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Harm Reduction Street Outreach (HRSO) project:

The 2022 - 2024 Final Evaluation Report

Submitted to:

The State of Indiana Division of Mental Health and Addiction (DMHA)

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PROGRAM BACKGROUND

Harm Reduction Street Outreach Teams

The Division of Mental Health and Addiction (DMHA) received funding from the Substance Abuse Mental Health Services Administration (SAMHSA) Prevention and Treatment Block Grants for COVID-19 relief and Opioid Settlement Funds. There is a great need for harm reduction services in the state of Indiana and this need has been exacerbated by the COVID-19 pandemic. With this funding, Rutgers University has overseen the evaluation of 18 harm reduction street outreach teams across the state of Indiana. Since the 1950s street outreach programs have addressed issues such as homelessness, violence, and disease prevention. Outreach teams informed by the philosophy and practice of harm reduction have demonstrated the ability to connect vulnerable persons who use drugs to health care services (Regis et al., 2020). Through the DMHA, the state of Indiana is funding the implementation of 18 harm reduction street outreach (HRSO) teams for three-years (January, 2022 – December, 2024). Table 1 provides a list of teams and their locations throughout this period. The HRSO teams are consist of one supervisor and at least two outreach (some teams have up to 8) workers who engage with community members to provide information on and referrals to substance use treatment services and wraparound services and distribute harm reduction kits.

Table 1: HRSO Providers

Team name	**Main Location**	**Y1-Y2**	**Y3**
AIDS Ministries/Health Plus Indiana	South Bend	Yes	Yes
The Artistic Recovery/Three20 Recovery	Chesterton	Yes	Yes
Fayette County Connection Café	Connersville	Yes	Yes
Gateway to Hope	Lafayette	Yes	No
Recovery Café Lafayette/Gateway to Hope	Lafayette	No	Yes
Indiana Recovery Alliance	Bloomington	Yes	Yes
Open Door Health Services/Muncie Folk Collective	Muncie	Yes	Yes
project.ME	Fort Wayne	Yes	Yes
The Never Alone Project	Indianapolis	Yes	Yes
We Bloom (Recovery Café Fulton County)	Rochester	Yes	No
We Bloom (Recovery Café Indy)	Indianapolis	Yes	No
Aspire/Step Up	Indianapolis	No	Yes
Damien Center	Indianapolis	No	Yes
Gary Harm Reduction	Gary	No	Yes
Healthy Communities of Clinton County Coalition	Frankfort	No	Yes
Holding Space Recovery	Austin	No	Yes
Imani Unidad	South Bend	No	Yes

Role of the Evaluation Team

Researchers from Rutgers, The State University of New Jersey, School of Social Work, and Wayne State University, Center for Behavioral Health and Justice were contracted by DMHA to conduct an evaluation and performance assessment of the current cycle of Substance Abuse Block Grant funding via the American Rescue Plan Act spanning January 2023 – October 2024. The purposes of the evaluation and performance assessment are to document the progress, successes, and challenges encountered during the implementation of the HRSO teams projects; identify strengths and challenges of the project; monitor performance on

targets established by the research team and DMHA; and to make recommendations for program improvements. A multi-methods evaluation design was utilized which is detailed in the Methods Section below. throughout the project, the evaluation team managed data for all HRSO teams, provided assistance and facilitated training in collaboration with the training and technical assistance (TTA) providers to HRSO teams, and reported findings to DMHA as requested.

Organization of the Report

This report describes the comprehensive evaluation activities of the HRSO teams which occurred from January 2022 – October 2024, and details HRSO teams' knowledge and acceptability of harm reduction and successes, challenges, and lessons learned. In the following section, an overview of the evaluation methodology, including qualitative and quantitative data sources and procedures, is presented. Next, findings from the evaluation study are discussed. The report ends by discussing conclusions and provides a review of the evaluation activities for future HRSO and other harm reduction interventions and programs recommended by the HRSO teams for DMHA and the State of Indiana to implement if interested in expanding harm reduction services across the state.

METHODS

The evaluation team conducted a multi-methods evaluation to assess the HRSO teams program consisting of three primary data sources: a monthly harm reduction kit distribution tracking sheet; a pre-survey and post/pre survey; and virtual learning meetings. Evaluation activities were approved by Rutgers IRB (#2022001629).

Harm Reduction Kit Tracking Sheets

At the outset of the HRSO project, each team was given a data collection tool to self-report outreach data. this tool was created to record each instance of interfacing with individuals during street outreach, and to keep count of how many harm reduction kits were distributed during those interactions. A "harm reduction kit" refers to pre-made resources that reduce risk of injury or infection among people who use drugs. Kits were assembled independently by each HRSO team based on the specific needs of their communities and reflected needs shaped by seasonal changes. Common harm reduction resources provided in the kits included, at minimum, naloxone, sterile water, and other local resources (e.g., food pantries, shelters, treatment centers). The kit tracking sheet also captured date of interactions, zip code where these interactions took place, and whether any emergency services were present and/or called for assistance.

Data were collected and submitted to the research team monthly and represent street outreach interactions occurring between January 1, 2022, and October 31, 2024. There was approximately 1% missingness where select monthly trackers were not sent by HRSO teams to the research team. Data were extensively cleaned to facilitate descriptive statistics reporting. For quality assurances purposes, descriptive statistics were uniformly exported into Excel to reduce the likelihood of transcriptions.

Pre-Survey and Post/Pre-Survey

The evaluation team created two brief online surveys via Qualtrics to ascertain HRSO teams' knowledge and attitudes regarding harm reduction practices and their experiences providing harm reduction services. The pre-survey was administered between December 2021 and January 2022 (N=31) and the post/pre survey was administered between September 2023 and October 2023 (N=16). The post/pre survey, or retrospective post-test, was used to measure participants perceived changed, particularly if self-evaluations were too generous in the pre-survey.

Both surveys included questions generated by the evaluation team to capture HRSO team members' self-assessment of harm reduction knowledge and comfortability in practicing and advocating for harm reduction as well as the Harm Reduction Acceptability Scale (HRAS). Only the pre-survey included the Brief Opioid Overdose Knowledge (BOOK) Questionnaire, and only the post/pre survey included two additional questions assessing program impact (see Appendix D). Both surveys were self- administered and submitted anonymously. Reponses were divided by survey section and questions that were left blank in any one section were excluded from analysis.

Self-Assessment of Harm Reduction Knowledge, Practice, and Advocacy

Questions to capture HRSO team members' self-assessment of harm reduction knowledge included questions about the number of harm reduction training hours, familiarity with harm reduction concepts and strategies, and programs and policies. (See Appendix A.) To capture HRSO team members' self-assessment of their comfortability in harm reduction practice, we asked how comfortable they felt utilizing harm reduction concepts and strategies in their day-to-day street outreach work. To capture self- assessment of comfortability in harm reduction advocacy, we asked how comfortable they felt discussing harm reduction concepts and strategies with their colleagues and then with community members.

Harm Reduction Acceptability Scale

The Harm Reduction Acceptability Scale (HRAS) is a 25-item measure used to ascertain attitudes towards harm reduction (Goddard, 2003). (See Appendix B.) Use of HRAS questionnaire scores have shown evidence of accurately identifying whether an individual has been exposed to information about harm reduction, as opposed to the more common (abstinence-based) approach used in the United States (Goddard, 2003).

Brief Opioid Overdose Knowledge Questionnaire

The Brief Opioid Overdose Knowledge (BOOK) questionnaire is a 12-item instrument that measures an individual's knowledge relevant to opioid use, opioid overdose, and responding to an opioid overdose (Dunn et al., 2016). (See Appendix C.) The BOOK questionnaire was given in the pre-survey but excluded from the post/pretest, as the true/false format is incompatible with the intention of capturing perceived growth.

Learning Meetings

Due to the lack of geographic proximity among teams, learning meetings were held virtually. The

evaluation team facilitated the learning meetings with HRSO teams to assess ongoing barriers, program successes, and technical assistance via harm reduction TTA providers. Data collection of the learning meetings was conducted by May who attended each learning meeting as an observer while Porath facilitated. During the learning meetings, May scribed detailed notes of the challenges, concerns, and successes as shared by HRSO team members. Field notes were coded and analyzed by the evaluation team using an iterative categorization methodology. Specifically, coding definitions were refined and revisions to the coding scheme based on emergent themes and consultation between the evaluation team and in concert with the TTA providers. Coding was completed by the evaluation team, all of whom are trained in qualitative data analysis. Primary themes from successes and challenges in engaging in HRSO work as well as TTA focus areas that were discussed at each learning meeting are presented below.

RESULTS

Results from evaluation data collection activities are presented below, starting with cumulative (Y1-Y3) reporting of the harm reduction kit tracking sheets, followed by results from the post/pre survey which, when possible, includes comparisons between items administered in the pre-survey, and finally, concludes with a thematic analysis of the learning meetings.

Harm Reduction Kit Tracking Sheets

Among the 18 Indiana-based street outreach teams there were 115,792 kits distributed during street outreach between January 1, 2022 and October 31, 2024. Due to cohort changes at Year 3, this number does not reflect three full years of distribution for all teams. Of that group, eight teams did outreach for all three years, two teams distributed in Y1-2 and did not continue into FY-2024, and eight grant recipients were added in Year 3.

The minimum number of kits distributed by a single grant recipient was 596 and the maximum reported was 34,310 (see Table 2). There were 39 recorded interactions between street outreach teams and emergency services from January 2022 through October 2024 which included 16 interactions with law enforcement, nine interactions with EMS, eight calls to 911, and five calls to a crisis line. There were 172 unique zip codes reported as serviced by street outreach teams from January 2022 through October 2024, with three as the minimum number of zip codes serviced by a single team throughout the project, and 39 as the maximum number of zip codes.

Table 2. Aggregated kit distribution among HRSO teams (*N*=18)

	Total	Minimum*	Maximum*
Kits distributed	115,792	596	34,310
Zip codes serviced	124	3	39
Kits distributed/month	3,406 (mean)	0	2,690

Note. *=by any one team

The original ten teams reported distributing 21,427 kits during the first ten months of HRSO activities, compared to 26,718 kits distributed by the eight new teams onboarded for Year 3. There are several factors that may be considered when assessing the increase in distribution among the newer cohort additions: fewer COVID-19-related staffing and supply chain disruptions in 2024 compared to 2022, more established HRSO technical assistance at the outset of the new teams' involvement, and increased awareness and

acceptance of harm reduction across the state may have contributed to this difference.

HRSO teams were provided an open text field within the kit tracking sheet to document their reflections on any successes and challenges encountered during outreach each month. Common challenges for the teams included, extreme temperatures, the COVID-19 pandemic (including supply chain disruptions) and other health/personal impacts on team members, maintaining strong relationships with unhoused communities after encampments were displaced by law enforcement, and stigma from the community. Successes shared by teams included the creation of new community partnerships, participation at community events, creating self-serve/anonymous naloxone pickup locations, providing community-based naloxone trainings, and developing a perceived sense of trust and gratitude from the communities serviced. Staffing was the most prominent issue brought up in both categories. Many teams shared that they struggled with hiring, high turnover, and staff working reduced hours due to COVID-19 and other health concerns. Conversely, once new staff were hired and trained, their presence and positive contributions were often celebrated as that month's major success.

Post/Pre Survey Results

There were 16 respondents representing nine HRSO organizations who submitted a post/pre survey. One team was not sent the survey due to HRSO nonadherence as communicated to the evaluation team by DMHA. Of eligible respondents, approximately 67% of HRSO team members completed the post/pre survey; however, high staff turnover makes total number of possible participants at the time of survey dissemination difficult to track precisely. Of the 16 respondents, four were HRSO administrators, nine were HRSO street outreach team members, and three performed both roles.

Self-Assessment of Harm Reduction Knowledge, Practice, and Advocacy

All respondents who completed the section on harm reduction knowledge and familiarity reported that they were either moderately or very familiar with harm reduction at the time of completing the survey, with none reporting a lack of familiarity with these concepts. Specifically, 100% reported they were "very familiar" with harm reduction concepts and strategies, 93% reported that they were "very familiar" with harm reduction programs and policies, and 80% were "very familiar" with programs and policies specific to Indiana. Out of a maximum possible score of 1.0 representing the highest expression of harm reduction knowledge and familiarity, the average score was 0.97, compared to an average score of 0.73 representing respondents' retrospective assessment of their knowledge prior to participation in HRSO. The 0.24-point increase was found to be statistically significant.

When reflecting on comfortability utilizing and advocating for harm reduction strategies, 100% of respondents reported that they were "very comfortable" doing so among all three social categories (i.e., clients, colleagues, and communities), giving an average score of 1.0. Participants scored themselves at an average of 0.78 when reflecting on their comfortability having these discussions prior to HRSO engagement. The 0.22-point increase was also found to be statistically significant. The retrospectives pieces of both sections of this self-

assessment were quite similar to the actual scores gathered from this section in the pre-survey (0.62 compared to 0.73 on knowledge, and 0.84 compared to 0.78 on comfort with advocacy).

Harm Reduction Acceptability Scale

Out of a maximum possible score of 1.0 representing the highest alignment with harm reduction attitudes regarding drug use and recovery support, the average score among survey respondents at the time of completion was 0.90, or generally high alignment with HR attitudes. Respondents retrospectively scored their attitudes similarly highly, at an average of 0.85, and the perceived change after program participation was not found to be statistically significant. Notably, the HRAS score from the pre-survey was much lower, at an average of 0.69. This may represent respondents overestimating their alignment with HR attitudes prior to program participation.

Self-Assessment of Program Impact

Respondents generally favored at least some program impact on HR knowledge and attitudes. 77% of participants responded that changes in their responses in the post/pre-evaluation of the previous sections of the survey could either "somewhat" or "mostly" be attributed to HRSO participation. The same proportion, 77%, reported that engagement with the learning meetings either "somewhat" or "mostly" inspired participants' efforts to use harm reduction strategies in their work.

Thematic Analysis of Successes, Challenges, and Topics Discussed in the Learning Meetings

During Years 1 and 2 of the project, eleven learning meetings occurred during the grant period and took place every other month between January 2022 and September 2023. The structure and content of the learning meetings evolved throughout the grant period, but in May 2022 (at the third learning meeting) they were formatted to include a combination of case presentation followed by a focused TTA session on a specific harm reduction and/or street outreach topic. Regarding the case presentation, 3 to 4 HRSO teams were asked by the evaluation team in advance of the learning meeting to present a case study about a client or situation. Using pseudonyms and withholding any other identifiable information HRSO teams considered sensitive to the client, each of the presenting HRSO team had approximately 10 minutes to informally share a situation with a client that they perceived as either a successful or challenging. A 10–15-minute large group discussion followed each HRSO teams' case presentation. The group discussion included shared celebration of team's successes, problem-solving of team's challenges, resource sharing, and oftentimes, disclosure from other teams of similar challenges. As hoped, case presentations often led to robust discussions around harm reduction street outreach tactics, trends, and ideologies. Furthermore, the case presentation format seemed to aid in building information sharing networks between HRSO teams as well as afford the TTA providers opportunities to deliver relevant and direct feedback on successes and challenges, and follow-up with teams separately on issues particular to that team. This format also seemed to increase participant willingness to share more personal perspectives and experiences. While some teams shared positive updates in the July 2023 learning meeting, the focus of this meeting was to obtain HRSO teams' feedback on the HRSO project and suggestions for directions for future HRSO projects. During the September 2023 learning meeting, the

evaluation team presented HRSO team members' feedback to ensure accurate representation and understanding of their recommendations. These recommendations are presented in the Next Steps section.

For the third year of HRSO, fourteen learning meetings occurred during the grant period between February and October 2024. The meetings held in February through May included all HRSO teams; however, due to the sheer number of organizations and attendees, the teams were split evenly into two separate monthly meetings to foster more collaboration and conversation. Thus, the remaining meetings were held bimonthly from June through October.

Initially, the meetings were formatted to include a combination of case presentation followed by a focused TTA session on a specific harm reduction and/or street outreach topic. Regarding the case presentation, 3 to 4 HRSO teams were asked by the evaluation team in advance of the learning meeting to present a case study about a client or situation. Using pseudonyms and withholding any other identifiable information HRSO teams considered sensitive to the client, each of the presenting HRSO team had approximately 10 minutes to informally share a situation with a client that they perceived as either a successful or challenging. A 10–15-minute large group discussion followed each HRSO teams' case presentation. The group discussion included shared celebration of team's successes, problem-solving of team's challenges, resource sharing, and oftentimes, disclosure from other teams of similar challenges.

In June, we strategically shifted away from case presentations in favor of more structured learning meetings where TTA providers offered expertise on best practices and established harm reduction standards with the teams. These still meetings provided valuable opportunities for HRSO team members to engage with TTA providers, ask questions, discuss challenges, and share their own best practices.

Learning Meeting Case Presentation Themes

Two main themes emerged during the learning meetings: 1) Engagement with local community organizations to build increased accessibility to overdose prevention resources, and 2) Managing fatal overdose, drug-related morbidity, and xylazine exposure. Subthemes included challenges in advocacy with the coroner's office, law enforcement, and healthcare systems to improve the treatment of people who use drugs.

Theme 1: Engagement with Local Community Organizations and Organizing Secondary Distribution Networks

HRSO teams made notable progress in building relationships with local organizations and community members to establish resources to allow for additional overdose prevention interventions. Successful outreach efforts included partnerships with hotels, smoke shops, bars, and even industrial construction sites, where harm reduction resources like naloxone were made available. One team described their collaboration with a local church, where harm reduction resources were distributed alongside food offerings. Another highlighted the success of former unhoused participants who became employees and helped recruit new participants. Over time, these efforts expanded to more marginalized communities, such as the unhoused, with new members even joining the HRSO Advisory Board to provide peer-to-peer outreach and contribute valuable insights. However, challenges persisted in some areas, particularly with property managers who resisted the distribution of harm reduction resources. For instance, a hotel manager expressed reluctance to allow naloxone distribution for fear it would signal an acceptance of drug use, while

another manager limited resources to hygiene kits. Despite these setbacks, teams viewed these interactions as initial steps toward building relationships that would foster greater support in the future.

Theme 2: Managing Fatal Overdose, Drug-Related Morbidity, and Xylazine Exposure

The second key theme focused on the growing concerns surrounding fatal overdoses, drug-related morbidity, and the rise of xylazine and other novel synthetic drugs in the drug supply. HRSO teams reported an increasing demand for sterile syringes, which were not funded by the current project, as they observed rising rates of infectious diseases like HIV and Hepatitis. One team faced resistance in their community to implementing a syringe disposal box, despite expressed support from local officials for addressing these issues.

Teams also shared their challenges in addressing the emergence of xylazine-related injuries. Xylazine has contributed to a rise in severe wounds and infections, particularly among individuals who refuse medical care. To address these concerns, TTA providers offered training on wound care, basic medical care, and responding to hypothermic participants, especially during cold weather. Recommendations included providing water-wicking clothing, muscle wraps, and warming resources to unhoused participants.

Additionally, teams were advised to involve medical professionals when signs of severe illness, such as disorientation or discoloration, appeared in participants. Many teams also noted a rise in overdose deaths linked to xylazine, with some participants experiencing wounds unrelated to injection drug use.

NEXT STEPS

This report details the activities and related outcomes of the HRSO pilot project that is supported by the DMHA. Overall, there is evidence to suggest that the HRSO teams have expanded access to harm reduction services and materials across the state of Indiana. In addition, there is evidence that HRSO teams gained valuable knowledge during the learning meetings, particularly on stimulant use and symptoms consistent with a stimulant-induced overdose, responding to emergent changes in the drug market (e.g., xylazine), access to naloxone and proper naloxone administration, confronting fentanyl misinformation, adapting harm reduction kits to seasonal changes, expanding HRSO services to include Hepatitis C testing and linkages to treatment, and interacting with the general public and institutions that may be uninformed about harm reduction.

During the final two learning meetings, the evaluation team facilitated a discussion with HRSO teams to understand changes they would recommend to future DMHA-funded HRSO projects. The main takeaway from these conversations was to encourage DMHA to shift from funding a portion of harm reduction activities (i.e., harm reduction street outreach) to funding full-fledged harm reduction practitioners across the state. These activities include furthering ongoing relationship building with other organizations and communities to ensure the availability of overdose prevention resources, ongoing professional development through education, training, and networking (e.g., funding to attend harm reduction conferences), increasing HRSO teams' capacity for data entry and data quality checks, and to provide robust case management for participants who elect for these supportive services.

Of note, this project is the first of its kind to dedicate funds for self-care, a component highly valued by the HRSO teams as it provided resources for self- and team-care activities, which they would typically lack time and resources to facilitate. HRSO teams were clear that these activities would not only improve the work of harm reductionists across the state but decrease the likelihood of burnout as HRSO team members would be engaged in a variety of tasks, which can offset the demands of outreach work. Future research should continue to explore effective methods for increasing public support for vital harm reduction services amid a historically fatal overdose crisis (Ahmad et al., 2023; Kulesza et al., 2015; Strickland et al., 2022). HRSO teams also advocated for improvements to funding HRSO work that supports a variety of purposes. If funding were made available, there was a consensus among the HRSO teams that there is a theoretical need for additional technology (e.g., drug checking equipment) and training to use these technologies. These services are not currently funded through this program. The reasoning for drug checking equipment is centered on the idea that if community members can access nearly real-time information about the illicit drug supply, then they can make a more informed decision about there drug use, thus decreasing the risk of overdoses in the state (Alexander et al., 2022; Wong et al., 2008).

HRSO teams also discussed the need for services and resources needed to meet the growing public health demands of the overdose crisis. Teams recommend that increasing staff funding so HRSO team members are employed full- time would not only further build harm reduction capacity throughout the state, but would relieve ongoing concerns regarding staffing turnover and, through providing support for full-time employees with benefits, would finally provide these harm reduction health workers, who are engaged in improving public health, with healthcare themselves.

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APPENDICES

Appendix A: Self-Assessment of Harm Reduction Knowledge, Practice, and Advocacy

1. How familiar are you with harm reduction concepts/strategies? (not at all familiar, slightly familiar, moderately familiar, very familiar, extremely familiar)
2. How familiar are you with harm reduction programs and policies? (not at all familiar, slightly familiar, moderately familiar, very familiar, extremely familiar)
3. How familiar are you with harm reduction programs and policies in Indiana? (not at all familiar, slightly familiar, moderately familiar, very familiar, extremely familiar)*
4. How comfortable do you feel utilizing harm reduction concepts/strategies in your day-to-day practice with clients? (extremely uncomfortable, somewhat uncomfortable, somewhat comfortable, extremely comfortable)
5. How comfortable do you feel discussing harm reduction concepts/strategies with your colleagues at work? (extremely uncomfortable, somewhat uncomfortable, somewhat comfortable, extremely comfortable)
6. How comfortable do you feel discussing harm reduction concepts/strategies with other people in your community who may not work in substance use treatment? (extremely uncomfortable, somewhat uncomfortable, somewhat comfortable, extremely comfortable)

Appendix B: Harm Reduction Acceptability Scale[2]

For each of the items, indicate the number that corresponds to your personal attitude (not necessarily the policy of your workplace).

strongly agree (1), agree (2), neither agree nor disagree (3), disagree (4), strongly disagree (5)

1. People with alcohol or drug problems who will not accept abstinence as their treatment goal are in denial.
2. It is not acceptable to teach injecting drug users how to use bleach to sterilize their injecting equipment.
3. A choice of treatment outcome goals (for example, abstinence, reduced use of drugs or alcohol, safer use of drugs or alcohol) should be discussed with all people seeking help for drug or alcohol problems.
4. People who live in government-funded housing must be drug and alcohol free.
5. Doctors should be permitted to prescribe heroin and similar drugs to treat drug addiction as long as doing so reduces problems such as crime and health risks.
6. Even if their drug use is stable, women who use illicit drugs cannot be good mothers to infants and young children.
7. Drug users should be given honest information about how illicit drugs may be used more safety (for example, how overdose or related health hazards may be avoided).
8. People with drug or alcohol problems who are not willing to accept abstinence as their treatment outcome goal should be offered treatment that aims to reduce the harm associated with their continued drug or alcohol use.
9. In most cases, nothing can be done to motivate clients in denial except to wait for them to "hit bottom."
10. It is acceptable to prescribe substitute drugs such as methadone to reduce crime and other social problems associated with illicit drug use.
11. Prisons should not provide sterilizing tablets or bleach in order for inmates to clean their drug injecting equipment.
12. As long as clients are making progress towards their treatment goals, methadone maintenance programs should not kick clients out of treatment for using street drugs.
13. Measures designed to reduce the harm associated with drug or alcohol use are acceptable only if they eventually lead clients to pursue abstinence.
14. People with drug and alcohol problems may be more likely to seek professional help if they are offered at least some treatment options that do not focus on abstinence.
15. The prescription of substitute drugs such as methadone should be forbidden.
16. People whose drug use is stable should be trained to teach other drug users how to use drugs more safely (for example, how to inject more safely).
17. Making clean injecting equipment available to injecting drug users is likely to reduce the rate of HIV infection.
18. Abstinence is the only acceptable treatment option for people who are physically dependent on alcohol.
19. It is possible to use drugs without necessarily misusing or abusing drugs.
20. Pamphlets for educating drug users about safer drug use and safer sex should be detailed and explicit, even if these pamphlets would be offensive to some people.
21. Opiate users should only be prescribed methadone for a limited period of time.
22. Drug injectors who are not willing to accept abstinence as a treatment goal at the beginning of treatment should be given easy access to clean injecting equipment to reduce the spread of HIV and other blood-borne

diseases.

23. Women who use illicit drugs during pregnancy should automatically lose custody of their babies.
24. People with alcohol or drug problems should be praised for making changes such as cutting down on their alcohol consumption or switching from injectable drugs to oral drugs.
25. Abstinence is the only acceptable treatment goal for people who use illicit drugs.

Appendix C: Brief Opioid Overdose Knowledge Questionnaire[3]

Instructions: For each of the following items, please circle whether you believe the answer is TRUE or FALSE. If you are not certain, please circle "I DON'T KNOW".

1. Long-acting opioids are used to treat chronic "round the clock" pain.	True	False	I Don't Know
2. Methadone is a longacting opioid.	True	False	I Don't Know
3. Restlessness, muscle andbone pain, and insomnia are symptoms of opioid withdrawal.	True	False	I Don't Know
4. Heroin, OxyContin, and fentanyl are all examples of opioids.	True	False	I Don't Know
5. Trouble breathing is NOT related to opioid overdose.	True	False	I Don't Know
6. Clammy and cool skin is NOT a sign of an opioid overdose.	True	False	I Don't Know
7. All overdose are fatal (deadly).	True	False	I Don't Know
8. Using a shortacting opioid and a long-acting opioid at the same time does NOT increase your risk of an opioid overdose.	True	False	I Don't Know
9. If you see a person overdosing on opioids, you can begin rescue breathing until a health worker arrives.	True	False	I Don't Know
10. A sternal rub helps you evaluate whether someone is unconscious.	True	False	I Don't Know
11. Once you confirm an individual is breathing, you can place him/her into the recovery position.	True	False	I Don't Know
12. Narcan (naloxone) will reverse the effect of an opioid overdose.	True	False	I Don't Know

Appendix D: Assessment of Program Impact

(Added in 2023 to post/pre survey)

1. If your ratings for the previous questions showed change from before HRSO and today, to what extent were those changes a result of your participation in the program, as opposed to other experiences in your life? (unsure/my ratings did not significantly change, mostly other factors, somewhat this program and somewhat other factors, mostly this program)
2. We have used Learning Meetings to help accomplish our program goals, including education, building relationships, and showcasing the work and ideas of the cohort. To what extent have your efforts to use harm reduction strategies in your practice been inspired by your experiences in the learning meetings, as opposed to factors in other parts of your life? (unsure, mostly other factors, somewhat this program and somewhat other factors, mostly this program.