

HEALING HANDS

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Photo courtesy of Brett Feldman, Keck School of Medicine, University of Southern California

Harm Reduction

"The story begins with the activists, workers, doctors, programmes and policy-makers committed politically and socially to opposing the legal suppression of drug use and the oppression of drug users in the 1960s and 70s. In the mid-1980s these alternatives began to be referred to collectively as part of the 'risk reduction,' 'harm reduction' and 'harm minimization' solution to the health problem of HIV/AIDS amongst injecting drug users (Velleman & Rigby, 1990). Harm reduction has since become identified with HIV/AIDS prevention but also with addictions treatment, and is now generally defined by medical programmes, professionals and policies," says Gordon Roe in "Harm Reduction as Paradigm: Is Better than Bad Good Enough? The Origins of Harm Reduction."¹

Despite this history, harm reduction initiatives continue to experience public and political controversy. A 2018 study found that "average Americans tend to view these strategies negatively. Among the 1,004 adults sampled, only 29 percent supported legalizing safe consumption sites in their communities and only 39 percent supported legalizing syringe services programs in their communities. Respondents who had negative views about these strategies also tended to have very negative views of opioid users."² Professionals working in the field of harm

reduction strive to counter negative public perceptions with data that shows how harm reduction initiatives save lives, and advocate for policies that acknowledge the social implications and health impacts of criminalizing and punishing illicit drug misuse in communities.³

The key principles associated with harm reduction can be applied to practice in a variety of health care settings, not just programs that work exclusively with people with substance use disorders. For health care providers working with people experiencing homelessness, substance use is an issue for many clients and can co-exist with and exacerbate a variety of health conditions, which makes an understanding of harm reduction relevant to many different aspects of clinical practice. This issue of *Healing Hands* will describe key principles and practices associated with harm reduction initiatives, as well as specific ways these principles and practices can be integrated into various settings that provide health care for people experiencing homelessness, including Health Care for the Homeless (HCH) health centers, homeless shelters, sobering centers, outreach programs, and other service provision sites such as drop-in centers.

WHAT IS HARM REDUCTION?

According to Harm Reduction International, "Harm reduction refers to policies, programmes and practices that aim to minimise negative health, social and legal impacts associated with drug use, drug policies and drug laws. Harm reduction is grounded in justice and human rights – it focuses on positive change and on working with people without judgement, coercion, discrimination, or requiring that they stop using drugs as a precondition of support."⁴ A previous issue of *Healing Hands* addressed harm reduction as person-centered care and a social justice movement, noting that "The practice of harm reduction promotes these rights: to be treated with dignity, to exercise self-determination related to use, and to expect and receive collaboration in therapeutic relationships."⁵

The Harm Reduction Coalition defines harm reduction as "a set of practical strategies and ideas aimed at reducing the public health risks associated with drug use. Harm Reduction calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs, and the communities in which they live, in order to assist them in reducing harm."⁶ **Lisa Raville** is the Executive Director of the Harm Reduction Action Center (HRAC), located in Denver, Colorado. The HRAC is Colorado's largest public health agency that works specifically with people who inject drugs, providing direct services including syringe disposal, vein care, resources and referrals to supportive medical service providers and substance use treatment navigators, and access to things like sterile syringes, naloxone (used to counter the effects of an opioid overdose and save lives), HIV/HCV/STI testing, and fentanyl testing strips. The HRAC also provides mobile syringe exchanges in the community three afternoons a week, coordinates syringe clean-up efforts in neighborhoods, and provides health education classes as a form of community health engagement. Beyond this, the HRAC is involved in political

advocacy and technical assistance for service providers and the broader community.

"Most people are already harm reductionists, even if they don't know it yet," says Ms. Raville: "What harm reduction does is it roots for people. It builds on successes. It asks: How can I support you for a safer and healthier you today? How can we be supportive of any change that can happen today? We want to prioritize goals for people, asking: How can I support



Photo courtesy of Lisa Raville,
Harm Reduction Action Center, Denver, CO

Some examples of services available to prevent harm from substance use include:

- » Impaired driving prevention programs. These programs increase awareness of the risks of driving under the influence of substances.
- » Outreach and support programs
- » Information and resources on safer ways to use substances. It covers opioid use, stimulants, and other substances.
- » Supply distribution and needle recovery programs
- » Options for opioid substitution (agonist) therapies such as methadone or suboxone
- » Take home naloxone kits. These kits include medication to reverse an opioid overdose. This helps prevent brain injury and death.
- » Supervised consumption/injection services and overdose prevention services. These services help prevent overdose deaths. They can reduce other harms by providing a safer, supervised environment for people using substances.
- » Mental wellness and healing support programs and centers
- » Peer support programs run and attended by people with experience using substances. The programs must receive enough funding for consistent service.

—From HealthLinkBC:

<https://www.healthlinkbc.ca/healthlinkbc-files/substance-use-harm-reduction>

you and what will change look like? You know you better than anyone in the entire world. [Harm reduction is] walking with somebody for a healthier and safer them. Then we all get to feel successful and build on those successes. It's time intensive, but worth it in the end to empower folks and help them enjoy small successes."

Ms. Raville notes that for health care providers working with clients who are at the intersection of substance use and homelessness, harm reduction can involve "reducing the harms associated with being unhoused... Housing is harm reduction for people unhoused, and housing first models are harm reduction. [But harm reduction is also a form of] crisis management on the streets. People don't have to quit using drugs to get moving forward. Some people will

never be sober, and relapse is also a part of recovery... But we want to help with little things that are actually huge barriers for folks who don't have access," such as getting an ID card, without making these services contingent upon sobriety.

Ms. Raville encourages care providers to visit www.harmreduction.org to learn more about the philosophy behind harm reduction, access publications and data, watch webinars and videos, and discover resources specifically for health care providers, including this guide to the overarching principles of harm reduction:

- **Harm Reduction is Pragmatic:** Harm reduction addresses drug misuse with realistic, evidence-based strategies that have been proven to work. Harm reduction emphasizes practical solutions that can be implemented in real life over idealistic impossibilities. Harm reduction recognizes that perfectionism is often the enemy of the good. Harm reduction recognizes that people choose to use drugs or alcohol because they perceive certain benefits which accompany the risks of using them. Harm reduction focuses on minimizing drug- or alcohol-related harms rather than attempting to eliminate drug or alcohol misuse altogether.

- **Harm Reduction Respects Individuality:** Harm reduction recognizes there are an infinite number of differences between individuals in terms of their personal value systems, their experiences, their environments, and even their physiologies. Harm reduction "meets people where they are." Harm reduction affirms the idea of "different strokes for different folks" and supports any positive change. Harm reduction recognizes that only the individual can decide if their best goal is safer use, reduced use, or quitting altogether. Not only is the individual best qualified, it is an inherent human right of the individual to make this choice for themselves. Harm reduction is compassionate and humanistic. Harm reduction is nonjudgmental and always respects the rights and choices of the individual.

- **Harm Reduction Focuses on Risks and Prioritizes Goals:** Harm reduction recognizes some drug-related risks are worse than others and seeks to help individuals to prioritize risks and find strategies to avoid them. Harm reduction seeks to encourage people to follow goals which are achievable rather than to demand an impossible level of perfection. Harm reduction seeks to help people recognize and prioritize the reduction of the highest risk behaviors first.

- **Harm Reduction Recognizes That Drug and Alcohol Consumption Exists on a Continuum:** Harm reduction recognizes there are a wide range of drug use behaviors which range from severe use to total abstinence. Harm reduction acknowledges that some ways of using drugs may be safer to the health of the individual and the larger community than others.

- **Harm Reduction is Tolerant and Accepting:** Harm reduction recognizes that prohibitionist strategies can often backfire and increase harm rather than reducing it. Therefore harm reduction concentrates on reducing or eliminating harms rather than on prohibiting behaviors. Harm reduction recognizes that successful abstinence is a great way to eliminate harm, but coerced abstinence often results in worsened behaviors and increased harm. Harm reduction offers realistic options for those who are unable

or unwilling to abstain from drugs or alcohol altogether. Harm reduction encourages people to forgive themselves and move on with life rather than beat themselves up with guilt and shame.

- **Harm Reduction is About Supporting the Individual's Power and Agency:** Harm reduction recognizes that the individual who uses substances is the primary agent of positive change. Harm reduction groups seek to support the individual to improve their life and do not seek to prioritize the group at the expense of the individual. Research shows that people

who believe that they are capable of making changes are the most successful at doing so. This is referred to as self-efficacy. Harm reduction recognizes people are able to make changes which they choose for themselves.

- **Harm Reduction is Not the Opposite of Quitting:** Harm reduction is supportive of individual choice. Harm reduction recognizes that some people find that their best option is to quit misusing some or all illicit drugs completely, and harm reduction is 100 percent supportive of the choice to abstain.



Photo courtesy of Lisa Raville,
Harm Reduction Action Center, Denver, CO

INTEGRATING HR PRINCIPLES AND PRACTICES

Harm reduction occurs in and across a broad spectrum of services. The core principles of harm reduction are clearly embedded in programs that are dedicated explicitly to harm reduction initiatives, such as overdose prevention

services. However, these principles can also find expression in other health care settings that serve people who experience homelessness and misuse substances, engage in other risky health-related behaviors, or have chronic mental and physical illnesses that are difficult to manage on the streets. This section will share experiences and ideas from professionals regarding how harm reduction principles can be integrated into HCH clinics, homeless shelters, sobering centers, street outreach programs, and other service provision sites such as drop-in centers.

HCH Clinics

Robin DeBates is the Center of Excellence Program Manager at Project HOME Services in Philadelphia, Pennsylvania. Project HOME is a multi-faceted organization that provides emergency shelter, permanent housing, employment opportunities, and health care services. The Center of Excellence is a collaboration between a housing-first organization, a syringe exchange/wellness service, and a clinic that provides medicines for opioid use disorder. Ms. DeBates works with the health services organization that provides medication-assisted treatment for people who use opioids, as well as alcohol and tobacco. (She notes that some people don't think about smoking cessation initiatives as harm reduction because usage is so common, and because mortality from tobacco use is more long-term than that associated with the use of other substances like opioids—but the familiar range of quitting-and-reducing-smoking approaches that people use over time can actually be a good entry point for talking to people about what harm reduction can look like when applied to other substances, as well.)

As a Federally Qualified Health Center (FQHC), primary care is provided at multiple clinical settings where clients

can access primary care with integrated behavioral health and case management. At different clinics, different services for people who use substances are available, including individual medical visits, group medical visits, and a psychosocial support group for people accessing medication-assisted treatment. These psychosocial support groups involve a structured check-in with participants, psychoeducational support and training, and prescriptions for medications to be dispensed at pharmacies, and are conducted by a medical provider, a psychiatrist or licensed behavioral health provider, and a member of the

housing case management team. Ms. DeBates notes that the advantages for this group-based model include consistency of scheduling and the social support; "people start to develop natural support networks, and they are really good at responding to each other and encouraging one another... There is a generosity of spirit among the participants." However, the

group setting can be challenging for participants who are experiencing high anxiety, are uncomfortable with groups, or are not well enough to converse.

Ms. DeBates also acknowledges there are limitations, in a clinical setting, on how much harm reduction can be implemented, "but there is also a lot more that we can do that most people would be surprised by... A lot of the ethical values of harm reduction fit in nicely with the values of our organization and the values we try to promote... We are dancing this middle ground between safe and appropriate practice (or at least traditional practice) and the harm reductionist perspective that is very much about education with ultimate freedom of choice."

As an example of this middle ground, Ms. DeBates describes their clinical approach to urine drug screens: "Many of us would prefer to not do them, or do them less. But to get insurance to pay for medication at the rate the patient and we have determined works best for the patient, we need at least one urine drug screen that we can submit to insurance. We're transparent about that with our folks. We tell them why we have to do them and acknowledge that in other settings urine drug screens can be used to take away freedom (e.g., with probation officer, housing, employment, benefits, etc.) We remind people that that's not what we are doing here, and that it is one point of data, not the whole story. We try to be transparent about things like that and where the pressure on us is coming from, and what things we have to do in order to keep the doors open and maintain a medication-assisted treatment program that could survive an audit. And then, showing empathy for why people are frustrated with these requirements, validating them, and noting the implicit social control

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- ROBIN DeBATES, CENTER OF EXCELLENCE PROGRAM MANAGER, PROJECT HOME SERVICES, PHILADELPHIA, PA



"Street Stuff" by Carolyn, Health Right 360, PhotoVoice Digital Exhibit

mechanism in the health care system. Talking about that openly and honestly and sharing the range of options for dealing with it."

One of the key harm reduction principles integrated into Project HOME programming is education. Recognizing that people have different goals and priorities related to their substance use, Ms. DeBates seeks to provide accurate information about drug use and medication-assisted treatment alike. For example, buprenorphine may be prescribed to treat withdrawal symptoms of opiate use, but not every client wants to use buprenorphine in the same way, so a harm reduction protocol would involve understanding how the client intends to use the medication to ensure they use it safely. Some clients may want to decrease their chaotic use of opioids—so they can go to work, attend appointments, maintain relationships, meet their basic needs, and increase general functionality—but total abstinence is not the goal. In these cases, says Ms. DeBates, "we talk a lot about precipitated withdrawal, because if you take it too soon, you're going to feel really sick. Especially with fentanyl having flooded the heroin market in our area—it seems like the effect of precipitated withdrawal, if you take buprenorphine too soon with fentanyl—is a lot harsher. So we ask folks: how are you taking it, how many times a week are you using, how are you spacing the dosing? We can talk about the roller coastering off and on to plan their use in a different, safer way."

These sorts of accurate and detailed conversations are not possible with an abstinence-only model, or if a relationship of trust has not already been established with the client. Ms. DeBates emphasizes that "one main goal of harm reduction is relationship first... If you don't have the relationship, it's unlikely that you will have trust or get accurate information in order to be as helpful as possible. Plus, relationships in and of themselves, for people who have experienced trauma (either before or because of homelessness and substance use) are curative for post-traumatic stress disorder and traumatic experiences. People knowing they have a place where they can show up, talk truthfully, and be validated, understood and supported goes a long way to supporting health and well-being overall."

Homeless Shelters

Lynea Seiberlich-Wheeler is a therapist and the Associate Director of Behavioral Health at West County Health Centers in Sonoma County, California. Previously, she was a clinical social worker at the Committee on the Shelterless (COTS), an agency which includes a homeless shelter, housing at market rates with case management, and permanent supportive housing units with case management. During her time there, the shelter was transitioning from a structured dry shelter environment, where all programs required strict sobriety, to a low-barrier system where



"Woman" by Gary, Health Right 360, PhotoVoice Digital Exhibit

sobriety was no longer a requirement for accessing services. Through this transition, the shelter utilized materials and trainings prepared by the National Harm Reduction Coalition, located in Oakland, California. As a shelter, there was less emphasis on clinical harm reduction in this process, but a heavy focus on the relational aspects of harm reduction.

Initially, behavioral rules were relaxed in order to reduce barriers to access that had previously been based on sobriety. Simultaneously, staff were trained in stigma reduction. "What we found in this process," says Ms. Seiberlich-Wheeler, "is stigma was not much of a problem for us. Everyone was super-accepting and wanted to get on board." Challenges arose, however, in the implementation of these relational principles, as behavioral rules for clients were relaxed: "We had an increase in staff calling out sick, feeling overwhelmed and unsupported, and putting themselves in situations where there was no boundary or structure in terms of what behavior was allowed from clients. In the shelter this became unsafe and actually increased harm instead of reducing harm."

After seeing these surprising outcomes amongst staff, shelter leadership decided to incorporate additional training on de-escalation skills and vicarious trauma, including Non-Violent Crisis Intervention training from the Crisis Prevention Institute. In these trainings, they worked to balance supportiveness to clients with the prioritization of creating a safe environment for everyone. Ms. Seiberlich-Wheeler explains that training staff in de-escalation and vicarious trauma proved to be an important piece of preparing staff to effectively engage with the harm reduction model, so staff members were prepared to support clients in their processes regardless of their relationship with substances, while also recognizing and holding boundaries related to their own safety and the safety of others at the shelter.

Another adjustment was to reintroduce some rules that had been discarded in the first phase of the shift to a low-barrier shelter environment. Some rules were re-implemented, “but with different consequences,” explains Ms. Seberlich-Wheeler: “So instead of banning people from services due to unsafe behavior, we implemented a pause in services until the behavior was corrected. It became a bit of a revolving door—which has negative connotations, but in this case was positive, as it meant unlimited tries, unlimited times a person could make a mistake then try again.” Most of the re-implemented rules were around safe behavior, such as violent behavior, yelling, etc., based on the principle that regardless of health-related behaviors such as substance use, “people have to be safe with other people in a public environment and not treat people badly. We reimplemented these rules, though, in a way that was more therapeutic and less punitive: We’re going to disengage with you until you are ready to reengage. We have forgiveness, but boundaries. This behavior is not okay, but you are always welcome to return.”

Sobering Centers

Shannon Smith-Bernardin is the President and Co-Founder of the National Sobering Collaborative, which works with sobering centers across the country that provide care to people who are acutely intoxicated. Sobering centers—which are also referred to as stabilization centers, recovery centers, and/or crisis stabilization centers—are facilities providing short-term (6- to 12-hour) stays for recovery during active alcohol and drug intoxication. These staffed facilities are alternatives to jail, emergency departments, and homeless shelters that may not accept clients who are actively intoxicated. Sobering centers are usually stand-alone facilities, but some are co-located with clinics, respite, detox centers, or other homeless service providers. A large proportion of people found in sobering centers are experiencing homelessness, though not everybody is. However, people experiencing homelessness are likely to be arrested for being intoxicated in public.

Since its founding in 2015, the National Sobering Collaborative has been conducting an environmental scan of sobering centers—which generally start in isolation as grassroots programs—to understand how many there are and what they are doing. It is estimated that there are at least 40 sobering centers in operation in the United States, and one-quarter of them are located in the state of California. Through understanding what is already being done at sobering centers, the Collaborative seeks to move forward conversations about standards of care, and also develop toolkits and development plans for organizations seeking to start or expand sobering center programs.

One common misconception about sobering centers is that they are the equivalent of managed alcohol programs. Full managed alcohol programs are facilities where participants

can use alcohol dosed for them, by staff members, and though they exist in other countries, cannot currently be found in the United States. (There are some wet shelters in the United States, where people can use alcohol on the premises and managed alcohol components may be included in programming.) Sobering centers, though, are spaces where people can recover safely from active intoxication. “It’s as low barrier as it can be,” says Dr. Smith-Bernardin: “Anyone can come in who is intoxicated and behaviorally appropriate... The vast majority of



Shannon Smith-Bernardin, National Sobering Collaborative

sobering centers take clients directly from the police. Some [sobering centers] can take ambulances. Many take walk-ins and transfers from emergency rooms once people have been medically cleared... Staff are skilled at de-escalation, and how to keep people safe so they won’t overdose, won’t freeze to death, won’t become ill if they have another illness. Most of the programs give some type of counseling, encourage referrals into treatment programs, and keep taking people again and again. There is no limit on how many times people can come in.”

Dr. Smith-Bernardin notes that substance abuse interventions often attend more to other drugs than they do to alcohol, but alcohol also needs a harm reduction process. “Many homeless shelters won’t take people while they are intoxicated,” she says, “but a person with addiction who has seizures could die if they try to sober up,” making ongoing alcohol use a complex barrier to treatment. She notes the Supportive Place for Observation and Treatment (SPOT) program implemented by the Boston Health Care

for the Homeless Program ⁷ found it takes an average of 13 visits before a person is "willing to try something new. It takes a lot of effort for people to believe they deserve to feel better." According to Dr. Smith-Bernardin, sobering centers can be "a welcoming environment for people who are very symptomatic at the moment" but also fit into a larger recovery-oriented system of care focused on harm reduction and health improvements: "How can we function as a hub for all the community resources that help people with substance use disorders? A sobering center is the perfect place to integrate folks into different services. They become a hub in the community for case management. For folks who are homeless, sobering centers can provide hygiene and personal services like showers and clothing. Then, ideally, the person wants to stick around and we can get them to better services."

Street Outreach

Brett Feldman is the Director of Street Medicine and an Assistant Professor of Family Medicine at the Keck School of Medicine of the University of Southern California. He started the USC's Street Medicine program that operates in Los Angeles, "but I don't teach outside of the streets," he explains: "We have students and fellows that come out with us, so I teach clinically on the streets using the streets as a classroom... Our street medicine program is considered full-service primary care. Our scope of practice is the same as in any brick and mortar clinic...but the entire practice is street-based. In terms of scope of practice, we know that health care is more than just an office visit. We dispense medications, draw labs, and could do point of care ultrasounds and EKGs on the street."



Photos courtesy of Brett Feldman, Keck School of Medicine, University of Southern California

The key advantage to this model of care is that it removes barriers to accessing health care, since people experiencing homelessness "by virtue of survival being their main focus, have many barriers to care, and competing priorities that make it virtually impossible to access a traditional health care system consistently," explains Mr. Feldman. "Daily concerns include the next meal, safety, where to sleep, the risk of authorities throwing their things away. This means the planning horizon is relatively short, maybe two days, so an appointment two weeks or two months in the future is too far away. They may also have to account for the amount of time it takes to take a bus to the office; it may be a multi-hour ordeal that means missing the

only meal of the day at a soup kitchen, or they may use heroin and know they will get sick in that amount of time."

Mr. Feldman believes resistance to harm reduction principles in the medical field can be a question of medical ego: "Clinicians feel that their recommendations are best, and they know the proper use of medication, and they don't want to be taken advantage of by a patient... But the best treatment is one that the patient will follow... We get caught up in hardline evidence-based medicine and optimal treatment, then our egos get in the way and the result is no treatment at all. We can start with evidence-based medicine then move beyond that to practice reality-based medicine. Our tactics need to represent our patients' realities." In practicing reality-based medicine, a

necessary first step is to ask the right questions of patients in order to understand the actual conditions of their lives, what they want from health care, and what behavioral changes they are willing to make in pursuit of their desired outcomes. "First," says Mr. Feldman, "you have to ask what they are willing to do. Patients living unsheltered are very open as to what they will and won't do. We can start there, where they want to start, then maybe go forward later."



The street outreach model of medical care out of necessity integrates harm reduction on multiple levels, as care providers are actively involved with people in the place that they live and may witness their clients engaged in harmful health behaviors. For example, says Mr. Feldman, "I had to wait outside of a patient's tent today while he injected meth before our conversation about managing heart failure. Many providers have patients who use meth in the setting of heart failure, but the

proximity is different." Intimacy with the realities of his patients' lives have informed Mr. Feldman's harm reduction approach to street medicine. As an example, he describes a patient living on the streets who has insulin-dependent diabetes. Statistics show that the best regimen for this condition is basal insulin in the form of once or twice daily injections, with regular meal coverage. However, a patient living on the streets may have limited access to food or water, not to mention appropriate conditions for storing medications, and so a harm reduction approach would attend to these realities: "We can give her enough insulin to cover her should she only eat one meal per day. This

will not control her diabetes to the recommended goal, but it will be better than what it is now. With one shot, she'll improve. Then, if we can get her to a more stable place with more consistent food, she may be willing to increase her dose of insulin."

Another example is his approach to prescribing suboxone, a medication-assisted therapy designed to help patients stop using heroin. "Some providers are pretty strict that if you continue to use heroin you can't get suboxone," he says, "but we've found that a lot of our patients almost use it as-needed. They continue to use heroin but they'll use the suboxone to prevent themselves from getting sick if they don't have money for heroin...or to create a window of time where they can keep an appointment, stand in line at the Department of Motor Vehicles (DMV) to get an ID, go to a cardiology appointment for their congestive heart failure, etc. Without the suboxone they would get sick and leave to try to find the drug... This also reduces risk of overdose and risk of committing crimes to get access to heroin... but what I'm describing is not a strict medical use of suboxone and a lot of people would disagree."

Case Study (from Brett Feldman):

Fred is a man in his mid-40s who has spent his adult life living on the streets of Los Angeles. As a child with an intellectual disability, he experienced abuse and neglect, and was placed in the foster care system, then aged out onto the street.

When Mr. Feldman and the street medicine team met Fred, he had diabetes and congestive heart failure from decades of chronic use of methamphetamines. Fred had used methamphetamines for so long that he could no longer inject intravenously and was "skin-popping," or injecting subcutaneously. As a result of this use, Fred had chronic skin abscesses (usually 6 to 12 at a time), and had gotten sepsis multiple times, resulting in hospitalizations and skin grafts.

Fred told the street medicine team that he was not interested in rehab, so they focused their efforts on wound care as a form of harm reduction, working on treating his abscesses and preventing Fred from becoming septic. Occasionally they asked if he was interested in rehab; every time, Fred said no.

After a year of wound care, Fred told the team that he was interested in rehab, and after a few weeks they got him in. "We had to be present with him for a year while he wasn't ready to stop using," explains Mr. Feldman, "but he knew who to ask when he was ready to go."

Mr. Feldman says that patients are often surprised when harm reduction language and practices are offered to them. "They're used to being treated with 'tough love,' where you've done these bad things so there needs to be punishment or consequences for your actions to get you on the straight and narrow. These patients have often been treated with an iron fist by the medical community, which is one of the reasons they stay away from it. So when we approach them with harm reduction...it gives them permission to be honest."

For health care providers seeking to integrate harm reduction principles into their work, Mr. Feldman advises: "The most important concept of harm reduction is to provide the patients first with tender love, and then with health care. There are many things that are distressing about homelessness, but when you ask people what is the worst part of homelessness, it isn't the material poverty, it's the spiritual poverty of feeling unwanted and unloved. Knowing that someone cares about you is the biggest protection. Remember these patients have lost everything. They've had enough tough; all they need is the love. This allows you to be present with them and accompany them on their journey wherever that starts. It bridges that divide that you started with when you first met them."

Drop-in Centers and Other Sites

Sara Framel is the Director of Outreach at Youth Services of Tulsa in Tulsa, Oklahoma. As one of the only youth-specific-serving agencies in the state, they have four buckets of services for ages 12-25: a counseling department that focuses on individual and family counseling, a youth development department that focuses on LGBTQ+ programming to help facilitate and build gay-straight alliances in middle schools and high schools, substance abuse counseling, and a youth shelter for teens between the ages of 12 and 17. In the outreach department that Ms. Framel oversees, outreach efforts are focused mostly on 18- to 25-year-olds, with a few younger teens as well. Services include transitional living programs, a social enterprise program that teaches employment skills, and a drop-in center that provides basic needs for youth experiencing street homelessness, including showers, clothing, laundry, internet, and a daily hot meal. Most youth find the drop-in center via word of mouth, but center staff also perform community outreach and work with community partners.

Ms. Framel acknowledges people have different definitions and practices associated with harm reduction, but notes that in her work with youth, "trust is such a huge issue... By using a harm reduction model and harm reduction language with youth, it helps build trust." She acknowledges that contexts vary for care providers: "In our drop-in center we have more freedom to speak

candidly with youth and speak about different things [such as comparing the relative danger of different substances]. We used to have clean needle kits that could be given if asked for. We just added sharp boxes into our bathrooms, after a lengthy discussion about the message it sent. We came back to the harm reduction piece that by putting the boxes in we aren't encouraging use, but we are encouraging safety. There's a big difference there, and I think the more we can educate and offer services to the youth, the more success we'll have if and when they are ready to approach us, disclose problems, and pursue treatments. Without having a relationship and offering that space, they may not ever feel comfortable coming to us to ask for what they need."

Once the trusting relationship has been established, use of harm reduction language can continue to facilitate it. Ms. Framel uses the example of a young person who has been honest with care providers about their IV meth use: "If they are trusting us enough to disclose that they are shooting meth, then we can have more intentional conversations with them—not by using language like 'you can't do this' or 'you shouldn't do this' or 'if you do this, then you can't come here.' Some community providers don't allow intoxicated people into the space. At our drop-in center, we take safety seriously and always address disruptive or aggressive behavior... but if a young person is intoxicated, we will still let them come in and get what they need. Harm reduction means recognizing the troubles our youth are going through while still maintaining safety. It's really important for us to not turn away a youth who is struggling... and to maintain a harm reduction culture and use harm reduction language rather than authoritative language with them."

Ms. Framel, along with the other care providers introduced here, emphasizes the inextricable connection between harm reduction and trauma-informed care. (As Mr. Feldman says: "If you are trauma-informed, you practice harm reduction.") "Drug use and other risky behaviors all come from somewhere... so I think harm reduction and trauma-informed care go hand in hand. I don't know that you can have one without the other, because I think they look really similar in how they're communicated and how relationships are built between those two... Every youth that comes through has a trauma history that they are negotiating.... Sometimes we, myself included, struggle with not seeing tangible success with our youth while we have them, and I think that can be really frustrating for those of us who feel like they are just spinning their wheels to help and support a young person while never actually seeing tangible success. However, we can't lose focus on doing our best to give them tools that they may be able to use in the future..."

"[The] relationship that you build with a young person really is going to be the biggest impact for them. I was at a conference in Florida a couple of months ago and someone said, 'your relationship with youth is an intervention in itself.' The more you work to build rapport and build a relationship, the more success you will see and the more you will be

able to support them... This is true for all humans, but especially with youth. [The keys are] trust, building relationships, and being consistent. The likelihood that they've never had someone care in their life is high. Be consistent and follow through to build trust. If you can't follow through, communicate why as quickly as possible. The last thing they need is another adult letting them down or not following

through. Be that person that changes their mind that there are people who aren't going to give up on you and are going to be truthful. We work our hardest to make sure we are being those people."



"Cooking 2" by Elisa, Health Right 360, PhotoVoice Digital Exhibit

CONCLUSION

Ms. Seiberlich-Wheeler tells the story of a group of medical residents who were trying to develop a needle exchange outreach van in Orange County, but were unable to gain enough community support for the program to have traction. "I think part of the problem," she explained, "was that they didn't articulate the impacts of their services outside of the four walls of what they were providing... I think that all public resistance to harm reduction initiatives is fear-based. So you can start with physical safety and make the case that these programs make the whole community safer." Providers of harm reduction services need to be part of community conversations about "not just what happens in the office, but what happens in the community outside the office" in order to combat public stigma about people who misuse substances and people who are experiencing homelessness. The trauma-informed, relationship-building principles of harm reduction can inform these important conversations currently occurring nationally, in communities, and within programs that provide services to people experiencing homelessness.

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