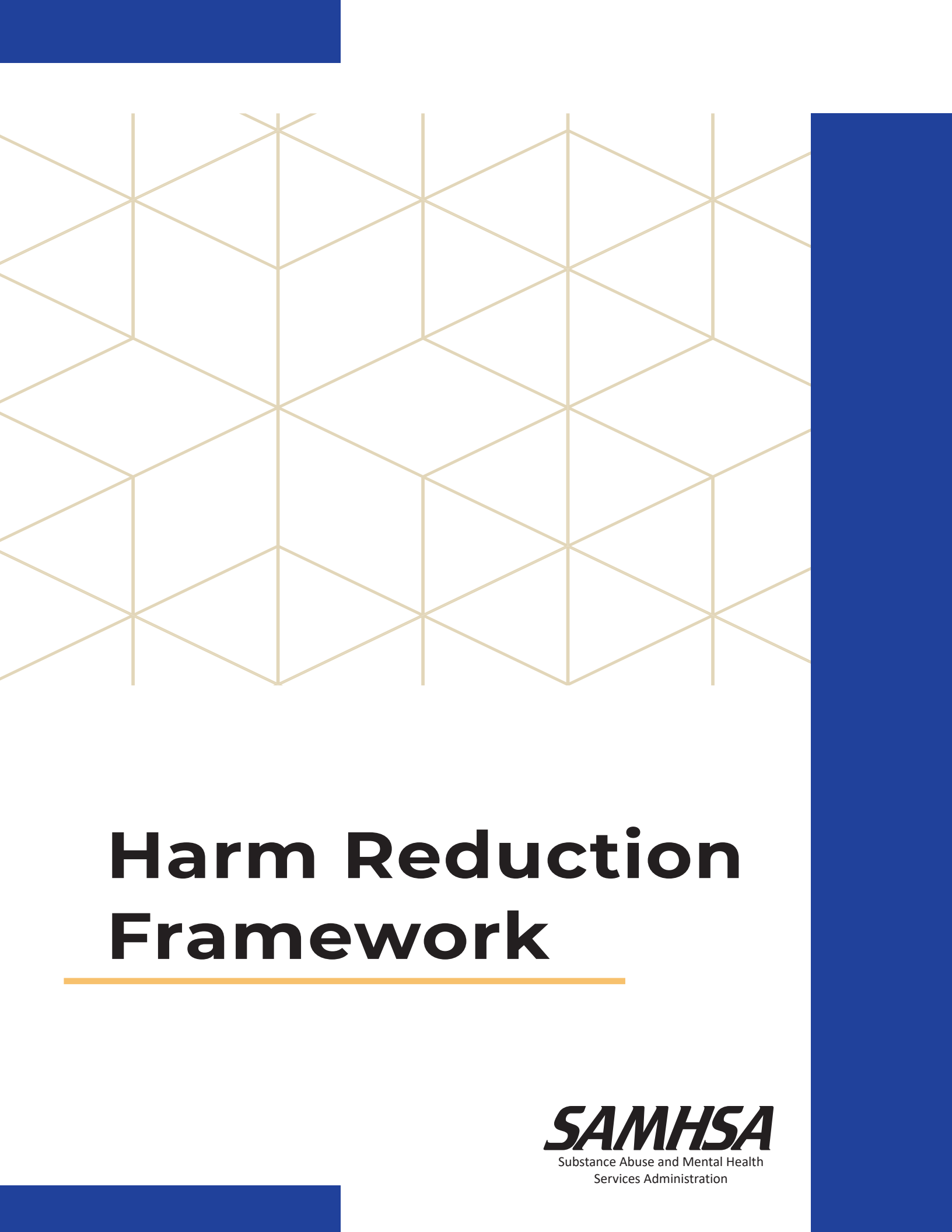




Harm Reduction Framework

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Harm Reduction Framework for People Who Use Drugs (PWUD)

The Biden-Harris Administration has identified harm reduction as a federal drug policy priority. The White House Office of National Drug Control Policy (ONDCP), in the [2022 National Drug Control Strategy](#), notes that harm reduction is a public health approach designed to advance policies and programs in collaboration with people who use drugs (PWUD) and is supported by decades of evidence. Harm reduction strategies are shown to substantially reduce HIV and hepatitis C infection among people who inject drugs, reduce overdose risk, enhance health and safety, and increase by five-fold the likelihood of a person who injects drugs to initiate substance use disorder treatment.^{1,2,3} In line with this, harm reduction is one of the four strategic priorities of the [U.S. Department of Health and Human Services \(HHS\) Overdose Prevention Strategy](#) developed to address the overdose public health emergency.⁴

In December 2021, the Substance Abuse and Mental Health Services Administration (SAMHSA) convened the first-ever federal Harm Reduction Summit, in partnership with the Centers for Disease Control and Prevention (CDC) and ONDCP. The Summit brought together more than 100 experts representing prevention, treatment, recovery, and harm reduction perspectives. Most importantly, Summit attendees included people with lived experience with substance use to help inform SAMHSA's policies, programs, and practices as they relate to harm reduction. Additional partners included community members, advocates, harm reductionists, providers, funders, and others who are affected by these issues.

SAMHSA's Harm Reduction Framework is one outcome of the Summit. This Framework is historic, as the first document to comprehensively outline harm reduction and discuss its role throughout HHS.

The Framework was developed and written in partnership with the Harm Reduction Steering Committee, composed of harm reduction leaders in the field from across the country. This group represents a broad array of backgrounds and experience, with most having lived experience of drug use. The Steering Committee synthesized findings from the Summit — including a definition of harm reduction, pillars and principles supporting that definition, and core practices that SAMHSA can support. The Framework is adapted from the Committee's final report.

This Framework will inform SAMHSA's harm reduction activities moving forward, as well as related policies, programs, and practices. SAMHSA's aim is to integrate harm reduction activities and approaches across its organizational Centers and initiatives, and to do so in a manner that draws on evidence-based practice and principles — while also maintaining sustained dialogue with harm reductionists and people who use drugs (PWUD). The Framework will also inform SAMHSA's thinking about opportunities to work with other federal, state, tribal, and local partners toward advancing harm reduction approaches, services, and programs.

SAMHSA defines harm reduction as a practical and transformative approach that incorporates community-driven public health strategies — including prevention, risk reduction, and health promotion — to empower PWUD and their families with the choice to live healthier, self-directed, and purpose-filled lives. Harm reduction centers the lived and living experience of PWUD, especially those in underserved communities, in these strategies and the practices that flow from them.

Brief History and Background of Harm Reduction

Harm reduction has a long history in the United States. The field itself and harm reduction practice emerged decades ago, as direct community action and mutual aid in response to effects of the “[War on Drugs](#),” an early and incomplete scientific understanding of substance use and substance use disorders, and government inaction to swiftly respond to the growing HIV/AIDS epidemic.⁵

In 1982, CDC published findings that the human immunodeficiency virus (HIV) is transmissible through the intravenous use of drugs.⁶ By 1983, PWUD began the distribution of sterile syringes to limit the transmission of HIV/AIDS.⁷ After the 1988 restriction on federal funding for the purchase of syringes for needle and syringe exchange programs, PWUD and allies who operated syringe services programs (SSPs) across the country began to organize their work.⁸ In 1992, the first Harm Reduction Working Group meeting in the United States was held in San Francisco to create a [unified definition of harm reduction](#). A major outcome of the group was the establishment of the [National Harm Reduction Coalition](#).⁹

Since the first Harm Reduction Working Group meeting in 1992, harm reduction has grown in scope and in practice. PWUD have innovated and sustained the movement despite criminalization of many harm reduction interventions and lack of financial and social support.

An important example is the advent of community naloxone distribution, which began in 1996.¹⁰ From 1996 through June 2014, 136 organizations reported distributing naloxone to 152,283 laypersons. Of the 109 organizations who collect reversal data, 26,463 overdose reversals were reported.¹¹ Although the number of organizations distributing naloxone has doubled and since 2013 has included organizations other than SSPs, in 2014, SSPs still accounted for 80 percent of the distribution effort to PWUD, as well as 80 percent of overdose reversals.¹²

In 2019, SSPs distributed 702,232 doses of naloxone to 230,506 people in communities across the country.¹³ Studies have shown that communities may experience up to a 46 percent reduction in opioid overdose mortality when more than 100 people who are likely to observe or experience an overdose per 100,000 population are enrolled into an Overdose Education and Naloxone Distribution (OEND) program.¹⁴ In addition, SSPs are associated with an estimated 50 percent reduction in HIV and hepatitis C incidence.^{15,16} When combined with medications that treat opioid use disorder (also known as medications for opioid use disorder or MOUD), hepatitis C virus and HIV transmission is reduced by more than two-thirds.¹⁷ The last few decades have solidified the evidence-based practices and individuals have become specialized subject matter experts in the field of harm reduction.

Addressing Health Inequities

In the spirit of [Executive Order 13985](#),¹⁸ SAMHSA is in the process of reviewing its policies to examine the intended and unintended impacts of its programs, policies, and procedures; incorporating racial justice and health equity into its policy goals; and advancing equitable support for Black, Latino, American Indian and Alaskan Native persons, Asian Americans, Native Hawaiians, and Pacific Islanders, and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, queer, intersex (LGBTQI+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely impacted by persistent poverty or inequality. This is proactively undertaken to address past and present inequities.¹⁸ Integrating harm reduction principles and approaches throughout the agency is one strategy for advancing that commitment.

Deficient social determinants of health and structural inequalities contribute to and exacerbate substance use, substance use disorder, and mental illness, and can and do have a profound impact on some populations. Most notably, persons who have a history of familial, community or racial trauma may be particularly in need of compassionate services to support their pathways to improved health outcomes. Community practitioners and behavioral health providers must be culturally responsive and attentive to health equity to effectively improve individual and population level health. For this to be accomplished, community trust and buy-in must be earned, and that begins with truth and reconciliation of a community's shared traumatic history and the structural racism that perpetuates inequities. On this foundation, trust and meaningful relationships can develop.¹⁹

“Formally acknowledging a community’s shared traumatic history is a fundamental step in preparing for and planning community engagement (CE) efforts that address health inequities.”¹⁹

This work is undertaken in partnership with SAMHSA’s Office of Behavioral Health Equity, which describes the work as: “Advancing health equity involves ensuring that everyone has a fair and just opportunity to be as healthy as possible. This also applies not only to behavioral health, but in conjunction with quality services, this involves addressing [social determinants](#), such as employment and housing stability, insurance status, proximity to services, culturally responsive care — all of which have an impact on behavioral health outcomes.”²⁰

Framework Overview

Harm reduction is practical in its understanding and acceptance that drug use and other behaviors that carry risk exist — and responds in a compassionate and life-preserving manner. Harm reduction seeks to reduce the harmful impacts of stigma, mistreatment, discrimination, and harsh punishment of PWUD, especially those who are Black, Indigenous, and other People of Color.²¹ Building community partnerships with harm reduction organizations can positively shape beliefs and attitudes, reduce stigma, and ensure the well-being of the community at large.²²

Harm reduction also accounts for the intersection of drug use, other stigmatized behaviors, and people's health. Fundamentally, a harm reduction approach meets people where they are, engaging with them and providing support.²³

Harm reduction opens the door to more options for PWUD, for whom traditional treatment approaches are inaccessible, ineffective, or inappropriate — and who want to make safer, healthier choices with their life and health. Access to harm reduction services is consistently shown to improve individual and community outcomes. By viewing substance use on a continuum, incremental change can be made, allowing for risk reduction to better suit a person's own individual goals and motivations.

Most importantly, harm reduction approaches save lives.

The SAMHSA definition of harm reduction contains **six pillars, 12 principles, and six core practice areas** that give life to harm reduction approaches, initiatives, programs, and services. The pillars are essential building blocks that are the foundation of what makes harm reduction effective. The pillars are further divided into supporting principles that are the specific concepts and ideals supporting each pillar. The SAMHSA Framework also describes the core components of community-based harm reduction programs.

Framing Harm Reduction

SAMHSA conceptualizes harm reduction as being a set of services, an approach, and a type of organization. Harm reduction has, at times, been reduced to a singular service or group of services, when in fact, its application goes well beyond this. Harm reduction as an approach — with supporting principles and pillars that can be applied to a variety of contexts — includes the provision of evidence-based treatment. An organization or an individual healthcare practitioner may not consider themselves as primarily providing harm reduction services but may adopt and apply practices and principles outlined in this Framework — to enhance the services they offer and engage with PWUD in a manner informed by these principles. Any organization who works with PWUD can benefit from the integration of harm reduction as an approach.

Harm reduction is also part of the continuum of care and a comprehensive strategy that includes prevention, treatment, recovery, and health promotion. All of these elements are necessary — and people weigh them differently in different situations, at different points in their lives, and relative to a wide range of substances and behaviors.

Prevention, in particular primary prevention, seeks to prevent problems before they start. That means preventing exposure to substances (or screening and intervening with early misuse), reducing risk factors, and strengthening protective factors at the individual, relationship, community, and society levels. Prevention also seeks to stop or delay the progression of substance use to a substance use disorder, as well as prevent other harms associated with substance use.

Harm reduction recognizes the complex relationship people may have with substances, starting from first use, through the many possible intervention points from there. Harm reduction does not minimize the inherent harms associated with drug use and acknowledges that reducing harm can take different forms for different people at different points, including with the use of medications to treat substance use disorders. Harm reduction is also inclusive of abstinence as a chosen pathway but not inclusive of abstinence as a coerced pathway.

Harm reduction services must adhere to the harm reduction approach to maintain fidelity to the evidence base and lead to better outcomes. This is exemplified by the concept of Community-Based Harm Reduction Programs (CHRP) described in this Framework.

Pillars of Harm Reduction

Table 1 summarizes the six pillars of harm reduction. Harm reduction initiatives, programs, or services should include these elements.

Table 1. Six Pillars of Harm Reduction

Harm Reduction...	
1. Is led by people who use drugs (PWUD) and with lived experience of drug use	Work is led by PWUD and those with lived and living experience of drug use. Harm reduction interventions that are evidence based have been innovated and largely implemented by PWUD. Through shared decision-making, people with lived experience are empowered to take an active role in the engagement process and have better outcomes.²⁴ Put simply, the effectiveness of harm reduction programs is based on the buy-in and leadership of the people they seek to serve. Organizations providing harm reduction services should have a formal mechanism to meaningfully include the voices of people with lived experience in the design, implementation, and evaluation of those services.²⁵ Adopting at least two of the following specific mechanisms of inclusion is mission critical: employment of people with lived experience in both intervention and administrative roles, advisory boards of PWUD, and the consultation of CHRP or any other peer-led organizations. It is important to note that while people in recovery and people who formerly used drugs have valuable experience, centering the perspectives of people who currently use drugs (and the intersectionality with other historically marginalized individuals) and have a working understanding of the current, dynamic, and rapidly changing landscape of drug use in a particular community in which an organization is working, is essential to successful engagement and outcomes. This is exemplified in the provision of OEND Programs.²⁶
2. Embraces the inherent value of people	All individuals have inherent value and are treated with dignity, respect, and positive regard. Harm reduction initiatives, programs, and services are trauma informed, and never patronize nor pathologize PWUD, nor their communities. They acknowledge that substance use happens, and the reasons a person uses drugs are nuanced and complex. This includes people who use drugs to alleviate symptoms of an existing medical condition.

Harm Reduction...(Cont.)	
3. Commits to deep community engagement and community building	All communities that are impacted by systemic harms are leading and directing program planning, implementation, and evaluation. Funding agencies and funded programs support and sustain community cultural practices, and value community wisdom and expertise. Agencies and programs develop through community-led initiatives focused on geographically specific, culturally based models that integrate language revitalization, cultural programming, and Indigenous care with dominant-society healthcare approaches.
4. Promotes equity, rights, and reparative social justice	All aspects of the work incorporate an awareness of (and actively work to eliminate) inequity related to race, class, language, sexual orientation, and gender-based power differentials. Pro-health and pro-social practices that have worked well for specific cultural and/or geographic communities are aligned with organizing and mobilizing, providing direct services, and supporting mutual aid among PWUD. CHRP's are often the best-placed organizations to respond to communities or individuals on racial justice and health equity issues, and provide services for Black, Latino, American Indian and Alaska Native persons, Asian Americans, Native Hawaiians, and Pacific Islanders, and other persons of color; members of religious minorities; LGBTQI+ persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely impacted by persistent poverty or inequality.
5. Offers most accessible and noncoercive support	All harm reduction services have the lowest requirements for access. Participation in services is always voluntary, confidential (or anonymous), self-directed, and free from threats, force, and the concept of compliance. Any data collection requires informed consent and participants should not be denied services for not providing information. This means using low-threshold evaluation and data collection systems to measure the effectiveness of harm reduction programs.
6. Focuses on any positive change, as defined by the person	All harm reduction services are driven by person-centered positive change in the individual's quality of life. Harm reduction initiatives, programs, and services recognize that positive change means moving towards more connectedness to the community, family, and a more healthful state, as the individual defines it. There are many pathways to wellness; substance use recovery is only one of them. Abstinence is neither required nor discouraged.

Supporting Principles

The pillars are supported and reinforced by 12 core principles that guide the work. As with the pillars, the principles are vital. Programs that do not incorporate all 12 principles risk violating the spirit of harm reduction.

Table 2. Principles of Harm Reduction

Supporting Principles	Principle Description
Respect autonomy	Each individual is different. It is important to meet people where they are, and for people to lead their own individual journey. Harm reduction approaches, initiatives, programs, and services value and support the dignity, personal freedom, autonomy, self-determination, voice, and decision making of PWUD.
Practice acceptance and hospitality	Love, trust, and connection are important in harm reduction work. Harm reduction approaches, initiatives, programs, and services hold space for people who are at greatest risk for marginalization and discrimination. These elements emphasize trusting relationships and meaningful connections and understand that this is an important way to motivate people to find personal success and to feel less isolated.
Provide support	Harm reduction approaches, initiatives, programs, and services provide information and support without judgment, in a manner that is non-punitive, compassionate, humanistic, and empathetic. Peer-led services enhance and support individual positive change and recovery; and peer-led leadership leads to better outcomes.
Connect with community	Positive connections with community, including family members (biological or chosen) are an important part of well-being. Community members often assist loved ones with safety, risk reduction, or overdose response. When possible, harm reduction initiatives, programs, and services support families in expanding and deepening their strategies for love and support; and include families in services, with the explicit permission of the individual.
Provide many pathways to well-being across the continuum of health and social care	Harm reduction can and should happen across the full continuum of health and social care, meeting whole-person health and social needs. In networking with other providers, harm reduction initiatives, programs, and services work to build relationships and trust with health and social care partners that embrace supporting principles. To help achieve this, organizations practicing harm reduction utilize education and encourage policies that facilitate interconnectedness between all parties.

Supporting Principles	Principle Description...(Cont.)
Value practice-based evidence and on-the-ground experience	Structural racism and other forms of discrimination have limited the development and inclusion of research on what works in underserved communities. Harm reduction initiatives, programs, and services understand these limitations and use community wisdom and practice-based evidence as additional sources of knowledge.
Cultivate relationships	Relationships are of central importance to harm reduction. Harm reduction approaches, initiatives, programs, and services are relational, not transactional, and work to establish and support quality relationships between individuals, families, and communities.
Assist, not direct	Harm reduction approaches, initiatives, programs, and services support people on their journey towards positive change, as they define it. Support is based on what PWUD identify as their needs and goals (not what programs think they need), offering people tools to thrive.
Promote safety	Harm reduction approaches, initiatives, programs, and services actively promote safety as defined by the people they serve . These efforts also acknowledge the impact that law enforcement can have on PWUD (particularly in historically criminalized and marginalized communities) and provide services accordingly.
Engage first	Each community has different cultural strengths, resources, challenges, and needs. Harm reduction approaches, initiatives, programs, and services are grounded in the most impacted and marginalized communities. It is important that meaningful engagement and shared decision making begins in the design phase of programming. Equally important is bringing to the table as many individuals and organizations as possible who understand harm reduction and who have meaningful relationships with the affected communities.
Prioritize listening	Each community has its own unique story that can be the foundation for harm reduction work. When we listen deeply, we learn what matters. Harm reductionists engage in <i>active listening</i> — the act of inviting people to express themselves completely, recognizing the listener's inherent biases, with the intent to fully absorb and process what the speaker is saying.
Work toward systems change	Harm reduction approaches, initiatives, programs, and services recognize that trauma; social determinants of health, such as access to healthcare, housing, and employment; inequitable policies; lack of prevention and early intervention strategies; and social support have all had a responsibility in systemic harm.

Core Practice Areas

Core practices are effective methods for harm reduction that reflect community understanding, experience, strengths, and needs. There are six core practice areas: (1) safer practices; (2) safer settings; (3) safer access to healthcare; (4) safer transitions to care; (5) sustainable workforce and field; and (6) sustainable infrastructure.

While not an exhaustive list, Table 3 provides key strategies and links to resources.

Anyone in the United States can access free, direct technical assistance (in any of the core practice areas) from SAMHSA and CDC. SAMHSA's [harm reduction webpage](#) offers resources, including allowable expenses for its grants that support harm reduction activities.

Table 3. Core Practice Areas

Examples of Practices	Supporting Resources and Evidence (Research- and Practice-based)
Safer Practices: Education and support describing how to reduce risk; provision of risk reduction supplies and materials	
Needs Based Syringe Services Programs (SSPs) — also referred to as syringe exchange programs (SEPs) and needle exchange programs (NEPs),* including secondary exchange. ^{1,17,19,22,26,27,28,29}	CDC Syringe Services Programs Technical Package SAMHSA TIP 33 Treatment for Stimulant Use Disorders SAMHSA TIP 63 Medications for Opioid Use Disorder
Safer smoking supplies/ distribution to reduce infectious disease transmission.* ^{29,30,31} *As permitted by law. No federal funding is used directly or through subsequent reimbursement of grantees to purchase pipes. Grants include explicit prohibitions of federal funds to be used to purchase drug paraphernalia.	CDC Stimulant Guide
Overdose education, overdose detection services, and naloxone distribution. ^{10,13,26,29,32}	CDC Lifesaving Naloxone Guide SAMHSA What is Naloxone? SAMHSA TIP 63 Medications for Opioid Use Disorder SAMHSA Opioid-Overdose Reduction Continuum of Care Approach (ORCCA) Practice Guide 2023 Engaging Community Coalitions to Decrease Opioid Overdose Deaths Practice Guide 2023

Examples of Practices	Supporting Resources and Evidence (Research- and Practice-based)...(Cont.)
Drug-checking education, fentanyl test strips, xylazine test strips and other assay test strips, FTIR spectrometers, and other drug-checking technology at community drug-checking sites. ^{33,34}	CDC MMWR: Rapid Analysis of Drugs: A Pilot Surveillance System to Detect Changes in the Illicit Drug Supply to Guide Timely Harm Reduction Responses Overdose Data to Action: Surveillance Strategies Drug Overdose CDC Injury Center SAMHSA Federal Grantees May Now Use Funds to Purchase Fentanyl Test Strips
Integrated reproductive health education, services and supplies, and sexually transmitted infection screening, prevention, and treatment. ^{35,36,37,38}	SAMHSA TIP 33 Treatment for Stimulant Use Disorders
Onsite access or immediate accessible referral to basic wound care supplies and services in the community. ³⁸	Wound Care & Medical Triage for People Who Use Drugs and the Programs That Serve Them NASTAD CDC Syringe Services Program Technical Package
Safer Settings: Access to safe environments to live, find respite, practice safer use, and receive supports that are trauma-informed and stigma-free	
Day centers and social spaces that offer harm reduction services, are low barrier, and are led and maintained by the communities they serve. ³⁹	SAMHSA Peer Support Services in Crisis Care
Access to safe and secure housing. ^{33,40}	SAMHSA Homeless & Housing Resource Center
Public health programs as alternatives to arrest and any legal system involvement. ^{20,41}	SAMHSA Criminal and Juvenile Justice Resources
Hybrid recovery community organizations providing peer-delivered harm reduction and recovery support services. ⁴²	Peer Recovery Center of Excellence

Examples of Practices	Supporting Resources and Evidence (Research- and Practice-based)...(Cont.)
Safer Access to Healthcare: Ensuring access to person-centered and non-stigmatizing healthcare that is trauma informed, including FDA-approved medications	
Low-barrier treatment services that offer a whole-person approach and rapid re-initiation, if needed. ⁴³	SAMHSA Practical Tools for Prescribing and Promoting Buprenorphine in Primary Care Settings
Flexible provision of services that offer medication starts at first visit or at home, choice of medications, and individualized dosages. ⁴⁴	SAMHSA Practical Tools for Prescribing and Promoting Buprenorphine in Primary Care Settings
Healthcare settings and providers are directly informed by harm reduction principles, pillars, and the people they serve. ^{45,46,47}	SAMHSA Engaging Community Coalitions to Decrease Opioid Overdose Deaths Practice Guide 2023
Nonpunitive care that consistently offers the standard of care in a nonstigmatizing, nonjudgmental manner and does not refuse healthcare based on stigma or personal beliefs about PWUD. ⁴⁸	Overcoming Stigma, Ending Discrimination
Mobile access and take-home methadone medication. ^{49,50,51,52}	SAMHSA Methadone Take-Home Flexibilities Extension Guidance
Mobile buprenorphine services, including telehealth options for initiation and continuity of care. ^{53,54,55,56}	SAMHSA The Physical Evaluation of Patients Who Will Be Treated with Buprenorphine at Opioid Treatment Programs
Access to new paradigms of care, including treatment specific to the use of all drugs and/or each drug. ^{57,58}	SAMHSA Treating Concurrent Substance Use Among Adults
Onsite or quick referral, low-barrier oral health services that are informed by lived experience of substance use. ⁵⁹	Oral Health, Mental Health and Substance Use Treatment

Examples of Practices	Supporting Resources and Evidence (Research- and Practice-based)...(Cont.)
Safer Transitions to Care: Connections and access to harm-reduction-informed and trauma-informed care and services	
Health hubs for PWUD/ integrated HIV, viral hepatitis, and healthcare services. ^{26,38,60,61,62,63,64}	Center of Excellence for Integrated Health Solutions CDC HIV Risk Reduction Tool
Expand telehealth, while also addressing low technology literacy and enhancing access in languages other than English. ⁵⁴	SAMHSA Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders SAMHSA Culturally Competent LEP and Low-literacy Services
Warm hand-off to and from emergency department programs — with low-barrier MOUD initiation and post- overdose services. ^{38,65}	SAMHSA Connecting Communities to Substance Use Services: Practical Tools for First Responders ACA Expanding Access to Medications for Opioid Use Disorder in Corrections and Community Settings
Medication access and treatment on-demand (abstinence not required). ^{26,66,67,68}	SAMHSA Practical Tools for Prescribing and Promoting Buprenorphine in Primary Care Settings CDC Linking People with Opioid Use Disorder to Medication Treatment
Onsite or immediate referral to accessible nutritional assistance, clothing, temporary shelter, and housing. ⁶⁵	SAMHSA Homeless & Housing Resource Center SAMHSA Expanding Access to and Use of Behavioral Health Services for People Experiencing Homelessness
Seamless coordination of care for individuals leaving carceral settings and treatment settings that do not offer medications, because people are at greatly heightened risk for overdose fatality when back in the community. ⁶⁵	SAMHSA GAINS Center ACA Expanding Access to Medications for Opioid Use Disorder in Corrections and Community Settings SAMHSA Best Practices for Successful Reentry from Criminal Justice Settings for People Living With Mental Health Conditions and/or Substance Use Disorders

Examples of Practices	Supporting Resources and Evidence (Research- and Practice-based)...(Cont.)
Sustainable Workforce and Field: Resources for maintaining a skilled, well-supported, and appropriately managed workforce and for sustaining community-based programs	
Organizational leadership from people with living and lived experience. ²⁶	ASPE Methods and Emerging Strategies to Engage People with Lived Experience SAMHSA Participation Guidelines for Individuals with Lived Experience and Family NHRC Peer Delivered Syringe Exchange (PDSE) Toolkit SAMHSA TIP 64: Incorporating Peer Support into Substance Use Disorder Treatment Services
Living wages and essential benefits for harm reduction workers. ^{69,70}	SAMHSA National Model Standards for Peer Support Certification
Wellness services and support for harm reduction staff and volunteers without mandated abstinence. ^{39,71}	SAMHSA National Model Standards for Peer Support Certification
Training and technical assistance for community-based providers. ³⁸	SAMHSA Practitioner Training
Include harm reduction expertise and lived expertise in the selection process of reviewers for harm reduction grants and other competitive processes. ⁷²	SAMHSA Grant Review Process
Sustainable Infrastructure: Resources for building and maintaining a revitalized and community-led infrastructure to support harm reduction best practices and the needs of PWUD	
Hire and appropriately compensate PWUD to inform policy at agencies that serve PWUD. ⁷³	SAMHSA National Model Standards for Peer Support Certification
Co-leadership of PWUD in organizational partnership in research. ⁷⁴	SAMHSA National Model Standards for Peer Support Certification
Promote education on the value of harm reduction services. ^{26,75, 76,77,78,79}	CDC/SAMHSA National Harm Reduction Technical Assistance Center SAMHSA Harm Reduction SAMHSA National Model Standards for Peer Support Certification

Community-Based Harm Reduction Programs (CHRP)

While integrating harm reduction (as an approach and as services) into a wide variety of settings is beneficial to the people who are served and impacted by them, SAMHSA is committed to supporting harm reduction organizations that are by and for their community — as they are mission critical for connecting to our communities' most marginalized individuals.

CHRP describe harm reduction organizations where people with lived and living experience lead the planning and oversight, program development and evaluation, and resource/funding allocation for an organization's harm reduction initiatives, programs, and services. CHRP also offer the core practice areas, as permitted by law. Harm reduction activities may be integrated into a comprehensive, person-centered program of care that includes treatment services that meet the specific needs of the community in which the program is housed.

In addition to programs being consistent with all aforementioned principles and pillars, CHRP should include people with lived experience as co-investigators in any research project. Boards, staff, and team members should be at least 51 percent those with lived experience. CHRP demonstrate meaningful connection to PWUD in their community, especially to communities most marginalized, and provide lowest-barrier, core harm reduction practices.

Conclusion

The Harm Reduction Summit was a groundbreaking event that engaged a diversity of perspectives across the fields of prevention, treatment, recovery, and harm reduction. More than 100 participants attended the Summit, representing the private sector, community-based organizations, health care, faith-based organizations, academia, researchers, funders, law enforcement, and leaders from federal, state, local, and tribal governments.

The subsequent Steering Committee synthesized and refined the Summit findings, providing guidance for this Framework. Moving forward, this Framework will inform SAMHSA's harm reduction activities, as well as related policies, programs, and practices. SAMHSA's aim is to integrate harm reduction activities and approaches across its organizational Centers and initiatives, and to do so in a manner that draws on evidence-based practice and principles — while also maintaining sustained dialog with harm reductionists and PWUD.

SAMHSA is committed to continued collaboration with PWUD and the field to put this Framework into practice, support and expand harm reduction approaches and services, and ultimately save lives.

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SAMHSA's mission is to lead public health and service delivery efforts that promote mental health, prevent substance misuse, and provide treatments and supports to foster recovery while ensuring equitable access and better outcomes.

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