge and skills provided to him surrounding harm reduction in his education, but also the attitudes held by certain practitioners surrounding working with addictions:

The way that I was trained, I think they tried to lay down a foundation for everything and not specialize at all, and so they weren't as into 'hey this is how this theoretical framework would work, this is how this setting would work,' it was all just blanket, foundational stuff, so didn't get any of [knowledge on harm reduction] from my training there. Also, I think there's a sense in a lot of the training that I've seen, especially for private practice counsellors, where I am sort of [in terms of] geographical and social location, there's a lot of folks going 'oh you just don't do addictions work, that's for other people so you won't need to know,' which is kind of troubling, as it turns out

Participant Five expressed that she felt unequipped by her formal education and had gaps in her knowledge concerning harm reduction when entering practice:

In my Bachelor's I took one addictions course, and then in my Master's program I chose as an elective to take a course on addiction. And that was the extent of training and I think we touched on harm reduction a bit, but not a lot. So when I first started, I really had to learn a lot about harm reduction.

Despite her aforementioned praises regarding her Master's program incorporating elements of harm reduction into some of her coursework, Participant Six also stated that addictions and substance use courses were not made available in her formal education:

There was no addictions courses in my program so no specific program ever fully addressed substance use

Participant Seven similarly expressed a gap in her formal education experience surrounding harm reduction:

Formal education during my graduate degree? Zippity doo-dah. We didn't learn about it

Participant Four discussed that some psychotherapists may be wary when addressing more high-risk behaviour and situations with clients due to concerns surrounding practitioner liability:

I think it's so hard because I think with something like risk assessment and managing risks, we're sort of given this set of expectations on what that's supposed to look like, or I think there's also a lot of fear that sometimes gets passed on in terms of ethical guidelines and a lot of clinicians are sort of operating from this fear around making sure they're covered if anything were [to happen].

Subtheme 5.2: Barriers for Clients

Five out of seven participants spoke specifically on barriers experienced by either their clients or people seeking help for their substance use more generally. This often revolved around internalized and social stigma, unaddressed needs that may require tending to before counselling can be effectively received, fear of repercussions from the justice system, and unique barriers experienced by vulnerable communities. Participant Five explains that stigma is the most significant barrier she perceives is experienced by her clients:

I think the biggest barrier is the stigma that's attached for people seeking and receiving treatment for substance use disorder, because it often takes the form of discriminatory attitudes, beliefs, even behaviours. It's that stigmatizing language that relies heavily on

the stereotypes to shame individuals, and so, with my clients that is a big part of why they may choose not to seek treatment because of the shame behind people - their neighbours, their family, their friends, knowing that they have a substance use issue. That stigma is huge

Participant Three explains that clients struggling to meet their basic needs may not yet be in a place of stability to address the underlying causes and contributing factors of their substance use, leading to a lack of adequate emotional and psychological support:

Even though there's no services here doesn't mean there aren't people who are using substances or opiates, it just means that they don't have the privilege or the stability to access counselling. It means their basic needs aren't being met whether it's housing or their need for a safer substance, so how could they come to individual counselling to do the trauma work?

Participant Six reported that working with clients involved in the justice system may lead to a lack of candid reporting surrounding their substance use due to fear of legal repercussions and disciplinary action:

A lot of my clients are on probation or federal parole and there's, for some, a risk for additional legal involvement, like additional charges or discipline from probation or parole if they present as high or still actively using. And so since [participant's agency] is removed from the justice system, supporting people where they're at, but also recognizing that we are related to the justice system and the justice system may not have room at this time to appreciate harm reduction work, and so I would say that it's a barrier, having people be open in talking about their substance use because they are trying to protect themselves from further justice involvement, so they're not always willing to disclose what their use looks like

Participant Seven discussed the unique challenges experienced by some Indigenous communities regarding accessing appropriate services to address their substance use concerns:

One of the barriers certainly is further referrals or further work. So one of the things I do is work with clients who are Indigenous and who are using, and there's not a lot of privacy for them in terms of if they really want to focus on their use and reducing their use. Our Indigenous communities are small in terms of people's knowledge of one another's business, and so very often, the people that I work with, they're fine to see me, I'm not a specialist in substance use, but they don't want to be referred or go to someone

who does specialize in that or a program that addresses that because of a lack of privacy in their communities. So that's certainly a barrier for them

Subtheme 5.3: External Barriers

Six out of seven participants spoke about the systemic and external obstacles they have encountered or observed throughout their experience in therapeutic practice. Components discussed included limiting policies and procedures of some counselling agencies, a lack of community resources, and difficulties experienced in the virtual implementation of harm-reduction approaches. Participant One disclosed that a former practice setting had certain guidelines and policies surrounding work with clients, which could have limited his capacity to engage in meaningful work surrounding client substance use:

At [participant's former counselling setting] there were limitations in that you could only see a client for... eight sessions let's say, and then after that, that was their allotment for the academic year. So that would've been a barrier if I had seen someone and they had stuck with me for that amount of time, as well as the implication that it's a school-based counselling thing, and we were emphasized to still focus on their academic performance, even if that's not really what they came here for. They were like, "how are you gonna really emphasize asking 'how is this impacting your school?', 'whether or not you can do these courses that you're in,'" things like that and so those would be more structural barriers from working in a larger organization

Participant Three explained that there is a stark lack of community resources available to clients in her local community:

In Nova Scotia, there's fentanyl here but not in the same way as Ontario or other provinces, and if there was, Nova Scotia would be devastated because our services are just lacking. In the area I'm in, I think there's an agency who maybe comes two or three times a month to do sharps exchange and to provide people sharps, and otherwise... I know there's a day program for opiate usage, and I can't remember if it's methadone or suboxone that they provide... but I don't know what I would do if I had people who needed harm reduction because there's so little here

Participant Five expressed that she has noticed a similar lack of resources in her community and broader geographic region:

I think there's a huge lack of resources, especially in rural communities

Participant Six shared the difficulties of utilizing harm reduction approaches with clients virtually:

I do a lot of phone counselling, so that's one way we limit a barrier, but it adds a barrier where I don't see them, I can't get the visual cues, body language cues of how they're coping. And so I would say that can be a barrier specifically for harm reduction because I'm just going off of what they're reporting to me and how their voice is sounding and how their speech is, and it's been a challenge for some individuals who are actively using because it's so hard to keep them engaged on the phone. We do welcome them to come in-person, but we also serve cities outside of London, we serve people around Ontario... so that's just a barrier I'd say because it's harder to support someone, educate them.

Chapter 5: Discussion

This study explored the experiences of social justice-informed counsellors to work with clients who use substances from harm reduction frameworks of care. Through a thematic analysis of seven participant interviews, five main themes emerged: axiology of harm reduction work, development of therapist surrounding harm reduction, main focuses of harm reduction work, external influences, and barriers to care. The following discussion will contextualize these results within previous research, discuss study implications, review limitations, and offer suggestions for future directions pertaining to research and counsellor education.

Axiology of Harm Reduction Work

All seven participants spoke to some extent about the foundational basis guiding their implementation of harm reduction in the counselling space. Some highlighted their commitment to upholding social justice and human rights for people who use substances as a vulnerable and

marginalized population. Others explored the pragmatic focus of harm reduction as a response to substance use, and the evidence basis underlying it. Others explored applying the general principle of harm reduction more broadly to include behavioural and safety client concerns such as self-harm and suicide risk assessment. All of these appear to fit appropriately in the existing literature. Harm reduction as an alternative intervention to abstinence was founded based on the socially just drive of minimizing barriers to care for people who use substances, with roots emphasizing advocacy for the destigmatization of drug use (Cavalieri and Riley, 2012; Singer 2018). With a history based in social justice demanding improved conditions for PWUD, it comes as no surprise that counsellors are driven in their use of harm reduction based on its emphasis on restoring client agency and autonomy in a traditionally marginalized population. Previous attempts to implement harm reduction into the therapeutic context also place importance on the restoration of human rights, such as agency and autonomy, and tailoring psychological treatments to what the client feels is reasonable and appropriate for their unique context and relationship with substances (Tatarsky & Kellogg, 2010). It has also been observed through previous research that positive opinions surrounding the implementation of harm reduction-related interventions aligns with one's interest and awareness of social justice (Jordan, 2021). An emphasis on social-justice and trauma-informed practice may therefore be an inextricable component of adopting a harm reduction framework when working with clients who use substances, as it inherently sees people who use substances as historically oppressed, mistreated, and marginalized, and seeks to alleviate the systemic harms brought about by drug criminalization and demands of adherence to abstinence, regardless of what the client actually wants for themselves.

Adoption of a harm-reduction approach due to the underlying evidence basis and realistic perspective also appears to adhere to the prior literature. Harm reduction approaches believe that one must acknowledge substances and substance use as realities existing in our society rather than ignoring it or simply casting judgment on it (National Harm Reduction Coalition, n.d.). In addition, harm reduction approaches understand that the complete eradication of substance use in our society is based on unrealistic ideals that have failed when implemented historically (Foundations Recovery Network, 2020). As Participant One had mentioned, a harm reduction lens acknowledges the reality of substance use in our society. Furthermore, harm reduction is informed by a plethora of evidence suggesting it can reduce the rate of overdose deaths and sustain life for PWUD, as well as lessen the transmission of preventable diseases (Ng et al., 2017; Greenwald, 2009). Echoing what was mentioned by Participant Three, harm reduction approaches are necessary in dire circumstances characterized by drug supply toxicity and high rates of opioid-related deaths, as is being documented in the current Canadian climate (Government of Canada, 2022). Harm reduction approaches may also appeal to individuals who cannot realistically maintain abstinence; as was mentioned previously, this may account for up to 60% of people who use substances that graduate from abstinence-based rehabilitation programs (National Institute of Drug Abuse, 2022b). Thus, the need for abstinence-only alternatives is evident and can offer additional options and supports for people who use substances to assist them in maintaining their wellness and safety; social-justice informed counsellors seem to recognize harm reduction as a worthwhile therapeutic approach based on this empirical foundation and recognize its utility based on population need.

Though this specific study focuses on the applicability and implementation of harm reduction surrounding substance use specifically, it was interesting to learn that social justice-

informed counsellors may apply these principles more broadly to other risk-taking behaviours such as self-harm, or situations that potentially compromise client's safety such as suicidality. For instance, both Participant Two and Participant Four spoke about how harm reduction can inform their work with clients who engage in non-suicidal self-injury, wherein immediate abstinence from the behaviour may be unrealistic and unattainable. There is some existing literature suggesting harm reduction approaches can be applied to addictive or high-risk behaviours beyond substance use, such as disordered eating and self-harm (Logan & Marlatt, 2010; James et al., 2017). Ultimately, more research is needed regarding the applicability and efficacy of harm reduction approaches for client behavioural concerns beyond alcohol and drug consumption.

Development of Therapist Surrounding Harm Reduction

All seven participants spoke about either their professional development surrounding harm reduction, or their reflections regarding their experiences and personal growth they have witnessed concerning substance use as a topic of discussion in the therapeutic space. In terms of the knowledge acquisition processes reported by practitioners, this appears to be at least partially consistent with the prior literature. Mancini and Linhorst (2010) suggests that access to adequate clinical supervision and opportunities for consultation with colleagues may contribute to an increased sense of confidence and competency when it comes to implementing harm reduction, as was observed in community mental health professionals. Participant Seven expressed that the biggest impact on her own learning related to harm reduction came from colleagues and clients. The practitioners interviewed reported mixed opinions regarding how adequately their formal education equipped them with the knowledge and skills needed to implement harm reduction approaches in psychotherapy. Some research does support the notion that psychotherapists

typically receive limited training in harm reduction strategies, and substance use interventions taught mainly focus on abstinence-based approaches (Denning & Little, 2011; Milet et al., 2021). Although other participants did mention that aspects of their formal education addressed the topic of harm reduction, they simultaneously reported gaps in their knowledge based on what was provided during their education experiences, suggesting that the extent of harm reduction's presence in formal education for those practicing psychotherapy is inadequate or limited. Furthermore, these participants also recalled acquiring additional information to supplement their comprehension on harm reduction through alternative sources, such as prior work experience, through meaningful consultation with colleagues, or through self-initiated learning opportunities.

In terms of self-reflection and reflexivity reported among some participants, this experience of directing a critical lens towards one's pre-existing beliefs regarding substance use and those that struggle with substances is also reported within the literature concerning harm reduction and the development of helping professionals. Counsellors in training reported that through experience working with clients who use substances, they were able to dissect and reflect on their prior internalized narratives surrounding substance use and addiction (Buser et al., 2022). This suggests that to some extent, development of practitioners regarding their understanding and acceptance of harm reduction as a meaningful avenue to engage with clients who use substances seems to occur through this exposure to the diversity and individuality observed in people who use substances as a population. This makes sense when we consider the basis of the Disease Model of addiction, which positions somebody as different than those who do not struggle with substance use because one of which is afflicted with a biologically-rooted ailment beyond their control and the other is not (Pickard, 2020). In contrast, the Biopsychosocial Model, which aligns most closely with a harm reduction approach,

acknowledges the functionality of substance use as a tool for coping with the suffering human beings more broadly are all potentially vulnerable to, thereby pushing the narrative that people who struggle with substance use are no different than those who do not (Kelly, 2015; Marlatt & Witkiewitz, 2010). This process of personal reflexivity reported on by some participants may reflect a personal transitioning of perspective on the nature of addiction from the more traditional models that were normalized historically towards a more nuanced, flexible, and client-centered understanding of substance use.

Several participants reflected on the feelings they experience when implementing harm reduction approaches within their practice. Emotional experiences commonly reported included being fearful, angry, concerned, compassionate, empathic, heartbroken; some participants spoke about the traumatic aspects that may accompany addictions work. These emotional experiences are not surprising when the current landscape surrounding substance use in Canada is considered. Research suggests that mental health professionals come to adopt and implement harm reduction approaches and interventions with clients through their own feelings of anger and frustration regarding addictions treatments and traditional narratives society perpetuates about substance use, as opposed to through prior training or the framework within which they were educated (Milet et al., 2021). These feelings of anger reported on may serve the function of driving social justice-informed practitioners to adopt more inclusive and low-barrier approaches to supporting clients struggling with substance use. Furthermore, when the mortality rate of people who inject drugs is considered (Ng et al., 2017), it follows that emotions such as concern for client well-being and fear surrounding the client's safety would accompany addictions work. For these reasons, it is pivotal that practitioners working with clients who use substances have access to adequate support systems of their own, as well as competent and thorough opportunities for

supervision to debrief and receive consultation, particularly when working with high-risk clientele.

Main Focuses of Harm Reduction Work

Six out of seven participants reported on some of the core components focused on within the psychotherapeutic setting when working with clients from a harm-reduction framework. This included operating from a client-centered approach, prioritizing clients' safety, exploring the function the substance use serves for the client in terms of coping or underlying vulnerability, and specific tools, interventions, and therapeutic strategies equipped. The majority of these findings appear to be consistent with the existing literature. Dr Andrew Tatarsky's Integrative Harm Reduction Psychotherapy (IHRP) conceptualizes substance use concerns in clients as highly diverse and individualized; no two clients will have precisely the same needs, strengths, and goals (Foundations Recovery Network, 2020). IHRP also recognizes that the etiology underlying substance use struggles are highly multifaceted and adopts a biopsychosocial lens towards understanding substance use. This appears to align with reports from participants on their implementation of a client-centered framework when utilizing harm reduction with clients and maintaining openness to direct the therapeutic process based on the client's unique presenting problem and goals for therapy. As well, the Biopsychosocial Model of addiction maintains that the underlying causes of one's engagement with substances is important to understand to administer support appropriately, which was mentioned by several practitioners when discussing their focus on the functionality of substance use for clients and what might be informing a client's decision to continue engaging in substance use (Foundations Recovery Network, 2020; Kelly, 2015).

As was reported in the pre-existing literature, there appears to be no universal method of incorporating harm reduction into the counselling space because it is so individualized and may look very different from one client to another (Denning & Little, 2011; National Harm Reduction Coalition, n.d.; Tatarsky & Kellogg, 2010). This seems to align with what was reported by practitioners when they discussed the client-centered approach maintained when implementing harm reduction with clients. As Participant Six mentioned, sometimes this means acknowledging that abstinence is the desired goal the client has for themselves and supporting them towards this desired result. This statement brings up an interesting misconception that harm reduction and abstinence are mutually exclusive manners of addressing substance use concerns. Abstinence is not seen as invalid from a harm reduction lens and can certainly be incorporated as a treatment goal for clients, so long as it is what the client chooses for themselves (National Harm Reduction Coalition, n.d.). Unlike abstinence-only services, harm reduction does not *require* abstinence from clients before administering support and treatment; it does not gatekeep services in the pursuit of abstinence. However, if a client sees abstinence as an appropriate goal that aligns best with the future that they want to work towards for themselves, harm reduction advocates should honour and respect the client's autonomy over their own substance use treatment goals and tailor their treatment planning accordingly. Emphasizing client-centered practice and allowing a person struggling with substance use to choose their own treatment goals helps to promote client agency and human rights, and attempts to dismantle the authoritarian relationship dynamic between treatment provider and client often seen in traditional abstinence-only, Disease Model intervention pathways (Denning & Little, 2011).

Several participants spoke about the nature of the therapeutic relationship as non-judgmental, supportive, and empathetic as a key component of their client-centered approach to

care. This is consistent with what is documented in prior literature. Harm reduction approaches tend to position a facilitative therapeutic relationship between counsellors and clients as crucial to success in creating sustainable change, and believe a positive and non-coercive interpersonal dynamic in treatment can serve a healing purpose in itself by restructuring narratives surrounding interpersonal connection and the client's capacity to build meaningful relationships (Tatarsky & Kellogg, 2010; Foundations Recovery Network, 2020).

Commonly utilized interventions and tools when implementing harm reduction that practitioners spoke about were also evident in the literature as recommended angles and approaches to work from harm reduction frameworks with clients. Two of the participants spoke about practical, community-based resources to offer clients struggling with substance use at different points of their interviews, including Participant Three, who explained that within her history of working in the public sector, she had worked with clients who were accessing OATs and on a safe supply program. This is consistent with strategies outlined by Tatarsky and Kellogg (2010), who recommend connecting clients with resources existing within the broader community, and other services that can provide tangible supports to protect the client from drug-related harms. Furthermore, motivational interviewing, which was mentioned by two of the participants as a strategy they commonly use to facilitate and encourage client change non-coercively, is also a known strategy and form of intervention recognized in the existing literature on harm reduction's implementation in psychotherapy (Logan & Marlatt, 2010).

External Influences

Six out of seven participants spoke about how external factors, such as the broader systemic beliefs surrounding harm reduction and substance use, or their workplace setting, influence their practice. Within the existing research and what is known about the Canadian

climate surrounding harm reduction, these reflections are not surprising. Many participants spoke about how despite strides in the acceptance and implementation of harm reduction in more Canadian communities, there exists simultaneously a growing resistance against acceptance of drug use and harm reduction strategies; this has been the case in Canada historically when changes to drug policy and social movements surrounding people who use drugs (PWUD) have taken place (Canadian Drug Policy Coalition, n.d.; Cavalieri & Riley, 2012). Attitudes towards PWUD remain rooted in stigma and harmful assumptions, and across Canada, recent policies in certain regions and provinces continue to reject harm reduction as a viable intervention for substance use and instead pursue more conservative approaches towards tackling Canada's drug crisis. Notably, Alberta's United Conservative Party has instilled policies focusing on "recovery-based solutions" (Chowdhury, 2023), which rejects harm reduction strategies and focuses on abstinence-only care. In 2023, Alberta's opioid poisoning deaths also rose by 25%, alongside this new provincial response to the opioid crisis (Chowdhury, 2023). Only time will tell whether or not Alberta's model for tackling the drug crisis produces fruitful results for their most vulnerable citizens, but current data suggests people continue to be harmed by the lack of viable interventions available to them.

Two participants spoke about their experience collaborating with external care providers, including the benefits and barriers they have observed with circle of care approaches. Wrap-around care is a commonly observed aspect of service provision in substance use treatments, typically through case management and a treatment team, wherein care providers from various professional or cultural disciplines work together to offer sufficient support for the client (Milaney et al., 2022). Participant Six discussed how collaboration with other service providers has offered consistent messaging to clients surrounding harm reduction and safer use and can

provide expertise towards components of care she may not feel competent to offer. On the other hand, Participant Five spoke about how service provision may be disjointed when professionals from other fields come in with their own biases and perspectives on addiction and substance use treatment, which leads to gaps in appropriate care and differing opinions on how best to approach treatment options. Furthermore, as per the Biopsychosocial Model, it is important to address the risks and vulnerabilities clients face that may be contributing to their continued utilization of substances and not to separate a client's addiction from the context in which their use exists (Kelly, 2015; Marlatt & Witkiewitz, 2010). As Participant Five spoke about when recounting her experience, certain professions may not always make the connection between contextual factors and substance use, seeing them as separate entities wherein one can be treated and addressed through services provided and one cannot. It appears as though counsellors who implement harm reduction frameworks encounter a specific barrier wherein different etiologies of addiction may be contributing to a gap in providing sufficient wrap-around services to clients in need, and may benefit from strategies to collaborate with professionals who possess different perspectives surrounding appropriate treatment avenues.

Three participants discussed how their workplace setting impacts their capacity to engage in counselling work with clients from harm reduction frameworks of care. Specifically, two participants explored how private practice counselling tends to grant certain privileges in terms of autonomy for therapists, as well as attracting a certain demographic of clients. This is particularly interesting when we focus specifically on substance use counselling. Participant Two mentioned at a later point of his interview how there exists a belief among private sector practitioners that the skills necessary to engage in addictions counselling with clients are not relevant to them. Indeed, it has been noted in the literature that counsellors appear to receive a

narrative that substance use requires the treatment of specialists and is not for general practitioners to engage in with clients to evoke meaningful change (Denning & Little, 2011). This is particularly troubling when we consider that one in five Canadians will struggle with a substance use disorder at some point in their lives (Carberg, 2023). Given the rate of Canadians who are struggling, or will struggle, with substance use, it is illogical to presume that addiction specialists have the capacity to address any and all concerns related to substances for those who need support. Therefore, it is important for counsellors to recognize that despite certain trends in client demographics, all practitioners should be equipped to work within the realm of substance use concerns with clients.

Barriers to Care

All seven participants spoke about the barriers they have experienced when engaging in psychotherapy from harm reduction frameworks of care. These barriers were identified to exist from within the practitioner, within or surrounding the client, or from the broader environment within which the counselor is administering therapy. The most common barrier identified for practitioners was a lack of formal education and training opportunities related to substance use counselling and harm reduction. As was mentioned when exploring participants' responses surrounding the subtheme of knowledge acquisition, the literature reports that most mental health professionals receive training focused on abstinence-only interventions, with little attention given to harm reduction approaches or strategies to provide client care (Denning & Little, 2011; Milet et al., 2021). As well, several participants spoke about how they either received more foundational training as a budding non-specialized practitioner, or how substance use courses were not offered or only offered as elective courses. This may speak to the aforementioned notion that touching on substance use within the therapeutic space requires a specialist in

addictions work, and that a general practitioner is ill-equipped to explore substance use concerns with clients (Denning & Little, 2011). There appears to be a gap in the professional development resources available to existing practitioners, as well as those in training, when it comes to substance use counselling skills. This is further evident when we look at the subtheme of knowledge acquisition, where several participants discussed that their awareness and comprehension of harm reduction was primarily self-taught or gained through experience in practice rather than primed within their formal education.

Many participants mentioned the barriers that primarily impact their clients and their capacity or willingness to seek support for their substance use challenges. Stigma was named by two participants as the primary barrier they see from within their clients that may inhibit them from receiving appropriate services. Stigma towards people who use substances is well documented in the literature and has been shown to contribute to decreased well-being in PWUD (Papamihali et al., 2020; Birtel et al., 2017; University of British Columbia Applied Science, 2022). Perhaps even more worrying is recognizing that stigma also appears to contribute to a decreased likelihood among people who use substances to ascertain appropriate care and support to address their concerns (Evans, 2019). This finding is especially pertinent if one considers that populations already experiencing marginalization often face what is known as ‘double stigma’ when they are also using substances (Scott & Wahl, 2011). This may mean that not only is stigma a barrier to care for the vulnerable population of people who use substances, but that clients facing additional vulnerabilities and oppression may be even less likely to access appropriate care and reap more negative impacts due to stigma than others. This concept is reflected in Participant Seven’s comment surrounding the lack of privacy available for Indigenous community members who want to seek help for their substance use. It seems there is

a great need for low barrier service availability that can be accessed by people who use substances discreetly, particularly for individuals who come from additional marginalized intersections.

Regarding external barriers, one of the main focuses mentioned by some participants revolved around access to external resources in the broader community. It is certainly possible that a lack of harm reduction resources exist, particularly in certain regions or communities across Canada. As Participant Five mentioned, she notices that rural communities face particular disadvantages when it comes to referrals and access to community programs that can help support people who use substances. It is also possible that practitioners are not made aware of harm reduction resources within their communities of practice. It is imperative that harm reduction programs and community-based accessible resources are made available to people who use substances across Canada, particularly low barrier supports and programs for communities that have historically been denied access to these opportunities. Furthermore, it is important for psychotherapists to be aware of the external resources available in their communities of practice in order to make appropriate referrals for clients who use substances and to provide necessary practical support to maximize client safety. This is also applicable regarding other external barriers that were mentioned, such as Participant One discussing his agency's policy and design, which prioritizes focus on academics and provides a limited allotment of sessions. In cases where a practitioner is facing structural barriers that inhibit their engagement in harm reduction or substance use service provision with clients, it is necessary that they are aware of other programs and agencies accepting clients that are offering substance use treatment options that align with the client's personal wishes and goals.

Implications

There are several implications to be drawn from this study related to counselling research, education and training, practice, and policy. Several participants have alluded to a need for more education and training opportunities within formal education spaces on harm reduction and tackling the topic of substance use within a psychotherapeutic context, even for general practitioners. When one is made aware of the fact that one in five Canadians will struggle with substance use concerns at some point in their lives (Carberg, 2023), it follows that the rate of Canadians in need likely outweighs the number of addictions specialists capable of providing care. If Canadian universities are not equipping new practitioners to enter into the field with the skills necessary to discuss substance use with clients in an anti-oppressive and trauma-informed manner, there is a potential risk that more harm than good can result for those in need of care. This is especially relevant when one considers that stigma already makes seeking out appropriate support that much more of a challenge for people struggling with substance use concerns (Evans, 2019). It is imperative that psychotherapists today are given the skills to feel competent to engage in meaningful work with clients across a spectrum of concerns, including substance use, and that knowledge is not gatekept to further harm and barr services for a population historically underserved and still in need of sufficient and socially just care. Possibilities to supplement practitioner knowledge in formal education could potentially mean engaging in class discussions on substance use and students' pre-existing biases and beliefs surrounding addiction and those who struggle with it. As well, illustrating the connection between trauma, as well as social determinants of health more broadly, and unsafe substance use could be a helpful perspective to instill. Finally, fostering opportunities for students to gain exposure and learn about addiction and the lived experiences of those struggling, either through media such as memoirs and documentaries or a guest speaker who is able and willing to share their personal experience

could help to promote reflexivity and insight. More research is ultimately needed to discern how to best teach and prepare budding mental health professionals going forward to foster competency in working with clients who use substances.

Further, there is a need for greater mental health supports for psychotherapists providing harm reduction to clients who use substances, given the reported emotional toll of substance use counselling amidst Canada's opioid crisis that several participants divulged. This may be formal, such as being enrolled in their own therapy or seeking out appropriate services to manage their distress, or informal, such as through consultation with appropriate supervision for necessary support and assistance, as was shown to be beneficial for other mental health professionals (Mancini & Linhorst, 2010). As well, some participants described experiencing an increased need for service collaboration and sufficient case management to offer multidisciplinary supports for clients using substances. Service collaboration and a multidisciplinary circle of care have been identified as some key components of implementing a harm reduction approach (Milaney et al., 2022), and it follows that counsellors should feel comfortable connecting with relevant service providers in their community to create collaborative relationships focused on best serving clients with complex needs, such as co-occurring substance use concerns and other mental health vulnerabilities that need to be addressed simultaneously.

Finally, it was identified by several participants that community resources, or the lack thereof, play a big role in making harm reduction's implementation with clients possible or not. Not only is there a pressing need for additional resources across Canadian communities that offer harm reduction-based supports and practical services, but it is imperative that service providers are made aware of the resources that exist within their communities and what they entail. As Canada continues to debate the viability of harm reduction strategies to tackle the opioid crisis,

time will tell whether this will involve becoming acquainted with newly funded resources and programs made available in our communities or just by staying informed on the state of existing resources and their degree of accessibility for PWUD.

Limitations and Future Directions

Although this study offers a nuanced look into the experiences of social justice-informed counsellors when implementing harm reduction with clients who use substances, there are limitations worthy of discussion. These limitations primarily exist due to the study's small sample size, such as the lack of marginalized voices included. For example, all seven participants identified as white, highlighting a need for future research to amplify and focus on BIPOC counsellors' input on harm reduction's role in the psychotherapeutic space. Furthermore, all participants were members of the CCPA's Social Justice Chapter or closely adjacent to members; social justice-informed counsellors who are not members of this particular organization may have different views. Further research could provide insight on what the experience of utilizing harm reduction in the counselling space looks for the average therapist in Canada, those who may or may not have social justice organizational affiliations or motivations. Finally, all of the practitioners interviewed were located in either Ontario or Atlantic Canada. As a result, these views may not be shared by mental health professionals practicing within other regions of the country, such as Western Canada, Quebec, and the territories. Further research on the experiences of counsellors within these regions may offer greater insight into this phenomenon, particularly provinces such as British Columbia and Alberta where controversial discourse on harm reduction and opioid response strategies have been evident in the public eye. As well, further information and research surrounding how current counselling education programs are equipping practitioners to work with clients who use substances within the

therapeutic space would be useful to recognize the specific gaps that exist within the formal education process.

Chapter 6: Conclusion

This study explored how social justice-informed counsellors utilize harm reduction strategies and operate from harm reduction approaches in the therapeutic space with clients who use substances. Seven members of the Canadian Counselling and Psychology Association's Social Justice Chapter, or adjacents to Chapter members, were interviewed on their experiences implementing harm reduction with clients. Five themes emerged from their responses: axiology of harm reduction work, development of therapist surrounding harm reduction, main focuses of harm reduction work, external influences, and barriers to care. Key contributions to the literature include what appears to be an inherent link and synchronicity between harm reduction and trauma-informed care for people who use substances, which seek to uphold the dignity and rights of this vulnerable population throughout the administration of care. Implications from this research include the need for more in-depth training provided to counsellors in their formal education surrounding harm reduction approaches, tangible intervention strategies, and skills for working with clients who use substances, as well as increased supports for psychotherapists working with clients who use substances to promote practitioner wellness, greater need for multidisciplinary service provision, and increased awareness and availability of resources for clients in need of harm reduction within the broader community. Future research could potentially focus on the experiences of diverse counsellors from underrepresented identities, the experiences of psychotherapists across different regions of Canada, and an investigation of the

education and training opportunities surrounding substance use available to counsellors today to identify the specific gaps that exist in knowledge acquisition, for the sake of promoting professional development and practitioner competence and confidence when working with vulnerable clients.

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Appendix A: Ethics Approval



Date: 8 March 2023

To: Dr. Jason Brown

Project ID: 122699

Study Title: Harm reduction in psychotherapy

Short Title: Harm Reduction in Psychotherapy

Application Type: NMREB Initial Application

Review Type: Delegated

Full Board Reporting Date: 14/Apr/2023

Date Approval Issued: 08/Mar/2023 11:00

REB Approval Expiry Date: 08/Mar/2024

Dear Dr. Jason Brown

The Western University Non-Medical Research Ethics Board (NMREB) has reviewed and approved the WREM application form for the above mentioned study, as of the date noted above. NMREB approval for this study remains valid until the expiry date noted above, conditional to timely submission and acceptance of NMREB Continuing Ethics Review.

This research study is to be conducted by the investigator noted above. **All other required institutional approvals and mandated training must also be obtained prior to the conduct of the study.**

Documents Approved:

Document Name	Document Type	Document Date	Document Version
Interview Guide	Interview Guide		
Email advertisement_CLEAN	Recruitment Materials		
LOI_CLEAN	Verbal Consent/Assent	07/Mar/2023	2

Documents Acknowledged:

Document Name	Document Type	Document Date	Document Version
Support Services	Other Materials		

The Western University NMREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the Ontario Personal Health Information Protection Act (PHIPA, 2004), and the applicable laws and regulations of Ontario. Members of the NMREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB. The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000941.

Please do not hesitate to contact us if you have any questions.

Sincerely,

Ms. Zoë Levi, Research Ethics Officer on behalf of Dr. Randal Graham, NMREB Chair

Note: This correspondence includes an electronic signature (validation and approval via an online system that is compliant with all regulations).

Appendix B: Recruitment Email**Study on Harm Reduction in Psychotherapy**

Jason Brown, Ph.D.

Principal Investigator

The Social Justice Committee Executive are interested in learning about the issues you consider important. We are seeking the views of members to inform our Chapter's planning and priority setting.

We are writing to request your participation in a study. We continue to recruit participants for a single 30-60 minute telephone or zoom interview focusing on psychotherapists' experiences. The purpose of the study is to explore the following question: "What is it like for social-justice informed counsellors to work with people who misuse substances from a harm reduction framework of care?"

Members of CCPA, who are either licensed to provide psychotherapy or counselling OR a student in counselling or psychotherapy training, are invited to participate.

Your views will assist the Chapter Executive with planning and priority setting. Our RA, Jillian Cramer will assist with the collection of interview data and use it for her Master's Thesis on Harm Reduction in Psychotherapy.

Results of this thesis will be shared with the CCPA membership and appear in scholarly publications.

If you are interested and agree, you would be asked to participate in a zoom interview at a mutually agreeable time. Questions will be provided in advance of the interview.

A \$10 Tim Hortons gift card will be emailed to you at the time of interview.

**For more information about this study, or to volunteer for this study, please contact:
Jillian Cramer**

Please note that email may not be considered a secure form of communication. For the purposes of recruitment and arranging interviews, we will be using email as the primary method of correspondence, however.

Appendix C: Letter of Information and Consent**Letter of Information and Consent****Project Title: Harm Reduction in Psychotherapy**

Dr. Jason Brown, Principal Investigator
Faculty of Education

Invitation to Participate

Because you are a member of the Canadian Counselling and Psychotherapy Association you are invited to participate in this research study. The study is open to any student or professional member of the Canadian Counselling and Psychotherapy Association.

Why is this study being done?

The purpose of the study is to explore the following question: "What is it like for social-justice informed counsellors to work with people who misuse substances from a harm reduction framework of care?"

How long will you be in this study?

It is expected that you would participate in a single zoom interview that is approximately 30-60 minutes long.

What are the study procedures?

You would set a mutually agreeable date and time for an interview with the Research Assistant. Interviews will be conducted via zoom. We will send the letter of information and interview questions to you via email before the date of interview.

On the date of interview, you will have the opportunity to ask any questions about the study. If you give consent to be interviewed and recorded the interview will commence. Zoom recording captures video as well as audio. We are only interested in the audio data and will destroy the video portion following the interview.

Interviews will include the questions: What does harm reduction mean to you? What are your personal beliefs surrounding harm reduction? What was the extent of your education and training surrounding

harm reduction? Could you elaborate on your experience working with individuals who misuse substances within your practice? Has your perspective on harm reduction approaches to care shifted as you have gained experience working with this population? What facilitates your use of harm reduction with clients who misuse substances within your practice? Do you experience barriers when implementing harm reduction with clients who misuse substances within your practice? What thoughts and feelings tend to arise for you when implementing harm reduction with clients within your practice? Has Canada's political and social climate surrounding harm reduction influenced your likelihood to implement it with clients in your practice?

You can choose not to answer any of the questions.

Permission to be recorded is required for participation.

Direct quotes will be used in reports and publications. Permission to use de-identified direct quotes is required for participation.

What are the risks and harms of participating in the study?

Discussion of harm reduction could elicit some emotional response or discomfort.

A list of telephone support services is available at the link below should you experience any discomfort because of participating in this study.

<https://www.opencounseling.com/hotlines-ca>

What are the benefits?

The possible benefit to you may be to have your experience reflected in research about harm reduction in psychotherapy practice. The possible benefit to society may be increased wellbeing for individuals receiving or delivering psychotherapy services.

Can participants choose to leave the study?

If you decide to withdraw from the study, you have the right to request (e.g., by phone, in writing) withdrawal of information collected about you. If you wish to have your information removed, please let the researcher know and your information will be destroyed from our records. Once the study has been published, we will not be able to withdraw your information.

How will participants' information be kept confidential?

Zoom recordings will be located on the local computer located in London, Ontario that is used for the interview. They will not be uploaded to zoom's cloud-based recording system.

Interview data will be collected and electronically transmitted by members of the research team, who may be working remotely. Your data will be stored in a secure environment on Office 365 that only the research team will have access to. Once the recording has been transcribed, the interview portion of recording will be deleted.

Researchers will ask participants for demographic information and responses to open ended questions listed in this letter. Only audio recordings (not video) will be retained for the purpose of transcription. Only the Principal Investigators and Research Assistant will have access to any of the study data.

The audio files and text files from the study will be retained by the researcher for 7 years. Audio files will be stored on the Principal Investigator's encrypted hard drive and text files will be retained in password-protected Word files. A list linking your name and pseudonym will be kept separate from your study file. If the results are published your name will not be used.

Delegated institutional representatives of Western University and its Non- Medical Research Ethics Board may require access to your study-related records to monitor the conduct of the research in accordance with regulatory requirements.

Teleconferencing/videoconferencing technology has some privacy and security risks. It is possible that information could be intercepted by unauthorized people (hacked) or otherwise shared by accident. This risk can't be eliminated. We want to make you aware of this.

Are participants compensated to be in this study?

You will be compensated for your participation in this research. A \$10 Tim Hortons gift card will be emailed to you at the time of interview.

What are the Rights of Participants?

Your participation in this study is voluntary. You may decide not to be in this study. Even if you consent to participate you have the right to not answer individual questions or to withdraw from the study at any time. If you choose not to participate or to leave the study at any time it will have no effect on your professional or employment status. You do not waive any legal right by consenting to this study.

It is important to note that a record of your participation must remain with the study, and as such, the researchers may not be able to destroy your signed letter of information and consent, or your name on the master list. However, any data may be withdrawn upon your request.

Whom do participants contact for questions?

If you have questions about this research study please contact Jason Brown, Principal Investigator.

If you have any questions about your rights as a research participant or the conduct of this study, you may contact The Office of Human Research Ethics. The Research Ethics Board is a group of people who oversee the ethical conduct of research studies. The Non-Medical Research Ethics Board is not part of the study team. Everything that you discuss will be kept confidential.

Project Title: Harm Reduction in Psychotherapy

Dr. Jason Brown, Principal Investigator
Faculty of Education

Participant name: _____

Have you read the Letter of Information and had the nature of the research explained to you?

Have all your questions been answered?

Do you agree to participate?

Yes

No

I consent to the use of unidentified quotes obtained during the study in the dissemination of this research.

Yes

No

I agree to be video and audio-recorded in this research.

Yes

No

My signature means that I have explained the study to the participant named above. I have answered all questions.

Signature

Date

Appendix D: Interview Guide



**Project Title: Harm Reduction in Psychotherapy
Interview Guide**

Participant Demographics

Employment Setting

e.g. Corrections, Education, Healthcare, Human Services, Private Practice

Number of years since professional registration

Registration Status

e.g. C.Psych., Canadian Counselling and Psychotherapy Association., C.C.C., College of Psychologists of Ontario, College of Registered Psychotherapists of Ontario, R.P.

Age

Highest Degree Awarded

e.g. bachelors, diploma, doctorate, masters

Gender Identities

e.g. Agender, Cisgender Female, Cisgender Male, Genderqueer, Non-binary, Transgender Female, Transgender Male, Prefer not to say

Ethnic Identities

e.g. Canadian, Chinese, Dutch, East Indian, English, Filipino, French, German, Indigenous,

Iranian, Irish, Italian, Jamaican, Korean, Pakistani, Polish, Portuguese, Scottish, Sri Lankan

Racial Identities

e.g. Black, East Asian, Indigenous, Latino, Middle Eastern, South Asian, Southeast Asian, White

Class Identities

e.g. low, middle, upper middle, working class, working poor

Religious Identities

e.g. Buddhism, Christianity, Hinduism, Islam, Judaism, Sikhism

Disability Identities

Do you identify as a person with a disability?

If yes, how do you identify?

e.g. emotional, intellectual, physical, social

Semi-Structured Interview

- 1) What does harm reduction mean to you?
- 2) What are your personal beliefs surrounding harm reduction?
- 3) What was the extent of your education and training surrounding harm reduction?
- 4) Could you elaborate on your experience working with individuals who misuse substances within your practice?
- 5) Has your perspective on harm reduction approaches to care shifted as you have gained experience working with this population?
- 6) What facilitates your use of harm reduction with clients who misuse substances within your practice?
- 7) Do you experience barriers when implementing harm reduction with clients who misuse substances within your practice?
- 8) What thoughts and feelings tend to arise for you when implementing harm reduction with clients within your practice?
- 9) Has Canada's political and social climate surrounding harm reduction influenced your likelihood to implement it with clients in your practice?