



# **HARM REDUCTION TECHNICAL ASSISTANCE STAKEHOLDER ANALYSIS**

*A Summary of Findings*

**SEPTEMBER 2022**

NATIONAL  
COUNCIL  
*for* Mental  
Wellbeing



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# Commonly Used Acronyms

ACRONYM	MEANING
<b>CCBHC</b>	Certified Community Behavioral Health Clinic
<b>CDC</b>	Centers for Disease Control and Prevention
<b>HHS</b>	U.S. Department of Health and Human Services
<b>HIV</b>	human immunodeficiency virus
<b>MAT</b>	medication-assisted treatment
<b>MOUD</b>	medication for opioid use disorder
<b>OEND</b>	overdose education and naloxone distribution
<b>ONDCP</b>	Office of National Drug Control Policy
<b>OPS</b>	overdose prevention site
<b>OUD</b>	opioid use disorder
<b>PWUD</b>	people who use drugs
<b>SAMHSA</b>	Substance Abuse and Mental Health Services Administration
<b>SSP</b>	syringe services program
<b>SUD</b>	substance use disorder



# Executive Summary

To address the nation's unprecedented overdose crisis and to improve the health of people who use drugs (PWUD), individuals should have access to a full continuum of care, including harm reduction services. Mental health and substance use disorder (SUD) treatment organizations play a vital role in supporting PWUD, including providing or linking them to harm reduction services and related supports. To better understand the technical assistance needs among mental health and SUD treatment providers related to adopting harm reduction services for PWUD, the National Council, with support from the National Association of County and City Health Officials, conducted a mixed-methods stakeholder analysis between February and July 2022.

The stakeholder analysis included a literature review and a national survey conducted with a convenience sample of mental health and SUD treatment professionals employed within National Council member organizations. A total of 151 eligible respondents participated in the survey representing at least 33 states. The majority of respondents who identified their professional role or title held leadership positions within their organizations. Respondent organizations primarily served urban or urban and rural areas.

Key takeaways from the analysis include:

1. There is a need and opportunity for mental health and SUD treatment organizations to increase their adoption of harm reduction services for PWUD and to establish partnerships with syringe services programs (SSPs) and community-based harm reduction organizations.
2. Mental health and SUD treatment organizations face several barriers to adopting harm reduction services, including funding, staff capacity, policies and laws; however, organizations also identified strong facilitators for harm reduction adoption, including leadership and staff support, the inclusion of peer support workers and people with lived experience and support from local and state health departments.
3. There is an opportunity to expand the provision of harm reduction-related technical assistance to mental health and SUD treatment organizations, and there is high interest in receiving technical assistance on a range of topics and through different modalities.

There were several limitations to the analysis, including that the respondents were a convenience sample of employees from National Council member organizations; the majority of respondents held leadership positions in their organizations; and questions requesting demographic and identifying information were optional to protect the privacy of respondents.



# Introduction

Between March 2021 and February 2022, more than 108,000 people died of a drug overdose in the United States, marking the highest ever recorded number of annual overdoses in our nation (Ahmad et al., 2022). In response to this unprecedented public health crisis, people who use drugs (PWUD) must have access to a full continuum of care and services, including harm reduction. Recently, federal investments and resources to support harm reduction services have increased. For example, in December 2021, the White House Office of National Drug Control Policy (ONDCP), Centers for Disease Control and Prevention (CDC) and Substance Abuse and Mental Health Services Administration (SAMHSA) hosted a two-day National Harm Reduction Summit to develop a framework of harm reduction for SAMHSA to guide policies, programs and practices (The White House, 2021). In 2022, the U.S. Department of Health and Human Services (HHS) included harm reduction in its Overdose Prevention Strategy, noting that “individuals inherently deserve services that promote health, regardless of whether they use drugs” (HHS, 2022). Harm reduction is also a key component of the ONDCP’s National Drug Control Strategy (ONDCP, 2022). Additionally, CDC and SAMHSA established an expanded National Harm Reduction Technical Assistance Center, which offers free assistance to anyone providing or planning to provide harm reduction services. The Technical Assistance Center is focused on supporting organizations that can improve outcomes for PWUD and the integration of harm reduction strategies and principles across the continuum of care (CDC, 2022).

As investments in harm reduction continue to grow, it is important to understand the harm reduction-related technical assistance needs of organizations across the continuum of care. Between February and July 2022, the National Council for Mental Wellbeing (National Council), with support from the National Association of County and City Health Officials, conducted a mixed-methods analysis to better understand the technical assistance needs related to adopting and implementing harm reduction services for PWUD among mental health and substance use disorder (SUD) treatment organizations. For the analysis, the National Council conducted a literature review and a national survey with a convenience sample of mental health and SUD treatment professionals who work at National Council member organizations. Key findings are discussed below.



# Background

While no one universal definition exists, in the context of substance use, harm reduction can be defined as a set of practical strategies and ideas aimed at improving health and reducing the negative consequences associated with drug use. Harm reduction includes evidence-based practices and services that result in the reduction of overdose deaths, life-threatening infections related to substance use, and chronic diseases such as HIV and hepatitis, among others. Harm reduction is also a movement for social justice built on a belief in, and respect for, the rights of PWUD (National Harm Reduction Coalition, 2020; SAMHSA, 2022). Harm reduction services include, but are not limited to, community outreach, syringe distribution, overdose education and naloxone distribution (OEND), drug checking, medications for opioid use disorder (MOUD), counseling and education, infectious disease prevention and treatment, wound prevention and care, mutual aid, peer support services, linkages to SUD treatment, including evidence-based treatment for opioid use disorder (OUD), and referrals to housing and social services.

Harm reduction practices are based on a strong body of evidence and have been evaluated extensively for their effectiveness (Harm Reduction International, 2021; Wakeman, 2019). Many harm reduction services, such as overdose prevention sites (OPS), safer use education and OEND, have been found to prevent overdose, improve health and engage people in treatment (Wakeman, 2019). In particular, syringe services programs (SSPs) have been found to effectively reduce the spread of infectious diseases such as HIV and hepatitis C, while also serving as a bridge to SUD treatment and other health services (CDC, 2019). Harm reduction interventions are also cost-effective, with investments in harm reduction services resulting in manyfold returns in reductions of cost due to fewer instances of infectious disease, ambulance calls, emergency department visits, hospital stays and overdose death (Irwin et al., 2017).

Crucial harm reduction services have been provided by SSPs and community-based harm reduction organizations for decades, beginning in the 1980s in the United States, even in the face of immense stigma and political opposition (Des Jarlais, 2017). More recently, mental health and SUD treatment organizations and recovery community organizations have started to expand access to harm reduction services as a critical part of the continuum of care for PWUD. Substance use prevention, treatment and recovery organizations can be a point in the continuum for providing harm reduction services directly to PWUD or referring them to other community-based organizations that provide the services. Because return to use is a common occurrence among people with SUDs, professionals who are employed by mental health and SUD treatment organizations frequently encounter PWUD in their work who would benefit from harm reduction services. Mental health and SUD treatment professionals have an opportunity to advocate for and facilitate access to harm reduction interventions (Javadi et al., 2021). Moreover, the attitudes of treatment providers can influence the adoption and outcome of evidence-based interventions (Aarons, 2005), further emphasizing the role of mental health and SUD treatment professionals in providing linkage to harm reduction services.

Research shows that some negative perceptions still exist among SUD treatment professionals when it comes to certain harm reduction strategies, such as OPSs. A survey of SUD treatment professionals found that only 30% of surveyed treatment professionals would be comfortable if an SSP or OPS were to open on their block, and 16% believed that OPSs would lead to increased substance use (Javadi et al., 2021). However, mental health and SUD treatment professionals' attitudes towards harm reduction approaches have become more supportive over time, especially regarding MOUD, such as methadone and buprenorphine, and the use of naloxone to reverse opioid overdoses (Javadi et al., 2021; Jordan, 2021). A recent survey of SUD treatment professionals conducted by Javadi and colleagues found that 90% of participants agreed that MOUD should be discussed with clients, and 80% agreed that SSPs and OPSs should be discussed (2021). In a survey of SUD treatment professionals, most respondents rated behavioral (e.g., providing syringes, safe injection education) or pharmaceutical harm reduction interventions as somewhat or completely acceptable (Lauritsen, 2017).



Recent survey data collected from samples of mental health and SUD treatment professionals show higher acceptance of harm reduction approaches, compared to studies that were conducted in the past (Jordan, 2021). In addition, mental health and SUD treatment professionals who have more experience with and knowledge about harm reduction tend to have more positive attitudes towards the approach (Bonar & Rosenberg, 2010; Javadi et al., 2021). Of note, attitudes towards harm reduction can be changed with education or trainings. Substance use treatment professionals who received an educational presentation on harm reduction had improved attitudes toward harm reduction afterwards (Goddard, 2003).

Given that mental health and SUD treatment professionals are critical to increase access to harm reduction services for PWUD, it is important to understand their attitudes toward harm reduction, availability of services and need for technical assistance in implementing harm reduction approaches. To investigate the status of harm reduction and other services for PWUD within mental health and SUD treatment organizations, the National Council team sought to address the following questions:

1. What types of harm reduction and other services for PWUD do mental health and SUD treatment organizations provide?
2. What are the facilitators and barriers to providing harm reduction services within mental health and SUD treatment organizations?
3. Which types of technical assistance would help mental health and SUD treatment organizations' efforts to provide harm reduction services?





# Methods

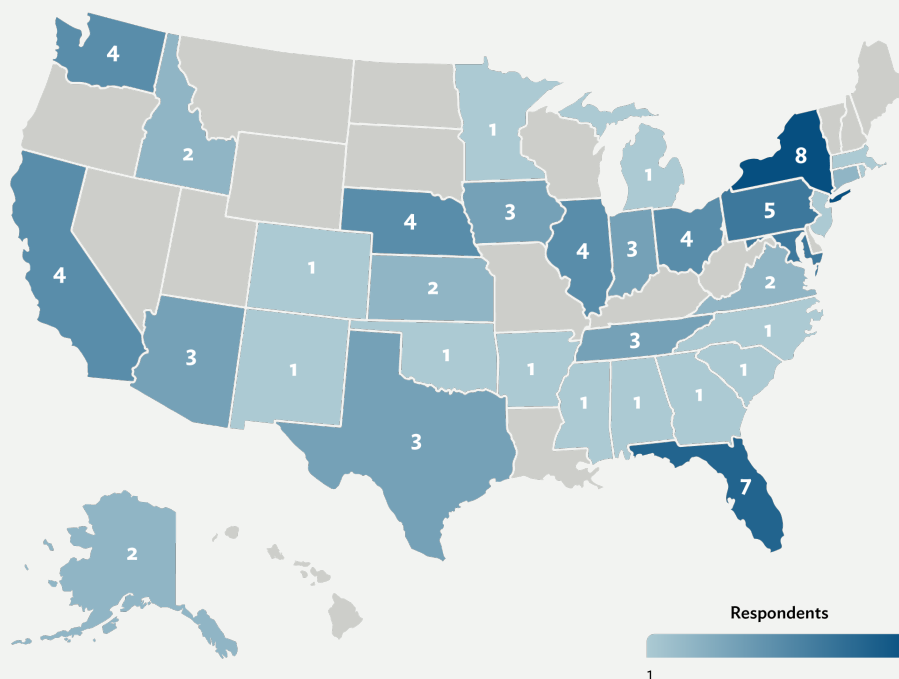
Between February and July 2022, National Council staff conducted a mixed-methods stakeholder analysis that included a review of published literature and web-based materials and a national survey conducted with mental health and SUD treatment professionals.

In May 2022, the National Council project team administered a national electronic survey to a convenience sample of National Council member organizations that are mental health and/or SUD treatment organizations. The survey was hosted on SurveyMonkey and was disseminated in May and June 2022 through the National Council's membership listserv. Participation in the survey was voluntary and the survey took approximately 15 minutes to complete. Participants who completed the survey had the option to provide contact information to be entered into a raffle for a free registration for the National Council's annual conference, NatCon23. Identifying information submitted for the raffle was kept in a separate password-protected database from the other survey data and was not used for the analysis. The survey included a mix of Likert-like scales and open-ended questions. The survey was open for responses for a period of two business weeks.

## OVERVIEW OF SURVEY RESPONDENTS

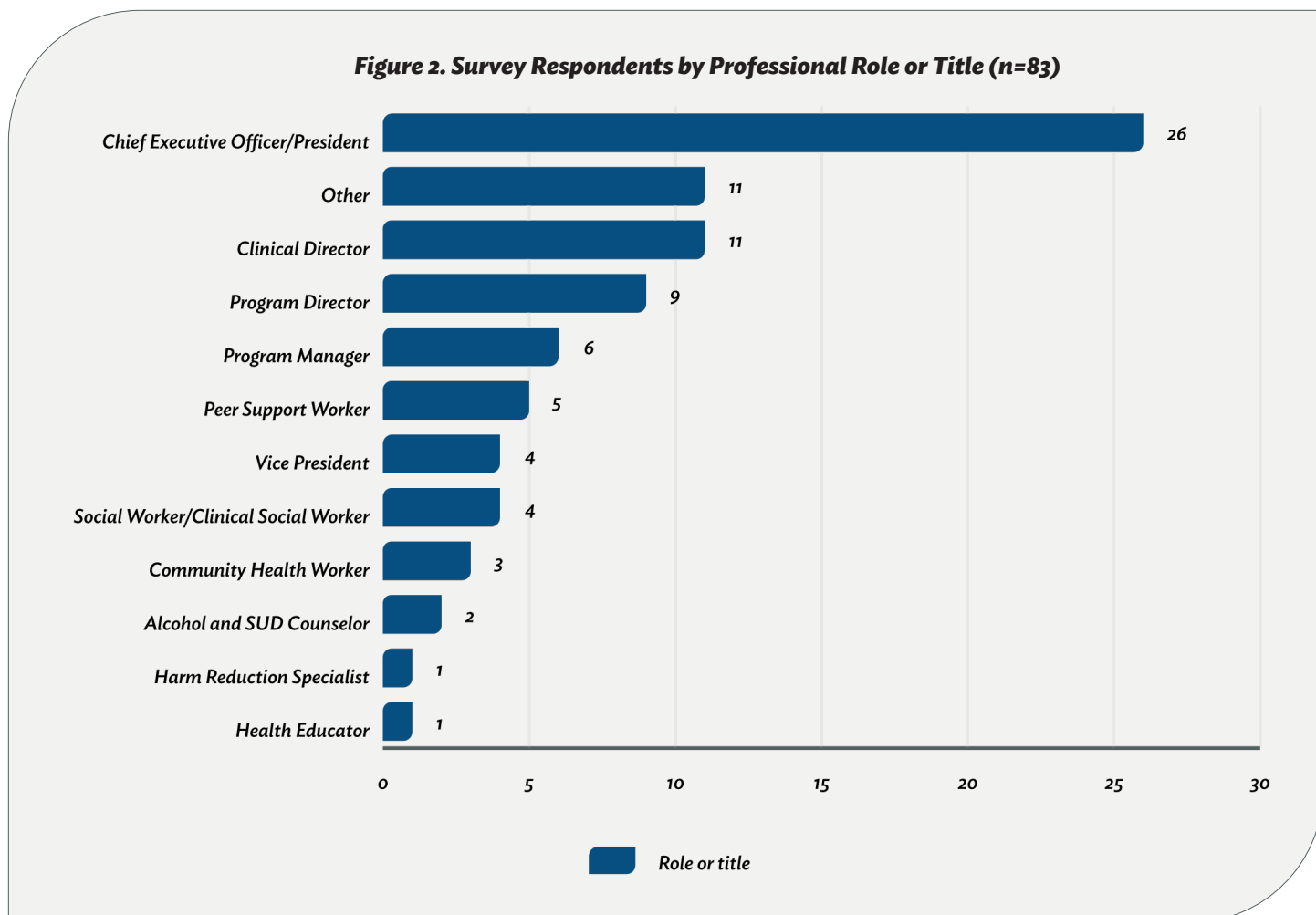
A total of 161 individuals responded to the survey, 10 of whom did not meet the participation criteria of being employed at a mental health or SUD treatment organization and were subsequently excluded from analysis. A total of 84 respondents identified the state in which their organization was located. Among those who identified their state, 33 states were represented by survey respondents. New York, Florida, Maryland and Pennsylvania had the highest number of survey respondents (Figure 1).

**Figure 1. Number of Survey Respondents by State (n=84)**





Of the survey respondents who identified their professional role or title (n=83), most held leadership positions in their organizations. Sixty percent identified themselves as an Executive Director, President, Chief Executive Officer, Vice President, Clinical Director or Program Director. Other types of professions represented included Program Managers, Peer Support Workers, Community Health Workers, Social Workers, Alcohol and SUD Counselors, a Harm Reduction Specialist and a Health Educator (Figure 2).



The most common types of organizations represented by respondents included community-based mental health agencies (32%), Certified Community Behavioral Health Clinics (CCBHCs) (15%), community-based SUD treatment agencies (14%), recovery community organizations (5%) and social services agencies (4%).

The majority of respondents reported that their organizations served people in urban communities (79%) and nearly half (44%) reported that they serve rural communities; approximately 4% reported they serve tribal or frontier communities. Many respondents reported that they serve both urban and rural communities.



# Findings

## CURRENT PROVISION OF HARM REDUCTION SERVICES

Survey respondents were asked to identify the harm reduction and other supportive services for PWUD their organization currently provides and plans to provide in the future from a comprehensive list of service types. A list of services for PWUD was included in the survey and was informed through conversations with harm reduction experts, staff of organizations that serve PWUD and a review of the literature. A total of 101 respondents answered this question.

Respondents' organizations were more likely to provide peer support services, counseling, outreach and engagement and education services and were less likely to provide core harm reduction strategies, such as syringe distribution and fentanyl test strips. The most common types of services for PWUD that respondents' organizations currently provide include peer support services (88%), individual or group counseling (86%), community outreach to and engagement of PWUD (79%), overdose prevention education (74%), naloxone distribution (67%), spiritual and emotional wellness services (54%) and housing services (51%). The least common types of services for PWUD provided by respondent organizations included harm reduction vending machines (4%), mobile methadone treatment (5%), mail-based harm reduction supply distribution (7%), telehealth-based methadone treatment (8%) and syringe distribution and services (8%) (Figure 3).

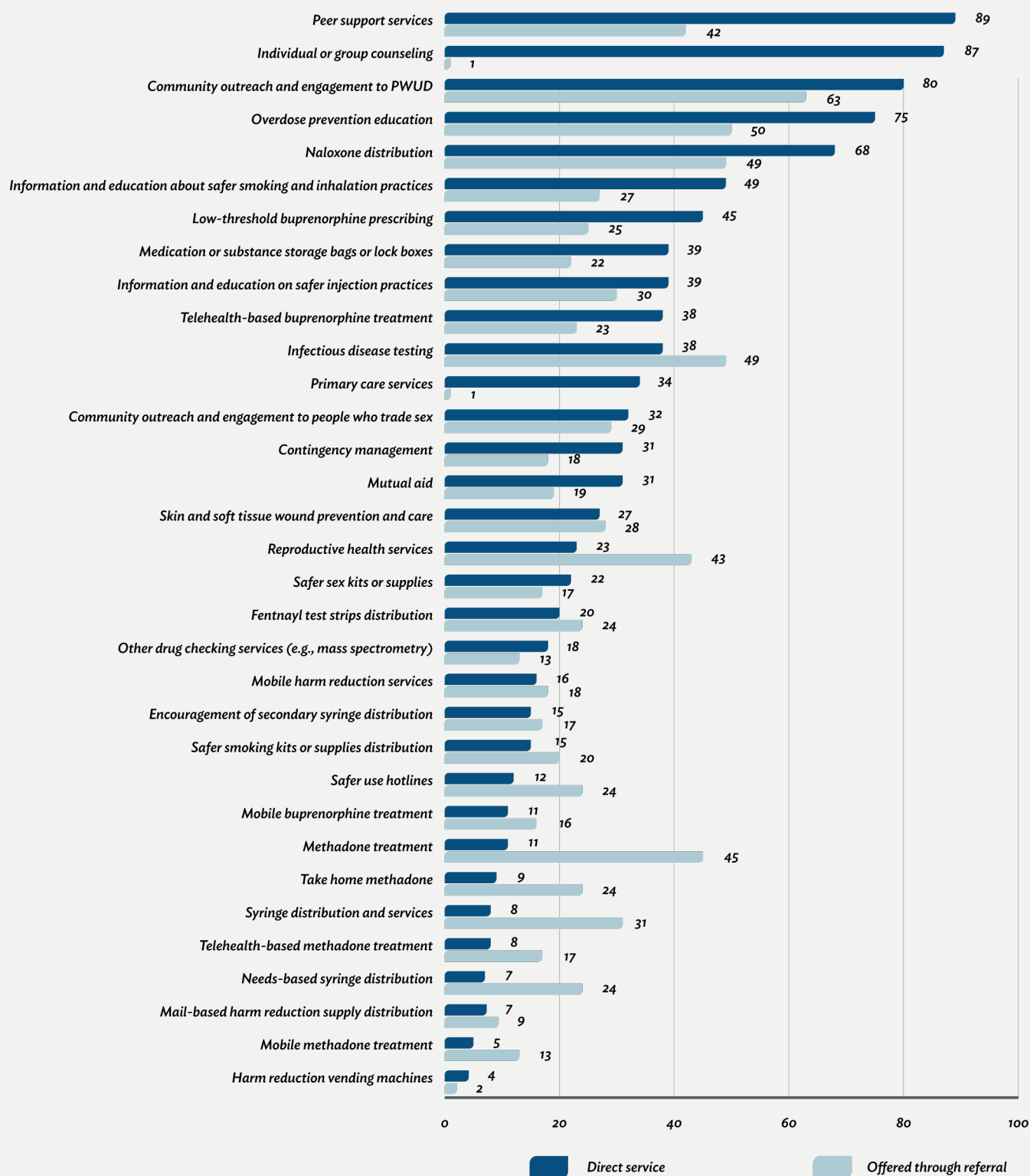
## Referrals to Harm Reduction Services

Survey respondents were also asked to identify harm reduction and other services for PWUD that their organization provides referrals to. A total of 93 individuals responded to this question. The most common services provided through referrals include community outreach and engagement of PWUD (68%), overdose prevention education (54%), naloxone distribution (53%), infectious disease testing (53%), methadone treatment (48%), reproductive health services (46%), peer support services (45%), syringe distribution and services (33%), information and education on safer injection practices (32%) and community outreach to and engagement of people who trade sex (31%). Some organizations indicated that they provide certain services directly as well as through referrals. For example, 88% reported they provide peer support services directly and 46% reported they provide this service through referrals as well (Figure 3).

The least common services referred to by respondent organizations include harm reduction vending machines (7%), mail-based harm reduction supply distribution (10%), other drug checking services, such as mass spectrometry (14%), mobile methadone treatment (14%) and mobile buprenorphine treatment (17%) (Figure 3).



**Figure 3. Services to Support PWUD Provided Directly (n=101) and/or through Referral (n=93)**



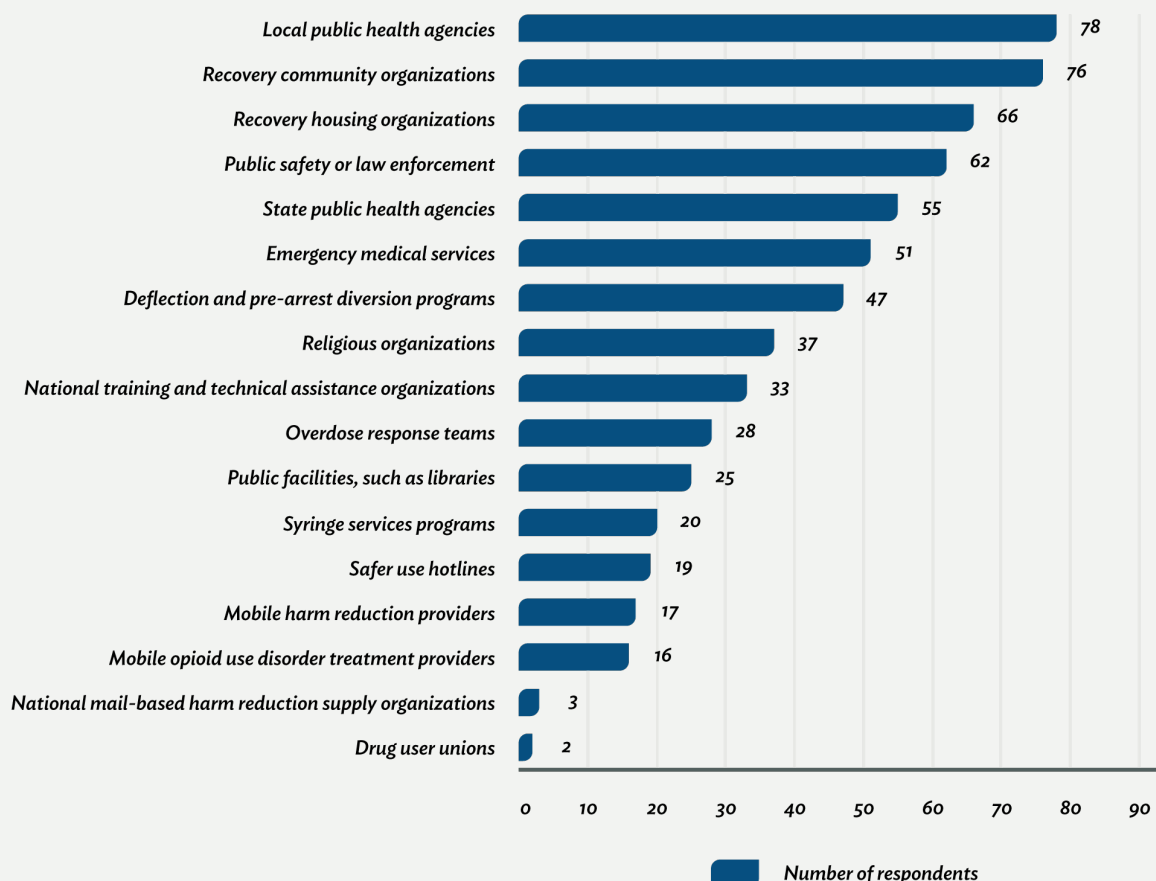


Our survey results are consistent with findings from other studies. Although many mental health and SUD treatment professionals hold favorable attitudes towards harm reduction services, most mental health and SUD treatment organizations do not directly provide harm reduction services, resulting in limited availability (Lauritsen, 2017). Lauritsen (2017) conducted a survey of 257 SUD professionals from the National Association for Alcoholism and Drug Addiction Counselors – the Association for Addiction Professionals, and found that less than 30% reported that their organization directly provided harm reduction services or MOUD, such as buprenorphine treatment (29%), naloxone (21%) and methadone treatment (20%). The least frequently provided services noted in the study included syringe distribution (7%) and drug checking (8%), whereas education about safer practices was provided by 29% to 36% of respondents' organizations (Lauritsen, 2017).

### Partnering Organizations

Survey respondents were asked to identify the types of partners their organizations collaborate with to improve the health of PWUD. A total of 94 individuals responded to this question. The most common types of partners included local public health agencies (83%), recovery community organizations (81%), recovery housing organizations (70%), public safety or law enforcement (66%), state public health agencies (59%), emergency medical services (54%) and deflection and pre-arrest diversion programs (50%). The least common types of partners included drug user unions (2%), national mail-based harm reduction supply distribution organizations (3%), mobile opioid use disorder treatment providers (17%), mobile harm reduction providers (18%) and safer use hotlines (20%) (Figure 4).

**Figure 4. Partnering Organizations Engaged to Improve the Health of PWUD (n=94)**

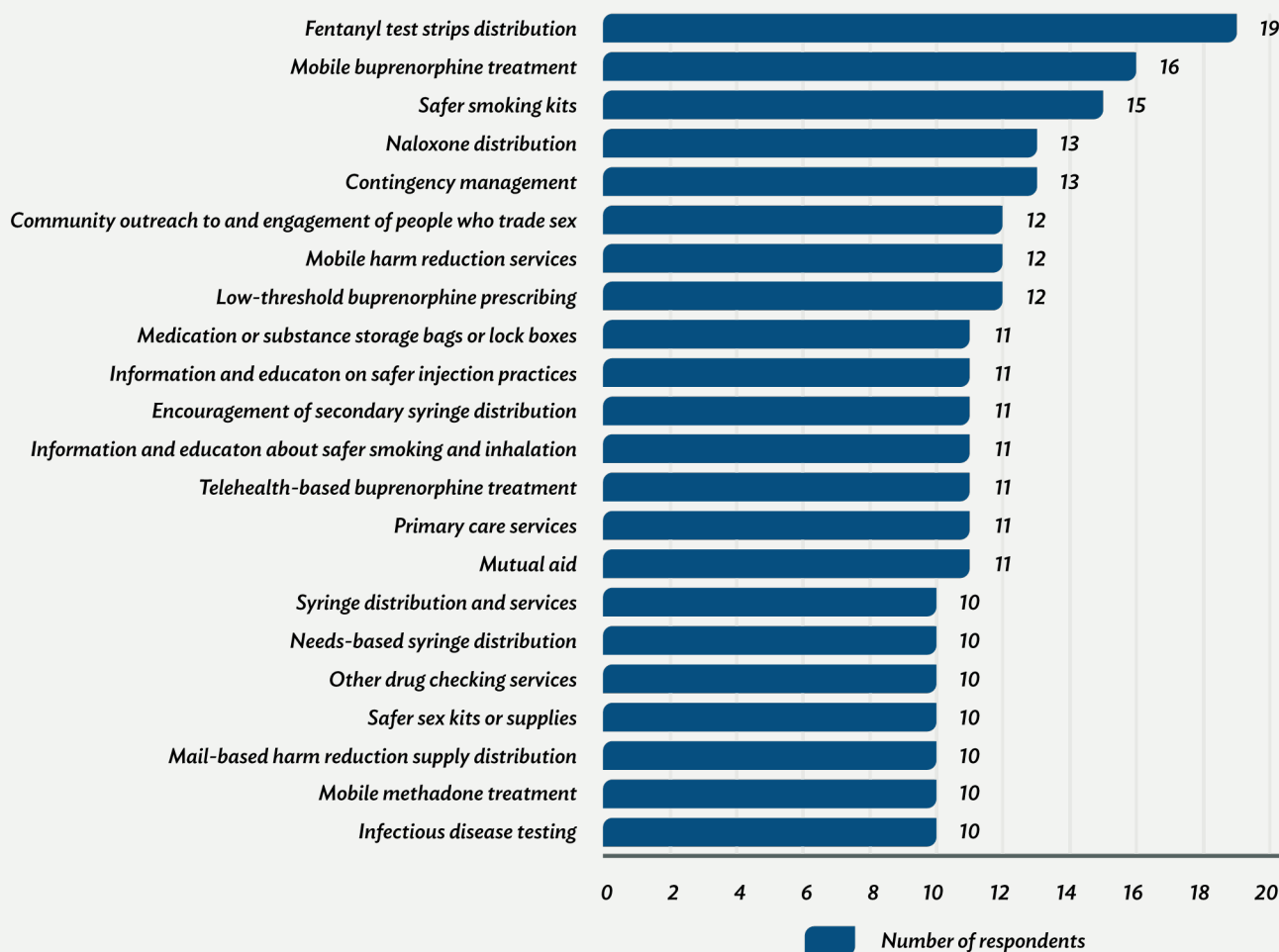




## FUTURE PROVISION OF HARM REDUCTION SERVICES

Respondents were also asked to identify harm reduction and other services for PWUD that their organizations do not currently provide, but plan to provide in the future. A total of 101 individuals responded to this question. The most common services that organizations plan to provide in the future include fentanyl test strips distribution (19%), mobile buprenorphine treatment (16%), and safer smoking kits (15%) (Figure 5).

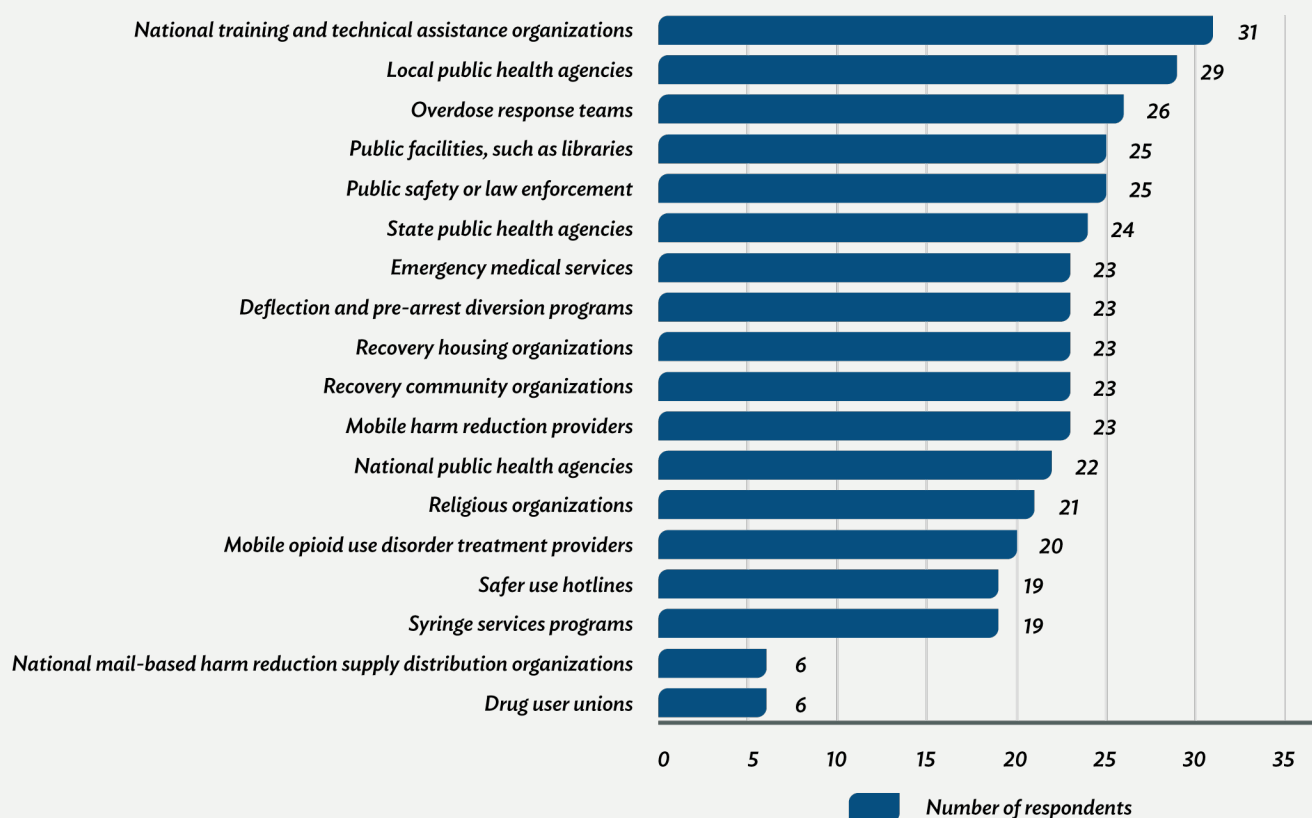
**Figure 5. Harm Reduction Services Respondent Organizations Plan to Provide in the Future (n=101)**





In addition to identifying which services respondent organizations planned to provide in the future, survey respondents were asked to identify any partners they planned to collaborate with in the future to improve the health of PWUD. A total of 94 individuals responded to this question. The most common types of future partners included national training and technical assistance organizations (33%), local public health agencies (31%), overdose response teams (28%), public safety or law enforcement (27%), public facilities, such as libraries (27%) and state public health facilities (26%). The least common types of future partners included drug user unions (6%) and national mail-based harm reduction supply distribution organizations (11%) (Figure 6).

**Figure 6. Future Partners that will be Engaged to Improve the Health of PWUD (n=94)**



Survey questions did not ask respondents to elaborate on why their organizations provided or did not provide certain services, referred to certain services or established specific partnerships; however, overall facilitators and barriers to adopting harm reduction services were explored and included opportunities for respondents to provide open-ended responses.



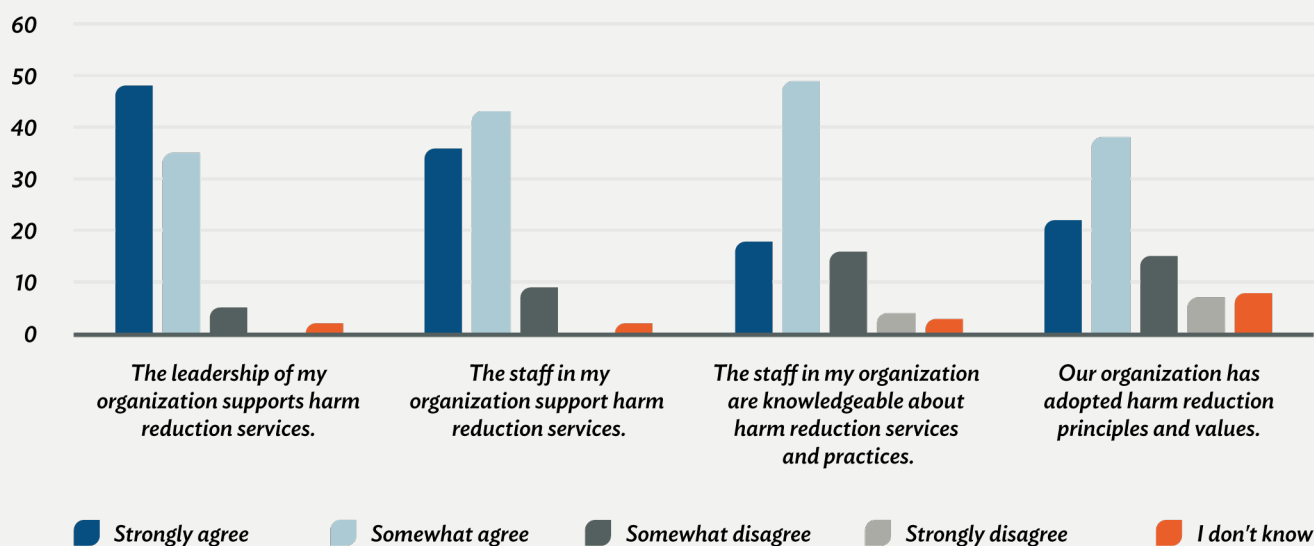
## FACILITATORS AND BARRIERS TO ADOPTING HARM REDUCTION

To assess respondent organizations' perceived facilitators and barriers to adopting harm reduction services, individuals were asked to read a series of statements and choose whether they "strongly agree," "somewhat agree," "somewhat disagree," "strongly disagree" or "I don't know." The statements included a range of potential factors, including organizational factors, related to harm reduction adoption, such as support by leadership and staff, staff knowledge, and whether the organization has adopted harm reduction principles and values; community support; law, policy and funding factors; and trust established with PWUD and community-based organizations that serve PWUD. Previous studies have found that the main barriers for providing harm reduction interventions within mental health and SUD treatment organizations included inconsistency with agency philosophy (Rosenberg & Phillips, 2003; Eversman, 2012); lack of staff, funding or other resources (Rosenberg & Phillips, 2003); and external factors such as insurance (Eversman, 2012).

### Organizational Factors

Among the categories of different factors that can act as facilitators or barriers to adopting harm reduction services, organizational factors were identified most as facilitators. More than 90% of respondents strongly agree or agree that their organizational leadership supports harm reduction services and 88% strongly agree or agree that staff in their organization support harm reduction services. It should be noted that the majority of survey respondents who identified their role or title held leadership positions in their organizations. Nearly 75% strongly agree or agree that staff in their organization are knowledgeable about harm reduction services. Two-thirds of respondents strongly agree or agree that their organization has adopted harm reduction principles and values while 25% strongly disagree or disagree with that statement (Figure 7).

**Figure 7. Organizational Factors that Impact Harm Reduction Adoption (n=90)**



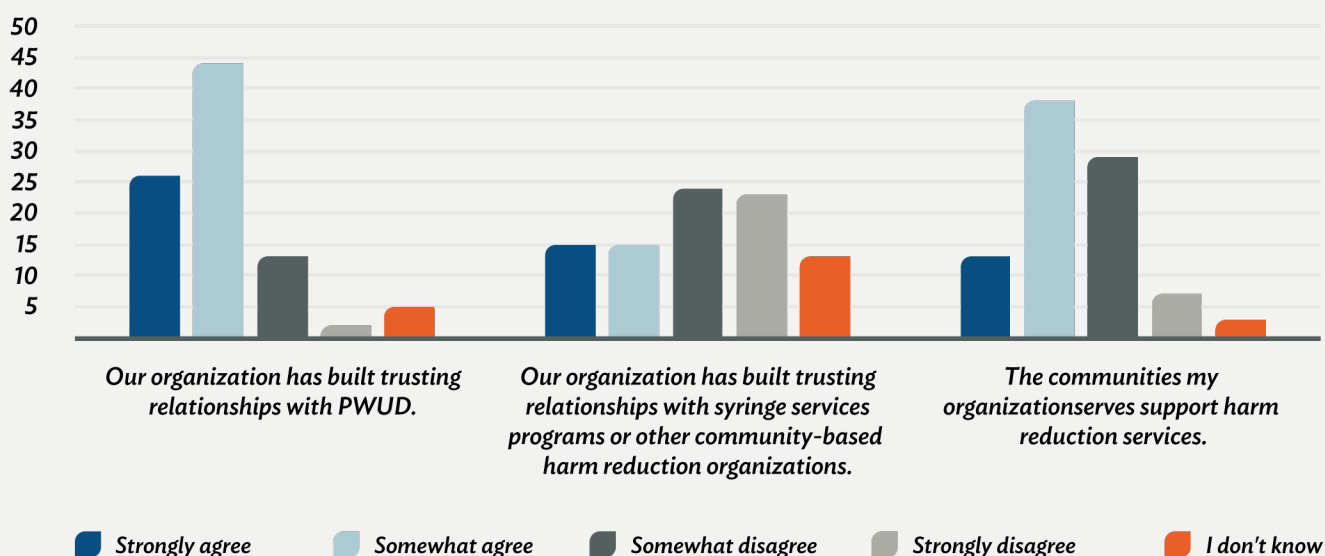




## Community Factors

Regarding community factors that impact harm reduction services, survey respondents reported that while they agree their organizations have built trusting relationships with PWUD, they were less confident about whether their organizations have built trusting relationships with SSPs or other community-based harm reduction programs. Seventy-eight percent of respondents strongly agree or agree that their organization has built trusting relationships with PWUD, 14% somewhat disagree, 2% strongly disagree and 6% do not know. Only 34% of respondents strongly agree or agree that their organization has built trusting relationships with SSPs or other community-based harm reduction organizations, 27% somewhat disagree, 26% strongly disagree and 14% do not know. With regard to broader community support for harm reduction services, more than half of respondents (56%) strongly agree or agree that the communities they serve support harm reduction services, 32% somewhat disagree, 8% strongly disagree and 3% don't know (Figure 8).

**Figure 8. Community Support Factors that Impact Harm Reduction Adoption (n=90)**



## Law, Policy and Funding Factors

Among law, policy and funding factors that impact the adoption of harm reduction services, survey respondents largely identified support from local and state public health agencies as facilitators but found law enforcement, local laws, state laws and funding to be barriers to their organizations' efforts.

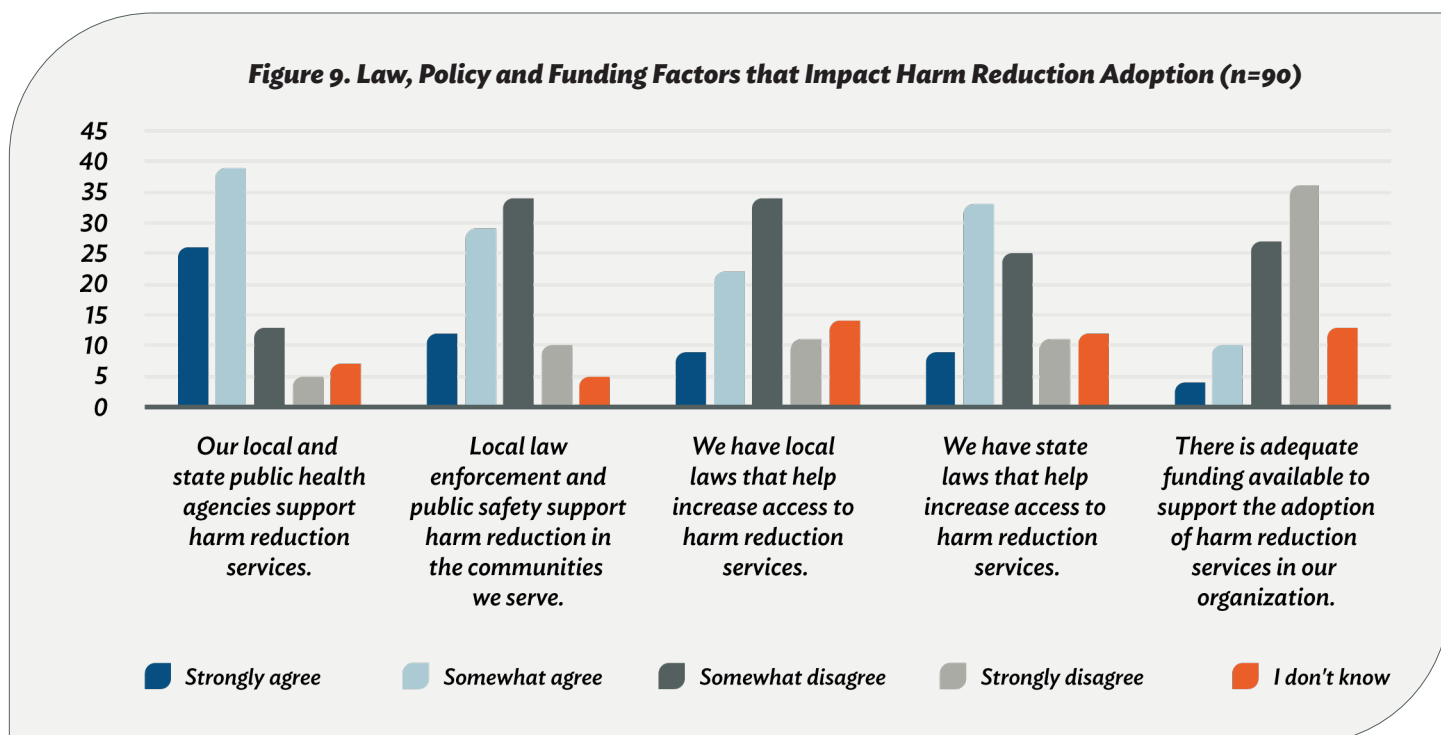
Seventy-eight percent of respondents reported that they strongly agree or agree that their local and state health agencies support harm reduction services, 14% somewhat disagree, 6% strongly disagree and 8% don't know.

With regard to local law enforcement, 13% of respondents reported that they strongly agree local law enforcement support harm reduction in their communities, 32% somewhat agree, 38% somewhat disagree, 11% strongly disagree and 6% don't know.



Ten percent of respondents strongly agree that local laws help increase access to harm reduction services, 24% somewhat agree, 38% somewhat disagree, 12% strongly disagree and 16% don't know. Similarly, 10% of respondents strongly agree that they have state laws that help increase access to harm reduction services, 37% somewhat agree, 28% somewhat disagree, 12% strongly disagree and 13% don't know.

Funding was the most commonly identified barrier to adopting harm reduction services. Only 4% of respondents strongly agree that there is adequate funding available to support harm reduction within their organization, 11% somewhat agree, 30% somewhat disagree, 40% strongly disagree and 14% don't know (Figure 9).



## Challenges to Adopting Harm Reduction Services

To better understand organizations' challenges related to adopting harm reduction services, survey respondents were asked an open-ended question: "What have been the greatest challenges to adopting harm reduction in your organization, if any?" Sixty-one respondents answered this question. Common themes that emerged included inadequate funding to support harm reduction services; a lack of education and training among providers and community members; a lack of resources, including resources to support PWUD; inadequate staff capacity; lack of community support; stigma and discrimination against PWUD and harm reduction; a need for culture change; policy and legal barriers; and a lack of organizational support, particularly among medical providers.

Inadequate funding was the most cited barrier among respondents to this question. Some respondents explained,

- "Insurances pay for abstinence-only programs."
- "We're a residential treatment program convincing funders (insurance) of the importance of harm reduction."
- "Lack of state and federal funding."



Regarding the need for culture change, several respondents commented on the need for a movement away from an abstinence-only based approach toward acceptance of harm reduction, particularly among law enforcement and criminal justice agencies. Respondents commented,

- *“Almost all of our clients are mandated to treatment by the courts, probation or parole, who are abstinence based in their philosophy.”*
- *“Resistance from criminal justice organizations.”*

Several respondents also commented on policy and legal barriers that have impacted their organizations’ harm reduction efforts. Respondents commented,

- *“Local/state prohibition against fentanyl test strips, which is something we definitely explored.”*
- *“State laws that have limited harm reduction programs, telehealth for buprenorphine and methadone prescribing and access. Advanced practice nurses have limited ability to proscribe MAT [medication-assisted treatment].”*
- *“Political pushback.”*

### Facilitators to Adopting Harm Reduction Services

Similar to identifying challenges, survey respondents were asked to identify the greatest facilitators supporting their organizations’ harm reduction efforts by answering an open-ended question. A total of 52 individuals responded to this question. Common themes that emerged include having support from local health departments and agencies; peer support or the inclusion of people with lived experience; collaboration; organizational leadership support; education and training; community support; having a champion; and having reimbursement for harm reduction services.

The most common facilitator identified through this question was having support from local agencies, including county and state health departments. Respondents commented,

- *“We have strong partnerships with various public health organizations.”*
- *“State government is trying to change the funding mechanisms to encourage harm reduction, but it is a new administration and not much has happened yet.”*
- *“State and local support for harm reduction services.”*
- *“Our county health department.”*

Several respondents also identified the inclusion of peer support workers and people with lived experience as a primary facilitator for their organizations’ harm reduction work. Respondents reported,

- *“Leadership and peer support specialists who have used harm reduction methods themselves.”*
- *“The need in our community and co-workers having lived experiences.”*
- *“Influence of peers.”*
- *“Employment of peer support workers.”*
- *“Peers and social work staff, especially those that are community based.”*



Community acceptance and involvement, including by community leaders, was identified as a facilitator by some respondents. They wrote,

- “Community involvement and our county’s mental health and recovery board.”
- “Naloxone has been embraced in the community.”
- “Some local leadership in politics has recently supported events that discuss harm reduction in substance use.”

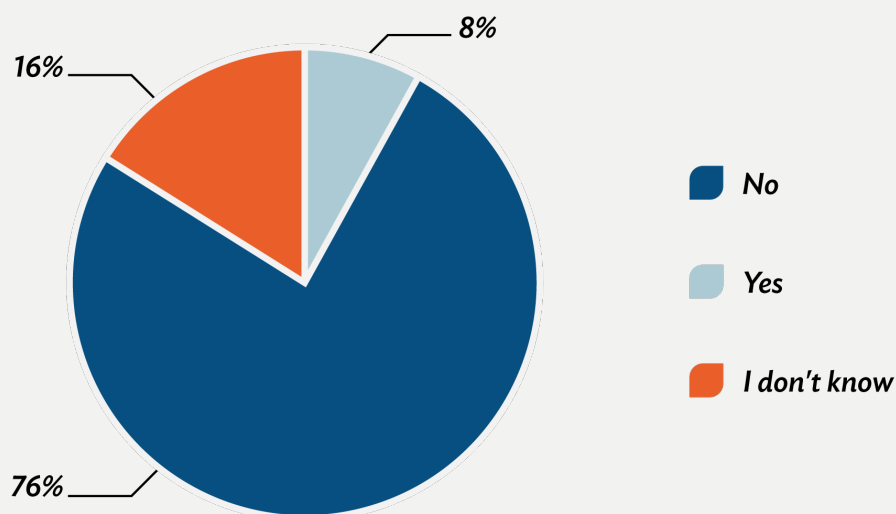
Collaboration was also a common theme among respondents, who noted their facilitators include,

- “Collaborating with agencies and law enforcement that engage with harm reduction practices.”
- “Collaboration among prevention, treatment and recovery organizations.”
- “Local consortiums and coalitions that advocate for adoption of harm reduction services.”
- “Public health partnership.”
- “Other grassroots-type organizations being willing to train and share knowledge.”

## TECHNICAL ASSISTANCE NEEDS AND PREFERENCES

Most survey respondents reported that they are not currently receiving technical assistance related to the delivery of harm reduction services. Of a total of 87 respondents, only 8% reported that their organization is receiving technical assistance related to harm reduction, 16% were unsure and 76% reported that their organization is not receiving technical assistance (Figure 10).

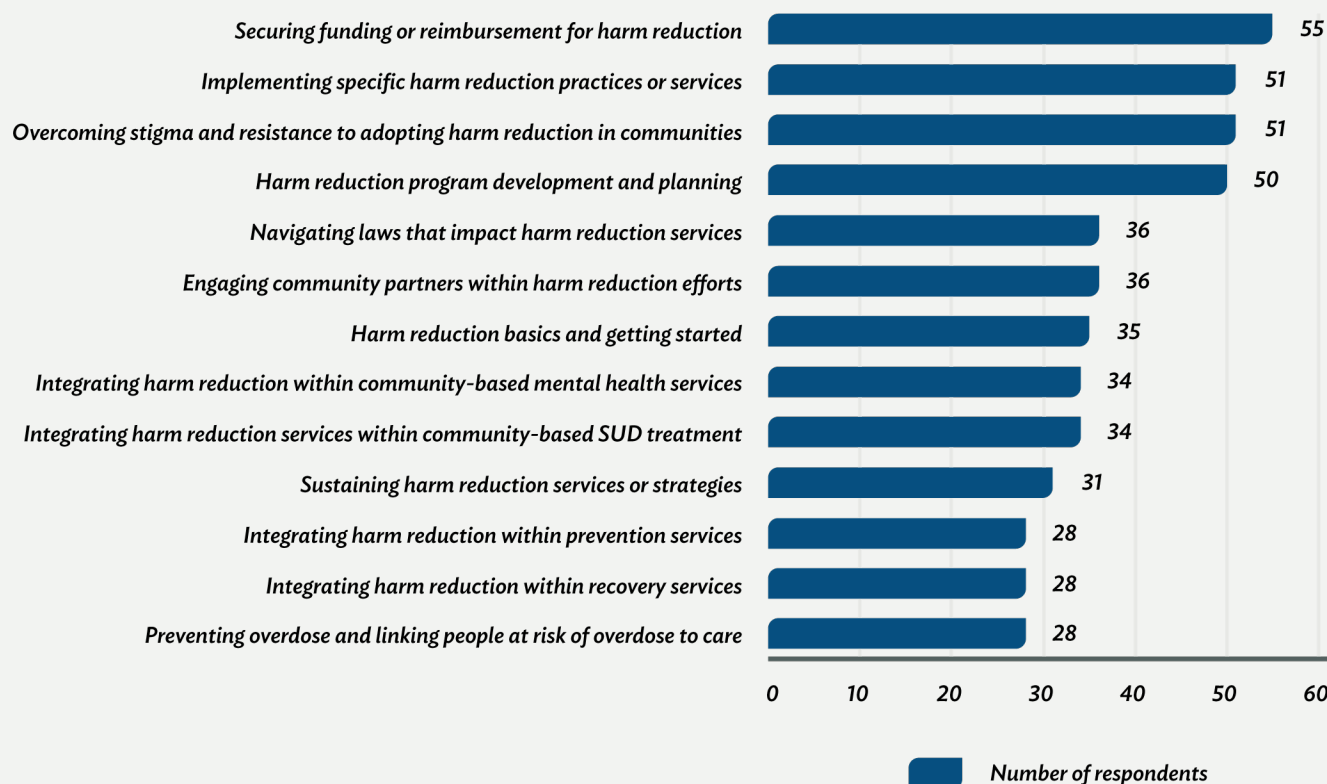
**Figure 10. Organizations Currently Receiving Technical Assistance to Support Harm Reduction Efforts (n=87)**





Respondents were asked to identify the areas of technical assistance that would most benefit their organization's efforts to implement harm reduction services. A total of 87 respondents answered this question. More than 30% of all respondents identified every option provided in the survey as an area of technical assistance from which they would benefit. More than half identified include securing funding or reimbursement for harm reduction strategies (63%), implementing specific harm reduction practices or services (59%), overcoming stigma and resistance to adopting harm reduction in communities (59%) and harm reduction program development and planning (57%) as technical assistance areas they would benefit from most (Figure 11).

**Figure 11. Technical Assistance Areas Organizations Would Benefit from the Most (n=87)**



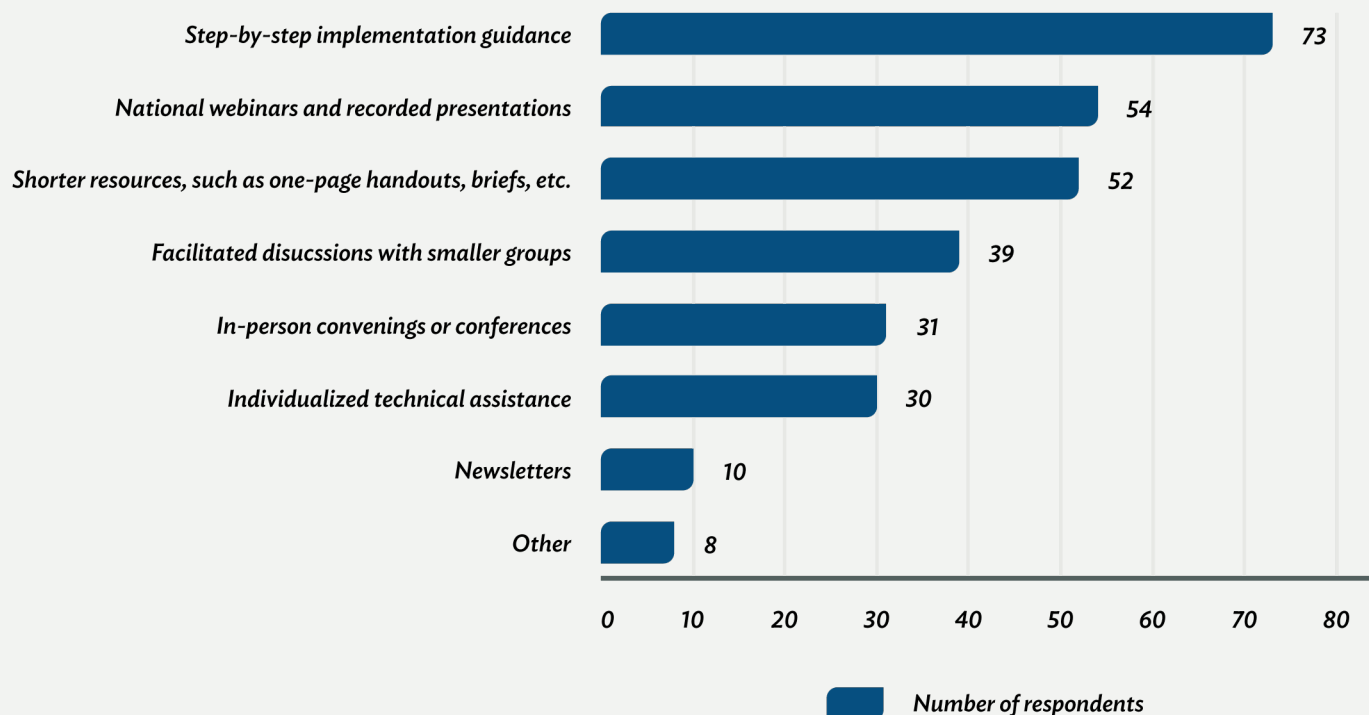
In addition to technical assistance areas of focus, respondents were asked to identify which types of technical assistance activities or resources would benefit their organization the most. Respondents were asked to choose their top three activities from a list and had the option of identifying other types of activities that would be beneficial that were not listed. Among a total of 87 respondents, the top five technical assistance activities identified included step-by-step implementation documents, such as toolkits or roadmaps (84%), national webinars and recorded presentations (62%), shorter resources, such as one-page handouts, briefs, checklists or resource guides (60%), facilitated discussions or conversations with smaller groups (45%) and in-person convenings or conferences (36%). Thirty-five percent of respondents chose individualized technical assistance (Figure 12).



Several respondents included comments or suggestions related to this question, including:

- “The facilitated discussions would be beneficial if they focused on identifying and implementing best practices.”
- “Rural area-specific information in contrast to larger cities.”
- “Community engagement to reduce stigma and educate the public.”
- “Successful campaigns to gain community acceptance.”
- “Virtual meetings, not in-person convenings.”

**Figure 12. Types of Technical Assistance Organizations Would Benefit from the Most (n=87)**





# Discussion

Survey data obtained from a national convenience sample of mental health and SUD treatment professionals demonstrate that:

1. There is a need for mental health and SUD treatment organizations to increase their adoption of harm reduction and other services for PWUD and to establish partnerships with SSPs and community-based harm reduction organizations.
2. Mental health and SUD treatment organizations face several barriers to adopting harm reduction services, including funding, staff capacity, policies and laws; however, organizations also identified strong facilitators for harm reduction adoption, including leadership and staff support, the inclusion of peer support workers and people with lived experience and support from local and state health departments.
3. There is an opportunity to expand the provision of harm reduction-related technical assistance to mental health and SUD treatment organizations and there is high interest in receiving technical assistance on a range of topics and through different modalities.

## NEED FOR INCREASED PROVISION OF HARM REDUCTION SERVICES AND PARTNERSHIPS

A need exists to increase access to harm reduction and other services for PWUD through mental health and SUD treatment organizations. Most mental health and SUD treatment organizations offer peer support services, counseling, outreach, engagement and education to PWUD, and naloxone distribution; however, few provide directly or through referral agreements core harm reduction services such as syringe distribution and fentanyl test strips. Up to 19% of respondents reported they plan to provide some harm reduction services in the future. The most common types of services planned for future provision include fentanyl test strips distribution followed by mobile buprenorphine treatment and safer smoking kits. Ten percent of respondents reported that they planned to provide syringe services in the future.

An opportunity exists to increase partnerships between mental health and SUD treatment organizations to increase access to harm reduction and other services for PWUD. Only 20% of respondents reported their organizations partnered with SSPs, 3% with national mail-based harm reduction supply organizations and 2% with drug user unions. Similarly, few respondents reported that their organizations were planning to partner with these organizations in the future. Only 19% reported planning to partner with SSPs, 6% with national mail-based harm reduction supply organizations and 6% with drug user unions.

Despite nearly half of respondents identifying local law enforcement as unsupportive of harm reduction in their communities (49% of respondents “somewhat disagree” or “disagree” that law enforcement support harm reduction in their communities), the majority of respondents reported that their organizations partner with public safety or law enforcement (66%) and 27% reported that they plan to partner with public safety or law enforcement in the future.

While only 8% of respondents reported that their organizations are currently receiving harm reduction-related technical assistance, 33% reported that they planned to partner with national training and technical assistance organizations in the future.



## LEVERAGING FACILITATORS AND OVERCOMING CHALLENGES

Survey respondents demonstrated that while they face several challenges to adopting harm reduction within their organizations, there are organizational factors that provide a strong foundation for supporting harm reduction services and approach to care. The large majority of respondents reported that they provide peer support services to PWUD, and also identified this as a main facilitator for adopting harm reduction at their organizations. The majority of respondents also reported that their local and state health departments were supportive of harm reduction and that they have established partnerships with their local public health agencies to improve the care of PWUD. The majority of respondents also identified leadership and staff support as a facilitator for harm reduction adoption.

The primary barriers faced by respondents' organizations were related to funding, staff capacity, policies and laws. Only 15% of respondents agree or somewhat agree that their organization has adequate funding to support harm reduction. Securing funding was also the most commonly identified area of technical assistance that would benefit respondents' organizations.

## TECHNICAL ASSISTANCE OPPORTUNITIES

The survey data supports a substantial opportunity and interest in delivering harm reduction-related technical assistance to mental health and SUD treatment organizations. While only 8% of respondents' organizations are currently receiving technical assistance, 33% reported that they planned to partner with national training and technical assistance organizations in the future. Furthermore, more than a quarter of all respondents identified each of the offered technical assistance focus areas as areas that would benefit their organizations. More than half of respondents identified four areas of technical assistance that would benefit their organizations most:

1. Securing funding or reimbursement for harm reduction.
2. Implementing specific harm reduction practices or services.
3. Overcoming stigma and resistance to adopting harm reduction.
4. Harm reduction program development and planning.

Similarly, survey respondents were open to technical assistance delivered through a range of different modalities. Step-by-step implementation guidance was identified as the modality that would benefit organizations the most (73%), followed by national webinars and recorded presentations (54%) and shorter resources, such as one-page handouts and briefs (52%).

## LIMITATIONS

This stakeholder analysis is subject to several limitations. A convenience sample of mental health and SUD professionals employed at National Council member organizations were recruited through an email listserv for participation. The National Council's membership is approximately 3,100 organizations, representing a small percentage of the total mental health and SUD organizations in the U.S. Therefore, the results of this survey should not be applied to mental health and SUD organizations generally. Additionally, this analysis did not examine responses among subgroups, such as through stratification by geographic location or type of provider organization.

To protect respondents' privacy, demographic data was not collected as part of the survey and geographic identifiers were optional for respondents to answer. Therefore, we do not have complete information about all of the respondents who participated in the survey. The majority of respondents who did identify their professional role or title reported that they held leadership positions within their organizations; more representation by staff at other levels may have resulted in different responses, particularly related to questions about organizational challenges and facilitators.





# References

- Aarons, G. A. (2005). Measuring provider attitudes toward evidence-based practice: Consideration of organizational context and individual differences. *Child and Adolescent Psychiatric Clinics of North America*, 14(2), 255–271. <https://doi.org/10.1016/j.chc.2004.04.008>
- Ahmad, F. B., Cisewski, J. A., Rossen, L. M., & Sutton, P. (2022). Provisional drug overdose death counts. National Center for Health Statistics. <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>
- Bonar, E. E. & Rosenberg, H. (2010). Substance abuse professionals' attitudes regarding harm reduction versus traditional interventions for injecting drug users. *Addiction Research & Theory*, 18(6), 692–707. <https://doi.org/10.3109/16066359.2010.483310>
- Centers for Disease Control and Prevention (CDC). (2019). *Summary of Information on the Safety and Effectiveness of Syringe Services Programs (SSPs)*. <https://www.cdc.gov/ssp/docs/SSP-Summary.pdf>
- CDC. (2022). National Harm Reduction Technical Assistance Center. <https://harmreductionhelp.cdc.gov>
- Des Jarlais, D. C. (2017). Harm reduction in the USA: The research perspective and an archive to David Purchase. *Harm Reduction Journal*, 14(1), 51. <https://doi.org/10.1186/s12954-017-0178-6>
- Goddard, P. (2003). Changing attitudes towards harm reduction among treatment professionals: A report from the American Midwest. *International Journal of Drug Policy*, 14(3), 257–260. [https://doi.org/10.1016/S0955-3959\(03\)00075-6](https://doi.org/10.1016/S0955-3959(03)00075-6)
- Harm Reduction International. (2021). *What is Harm Reduction?* [https://www.hri.global/files/2021/05/05/What\\_is\\_Harm\\_Reduction\\_English\\_HRI.pdf](https://www.hri.global/files/2021/05/05/What_is_Harm_Reduction_English_HRI.pdf)
- Irwin, A., Jozaghi, E., Weir, B. W., Allen, S. T., Lindsay, A., & Sherman, S. G. (2017). Mitigating the heroin crisis in Baltimore, MD, USA: A cost-benefit analysis of a hypothetical supervised injection facility. *Harm Reduction Journal*, 14(1), 29. <https://doi.org/10.1186/s12954-017-0153-2>
- Javadi, R., Lagana, K., Krowicki, T., Bennett, D., & Schindler, B. (2021). Attitudes toward harm reduction among substance use treatment professionals in Philadelphia. *Journal of Substance Use*, 1–6. <https://doi.org/10.1080/14659891.2021.1961320>
- Jordan, J. R. (2021). *Come as You Are: The Acceptability of Harm Reduction Approaches for Opioid Use Disorder among Professional Counselors*. [Doctoral dissertation, Virginia Tech]. Virginia Tech Electronic Theses and Dissertations. <https://vtechworks.lib.vt.edu/handle/10919/102979>
- Lauritsen, K. J. (2017). *Do Psychological Characteristics of Addiction Treatment Professionals Predict Acceptance of Harm Reduction Interventions?* [Doctoral dissertation, Bowling Green State University]. OHIOLink Electronic Theses & Dissertations Center. [http://rave.ohiolink.edu/etdc/view?acc\\_num=bgsu1497572679919639](http://rave.ohiolink.edu/etdc/view?acc_num=bgsu1497572679919639)



National Harm Reduction Coalition. (2020). *Principles of Harm Reduction*.

[https://harmreduction.org/wp-content/uploads/2020/08/NHRC-PDF-Principles\\_Of\\_Harm\\_Reduction.pdf](https://harmreduction.org/wp-content/uploads/2020/08/NHRC-PDF-Principles_Of_Harm_Reduction.pdf)

Office of National Drug Control Policy (ONDCP). (2022). National Drug Control Strategy.

<https://www.whitehouse.gov/wp-content/uploads/2022/04/National-Drug-Control-2022Strategy.pdf>

Substance Abuse and Mental Health Services Administration (SAMHSA). (2022, June 8). *Harm Reduction*.

<https://www.samhsa.gov/find-help/harm-reduction>

The White House. (2021, December 16.) Readout: White House, HHS Host National Harm Reduction Summit. <https://www.whitehouse.gov/ondcp/briefing-room/2021/12/16/readout-white-house-hhs-host-national-harm-reduction-summit/>

U.S. Department of Health and Human Services (HHS). (2022). Overdose Response Strategy, Harm Reduction.

<https://www.hhs.gov/overdose-prevention/harm-reduction>

Wakeman, S. E. (2019). Harm Reduction Approaches for Opioid Use Disorder. In J. F. Kelly & S. E. Wakeman (Eds.), *Treating Opioid Addiction* (pp. 169–180). Springer International Publishing. [https://doi.org/10.1007/978-3-030-16257-3\\_8](https://doi.org/10.1007/978-3-030-16257-3_8)