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**PROVIDER PERCEPTIONS OF PEOPLE WHO INJECT DRUGS AND HARM
REDUCTION APPROACHES**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirement
for the degree of Master of Social Work.

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2017

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Provider Perceptions of People
Who Inject Drugs and Harm
Reduction Approaches

ABSTRACT

People who use injection drugs (PWID) continue to face high rates of death and disease, further exacerbated by the ongoing opioid epidemic. Research indicates that stigma toward this population is high among health care providers, which is shown to result in poor health outcomes and ostracize these high-risk patients from treatment. In the U.S., the dominant substance treatment model is abstinence-based, despite evidence from around the world supporting use of harm reduction interventions which focus on goals to reduce the harmful impacts of drug use to individuals and communities. This quantitative study examined nurses' attitudes toward PWID and nurses' receptivity to harm reduction treatment approaches. The lack of a statistically significant relationship between attitudes and behaviors may be attributable to survey methodology, hospital culture, and a bias towards reporting social desirable answers. However, findings of areas of stigma and receptivity may be useful in revising training and program implementation.

TABLE OF CONTENTS

LIST OF TABLES.....	ii
CHAPTER	
I. INTRODUCTION.....	1
II. LITERATURE REVIEW.....	4
III. METHODOLOGY.....	18
IV. FINDINGS	25
V. DISCUSSION.....	41
REFERENCES	51
APPENDICES	
Appendix A: Survey Tool	55
Appendix B: Smith College HSR Approval Letter.....	57
Appendix C: Informed Consent.....	58

LIST OF TABLES

Table	Page
1. Total number of surveys from inpatient units.....	26
2. Survey Response Results: Demographic Questions.....	26
3. Survey Response Results: Stigma-based Questions.....	28
4. Survey Response Results: Efficacy-based Questions.....	30
5. Survey Response Results: Harm Reduction-based Questions.....	32
6. Survey Response Results: Harm Reduction Intervention Questions.....	34
7. Survey Response Results by Unit: I feel like we are keeping patients safe while they detox.....	37
8. Survey Response Results by Unit: My coworkers feel like we can decrease the chances of IV drug using patients from dying of getting HIV/AIDS.....	37
9. Survey Response Results by Unit: Be provided detailed directions to places where they can get free sterile injection supplies.....	38

CHAPTER I

Introduction

People who inject drugs (PWID) suffer disproportionately high disease and mortality rates. Injection drug use exposes individuals to a myriad of preventable health complications, as well as social and economic devastation (Salvalaggio, 2010). PWID drugs comprise 2.6 percent of the U.S. population age 13 and over (Lanksy, et.al., 2014). Despite the high burden of illness, PWID underuse preventative healthcare services and often fear seeking treatment for serious medical concerns or addiction treatment. Currently, only limited literature exists investigating the social and interpersonal barriers to this marginalized population seeking treatment (Salvalaggio, 2010).

Addiction treatment in the U.S. continues to be mostly, if not entirely, abstinence-based, despite other developed nations throughout the world taking a harm reduction approach. Harm reduction programs aims to reduce individual and societal drug-related harms rather than enforce zero-tolerance policies focused on blaming those with addictions. These approaches to substance use are shown to be highly efficacious at improving public health as well as being low cost. Despite the evidence showing harm reduction interventions decrease rates of death and disease, provide access to sobriety support, and lead to lower health care expenditures, the U.S. continues to prefer abstinence-based approaches (Kyser, 2010).

The literature shows that most health professionals hold negative stereotypes of PWID and project these perceptions of illicit drug use onto patients (McLaughlin & Long, 1996). Studies also show that despite their training and responsibilities, health care providers show the same rates of prejudice and stigma as the larger population. Stigma may be one of the main reasons for the low numbers of PWID seeking treatment (Lloyd, 2010). Studies illustrate that health care and addiction treatment providers support abstinence-based interventions more than harm reduction despite the evidence. Existing research has investigated perceptions that providers may have against substance users, as well as examined the receptivity providers have toward particular harm reduction interventions. The relationship between stigma held by treatment providers and their subsequent receptivity to providing harm reduction services has rarely been explored.

This research explored the question: How do staff perceptions of people who inject drugs (PWID) affect their willingness to provide harm reduction services? This study examined the opinions of milieu staff at an inpatient psychiatric hospital providing detoxification services, exploring such questions as, How do staff feel about PWID? What are their feelings about harm reduction approaches to treatment? And finally, is there a relationship between these attitudes? A quantitative, Likert scale survey, was used to gather these data on nurses employed on inpatient adult units at a private nonprofit psychiatric hospital. These data may be used by this hospital or others to examine attitudes toward PWID, harm reduction versus abstinence-based services, areas for improvement of patient care, as well as contribute to the literature on addiction, stigma, and harm reduction.

Social workers are providers within healthcare and addiction treatment facilities, yet are specifically trained to examine their biases, and implement interventions based on patient self-determination. This places social work in a unique position to investigate provider-patient relationships, areas for increasing understanding, and improving access to equitable care for those most in need, and at the highest risks. Specializing in advocating for those most societally stigmatized is a hallmark of the profession and exploring the social barriers to care is imperative to increasing quality of life, and keeping patients alive.

CHAPTER II

Literature Review

Key Terms

People who inject drugs (PWID): This term is used to describe those who use substances by means of injection rather than the generally used IVDU (intravenous drug user) which often has a negative connotation, defining and categorizing people by one action/activity.

Stigma: When a person possesses a status that makes them less acceptable in others' eyes, which changes their interactions with others, and creates a power dynamic (Lloyd, 2010).

Harm reduction: An empowerment approach to minimize the adverse effects of drug use that aims to promote the recipient's active participation in community public health.

A Public Health Crisis

People who inject drugs experience a high, and largely avoidable morbidity and mortality burden. These health disparities are compounded by stigma associated with injection drug use, which can leave this population fearful of accessing health care and substance use services. They are at high risk for contracting blood-borne pathogens include hepatitis B and C and HIV, as well as life threatening infections including tetanus, abscesses, and endocarditis (infection of the lining of the heart's valves) (Centers for Disease Control, 2015). More than 1.2 million Americans are currently infected with HIV with about 50,000 new infections each year (CDC, 2015). In 2012, PWID represented about 20 percent of those living with HIV, "50 percent of the

3.2 million people living with hepatitis B” virus, and 68 percent of hepatitis C. (Doan, 2013, p. 1 & Harm Reduction Coalition, 2015). Ongoing treatment of an HIV positive individual is estimated to cost at least \$400,000, and costs of hepatitis treatment are estimated to be even higher (Salvalaggio, 2010).

Injection also poses the greatest risk of lethal overdose due to large amounts of a substance (and additional contaminants) into the bloodstream at once (CDC, 2016). During 2014 alone, 47,055 drug overdose deaths occurred in the United States, with the majority resulting from opioid use, most often heroin (CDC, 2016). “Overdose deaths from opioids, including prescription opioids and heroin, have more than quadrupled since 1999,” resulting in about half of a million lives lost to opioid overdoses since then (CDC, 2016, Kounang, 2015). “Deaths from overdoses of prescription drugs and heroin continue to be the leading cause of unintentional death for Americans...1.5 times greater than the number killed in car crashes” (Kounang, 2015).

Substance use and dependence are a major contributor to national health care expenditures, mainly due the high volume of emergency services being used. In 2012 alone, there were 1,075,600 inpatient hospital admissions in the U.S. for a primary diagnosis of substance use disorder or co-occurring substance use and mental health disorder. This had an aggregate cost of \$6.4 billion, with 56 percent funded by public health insurance (Medicaid/Medicare), and 16 percent uninsured (Heslin, Elixhauser, & Steiner, 2015).

Substance Use and Intervention

Theoretical Models

Generally, four different models are used to conceptualize substance use behavior and addiction. The *temperance model* was the original approach, popular with the prohibition

movement and based on enforcement. This is the concept of doing away with the “demons” of alcoholism to protect middle class women and children from poverty (Kyser, 2010). The *disease model* began around the 1930’s asserting that addiction was an illness that users were completely powerless against, only treatable by immediate abstinence. This view is that users cannot be left to make coherent decisions for themselves as they are incapable of sound judgment, and social interventions must be implemented to force people into abstinence (Kyser, 2010). In the United States, the *disease model* is now used almost exclusively in treatment programs and lends itself readily to the medical setting (Kyser, 2010).

The *moral model* is based on the concept that substance use is immoral and therefore substance users are willfully violating the rules of society by making immoral choices and must be punished or spiritually persuaded to abstinence. Similar to temperance, the moral model views drug use as an evil of society rather than a public health issue (Kyser, 2010). Currently the moral model predominates U.S. Drug Policy, where the criminal justice system attributes drug use to willful and immoral choices, necessitating punishment. (Lloyd, 2010). While stigmatization can be viewed as an inherent function of morality models, it is also intrinsically tied to the *medical/disease model*. Although medicalization may seem to destigmatize drug use, many diseases have historically been feared, stigmatized, or associated with personal responsibility (Lloyd, 2010). “In spite of two centuries of claims that addiction is a disease, and more recently that it is similar to other chronic disease states, the idea that addiction is rooted in repeated bad choices remains widely compelling” (Baumohl et al., 2003, as quoted by Lloyd, 2010, p. 53).

Finally, the *biopsychosocial approach* to addiction aims to gain a holistic understanding of the biological, psychological, and social impacts of treatment on an individual and their

environmental and familial system. This recognizes the diversity and complexity of substance dependence and the positive and negative impacts treatment can have (Kyser, 2010).

Harm Reduction in the U.S.

While abstinence-based programs dominate behavioral health services in the US; other developed nations across Europe, Canada, and Australia utilize harm reduction components which are shown to have positive health outcomes (Kyser, 2010). Harm reduction is a treatment approach aimed at reducing negative consequences associated with drug use with the belief that people who use substances have the human right to make their own informed decisions. It accepts that eradication of all substance use is unrealistic, and takes a public health approach to reducing risk by providing information and resources to respect an individual's autonomy, with the goal of abstinence only if that is the client's goal (Doan, 2013). While critics of harm reduction feel that this approach condones and encourages further drug use, statistics show that providing non-judgmental public health information for safer use can reach more individuals, improve health for the larger community, and build relationships that can lead individuals to seek treatment supports (Harm Reduction Coalition, 2015).

Some harm reduction efforts include: syringe exchange programs (SEPs); medication assisted treatment including opioid substitution therapies (Methadone or Suboxone); education on using substances by a safer route; education on infection prevention, safety, and overdose prevention; Naloxone (Narcan) overdose reversal medication; and supervised drug consumption areas. Numerous studies have provided evidence that harm-reduction programs including syringe exchange, and methadone maintenance programs have effectively limited the spread of infection, most notably HIV (Reid, 2002). Through nation-wide new HIV infection mandatory reporting,

the Journal of the American Medical Association reports that syringe exchange programs have helped to lower the incidence of HIV by 80% among PWID, despite HIV rates in other groups continuing to increase (Hall, et.al, 2008).

“The U.S. continues to be the only developed country in the world to prohibit government funding for SEPs [Syringe Exchange Programs]” (Doan, 2013). The European Union has prioritized securing political commitment for harm reduction, based on the evidence of the cost-effectiveness of scaling up these programs (European Monitoring Centre for Drugs and Drug Addiction, 2010). While HIV rates are stabilizing in Western and Central Europe, they are increasing in the Eastern side of the continent correlating to insufficient availability of harm reduction services, due to political focus on law enforcement, and laws limiting medication assisted treatments and syringe exchange programs (EMCDDA, 2010). In a meta-analysis of Methadone maintenance treatment in Sweden, Germany, Australia, and the U.S., “MMT [Methadone] use reduced the risk of death by 75 percent, due almost entirely to decreases in deaths due to overdose” (EMCDDA, 2010, p. 141). One study of a Chicago peer Naloxone distribution program, found that despite the fourfold increase of heroin overdose deaths from 1996-2000 prior to the program, after implementation, this trend was reversed, resulting in 20 percent decrease in deaths in 2001 (EMCDDA, 2010).

Harm reduction efforts are also found to be cost effective and offer care that can feel less stigmatizing to PWID. Harm reduction interventions are considered to be “low-cost, high-impact”, with implementation usually being inexpensive, but having high, measurable impact on individual and community health. This acknowledges that small incremental changes made by many people often have a larger impact than heroic gains for just a few (Harm Reduction Coalition, 2015).

Many proponents of harm reduction approaches to treatment point out that the adverse health effects including HIV, disproportionately affect already marginalized groups including: women, people of color, individuals with low socioeconomic status, men who have sex with men (MSM), and those involved in sex work, arguing that the current political morality stance views this ‘throwaway’ population as possibly deserving of the ‘consequences’ of illicit drug use (Bowen, 2012). They point out a contradiction between the evidence-based recommendations and the policies (Doan, 2013). Barahona (2009) quotes former Surgeon General David Satcher stating “One of the worst things that can happen in this country is for us to say, if the science doesn’t agree with our perspective, then we want to suppress the science.”

Critics of Harm Reduction

Opponents view harm reduction as inherently unethical and as a promotion of intravenous drug use. This anti-drug political and moral stance includes groups that generally align with conservative family values, pushing for funding of abstinence-based programs instead (Laconte, 2003). Barahona (2009) quoted subcommittee member Todd Tiahrt (R-KS) stating "I am very concerned that we would use federal tax dollars to support the drug habits of people who desperately need help." Harm reduction programs do not send the “tough on drugs” message many politicians and groups such as the Drug Free America Foundation feel is appropriate. “The only sure way to prevent drug-related harm is to prevent or to stop drug use. Any efforts that fail to strive toward this goal should be viewed with skepticism and challenged as "harm promotion" rather than harm reduction” (Drug Free America Foundation).

Political Climate

Despite the provisions of the 2008 Mental Health Parity and Addiction Equity Act, which states that insurance companies cannot limit mental health treatment payments more than physical health, there is no stipulation requiring a variety of treatments to be provided (CMS, 2016). Within the U.S. system, some treatments such as medication assisted therapies and overdose reversal medication have recently increased in common use in the medical model for the non-incarcerated population. Supervised consumption areas and syringe exchange (SEPs) at prisons remain illegal in the US, and SEPs are currently legal only on a state-by-state basis, and with many limiting restrictions (Doan, 2013). Federally, there is a ban on government funding for Syringe Exchange Programs. During the Obama administration, the president voiced support for programs such as SEPs, and attempted to include language to lift this ban several times, including this in the federal budget (Doan, 2013). In 2010, this was successfully passed, however in 2011, with political threats of a government shutdown, Congress reinstated this ban as a part of the budget for fiscal year 2012, which has continued to be a part of the budget each year since (Doan, 2013).

Former president Obama's 2017 budget allocated \$1.5 billion to fund substance use treatment programs and prevention strategies due to the opioid epidemic (HHS, 2016). This did include an increase in medication assisted therapies, however, as stated above, many other harm reduction efforts are unable to be funded federally, and treatment programs are almost entirely abstinence based.

As of the writing of this, the Trump administration has proposed a 95 percent cut in funding for the Office of National Drug Control Policy, which is the department leading the fight against the national opioid epidemic (Rappeport, 2017). Despite Trump's promises made up until

three months ago to defeat this epidemic ravaging communities, deep cuts continue to be proposed in exchange for increasing military funding. In addition, the proposed health care bill passed by the house of representatives would cause an estimated 3 million Americans to lose some or all of their addiction treatment coverage (Lurie, 2017). Attorney General Sessions has made clear his support for ‘War-on-Drugs’-era policies including mandatory minimum sentences for non-violent drug offenses, which have been proven to be ineffective at reducing crime, and have aided in increasing prison populations by about 600 percent (Gotsch & Mauer, 2017). With the current political climate strongly supporting reverting back to seemingly draconian moral-model policies while cutting psychiatric and substance use treatment, it is difficult to anticipate a move toward funding any progressive harm reduction resources.

Seeking Treatment

Stigma may be one of the main factors for the low number of substance users in treatment (Lloyd, 2010). “Some users feel that the very act of seeking treatment serves to cement an ‘addict’ or ‘junkie’ identity, which can lead to further rejection from family and friends” (Lloyd, 2010, p.8). Many PWID feel unsafe seeking medical or substance abuse treatment at traditional clinics or hospitals due to past negative experiences and fear of discrimination. One long-term study found that 76% of participants at syringe exchange programs received their medical and preventive services exclusively through SEPs (Harm Reduction Coalition, 2010, p.1). An Australian study of discrimination, found that PWID report discrimination with doctors and in hospitals more than any other area of society, including interactions with family, employers, police, and in prisons (Hargraves, 2015).

The Public Health Sector and Social Work

Direct service staff act as gatekeepers to not only further services, but more importantly, provide education and connection. The two to four days that a patient is admitted for detoxification is an invaluable intervention point where patients have an opportunity to reevaluate and plan for a return to their life. Often, this immediately follows a serious injury or near fatal drug overdose. Clinician's ability to build positive rapport with patients may impact their health outcomes and there is a lack of research comparing providers' regard for substance using patients with their willingness to use empowerment model approaches. Public health interventions often do not recognize the agency of the target individual, honoring their ability to protect themselves and support their community. It is important to understand the stance of those working directly with this high-risk population and assess whether they are receptive to these models.

The results of this research may be used to explore if stigma is present in the clinician-patient relationship, helping to determine if discrimination might be experienced by PWID when attempting to seek treatment at this hospital. This may help to inform areas where social work may be able to intervene with education on how to provide strengths-based and client-led interventions. With training in providing culturally congruent therapeutic services, social workers have the unique ability to approach the substance dependence crisis from a lens of understanding systemic oppression and vulnerability in these communities, as well as the intense judgment and stigma PWID face when attempting to receive health treatment. Addressing the large health and health care disparities that PWID face is imperative in mitigating the devastating effects of injection drug addiction. Assisting providers in better meeting their needs for humane and culturally congruent services may create more inclusive environments where health care will

be more effective and more people in need will seek services. Bridging the gap between health services, which often feel demanding and paternalistic, and the patients who need these services most, social work can be at the forefront of advocating for the importance of a therapeutic alliance built on social justice. As written in the NASW Code of Ethics (NASW,2008 (pp. 5–6). “Social workers promote clients’ socially responsible self-determination. Social workers seek to enhance clients’ capacity and opportunity to change and to address their own needs” (pp. 5–6).

Existing Empirical Research

All applicable empirical studies summarized below highlighted that providers tend to hold negative perceptions of patients who use substances, and thus may benefit from further education and training around addiction related stigma (Bonar & Rosenburg, 2010; Carol,1993; Ford, 2011, Kyser, 2010; Salvalaggio, 2008; Lloyd, 2010). Bonar & Rosenburg, (2010) used a *Treatment Attitudes Scale (TAS)* survey to compare provider attitudes of harm reduction with traditional (abstinence-based) approaches to treatment for PWID, finding that traditional approaches were slightly preferred by treatment providers, including when patients were HIV positive. In this study, a case vignette of a substance using patient was presented to participants followed by completing the Likert-scale questions whether or not they felt a certain treatment approach would be helpful or harmful to the patient. Bonar’s (2010) follow up study found that most clinical administrators at substance abuse treatment facilities and licensed chemical dependency counselors felt that overdose prevention harm reduction education was actually harmful to patients, versus feeling that blood-borne pathogen harm reduction education was somewhat helpful to patients. Although this study did not examine why the later explanation

was preferred, the specific type of harm reduction approach is an important distinction that few other studies examined.

Carroll's (1993) study of provider attitudes toward substance users found much more pessimistic results, showing stark differences depending on staff role. Using a Likert-type attitudinal scale, it was found that the more experience and training the staff had, the more positive the perception they had of substance users, particularly those who were HIV positive. The fundamental difference appeared to be whether or not a staff member had specifically chosen to work with substance users, with substance abuse counselors having the most positive perceptions, and non-psychiatric nurses having the most negative. This is similar to Ford's (2011) study of nurses, which uses survey and interviews, finding that a lack of education creates a situation where nurses feel that they are in danger and that substance using patients are manipulative and irresponsible. Ford's study highlights the importance of exploring staff's interpretation of specific patient behaviors on the inpatient unit.

Another assessment scale, the *Harm Reduction Assessment Scale*, was used in Kyser's (2010) study of licensed counselors' willingness to use harm reduction. This study indicated that there was no correlation between counselor religion and attitudes, however there was a more positive view of harm reduction if the counselor lived in an urban setting, or had a loved one with an addiction history. Salvalaggio's (2008) study of patient- provider rapport involved focus groups of both PWID and providers, exploring demographics and potential biases. Salvalaggio (2008) similarly found that rapport (defined as a positive, autonomous, relationship with open communication) directly affected PWID's willingness to have a primary care provider, and poor rapport increased negative health events requiring more emergency services.

Using meta-analysis of the literature around stigma toward drug users, Lloyd (2010) compares public perception with healthcare provider perception illustrating similarities. Lloyd also compares this stigma to that of mental illness, finding that there is more fear and blame associated with drug use, highlighting the lack of addiction education for health care providers, and the indication that drug users are avoiding seeking help due to this stigmatization. Some studies analyzed showed that “a substantial proportion of ‘tomorrow’s doctors’ continue to hold negative stereotypes about substance misuse” and that “the majority of health professionals hold negative, stereotypical perceptions of illicit drug users” (Lloyd 2010, p.30). Many studies illustrated attitudes among nurses, “whose prejudice, according to these authors, prevent them from carrying out “effective and humane nursing care” to problem drug users” (Lloyd, 2010, p.30). Providers appeared to be mainly concerned with substance using patients being solely “medication-seeking”, even citing that their training supports treating these patients with a level of suspicion. “We found that the care had a different tone or quality when patients had alcohol or drug problems” (p. 31). Lloyd (2010) points out that health professionals are subject to the same broader influences that create stigma in the public, and are provided very limited addiction-focused education in medical and nursing school.

Limitations

Due to the prominence of the abstinence-based models such as disease and morality-based treatment used in the U.S., most of the studies were conducted in other countries which may have differing public perceptions and governments open to this form of outreach and treatment. Most studies, such as Carroll (1993) and Ford (2011), focused on substance use in general rather than specifically injection drug use which appears to carry among the highest

levels of stigma. Studies like Kapur (2016) focused strictly on perceptions of social justice in harm reduction with staff members who provide this education as a part of their position. This population of participants differed greatly from other studies: their results align with a more positive and empathetic perception of their patients compared to the more common medical and behavioral health staff that directly interact with PWID. This may be due, in part, to the differing education and treatment models around substance use that behavioral health professionals receive compared to medical professionals.

Summary

With increasing rates of serious illness and death experienced by PWID, there is an urgent need for health services to better reach and serve this population. The existing research indicates that medical and behavioral health providers possess a negative stigma toward substance users. Stigma and lack of positive rapport were found to impact not only patients' experience, but also directly result in poorer health outcomes. Despite the evidence, providers tend to prefer traditional modes of treatment over self-determination models such as harm reduction. The research literature collectively represents studies of either provider perceptions of patients who use substances or perceptions of harm reduction approaches. Harm reduction education inherently requires a regard for individuals' self-determination and autonomy, however there have been no studies found to investigate if providers feel that their patients are entitled to these rights. This efficacious treatment method cannot simply be implemented as evidence-based practice without viewing the attitudes towards and knowledge of addiction treatment. This study intends to investigate whether there is a relationship between the frontline providers' perceptions of PWID and harm reduction outreach efforts. The current literature

provides insight into differing biases of direct service staff. The results of this study may provide one important example of why harm reduction intervention is rarely considered as a viable treatment option in the U.S. and illustrate challenges to its implementation in treatment settings.

CHAPTER III

Methodology

The exploratory study was conducted using quantitative survey design provided to milieu staff at a private psychiatric hospital in a medium-sized urban area. This psychiatric hospital provides behavioral health services including inpatient drug and alcohol detoxification. A survey was developed and administered by the researcher. Likert Scale-type questions were asked on the survey to measure nurses' attitudes towards PWID, feelings of self-efficacy, and receptivity to harm reduction philosophies and interventions. This allowed for quantitative analysis of attitudes and feelings, enabling the participant to select the option they most align with.

Both convenience and purposive sampling methods were used to select participants. Due to the researcher's current employment at the Hospital, the researcher had access to these potential participants and was aware of the nature of the work done on the units. Due to the nature of setting, this non-random sampling was used to try and capture as many staff working directly with this population on a regular basis as possible, with the intention of gathering a more in-depth representation of the staff in this hospital.

Institutional Review Board

Early in the proposal development stage, the researcher explored potential challenges in obtaining approval through either the hospital's Institutional Review Board (IRB) or Smith College's Human Subjects Review Board (HSR). The researcher was informed by a representative from the hospital's IRB that it was likely that approval would be most appropriate through Smith College's HSR, rather than the hospital. The researcher submitted the proposal

and obtained approval for this research project through the HSR (see Appendix B). When submitting documentation of the approval to the hospital the writer was informed that the study did not meet requirements for ceding review to Smith College's HSR, however due to the minimal risk and lack of patient involvement, that it met requirements for being exempt from the hospital's IRB process. After submitting required documentation, this request was denied, and expedited review through the IRB was then submitted by the researcher (see Appendix C). This was reviewed by doctors from the hospital and letters from departments affected were obtained by the researcher at the IRB request. The unanticipated steps for review by separate entities with differing revisions and requirements significantly extending the approval process, leaving shorter than expected time for data collection. This may have impacted the sample size due to limited time to allow for surveys to be returned and the amount of staff meetings the researcher was able to attend for recruitment.

Sample

Selection Criteria

Participants of this study were paid employees of a private, non-profit psychiatric hospital who work as nurses on inpatient units. Nurses are one position that generally functions as milieu staff and have the majority of interactions with patients throughout their shift. Nursing staff employed on all inpatient units were included, except for those working exclusively on adolescent and geriatric units which specialize in the unique needs of these age groups. Social workers were not used in this study to avoid potential conflict with the researcher currently employed in this department. Staff who do not work directly with patients on the unit, including management level nurses were excluded due to this study not directly pertaining to their work.

Nursing staff were asked if they ever work with any patients detoxing from drugs used by injection route of administration. This was clarified to participants include only a population who used substances and not medication as prescribed (i.e., insulin). They were required to respond affirmatively, that they did work with this population to be eligible for the study.

Recruitment

Participants were recruited through the staff meetings held each shift for nurses on each unit. The researcher remained in contact with both the Director of Patient Experience and the Director of Addiction Services at the Hospital to discuss this recruitment process. The Director of Patient Experience presented a brief overview of the research proposal to both the Director of Nursing and Nursing Supervisors during a supervisor meeting. The researcher received approval from the hospital's Director of Nursing and the hospital's Institutional Review Board. The researcher then contacted each of the six inpatient units' respective Nursing Supervisors requesting attend a "change of shift" unit meeting to presented the study, survey, and informed consent. The researcher attended one afternoon meeting on each unit when morning and evening shifts overlap. During this unit staff meeting, the researcher gave a brief overview of the inclusion criteria, study, and reviewed the informed consent. Any questions were answered by the researcher. Of which there were few, mainly about logistics of where to drop off surveys and what needed to be done with informed consents. All nurses who answered that they work with patients who use injection drugs were asked if they were willing to participate. All willing to participate were provided a written copy of the informed consent to retain for their records and a paper copy of the survey. The writer placed one locked survey drop box in the staff area or

“chart room” of each unit, marked with a date one week from distribution, when this box would be picked up by writer.

Ethics and Safeguards

Due to the researcher’s dual role in the hospital as an occasional per-diem employee, there was concern that staff may have felt either more or less compelled to participate in the research. This may be due in part, to concern that their anonymity would have been compromised due to being able to be identified by their survey. To mitigate this issue, identifying demographic questions were not included in this survey and no identifying information was gathered. Informed consents were not linked to surveys or required to be signed or returned by participants. This, in conjunction with having a locked drop-box, prevented even the researcher from having knowledge of participants’ individual responses or who participated. It was possible that participants had concerns that their participation or nonparticipation may somehow affect their employment, or that their survey information would not be kept confidential from supervisors. No one, including the researcher, had knowledge of who did or did not participate as long as participants chose to utilize the drop-box unobserved. Participants were informed of this option verbally and in the informed consent. Participants were also informed in detail that information would only be shared in aggregate form.

Power dynamics were evident in this setting due to the hierarchy of staff both by position, and within the same role. There was also the inherent power dynamic as the researcher, with possible concerns about the impact of these findings on participants’ daily work life. Through a thorough explanation of confidentiality, anonymity, and the purpose of the study, the researcher hoped to address these potential concerns. As a per-diem staff member, the researcher’s own role

may be not have been as clearly defined, although appeared to be lessened as the researcher was not working directly with these staff members on any regular basis.

Both anonymity and power dynamics are challenging ethical issues in the workplace where employees must consider how participation in any study could conceivably negatively affect them. With this in mind, it is clear that responses may have been skewed by concern that their identity could be determined, or that it may indicate that they and their colleagues were not effectively completing their job. Social desirability was also considered in its potential impact in skewing if participants anticipate desired responses. There may have been concern for the implications that this may create a change in policy and how their position is performed, increasing work load. By providing detailed information about the risks and benefits of participation and explanation of the purpose while highlighting of the value of honest responses, the researcher hoped to mitigate these concerns.

Data Collection

The researcher presented the survey and information regarding the research and informed consent to all milieu staff during a daily meeting. All nursing staff working on any of the six inpatient units (excluding the geriatric and adolescent inpatient units) who stated that they have worked with patients detoxing from injection drugs were eligible to participate. The researcher answered questions from potential participants and reiterated contact information for researcher for additional questions. All interested in participation were distributed an informed consent to for their records. Participants received a hard copy of the 30-question survey to complete outside of this meeting as the meeting did not allow time for completion and may not have been as private as participants may have preferred. A locked drop-box was placed in a staff area of the

unit where participants placed completed surveys over the following week. The researcher also placed a sign on the drop-box indicating the deadline for returning surveys. The surveys were both anonymous and confidential, were not coded, and did not include any identifying information to allow participants more comfort in accurate opinions. Participants were informed that they were able to deposit a survey any time over the following week, allowing for privacy if they chose to keep their participation unknown to coworkers or supervisors.

Survey

This survey was designed by the researcher, with the final section's measure development influenced conceptually by Bonar & Rosenberg's (2010) Treatment Attitudes Scale, and the later Treatment Attitudes Scale-Revised adapted by Fillmore (2015). The researcher did not have access to either Bonar & Rosenberg's (2010) or Fillmore's (2015) survey tools, however utilized the studies' findings to help create organization for this subsection, and assist in developing several questions regarding types of harm reduction interventions. Using two multiple choice questions and 28 Likert scale questions, the first section allowed responses based on *"how much do you agree or disagree with the following statements"* allowing for five potential responses from *strongly disagree* to *strongly agree*. This included questions based on common perceptions of people who inject drugs and also patients who use injection drugs informed by the literature. This section also included three questions which also addressed feelings of staff efficacy, both to determine efficacy, but also to limit effects of social desirability by limiting the focus on stigma. An example is: *"I feel like I can positively impact the recovery process for patients on the unit."* The final section asked participants *"How beneficial would the following be to our patients who use injection drugs? (Heroin, opiates, cocaine, etc.)"* with five options from very beneficial to very harmful. An example is: *"Be provided detailed directions to*

places where they can get free sterile injection supplies". See Appendix A for a copy of full survey.

Data Analysis

All data were gathered from hard copies of the survey and entered into Microsoft Excel, then were re-entered by a colleague to ensure it was free from entry error. The researcher ran descriptive statistics on each individual survey question. The items were then compiled into groupings addressing the 5 key topic areas of interest: *sample characteristics stigma*, *provider efficacy*, *harm reduction philosophy*, and *harm reduction interventions*. Responses with multiple answers chosen, with written in responses, or unclear responses were reclassified as "blank" responses. Comparisons were performed between groups (e.g. sample characteristics: anticipated working with this group vs. did not anticipate; with stigma: feeling that IV drug using patients deserve treatment). Chi-square tests were used to determine whether there is a significant difference in the distribution of responses to an item. Although the survey did not include an item about which units participants work on, the researcher collected units separately and included this information for comparative analysis.

CHAPTER IV

RESULTS

This exploratory study was conducted using a closed-ended, 28-question survey provided to milieu staff at a private psychiatric hospital in a medium-sized city. The purpose of the study was to explore providers' perceptions of people who inject drugs (PWID) and their attitudes toward harm reduction treatment method. Specifically, to look for any relationships between sample characteristics, stigma, self-efficacy and attitudes towards harm reduction treatment methods. The sample consisted of 41 participants across six inpatient hospital units who agreed to complete and return the survey. This chapter contains descriptive statistics of the quantitative data obtained. Although no statistically significant relationship between attitudes and knowledge of harm reduction was found, staff perceptions of both patients who use injection drugs and interventions for treatment are detailed.

Descriptive Statistics

Sample Characteristics

A total of 41 staff members completed and returned surveys from the six inpatient behavioral health units. Between five and ten surveys were submitted from each unit with three units being "General Treatment Units", two units "Intensive Treatment Units", and one "Alcohol and Drug Inpatient Unit". Given that some units float between two units, and others work

overnight and varying shifts, counts of the total possible participants' pool are not available. The larger General Treatment Units were more represented, completing 63 percent of surveys. From Table 1 it is clear that due to the small sample size, and lower potential participant pool from smaller units, comparison by unit potential is limited.

Table 1
Total number of surveys from inpatient units

Inpatient Unit	Surveys completed	Percentage of total N
General Treatment	26	63.41%
Intensive Treatment	10	24.39%
Alcohol and Drug	5	12.20%
Total Surveys	41	

In order to decrease potential concerns of anonymity, demographic questions were generally excluded from the survey. Two sample characteristic questions that were not identifying were asked with the option to not answer (see below). The clear majority of staff surveyed anticipated working with PWID when beginning their position and most staff also had a personal connection to addiction.

Table 2
Survey Responses Results: Sample characteristic questions

Survey Question	No	Yes	Prefer not to answer
When I started at this hospital, I anticipated that I would be working with patients detoxing from IV drugs.	7.32%	92.68%	0.00%
I have personally been affected by addiction. (Myself or someone I love)	32.50%	67.50%	0.00%

Stigma

As defined by Lloyd (2010), stigma is seen when a person possesses a status that makes them less acceptable in others' eyes, altering their interactions with others, and creating a power dynamic (Lloyd, 2010). Stigma has historically been experienced by PWID in all areas of society. Within the health sector, stigma from providers has been found to profoundly impact not only patients' experience, but also directly result in poorer health outcomes, likely contributing for the low number of PWID having primary care, or seeking addiction treatment (Harm Reduction Coalition, 2010 & Lloyd 2010). Table 3 illustrates the results from specific questions that targeted stigmatizing identities often attributed to substance using individuals and specifically PWID, however many other questions also have overlapping themes of stigma.

Eleven 4-point Likert-scale questions on the survey directly addressed common perceptions of PWID that both providers and lay persons may have. These questions sought to determine how much a provider agreed or disagreed with common stigmas which attribute character with the act of using injection drugs. This included exploring themes often present in morality model beliefs of addiction such as: personal responsibility, how deserving they are of treatment, and character assumptions such as being dangerous, manipulative, lazy, or selfish.

Table 3
Survey Response Results: Stigma-based Questions

Stigma Based Questions	Strongly Agree	Agree	Disagree	Strongly Disagree
I am concerned about the safety of the very mentally ill patients when they are around drug users on the unit	10.26%	25.64%	51.28%	12.82%
The patients here for psychiatric emergencies deserve treatment more than those here for detox	0.00%	7.50%	62.50%	30.00%
IV drug users are not that worried about dying	4.88%	4.88%	70.73%	19.51%
Our heroin addicted patients often game or abuse the system	10.00%	55.00%	35.00%	0.00%
I have heard how frustrated coworkers are working with addicted patients	24.39%	58.54%	12.20%	4.88%
I feel uncomfortable working with the drug users on the unit	4.88%	0.00%	51.22%	43.90%
IV drug users have an interest in keeping themselves safe	5.00%	67.50%	22.50%	5.00%
If they really wanted it and worked for it, most of my patients would have gotten sober.	5.13%	30.77%	51.28%	12.82%
Consequences of drug use such as arrest, prison time, or loss of family support may be helpful for this population	4.88%	21.95%	63.41%	9.76%
IV drug users do not fully understand the consequences of their actions	2.50%	32.50%	57.50%	7.50%
IV drug using patients are generally out for their own interest and not thinking about others	13.16%	28.95%	50.00%	7.89%

Most participants felt that substance detoxing patients were deserving of treatment with only 7.5 percent reporting that PWID required treatment less than other patients indicating a low level of stigma in the area of PWID being “deserving” enough. This may be due to the medical necessity of medical detox for particular substances, and subsequent health risks. There also appeared to be a consensus with 91 percent felt or strongly felt that PWID are in fact worried about dying, indicating low stigma in area of personal responsibility and regard for personal safety. Most staff who participated reported feeling comfortable working with patients who use injection drugs. One area that where there appeared to be high stigma was, “I have heard how frustrated coworkers are working with addicted patients”. Only 16 percent of respondents

disagreed with the statement potentially indicating most staff feel their coworkers are unhappy working with this population. Interestingly, another interpretation may be that there may be an element of social desirability and challenge providing honest responses in other questions that was less present here when asked about coworkers rather than themselves.

Responses seemed to go against the “social desirability” trend in areas such as feeling that patients who use opioids “game or abuse the system” where 65 percent agreed and no respondents strongly disagreed. This indicates a higher level of stigma in terms of PWID being thought to be manipulative and ‘abusing the system’ which may correlate with the high level of frustration in the previous question. Similarly, almost half of respondents agreed that PWID are generally “out for their own interest” showing a moderate level of stigma amongst staff in character association of selfishness. Thirty-six percent of participants reported being worried about safety of mentally ill patients in the presence of substance using patients. This appears to indicate a moderate level of stigma in the area of perception of PWID as dangerous to society. This character assumption is particularly interesting as severely mentally ill individuals are also often stigmatized as dangerous by society. This aligns with Lloyd’s (2010) study which found higher rates of fear and blame toward substance using population than the severely mentally ill. This may be indicative of the staff culture within a psychiatric hospital which may have worked to remove some stigma of the mentally ill, but separated those individuals from addicted patients.

Efficacy

Although there was not a particular hypothesis around staff’s perceptions of their own efficacy, it appeared worthwhile to determine impressions of their ability to impact the outcome and quality of life for patients. Exploring areas where staff may feel more or less able to

influence the health of their patients may impact willingness to invest in patients’ self-determination and therefore harm reduction interventions.

Table 4
Survey Response Results: Efficacy-based Questions

Efficacy Based Questions	Strongly Agree	Agree	Disagree	Strongly Disagree
I feel like I can positively impact the recovery process for patients on the unit	14.63%	78.05%	4.88%	2.44%
I feel like we are keeping patients safe while they detox	50.00%	37.50%	7.50%	5.00%
My coworkers feel like we can decrease the chances of IV drug using patients dying or getting HIV/AIDS	0.00%	47.50%	47.50%	5.00%

Nearly all participants (93 percent) felt they could positively impact the recovery process for patients. Similarly, 88 percent felt they are keeping patients safe while detoxing. Of note, one participant commented a concern that, “We do not automatically restrict patients from having visitors when they are on general treatment units, there have been issues with visitors bringing drugs to the unit and there are no screening measures for these people in place to prevent this.” Contrasting these first two questions with reports of high efficacy, about half of all participants disagreed (53 percent) that their coworkers felt they could decrease the chances of patients (PWID) from dying or acquiring HIV/AIDS. This question was phrased to include “my coworkers” rather than “I” to limit response based on social desirability, and gather data based on general perception among staff. This may be partially responsible for this report of feeling low efficacy in area of decreasing death and HIV rates, perhaps indicating sobriety as the focus of detox treatment rather than limiting mortality and morbidity. This final question appears to be a prerequisite for measuring receptivity to harm reduction intervention, as reducing death and disease are a main goal, perhaps indicating priorities within the staff or hospital culture that are misaligned to harm reduction and public health goals.

Harm Reduction

Harm reduction efforts are found to be cost effective and offer care that can feel less stigmatizing to PWID. Harm reduction interventions are “low-cost, high-impact”, with implementation usually being inexpensive, but having high, measurable impact on individual and community health (Harm Reduction Coalition, 2015). Six 4-point Likert-scale questions were asked which addressed themes of harm reduction education or touched on the over-arching philosophy of harm reduction to determine the level to which staff may agree or disagree with this general approach to treatment. This included potential for goals other than sobriety, self-determination, public health goals, and increasing quality of life and safety by providing education on disease and overdose prevention. It may be noted that many of these questions may also overlap with themes of attitudes and stigma.

Table 5
Survey Response Results: Harm Reduction Based Questions

Harm Reduction Based Questions	Strongly Agree	Agree	Disagree	Strongly Disagree
Consequences of drug use such as arrest, prison time, or loss of family support may be helpful for this population	4.88%	21.95%	63.41%	9.76%
The goal of sobriety is the only helpful goal in recovery from IV drug use	0.00%	15.38%	71.79%	12.82%
My coworkers are worried about our IV drug using patients contracting HIV	2.50%	40.00%	42.50%	15.00%
My coworkers here are worried about our patients overdosing after discharge	12.50%	72.50%	12.50%	2.50%
Educating addicts on preventing overdose is harmful because it removes the natural consequences of drug use	0.00%	0.00%	62.50%	37.50%
All patients with a history of opioid addiction, their families, emergency medical technicians, and all police should carry Narcan	38.46%	38.46%	15.38%	7.69%

Only 15 percent of respondents felt that sobriety was the only helpful recovery goal for patients, indicating fairly strong support for harm reduction goals which may be based on improving safety and quality of life rather than sobriety. 26 percent felt that arrest, prison, and loss of family may be helpful for PWID. Although the majority did not agree, this appears to indicate moderate support for a moral model of intervention including punishment rather than harm reduction or even a disease model of treatment.

Fourteen percent reported that coworkers were not worried about patients who use injection drugs overdosing. However less than half (42.5 percent) reported that their coworkers worried that these patients could contract HIV. These results again may be impacted by participants reporting less socially desirable responses when asked about colleagues versus themselves. It is striking that within a hospital setting working with injection drug users that most staff would not have concerns about HIV/AIDS, considering their extensive medical and public health training. This likely has a strong impact on how receptive or necessary staff feel harm reduction interventions are, as many work to prevent the spread of blood-borne pathogens. It was notable that no staff felt that overdose education was harmful because it removes natural consequences of overdose. This contrasted responses to the question about Narcan being carried by family, patients, and emergency services. Although most agreed that Narcan should be carried, 23 percent disagreed or strongly disagreed. This appears to be somewhat contradictory as 85 percent of respondents stated that their coworkers are worried about overdose, and the best tool available at preventing the “consequence of overdose” --which is death--is Narcan. This is particularly interesting as reports of opioid overdose in this area have continued to rise, and currently all hospital staff are instructed to provide Narcan and instructions for use at discharge for all patients with a history of opioid abuse and their families. One quarter of the staff felt that

Narcan should not be distributed, which may signal that the implementation of this policy is not as institutionalized as perhaps assumed by hospital administration.

Harm Reduction Interventions

Nine 5-point Likert-scale type questions were asked about specific harm reduction education interventions' helpful or harmfulness. This scale was developed by the researcher with conceptual influence from the results of Bonar & Rosenberg's (2010) Treatment Attitudes Scale, and the later Treatment Attitudes Scale-Revised adapted by Fillmore (2015). The goal of this was to directly target several concrete areas of potential harm reduction intervention that is commonly practiced in health care and addiction treatment in other nations, and within many syringe exchange programs within the U.S. With little medical education or public information about harm reduction the researcher did not directly refer to "harm reduction" and instead described the potential activity. Most were geared at providing health education to allow patients to decrease their chances of overdose and/or transmission of disease.

Table 6
Survey Response Results: Harm Reduction Intervention Questions

How beneficial or harmful would the following be to our patients who use injection drugs:	Very beneficial	Beneficial	Neither	Harmful	Very Harmful
Be encouraged to use substance by other route (nasally or smoking instead of injecting)	0.00%	15.38%	51.28%	20.51%	12.82%
Learn to clean injection equipment with bleach	10.00%	30.00%	32.50%	15.00%	12.50%
Be encouraged to use a "test shot" (injecting a small amount first to see the potency of their drugs)	10.00%	25.00%	37.50%	17.50%	10.00%
Be counseled about using with others or in more public places	8.11%	40.54%	35.14%	8.11%	8.11%
Learn to dispose of needles in puncture-proof containers (e.g. water bottle)	36.84%	50.00%	10.53%	2.63%	0.00%
Be provided detailed directions to places where they can get free sterile injection supplies	30.77%	41.03%	20.51%	5.13%	2.56%
Be counseled about using one drug at a time (e.g. risks of benzodiazepines and heroin)	28.21%	56.41%	15.38%	0.00%	0.00%
Be encouraged to consider medication assisted therapy (Methadone, Suboxone, Vivitrol)	50.00%	45.00%	5.00%	0.00%	0.00%
Be counseled on rotating their injection sites	20.51%	43.59%	28.21%	7.69%	0.00%

Overall there was a very high rate of response for the “neither beneficial or harmful” category. There could be several reasons for choosing this neutral category including:

- Respondents being unclear about what this intervention is.
- Lack of concern or knowledge of the potential harm to PWID.
- Never having previously thought about the potential for the intervention.
- Feeling that providing this intervention would have very minimal follow-through from patients therefore preventing impact.
- Participants having a general lack of interest in these types of intervention.
- Treatment goals around abstinence rather than reducing harm, perhaps feeling that although harm reduction is generally not harmful, it is also not what patients need.

Overall, there was a similar level of support for overdose prevention and disease prevention interventions, but high support for recovery-focused and public safety interventions. This may indicate concern for PWID harming others rather than being harmed, as seen in the question about disposing needles. The intervention staff felt that medication assisted recovery (MAT) was most beneficial which is currently widely used in this hospital, with no staff reporting this as harmful and half finding it “very beneficial”. This high level of support may indicate a level of comfort and support created by the norms of the larger hospital culture, and the sudden increase of MAT in the media. Also largely supported as beneficial or not harmful were: “learning to dispose of needles in puncture proof container” which only 3 percent found to be harmful, “being counseled about using one drug at a time”, which no staff found to be harmful, and “counseled about rotating injection sites”, which 8 percent reported to be harmful to patients.

Encouraging patients to use substances by another route rather than injecting had the lowest support, with staff overall finding this harmful, half of respondents stating “neither” and 15 percent reporting this as beneficial. This seemed surprising as there was support for rotating areas of injection, however not for using substances in a way other than injection which is largely known to be the most dangerous route. “Learning to clean injection equipment with bleach” (disease prevention) and “using a ‘test shot’ (overdose prevention) had more diverse responses, overall showing participants found them to be slightly beneficial.

Other Responses

Due to distribution as a printed survey, rather than electronic, there were several surveys where questions were left blank, including one survey where one side was left blank. There were

several responses where more than one response was selected, leading the researcher to consider the response “blank”.

On two surveys completed on the Alcohol and Drug Inpatient Unit, several questions had comments or were crossed out and rewritten before being responded to, altering the meaning of the response. The researcher considered these as blank, in order to avoid misinterpreting intent. Although these responses were unable to be used for the statistical analysis, they nevertheless represent useful data. Some examples of this are: "Their brains become rewired- It's a disease!!" in response to the question “IV drug users do not fully understand the consequences of their actions”. "I'm happy they don't give up" in response to question “If they really wanted it and worked for it, most of my patients would have gotten sober”. In response to a harm reduction intervention question such as “Be counseled about using one drug at a time” a participant crossed out "using one drug at a time" and wrote "not using any drugs". Indicating a lack of support for the harm reduction intervention, and a strong support for abstinence only interventions. With only five participants from this unit, results may have been skewed.

Findings by Unit

All findings were analyzed by type of unit that the staff member works on. In the majority questions with a theme of stigma where there was measurable difference between unit type, the general treatment units rated with slightly higher stigma towards PWID. As expected, the alcohol and drug inpatient detox units, reported the least stigma, but only slightly lower than the intensive treatment units. In areas of efficacy, there was more notable difference between type of unit in two particular questions.

Table 7

*Survey Response Results by Unit: I feel like we are keeping patients safe while they detox**

I feel like we are keeping patients safe while they detox				
Unit Type	Agree	Disagree	Blank	Total Unit Response
General Treatment	84.62%	11.50%	3.85%	100.00%
Intensive Treatment	100.00%	0.00%	0.00%	100.00%
Substance Detox (Alcohol and Drug Inpatient)	60.00%	40.00%	0.00%	100.00%

Table 8

*Survey Response Results by Unit: My coworkers feel like we can decrease the chances of IV drug using patients from dying or getting HIV/AIDS**

My coworkers feel like we can decrease the chances of IV drug using patients dying or getting HIV/AIDS				
Unit Type	Agree	Disagree	Blank	Total Unit Response
General Treatment	38.46%	61.54%	0.00%	100.00%
Intensive Treatment	40.00%	50.00%	10.00%	100.00%
Substance Detox (Alcohol and Drug Inpatient)	100.00%	0.00%	0.00%	100.00%

* Results from “strongly agree” and “strongly disagree” were combined with “agree” and “disagree” for this interpretation and simplified presentation.

As shown on Tables 7 and 8, while the addiction unit staff felt that they were least effective at keeping PWID safe while admitted to the hospital, they conversely felt more than twice as effective at decreasing the chances PWID dying or contracting HIV. The later could indicate a greater awareness of risks for patients who use injection drugs, or perhaps more consideration of these risks within the treatment of these patients. The strong feelings of efficacy lead to questions of how these staff are decreasing the chances of HIV or death post discharge as education efforts around these would likely indicate that harm reduction education is happening on the unit.

In areas of harm reduction, as expected, the addiction unit was far more supportive of Narcan distribution and was more than twice as concerned about their injection drug using patients contracting HIV or dying as other units. There was one significant outlier:

“Consequences of drug use such as arrest, prison time, or loss of family support may be helpful for this population”. For this question, the addiction unit agreed more than other units. This result

is a surprising contradiction to other results, possibly indicating some support for a moral model of intervention where PWID are seen to need punishment to motivate change.

In each area of specific harm reduction intervention except one, the general treatment units had the least support with both the substance and intensive units reporting similar levels of support, as seen in Table 9.

Table 9

*Survey Response Results by Unit: Be provided detailed directions to places where they can get free sterile injection supplies**

Be provided detailed directions to places where they can get free sterile injection supplies					
Unit Type	Beneficial	Harmful	Neither	Blank	Total Unit Response
General Treatment	53.85%	7.69%	30.77%	7.69%	100.00%
Intensive Treatment	90.00%	10.00%	0.00%	0.00%	100.00%
Substance Detox (Alcohol and Drug Inpatient)	100.00%	0.00%	0.00%	0.00%	100.00%

* Results from “very beneficial” and “very harmful” were combined with “beneficial” and “harmful” for this interpretation and simplified presentation.

The general treatment units also had the highest rates of responses for “neither harmful or beneficial” nearly all intervention questions. This could indicate more uncertainty about how harm reduction could be beneficial or may feel of less concern on these psychiatric units where substance use may not always be a focus of treatment. Overall, the addiction unit generally had the most support for disease prevention interventions, while the intensive unit had the most support for overdose prevention interventions. This aligns with addiction unit rating worry about patients contracting HIV at twice the rate of other units, while the intensive unit had the highest support for Narcan being provided.

Inferential Statistics

There were no statistically significant relationships found between level of stigma and harm reduction receptivity in the sample. To test the hypothesis that there would be relationships

between these variables, stigma-based questions and efficacy questions were compared to harm reduction interventions using chi squares. In each of these, $P > 0.5$ indicating a lack of significance.

Summary of Major Findings:

This exploratory study resulted in no statistically significant relationships between milieu staff's perceptions of PWID and their attitudes about harm reduction: However, descriptive results did provide some interesting insights on stigma, efficacy, and receptivity to interventions. Areas of high stigma included: providers' frustration working with this population and providers feeling that PWID "game or abuse the system". Areas of lower stigma included: feeling PWID deserved treatment, and have a sense of responsibility for their own life. Staff appeared more likely to portray their colleagues as having high stigma than themselves and in fact felt there was a great deal of frustration among coworkers. Overall providers reported feeling effective at treated PWID while admitted, but felt they would not be able to decrease morbidity and mortality for patients.

Participants' receptivity to harm reduction principles were mixed, with somewhat inconsistent reports. Overall most participants were in support of harm reduction philosophies to treatment, but it was not a statistically significant difference. In regard to particular harm reduction interventions, respondents overall supported these with most support for medication assisted therapy. There was generally higher receptivity to HR interventions which had an inherent disease model theme that more easily adapt to a medical model of treatment. Most notable was the very high responses of "neither beneficial or harmful" on the interventions. By

unit, there was variability among units with general treatment unit's showing slightly higher stigma, and slightly lower HR receptivity.

Chapter V

Discussion

A comprehensive public health perspective to treatment must be taken to address the epidemic levels of overdose and disease burden among people who inject drugs. The criminalization of injection drug users has created a public stigma that penetrates every area of society, causing catastrophic social and health outcomes. In order for evidence-based interventions to be implemented to address this health crisis, the stigma of health care workers must be evaluated and addressed. As authorities on health, nurses have the potential, and arguably, the responsibility, to combat stigma and act as advocates in the larger community.

There is evidence that nurses' ability to effectively treat and advocate for patients is hindered by this social stigma. Previous studies have emphasized provider-patient rapport in effective treatment outcomes (Salvalaggio, 2008), and the prerequisite of support for patients' self-determination in harm reduction work (Harm Reduction Coalition, 2015). This study sought to determine the level and types of stigma that nurses have working with PWID at this hospital. It also sought to ascertain perceptions of harm reduction and evaluate any correlation between stigma and harm reduction receptivity.

Findings and the Literature

The findings of this study illustrate some of the specific areas of stigma among nurses working with PWID on inpatient detox units at this hospital. This study generally supported the existing literature on provider stigma in healthcare and substance use treatment. Research such as

Ford (2011) found high levels of stigma in nurses working with substance users, feeling they are dangerous, irresponsible and manipulative. This study supports these findings, most notably, ideas of PWID being manipulative. Lloyd (2010) also found high levels of stigma among providers who work with substance using populations, emphasizing this was at even higher rates than other stigmatized groups such as the severely mentally ill. This was particularly pertinent in this study psychiatric hospital staff, and was also supported with many staff expressing frustration with PWID over patients receiving other mental health treatment. Salvalaggio's (2008) study of rapport, found that without positive rapport between patient and provider, PWID have poorer health outcomes and do not seek treatment. The results of this study emphasize areas where PWID may be experiencing prejudice and poor provider-patient rapport, potentially threatening public health.

Studies such as Bonar & Rosenberg (2010), found that providers generally favored "traditional" modes of treatment to harm reduction modes most notably with overdose prevention methods which they found to be somewhat harmful. This research illustrated stronger support for various interventions, such as those with a recovery and public safety focus, with similar support for both overdose and disease prevention measures. It is likely that the spike in opioid overdose awareness in recent years and the increase in acceptability of medical treatment (such as medication assisted therapies) may have affected these results.

Existing research shows the both the efficacy of harm reduction, and health care workers' generally low receptivity to it, however there has not been research attempting to link this to stigma and perceptions of PWID. Due to the social justice and self-determination philosophy of harm reduction, it was hypothesized that nurses with higher levels of stigma would be less receptive to harm reduction concepts and interventions. There were no statistically significant

findings indicating a correlation between these two attitudes. These results contrast with theories and literature indicating a need for more research to investigate. These unexpected findings present an avenue for raising new questions for further studies to explore.

Inconsistent Responses

Many responses were unexpected based on other responses. Support appeared inconsistent, with seemingly contradictory responses to questions which addressed similar issues. An example of this inconsistency is that participants who felt worried about patients contracting HIV or dying, did not support interventions to attempt to prevent death or HIV infection at any significantly higher rate than those who did not feel worried about this. Another example of unexpected inconsistency, is that those who reported worry about overdose, did not report support for Narcan or prevention education at any higher rates than those who did not report worrying about overdose. This lack of any expected relationship may represent a lack of interest in accurately completing the survey due to the high numbers of research studies conducted in this setting.

Social Desirability

Another hypothesis for these inconsistencies is that participants did not honestly self-report. Both the reliability and validity of the results may have been influenced by social desirability bias due to the sensitive nature of a survey investigating stigma. Randall & Fernandes (1991) report that the tendency to deny socially undesirable personal traits on self-report questionnaires may pose more of a risk to validity on ethics research than traditional investigations, finding even assurance of anonymity will not remove this bias. In their study

assessing nurses level of caring for their patients, Cossette et.al (2005) asserted that, “Control for social desirability is rarely used in studies on nurse–patient interactions when using a self-report scale; social desirability is important to consider for future research. It also suggests that other data collection methods, for example observation techniques, should be considered (p 682).”

Randall & Fernandez (1991) also differentiate an additional layer to the bias, the self-deception bias, which refers to the unconscious tendency to see oneself in a more positive light. This may be seen in this research as respondents provided significantly less desirable (higher stigma) responses when they were asked about “coworkers” versus themselves. This indicated that nurses felt their coworkers possessed higher stigma than themselves, likely indicating unreliable self-reports, and elevated sense of personal ethics. Changing questions to all reflect attitudes of colleagues may be an area of future study, as this appears to have significantly lowered the social desirability bias.

Social desirability may also have impacted self-reports due to respondents worrying about the larger implications on their job. This may be due to feelings that these topics were outside of the scope of responsibility for their position. This could be evidenced by the reports of high efficacy of “keeping patients safe while they detox”, but low reports of feeling that they “can decrease the chances of patients dying or getting HIV”. With nurses often working long hours and managing a high patient load, they may worry about adding additional responsibilities to their positions.

“Neither” Responses

There was a very high frequency of “neither beneficial or harmful” responses on questions where this was an available answer. This may be due to respondents feeling harm reduction is outside of the scope of their position, or that they may lack general awareness.

Participants may not be aware of what these interventions are, or how they may be beneficial to PWID. Nurses may be uninformed of the level of risk that PWID face, or do not have education on health care disparities or rates of mortality. “Neither” responses may represent a lack of interest or investment in responding to the survey, acting as a ‘non-response’, or avoiding socially undesirable responses.

Models of Addiction Treatment

Many of the themes of stigma common to substance users are based on the *moral model* of addiction, where the individual is both without morals, and in need of punishment. Findings showed some support for this concept, but overall a much larger and expected support for the *disease model* which is exclusively used in U.S. treatment settings, and considered to be the humane alternative to the *moral model* (Kyser, 2010). This study showed generally higher receptivity to harm reduction interventions which could most easily adapt to the *disease model* of treatment where providers may have the expectation that the patient’s goal is sobriety from all substances. This is not surprising as medical settings are designed to treat diseases and these interventions may be most easily adapted. This was seen throughout the stigma and efficacy-based questions with one respondent writing in “It’s a disease!”. The education about substance use across disciplines in the U.S. has begun to focus on this less blame-based concept, yet alternatives or complements to the *disease model* are rarely discussed, and many providers may not have knowledge of them. Building off this *medical model* to a more *holistic* public health perspective, which considers psychosocial factors, as used in much of Europe, Canada, and Australia, provides opportunities for more treatments that can reach more people in need (Kyser, 2010).

Hospital Culture

Lloyd (2010) found nurses and other providers to be subject to the same larger cultural influences and prejudices as the rest of society, however they have the unique potential to greatly impact the lives of those most in need. It appears that the larger culture of this hospital setting may substantially impact perceptions of patients and interventions. Several harm reduction interventions were largely supported, with most being already implemented to some extent in this, or other hospitals. The acceptance of various philosophies and ideas appears to be influenced by the cultural norms of the setting. Although research supports progressive harm reduction services, the hospital seems to have the goal of emergent medical stabilization only, and appears not to convey the impact staff have on the ongoing safety and survival of their patients. This may indicate that nurses' beliefs and willingness to provide treatment is subject to the culture created by the hospital, evidenced by staff's current receptivity to medication assisted therapies which has been embraced by the larger administration. Respondents' report of their coworkers being frustrated by, and having stigma against PWID indicates that, although they may not feel stigmatizing themselves, they may perceive the hospital culture to be stigmatizing. This may represent a culture of milieu staff feeling unsupported where self-reporting accurately may feel unsafe. This may be in part due to high patient loads, staffing budget cuts, and job performance expectations. Additionally, this could indicate a culture that feels competitive and does not support personal accountability, where staff do not feel able to take on responsibility for patient outcomes, and feel defensive about their own rapport with patients. Although nurses may have concerns they are not fully represented by administration, the leadership has a clear ability to continue to move toward creating an environment which supports staff in reducing the dangers of drug use for their patients.

The overall lack of concern about patients contracting HIV or dying after discharge, particularly stood out in contrast to expected responses and likely accounted for modest support for interventions. This response was confounding in part due to the medical nature of treatment here, and the expectation that nursing staff would be acutely aware of the high rates of HIV, and the risks their clients' face. There is evidence that as Americans' fears of HIV/AIDS have dissipated, with public discourse a characteristic of the 1990's, awareness of risk has decreased and HIV rates have been on the rise. If there is not knowledge and alarm around the very real risks of infection and death for these very high-risk patients, there would not be a desire for more effective interventions. Harm reduction seeks to reduce mortality and morbidity, however if the risks are not realized by key health care providers, the solutions will not be either.

Limitations of This Study

The study design of a convenience sample within one hospital setting, as well the relatively low number of participants (N=41), greatly limited the generalizability of the findings. This is especially true for findings based on unit, most notably the Drug and Alcohol unit, with N=5, causing results to have low reliability compared with the General Treatment Unit. Results suggest that the survey tool may have limited value in this setting and may be more useful in conjunction with qualitative measures such as focus groups. The lack of expected relationships discussed above contrast findings of the literature, indicating need for further study.

Strengths

Although there is very limited generalizability to the results, they nevertheless offer a start to exploring the rapport between providers and patients in this hospital, and offer some

indication of areas for implementation of harm reduction education. Identification of specifically high levels of stigma offer useful data to hospital administration to consider the effects on patients and areas of further outreach and education to staff. General support for harm reduction interventions illustrates potential for implementation on all units. The relationship between stigma on varying types of units offers a window into the microcosm of the larger hospital culture and areas of strength and need.

Implications for Social Work and Further Study

The results of the study point to a need for further assessment and specialized training for medical staff working with PWID. Stigma and blame are known to prevent provider-patient relationships from forming, limiting effective outcomes, and leaving potential patients fearful of seeking services. Stigma and disease models can prevent providers from viewing patients as capable of deciding their treatment, possibly leading to providers selecting abstinence-only models of intervention, shown to alienate patients who inevitably encounter relapse.

Social work has a unique social justice orientation to public health, with a focus on providing services based on clients' identified desires and goals. As part of training, social workers are taught to interrogate their own biases in the context of our larger culture, to determine the most client-centered treatment possible. Stigmatized individuals living at the margins, require this to be able to access care, and at times, to stay alive. Substance use treatment institutions are generally based on moving patients to abstinence, despite the needs and goals of the patient. Viewing patients as *diseased* has historically been used to advocate for medical treatment for PWID and furthered judgment of individuals as incapable, and defective. Social work education is based on building therapeutic relationships and offering information to honor

the patients' choices, even if this is substance use, or injection drug use. This realistic approach to reducing individual and societal harm is imperative to implementing harm reduction interventions within institutions. Working to shift institutional culture to a model of holistic patient self-determination and mutual respect is a daunting task, however a perfect avenue for social work to advocate for integrating agency goals and community needs.

The non-significant findings of a relationship between perception of patients and receptivity to harm reduction interventions may lead to research on other effects of provider stigma for this population. Additional questions comparing harm reduction and abstinence-based treatment may help to provide context to participants, and could preface training on health disparities and efficacy of these interventions. This may also indicate a need to gain more nuanced qualitative data on perceptions of various harm reduction or other interventions, such as interviews or focus-groups. Gaining more information to clarify perceptions and inconsistencies, as well as to determine level of awareness would assist in determining next steps in implementation of education programs.

Conclusion

A review of the literature highlighted evidence of provider prejudice and stigma, while also indicating this has a catastrophic impact on getting PWID access to medical treatment. The literature also illustrated the low cost and high efficacy of harm reduction interventions, as well as the inherent need for respect, self-determination, and rapport between patient and provider. With very limited adoption of this efficacious and client centered form of treatment, questions arise about what could impact providers' receptivity to offering this to their high-risk patients. Although this study did not identify statistically significant relationships between stigma and

harm reduction, inconsistent responses and low participation may have had an effect on the validity of this self-reported data by psychiatric nurses working with PWID. Nevertheless, it is evident that more education within medical and addiction treatment settings may be beneficial in continuing to explore the disconnect between the most at-risk patients, and potentially life-saving interventions.

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Appendix A: Survey Tool



By checking this box, I am providing authorization that I have read the informed consent form associated with this study and freely decided that I will participate in the project described in the consent form. Its general purposes, the nature of my involvement, and possible hazards and inconveniences have been explained to my satisfaction.

Please answer the following anonymous and confidential survey to the best of your ability pertaining to your experiences with people who use injection drugs.

	YES	NO	I'D PREFER NOT TO SAY
1. When I started at this hospital, I anticipated that I would be working with patients detoxing from IV drugs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. I have personally been affected by addiction (myself or someone I love)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please indicate how much you agree or disagree with the following statements:

	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE
3. I am concerned about the safety of the very mentally ill patients when they are around drug users on the unit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. The patients here for psychiatric emergencies deserve treatment more than those here for detox	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. IV drug users are not that worried about dying	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. My coworkers feel like we can decrease the chances of IV drug using patients dying or getting HIV/AIDS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Our heroin addicted patients often game or abuse the system	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. I have heard how frustrated coworkers are working with addicted patients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. I feel uncomfortable working with the drug users on the unit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. IV drug users have an interest in keeping themselves safe	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. I feel like I can positively impact the recovery process for patients on the unit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. If they really wanted it and worked for it, most of my patients would have gotten sober.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Consequences of drug use such as arrest, prison time, or loss of family support may be helpful for this population	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. IV drug users do not fully understand the consequences of their actions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. IV drug using patients are generally out for their own interest and not thinking about others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please indicate how much you agree or disagree with the following statements:

	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE
16. The goal of sobriety is the only helpful goal in recovery from IV drug use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. My coworkers are worried about our IV drug using patients contracting HIV	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. My coworkers here are worried about our patients overdosing after discharge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. Educating addicts on preventing overdose is harmful because it removes the natural consequences of drug use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. All patients with a history of opioid addiction, their families, emergency medical technicians, and all police should carry Narcan	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. I feel like we are keeping patients safe while they detox	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How beneficial or harmful would the following be to our patients who use injection drugs? (Heroin, opiates, cocaine, etc.)

	VERY HARMFUL	HARMFUL	NEITHER HARMFUL NOR BENEFICIAL	BENEFICIAL	VERY BENEFICIAL
22. Be encouraged to use substance by other route (nasally or smoking instead of injecting)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. Learn to clean injection equipment with bleach	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. Be encouraged to use a "test shot" (injecting a small amount first to see the potency of their drugs)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25. Be counseled about using with others or in more public places	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26. Learn to dispose of needles in puncture-proof containers (e.g. water bottle)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27. Be provided detailed directions to places where they can get free sterile injection supplies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
28. Be counseled about using one drug at a time (e.g. risks of benzodiazepines and heroin)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
29. Be encouraged to consider medication assisted therapy (Methadone, Suboxone, Vivitrol)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
30. Be counseled on rotating their injection sites	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Fillmore, S., & Hohman, M. (2015). Traditional, alternative, and harm reduction approaches: What do social work students think? *Journal of Social Work Practice in the Addictions, 15*(3), 252-266.

**This study protocol has been reviewed and approved by the Butler Hospital Institutional Review Board Committee (HSRC).*

Additional Comments?:

Appendix B: Smith College Human Subjects Review Approval Letter



School for Social Work

Smith College

Northampton, Massachusetts 01063

T (413) 585-7950 F (413) 585-7994

January 19, 2017

Ciara Devozza

Dear Ciara,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, EdD

Co-Chair, Human Subjects Review Committee

CC: Alisa Ainbinder, Research Advisor

Appendix C: Informed Consent

██████████ HOSPITAL CONSENT FOR PARTICIPATION IN A RESEARCH PROJECT

Provider perceptions of people who inject drugs and harm reduction approaches

Sponsorship

This study is being conducted as a research requirement for completion of the researcher's Master's degree in social work (MSW) through Smith College School for Social Work. There is no funding or sponsorship for this study.

Invitation to Participate and Description of Project

You are being invited to participate in a study designed to learn more about providers' perceptions of treating patients who use intravenous drugs. You are being asked to participate because you are a nurse on ██████████ Hospital inpatient unit who has worked with patients who use injection drugs. Your participation in the study will last only the time period for completion of this one-time survey. When the survey is returned via the locked drop box, your participation will end. You will have up to one-week to complete the survey. It will require approximately ten minutes of your time.

In order to decide whether or not you wish to be a part of this research study, you should know enough about its risks and benefits to make an informed judgment. This consent form gives you detailed information about the research study which a member of the research team will discuss with you. This discussion should go over all aspects of this research: its purpose, the procedures that will be performed, risks associated with the procedures, possible benefits of participation and possible alternatives. Once you understand the study, you will be asked if you wish to participate; if so, you will be provided a copy of this form and the survey to complete.

Description of Procedures

If you decide to participate, you will be asked to complete the attached survey honestly, to the best of your ability. The total time for survey completion will be five to ten minutes. This will be the only requirement of participation. You may choose to complete this survey at this time, or you may complete it within one week and deposit the completed survey into the locked drop box provided on the unit. Please only complete one survey.

Risks and Inconveniences

There are no reasonable foreseeable or expected risks. As a confidential and anonymous survey, risks to participants are greatly minimized. Participation or non-participation will not affect your employment at ██████████ Hospital. No one will have knowledge of which staff have participated if your survey is placed into the drop-box at a time that it will not be observed by others.

Confidentiality

This study is anonymous. Individual survey results will not be shared. We will not be collecting or retaining any information about your identity. The researcher will have no knowledge of who the participants are and no demographic or identifying information will be collected. Your participation will

be kept confidential. The researcher will not include any information in any report that may be published that would make it possible to identify you. You will not be personally identified in any reports or publications that may result from this study. The confidentiality of the information you provide to us will be maintained in accordance with state and federal laws. All information will be summarized and no individual survey information will be used. Surveys will not be shared with [REDACTED] Hospital administration or staff. Results will be shared only in aggregate with Smith College School for Social Work and [REDACTED] Hospital administration. An example of aggregated results would be “29 percent of participants stated that they were satisfied with current scheduling and 63 percent felt that more options should be offered”. Results regarding data from each specific unit will not be provided to the hospital administration.

If you would not like other staff or supervisors to be aware of your participation, you may choose to deposit your completed survey into the secure drop-box unobserved, anytime during the next week. All research materials including surveys, analyses, and consent/assent documents will be stored in a secure location for six years according to [REDACTED] regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. We will not include any information in any report we may publish that would make it possible to identify you.

Benefits

The benefits of participation include having an opportunity to share opinions about issues important to you confidentially and anonymously. With recent political focus on increasing services for intravenous drug users, understanding the perspective of service providers is invaluable. The field of social work can benefit from this data by gaining an increased understanding of the concerns and challenges of front line medical staff working with a high-risk population. This research may also be helpful in gaining connections between provider experience and methods of efficacious service delivery.

Economic Considerations

You will not receive any financial payment for your participation.

Alternative Treatments/Alternative to Participation

No treatments are being offered in this study. The decision to participate in this study is entirely up to you. You may refuse to answer any question or withdraw from the study, without affecting your relationship with the researcher of this study or Smith College. You may withdraw up until you deposit your completed survey. You will be unable to withdraw after this point as it will be impossible to identify your individual survey. Your decision to refuse will not result in any loss of benefits to which you are otherwise entitled.

Financial Disclosure

Not applicable.

Voluntary Participation

You are free to decide whether or not to participate in this study, and you are free to withdraw from the study at any time. A decision not to participate or to withdraw from the study will not adversely affect your current or future interactions with [REDACTED]

Questions

In preparation of this consent form, it was necessary to use several technical words. Please ask for an explanation of any that you do not understand.

Due to the anonymity of this survey, your signature is not needed. You may keep this form for your records.

If you have further questions about this project please contact Ciara DeVozza, [REDACTED]
[REDACTED]. If you have questions about your rights as a research subject,
please contact [REDACTED]
[REDACTED]

**THIS FORM IS NOT VALID UNLESS THE FOLLOWING
BOX HAS BEEN COMPLETED BY THE IRB OFFICE**

<p>THIS FORM IS VALID UNTIL</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p>
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