Boosting the Power of Harm Reduction:

Creating a Comprehensive and Culturally Responsive System of Care Serving People Experiencing Homelessness with Substance Use Disorders

Rachel Post, M.S.S.W.
Rebecca Boss, M.A.
LaMont Green, D.S.W.

November 2022

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TECHNICAL ASSISTANCE COLLABORATIVE

Introduction

Drug overdose deaths have been rising precipitously[1] over the past few years, with particularly devastating results among African Americans, Latinx people, and American Indians and Alaska Natives.[2] One of the populations most directly affected by this crisis is people experiencing homelessness. A growing body of research has documented that substance use disorders (SUDs) are strongly associated with homelessness, a condition that brings its own health risks while exacerbating the negative health effects of substance use. Studies have shown a disproportionately high number of overdose deaths among homeless individuals in recent years, with methamphetamine and synthetic opioids such as fentanyl contributing to this trend.[3, 4] In this context, it is time to combine our best knowledge and most effective interventions to reduce overdose deaths and address both substance use and homelessness.

Harm reduction must be a fundamental element in this effort. Practitioners of harm reduction employ a non-judgmental and non-coercive approach to authentically engage people with SUDs in the services they desire, positioning them as primary agents both in their own care and ultimately in SUD program design and policies.[5] The surge in drug-related fatalities among the homeless population necessitates new engagement strategies: harm reduction alone is not enough, and must be paired with culturally responsive and best practice supportive housing, on-demand treatment, and peer-delivered recovery supports. In this brief, we build the case that combining these strategies is imperative to break the cycle of addiction and homelessness, support recovery, and reduce the risk of death by overdose. To realize this goal, we recommend specific actions for system- and provider-level stakeholders to take toward the creation of a culturally responsive, integrated, best practice continuum of care.

Combining harm reduction with culturally responsive supportive housing, on-demand treatment, and peer-delivered recovery supports is imperative to breaking the cycle of addiction and homelessness.

Background

Harm reduction, supportive housing, SUD treatment, and recovery supports are known best practices with demonstrated positive outcomes, yet systems often fund and implement these interventions independently of each other, limiting the availability of comprehensive interventions to address the complex intersection of homelessness and substance use. In most communities, supportive housing and SUD treatment programs are operated by different agencies funded through separate federal, state, and local sources. U.S. Department of Housing and Urban Development (HUD)-funded homelessness Continuums of Care (CoCs) seldom partner with SUD treatment providers to combine their services with supportive housing resources in a coordinated fashion. State Medicaid Agencies and Single State Agencies responsible for organizing and financing SUD treatment services may not be effectively collaborating with housing providers to make a range of supportive services available for individuals with SUD. Meanwhile, harm reduction programs have historically been financed and operated by grassroots advocacy and non-governmental organizations, a situation that grew out of federal funding restrictions. Additionally, peer recovery supports, when available, are often inadequately integrated with the rest of the SUD continuum of care, and their funding tends to rely on time-limited discretionary grants. Furthermore, community-based organizations operated by and for BIPOC communities may not have had opportunities to expand their array of services to meet the need among people with SUDs for culturally responsive and supportive housing, treatment, and recovery supports.

The synergistic effect of leveraged best practice interventions is needed to comprehensively address the intersection of SUDs and homelessness, and to prevent further overdose deaths. Bringing these interventions together to succeed against a complex problem requires that the systems responsible for designing and implementing such interventions — as well as homeless and SUD service and recovery support providers — understand how these strategies can best be aligned.

Harm Reduction

Harm reduction is a pillar of the U.S. Department of Health and Human Services' (HHS) overdose prevention strategy because it is critical to keeping people who use drugs not only alive, but as healthy as possible.[6] The founding principles of harm reduction place people at the center of decision-making about their own substance use, reducing risk through education, resources that promote safe use, and opportunities to seek treatment and recovery. Rather than working solely to support reduced risk in substance use, harm reduction attempts to offer an entire continuum of supports that can help individuals move from active use to lower-risk use, abstinence, recovery, health, and wellness if and when they are ready. This is done by meeting people "where they are" and on their own terms, incorporating a spectrum of strategies that may serve as a pathway to additional treatment, recovery supports, and housing.

Despite the importance of harm reduction tools such as overdose prevention education and the distribution of naloxone, fentanyl test strips, and safe smoking kits, some providers continue to exhibit a lack of acceptance of harm reduction principles in favor of abstinence-only approaches to SUD treatment. Further, stigma remains evident against individuals who continue to be active substance users.[7] Many homeless services and supportive housing programs embrace "low-demand" approaches that do not require abstinence or treatment compliance as a condition of program entry or continued stay in order to engage homeless individuals, but do not actively use harm reduction strategies to help people with SUDs become stably housed or engage in treatment. For example, the evidence-based Housing First approach to serving homeless individuals with behavioral health needs features harm reduction as essential to effectively addressing homelessness and improving behavioral health outcomes. However, many programs claiming to use the Housing First model do not have the appropriate protocols or ongoing training and clinical supervision in place that would support effective operationalization of harm reduction interventions throughout the length of participants' stays in these programs.[8]

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Supportive Housing

Without safe and affordable housing, effectively addressing SUDs is nearly impossible. Yet individuals with SUDs who are experiencing homelessness face multiple barriers to accessing and maintaining housing. Many have criminal records, poor credit, or outstanding rent and utility arrears that complicate or even prevent access to housing. Additionally, active substance use may result in behaviors that impair their ability to be a safe and responsible resident, increasing the risk of eviction or discharge back into homelessness.[9] Further, some operators of supportive housing place restrictions on program entry or continued stay based upon a participant's choice to receive medication-assisted treatment (MAT).

Supportive housing works because it combines time-unlimited affordable housing assistance with voluntary and individualized wraparound services and supports that are offered in the community to help individuals access and maintain housing. Permanent supportive housing (PSH) programs operated with fidelity to researched models have been found to reduce homelessness, increase housing stability, improve health, and lower public costs by reducing reliance on emergency services.[10]

Communities vary in the degree to which a full range of supportive housing models are available to people with SUDs who are exiting homelessness. However, offering a range of models is important. For example, individuals actively engaged in substance use who express no desire to abstain from their use may best be engaged into high-touch, low-demand PSH models like Housing First that actively utilize the harm reduction approach and continually seek to engage individuals in services, while others may prefer to live in a sober living community or recovery housing. Housing choice is essential to achieving successful outcomes in both low-demand and sober living communities.[11] Housing-choice-oriented systems employ harm reduction to assist people who are still in the active use phase of their SUD, supporting their progress toward optional engagement in SUD treatment and facilitating their choice of housing that is supportive of their recovery practices.

Treatment on Demand

Another key pillar of the HHS overdose prevention strategy is to ensure that when a person is ready, high-quality treatment is available without delay.[12] Barriers to treatment admission — such as lack of insurance coverage, transportation challenges, organizational capacity limits, or ineffective admission procedures — result in lost opportunities and even in avoidable loss of life, and are compounded by the challenges of homelessness. The opioid overdose epidemic, combined with the COVID-19 pandemic, has served to hasten the development of low-barrier treatment options. These care delivery models seek to engage people when they are ready by being flexible; available in convenient locations (which may include mobile services or co-location in other service delivery settings); centered on a harm reduction approach; and prepared to offer medications with minimal limitations.[13] Today's heightened concern regarding opioid-related deaths also makes harm reduction, supportive housing, and recovery support programs good potential partners for SUD treatment providers seeking to engage hard-to-reach individuals — including those experiencing homelessness — in new, more accessible models of treatment delivery.

One example of combining on-demand treatment supports with harm reduction, supportive housing, and recovery supports is Pathways to Housing PA, a Housing First program that incorporates specific interventions to meet the needs of individuals with opioid use disorders who are experiencing homelessness. A team of providers that includes recovery peer specialists utilizes harm reduction strategies to engage people who are actively using opioids into housing. The program works with a satellite Federally Qualified Health Center (FQHC) to access on-demand MAT, and to equip each enrollee with naloxone to reduce their risk of death from overdose. For those who desire alcohol- and drug-free housing, a transition to the city's network of recovery housing is available.[14]

Recovery Supports

Harm reduction is essential in saving lives — but to achieve recovery, it is essential to incorporate hope for a *better* life that includes health, home, purpose, and community. This is why recovery supports are another pillar of the HHS overdose prevention strategy.[15] Recovery supports can foster wellness by facilitating linkages to and coordination among health and behavioral health care providers, social service agencies, legal systems, housing operators, and other community support systems. Since many of these systems do not offer warm handoffs or care coordination, recovery supports often fill in the gaps by supplying these linkages. Recovery supports are typically offered through mutual aid groups (i.e. Narcotics Anonymous, SMART Recovery, Women for Sobriety), recovery community organizations (RCOs), recovery-focused collegiate programs, and peer mentorship.

Like harm reduction, recovery supports work best when they promote partnership with people to identify and access the supports they want. Some RCOs provide leadership development to promote civic engagement to fight discriminatory laws and policies that stigmatize SUDs.[16] While recovery supports are increasingly recognized as an important part of the continuum, treatment systems vary in commitment to funding and requiring the incorporation of such supports, due to the still limited evidence base regarding their effectiveness. Many individual SUD treatment providers are similarly disinclined to incorporate recovery supports due to limited evidence and guidance on how to do so effectively. The lack of support and guidance regarding the role of peer recovery providers, for example, contributes to wide variation in how providers integrate this role within programs, but may also present opportunities for defining it in a way that supports effective integration of harm reduction, treatment, and supportive housing programs and services.

Cultural Responsiveness and Power Analysis

A focus on racial equity at all levels of policy, design, and implementation is fundamental to the successful combination of these interventions. Racial and ethnic disparities are widely documented among people who experience homelessness, and also among those who enter and complete SUD treatment.[17, 18] While the etiology of such disparities is complex, culturally responsive engagement and service delivery emerge as salient drivers of success in efforts to improve equity. In turn, operationalizing cultural responsiveness requires a set of policies, practices, and attitudes grounded in a trauma-informed and healing-centered awareness of the cultural assets, indigenous knowledge, and resiliency of communities of color. A culturally responsive approach must also be rooted in a power analysis conducted by government, providers, philanthropy, policymakers, and the greater community to examine ways that harm reduction, supportive housing, recovery support, and treatment systems may be reinforcing patterns of oppression instead of truly working to eliminate disparities. This type of

analysis can help facilitate the reclamation of power by historically disenfranchised communities.

Restoring power requires engaging with communities to share decision-making and lift up solutions developed by those most directly affected by substance use. To reduce inequities and improve outcomes for the communities that have experienced the greatest impact, today's harm reduction, supportive housing, recovery supports, and treatment systems must be redesigned to eliminate racial and social disparities. State and local governments must cultivate strong collaboration with affected communities, the behavioral health system, housing, and social services, utilizing a racial equity and social justice lens. Examples of community planning processes and tools that center racial equity and social justice, and that facilitate the sharing of decision-making power, are offered in this brief's Spotlight sidebars, and can be adapted to assist states and communities as they set out to plan, design, and implement culturally responsive and integrated interventions to address SUD and homelessness.

At the direct services level, harm reduction interventions must acknowledge the impact of poverty, classism, racism, social isolation, trauma, sex and gender-based discrimination, and other inequities in people's vulnerability to drug-related harm. Harm reduction functions at the intersection of several health care and housing movements, and must also work to heal the harms caused by racialized drug, health care, and housing policies. For example, the so-called national "war on drugs" launched in 1971 profoundly affected people of color and was manifested through racial discrimination by law enforcement, especially as this policy was ramped up in the 1980s and 1990s.[19] By upholding the central tenets of harm reduction and placing those most directly affected by substance use in decision-making authority, the balance of power is shifted, allowing disparities in access to treatment, health care, and housing to be corrected.

Further, by supporting the dignity of personal decision-making in the types of housing environments and associated services that individuals want, a housing-choice-oriented system works to overcome the power imbalance between providers and the people they serve. In terms of recovery supports, examples of culturally responsive programs exist across the country, including mutual aid groups led by and for specific communities of color, disability groups, and LGBTQ2S+ communities. White Bison, in Colorado Springs, CO, offers culturally based healing to indigenous people through a model known as Wellbriety.

Ensuring the involvement of peer providers representative of the populations they serve is essential to engaging individuals in their own recovery journey, and can improve recovery programming, supportive housing, and harm reduction interventions by providing more culturally

Spotlight: King County Regional Homelessness Authority

In 2018, the City of Seattle and King County (WA) collaborated with National Innovation Services (NIS) on a community engagement process to design a stronger regional response to the homelessness system. The result of this process was the inauguration of the King County Regional Homelessness Authority (KCRHA). People with lived expertise of homelessness and SUD, and members the communities most affected by homelessness, were engaged throughout planning, research, design, governance, and implementation. Drawing on feedback from people with lived expertise, KCRHA and the Lived Experience Coalition — a grassroots effort unifying the voices of people with lived experience of homelessness — codeveloped a Systems Advocate Peer Navigation Workforce. Systems Advocates engage in outreach, serve as coaches, and help unhoused folks experiencing homelessness, including those with SUDs, establish connections to services, while navigating multiple systems toward the goal of housing and wellness.

Spotlight: Heart Equity Action Lab (HEAL) Racial Equity and Social Justice Tool

An example of a community planning effort that centered racial equity and social justice is the process the HUD-funded Youth Homelessness Demonstration Program (YHDP) went through by using the Heart Equity Action Lab (HEAL) Racial Equity and Social Justice Tool. Based on feedback from YHDP communities, this resource was created to ensure that any given planning process is culturally responsive by sharing decision-making power with youth and young adults while addressing racism and other forms oppression that create barriers to a transformative and equitable homelessness system. This tool can be adapted to assist a state's or community's SUD treatment, recovery supports, supportive housing, and harm reduction systems in unearthing and remediating the persistent drivers of inequity for racially marginalized and historically disenfranchised groups.

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responsive services. Peer providers are a critical workforce partner in engaging those experiencing homelessness and providing vital connections to treatment and other recovery supports. Peer providers' personal experiences with homelessness, substance use treatment, incarceration, and successful reintegration are critical to deeply engage participants and show them that success is possible. They serve as trusted members of the community, and can help individuals navigate the processes required to access housing; once a person is housed, peer providers can help them maintain their housing by offering resources to enrich their recovery journey, health, and wellness. While more research is needed to measure the efficacy of peer-provided recovery supports, reviews of literature have found that "these services were associated with reduced substance use and SUD relapse rates, improved relationships with treatment providers and social supports, increased treatment retention, and greater satisfaction with treatment."[20]

Recommendations to Coordinate Systems and Align Interventions

Because multiple systems and agencies are responsible for various parts of addressing SUD among those experiencing or at risk of homelessness, efforts must be aligned and coordinated to maximize resources and achieve the best outcome while reducing duplication of effort.

Federal Coordination and Alignment Recommendations

Federal action to advance best practice combined interventions takes place primarily through policy-setting and grantmaking, with responsibilities shared by several agencies. Coordinated policy and messaging, shared guidance, and (where possible) coordinated grant- and decision-making among federal agencies, will maximize the impact of new policies, and help improve coordination at the state and local levels. The White House's National Drug Control Strategy names over 15 federal agencies that will work to address SUDs through advancing racial equity; enhancing access to evidence-based treatment and harm reduction practices; and expanding recovery support services. The *Strategy* specifically acknowledges the role of harm reduction programs, including those that incorporate peers with lived experience, in reaching and engaging people experiencing unstable housing or homelessness, and in connecting individuals to services and supports that address social determinants of health including housing.

HHS's Centers for Medicare and Medicaid Services (CMS), Health Resources and Services Administration (HRSA), and Substance Abuse and Mental Health Services Administration (SAMHSA), as well as HUD, are among federal agencies that could form an interagency task force to advance federal policy and funding to tackle the challenges outlined in the Office of National Drug Control Policy's *National Drug Control Strategy*, encouraging states and providers to intentionally combine culturally responsive harm reduction, supportive housing, on-demand treatment, and recovery supports for the target population. Such a task force could produce guidance on fully funding and combining these best practice interventions; encourage grantmaking that pilots them; and generate shared messaging to states regarding the need for a culturally responsive and coordinated continuum of care to address SUDs and homelessness.

Recent federal funding opportunities are already fostering local coordination in addressing homelessness and SUDs. For example, a recent competitive funding opportunity offered by HUD to address unsheltered and rural homelessness in local communities offers applicants additional points for leveraging health care resources, including behavioral health care and recovery supports; for illustrating how they will include people with lived experience (PWLE) in program design and delivery; and for planning to support equitable community development for underserved populations.[21]

State Coordination and Alignment Recommendations

States can use their policy levers (established practices and mechanisms of government agencies) to achieve system-wide change.[22] State and local policy levers can create or expand culturally responsive harm reduction, housing, treatment, and recovery support services in several ways:

- Incorporate the voices of PWLE in policy and funding decisions
- Advance culturally responsive care within existing services
- Create funding opportunities for nontraditional partnerships
- Identify and address regulatory barriers to harm reduction, supportive housing, recovery support services, and on-demand treatment strategies
- Cultivate cross-agency partnerships to braid funding that supports alignment of resources
- Support creation or enhancement of workforce career pathways for PWLE

Incorporate People with Lived Expertise into Policy and Funding Decisions

Single State Agencies administer SAMHSA's Substance Abuse Treatment and Prevention Block Grants (SAPTBG) and State Opioid Response (SOR) grants. States use these grants for prevention, treatment, recovery supports, and other services to supplement Medicaid, Medicare, and private insurance services. Many states engage community voice, especially PWLE, in identifying needs and prioritizing services for funding. The state of Washington's Health Care Authority enhanced the role of PWLE in policy decisions by creating an Office of Recovery Partnerships that works closely with people who have been recipients of mental health and substance use services to influence and inform health care policies. States and localities can look to inclusion of PWLE to cultivate system-wide change that promotes the combined interventions discussed in this brief.

Advance Culturally Responsive Care within Existing Services

SAMHSA requires its grantees to submit a Disparity Impact Statement that identifies how data on access, use, and outcomes will be used to identify underserved ethnic and racial minorities and LGBTQ populations.[23] In addition, states can create regulations or certification standards to ensure program compliance with Culturally and Linguistically Appropriate Services (CLAS) standards.[24] California opted to require each county behavioral health department to develop and annually update a cultural competency plan aimed at reducing behavioral health service disparities in underserved populations.[25] In 2019, California passed legislation funding the Community Mental Health Equity Project, a multiagency government collaborative that provides no-cost training, technical assistance, and supportive resources to county behavioral health agencies and community providers.[26] When combining interventions, states and communities can examine how to prioritize equity in their policies, budgets, and contracting practices in ways that promote cultural responsiveness.

Create Funding Opportunities for Nontraditional Partnerships

Partnerships with trusted community leaders, including those who function as service providers, have proven to be an effective strategy to build trust between disenfranchised communities and policymakers at the state and local government levels.[27] [28] However, many states face barriers in directly funding providers operated by disenfranchised communities. Such entities may have a limited infrastructure, making it difficult for them to secure state and local contracts that come with complicated and burdensome administrative requirements. Recognizing these challenges, the State of New York funded Friends of Recovery NY to provide technical assistance and support to existing and developing RCOs. These independent nonprofit organizations led by recovery allies are making a difference in their communities using lived expertise to work with people in need. States, counties, and municipalities can consider ways to simplify their request-for-bids processes and contracting requirements in order to include more of these smaller organizations to expand the offering of recovery support services in coordination with supportive housing and harm reduction services for people with SUDs who are experiencing homelessness.

Identify and Address Regulatory Barriers

States should identify and address regulatory barriers to harm reduction, supportive housing, recovery support services, and on-demand treatment strategies. In the midst of a national overdose epidemic, states are expending significant resources in efforts to save lives. However, many states continue to maintain regulations for opioid treatment programs that are inconsistent with best practices and may actually create barriers to life-saving treatment.[29]

Contingency management, an evidence-based practice in the treatment of methamphetamine use disorder, may be unavailable in some states where laws or regulations limit its use.[30] As federal agencies act to reduce barriers

through mobile treatment options, easing restrictions on methadone take-home requirements, and increasing Medicaid support for recovery support services, the onus is now on states to examine laws and regulations that may adversely affect the most vulnerable populations. Distribution of safer drug smoking supplies is illegal under the federal Drug Paraphernalia Act of 1979, making distribution of these supplies illegal in any state that has adopted the Act's language.[31] Similarly, while fentanyl test strips have been proven effective as a harm reduction tool enabling people to know what is in their drug supply, many states still have laws that prohibit their use.

In March 2022, Wisconsin Governor Tony Evers signed into law S.B. 600, which decriminalized the use of fentanyl test strips. The state law previously defined "drug paraphernalia" to include testing equipment used, designed for use, or primarily intended to identify or analyze the strength, effectiveness, or purity of controlled substances or controlled substance analogs. The new law exempts fentanyl-testing strips from that definition. Additionally, federal and state governments can codify through law core components of supportive housing programs including the implementation of harm reduction interventions, as well as connections with SUD treatment and recovery supports. The California legislature passed a law in 2016 requiring all housing programs to adopt the Housing First model and identifying services informed by a harm reduction philosophy as one of its core components.[32] States can build on this type of legislation through policy, funding, and regulations to ensure that services are fully implemented to support housing stability and recovery. This strategy includes examining Medicaid's role in expanding coverage of harm reduction and supportive housing services, as well as recovery supports, for individuals with SUD.

Cultivate Cross-Agency Partnerships

Similar to the recommendation to coordinate and align federal agencies, states also need interagency initiatives to promote a seamless system of care that offers all of the described interventions. The State of Ohio offers an example with its Opioid Task Force, which developed a collaborative partnership to promote alignment and unified goals centered on data analytics. The Ohio Department of Mental Health and Addiction Services awarded funding to two cohorts of Ohio communities to participate in its Community Collective Impact Model for Change (CCIM4C) initiative, a two-year program to reduce opioid-related deaths and increase access to treatment. Through the initiative, 18 communities utilized a data-driven strategic planning process based on collective impact to address the opioid crisis and social determinants of health. Each community designated a backbone organization that identified the scope of the problem and available interventions already in place in the area and brought together stakeholders from multiple sectors. The teams developed a strategic plan that went beyond typical responses to the opioid crisis, addressing factors such as childhood trauma, poverty, unstable housing, unequal economic opportunity, and social isolation. A key component of the CCIM4C initiative's success was that each community created a local ecosystem that reflected its own context and included a wide range of organizations in developing a common agenda to address the opioid epidemic.

Create or Enhance Workforce Career Pathways for People with Lived Expertise

Finally, states must support system transformation that addresses disparities among marginalized populations by investing in workforce development among PWLE through peer-provider certification programs.[33, 34] Many states have invested substantially in this area, in recognition that a peer provider workforce tremendously increases a system's ability to reflect the specific experiences, ages, races, cultural backgrounds, disability status, religions, gender identities, and sexual orientations of clients served. This representation not only improves client outcomes but also boosts a system's overall effectiveness.[35] As an example, Georgia's Department of Behavioral Health and Developmental Disabilities funds the Certified Addiction Recovery Empowerment Specialist (CARES) Academy to create a workforce of peers who provide recovery support services to Georgia's communities. This is the first peer certification program in the nation to be Medicaid-billable. The Georgia Council on Substance Abuse, a statewide RCO that has provided advocacy, training, education, and peer recovery supports for over 20 years, operates the CARES Academy. Over 500 peers have gained certification through the Academy's 40-hour training curriculum and examination process.

Local Coordination and Alignment

Local coordination and alignment of resources across systems will likely be more achievable when federal and state agencies align their systems and resources through regulatory changes and directives. Local partnerships and coordinated efforts should be designed intentionally to integrate interventions within a coordinated continuum, with specific attention to several priorities:

- Development of a robust memorandum of understanding (MOU) or strategic partnership agreement between partner agencies; including funders; providers; agencies governed by and serving marginalized populations; and PWLE.
- Partnership planning that uses the Heart Equity Action Lab (HEAL) Racial Equity and Social Justice Tool or another process that leads with a racial equity and social justice lens.
- Staffing across the continuum that reflects the racial, ethnic, gender, sexual orientation, and linguistic diversity of program participants.
- Staffing that employs PWLE at all levels, from leadership to frontline positions.
- The promotion of housing choice and the availability of low-barrier and recovery housing options with flexibility to transition from one model to another as desired.
- Culturally responsive programming in all interventions that embeds cultural humility into the continuum of services offered.[36]
- Protocols that promote rapid responses to drug overdoses in order to reduce mortality; optimize engagement in on-demand treatment and recovery support services; and support the needs of property owners.
- Recognition of the benefits of MAT and promotion of this evidence-based practice.
- Capacity for recovery support services to be available to all those touched by the system.
- Availability of harm reduction practitioners.
- Motivational interviewing as a practice to support clients in identifying what recovery looks like and supporting the steps to achieve it.
- Promotion of overdose prevention and response plans and an Advance Care Plan[37] to help individuals reduce risk and identify an emergency contact in the event of overdose or death.
- Increased access to harm reduction resources and supplies (e.g., safe injection sites, fentanyl test strips, safe smoking kits).
- Employment of certified peer specialists who can support clients by offering shared understanding, respect, and empowerment in service navigation and by modeling what long-term recovery can look like.
- Partnerships with SUD treatment providers to offer on-demand withdrawal treatment, inpatient and outpatient treatment, MAT, and contingency management.[38]
- Qualitative and quantitative analysis of outcomes and continuous quality improvement.

Where combined interventions do exist that include culturally responsive harm reduction, housing, treatment, and recovery supports, scaling them to meet the need — whether in a particular locality or statewide — is complicated by scarcity of funding resources, administrative burdens, and complex partnership agreements required to braid funding streams. System change to improve the flexibility and braiding of funding is possible when stakeholders come together to coordinate resources.

Conclusion

The rate of deaths resulting from drug overdoses shows clearly that comprehensive interventions are required. An “all hands on deck” approach is called for, bringing together and coordinating *all* the resources necessary in order to meet the needs of our most vulnerable community members: people with SUDs who are experiencing homelessness. The examples and resources listed in this brief can be used to advance state and local planning efforts to build SUD systems that are comprehensive, inclusive, and effective.

Endnotes

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