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Harm Reduction in Rural Areas: A Workbook for Homeless Response System Staff

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HOMELESS & HOUSING RESOURCE CENTER

SAMHSA
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Contents

Disclaimer

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Introduction

The *Harm Reduction in Rural Communities* workbook is designed to help rural areas implement harm reduction strategies, including Housing First principles. It addresses the unique challenges communities may face if they have not yet adopted harm reduction methods or have struggled to acquire the capacity and knowledge to do so. This workbook focuses on the practical implementation of these principles to encourage readers to think about how they can best adopt harm reduction and Housing First strategies in their communities. The following pages contain facts, implementation strategies, reflection questions, and links to more information.

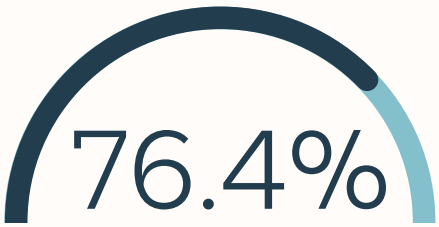
1 Workbook 1: Overview of Harm Reduction Principles for Rural Communities

Harm reduction is an approach to helping communities support individuals with behavioral health issues by focusing on preserving and protecting their health, even when they are not ready or able to stop using substances. Harm reduction is an integral component of a full continuum of care, encompassing health promotion and prevention, early intervention, treatment, recovery support, and continuing care. Practicing harm reduction involves meeting people where they are in their journey while not leaving them there—to create positive change in their lives through practical tools, choice, hope, engagement, health promotion, and consistent positive regard. It also includes providing interventions to enhance safety in high-risk behaviors such as substance use and self-harm and using motivational strategies to encourage positive behavior change.

Harm reduction resources may not be as accessible in rural communities as in urban areas. More densely populated areas usually receive more resources, leaving many residents in rural areas with little to no support as well as limited education about protecting their health when engaged in substance use.

Harm reduction focuses on engaging directly with individuals with behavioral health conditions, regardless of their involvement in treatment. According to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2024: 44), "Among people aged 12 or older in 2023 who were classified as needing substance use treatment in the past year, 12.8 million people (about 23.6 percent) received substance use treatment in the past year." This means that 76.4 percent of the people who needed substance use treatment within the past year did not receive it. Harm reduction outreach services can act as a crucial link between people in the community and the treatment system.

Harm reduction recognizes that untreated behavioral health conditions are a reality in many communities. It focuses on minimizing the harm associated with high-risk behaviors and on keeping people safe, healthy, and alive. Harm reduction acknowledges that traditional approaches to engaging people in treatment and recovery services do not work for everyone and that not everyone is ready for treatment at any given moment. This approach works to meet people where they are, measuring success not by the absence of symptoms but by positive behavior change, no matter how small, upon which to build future recovery efforts.



76.4 percent of the people who needed substance use treatment within the past year did not receive it.

Substance Abuse and Mental Health Services Administration's Key Substance Use and Mental Health Indicators in the United States *Report*

Taking a harm reduction approach means recognizing the limitations of forcing someone into treatment and honoring a person's autonomy in deciding their own path and timeline. It involves believing all people are capable of change and will do so when they are ready and their circumstances allow. For example, people who inject drugs are at risk of serious health conditions associated with unsafe injection practices. The person may not be ready to stop using substances, but teaching safe injection practices and connecting them with new and sterile injection equipment can reduce the risk of contracting and spreading infectious diseases, such as hepatitis C and HIV (Homeless and Housing Resource Center [HHRC], 2021).

Although harm reduction practices such as providing sterile needles to someone injecting drugs or offering condoms to someone engaging in sex work, may seem counterintuitive on the surface, their effectiveness is undeniable. Among many benefits, the Centers for Disease Control and Prevention (CDC, 2024) found that people who access harm reduction services such as syringe service programs are three times more likely to quit injecting substances and access treatment. The power of harm reduction may lie in its ability to navigate the underlying forces at play driving addictive or compulsive behaviors (HHRC, 2021).

The following pages outline ways to think about harm reduction, including strategies for advocacy and implementation within a rural community. Each section provides information about harm reduction and reflection questions about what harm reduction could look like in different areas.

Reflection questions:

- *What comes to mind when you hear the term "harm reduction"? What does it mean to you? (It is OK if your feelings are positive, negative, or a mix of both.)*
- *Is your community familiar with harm reduction programs or ideas? How does it view them?*
- *Can you think of examples of harm reduction in your community? What are they?*
- *Are there currently any unaddressed needs in your community that come to mind? What are they?*

2 Workbook 2: Principles of Harm Reduction

The harm reduction approach is a person-centered model, putting the participants in charge of their care and recovery journey. The National Harm Reduction Coalition (2024) has formulated the following principles:

1. *Harm reduction seeks to neutralize harmful behaviors by looking at high-risk behaviors in a nonjudgmental way. Neutralizing these behaviors works to reduce the stigma and shame that create barriers to services.*
2. *Harm reduction accepts that high-risk behaviors are part of the world and that people are going to engage in them with or without support services. It focuses on keeping people alive, protecting their health, and using determinants such as quality of life and perceived well-being as markers of successful interventions.*
3. *Harm reduction acknowledges that each recovery journey is unique and respects each person's autonomy to make their own decisions about how and when they will access recovery supports.*
4. *Harm reduction offers nonjudgmental, noncoercive, and compassionate care, regardless of substance use status. Harm reduction* ***does not require abstinence from harmful behaviors as a precondition.***
5. *Harm reduction ensures people with behavioral health conditions have input and active collaboration in the development and provision of services and programs.*
6. *Harm reduction acknowledges that behavior change happens on a continuum and that progress can be made along the way with small positive behavior changes that will build on one another.*
7. *Harm reduction recognizes that engagement in high-risk behaviors should not forfeit a person's right to health care and social services. Other approaches frequently use access to services to coerce people into recovery, whereas harm reduction acknowledges that services based on compliance preclude many people from accessing services.*
8. *Harm reduction recognizes that high-risk behaviors are often used as a form of self-medication. Harm reduction seeks to provide people with new, healthier ways of coping while also lessening difficult circumstances through the provision of services and referrals.*

Understanding why harm reduction works

Harm reduction acknowledges that substance use is not simply about *making poor choices*, a foundational premise of many traditional treatment interventions. Rather, it appreciates that there are many factors at play, including experiences of poverty, racism, and discrimination as well as individual factors like biology, social isolation, and traumatic experiences (HHRC, 2021). Self-medication through high-risk, compulsive behaviors provides a means of survival for people coping with difficult circumstances and overwhelming emotions.

Harm reduction recognizes that the "blaming and shaming" approaches of the past may only compound a person's trauma and feelings of isolation and shame, inadvertently perpetuating harmful behaviors. Shame is one of the major drivers of harmful behaviors, as people attempt to escape painful feelings of low self-worth. To implement harm reduction approaches, it is critical to examine internal attitudes and practices as well as organizational culture to discern and address any remnants of punitive, shaming attitudes toward people with behavioral health conditions engaging in harmful behaviors. These attitudes—often reflected in television, movies, news, and social media—persist despite decades of research showing that behavioral health conditions are chronic and treatable brain conditions caused by the complex interplay among biology, environment, and behavior (HHRC, 2021).

Reflection questions:

- *What are some examples of portrayals of behavioral health conditions in the media?*
  - *How might these influence the general public's opinion of a person with behavioral health conditions?*
- *Could negative, violent, or even comical exaggerations of behavioral health conditions affect how a person with that diagnosis might see themselves?*

Taking a harm reduction approach acknowledges behavioral health conditions as complex conditions and responds by offering nonjudgmental, compassionate, person-centered care and support that the person finds useful and feasible.

Over time, this approach dismantles the feelings of shame that often drive harmful behaviors and thus loosens the compulsion to self-medicate, breaking the cycle of shame and compulsive behavior (HHRC, 2021).

Harm reduction allows provider agencies to build trust and develop relationships with people who are often distrustful because of past experiences of discrimination, shaming, and rejection from family members, treatment systems, and society at large.

> "As we use harm reduction strategies, we become a safe space where a person can and will turn to when they are ready to make a change" (HHRC, 2021).

Key components to consider with harm reduction

WAYS TO FOSTER SAFETY AND COMFORT

To create an environment conducive to recovery and healing, provider agencies can implement several tangible approaches:

- Designing a calming, soothing office environment and greeting individuals warmly by name upon arrival

- Ensuring posters, signs, and images are welcoming to all and offering diverse literature options, including materials in languages other than English
- Inviting individuals to bring a support person with them and providing relaxed, unhurried attention throughout their visit
- Addressing and validating any concerns as understandable and normal, asking what would make people feel most comfortable, explaining the purpose of each step, and seeking permission before proceeding
- Encouraging questions at any point and offering options for calming and self-regulation, such as grounding techniques, music, or stress balls
- Providing as much control and choice as possible regarding the process and being straightforward and generous with information
- Recognizing that working with people who have experienced trauma can be challenging and that maintaining one's own recovery and self-awareness is crucial for navigating these challenges successfully
- Prioritizing one's wellness as a way of building the resilience needed to thrive in this demanding work

To practice trauma-informed services, it is important to remember the tip from a worker in rural North Carolina. She said workers should not pour from an empty cup, or even a full cup, but rather the "saucer," which holds the overflow of energy once a worker has fully met all their own needs.

Self-compassion and self-care are critical components of harm reduction work.

Harm reduction philosophy for the helper

The philosophy of harm reduction extends beyond the context of substance use treatment. Being kinder, gentler, and more receptive to incremental change can be applied to any goals or changes to behavior, including the lens in which a provider treats themselves and practices self-care.

Reflection questions:

- *What do you know about and/or practice when it comes to self-care?*
- *What are some of the basic things you practice to remain energized? What happens when you do not meet your goals (e.g., those related to consuming nourishing foods or exercising)? How do you feel afterward? What do you say to yourself?*
- *What is one current behavior you wish you could change?*
- *How would you make a small change from a harm reduction perspective?*
- *Are there ways to incorporate the "Ways to Foster Safety and Comfort" list above into your work and/or home environment?*

3 Workbook 3: Myths and Facts about Harm Reduction

There are many myths about harm reduction. Being aware of these myths and preparing talking points in response can help address misinformation and ideological and political barriers to harm reduction services. Here are some examples of countering myths with facts about harm reduction.

✗ **Myth:** Rural America does not have a substance use issue.

✓ **Fact:** Although many people associate substance use with more densely populated communities, many residents of rural areas also struggle with substance use disorders (Center for Behavioral Health Statistics and Quality, 2024). Overdose rates are 45 percent higher in rural areas than in urban ones (Clary et al., 2020). Stress impacts everyone. Because communities in rural or frontier areas receive fewer resources, residents can sometimes be at an even greater risk of overdose or other harms associated with substance use.

✗ **Myth:** Americans who live in rural communities will usually be opposed to harm reduction.

✓ **Fact:** While the term "harm reduction" may not resonate or may even have negative connotations with some people, many residents of rural communities want to be able to help protect their loved ones and neighbors from the harms of substance use. It is a matter of determining what each community needs and what works best for them. This may include the language that the community uses to describe methods and resources for harm reduction. Some communities may prefer to specifically use language to identify the goal (e.g., "eliminating fentanyl" or "promoting safer and healthier families") rather than discussing the philosophy of harm reduction. No matter the language, communities can still support the goals of protecting residents and reducing threats to loved ones and neighbors.

✗ **Myth:** Harm reduction enables risky behavior (such as substance use).

✓ **Fact:** According to sources cited in an article by the Patient Safety Network (Salisbury-Afshar et al., 2024), harm reduction services do **not** exacerbate high-risk behaviors (like drug use), nor do they undermine treatment efforts—they actually improve outcomes. Studies have shown benefits, such as reduced overdose risk and improved access to care (Levengood et al., 2021).

✗ **Myth:** Harm reduction increases crime and makes communities less safe.

✓ **Fact:** According to the CDC (2024), more than three decades of data show harm reduction programs are **not** correlated with any increase in crime. In fact, they support people exiting the criminal legal system because they increase the prospect of participation in treatment services. They additionally support community safety by reducing the risk of encounters with discarded needles. Communities that have syringe services programs (SSPs) report seeing fewer discarded syringes in public spaces like parks and sidewalks than do communities without harm reduction programs (Kral et al., 2021; Levine et al., 2019).

✗ **Myth:** Showing positive regard for or compassion to people who engage in high-risk behaviors enables them.

✓ **Fact:** Feelings of shame and social isolation perpetuate harmful behaviors. Showing consistent positive regard to a person with a behavioral health condition works to reduce that shame and promote inclusion. Canadian psychologist Bruce demonstrated this through his study "Rat Park," in which he learned that in a safe and connected environment, one will avoid substances when given the option (Gage and Sumnall, 2019).

When addressing any potential myths with community members or even colleagues around the subject of harm reduction, it is important to keep compassion at the forefront of all responses. Change can be difficult, especially when it challenges previously held beliefs or fears. It is important to remember that the foundation of harm reduction is meeting people where they are and using empathy to help them move forward in a way that feels manageable. When communities live in fear and grief, it will be crucial to extend the same understanding and patience.

? Reflection questions:

These myths are commonly held beliefs about harm reduction implementation, and most people feel conflicted about at least one of them.

- *Which of the myths resonates the most with you, and how do you feel about reading the "factual" information that challenges it?*
- *Do you feel that some of these myths may be influencing your community's perception of harm reduction?*
- *Are there any other perceptions or beliefs about harm reduction not mentioned above?*

4 Workbook 4: Housing First

Housing First is a housing assistance model that provides safe, stable housing as the first priority to people experiencing homelessness. It is an evidence-based practice, recognized as a proven method for ending all types of homelessness (United States Interagency Council on Homelessness, 2022). Housing First programs assist with providing housing to populations that have historically been marginalized—including people who are experiencing chronic homelessness, individuals living with HIV, and individuals experiencing mental illness—without requiring sobriety or other conditions as a prerequisite (National Alliance to End Homelessness, 2022). The stability Housing First programs provide reduces the costs associated with hospital stays, nursing homes, prisons, and residential substance use treatment programs (U.S. Department of Housing and Urban Development, 2023). However, the availability and funding of these programs can be challenging, especially in rural and frontier communities.

Traditionally, many housing programs have required sobriety before offering housing, leaving people with active substance use issues particularly vulnerable. Individuals living in unsheltered environments have been susceptible to additional stressors, such as violence, exploitation, weather, pollution, and poor sanitation (Richards and Kuhn, 2023). Experiencing homelessness can either significantly increase the likelihood of substance use disorder or worsen existing substance use (Richards and Kuhn, 2023). Housing First programs offer a more effective approach to breaking the cycle of homelessness and substance use, but implementing these programs in rural settings presents unique challenges. Limited transportation and resources, coupled with a limited housing stock, contribute to the difficulty of establishing these programs in less populated areas (Byrne et al., 2020; Stefancic et al., 2013).

Housing First as critical harm reduction: Housing is health care

Housing First uses a harm reduction model that provides services and resources to increase safety and support incremental progress. It offers practical, compassionate care management and recognizes the complexity of trauma and substance use (Gaetz et al., 2013). This approach respects individual choices and promotes stable housing as the foundation for addressing substance use and improving well-being. Stable, permanent housing can be the starting point for contemplation and action in addressing substance use and its impact on residents' lives, well-being, and abilities. People experiencing homelessness are more likely to contemplate changing their substance use and following a pathway to recovery if they live in safe, stable housing with access to supports rather than living on the streets or in an emergency shelter.

Overview of Housing First principles

Housing First has gained in popularity with service providers, funders, and government agencies over the past ten years, leading to better participant outcomes and more funding opportunities (Gaetz et al., 2013).

Many agencies have developed policies and procedures that focus on the immediate context and issues they face, while maintaining fidelity to several core principles.

Rural housing programs have often found it hard to implement Housing First principles, partly because of a lack of internal capacity and partly because of fewer resources being available. Rural communities need to adapt these principles in a way that works for their community while remaining true to the original concepts. The following principles appear in *Housing First in Canada: Supporting Communities to End Homelessness* (Gaetz et al., 2013).

PRINCIPLE: IMMEDIATE ACCESS TO PERMANENT HOUSING WITH NO HOUSING READINESS REQUIREMENTS

Housing First does not require any applicant to prove that they are "ready" for housing or fulfill any prerequisites but instead strives to ensure they receive permanent housing that is safe and secure as quickly as possible. Once housed, participants have the option to participate in a variety of services, but they are not required to do so.

Reflection questions:

- *What are your housing program's eligibility criteria?*
  - *Which of these are federal or Continuum of Care requirements, and which are specific to your program? Are the eligibility criteria necessary for program management?*
  - *Have you reviewed your eligibility/admission criteria to see whether any subpopulations are disproportionately affected by your admission process? (Look at the HMIS data to see if the population of the program reflects the demographics of the overall population of people experiencing homelessness in your community.)*
- *Who struggles and faces challenges in your program and why?*
- *What keeps someone from being accepted into or receiving services from your program?*

PRINCIPLE: CHOICE AND SELF-DETERMINATION

In Housing First programs, participants have a choice of the services and housing they receive or whether they receive these services and supports at all. Residents have the right to change their minds about the types, locations, and pace of services at any point without their housing being affected.

Reflection questions:

- *How do you support residents in making decisions concerning their preferred style and type of housing?*

- *What services are residents required to engage in? What if they do not want or feel ready to engage in services?*
- *How do you feel when a resident makes a decision with which you do not agree?*
- *What do you do when a resident makes a decision that you do not feel is right for them?*

PRINCIPLE: RECOVERY ORIENTATION

Housing First strives to ensure that a person's needs are met and that their well-being is supported in a recovery-oriented way that places the individual at the center of their care. Needed services and supports will look different for each person and can change throughout someone's recovery journey.

Reflection questions:

- *What are the people you are working with recovering from?*
- *When you think about making changes in your life, what does it mean to you? What do you think change means to the people you work with? What are the similarities or differences?*

PRINCIPLE: INDIVIDUALIZED AND RESIDENT-DRIVEN SUPPORTS

Housing First programs offer services specific to each person, and that may include housing, physical and behavioral health, educational or vocational training, culturally-specific resources, and income support.

Reflection questions:

- *How can you ensure you provide a sufficiently wide range of treatment and supports?*
- *How can you make it clear that participation in treatment/supports is voluntary?*
- *Will residents be able to provide input on what they need? How will that input be reflected in your range of treatment and supports?*

PRINCIPLE: SOCIAL AND COMMUNITY INTEGRATION

Housing First recognizes that when a person receives housing, their social network may change (particularly if they are moving from a congregate living situation to scattered-site housing). This may be especially significant for Housing First programs in rural areas, where available housing stock may be scattered throughout a large geographic area. The model offers a variety of ways to remain integrated into a community and to forge new connections.

In rural communities, there may be less of a choice in community activities and resources, they may be less well known, and those that are available may have reduced hours of operation or require a longer commute.

Housing staff and care coordinators can support residents by learning about the available resources in their community and providing a warm handoff or accompanying them on their first visit. Additionally, residents may know the professionals that work at or run the resources and may be reluctant to use them, feeling that their history of substance use may count against them. In these cases, housing staff members and care coordinators can act as a bridge between the resident and the service, supporting the resident and encouraging the service to take a welcoming and low-barrier approach.

A scattered-site model provides housing and support services to people experiencing homelessness in individual units throughout a community rather than having all residents live in one building. This approach allows residents to be less isolated from the larger community and hopefully less stigmatized as well. The use of this model might allow residents to feel more comfortable using community resources.

Reflection questions:

- *What are some examples of social or cultural engagements that your residents might be able to participate in?*
- *How do you encourage residents to build relationships within their community?*

Equity issues

When implementing any program, it is important to ensure everyone has access to the services and housing they choose, regardless of their race or ethnicity. People of color are experiencing homelessness at disproportionately high rates because of systemic, institutional, and interpersonal racism (Olivet et al., 2018).

In addition, BIPOC, LGBTQI+, and other historically marginalized and excluded communities may experience unique barriers that limit their access to mental health care, substance use treatment programs, and primary health care. For example, some individuals and families have had negative experiences with health care services and systems, resulting in mistrust (Meléndez Guevara et al., 2021; O'Keefe et al., 2021). This includes historical or intergenerational trauma due to harmful systems and practices that are often not acknowledged by service providers (Kirmayer & Gómez-Carrillo, 2019; Komro et al., 2022). It is important to note that the historical and intergenerational trauma experienced by Native American and Native Alaskan people might contribute to health disparities and opioid overdose or death rates at equal or greater levels than in white populations (Komro et al., 2022).

Some individuals from other countries may not be able to access services because of language or cultural barriers or concerns about punitive measures that could impact their immigration status (Mitra & Lee, 2023). Within the criminal legal system, people of color, especially Black individuals, are incarcerated at higher rates than white people (Carson, 2020), and LGBTQI+ individuals are incarcerated at higher rates than the general population (Santos, 2021). Access to substance use and mental health treatment and recovery options, including culturally responsive services, are severely limited within prisons and jails, which disproportionately affects people of color as well as LGBTQI+ individuals.

Enhancing equity in Housing First programs is critical. Programs can start by integrating equity into their vision, mission, and goals with a focus on addressing the needs of the communities most affected

by homelessness. Key strategies include offering bias and anti-racism training for frontline staff and collaborating with individuals with lived experience to develop community-driven solutions. Programs should also shift toward a "screen in" approach for participant intake and prioritize hiring staff who have this lived experience, ensuring the team reflects the racial and ethnic diversity of those being served. Another key strategy is to strengthen partnerships with service providers, landlords, and workforce development programs to expand support networks. Additionally, regularly tracking and analyzing disaggregated data can help programs understand who is receiving referrals, what services are being offered, and whether those services are effectively reaching and benefiting everyone.

Reflection questions:

- *Does your agency offer equity training and have organizational discussions about equity issues?*
- *Does your program staff reflect the demographics of the people experiencing homelessness in your community?*
- *Is your program inclusive of a variety of cultures? How so? Do you offer culturally specific programs or links to services in the community?*
- *What community partner agencies could help provide resources and support if your program is unable to do so directly?*
- *Is your agency able to offer a translation service or provide services in other languages?*
- *Do you have a staff team that speaks the languages used in your community?*

5 Workbook 5: Housing First Principles in Rural Communities

Housing First principles can be effective in rural communities but may require some adaptation to succeed, meaning that the style and delivery of Housing First programs may differ depending on the unique circumstances of the rural community. Certain factors can make rural implementations of the Housing First approach to service delivery challenging, including access to fewer resources to support people experiencing homelessness, housing providers that may not have experience related to behaviors stemming from behavioral health issues and substance use disorder, and the stigma associated with these issues. Additionally, many people experiencing homelessness in rural areas may hide within the community—for example, they may sleep in cars parked in remote areas or tents in wooded areas. Rural leaders and community members are often unaware of any significant numbers of people experiencing homelessness and can be reluctant or unwilling to admit the issue of homelessness and how it affects their community, thus making it difficult to develop the community consensus needed for a Housing First project.

Key partners

To implement a Housing First program, buy-in at all levels is essential. The executive management of the provider agency should have a clear understanding of the components of a Housing First program, and they along with the board of directors should take part in an external marketing strategy to identify the key partners within the community. Building these critical partnerships can be challenging but is essential.

Rural communities often have a few key individuals with great influence on what does or does not happen within the community. Finding these leaders early and encouraging them to champion the cause will help with outreach and marketing. In addition, people in rural communities must often wear many hats and serve in more than one role or position. Therefore, it is important to think creatively to find thought and practice partners who can outreach and market to multiple audiences.

While a program is identifying community champions, the provider agency can start to find partner agencies that can contribute to the Housing First program. Examples usually include representatives from the behavioral health, labor, education, and criminal legal systems as well as the U.S. Department of Veterans Affairs and public housing authorities. However, rural Housing First programs may need to adopt a different focus and have partners such as places of worship, faith-based organizations, libraries, gas stations, and stores playing a more active role. Friends, family members, and neighbors in the local area may also be willing to participate in implementation activities.

Housing First challenges in rural settings

Rural communities often have less capacity than more densely populated areas to provide intensive housing support and care coordination. This means that many rural programs will need to provide care coordination

(also called case management) at a less intensive level and use local community resources and supports to offer additional services not provided by the care coordination team. Rural Housing First programs may also consider using project staff who are comfortable with travel. Stefancic et al. (2013) noted that telehealth can also be incorporated into the Housing First model, increasing accessibility between care managers and residents and offering more opportunities for connection (DeLaCruz-Jiron et al., 2023; Stefancic et al., 2013). In recent years, care managers have used phone calls and texting to maintain communication.

As with many communities nationwide, housing stock availability can be a challenge. There is frequently an affordable housing shortage within rural communities, and finding safe, stable housing close to community resources and transportation can be difficult. Providers will need to bring significant resources to identify suitable housing for their residents. This may include hiring a landlord engagement specialist who can focus on building relationships with property owners and securing housing. Additionally, programs may need to adjust staff-to-resident ratios to incorporate more travel time across communities, and providers will need to implement policies and procedures to support staff traveling alone in areas without full cellular service.

Reflection questions:

- *What are the principal challenges to implementing a Housing First program in your community? Are they listed above, or are they different?*
- *How large of a geographical area will you cover in your project? Will care managers be able to provide support in person, or will you need to use other ways to maintain contact or conduct care coordination sessions?*
- *Consider your staffing model. Will your staff members need to cover all aspects of support, or will you be able to employ staff members who can focus on one aspect of this program? How can staffing at partner agencies complement your program's staffing?*

6 Workbook 6: Harm Reduction Strategies and Implementation

The following pages contain summaries of common harm reduction techniques and best practices. Links to handouts with tips and highlights are available at the end of this workbook for future reference and to share with community partners. The need for and availability of community resources will vary, and this is not a comprehensive list of harm reduction techniques. Communities will need to determine what works best in their area.

Injection safety

The historic lack of harm reduction resources means that many people use substances without knowing how to properly inject, which puts them at risk of injury and illness. Safer injection practices reduce the risk of infections, vein collapse, and abscesses. Safer needle exchange and disposal programs keep individuals and larger communities safer from blood-borne illnesses.

Safer injection harm reduction strategies include the following (HHRC, 2021):

- Acknowledging that some injection sites are more dangerous than others:
  - Arms are safest
  - Hands and feet are less safe
  - The groin, neck, and head areas are extremely risky injection sites
- Rotating injection sites to protect veins
- Using a tourniquet to make preferred veins easier to find
- Washing hands and using an alcohol swab to clean the injection site to prevent bacterial infections
- Using a new needle every time because needles quickly become dull, potentially causing vein damage
- Using the thinnest (highest-gauge) needle possible to make the smallest possible puncture wound
- Using sterile water to dissolve substances for injection to minimize bacteria exposure
- Using new filters, cookers, and other injection equipment each time to prevent the growth of bacteria and spread of infectious diseases
- Using powdered vitamin C rather than vinegar or lemon juice to dissolve crack cocaine

Reflection questions:

- *Do any of the safe injection techniques surprise you?*
- *Are there any supplies that may take special planning or funding to provide?*
- *If your organization made a "safe injection kit," what would it include?*
- *What resources exist in your area related to wound care for people who inject drugs?*
- *Do you feel comfortable talking to residents who inject drugs about injection safety? If not, what could help make that conversation more comfortable (e.g., more education, role-play or practice conversations, use of a team approach rather than individual)?*

Note: Not all communities are approved to distribute clean needles, and agencies may need to refer to local laws. However, the goal of harm reduction is to increase opportunities for safety—small improvements are still improvements.

Alcohol safety

According to the University of Washington (Nodell, 2021) and the Hazelden Betty Ford Foundation (2023), harm reduction techniques related to alcohol use include the following:

- Tracking changes in alcohol use over time
- Considering replacement activities for drinking alcohol
- Setting goals related to alcohol use that fit into life goals
- Eating while drinking alcohol
- Being aware of negative interactions of alcohol and any medications being taken
- Trying to limit alcohol use to certain days or times
- Speaking with a health care provider about anti-craving medications
- Using a designated driver
- Alternating alcoholic drinks with nonalcoholic drinks
- Consuming drinks with lower alcohol levels

Reflection questions:

- *What programs related to alcohol safety exist in your community?*
- *What are your community's attitudes and beliefs about alcohol?*

- *Are there culturally specific factors such as social, religious, or traditional-historical practices within the community relating to alcohol use?*
- *Are there community resources in place to help with harm reduction if a person wants to make changes?*
    - *What are those resources?*
    - *What resources are lacking?*
- *What needs to be in place for a person to exercise the harm reduction techniques listed above?*

Opioid overdose

Opioids, also known as painkillers, are highly addictive medications primarily prescribed to treat pain. They also come in the form of street drugs such as heroin and (in recent years) fentanyl, an illegally made synthetic opioid 50 times stronger than heroin (NIDA, 2021). According to SAMHSA (2024), in 2023 approximately 5.7 million people aged 12 or older in the United States had an opioid use disorder.

When taken in too high of a dose, opioids repress the brain stem, which controls breathing, to the point that a person will stop breathing altogether, putting them at risk of death. This is known as an opioid overdose. According to the National Center for Health Statistics, "drug overdoses are one of the leading causes of injury death in adults" (Spencer et al., 2024).

A medication known as naloxone (brand name Narcan) can reverse opioid overdose. Naloxone works by dislodging the opioids from their receptors in the brain, awakening the brain stem so the body begins breathing again. Needle exchange programs, major pharmacies, naloxone vending machines, the mail (in some states), or drop-in sites can all distribute Narcan/naloxone.

Reflection questions:

- *What programs related to overdose prevention and response exist in your community?*
- *Does your program or place of work have overdose response protocols?*
- *Do you know how to respond to or assist someone you believe is experiencing an overdose?*
- *What are local sources for obtaining naloxone/Narcan in your area? Are they free? Do they require a prescription?*
- *Where can a person obtain fentanyl testing strips in your community?*

COMMUNITY NARCAN TRAINING

Businesses, community organizations, schools, churches, and others may benefit from holding free Narcan trainings and distribution events. Providing opportunities to familiarize the community with Narcan and how to use it can help increase confidence in taking care of one another when it comes to potential overdose.

There are simple use instructions printed on the Narcan box, and SAMHSA has published an opioid overdose prevention and response toolkit.

Some people may be hesitant to intervene during an overdose because they fear legal repercussions. It is important to be aware of Good Samaritan laws regarding assisting someone who is overdosing (these may vary by state) and make the public aware of these laws. Depending on state laws, individuals with existing or outstanding warrants may be exempt from arrest. If citizens do not fear arrest, they may be more likely to assist and remain with the person in active overdose until emergency services arrive.

Reflection questions:

- *What are your community's rules for "Good Samaritans" (people who assist someone in an emergency)?*
- *Is there a risk of the helper being arrested if they remain on-site for emergency response crews while intoxicated, in possession of substances, or if they have outstanding warrants?*
- *Why is it a good idea to educate people about their rights when helping others?*

Infectious disease transmission

Substance use puts people at increased risk of infectious diseases, including potentially life-threatening blood-borne diseases such as HIV and the hepatitis C virus. Rates of infectious diseases, including sexually transmitted infections (STIs), are rising in many rural areas (Jenkins et al., 2021). Reasons for this may include reduced access to education and prevention resources and the defunding of educational and preventative programs.

These infections primarily spread through the use of shared drug tools (needles, pipes, straws, etc.) that have the potential for blood exposure. However, contaminated equipment is not the only way substance use contributes to disease. Substance use also impairs judgment, which can increase the chance of risky sexual behaviors; people may also engage in transactional sex to support their substance use. Both put a person at increased risk of contracting HIV as well as other STIs, such as gonorrhea, chlamydia, and syphilis. Although some STIs can be easily treated with antibiotics, they can easily spread and result in long-term complications if left untreated.

Reflection questions:

- *What do your community rates/occurrences currently look like for each of these domains? (Use the Recovery Ecosystem Index Mapping Tool for further research.)*
- *What programs exist in your area for the prevention of infectious disease transmission?*
- *Do you see any gaps that exist?*

- *Are there specific community needs that would be beneficial to focus on?*
- *Where would someone in your community go to receive information on the prevention of infectious diseases?*
- *What are current community attitudes toward disease prevention?*

FEATURED TOOL: RECOVERY ECOSYSTEM INDEX MAP

The Recovery Ecosystem Index Map, supported by the Health Resources and Services Administration, contains features such as searchable state- and county-level information on the following factors:

- Availability of substance use treatment, medication-assisted treatment, mental health treatment, SSPs, NA meetings, and SMART meetings
- Availability of Drug-Free Communities Coalitions and drug courts
- State policies related to substance use, including those related to probation and parole violations, Good Samaritan laws, insurance coverage, and SSPs
- Availability of social associations
- Rates of death from drug overdoses and opioid overdoses
- Demographics
- Access to broadband internet service
- Housing cost burden

7 Workbook 7: Advocating for Harm Reduction in Rural Communities

Advocacy can be the key to shifting a community from a place of fear and judgment to a home of safety and support. If a community can be a part of a system of support, a person's chances of recovery greatly increase (Stevens et al., 2018). People with behavioral health conditions have historically suffered marginalization and stigmatization and so may be mistrustful of treatment systems and seeking help. In rural communities, according to a worker in Oklahoma, "everybody knows everybody's business." This can add additional pressures for people trying to hide or suppress their struggles to maintain acceptance and connection to their family members, friends, and neighbors. A person who fears rejection and judgment from their community could greatly benefit from the advocacy of others to help amplify their voice, remove stigma and barriers to recovery, and create a community of inclusivity.

Levels of advocacy

Advocacy is essential for lasting community change. The most important levels in this movement are individual advocacy ("little a") and systems advocacy ("big A").

INDIVIDUAL ADVOCACY—"LITTLE A"

Individual advocacy refers to advocacy on behalf of an individual. This can be informal, such as helping family members understand a person's diagnosis, or formal, such as advocating for the needs and desires of an individual in a treatment team meeting, assisting an individual with accessing community benefits, or helping an individual file a grievance. Individual advocacy is an opportunity to promote choice and self-determination to champion an individual's preferred path forward.

? Reflection questions:

- *Think about a scenario in which you or someone you knew had to be an advocate for someone.*
  - *What tools, connections, and strategies did you (they) use?*
  - *What was the outcome?*

SYSTEMS ADVOCACY—"BIG A"

Systems advocacy refers to action taken to change policies, laws, and practices on a local, state, or national level. This kind of advocacy may include working with legislators and community leaders and includes educating people in power and community members on behavioral health conditions, reducing stigma, and

sharing best practices and research. It is important to note, however, that there might be organizational guidelines around this kind of advocacy—for example, what can be done "on the clock" and what must be done on personal time.

Within treatment systems, workers can advocate for and hold colleagues accountable to providing best practices, such as person-centered care, empowering language, and encouraging acceptance and promotion of multiple pathways of recovery. Additionally, ensuring access to resources such as mobile and community-based treatment teams and supplies as well as reducing or eliminating barriers to treatment (e.g., housing and shelter, medication, harm reduction supplies and testing) would be important components of "big A" advocacy.

Reflection questions:

- *Who are your community "champions" for change (e.g., legislators, business leaders, faith leaders)?*
- *Who could you partner with to form a coalition for change?*

Setting the tone and approach

The main motto for harm reduction is "meet them where they're at." The same is true for eliciting buy-in for the approach itself. When using social media and other platforms to reach community members, it is important not to judge or respond negatively to concerns and misguided beliefs because doing so only creates more resistance. Instead, it is important to welcome all, encourage questions and exploration, create safe spaces for dialogue, and make people feel safe sharing what they have heard or believe.

Maximizing engagement

Human beings are complicated, and research and data alone may not change their minds or behaviors. Therefore, it is important to frame messages in such a way that people will be responsive to them. Best practices for maximizing audience engagement are as follows.

INCORPORATING SHARED VALUES

When providing behavioral health care services for residents of rural and frontier areas, it is important to consider the stigma of behavioral health conditions in cultures that often value self-reliance. Lack of acceptance of behavioral health conditions as medical diseases can create barriers to care. Unlike physical diseases and conditions, behavioral health conditions—which may have fewer tangible symptoms, depending on severity—are often viewed as matters of self-control and "grit."

Appealing to shared values is often an effective strategy. Rural communities tend to value faith, perseverance, and personal redemption as well as the belief that anyone can turn their life around. "We take care of our own here" and "Help your neighbors" are often deeply held values in rural towns. For example, one rural provider partnered with a local church to provide snacks and activities for families waiting to receive harm reduction services. Featuring these aspects of the recovery journey in public education campaigns can go a long way to increasing buy-in from rural community members.

FORMING RURAL HARM REDUCTION PARTNERSHIPS

According to a qualitative study published in 2021, a key component of effectively implementing harm reduction in rural communities is working to obtain "buy-in" from a wide range of local community partners and residents (Childs et al., 2021). Changing the tide alone can be a daunting task, so the more allies that can be recruited, the greater the impact will be. Creating partnerships and alliances in the community is pivotal to changing false narratives around addiction and harm reduction.

Asset mapping

Asset mapping can be an effective way of uncovering potential allies. Asset mapping refers to the general process of identifying and gathering information about a community's assets and key players. An asset is any organization, resource, or strength already existing within a community that helps uncover effective solutions, promote social inclusion, and improve its citizens' health and well-being. Through the mapping process, communities can identify the key potential players for outreach.

Processes for community asset mapping appear in this toolkit for Community Assessment or in the HHRC *Guide to Resource Mapping and Assessing Community Needs*.

Important partnerships

For promoting acceptance and adoption of harm reduction, important partnerships in rural communities may include clergy, law enforcement, schools, PTA organizations, health-care providers, librarians, local government officials, or social service organizations.

PROMOTING BUY-IN

When approaching potential community partners, agencies may need to lay some groundwork to get buy-in because there continues to be copious amounts of misinformation about harm reduction and what it means to a community. Strategies for approaching potential partners include the following:

- Offering calm and warm conversations about harm reduction
- Not shaming someone for their beliefs or any misinformation they bring and providing factual information in collaborative rather than argumentative ways
- Inquiring about people's concerns with interest and trying to understand their perspective to better strategize effective ways to frame the message
- Offering empathy and compassion rather than creating demands or directives—just as these are the key to harm reduction services, they also work to promote buy-in for the services themselves
- Promoting facts about substance use disorder, specifically that it is a medical condition just like heart disease, diabetes, and other chronic conditions; a recent study conducted in rural South Carolina found that among survey respondents, acceptance of the disease model of substance use disorder positively correlated with support for the harm reduction approach and associated services in their communities (Heo et al., 2023)

Developing partnerships in the community and working together toward common goals helps break down barriers and misperceptions while promoting compassion, understanding, and life-saving interventions for residents of rural communities.

Reflection questions:

- *Who are currently your most effective partners in the community? Who has the potential to become a community partner?*
- *How will you establish partnerships with those agencies?*
- *Who are the key champions in your community that you can talk to about supporting the program?*
- *Have you found effective ways to frame the messaging for your community?*
- *What would you share with others who were having a difficult time making progress or unsure of how to engage their communities effectively?*

Addressing the silos in continuums of care

It is not uncommon for rural communities to become siloed from one another. Funding, legal, and treatment jurisdictions may place boundaries around counties, cities, and states, which can pose navigation difficulties for people in need of care. For some residents near a county or state border, a facility in another region may be the closest and most familiar location for receiving care, but this can lead to difficulties in access.

One way to address these silos is through mutual and shared language. A provider from rural West Virginia said it is critical that all members of a coalition or collaboration share similar language and a shared goal that meets all participants' needs. He also stated that one goal of his coalition was "shifting from 'resource disparity' to 'resource equity,'" meaning that approaching the larger state or other funding resource would mean acknowledging that the most densely populated areas receive the bulk of resources, leaving the rural "outliers" with little support. Creating a shared vision and communicating with language such as "we are seeking resource equity for all West Virginians in need across our state" helped highlight a need for a new focus in West Virginia. A coalition creates its own team culture. Language matters, and it is essential to have a clear and shared definition of important terms such as "resource equity."

Reflection questions:

- *How do individuals communicate across county lines, and how can communities collaborate when jurisdiction is limited across these boundaries?*
  - *What is working so far?*
  - *What is missing?*
- *How does your community understand and accept the term "harm reduction"?*
- *Is there a word or phrase that resonates better?*

- *What actions, resources, practices, and goals will be a part of the community's harm reduction plan?*

Conclusion

It is important for providers to remember that although harm reduction is a best practice and can help people make immediate changes in their lives, it truly is a "long game" when it comes to changing attitudes and implementing resources. It is a movement that takes time, and the people working for change can feel discouraged or even exhausted at times. It will be important to remember that even when changes are not immediately apparent, every effort counts. Every rural worker who contributed to the ideas in this workbook viewed themselves as "just one person," but their work has helped build a nationwide force that is gradually reaching everyone, regardless of where they live or where they are on their recovery journey. This work saves lives, restores families, and makes communities better for everyone who lives there.

Thank you for being a part of it.

Additional Resources

- Harm reduction Tip Sheet on the C4 Harm Reduction page
- Opioid Overdose Prevention: Program Inventory on the Praxis OOD page
- STIs at a Glance on the Praxis VH page
- Sexual Behaviors & Harm Reduction Strategies on the Praxis HR page
- Trauma-Informed Care on the Praxis TTA page

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