

University of Rochester

Journal for Law, Politics &

Foreign Policy

Volume I | Issue I
Spring 2026

Individual Article

Addressing Overdose Through Harm
Reduction: A Policy Approach to
Health Equity
Ella Klopfer



UofR



Addressing Overdose Through Harm Reduction: A Policy Approach to Health Equity

Ella Klopfer

University of Rochester

Amid rising overdose deaths driven by fentanyl and polysubstance use, this paper evaluates harm reduction as an equity-oriented public health policy response. Using epidemiological data, existing harm reduction literature, and a local case study from Rochester, New York, the analysis highlights how stigma and criminalization shape both overdose risk and policy implementation. The paper argues for formal policy support of harm reduction as a necessary strategy to reduce preventable deaths and health disparities.

I. Background

The United States continues to face an escalating overdose crisis, driven largely by fentanyl and other synthetic opioids, cocaine, alcohol, and polysubstance use. Healthy People 2030 is a federal initiative led by the U.S. Department of Health and Human Services that sets science-based objectives to improve the health of Americans over the next decade. It identifies preventing substance use disorders and reducing overdose deaths as a national priority, making harm reduction strategies central to public health goals.¹⁰ Nationally, overdose deaths surpassed 100,000 annually in recent years, reflecting the scale of this crisis across the U.S. population¹. This makes overdose prevention one of the most urgent challenges in public health.

Harm reduction refers to a set of public health policies and practices designed to minimize the negative health, social, and legal consequences associated with substance use, without requiring abstinence as a condition for care.² Rather than focusing on eliminating drug use, harm reduction emphasizes pragmatic, evidence-based interventions that reduce immediate risk and promote dignity, autonomy, and engagement with health services. This approach challenges traditional zero-tolerance models by meeting people where they are. Examples include syringe service programs (providing sterile needles to prevent infections like HIV and hepatitis C), naloxone distribution (a medication that

reverses opioid overdoses), fentanyl/xylazine test strips, and managed alcohol programs. Internationally and nationally, harm reduction is recognized as an evidence-based strategy that saves lives. The Cochrane Review on managed alcohol programs notes that while more research is needed, early evidence suggests that these programs improve treatment engagement, reduce risky drinking practices, and enhance social functioning.⁷ These findings align with Healthy People 2030’s focus on expanding harm reduction access as a way to reduce overdose mortality and improve health equity.

II. Localizing the Overdose Crisis: Evidence from Monroe County

In Monroe County, a small county in northern New York where Rochester is located, this crisis is particularly severe. Overdose deaths increased from 346 in 2021 to 512 in 2023, a nearly 50% rise in just two years⁶. This surge reflects the dangers of fentanyl (present in more than 83% of cases) and the prevalence of polysubstance use, with most overdose cases involving a combination of opioids, cocaine, alcohol, or benzodiazepines.⁶ In Rochester, the overdose crisis reflects deep inequities. In 2023, Black residents represented nearly 40% of overdose deaths while making up just 16.5% of Monroe County’s population. Men were nearly three times more likely than women to die from overdose, and victims ranged in age from under 20 to 85 years, showing that substance use affects people across all stages of life.⁶

Year	Total Deaths	Median Age (range)	Gender (%)	Race/Ethnicity (% of overdose deaths)	% Hispanic (any race)	Key Substances Present
2021	346	~47 (<20–80+)	Male: 74% Female: 26%	White: 65.9% Black: 31.5% Asian: <1% Other: 1%	~9.5%	Fentanyl: 83% Cocaine: 70%
2022	406	~49 (<20–83)	Male: 74% Female: 26%	White: 63% Black: 35% Asian: 1% Other: 1%	~10%	Fentanyl: 83% Cocaine: 73%

2023	512	50 (<20–85)	Male: 74.2% Female: 25.8%	White: 59.0% Black: 39.6% Asian: 1.0% Other: 0.4%	10.4%	Fentanyl: 83.4% Cocaine: 77.7% Alcohol: 31% Xylazine: 14.1%
------	-----	-------------	--	--	-------	--

Figure 1: Overdose Deaths in Monroe County, 2021–2023

The patterns in Figure 1 show that the overdose crisis in Monroe County is deeply intertwined with broader social determinants of health. The disparities by age, race, and gender suggest that overdose is not simply the result of individual behavior but is shaped by structural inequities and environmental conditions. For example, the data reveal that overdose deaths disproportionately affect Black residents, who make up a much larger share of deaths compared to their share of the county population. This overrepresentation reflects the cumulative effects of systemic racism and unequal access to health services and safe environments. Similarly, the consistently high proportion of men among overdose victims highlights the ways that gendered patterns of drug use and barriers to care place certain groups at greater risk.

The presence of fentanyl in the overwhelming majority of cases, as well as the frequent co-involvement of cocaine, alcohol, and emerging substances like xylazine, underscores how the changing and unpredictable drug supply drives risk. These trends point to the urgency of harm reduction approaches that provide tools for safer use. Against this backdrop, Trillium Harm Reduction, based in Rochester, New York, plays a critical role in providing lifesaving services, support, and dignity to individuals and families affected by substance use.

III. Trillium Harm Reduction as a Community-Based Response

The mission of the Harm Reduction Services provided by Trillium Health, a community health center based in Rochester, is to be “safe, anonymous, non-judgmental⁹. This means every individual who enters their doors is treated with dignity, respect, and compassion. The organization operates as a hub for people who use drugs, their families, and the broader Rochester community. At Trillium, harm reduction extends beyond just a theoretical framework and is utilized as an everyday practice. Staff and volunteers provide essential tools, such as naloxone kits, fentanyl/xylazine test strips, syringe services, and connect clients to broader health and housing resources. Trillium promotes a stigma-free environment, which is vital for reaching those who are hesitant or fearful of

engaging with traditional health systems. Most importantly, clients are not required or expected to stop using substances in order to receive care, which allows Trillium to engage with a much larger demographic of users. Clients include individuals experiencing homelessness, long-term substance use, or unstable housing. Many are navigating complex barriers such as structural racism, trauma, or poverty that put them at higher risk for overdose. By offering a confidential and judgment-free space, Trillium allows clients to feel respected and supported, whether they are seeking immediate overdose prevention tools or longer-term pathways into treatment.

Trillium Harm Reduction's work exemplifies a broader shift in U.S. public health policy, moving away from criminalization and abstinence-only approaches toward harm reduction as a recognized best practice. Harm reduction acknowledges that substance use is shaped by the social determinants of health rather than individual behavior alone. By reducing the immediate harms associated with drug use, programs like Trillium also create opportunities for long-term healing and reintegration into the community. Policy support is critical to sustaining and expanding this work. Local and state governments can amplify Trillium's impact by expanding funding for naloxone distribution and fentanyl and xylazine test strips, supporting legislation that legalizes and protects syringe exchange programs, investing in managed alcohol and housing-first programs for people at the highest risk, and integrating harm reduction into mainstream healthcare and public health systems. Such policies align closely with Healthy People 2030 objectives and have the potential to reduce health inequities, prevent avoidable deaths, and decrease long-term healthcare costs. Supporting Trillium Harm Reduction ultimately means supporting a vision of Rochester where overdose deaths decline, stigma diminishes, and people who use drugs are seen as valued members of the community. Trillium's mission ensures that more lives will be saved and more individuals will have the chance to pursue treatment.

IV. Theoretical and Empirical Foundations of Harm Reduction

Building on the national and local context of the overdose crisis and Trillium Harm Reduction's mission to provide nonjudgmental care, it is important to situate this work within the broader body of public health research on harm reduction. While Trillium's approach is grounded in community practice, it is also strongly supported by a growing literature that frames harm reduction as an evidence-based, ethical, and equity-oriented intervention. In "Harm Reduction Principles for

Healthcare Setting,” author Mary Hawk outlines six key principles that guide harm reduction in healthcare: humanism, pragmatism, individualism, autonomy, incrementalism, and accountability without termination. These principles encourage providers to develop interpersonal relationships with the people they help, assisting in the acknowledgement that progress oftentimes happens gradually. Hawk and colleagues found that when providers adopt these principles, patients show greater trust and engagement, even if they are not ready to stop using substances². Trillium Harm Reduction reflects this approach through its commitment to being stigma-free and nonjudgmental. Staff respect each client’s autonomy and focus on immediate safety rather than abstinence, showing that harm reduction can create both trust and better health outcomes long term.

Research also highlights that harm reduction is most effective when led by communities themselves. Jill Owczarzak and others examined street-based peer outreach workers in Baltimore and found that peers viewed harm reduction not only as a survival tool but also as a way to rebuild dignity in communities stigmatized by drug use. Because these workers had personal lived experiences, they were able to connect with clients in ways traditional providers could not⁸. These relationships transformed harm reduction from a clinical service into a shared process of care. Trillium takes a similar approach, extending its work beyond the walls of the facility and into the community. Staff members regularly engage in off-site outreach, distributing harm reduction kits, warm clothing, blankets, and food throughout Rochester. These efforts exemplify meeting people where they are, both physically and emotionally. Many staff members are deeply rooted in the neighborhoods they serve, often recognizing clients on the street by name. This familiarity allows Trillium to create ongoing relationships that extend beyond service transactions. By combining on-site services with off-site engagement, Trillium reinforces the idea that harm reduction is not confined to a program or building, but is a living practice that thrives through connection and community involvement. Research provides further evidence for the effectiveness of harm reduction interventions through Levensgood et al.’s systematic review of supervised injection facilities, “Supervised Injection Facilities as Harm Reduction: A Systematic Review”. The authors found that these facilities consistently reduced overdose deaths and the transmission of infectious diseases without increasing drug use or community crime. They also reported that people who used supervised injection sites were more likely to engage with healthcare and pursue treatment options⁴. These findings show how safe, accessible spaces can serve as an essential bridge between marginalized individuals and formal systems of care. Although Trillium does not operate a supervised consumption site, the underlying principle is the

same. The organization's harm reduction hub serves as a safe, nonjudgmental space where people can access sterile syringes, naloxone, and testing materials while also building relationships with staff who can connect them to additional resources, such as supervised injection sites in Rochester, if that's what they need. The focus is not solely on reducing overdose risk, but on creating a welcoming environment where clients feel comfortable returning and receiving care long-term.

However, it's important to note that research shows that not all groups have equal access to these services. Katrina Milaney's research, "A scoping review of opioid harm reduction interventions for equity-deserving populations," reveals that opioid harm reduction programs are often underdeveloped for women, racialized communities, and Indigenous peoples. They argue that equity must be central to harm reduction policy, as systemic racism and stigma continue to limit access to care⁵. This finding is especially relevant to Monroe County, where overdose rates among Black residents remain disproportionately high. Trillium's open-door policy, emphasis on anonymity, and active outreach efforts allow it to reach individuals who might otherwise avoid healthcare systems out of fear or mistrust. In this way, the organization reflects what Milaney and colleagues describe as an equity-oriented model that actively challenges exclusion through accessibility and respect.

V. Practice-Based Insights from a Harm Reduction Setting

Together, these studies show that harm reduction succeeds when it is relational, inclusive, and community-based. The literature mirrors what I've seen firsthand as an intern at Trillium. During my internship, I observed several moments that captured how harm reduction is practiced in real life. One such moment occurred during a routine syringe exchange. A client came in, greeted me warmly, and asked for clean syringes. A staff member brought him to the back room, where I was able to observe the exchange. The interaction felt natural and equal, like a conversation between two people who knew each other and shared mutual trust. They sat together at the same table, looking eye to eye in a way that emphasized respect instead of hierarchy. They discussed supplies openly, without shame or judgment. When the client left, he stopped to talk to my supervisor, addressing her by name, catching up about life outside of Trillium. It was clear he felt comfortable and safe in that space. This encounter captured what Hawk et al. describe as the principles of humanism and autonomy². The care he received emphasized respect and placed the power in the hands of the client. What struck me most was that engagement itself was the intervention. The environment, tone, and respect shown by the

staff made it possible for the client to return and stay connected to care.

Another example that stands out to me was when I shadowed my supervisor using a vein reader. A vein reader is a device that helps clients identify safe injection sites on their body by projecting a map of their veins onto the machine. From there, staff can draw on their skin and mark the safest places for them to inject. The woman who came in had a very specific set of circumstances: she preferred to inject only in the veins on her upper thighs or vaginal area, so the marks wouldn't be visible to others. Rather than questioning or judging her choices, my supervisor used the vein reader to help her find safe access points that fit her preferences. This moment demonstrated harm reduction's principle of individualism and autonomy. Every person's experience, body, and needs are different. Trillium recognizes this, allowing clients to maintain control over their decisions. Instead of imposing a single definition of what care looks like, Trillium's staff worked collaboratively with the client to find a solution that made her feel both comfortable and empowered. What connects these examples is the consistent way Trillium centers care on the client. Every interaction I've observed begins with a choice: a greeting of "Hello, what can we do for *you* today?" or questions like "What kind of syringes do *you* need?" and "Would *you* like any kits?" These small but intentional phrases place power in the hands of the client, making them active participants in their own health decisions. These moments became the foundation for how I started to understand harm reduction on a deeper level. What I initially saw as individual examples of respectful care eventually revealed themselves as part of a much larger pattern. Trillium's approach is not defined by isolated interventions, but by a consistent practice that places power and autonomy in the hands of the clients. Together, these interactions illustrate how harm reduction at Trillium operates through relational care. Whether through individualized services like vein mapping or through everyday exchanges, Trillium, as well as other Harm Reduction institutions, consistently centers the lived experiences of the people it serves.

VI. A Push for Policy Support

The evidence presented in this paper, alongside my own experiences, underscores that harm reduction is not a marginal or experimental response to the overdose crisis, but a well-supported public health strategy that warrants sustained policy backing. At both the national and local levels, overdose deaths continue to rise despite decades of punitive, abstinence-only approaches. In Monroe County, the rapid increase in overdose mortality demonstrates the limitations of criminalization-

focused responses and highlights the need for interventions that reduce immediate risk while addressing structural inequities.

Research consistently shows that harm reduction interventions reduce overdose deaths and infectious disease transmission without increasing drug use or crime. Importantly, public opinion data challenges the assumption that harm reduction lacks political feasibility. In a U.S.-based study examining public support for federal funding of harm reduction strategies, Kulesza et al. found that a majority of respondents expressed support for needle and syringe programs and supervised injection facilities when these interventions were framed as evidence-based and lifesaving. Their study, “Correlates of Public Support Toward Federal Funding for Harm Reduction Strategies,” further demonstrated that support was strongly associated with lower levels of stigma toward people who inject drugs and a belief that individuals who use drugs deserve help rather than punishment³. Similarly, a large population survey conducted in Canada by Wild et al. reinforces these findings. In “Public Support for Harm Reduction: A Population Survey of Canadian Adults,” the authors found majority public support for several harm reduction interventions, including naloxone distribution, drug checking, needle distribution, and supervised drug consumption services¹¹. Their analysis shows that personal familiarity with and reduced social distance of people who use drugs significantly increased individuals’ support for harm reduction policy. Together, these studies suggest that opposition to harm reduction is not fixed, but shaped by stigma and political framing. Community-based organizations such as Trillium Harm Reduction illustrate how policy support can translate evidence into practice. Trillium’s low-threshold, nonjudgmental model aligns with the core principles identified in the harm reduction literature, while also addressing racial and socioeconomic inequities that characterize the overdose crisis in Rochester. However, organizations like Trillium operate within fragile policy environments, often reliant on limited funding streams and subject to shifting political priorities. Without explicit legal protections and stable public investment, the reach and sustainability of harm reduction services remain constrained.

Policy support for harm reduction should therefore move beyond rhetorical endorsement and toward concrete institutionalization. At the state and local level, this includes expanding dedicated funding for naloxone distribution and drug checking technologies; removing legal barriers to syringe service programs; supporting managed alcohol and housing-first models for individuals at highest risk; and formally integrating harm reduction services into public health and healthcare systems. At the federal level, aligning drug policy with Healthy People 2030 objectives requires reframing substance

use as a public health issue rather than a moral or criminal failing. Evidence from both U.S. and Canadian contexts suggests that policies grounded in public health, rather than punishment, not only save lives but also reduce long-term healthcare and criminal justice costs.

As the overdose crisis continues to evolve, jurisdictions that invest in harm reduction infrastructure will be better positioned to reduce mortality, address health inequities, and build pathways to care for people who use drugs. Trillium Harm Reduction offers a local model of what is possible when policy, evidence, and community-based practice align. Scaling such efforts through formal policy support is a necessary step toward a more effective and equitable response to the overdose crisis.

References

1. Centers for Disease Control and Prevention. (2023). Provisional drug overdose death counts. Retrieved September 17, 2024, from <https://www.cdc.gov/overdose/deaths>
2. Hawk, M., Coulter, R. W. S., Egan, J. E., Fisk, S., Friedman, M. R., Tula, M., & Kinsky, S. (2017). Harm reduction principles for healthcare settings. *Harm Reduction Journal*, 14(1), Article 70. <https://doi.org/10.1186/s12954-017-0196-4>
3. Kulesza, M., Teachman, B. A., Werntz, A. J., Gasser, M. L., & Lindgren, K. P. (2015). Correlates of public support toward federal funding for harm reduction strategies. *Substance Abuse Treatment, Prevention, and Policy*, 10(1), Article 25. <https://doi.org/10.1186/s13011-015-0022-5>
4. Levensgood, T. W., Yoon, G. H., Davoust, M. J., Ogden, S. N., Marshall, B. D. L., & Purington, N. (2021). Supervised injection facilities as harm reduction: A systematic review. *Preventive Medicine*, 150, 106662. <https://doi.org/10.1016/j.ypmed.2021.106662>
5. Milaney, K., et al. (2022). Opioid harm reduction interventions for equity-deserving populations: A scoping review. *Harm Reduction Journal*, 19(1), Article 18. <https://doi.org/10.1186/s12954-021-00599-y>
6. Monroe County Office of the Medical Examiner. (2023). 2023 overdose deaths in Monroe County annual report. Office of the Medical Examiner, Monroe County, New York.
7. Muckle, W., Muckle, J., Welch, V., & Tugwell, P. (2012). Managed alcohol programs for homeless populations: A systematic review. *Cochrane Database of Systematic Reviews*, (12). <https://doi.org/10.1002/14651858.CD008058.pub2>
8. Owczarzak, J., Dickson-Gomez, J., Saunders, E. C., & Tobin, K. (2024). A qualitative exploration of harm reduction in practice by street-based providers. *Harm Reduction Journal*, 21(1), Article 12. <https://doi.org/10.1186/s12954-024-01076-w>
9. Trillium Health. (n.d.). Harm reduction services. Retrieved September 17, 2024, from <https://www.trilliumhealth.org/patient-and-community-services/harm-reduction>
10. U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2020). *Healthy People 2030: Reduce drug overdose deaths*.

Retrieved September 17, 2024, from <https://health.gov/healthypeople/objectives-and-data/browse-objectives/drug-and-alcohol-use/reduce-drug-overdose-deaths-su-03>

11. Wild, T. C., Koziel, J., Anderson-Baron, J., Asbridge, M., Belle-Isle, L., Dell, C., ... Hyshka, E. (2021). Public support for harm reduction: A population survey of Canadian adults. PLOS ONE, 16(5), e0251860.
<https://doi.org/10.1371/journal.pone.0251860>

