ORIGINAL RESEARCH

Mental Health Prescribers' Perceptions of Patients With Substance Use Disorders and Harm Reduction Services

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Background: The Veterans Health Administration (VHA) has published guidelines outlining the legal authority to operate syringe services programs. To aid in the implementation of harm reduction programs at VHA medical centers in Maryland; Washington, DC; and West Virginia, the perceptions of harm reduction tools by mental health prescribers were evaluated.
Methods: A mixed-methods analysis examined mental health prescriber perceptions of patients with substance use disorders (SUDs) and their willingness to provide harm reduction tools. A survey was conducted followed by a voluntary postsurvey interview. A descriptive analysis was performed on responses. Notes from postsurvey interviews were analyzed using the Prosci Awareness, Desire, Knowledge, Ability, and Reinforcement (ADKAR) Model for Change Management.
Results: Prescribers felt comfortable and confident in their abilities to educate patients to reduce harm related to substance use. Survey results were mixed regarding comfort in working with people with or without SUDs. Prescribers were represented across the continuum of the ADKAR change model and were more willing to provide naloxone than fentanyl test strips or syringes. Prescribers expressed mixed opinions on the use of harm reduction tools for patients with SUDs. Some prescribers viewed harm reduction as part of a treatment plan, while others viewed a return to drug use as a failure of treatment.
Conclusions: This study highlights the need for additional interventions to address clinician hesitancy and concerns surrounding harm reduction tools to successfully implement harm reduction programs across the VHA.

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The Public Health and Welfare Act of 1988 prohibited the use of federal funds to "provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs."[1] Although the Act included the caveat that the US Surgeon General may determine that "a demonstration needle exchange program would be effective in reducing drug abuse," and thus federal funds could be used, the legislation prohibited federal, state, and local agencies from funding syringe services programs (SSPs). SSPs use various harm reduction tools to improve public safety and reduce the potential harmful consequences of risky behaviors, similar to how using a seat belt while driving reduces the risk of injury or death.[2] SSPs are rooted in evidence-based practices, and several studies, according to the Centers for Disease Control and Prevention, have found that people who use drugs (PWUDs) who use community-based SSPs are 5 times more likely to enter treatment than those who do not use these programs. Additionally, these programs have shown an estimated 50% reduction in HIV and hepatitis C infections.[3]

Amid a 2015 HIV outbreak in Indiana among individuals sharing needles for injection drug use, Congress passed an omnibus spending bill that partially lifted the federal funding restriction. Federal funds now may be used for operational costs that support SSPs but may not be used to purchase syringes themselves.[4]

Following the 2015 legislation, federal agencies began implementing SSPs. The Veterans Health Administration (VHA) established SSPs at 3 medical centers in 2017.[5] Veterans who participated in the programs were able to access supplies (eg, syringes, fentanyl test strips, wound care kits, and condoms) through donations to US Department of Veterans Affairs (VA) medical centers (VAMCs). The success of these programs laid the foundation for the VHA to implement SSPs nationally. VHA SSPs provided access to naloxone (an opioid overdose reversal medication), fentanyl test strips, condoms, sterile syringe distribution, testing for blood-borne viruses, HIV pre-exposure prophylaxis, as well as educational materials and resources, and low-barrier access to drug treatment (eg, medications for opioid use disorder [OUD]).

In 2020, the Biden Administration outlined 7 drug policy priorities, which included enhancing evidence-based harm reduction efforts.[6] This policy also discussed mandates for federal agencies to remove barriers to federal funding for purchasing syringes and other harm reduction supplies. The VHA responded to the policy by publishing guidance that recommended VAMCs develop and/or ensure veterans have access to harm

TABLE 1. Survey Respondent Demographics (N = 66)

	No. (%)
Prescriber type	
Medical doctor	31 (47)
Nurse practitioner	12 (18)
Doctor of osteopathic medicine	7 (11)
Physician assistant	7 (11)
Doctor of pharmacy	9 (14)
Time in practice	
0-5 y	16 (24)
6-10 y	12 (18)
11-15 y	14 (21)
16-20 y	7 (11)
> 20 y	17 (26)
Veterans Affairs medical center location	
Martinsburg, WV	17 (26)
Baltimore, MD	17 (26)
Washington, DC	12 (18)
Clarksburg, WV	9 (14)
Beckley, WV	7 (11)
Huntington, WV	4 (6)
Substance use disorder treated	
Alcohol	62 (33)
Cannabis	40 (21)
Opioid	38 (20)
Stimulant	37 (20)
Other	10 (5)
Met with academic detailer on harm reduction prior to survey	33 (50)
No	28 (42)
Unsure	5 (8)

reduction services in the community, where state law is not legally more stringent.[7]

In 2025 the Trump administration Statement of Drug Policy Priorities encouraged local jurisdictions to increase the availability of drug test strips and naloxone.[8] These significant policy shifts moved SSPs from being housed mostly in local public health departments and community-based organizations to also being available at health care facilities.[9] VAMCs have unique opportunities to provide universal health care that includes both prevention services and other medical management to PWUD.

One study assessed staff perceptions of PWUD at a VAMC in preparation for a training program about harm reduction. The results indicated an overall positive staff perception of PWUD, although only the Drug and Drug Problems Perceptions Questionnaire (DDPPQ) was administered, which assessed comfort of working with this population and not explicitly the use of harm reduction.[10] Another study interviewed clinical pharmacists, primary care clinicians, social workers, and directors of addiction and mental health services to determine barriers and facilitators (ie, potential opportunities to promote change) to implementing harm reduction at the VHA. The study identified barriers to be a lack of knowledge, time, and comfort, while suggesting opportunities for improvement were engagement of champions, communication and educational strategies, and adaptation of existing infrastructure.[11]

While these findings are insightful for the VHA to disseminate a harm reduction program, there remains a gap in assessing staff willingness to provide harm reduction services. Evidence on harm reduction services among veterans is limited and more research is needed to better understand the role of these services and acceptance among enrolled veterans and VHA staff. Specifically, more research is needed on health care practitioners' (HCPs) perceptions of harm reduction use.

Mental health care practitioners frequently treat patients with substance use disorders (SUDs), making them an ideal initial cohort to assess willingness to provide harm reduction to this population. By analyzing mental HCPs' perceptions, additional interventions could be identified, implemented, and evaluated to improve their willingness to provide harm reduction tools.

This project focused on mental health clinicians with prescribing privileges: physicians (allopathic and osteopathic physicians), nurse practitioners, physician assistants, and clinical pharmacist practitioners. Mental health prescribers were selected because they are uniquely positioned at the intersection of prevention and treatment in drug use. Furthermore, mental health prescribers at the VAMCs included in this study are usually the primary point of entry to SUD clinics. This mixed-methods study used an anonymous online survey and voluntary postsurvey discussions with mental health care prescribers to elaborate on their beliefs and attitudes, providing deeper insight into their responses regarding harm reduction.

METHODS

This project was conducted by the Veterans Integrated Services Network (VISN) 5 academic detailing team. VISN 5 serves veterans from economically and demographically

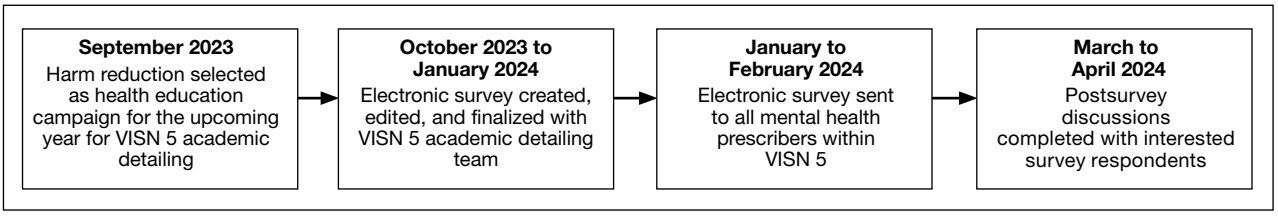

FIGURE 1. Project Timeline
Abbreviation: VISN, Veterans Integrated Services Network.

diverse areas in Maryland; Washington, DC; West Virginia; and portions of Virginia, Pennsylvania, Ohio, and Kentucky. VAMCs in Baltimore, Maryland, and Washington, DC, serve a largely urban population while the 4 West Virginia facilities in Martinsburg, Huntington, Beckley, and Clarksburg, serve a largely rural population. West Virginia has been the epicenter of the opioid crisis and consistently has the highest drug overdose deaths per capita in the United States.[12] Among cities, Baltimore, Maryland, has the highest number of drug overdose deaths per capita with 174.1 per 100,000 people.[12,13]

At the time of this project, the 6 VISN 5 VAMCs had established overdose education and naloxone distribution (OEND) programs. Although OEND programs have existed since 2013, VISN 5 SSPs and harm reduction services that provided fentanyl test strips were only available at the Martinsburg, Beckley, and Huntington VAMCs. All 6 VAMCs had substance use treatment programs with a variety of inpatient and outpatient mental health services. The Washington, DC and Baltimore VAMCs had opioid treatment programs that provided methadone maintenance.

The VISN 5 academic detailing team consists of 7 clinical pharmacists. These academic detailers plan annual systematic interventions to provide medical knowledge translation services on health-related campaigns. Academic detailers are trained in change management and motivational interviewing. They uniquely facilitate conversations with HCPs on various topics or campaigns, aiming for quality improvement and behavioral change through positive relationships and sharing resources.[14] Academic detailing conversations and relationships with HCPs involve assessing and understanding HCP behaviors, including barriers and readiness to change to align with the goal of improving patient outcomes. Academic detailing has improved practice behaviors around providing OEND in VHA.[15]

To prepare for a harm reduction campaign, the academic detailers sought to gain insight from target VISN 5 mental health prescribers. Figure 1 outlines the project timeline, which started with emails inviting mental health prescribers to complete an anonymous online survey. Academic detailers from each site emailed mental health prescribers who completed the survey to determine interest in expanding on survey findings. Mental health prescribers who completed the survey could participate in a postsurvey discussion.

Surveys

Between January 29, 2024, and February 22, 2024, the academic detailers emailed facility mental health prescribers (N = 156) a link to an anonymous 15-question survey. The email informed recipients of the survey's purpose: to gain a better understanding of prescriber perceptions of veterans with SUD and harm reduction programs and their willingness to provide harm reduction tools, to better determine interventions that could be implemented.

The survey collected prescriber demographic data and their perceptions of PWUD and harm reduction tools and education. Survey questions were extrapolated from validated surveys (eg, DDPPQ) and survey-based implicit association test.[16,17] The survey used multiple choice and 5-point Likert scale questions. Mental health prescribers were asked about their role at the VHA, years in practice, medical center affiliation, type of SUDs treated (eg, opioid, stimulant, alcohol, cannabis, or other), and whether they had previously met with academic detailers about harm reduction.

Respondents read statements about patients with or without SUD and provided

TABLE 2. Follow-Up Interview Analysis

Interviewee	Location	Clinician type	Detailer identified ADKAR		Clinician identified	
			Stage	Opportunities	Barriers	Opportunities
1	Baltimore, MD	PA	Reinforcement to sustain the change	Reinforce by recognizing success and ask if they would want to assist with analysis for low adoption	Lack of more mobile services	Small group discussions with MD peers
2	Baltimore, MD	NP	Desire to support and participate in change	Identify personal benefits of adoption	Lack of confidence; lack of awareness of use in VA	Education to improve confidence
3	Washington, DC	MD	Awareness of the need for change	Address stigma around continued drug use	Lack of time to discuss harm reduction with patients; feeling that SUD clinicians offering harm reduction is not appropriate	Optimize time with patients to discuss harm reduction
4	Beckley, WV	PharmD	Knowledge of how to change	Provide access and time for training; job aids to assist with the learning process	Lack of comfort with harm reduction products	A flowchart or print resource (eg, job aids) on when to offer to patients
5	Huntington, WV	MD	Reinforcement to sustain the change	Reinforce by recognizing success and ask if they would want to assist with analysis for low adoption	None	Data-driven didactic presentations
6	Clarksburg, WV	MD	Reinforcement to sustain the change	Reinforce ability to to adopt harm reduction	Unfamiliar with local laws	Clear universal VA processes
7	Martinsburg, WV	MD	Desire to support and participate in change	Identify personal benefits of adoption	Lack of knowledge and time to gain new knowledge	Optimize time with patients to discuss harm reduction

Abbreviations: ADKAR, Awareness, Desire, Knowledge, Ability, and Reinforcement; MD, medical doctor; NP, nurse practitioner; PA, physician assistant; PharmD, doctor of pharmacy; SUD, substance use disorder; VA, US Department of Veterans Affairs.

Likert scale responses describing their regard, level of comfort, and preferences. The survey included Likert scale questions about respondents' comfort in providing harm reduction education and supplies. Respondents also noted whether they believed harm reduction reduced substance use, harm reduction tools encourage people with SUD to continue using drugs, and whether HCPs can impact clinical change.

Postsurvey interviews with predetermined questions were conducted in-person or via video conference with ≥ 1 prescriber at each VAMC by an academic detailer. The postsurvey discussion offered an opportunity for respondents to further elaborate and describe previous experiences and current beliefs that may affect their attitudes toward people with SUD and their views on harm reduction. Participants received no compensation for survey completion or interviews.

Analysis

The Washington VAMC Institutional Review Board reviewed and approved this project as quality improvement with potential publication. No inferential statistics were calculated. Survey participant demographics were reported using frequencies and proportions reported for categorical variables. Notes from follow-up interviews were analyzed using the Prosci Awareness, Desire, Knowledge, Ability, and Reinforcement (ADKAR) Model for Change Management.[18] This framework is used by academic detailers to determine a prescriber's stage of change, which helps select the appropriate resources to move the clinician along a change framework. Completed postsurvey interview sheets, including notes written by the academic detailer, were analyzed by the project lead (NJ) who reviewed each interview sheet and analysis with the academic detailer who led the discussion.

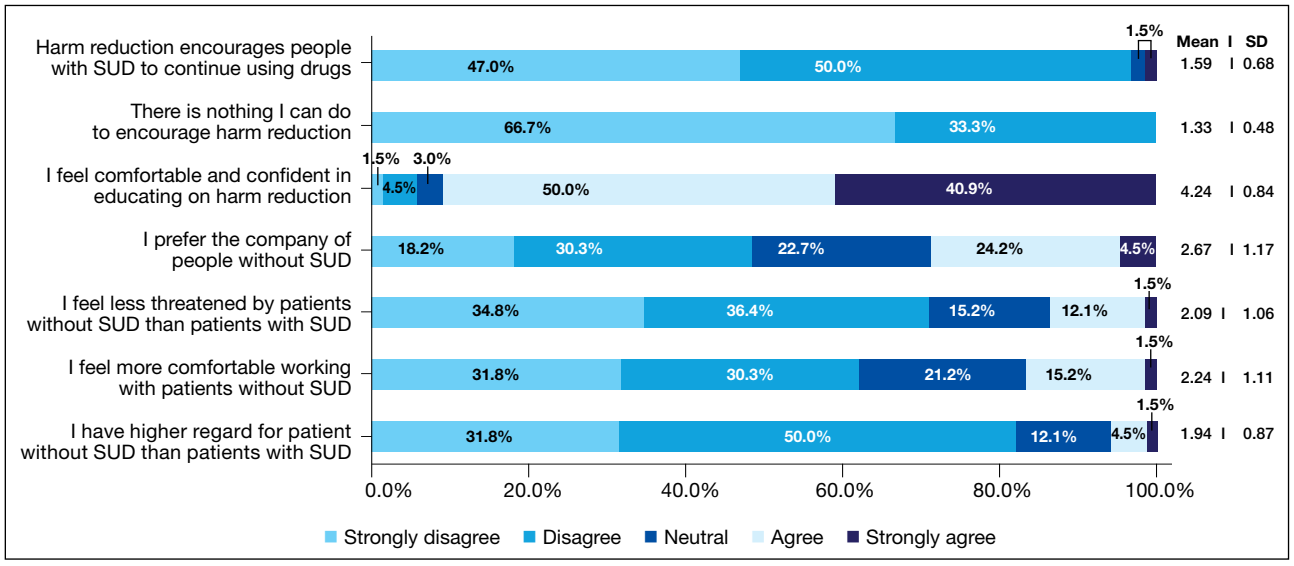

FIGURE 2. Respondent Attitudes About Harm Reduction and Patients With SUD

Abbreviation: SUD, substance use disorder.

RESULTS

Sixty-six respondents completed the online survey (42% response rate), and 7 mental health prescribers participated in a postsurvey discussion. Thirty-one participants (47%) were physicians and 17 (26%) were in practice for > 20 years. Response rates reflected the size of mental health staff at each VAMC at the time of the survey: 17 respondents (26%) worked at each of the Martinsburg and Baltimore VAMCs, with fewer at the other VAMCs (Table 1). Alcohol use disorder was the most commonly reported SUD treated (n = 62; 33%), followed by cannabis use disorder (n = 40; 21%), OUD (n = 38; 20%), and stimulant use disorder (n = 37; 20%).

Respondents felt comfortable and confident educating patients on ways to reduce harm related to substance use (91%; mean [SD], 4.24 [0.84]). Most prescribers surveyed (97%; mean [SD], 1.59 [0.68]) disagreed or strongly disagreed that harm reduction encourages patients with SUD to continue using drugs, and all prescribers surveyed disagreed that there is nothing they can do to encourage harm reduction. Survey results were mixed for personal comfort in working with people with SUD vs people without SUD (Figure 2). Respondents were most willing to provide naloxone (95%; mean [SD], 4.71 [0.78]), compared to fentanyl test strips (61%; mean [SD], 3.61 [1.41]) or syringes (39%; mean [SD], 3.18 [1.39]). Respondents were neutral or least willing to provide syringes (Figure 3).

Seven postsurvey interviews were completed between academic detailers and mental health clinicians across the 6 VAMCs. Respondents included 1 physician assistant, 1 nurse practitioner, 1 pharmacist, and 4 physicians. Notes were analyzed using the ADKAR Change Competency Model to organize clinician stages of change (Table 2).

Barriers identified by interviewees included lack of mobile services, lack of confidence and awareness of the availability of harm reduction at their respective medical center, lack of time to discuss harm reduction, negative sentiments toward providing SUD-related harm reduction, discomfort with harm reduction products, and lack of knowledge and time to learn about harm reduction services. Opportunities identified to drive change in practice included additional time allotted during patient appointments, educational discussions and presentations to increase knowledge of and comfort with harm reduction tools, a clear clinical patient care workflow and process for harm reduction services, and reinforcement strategies to recognize success.

DISCUSSION

This project investigated mental health prescribers' perceptions of harm reduction at

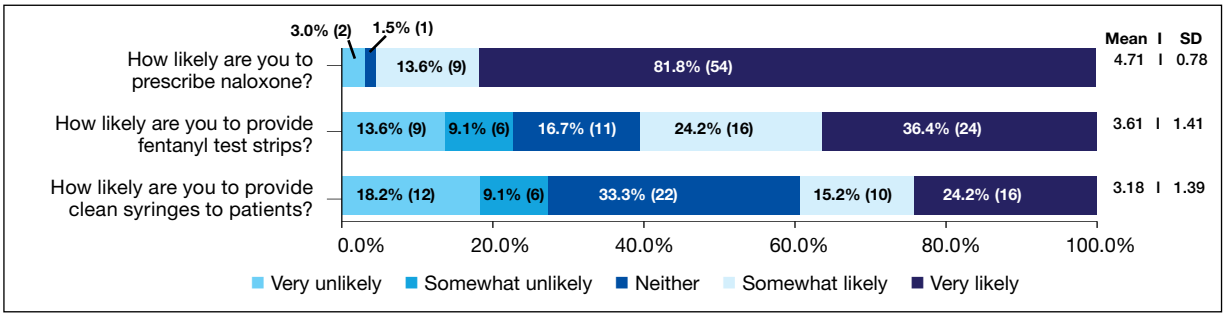

FIGURE 3. Respondent Willingness to Provide Harm Reduction Tools

VAMCs in West Virginia, Maryland, and Washington, DC. While previous studies have demonstrated the efficacy of harm reduction tools, there is a lack of research on HCPs willingness to use these resources. This study suggests that while most respondents feel confident in and see the value of offering harm reduction resources to patients, a disparity exists between which resources HCPs are more likely to use and factors that would further enhance their ability to integrate harm reduction into practice. The follow-up interviews provided additional insight into the survey results.

Most respondents met the awareness and desire stage and moved to the knowledge, ability, or reinforcement ADKAR stage. It would be reasonable to extrapolate that most of the respondents felt comfortable with and were very likely to offer certain harm reduction tools. In the ADKAR interview analysis, the most common factors needed to drive change included having more time during patient appointments, additional education, clear processes for harm reduction services, and reinforcement strategies to sustain change. Respondents noted that harm reduction discussions took extra time in their already limited appointments with patients, which may have limited time for discussions surrounding all other mental health concerns. These discussions often necessitate in-depth conversations to accurately understand the patients' needs. Given HCP time constraints, they may view harm reduction as lower in urgency and priority relative to other concerns. While most respondents were in the reinforcement phase, it is important to note the ADKAR model is fluid, and therefore an HCP could move forward or backward. This movement can be noted in the postsurvey interviews where, for example, prescriber 6 was determined to be in the reinforcement stage since they had already discussed harm reduction with patients. However, prescriber 6 also noted a barrier of unfamiliarity with local laws, which could shift them to the ADKAR knowledge stage.

Respondents noted that education through didactic sessions could lead to better incorporation of harm reduction into patient care. While harm reduction has evidence supporting its effectiveness, the respondents noted willingness to discuss harm reduction when treatment fails or the patient refuses treatment or referrals. Respondents expressed mixed opinions on use of harm reduction tools among patients with SUDs as some prescribers viewed harm reduction as part of a treatment plan and others viewed a return to drug use as a failure of treatment. Furthermore, respondents expressed hesitancy surrounding certain harm reduction tools, such as fentanyl test strips or syringes, and perceived these supplies as intended for medical use rather than harm reduction. HCPs may feel uncomfortable offering these supplies for drug use, despite their use for reducing risk.

Most responses were received from VAMCs with large mental health substance use programs. Respondents at larger, urban facilities (Washington, DC, and Baltimore, Maryland) expressed more hesitancy around using harm reduction tools despite having more harm reduction resources available compared to smaller or rural sites. These results align with previous studies that found no difference in prescribers providing medications for OUD in rural and urban VAMCs, showing urban sites, despite more resources, are not more willing to provide harm reduction or other addiction services.[19] This evidence might indicate that urban sites may not use available resources

(eg, methadone clinics) or that rural sites can provide just as robust medications for OUD care as urban sites.

Follow-up interview analysis indicated that HCPs lack knowledge of certain harm reduction tools. One-on-one peer discussions, like academic detailing, can facilitate discussions around a prescriber's role in harm reduction, address gaps in knowledge by sharing what is available at the facilities for harm reduction, and suggest conversation points to help prescribers start harm reduction discussions with patients unwilling to begin treatment. Additionally, academic detailing can connect prescribers to available resources in the community to provide pragmatic approaches and suggestions. A clear and consistent treatment process may reduce barriers by reassuring prescribers they have support and by providing consistent directions so that prescribers do not waste time.

Reinforcement is important for sustaining change. VAMCs could consider positive feedback and other evidence-based reinforcement strategies (eg, social recognition, continuing education) to communicate that these changes are noticed and appreciated.[20] Late adopters may also be influenced by seeing positive feedback and results for peers. Systematic changes can be the catalyst for and sustain individual change.

Shifting perceptions and adopting change may be challenging, especially for SUD, which can be highly stigmatized. Promotion of successful change should be multifaceted and include both system and individual approaches. VHA systemic changes that could contribute to positive change include provision of time and access to SUD treatment training, a clear and sustainable treatment process, and reinforcement by recognizing success. In addition, facility leadership could provide support through dedicated time and resources during the workday for SUD treatment and harm reduction training. Support could empower HCPs and convey leadership support for harm reduction. This dedicated time could be used for didactic lecture sessions or individual meetings with academic detailers who can tailor discussions to the prescriber's practice.

Strengths and Limitations

This survey included prescribers from a range of mental health care practice settings (eg, inpatient, outpatient clinic, rural, urban) and varied years of experience. This variety resulted in diverse perspectives and knowledge bases. Postsurvey interviews allowed academic detailers to gain deeper insight into answers in the survey, which can guide future interventions. Postsurvey interviews and application of the ADKAR model provided additional viewpoints on harm reduction.

A limitation of this project is the absence of an assessment of respondents' harm reduction knowledge accuracy. Although respondents reported confidence in discussing harm reduction with patients, the survey did not assess whether their knowledge was accurate. Additionally, the survey did not ask about the availability of syringes and test strips at the prescribers' VAMC, which could explain discrepancies in responses between naloxone and other forms of harm reduction (drug test strips and syringes were not available to all HCPs in the VISN). This lack of availability may have skewed responses. West Virginia SSPs, for example, were closed following legislative changes, which may contribute to stigma.[21]

Not all respondents were asked to do a follow-up interview, which limited the perspectives included in this study. Each site had ≥ 1 follow-up interview to limit the academic detailer's workload. The initial survey included the phrase clean syringe, which can be stigmatizing and insinuate that PWUD are not clean. The preferred term would have been sterile syringe.[22]

CONCLUSIONS

This survey of mental health prescribers found that most respondents are comfortable treating patients with SUD and confident in educating patients on harm reduction. Additionally, most respondents were more willing to provide naloxone vs fentanyl test strips or sterile syringes. A lack of time and awareness was the most frequently cited barrier to harm reduction services. As the VHA continues to expand access to harm reduction programs, which have proven to increase treatment rates and reduce disease, it will be imperative for HCPs, including mental health prescribers, to recognize the benefit of

these programs for veterans with SUD. Future interventions should be designed and evaluated in collaboration with all HCPs and patients. This project determined ways to promote change for prescribers, but it will be important for further research to continue those conversations and incorporate patient perspectives.

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Ethics and consent
The Veterans Affairs Washington, DC Institutional Review Board approved this quality improvement project for potential publication.

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