Mountain Plains ATTC (HHS Region 8)

ATTC Addiction Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

Harm Reduction Perceptions, Practices, and Training/Technical Assistance Needs Among Substance Use Disorder Treatment and Recovery Service Providers in HHS Region 8

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Introduction

The purpose of the Mountain Plains Addiction Technology Transfer Center (ATTC) is to improve the capacity of the substance use disorder (SUD) treatment/recovery services workforce in HHS Region 8, by using state-of-the-art training/technical assistance, innovative web-based tools, and proven workforce development activities to expand access to learning, change clinician practice, and advance provider efficiencies, resulting in improved client outcomes.

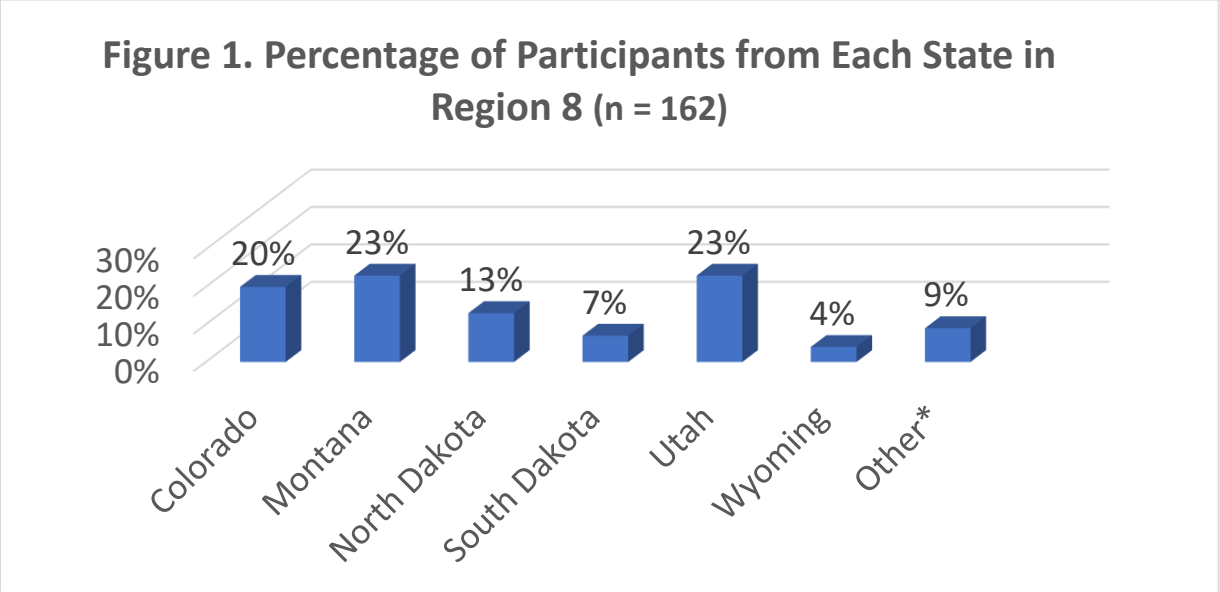
In spring of 2023, Mountain Plains ATTC conducted a survey in an effort to better understand the training and technical assistance needs of individuals providing SUD treatment and recovery services in Region 8. The purpose of the survey was to determine providers' perceptions, practices, and training/technical assistance needs, specifically in relation to harm reduction (HR) services/activities for SUDs. An invitation to participate in the survey was emailed posted on the Mountain Plains ATTC website and was sent to all constituents within Region 8 for which the Mountain Plains ATTC had email addresses. In addition, participants were asked to invite others within their agencies and networks to participate. The survey was completed between March 9 to April 12, 2023. Approval to conduct the survey was obtained from the University of North Dakota Institutional Review Board.

Results from this survey will help Mountain Plains ATTC better collaborate with providers and stakeholders throughout the region in the development of new products, training materials, and technical assistance. It is also hoped that this report will provide readers with a snapshot of the perceptions, practices, and technical assistance/training needs of the SUD provider services workforce in Region 8.

Characteristics of Participants

A total of 182 individuals began the survey. However, six of these individuals did not respond beyond the first question, which asked if they wished to continue with the survey. In addition, those participants who indicated they worked in a state other than those within Region 8 (n = 14) were not allowed to proceed with the survey. Thus a total of 162 participants made up the final sample. Reponses from these 12 individuals were reviewed and form the basis of this report. It should be noted that not all of these 162 participants answered all of the remaining questions, and the numbers of those answering questions decreased as the survey went on. The number of total respondents for individual questions is denoted by "n = __" in each of the figures.

As can be seen in Figure 1, there were participants from each state in Region 8, with the largest percentages coming from Colorado, Montana & Idaho.



*Note: Those who reported "Other" were not allowed to proceed with survey, and are not included in the total number of 162

Figures 2, 3, and 4 illustrate the ages, genders, and races of the survey participants. Overall the majority of participants were between the ages of 40 and 69 (70% of total), female (67%), and White (80%). However, other ages, genders, and races were also represented. The largest group of non-white participants were Native Americans at 8%.

Figure 2. Ages of Participants
(n = 159)

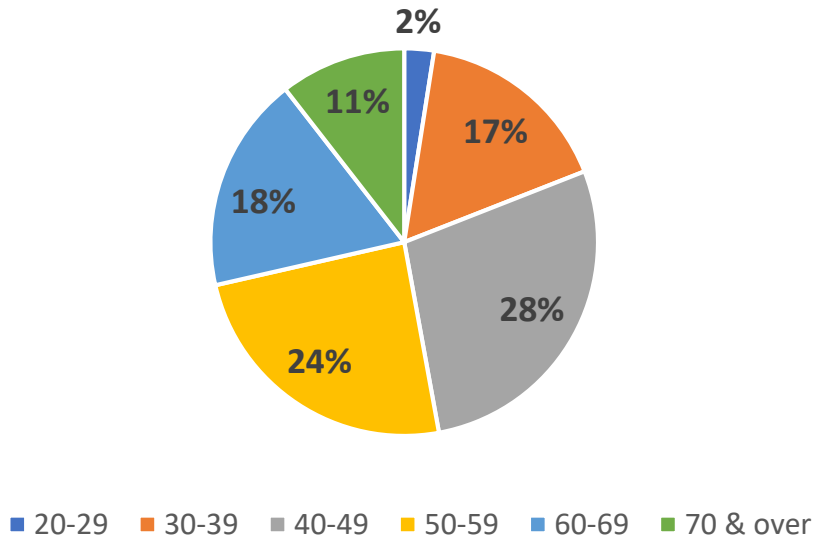
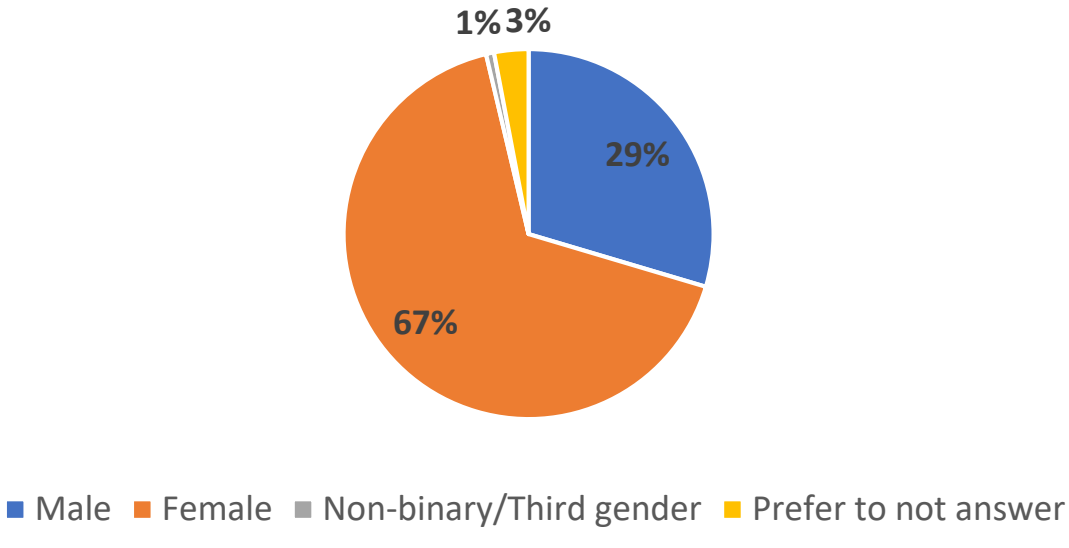
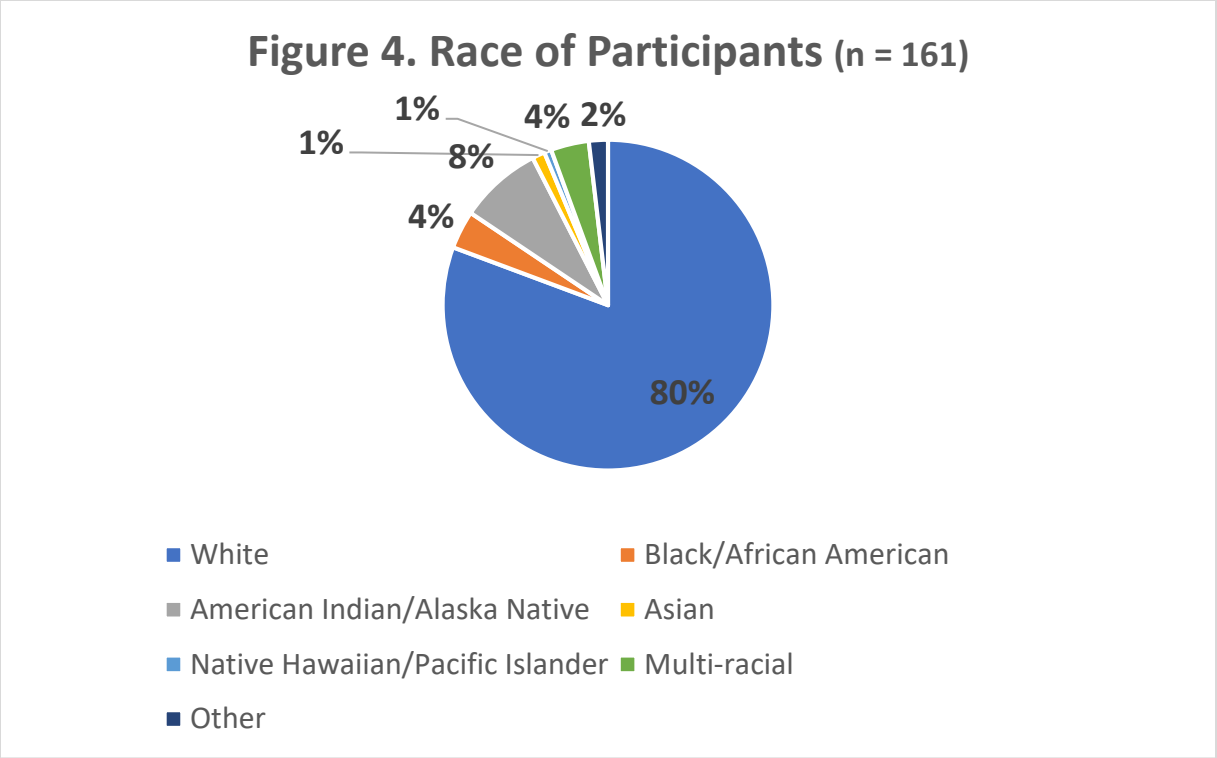
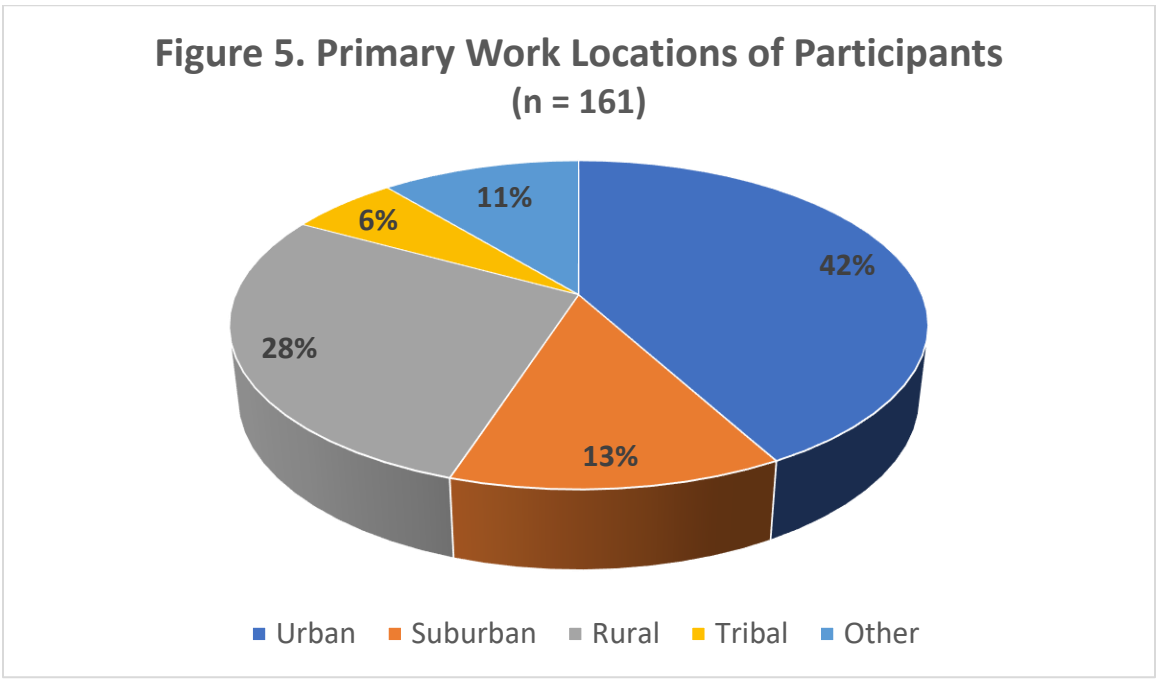


Figure 3. Gender of Participants (n = 162)

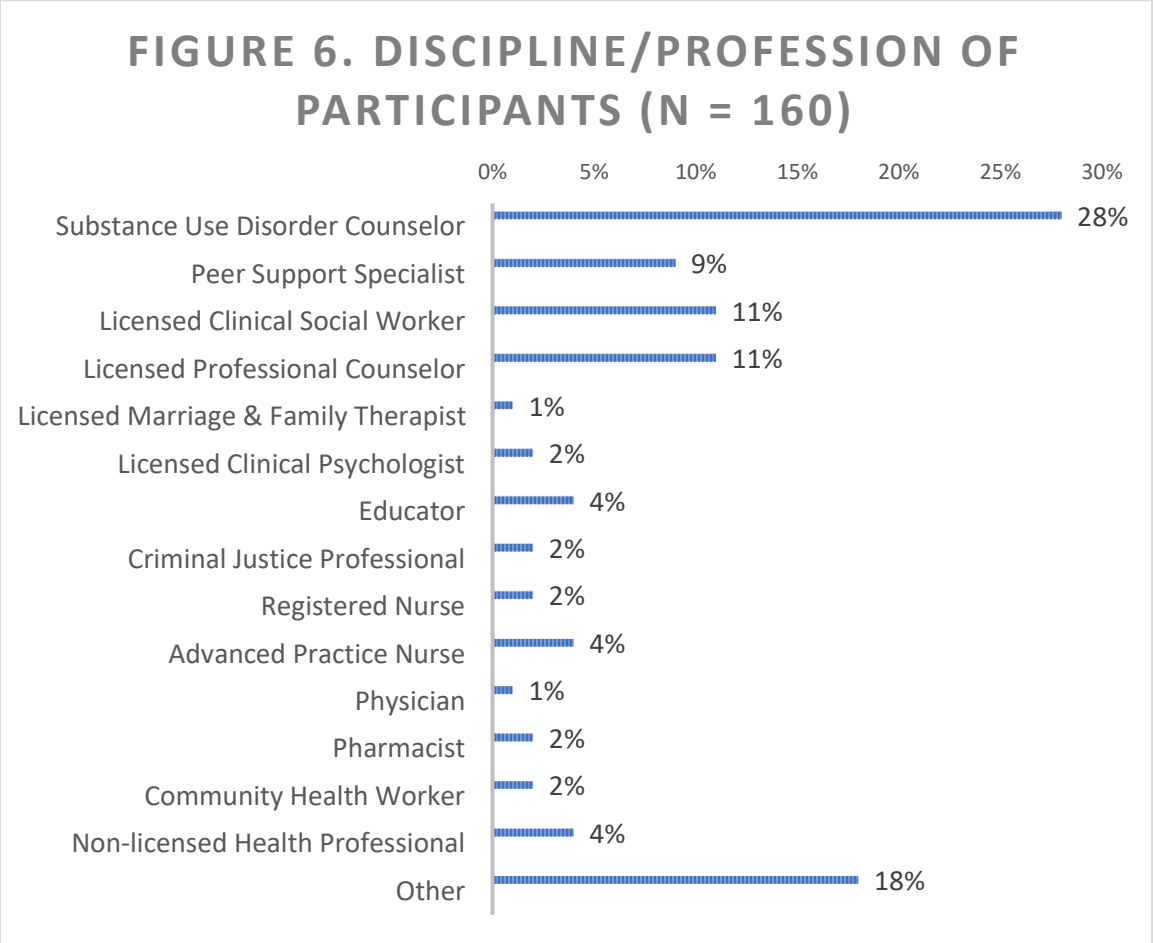




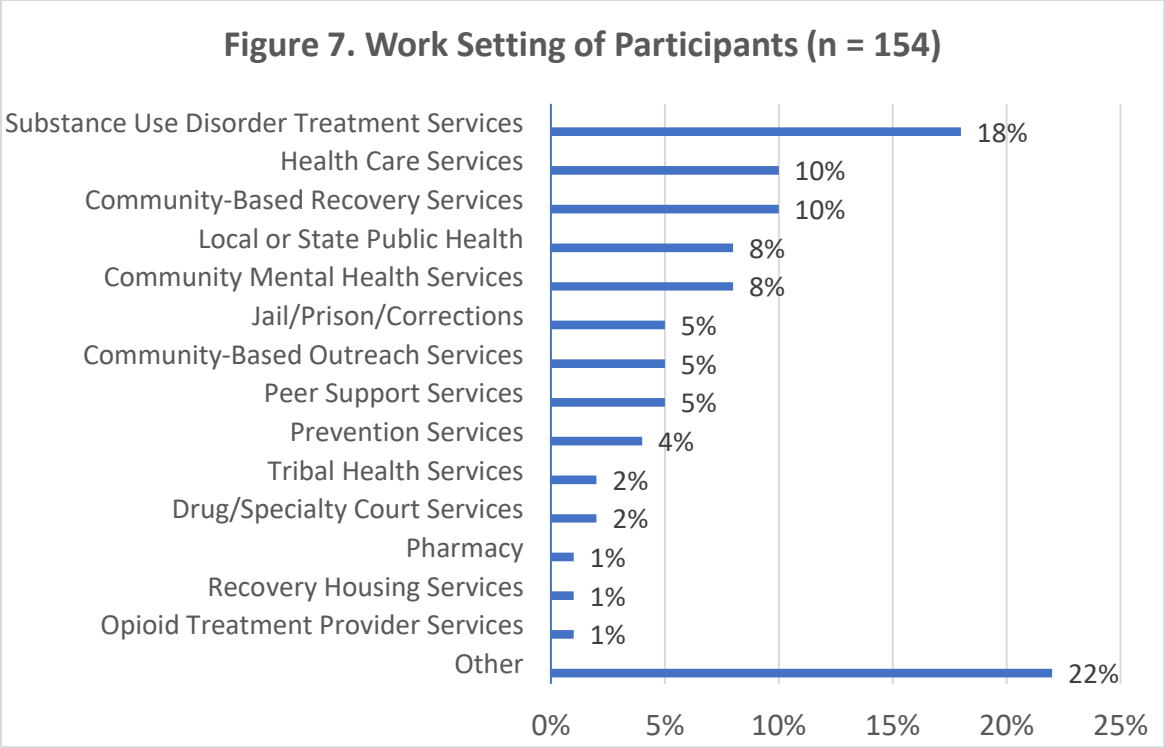
In terms of the locations of work settings, 42% reported working in urban settings, 13% in suburban, 28% in rural, and 6% in tribal communities, as can be seen in Figure 5. A total of 11% identified a setting other than these categories.



A wide variety of disciplines/professions were represented in the overall sample, as can be seen in Figure 6. The largest percentage of participants identified as Substance Use Disorder Counselors (28%), with Licensed Clinical Social Workers and Licensed Professional Counselors each making up 11% of the sample. Eighteen percent of the participants identified as a member of a discipline/profession "other" than those listed. Some commonly listed by participants were: Administrator, Case Manager, and Prevention Specialist.



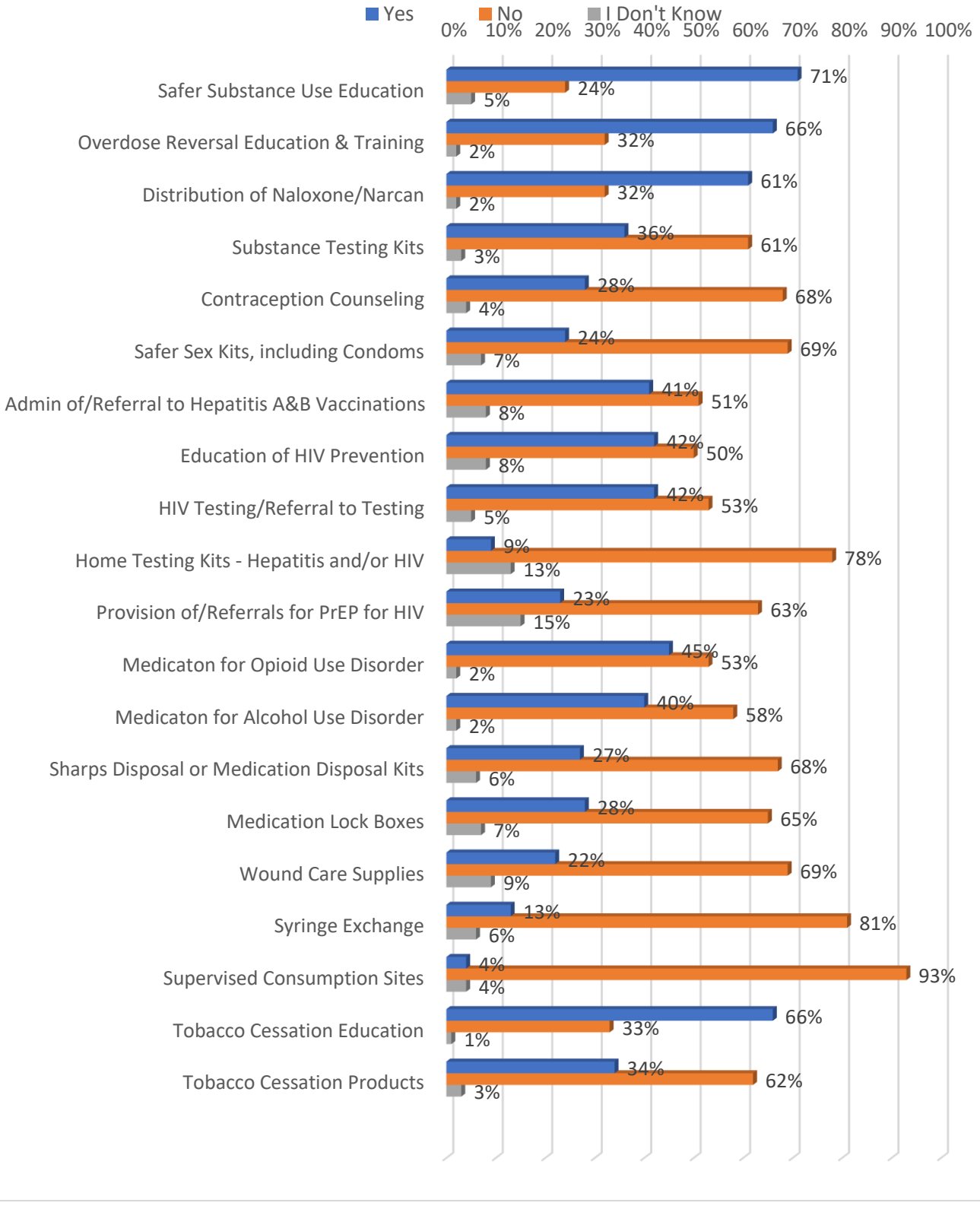
As can be seen in Figure 7, there was also a wide variety of settings in which participants worked. The most common reported work setting was at a Substance Use Treatment Services agency (18%), followed by Health Care Services and Community-Based Recovery services, both at 10%. Twenty-two percent of the participants indicated a work setting other than those listed. Some of these included Higher Education, Private Practice, State Government, and Juvenile/Adolescent Services.



Agency Services/Products (Harm Reduction Related)

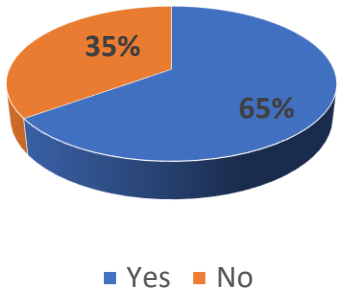
In the survey, participants were provided a list of services and products (See Figure 8). They were asked to indicate if their agency did or did not provide these services/products, or if they did not know. At this point in the survey, there had been no mention of harm reduction. Further, in an attempt to avoid bias, the list was not framed as harm reduction services/products. The services/products which were provided by the majority of participants included Safer Substance Use Education (71%), Overdose Reversal Education and Training (66%), Distribution of Naloxone/Narcan (61%), and Tobacco Cessation Education (66%). Those that were provided the least often (less than 25%) included Safer Sex Kits, Including Condoms (24%) Provision of/Referral for PrEP for HIV (23%), Wound Care Supplies (22%), Syringe Exchange (13%), FDA Approved Home Testing Kits for Hepatitis and/or HIV (9%), and Supervised Consumption Sites (4%). It is interesting to note that 4% of participants indicated that their agency provided a supervised consumption site, despite the fact that such services are not legal within any of the six states in Region 8,

Figure 8. Agency Services/Products Provided to Persons with SUDs (n = 117 - 130)



Once participants completed their responses to the previous list, they were then asked to indicate if they were providing harm reduction services to persons with SUDs. As depicted in Figure 9, 65% of participants responded that they were providing HR services, and 35% said they were not. It is interesting to note that a greater percentage of participants indicated that they were providing Safer Substance Use Education and Overdose Reversal and Education (71% an 66%, respectively). Thus, it is possible that participants may not recognize these types of services as harm reduction.

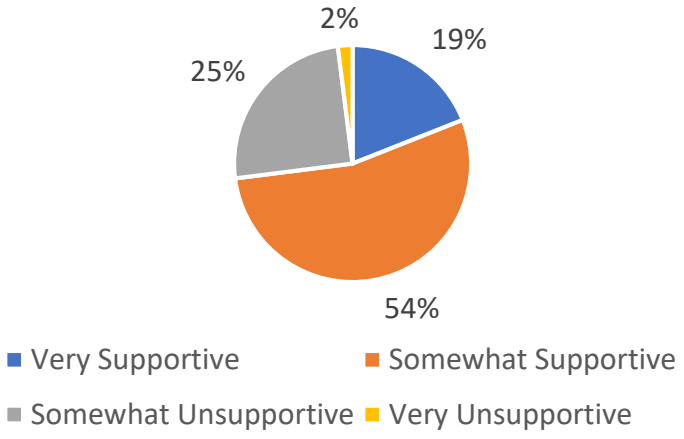
Figure 9. Are You Providing Harm Reduction Services to Persons with SUD?(n = 144)



Community Support for Harm Reduction Work

Those participants who indicated they were providing harm reduction services were asked to rate how supportive their community was in relation to their harm reduction work. Table 10 illustrates the findings for this question, with 73% of respondents indicating the community was very or somewhat supportive, and 27% indicating the community was somewhat or very unsupportive.

Figure 10. Perceived Support from Community for Harm Reduction Work (n = 91)



The participants who indicated their community was either somewhat or very supportive of their harm reduction work were then asked to describe how the community supported their work. The most common response was in relation to **Narcan/Naloxone training and distribution.** Many participants indicated that they received numerous requests for Naloxone education from various agencies/organizations within their communities. Multiple also indicated that the community was supportive of their own or other agency distribution of Naloxone.

Another common way that participants found community support for their harm reduction work was through **community partnerships** in which other agencies would refer clients for harm reduction services or by partnering in multi-agency projects. Being invited to community partner events, as well as the public attending community events was also perceived as supportive. Others noted that **media** was another way they found support for their work, in that community members and other agencies often shared their social media posts and notices of events. One participant also noted that they *"have some good relationships with local journalists."*

Several participants noted that harm reduction services were particularly supported for **youth** in their communities. As one participant noted *"They want us to be providing positive messages to the youth and families, so they are open to events that support prevention of addiction and overdose."* Another noted that the juvenile services and county workers were particularly supportive of their work.

Volunteering by community members was also noted as supportive of harm reduction work. In the words of one participant*, "We have many volunteers, mostly students and people in recovery, who do great work for us."* Donations of *"time, money, packing supplies, etc."* were also an indication of support from the community.

Finally, participants noted several ways in which **policy** provided support for harm reduction work. The following quotes indicate how policy at the state or local level was felt to support participants' harm reduction work:

- *"It's part of the state plan and many stakeholder agency plans to provide harm reduction and prevention services."*
- *"Support from the governor and his wife."*
- *"Legislation to support treatment of substance use, including harm reduction with Methadone as well as other harm reduction programs."*
- *"A safe housing harm reduction program through the county."*

Ways in Which Community is Unsupportive

Participants who indicated their community was either somewhat or very unsupportive of their harm reduction work were asked to describe how they were unsupportive. **Lack of awareness and knowledge** was seen as a major factor in why communities may be unsupportive of harm reduction efforts. For example, one individual who worked in corrections noted *"Staff are sometimes confused and frustrated about having these substances introduced into the system when they work so hard to keep them out (i.e. suboxone). They struggle to understand why we would put someone back on a substance when they have been 'clean' for so long while incarcerated."* A lack of knowledge then contributes to **stigma**, judgement, and overall lack of support for harm reduction. As one individual noted "*If we were to have a syringe exchange it would be frowned upon as something that would encourage 'those people' to come to the community. In the meantime, drug use continues to increase and resources are limited."*

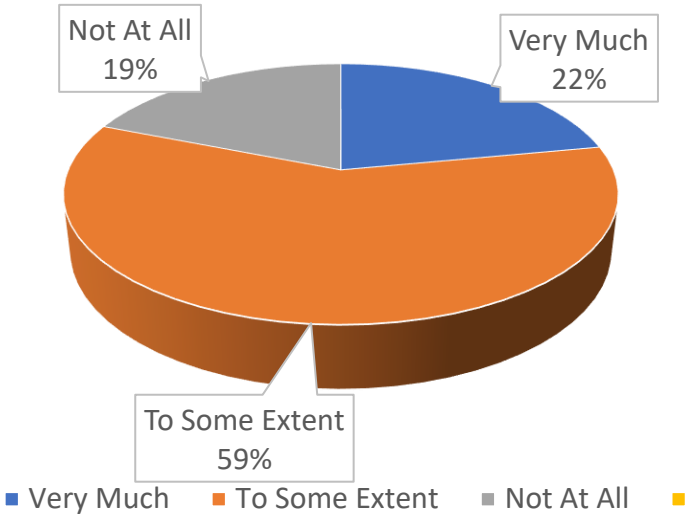
Others noted that **expectations of complete abstinence** tended to dominate in their communities, and that harm reduction efforts were often seen as **condoning drug use**. As one participant noted *"Most people in this community think that harm reduction equals use promotion."* Several noted that lawmakers and law enforcement/judicial members, in particular, commonly had expectations and acceptance of abstinence-only goals, as illustrated in the following quotes:

- *"Any conversation regarding harm reduction, no matter how much education we provide, leaves community lawmakers with the idea that we are condoning drug use. They feel we have become the drug dealer and there is 'no way' that individuals can get better through harm reduction methods. Most of the time they won't even let us in the door to start a conversation unless we mask it with other needs."*
- *"There is still a lot of black/white thinking, in which people think that any use is bad. This comes from the courts and probation officers. People are punished, even if they cut back or ceased more dangerous forms of use, such as stopping IV use and only smoking the substance."*
- *"I have had residents, law enforcement, even community politicians tell me that people who overdose do not deserve to be revived, or that 'those people' don't deserve access to healthcare."*

Stigma/Community Attitudes

Those who indicated that they were providing harm reduction services through their agency/organization were asked to indicate the extent to which stigma/community attitudes affected their HR work. As Figure 11 illustrates, only 19% felt that stigma/community attitudes did not at all inhibit their HR work, while a total of 81% felt that inhibited their HR work either very much or to some extent.

Figure 11. Extent to Which Stigma/Community Attitudes Inhibit Participants' Harm Reduction Work (n = 93)



Participants who indicated that stigma/attitudes inhibited their HR work very much or to some extent were then asked to describe how their HR work was inhibited by stigma/community attitudes. Common responses fell into the category of **keeping people from getting services.** Participants noted that while stigma related to substance use and treatment was still very prominent in their communities, the stigma of harm reduction efforts was often equally present. *"Public attitudes towards substance use causes those in need to not show up"* and for those who do seek treatment, the stigma/attitudes toward MOUD and other HR efforts *"can make it so that clients do not want to take their medications."*

Several participants acknowledged that negative community attitudes largely came from lack of knowledge or ignorance of evidence-based treatment strategies. This caused *"many in the community, including those in recovery, who believe harm reduction and those who provide services to those who continue to use substances more safely are 'enabling' the behavior."* In some communities, strict religious beliefs may also create negative attitudes to harm reduction, which can result in *"extreme shame regarding drug use. Their zero tolerance of all substances leaves the message that 'you deserve the hell you are in when you started sinning and doing drugs.' They feel full abstinence is the only way to forgiveness."*

Others indicated that stigma was also present in their healthcare communities, which then influenced the heathcare received by clients. As one participant noted *"Our clients are not always met well in the community for medical services."* Some noted that while some agency administrators within the community expressed support for HR efforts, that did not always "trickle down" to those at the staff level. *"There's a lot of praising harm reduction at the leadership level, but providers will often decline to [prescribe] medications (i.e. MOUD) or refer someone to another agency in the community who will."*

An additional way that stigma and negative attitudes about HR affected participants' work is that those attitudes lead to **lack of funding, resources and even supplies** for HR work. Some noted that the community's lack of knowledge and stigma related to HR directly influenced the lack of services in the community. One participant stated *"We have tried many times to get a detox center in our town. It is desperately needed but there is no support from the hospital or community."* Another reported *"We have been unable to set up our outreach sites at a lot of locations. Businesses have told us that they will not put up sharps boxes or have Naloxone."*

Barriers to Providing Harm Reduction Services

Participants who indicated "No" when asked if they were providing HR services were asked to describe what they perceived as barriers to them being able to provide these services. These participants also described **stigma** as a factor. As one individual stated, *"not all harm reduction strategies are supported—lots of pushback from stakeholders."*

Another common barrier noted was in relation to **lack of capacity**. Several participants reported that they would need more funds and additional personnel to be able to provide HR services. Some also noted that this lack of capacity was due to various **policy** decisions. As one individual noted *"state policies, law, regulations, politics and federal regulations"* can all be barriers to providing HR services. Policies within the court and regulation systems can also present a barrier. In one participant's words: *"The court system and DCFS tend to take an abstinence approach to treatment so other forms of harm reduction are really not utilized."*

Another barrier noted was **lack of education/training**. This was identified as an issue for not only treatment providers, but for policy/decision makers, and for the community as a whole. One participant noted *"I'm not sure how to go about it."* Another explained: *"Stakeholders/decision makers in our organization do not have enough information about what it is and how to provide it."*

Finally, several participants in this group indicated that either they or their agency/organization **did not believe that harm reduction services were effective**. Some participants perceived the organizational philosophy did not allow for HR work. *"My place of business does not advocate for harm reduction. We only teach abstinence and total sobriety."* Several participants related that, at an individual level, they did not believe that HR activities actually worked. One participant stated: *"Harm reduction is not working. There were 107,000 overdose deaths in this country last year. NIDA/SAMHSA, etc. need better strategies than current harm reduction."* There was also concern expressed regarding the morality and legality of providing harm reduction services, stating that HR activities *"require providers to accept, condone, or play a role in an illegal activity."*

Overdose and Narcan/Naloxone

All survey participants were asked about their practices with overdose and Naloxone/Narcan. Figure 12 shows that 73% of participants had at least one experience assisting in managing a

person experiencing an overdose. However, as seen in Figure 13, only 53% of participants routinely carry Naloxone/Narcan with them.

Figure 12. Percentage of Participants Who Have Assisted In Managing A Person Experiencing An Overdose (n = 129)

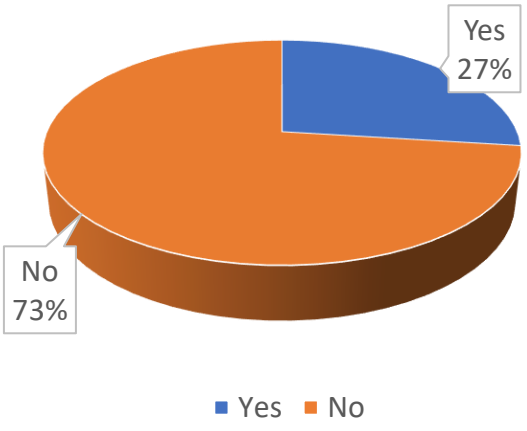
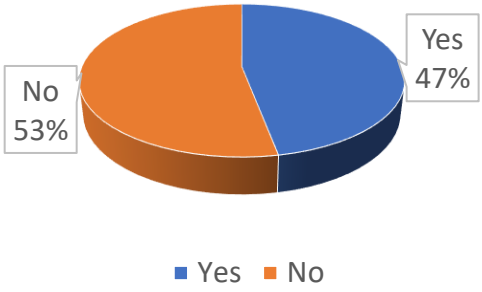
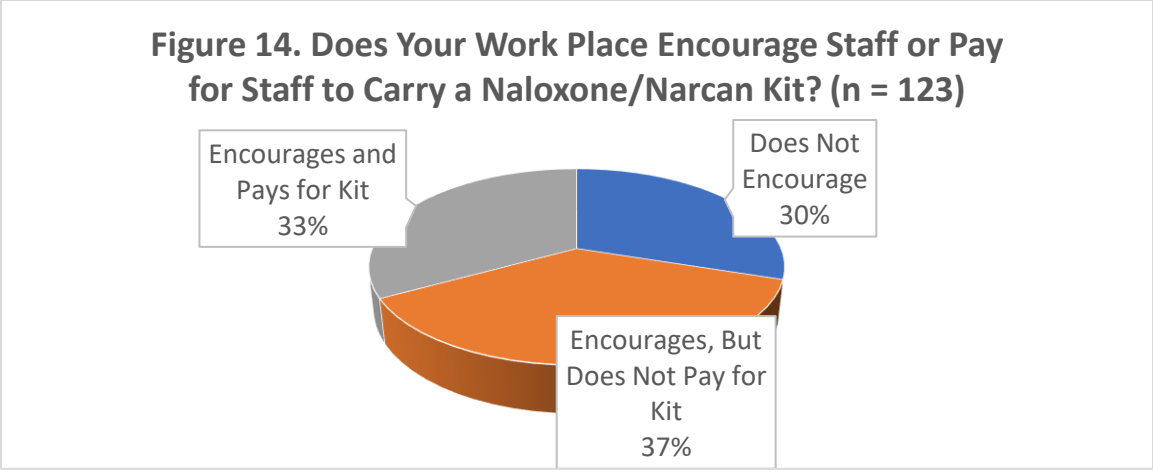


Figure 13. Percentage of Participants Who Carry a Naloxone/Narcan Kit (n = 129)



All participants were then asked if their workplace encourages them to carry a Naloxone/Narcan kit and if their employer pays for the kit. As can be seen in Figure 14, 30% of participants do not receive encouragement from their employer to carry a kit. However, a total of 70% are encouraged to carry a kit, with 33% having their employers even pay for the kit for employees to carry.



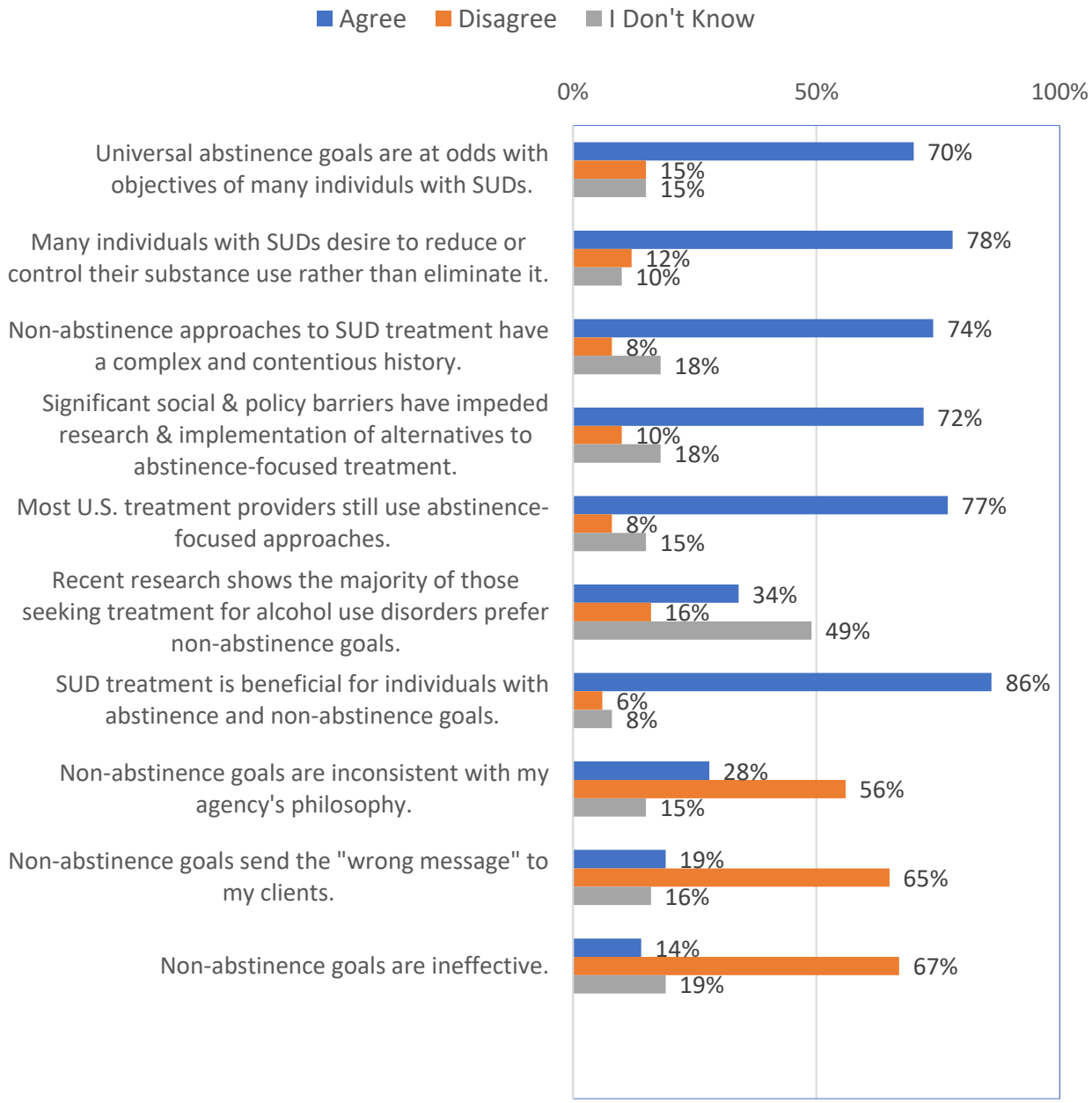
Knowledge and Beliefs Related to Harm Reduction

Survey participants were provided a series of ten statements related to their knowledge and beliefs about harm reduction and asked if they agreed, disagreed, or did not know. The statements were derived from a recent review of evidence related to harm reduction/non-abstinence treatment (Paquette, Daughters & Witkiewitz, 2022). Figure 15 shows the results of these statements.

Statements 1 – 7 are related to knowledge of harm reduction/non-abstinence and are all true, based upon existing research. The majority of participants (70% – 86%) were appropriately in agreement with six of the seven statements. However, for one statement, "Recent research shows the majority of those seeking treatment for alcohol use disorders prefer non-abstinence goals," only 34% were in agreement, while 16% did not agree and 49% did not know.

The final three statement were related to agency philosophy and personal beliefs. A total of 28% of participants indicated that non-abstinence goals are inconsistent with their agency's philosophy, and another 15% did not know. In relation to personal beliefs, 19% agreed with the statement "Non-abstinence goals send the 'wrong message' to my clients" and 14% agreed that "Non-abstinence goals are ineffective." It is of note that in relation to these two statements, 16% and 19%, respectively, "did not know."

Figure 15. Participants' Knowledge and Beliefs Related to Harm Reduction Activities (n = 116)



T-tests were utilized to determine if there were any significant differences related to knowledge and beliefs between groups. Substance Use Disorder Counselors were compared to “Others” (defined as all other groups) and those working in Rural and Tribal locations were compared to “Others” (defined as urban, suburban or other locations). Using a p-value of 0.05, there were no significant differences when comparing the combined means for all of the knowledge and belief questions together for Rural/Tribal compared to Other, as can be seen in Table 1. There

were also no significant differences when the two groups were compared on each individual knowledge and belief item, as Table 2 demonstrates.

Table 1. Comparison of Mean Scores of All Knowledge and Belief Items—Rural/Tribal vs. Other

Work Setting	N	Mean	SD	t	df	p
Rural/Tribal	38	1.70	0.45	1.24	112	0.22
Others	76	1.60	0.36			

Table 2. Comparison of Mean Scores of Individual Knowledge and Belief Items—Rural/Tribal vs. Other

		N	Mean	SD	t	df	P
Universal abstinence goals are at odds with the objectives of many individuals with SUDs	Rural/Tribal	38	1.53	.797	.653	113	.515
	Others	77	1.43	.733			
Many individuals with SUDs desire to reduce or control their substance use rather then eliminate it	Rural/Tribal	38	1.24	.542	-1.071	113	.286
	Others	77	1.38	.708			
Non-abstinence approaches to SUD treatment have a complex and contentious history	Rural/Tribal	38	1.61	.887	1.561	113	.121
	Others	77	1.36	.724			
Significant social and policy barriers have impeded research and implementation of alternatives to abstinence-focused treatment	Rural/Tribal	38	1.58	.858	1.047	113	.297
	Others	77	1.42	.750			
Most U.S. treatment providers still utilize abstinence-focused approaches	Rural/Tribal	38	1.53	.797	1.581	113	.117
	Others	77	1.30	.689			
Recent research shows that the majority of those seeking treatment for alcohol use disorders prefer non-abstinence goals	Rural/Tribal	38	2.11	.863	-0.280	113	.780
	Others	77	2.16	.933			
SUD treatment is beneficial for individuals with abstinence and non-abstinence goals	Rural/Tribal	38	1.29	.654	0.919	112	.360
	Others	76	1.18	.534			
Non-abstinence goals are inconsistent with my agency's philosophy	Rural/Tribal	38	1.95	.733	.809	112	.420
	Others	76	1.84	.612			
Non-abstinence goals to send "the wrong message" to clients	Rural/Tribal	38	2.03	.677	0.779	112	.438
	Others	76	1.93	.550			
Non-abstinence goals are ineffective	Rural/Tribal	38	2.16	.679	1.382	112	.170
	Others	76	2.00	.516			

The same was true when the responses of Substance Use Disorder Counselors were compared to Others. There were no significant differences when the mean scores were compared for all items combined (see Table 3) or when the means of individual items were compared (see Table 4).

Table 3. Comparison of Mean Scores of All Knowledge and Belief Items—SUD Counselors vs. Others

Profession	N	Mean	SD	t	df	p
SUD Counselors	39	1.57	0.37	-1.39	113	0.17
Others	76	1.67	0.40			

Table 2. Comparison of Mean Scores of Individual Knowledge and Belief Items—SUD Counselors vs. Others

		N	Mean	SD	t	df	P
Universal abstinence goals are at odds with the objectives of many individuals with SUDs	SUD Counselors	39	1.36	.668	-1.000	114	.319
	Others	77	1.51	.788			
Many individuals with SUDs desire to reduce or control their substance use rather then eliminate it	SUD Counselors	39	1.18	.389	-1.745	114	.084
	Others	77	1.40	.748			
Non-abstinence approaches to SUD treatment have a complex and contentious history	SUD Counselors	39	1.41	.818	-.286	114	.775
	Others	77	1.45	.770			
Significant social and policy barriers have impeded research and implementation of alternatives to abstinence-focused treatment	SUD Counselors	39	1.51	.823	.460	114	.646
	Others	77	1.44	.769			
Most U.S. treatment providers still utilize abstinence-focused approaches	SUD Counselors	39	1.31	.694	-.826	114	.410
	Others	77	1.43	.768			
Recent research shows that the majority of those seeking treatment for alcohol use disorders prefer non-abstinence goals	SUD Counselors	39	2.00	.946	-1.242	114	.217
	Others	77	2.22	.883			
SUD treatment is beneficial for individuals with abstinence and non-abstinence goals	SUD Counselors	39	1.15	.489	-.849	113	.397
	Others	76	1.25	.614			
Non-abstinence goals are inconsistent with my agency's philosophy	SUD Counselors	39	1.79	.656	-.984	113	.327
	Others	76	1.92	.648			
Non-abstinence goals to send "the wrong message" to clients	SUD Counselors	39	1.90	.598	-.880	113	.381
	Others	76	2.00	.589			
Non-abstinence goals are ineffective	SUD Counselors	39	2.05	.560	-.012	113	.991
	Others	76	2.05	.586			

Training/Technical Assistance Needs

An important part of this survey was to determine the training and/or technical assistance needs of providers in Region 8. All participants were asked open-ended questions to identify their training needs. Data was collected from both those who identified they were NOT providing HR activities and from those who identified that they were providing HR. This latter group was also asked to identify any technical assistance needs they had in the HR work they were doing.

Training For Those Who Identified as NOT Providing Harm Reduction Activities

Participants who indicated they were NOT providing HR services indicated several topic areas that were of interest to them in relation to HR. Multiple indicated they would like **introductory training** to help them *"understand harm reduction and why it is important."* One individual suggested that framing HR training *"based on social justice advocacy would be helpful."*

Another commonly identified need was training on **how to communicate the importance of HR strategies to stakeholders**. As one participant noted, *"Some of the common arguments can be challenging to overcome."* Law enforcement, the court system, and local politicians were identified as stakeholders that participants were particularly interested in learning how to address effectively.

There were a few participants that indicated they were not sure what training(s) would be helpful. Additionally, a few participants reported that they were not interested in HR training because either their agency did not advocate for HR or they did not believe that HR efforts are effective. For example, one participant stated: *"Harm reduction does not work. Let's get back to 'treatment works' and get people into treatment, not drug replacement therapy."*

A few other training topics were identified by individuals in this group. These included:

- Contingency management for methamphetamine use
- Local resources
- Adolescents
- Support of rural harm reduction efforts
- *"What this would look like in the counseling process and how to measure when you would conclude counseling services"*

Training For Those Who Identified as Already Providing Harm Reduction Activities

Among those participant who identified that they ARE providing HR activities, the most common response to what types of training would be helpful, was "**any**." Similar to those in the the other group who identified as NOT providing HR services, several in this group also identified that **introductory training** would still be helpful and may help to reduce the stigma associated with it. As one participant noted, *"Harm Reduction 101—what does harm reduction really mean? Identifying that harm reduction does not equal being accepting of persons using*

substances." It was also noted that including examples and success stories in the introductory training would be helpful.

An additional training topic commonly identified with this group was training on current **evidence-based practice** related to HR. One participant noted that this training should include the evidence for all aspects of harm reduction that are important for individuals with substance use disorders: *"Different pathways to recovery and harm reduction methods other than syringe exchange (the most well-known and often the only discussed method). I think training related to safe sex or other non-drug use harm reduction would be great."*

Another area identified by several participants was HR training related to **special populations**. Those specifically mentioned were rural, adolescents, pregnant women, communities of color, Native Americans, and religious communities.

Strategies to educate community members and stakeholders about the positive effects of harm reduction was also a common topic identified by this group. It was noted that by providing information about the evidence to support HR practices, community myths and stigma could be reduced and community/stakeholder attitudes might become more positive toward HR efforts. Several also noted that information and statistics about how HR efforts might result in crime reduction, economic impact, and health and safety of the public, and how to discuss these topics with stakeholders would be helpful. One participant stated, *"Educate on the benefits of harm reduction and the consequences of not providing these services. Not just the consequences to the individual using, but to the community at large."* Another noted that *"Train-the-Trainer opportunities on how to provide training on harm reduction to the community through virtual or hybrid options" w*ould be helpful.

A few other HR related training topics were also mentioned by this group of participants. These included:

- Ethics and boundaries
- Community Resources
- Motivational Interviewing and the intersection with harm reduction

Technical Assistance For Those Who Identified as Already Providing Harm Reduction Activities

Participants who identified that they are providing HR activities were also asked to comment on what types of technical assistance related to HR would be helpful. The two most common responses, which were approximately equally given, were **"Any"** and **"Not Sure/None."** However, several participants did provide ideas for needed technical assistance. Several noted the importance of their staff having access to the latest research and **evidence-based practice strategies** in relation to harm reduction. Others indicated a need for **education materials and supplies** for patients. One individual noted *"I would like to have ready information to give to people with substance use disorders, so that they would know how to be able to protect themselves."*

Some indicated that technical assistance to help them **move from training to implementation** at the local agency/organizational level is needed. A few noted that assistance with **policy formulation** *"at all levels—agency, government, legislative"* would be helpful. And finally, several noted that assistance with **developing positive HR messages for the community** (e.g. social media messages, letters to editor, newspaper articles, etc.).

Discussion

SAMHSA defines harm reduction as "an approach that emphasizes engaging directly with people who use drugs to prevent overdose and infectious disease transmission, improve the physical, mental, and social wellbeing of those served, and offer low-threshold options for accessing substance use disorder treatment and other health care services" (SAMHSA, 2022). Harm reduction also offers an alternative to abstinence as a singular goal (Taylor et al., 2021). This definition is broad in that it includes more than just a sole focus on eliminating use, but rather using a variety of services and products that are targeted at decreasing the overall harm caused by substance use disorders. This includes, for example, services and supplies focused on overdose reversal, substance test kits, safe medication disposal, lock boxes, medications for opioid use disorders (MOUD), and medication for alcohol use disorders (AUD). Further, SAMHSA also includes a focus on prevention and treatment of other health conditions that may result from SUDs. Thus, products and services such as safer sex education and kits, wound care kits, education and testing/treatment services for viral hepatitis and HIV, syringe exchange programs and sharps disposal are also part of SAMHSA's harm reduction focus (SAMHSA, 2022).

This survey did not provide a definition of harm reduction for participants, nor did it indicate at the outset of the survey that the overall focus was on harm reduction. This was done purposefully to try to minimize any bias that participants may have associated with the concept of harm reduction. Midway through the survey, participants were asked if they engaged in harm reduction activities. It is interesting to note that while 65% of participants indicated that they were providing harm reduction activities, 71% has previously indicated they were providing safer substance use education and 66% indicated they were providing overdose reversal education and training. Thus some participants were providing harm reduction activities in these two forms, but did not recognize it as such. The responses to open ended questions also indicated that many participants seemed to have a fairly narrow definition of what constitutes harm reduction in relation to SUDs. Most comments were related to MOUD only. Education on understanding harm reduction which embraces the broader SAMHSA definition and recommended products and services may be warranted.

It is also interesting to note that 4% of participants indicated that their agency was providing safe consumption sites, despite the fact that only two U.S. states have legalized this form of harm reduction (Rhode Island and, most recently, Minnesota; both outside of Region 8). While we cannot be certain that this service is not being provided in any Region 8 states, it is possible that participants who responded "yes" may not have understood the term. While evidence

from other countries, which more freely allow safe consumption sites, indicates that this form of HR has been shown to decrease the harms of opioid use including reducing overdose morbidity and mortality, decreasing HIV and hepatitis C infection, lowering rates of public syringe disposal, significant improvements in access to addiction treatment programs, and have not led to increases in crime or drug use in the neighborhoods where they are located (Barry et al., 2019; Levengood et al., 2021).

This harm reduction approach is being considered in multiple jurisdictions in the U.S., but widespread adoption is hampered in part due to low levels of public support for establishing these sites (Barry et al., 2019). One study found that only 29% of U.S. adults, in a nationally representative sample, supported legalization of safe consumption sites (McGinty et al., 2018).

Among participants who were providing harm reduction services and products, 73% felt their communities were supportive of their HR activities, with Narcan/Naloxone training and distribution being the most common type of activity that was supported. Other participants noted that prevention activities with youth were supported in their communities. Other ways that participants noted community support for HR activities were through community partnerships, volunteering, media support, and policies which actively supported HR work.

For the 27% of participants who were providing HR activities and identified their communities as non-supportive, lack of knowledge and stigma were described as the primary causes for lack of support. In addition, expectations for complete abstinence among community members resulted in a belief that HR activities may condone and even promote drug use. Contrary to that common belief, the National Academies of Sciences, Engineering, and Medicine (2019) issued a report on MOUD, concluding that buprenorphine, methadone, and naltrexone save lives, Futher, the report found that MOUD and are effective in reducing illicit opioid use, reducing relapse, protecting from overdoses, promoting treatment engagement, reducing criminal involvement, and improving functioning.

Stigma was also seen as a major barrier to HR work among those who indicated they were providing HR activities. These participants identified that the stigma prevents those who need SUD treatment and recovery services from getting them, and also results in lack of funding, resources, and supplies for HR work. These findings related to the effect of stigma are supported by current evidence (Adams & Volkow, 2020).

Among the 35% of participants who identified they were not providing HR services, stigma, lack of capacity, policies, and lack of education on HR were cited as reasons they are not providing these services. In addition, some of this group of participants indicated that they believed HR activities are not effective.

A majority (53%) of participants reported that they personally carry a Narcan/Naloxone kit with them. It is interesting to compare this to the 70% of participants who indicated that their employer encouraged them to carry a kit, with 33% of employers even paying for it. Thus, even with agency encouragement, some participants do not carry a kit.

In relation to participants' knowledge related to HR, the majority (70 – 86%) of participants correctly agreed with current evidence. The one exception was in relation to client treatment goals for alcohol use disorder ("Research shows the majority of those seeking treatment for alcohol use disorders prefer non-abstinence goals"). Only about a third (34%) of participants agreed with this statement; only 16% disagreed, and 49% did not know. Thus, future HR training should incorporate evidence related to client goals for treatment and recovery. Current evidence does support that many clients have goals other than abstinence for their treatment and recovery from both AUDs and OUDs (Hay, Huhn, Tompkins, Dunn, 2019; Paquette et al., 2022). Additionally, it is important to note that in relation to personal beliefs about non-abstinence goals specifically, 19% of participants agreed with the statement "Non-abstinence goals send the 'wrong message' to my clients" and 14% agreed that "Non-abstinence goals are ineffective." Further, a total of 28% of participants indicated that non-abstinence goals are inconsistent with their agency's philosophy. While changing personal beliefs and agency philosophies can be a difficult undertaking, including evidence-based outcomes related to HR strategies may be helpful to include in trainings for these groups of people.

Overall, some similar training needs were identified among both groups of participants (those who are engaged in HR and those who identified that they are not). Both groups indicated that "any" training in relation to HR would be helpful, as well as introductory/basics of harm reduction training, and evidence based practices related to HR. Both groups also had an interest in training on how to educate and communicate with their communities and stakeholders. Those who are already engaged in HR indicated that training on special populations (e.g. rural, adolescents, pregnant women, communities of color, Native Americans, and religious communities) would be helpful. This group also identified several technical assistance needs which included strategies to move their agencies from training to implementation, access to evidence based practices, educational materials and supplies for patients/clients, assistance with policy formulation, and developing positive HR messages for communities.

Limitations

The results of this survey have some limitations. It is unknown how representative this sample of providers is in relation to the entire population of those providing SUD treatment and recovery services in Region 8. Additionally, the response rate to the survey cannot be ascertained since there was an open invitation to participate in the survey that was delivered through multiple sources and the number of individuals who received the invitation to participate is unknown. It is likely that the recruitment efforts did not reach every Region 8 provider who would be appropriate to complete the survey. Further, as noted, not all individuals who participated in the survey completed all questions, thus there was missing data for some questions.

Despite these limitations, the findings of the survey present an overall picture of the harm reduction practices, knowledge and beliefs of those providing SUD treatment and recovery

services within Region 8. Survey results regarding training and technical assistance preferences among participants is also very informative and will help the Mountain Plains ATTC and others coordinate training and technical assistance efforts to assist these providers with their identified needs.

Resources for Further Information

Mountain Plains Addiction Technology Transfer Center (MPATTC): Provides training and technical assistance to stakeholders within HHS Region 8. https://attcnetwork.org/centers/content/mountain-plains-attc

Substance Abuse and Mental Health Services Administration (SAMHSA): This page provides an overview of harm reduction for persons with SUDs. https://www.samhsa.gov/find-help/harm-reduction

National Harm Reduction Technical Assistance Center: Provides free help to anyone in the country providing (or planning to provide) harm reduction services to their community. https://harmreductionhelp.cdc.gov/s/

U.S. Department of Health and Human Services, Overdose Prevention Strategy: A collective strategy to prevent overdoses and save lives by ensuring equitable access to essential health care and support services without stigma. https://www.hhs.gov/overdose-prevention/

National Harm Reduction Coalition: A nationwide advocate and ally for people who use drugs. Serve as a catalyst and incubator, repository and hub, storyteller and disseminator for the collective wisdom of the harm reduction community. https://harmreduction.org/movement/

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