FACT SHEET MARCH 2026

Harm Reduction Approaches to Supporting Clients with Past or Current Substance Use in Medical Respite Settings

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

INTRODUCTION

Substances — including alcohol, tobacco, marijuana, illicit drugs like cocaine, and manufactured drugs like fentanyl — are widely used in the United States, with 16.8% of Americans age 12 and older having a past-year substance use disorder in 2024. In the same year, only one in five people (19.3%) needing substance use treatment received it, demonstrating a need for increased treatment services and improved access.[1]

The prevalence of both past and active substance use make substance use disorders a common comorbidity among people receiving medical respite care, and lack of access to treatment makes medical respite care especially important for people with co-occurring medical and substance use needs.

Given the importance of these services, it is essential that medical respite programs understand and can apply evidence-based harm reduction models to support people with substance use disorders. These models can include medication-based supports, behavioral supports, program policies to promote safety and client-centered care, and access to resources like safer use supplies and naloxone for overdose support.

Stays in medical respite offer an excellent opportunity for clients to consider engaging in substance use treatment or modifying their use. The stability of medical respite programs – providing medical supports and consistent access to lodging, food, and medications – can actively facilitate clients' desired behavior changes and substance use goals, even if their goal is not complete abstinence.

Harm reduction approaches and practices have been shown to reduce overdose risk and result in improved recovery outcomes when compared to abstinence-only based interventions. Because clients may fall along a continuum of recovery – ranging from active use, to recent recovery, to long-term abstinence and to relapse, it is important for all programs to be aware of these proven interventions, regardless of their specific policies on substance use.

Because clients may fall along a continuum of recovery — ranging from active use, to recent recovery, to long-term abstinence and to relapse — it is important for all programs to be aware of these proven interventions, regardless of their specific policies on substance use.

FUNDING NOTE

This resource was developed in partnership with the United Healthcare Foundation as part of a project focused on expanding capacity for behavioral health services in medical respite care programs.

SUBSTANCE USE AND EXPERIENCE OF HOMELESSNESS

Experiences of homelessness and substance use are related for many people.[2,3] Substance use challenges can be a factor in the loss of housing, and the trauma and insecurity of homelessness can lead to the start of substance use, increased use, or using new substances. While statistics about the prevalence of substance use among people experiencing homelessness are varied, in general people experiencing homelessness have a higher prevalence of substance use compared to the general population. [3,4] Studies using existing data have shown that drug overdose is a leading cause of death among people experiencing homelessness across all age groups, and especially for those under the age of 45. [5,6]

As with the general population, people experiencing homelessness may use substances for a variety of reasons, including pleasure, to ease social anxiety, for stress relief, to cope with difficult situations, or due to dependence and withdrawal avoidance. Experiences of homelessness also create unique drivers of substance use and difficulty accessing treatment, including:

Safety concerns: Staying outside can be dangerous, and some people use substances like stimulants in order to stay awake to protect themselves and their belongings.

Experiences of trauma: Homelessness itself is considered a traumatic experience, and people often use substances as a coping mechanism or to treat mental health symptoms.

Lack of stability: It is very difficult to be consistent with treatment and recovery from substance use when basic needs like shelter and food are not being met.

Decreased access to care: Challenges such as inconsistent access to transportation, lack of medical insurance or inability to pay co-pays, lack of photo identification, and inconsistent access to a phone can make it difficult to access consistent care and substance use treatment.

Stigma and discrimination: People may face stigma based on their housing status and substance use, and past experiences of poor treatment can lead people to avoid or delay care, even if they are interested in stopping or decreasing use.

WHAT IS HARM REDUCTION?

Harm reduction is an approach to substance use that seeks to reduce potential harms related to using substances, regardless of whether someone is ready to completely stop using or not. Harm reduction approaches can be applied beyond substance use to other health behaviors.

Harm reduction recognizes that substance use occurs across a spectrum; safer use, reductions in use, abstinence, and relapse all have a place in harm reduction approaches. Harm reduction is responsive to individuals' personal substance use goals and supports creative and collaborative problem solving to reach them.

Harm reduction approaches intentionally make treatment and recovery services easier to access and easier to stay engaged with; these approaches are often referred to as "low-threshold" or "low-barrier" services.

Harm reduction approaches intentionally make treatment and recovery services easier to access and easier to stay engaged with.

WHY IMPLEMENT HARM REDUCTION APPROACHES?

Decades of research have demonstrated that harm reduction approaches are effective. Harm reduction practices like low-threshold buprenorphine treatment programs, managed alcohol programs, making naloxone available to reverse opioid overdose, and syringe service and safer use programs are effective at reducing overdose,[7] decreasing the spread of infectious diseases,[8] improving rates of entry to health care and treatment,[7] increasing treatment initiation and treatment longevity,[9,10,11] and decreasing stigma.[12,13]

Harm reduction approaches are consistent with patient-centered care models that promote autonomy and shared decision-making in health care, which also align with the Guiding Principles for Medical Respite Care.

Harm reduction directly addresses and works to reduce stigma in health care settings by accepting where people are with their substance use, listening to their goals and concerns, and co-creating a plan to reduce potential harms and reach substance use goals. Individuals interested in changing their pattern of substance use frequently integrate harm reduction tools and approaches as core strategies during their journey to safer use. Harm reduction also helps to recognize that people who use substances may still be motivated to address other health conditions or concerns, and a harm reduction approach can create access to meeting those goals.

Harm reduction focuses on safety and decreasing the potential for harm. This approach can apply beyond individual clients to the community of residents and staff in a medical respite, providing a framework for balancing individual and community needs and addressing concerns through open communication and clear program guidelines.

A harm reduction approach allows a much more diverse community – one that is more reflective of the overall community of people experiencing homelessness – to access medical respite care and receive needed supports, including substance use treatment. The ability to address medical conditions within a medical respite program may also facilitate access to long-term [inpatient] substance use treatment, which often requires addressing acute medical needs first.

Even in abstinence-only programs it is important to know how best to respond to relapse and substance use in ways that promote recovery, improve safety, decrease stigma and shame, and allow people to remain in care and continue receiving services.

IMPLEMENTING HARM REDUCTION STRATEGIES IN MEDICAL RESPITE SETTINGS

Beyond understanding the philosophy and general approach of harm reduction, it is important to understand the specific strategies and implementation practices that put harm reduction into practice. Principles and practices specific to medical respite settings are explored below, including examples of applicable interventions and policies.

1. Fostering Open Communication About Substance Use

Asking questions about past and current substance use and sharing information on medical respite policies and resources related to substance use can begin even before program admission. Pre-admission conversations with referral sources, admission paperwork, and information gathered at program intake are all a time to ask routine questions about health history, including past and current substance use and any treatment and/or withdrawal needs.

Admission is also a time to review medical respite policies with regards to intoxication and substance use on site, focusing on the importance of individual, community, and staff safety, as well as the process for any policy violations.

This is also a time that referrals can be made to outpatient treatment services or that in-house medications like buprenorphine or nicotine patches, or medications to manage withdrawal, can be prescribed. Following the low-threshold treatment model, the start of treatment or withdrawal management should not carry an expectation that clients will completely abstain from any substance use moving forward (though policies regarding no use on-site may be in place). Identification of the need for ongoing medication to reduce or address withdrawal is important for clients' health and safety, as is education on the increased risk for overdose after hospitalization.

Example Interventions and Policies:

- Include routine questions about past and current substance use as part of admission and intake using non-judgmental questions and emphasizing that these questions are for support and safety of the client.
- Create pathways for easy referral to substance use treatment resources for anyone who is interested, including methadone and outpatient programs.
- Create internal procedures for the rapid initiation of outpatient medication treatment options (for example buprenorphine or naltrexone) upon admission, either using on site clinical staff or through organizational partnerships.
- Create internal protocols for the initiation of withdrawal supports, including medications, for those who are interested.
- Work with referring hospitals to initiate medication treatment options prior to discharge and ensure continuation upon medical respite admission, either through internal prescribing or supporting external referrals.
- Work with referring hospitals to manage acute withdrawal prior to medical respite admission and create care plans for ongoing management of symptoms and treatment.
- Support staff in promoting open communication about substance use, medical respite policies around substance use, and how policy incursions are handled, for example through conversation guides or training.

2. Developing Relevant Policies and Related Procedures to Address Substance Use

It is important to develop policies around each program's harm reduction approach that reflect organizational values. Policies may pertain to program admission and the inclusion of people with substance use history, active use, or recent recovery. Policies should also reflect how admission and intake will address current treatment and withdrawal needs, overdose response procedures, setting up ongoing supports at program discharge, and how policy incursions related to substance use will be handled.

Example Interventions and Policies:

- Develop policies regarding substance use on site, possession of substances and drug use supplies on site, and intoxication on site.
- Develop alternatives to storing substances on site, for example using amnesty boxes for safe disposal or storage, or the use of locked personal storage facilities within the medical respite.
- Develop partnerships with other organizations that could provide needed services for active use or relapse that are not provided by the medical respite program. For example:
  - Safe spaces where people under the influence can spend time (during the day) such as drop-in centers, sobering centers, or harm reduction spaces
  - Safer use and harm reduction supplies
  - Harm reduction based or low-threshold substance use treatment and supports
  - Supports for relapse, including referrals to treatment options, counseling and groups, or other supports
- Develop policies to manage substance use-related incidents or rule violations, including shared care planning and behavior change plan development, options for increased supports (including through external partners), and how to manage repeat incidents. Options for increased supports might look like:
  - Referral/linkage to medication assisted treatment modalities, or starting those treatments through medical respite program staff
  - Referrals to more intensive outpatient substance use treatment, such as a day program that would allow the person to remain in medical respite care
  - Working with clients to develop strategies to address substance use cravings while in the medical respite setting, for example creating a list of people to reach out to if experiencing cravings (including staff), or attending a support group or meeting on or off-site
- Develop treatment protocols for medical respite providers to address substance use related needs like interest in treatment or need for withdrawal support. Similar protocols for when on-site prescribing is not available could support staff in making decisions around referrals for similar services.
- Develop discharge policies, for both planned and unplanned/early discharge, that include management of any substance use needs, including warm handoff to ongoing treatment and a medication supply at discharge (as applicable).
- Policies and staff training for how to respond to overdose or suspected overdose events on site, including provision of naloxone that is accessible by staff and residents.
- Implement fall risk prevention strategies overall, and targeted interventions for people who may be using substances, for example making sure assistive devices are within reach, clearing any clutter from personal spaces, placement of grab bars/rails in hallways, bathrooms.

3. Maintaining Individual and Community Safety

Harm reduction is a welcoming and non-judgmental approach that aims to make medical respite care accessible to a wider range of people, including those with current, recent, or past substance use. Harm reduction is also focused on safety and risk reduction overall, and having a harm reduction approach does not mean that programs cannot have rules in place, such as no substance use on-site, that keep both individuals and the entire community – including staff – safe.

Harm reduction approaches call for thoughtfully and flexibly balancing the priorities of access to care and safety with the needs of the entire community, including other residents who may be impacted by things like intoxication on site. Programs can use policies and a community-oriented approach to help strike this balance.

Harm reduction approaches call for thoughtfully and flexibly balancing the priorities of access to care and safety with the needs of the entire community.

Example Interventions and Policies:

- Clear program rules and expectations for behavior that facilitate a safe environment; these expectations apply regardless of whether or not someone is using. Such expectations can help staff guide interactions and de-escalation, and treat all medical respite residents equitably.
- Open communication about substance use and challenges within the community, including providing forums for community discussions or groups related to substance use and recovery. Community conversations focus on the community in general or on proposed policies, not on the actions of single individuals.
- Use of affinity-groups to provide supports, for example facilitation of support groups for those in recovery or supporting access to similar off-site groups.
- Developing policies and processes for conflict resolution between residents and making residents aware of these resources at intake. These approaches can go beyond just addressing issues related to substance use.
- Development of policies and training for staff on working with people who use drugs or who are under the influence, including de-escalation, overdose response, and psychological safety for staff.
- If a medical respite allows people who have recently used to be on-site, creating "sober spaces" (e.g. a communal space for watching television) that will remain safe for those in recovery who do not want to be around active use.
- Creating mechanisms for review of current policies and practices related to substance use so that staff can bring up concerns or ideas to improve how the program functions. These reviews can also help programs adapt to changes that may be occurring as a result of changes in supply or substances used by the community.
- Provide resources like sharps containers on site so that if on-site use does occur, improperly disposed of supplies like pipes and syringes do not pose a risk to other residents and staff.

4. Providing Responsive Supports

A key component of a harm reduction approach is providing patient-centered supports and shared decision-making around people's health and substance use goals. Substance use disorders are chronic conditions, and as with other chronic conditions, people usually need ongoing support and treatment that is appropriate and responsive to specific needs. As with conditions like diabetes or mental illness, people with substance use disorders will have periods of managing the condition well and other times of increased struggle and difficulty. Medical respite programs can work to develop care plans that address substance use goals among overall medical, behavioral health, and social/housing goals.

Example Interventions and Policies:

- Include discussions of substance use history, current substance use or needs, and goals around substance use as part of care planning at admission and ongoing through a medical respite stay.
- In completing care planning, consider how substance use has or is impacting a person's overall health, how – if at all - it is impacting their ability to reach other health goals related to their stay at medical respite, and how – if at all – it presents any safety concerns based on behaviors. Use information gathered to create a responsive and personalized care plan.
- Identify co-occurrence of pain and advocate for adequate pain management treatment; adequate pain management can support a person's desire to decrease use of non-prescribed substances.
- Utilize policies related to rule violations or behavior-related incidents, including with regards to substance use, as a way to revisit and develop behavior plans; include regular check-ins on progress and challenges.
- Create discharge plans that address each person's medical, behavioral health, and social needs, including substance use. This might look like health education on overdose risk, providing naloxone at discharge, and connecting people with treatment supports and harm reduction services.

STRATEGIES FOR SUPPORTING PEOPLE WHO MAY BE INTOXICATED

While state and federal law prohibits on-site substance use, it is possible that programs may experience people being intoxicated, or believed to be intoxicated, on site (having used elsewhere). This can occur regardless of a program's policy on active substance use during program participation. There are several strategies to consider to support individuals, staff, and the medical respite community should on-site intoxication occur. While people may display different behaviors depending on the substance(s) used, what is most important is focusing on safety and responding to any symptoms or challenges a person may be experiencing. Each individual and situation is unique, and it is important to remember that clinical/professional judgement must be used when assessing intoxication, in particular determining if something is an emergency. Consider the following strategies to help manage substance-use related behaviors:

- Always involve emergency medical services if you believe the person is at immediate risk of serious harm or death
- Ask two questions regarding the person and situation:
  - Is the individual safe?
  - Is the person currently behaviorally appropriate to be where they are right now?
- Increase wellness checks on people who may be intoxicated or who staff are concerned about
- Talk with the person about your observations and/or concerns and ask what might be supportive; this could include a discussion of what substance(s) were used

- Utilize de-escalation and re-directing techniques for people who may be agitated, for example suggesting people move to a private space or out of common areas if being overly loud or disruptive
- Provide emotional support, both to the intoxicated person and to community members who may be impacted
- Support and facilitate people's right to feel safe in common spaces; this might look like asking an intoxicated person to move to another area (with support) or go outside (if appropriate)
- For people who have used sedating substances (for example alcohol, benzodiazepines, or opioids):
  - Monitor for sedation/over-sedation; confirm the availability and access of naloxone and respond if concern for overdose
  - Reduce fall risk, for example by removing obstacles or having the person sit down
- For people who have used stimulants (for example cocaine or methamphetamines):
  - Reduce additional stimuli, for example by having the person move to a quiet location
  - Promote hydration and snacks
  - Provide reassurance if the person is feeling paranoid or at risk

The immediate response to intoxication should be focused on safety and support rather than on discipline.

Addressing instances of substance use, developing a client agreement or behavior plan, and/or making decisions about disciplinary actions should occur once the person is no longer intoxicated and when they are calm and ready to engage. The immediate response to intoxication should be focused on safety and support rather than on discipline.

TALKING ABOUT SUBSTANCE USE

People can sometimes be nervous or uncomfortable when bringing up substance use or asking what can feel like personal or potentially stigmatizing questions. In general, there are several strategies that can make any potentially difficult conversation easier:

- Allow adequate time for the conversation. In many cases, the first opportunity to discuss substance use may be before or at admission to medical respite.
- Sit down with the person and position yourself so you are at their level (not standing or sitting above them, if possible).
- Give the person your full attention and minimize interruptions, including minimizing typing on a computer, looking at a screen, and writing extensively, if possible.
- Focus on open-ended questions rather than yes-no questions to allow the person to provide their story and perspective.
- Provide explanations for why you are exploring particular questions or topics.
- Share that the conversation is ongoing and open, as clients may be more willing to share additional information as they build trust and rapport with medical respite program providers.

The following can be helpful when asking specifically about substance use:

- Be careful not to imply or openly demonstrate judgement or stigma in your questions or how you respond to people's answers.
- Normalize substance use history as a part of a person's health history. Substance use history, current use, and treatment history are just as important as chronic illnesses like asthma or diabetes and any surgical or hospitalization history.
- Explain why substance use history is important. For example, "We want to make sure we support all of your needs, including if you want support with recovery goals, getting treatment or help with withdrawal, or other supports for substance use."
- Explain that it is not necessary to disclose everything/anything during the first conversation, and that support will be available if and when they feel ready to talk about it or need help.
- Within the medical respite setting, explore if substance use is related to managing any symptoms of physical or mental health conditions, which may help with identifying follow-up providers or advocating for care (e.g. help with sleep, pain, mental health symptoms).
- Approach conversations with an open mind, caring, and curiosity. Provide space for people to tell their story and share their concerns and hopes.

CONCLUSION

Harm reduction is an evidence-based approach that has been shown to reduce stigma, promote safer substance use, reduce overdose, and support entry to treatment. By employing harm reduction practices, medical respite programs can provide services to a wider range of people that better reflects the population of people experiencing homelessness. Medical respite care presents a unique opportunity for people to experience stability and consistent medical support along with the ability to address substance use goals and safer substance use.

ADDITIONAL RESOURCES

- NHCHC: Foundations of Harm Reduction and Substance-Specific Guidelines
- NHCHC: Harm Reduction in Medical Respite Care
- NHCHC: Promising Practices – Providing Behavioral Health Care in a Medical Respite Setting
- NHCHC: Principles of De-Escalation
- NHCHC: Psychological Safety for Health Care for the Homeless Settings Webinar
- NHCHC: Buprenorphine and Overdose Prevention
- SAMHSA's Homeless and Housing Resource Center: Low Barrier Shelter Fact Sheet and Webinar
- SAMHSA's Homeless and Housing Resource Center: Getting Started with Contingency Management
- National Harm Reduction Coalition: Understanding Naloxone

1 Substance Abuse and Mental Health Services Administration. (2025). Key substance use and mental health indicators in the United States: Results from the 2024 National Survey on Drug Use and Health (HHS Publication No. PEP25-07-007, NSDUH Series H-60). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/data-we-collect/nsduh-national-surveydrug-use-and-health/national-releases

2 Assaf, R. D., Morris, M. D., Straus, E. R., Martinez, P., Philbin, M. M., & Kushel, M. (2025). Illicit substance use and treatment access among adults experiencing homelessness. JAMA, 333(14), 1222. https://doi.org/10.1001/jama.2024.27922

3 Coombs, T., Abdelkader, A., Ginige, T., Van Calster, P., Harper, M., Al-Jumeily, D., & Assi, S. (2024). Understanding drug use patterns among the homeless population: A systematic review of Quantitative Studies. Emerging Trends in Drugs, Addictions, and Health, 4, 100059. https://doi.org/10.1016/j.etdah.2023.100059

4 Doran, K. M., Rahai, N., McCormack, R. P., Milian, J., Shelley, D., Rotrosen, J., & Gelberg, L. (2018). Substance use and homelessness among emergency department patients. Drug and Alcohol Dependence, 188, 328–333. https://doi.org/10.1016/j.drugalcdep.2018.04.021

5 Han, B. H., Doran, K. M., & Krawczyk, N. (2022). National trends in substance use treatment admissions for opioid use disorder among adults experiencing homelessness. Journal of Substance Abuse Treatment, 132, 108504. https://doi.org/10.1016/j.jsat.2021.108504

6 National Health Care for the Homeless Council. (2024). Mortality and homelessness. https://nhchc.org/wp-content/uploads/2024/11/mortality-and-homelessness.pdf

7 Razaghizad, A., Windle, S. B., Filion, K. B., Gore, G., Kudrina, I., Paraskevopoulos, E., Kimmelman, J., Martel, M. O., & Eisenberg, M. J. (2021). The effect of overdose education and Naloxone Distribution: An umbrella review of systematic reviews. American Journal of Public Health, 111(8), 1516–1517. https://doi.org/10.2105/ajph.2021.306306a

8 Broz, D., Carnes, N., Chapin-Bardales, J., Des Jarlais, D. C., Handanagic, S., Jones, C. M., McClung, R. P., & Asher, A. K. (2021). Syringe Services Programs' role in ending the HIV epidemic in the U.S.: Why we cannot do it without them. American Journal of Preventive Medicine, 61(5). https://doi.org/10.1016/j.amepre.2021.05.044

9 Lyle, V., Harris, S., Heidari, O., Boulton, K., Hulsey, E., Saloner, B., & Gibbons, J. (2024). Association between high-threshold practices and buprenorphine treatment termination. International Journal of Drug Policy, 124, 104318. https://doi.org/10.1016/j.drugpo.2024.104318

10 Payne, B. E., Klein, J. W., Simon, C. B., James, J. R., Jackson, S. L., Merrill, J. O., Zhuang, R., & Tsui, J. I. (2019). Effect of lowering initiation thresholds in a primary care-based buprenorphine treatment program. Drug and Alcohol Dependence, 200, 71–77. https://doi.org/10.1016/j.drugalcdep.2019.03.009

11 Patterson, A., Davis, Z., Smith, M., Adebayo, N., Perez, M., Guzman, M., Griffin, T., Watson, D., Poorman, E., Karnik, N. S., & Messmer, S. (2025). Low-threshold buprenorphine in non-traditional settings: A scoping review. Substance Use: Research and Treatment, 19. https://doi.org/10.1177/29768357251371854

12 Frankeberger, J., Gagnon, K., Withers, J., & Hawk, M. (2022). Harm reduction principles in a Street Medicine Program: A qualitative study. Culture, Medicine, and Psychiatry, 47(4), 1005–1021. https://doi.org/10.1007/s11013-022-09807-z

13 Fraimow-Wong, L., Martín, M., Thomas, L., Giuliano, R., Nguyen, O. K., Knight, K., & Suen, L. W. (2024). Patient and staff perspectives on the impacts and challenges of hospital-based harm reduction. JAMA Network Open, 7(2). https://doi.org/10.1001/jamanetworkopen.2024.0229

NATIONAL HEALTH CARE *for the* HOMELESS COUNCIL

ABOUT NHCHC

The National Health Care for the Homeless Council is the premier national organization working at the nexus of homelessness and health care. Grounded in human rights and social justice, the NHCHC mission is to build an equitable, high-quality health care system through training, research, and advocacy in the movement to end homelessness. Visit nhchc.org to learn more.