KENTUCKY DEPARTMENT FOR PUBLIC HEALTH

Guidelines for Kentucky Local Health Department Harm Reduction Service Programs, 2026

Kentucky Public Health

Prevent. Promote. Protect.

Contents

Acknowledgments and Purpose Statement

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Purpose Statement: The purpose of the Guidelines for Kentucky Local Health Department Harm Reduction Service Programs is to provide a comprehensive framework for Local Health Departments (LHDs) in Kentucky to develop, implement, operate, and evaluate Harm Reduction Service Programs (HRSPs), including those operating with or without a Syringe Service Program (SSP). These Guidelines are intended to support LHDs in delivering evidence-based, participant-centered public health services that reduce overdose deaths, prevent the transmission of infectious diseases such as HIV and Hepatitis C, increase access to healthcare and social services, and improve health outcomes among People Who Use Drugs (PWUD). The Guidelines establish recommended practices related to program governance, participant rights,

community engagement, data collection, operational procedures, workforce training and safety, outreach, education, and linkage to care.

Executive Summary

HRSPs are evidence-based public health interventions designed to reduce overdose deaths, decrease the transmission of HIV and Hepatitis C, and improve access to healthcare and social services for PWUD. These Guidelines establish a comprehensive framework for LHDs in Kentucky to implement, operate, and sustain HRSPs, including SSPs, in accordance with Kentucky law, public health best practices, and evidence-based harm reduction principles.

Kentucky legalized SSPs through Senate Bill 192 in 2015, authorizing LHDs as the only entities permitted to operate syringe exchange programs within the Commonwealth following required local approvals. These Guidelines outline operational standards, participant protections, data collection expectations, occupational safety procedures, outreach practices, and linkage-to-care strategies intended to support safe, effective, and community-responsive program implementation.

The document emphasizes that harm reduction is a person-centered approach grounded in dignity, respect, autonomy, and low-barrier access to care. HRSPs recognize substance use as a complex public health issue and seek to reduce harms associated with drug use while empowering participants to define their own goals and pathways toward improved health and wellbeing.

The Guidelines further recognize the significant barriers experienced by PWUD, including stigma, housing instability, transportation challenges, limited healthcare access, and workforce shortages. Programs are encouraged to address these barriers through trauma-informed, culturally responsive, and community-centered approaches.

In addition to providing direct Harm Reduction Services, HRSPs serve as an important point of connection between participants and broader healthcare and social service systems. By fostering trust and reducing barriers to care, HRSPs create opportunities for increased engagement in preventive healthcare, treatment services, and recovery support.
Ultimately, these Guidelines are intended to assist Kentucky LHDs in developing sustainable, legally compliant, and evidence-based HRSPs that improve individual and community health outcomes, strengthen public health infrastructure, and save lives.

Legal Authority and Program Governance

Harm Reduction Service Programs (HRSPs) are evidence-based public health interventions intended to reduce overdose deaths, decrease the transmission of bloodborne infections such as HIV and Hepatitis C, and improve access to healthcare and social services for People Who Use Drugs (PWUD). Harm reduction incorporates practical strategies designed to meet individuals where they are while supporting participant-defined goals and positive change.

Pursuant to Kentucky law, Local Health Departments (LHDs) are the only entities authorized to operate Syringe Service Programs (SSPs). Senate Bill 192, enacted during the 2015 Kentucky General Assembly Regular Session and codified under KRS 218A.510, authorized LHDs to establish syringe exchange programs following approval from required governing bodies. Prior to the implementation of an SSP, an LHD shall obtain approval from:

- The Local Board of Health governing the LHD;
- The legislative body of the city, if located within city limits; and
- The county legislative body.

If the LHD has obtained all required approvals outlined above, it may partner with non-governmental organizations through a local memorandum of understanding to expand access to SSPs within its jurisdiction. The LHD must maintain full responsibility for and oversight of all services provided through such partnerships and ensure compliance with all applicable laws, regulations, and requirements.

Programs shall operate in compliance with:

- Applicable CDC recommendations;
- Kentucky Department for Public Health Clinical Service Guide;
- KRS 217.186;
- KRS 218A.500–218A.510;
- Local ordinances and administrative procedures; and
- OSHA Bloodborne Pathogen Standards.

LHDs should establish written operational procedures that include:

- Community engagement procedures;
- Documentation requirements;

- Fiscal accountability;
- Incident reporting;
- Program governance and oversight;
- Quality improvement processes; and
- Staff responsibilities.

All HRSPs should operate according to the following guiding principles:

- Cultural humility and responsiveness;
- Evidence-based and participant-centered practices;
- Low-barrier access to services;
- Recognition of the dignity and value of all individuals;
- Reduction of stigma and discrimination;
- Respect for participant autonomy and self-determined goals; and
- Trauma-informed approaches.

Participant Rights and Program Standards

HRSPs shall maintain written policies on Participant Rights and Program Expectations to ensure that services are delivered in a safe, respectful, and equitable manner. Participant rights should include:

- The right to access available services and harm reduction supplies;
- The right to be treated with dignity and respect regardless of race, ethnicity, gender identity, sexual orientation, national origin, religion, disability, housing status, or substance use history;
- The right to privacy and confidentiality to the fullest extent permitted by law;
- The right to receive information and education regarding overdose prevention, safer use practices, and infectious disease prevention;
- The right to receive services free from discrimination, harassment, threats, bullying, or intimidation;
- The right to receive trauma-informed and participant-centered care; and
- The right to request referrals to healthcare, behavioral health, treatment, housing, or social services.

Programs should clearly communicate participant expectations and responsibilities during enrollment and throughout service participation. Participant responsibilities should include:

- Following established safety policies and procedures;
- Maintaining the confidentiality of other participants;
- Properly disposing of used syringes;
- Refraining from illegal activity on LHD property;
- Refraining from threatening or violent behavior;
- Treating staff, volunteers, and other participants with respect; and
- Utilizing supplies for their intended purposes.

Programs should post Participant Rights and Expectations in visible service areas and provide accommodations for individuals with limited literacy or language barriers. Translation and interpretation services should be made available whenever feasible. Programs should utilize trauma-informed approaches, recognizing the impact of trauma, substance use stigma, discrimination, housing instability, poverty, violence, and systemic inequities on participant health and well-being.

Community Engagement and Assessing Needs

Successful implementation of HRSPs requires collaboration among community stakeholders, public health agencies, healthcare providers, behavioral health systems, recovery organizations, and individuals with lived and living experience. LHDs should engage stakeholders early and consistently throughout planning, implementation, and evaluation activities. Stakeholders may include:

- Community Mental Health Centers;
- Community outreach groups;
- Faith-based organizations;
- Federally Qualified Health Centers;
- Hospitals and healthcare systems;
- Housing organizations;
- Individuals directly impacted by substance use;
- Jails and correctional facilities;
- KY-ASAP Boards;

- Law enforcement agencies;
- Pharmacies;
- Public libraries;
- Recovery Community Organizations;
- Schools and universities;
- Small businesses; and
- Substance Use Disorder treatment providers.

Community readiness activities may include:

- Advisory boards;
- Community Health Assessments;
- Community Health Improvement Planning processes;
- Focus groups;
- Public meetings;
- One-on-one interviews; and
- Stakeholder surveys.

Programs should utilize epidemiological and local data to support implementation and funding opportunities. Relevant data sources may include:

- 2025 Kentucky Drug Overdose Fatality Report;
- Behavioral Risk Factor Surveillance System;
- Kentucky Drug Overdose and Related Comorbidities County Profiles, 2024;
- Kentucky Harm Reduction Services, 2024;
- Kentucky Hepatitis C Elimination Plan;
- Kentucky HIV/AIDS Surveillance Report, 2025;
- Kentucky Maternal Mortality Review, 2025 Report;
- Kentucky Minority Health Status Report, 2025;
- Kentucky Neonatal Abstinence Syndrome, 2025;
- Kentucky Resident Drug Overdose Deaths, 2020-2024 Report, County Data Appendices;
- Kentucky Resident Drug Overdose Deaths, 2020-2024 Report;

- Kentucky Resident Emergency Department Visits for Nonfatal Drug Overdoses, 2020-2024 Report;
- Kentucky Resident Emergency Department Visits for Nonfatal Drug Overdoses, 2020-2024 Report, County Appendices; and
- Kentucky State Health Improvement Plan 2024-2028.

Assessment of community needs should include consideration of the most impacted neighborhoods, populations with the greatest unmet needs, and areas with limited access to private or public transportation. When determining HRSP site locations, it is considered a best practice to use these assessments to guide decision-making while also engaging elected officials, nearby businesses, and community members to promote community awareness, support, and accessibility.

LHDs are encouraged to visit existing HRSPs in Kentucky to observe operational models, outreach practices, staffing structures, and community engagement strategies. Programs should also develop community education initiatives designed to reduce stigma and misinformation regarding harm reduction and evidence-based public health practices.

Funding and Program Sustainability

HRSPs should pursue funding through federal, state, local, philanthropic, and community-based sources. Programs should review all Notices of Funding Opportunities (NOFOs) to ensure compliance with allowable expenses, reporting obligations, and funding restrictions. Potential funding sources may include:

- Community donations;
- Federal grant opportunities;
- Foundation grants;
- Healthcare partnerships;
- Local government appropriations;
- National Opioid Settlement Funds; and
- State public health funding.

Kentucky's opioid settlement funds were established to support opioid remediation activities, including overdose prevention, harm reduction programming, treatment access, recovery services, and community-based prevention efforts. For additional information on Kentucky's opioid settlement funding, please visit the Kentucky Opioid Abatement Commission.

Programs should develop sustainability plans addressing:

- Community partnerships;
- Evaluation and reporting requirements;
- Long-term funding strategies;
- Mobile outreach costs;
- Staffing and workforce retention;
- Supply acquisition; and
- Volunteer coordination.

Programs are encouraged to cultivate partnerships supporting donations of:

- Backpacks and sleeping bags;
- Food and snacks;
- Harm reduction supplies;
- Hygiene products;
- Outreach materials; and
- Weather-related supplies.

Programs are encouraged to incorporate Community Health Workers, Peer Support Specialists, and individuals with lived and living experience as integral members of the harm reduction workforce. These individuals play a critical role in fostering trust, enhancing participant engagement, improving care coordination, and facilitating linkage to health, behavioral health, and social support services.

Data Collection and Program Evaluation

Programs should establish secure systems for collecting, storing, and reporting program data. The Kentucky Harm Reduction Services REDCap Project is the preferred statewide data collection platform administered by the Kentucky Department for Public Health. Data collection may include:

- Basic demographic information;
- Drug checking test strip distribution;
- HIV and Hepatitis C testing;
- Naloxone distribution;

- Participant encounters and outreach activities;
- Referrals provided;
- Syringes distributed and returned;
- Unique participant identifiers; and
- Wound care supplies distributed.

Programs not utilizing REDCap should submit aggregate quarterly reports to the Kentucky Department for Public Health Harm Reduction Branch at harmreduction@ky.gov. Programs should collect only data necessary for program operations, evaluation, funding requirements, and public health monitoring while not collecting personally identifiable information. Process monitoring activities should evaluate:

- Number of participant encounters;
- Outreach activities;
- Referrals provided;
- Services utilized;
- Supply distribution trends; and
- Syringes distributed and returned.

Outcome monitoring activities should evaluate:

- Changes in safer use practices;
- Community impact indicators;
- Linkage to care outcomes;
- Overdose prevention outcomes;
- Participant satisfaction; and
- Service accessibility.

Programs should utilize data to inform quality improvement, operational planning, funding applications, and stakeholder reporting.

Syringe Service Operations and Safety Procedures

Programs operating SSPs may utilize one or more syringe exchange models, including:

- Needs-based negotiated exchange: Under the needs-based negotiation model, an HRSP does not impose a strict limit on the number of sterile syringes distributed based on the

number of syringes returned. Instead, syringe distribution is guided by an assessment of the participant's individual needs, including injection frequency, risk behaviors, and the anticipated time until the participant can access services again. While participants are strongly encouraged to return used syringes for safe disposal, access to sterile supplies is not denied when returns are unavailable. Some programs may establish an upper distribution threshold for operational purposes; however, participants are generally permitted to access services as often as needed. This approach prioritizes harm reduction, overdose prevention, and the reduction of infectious disease transmission.

- One-for-one plus exchange: The one-for-one plus exchange model expands upon the strict one-for-one approach by allowing participants to receive additional sterile syringes beyond the number returned. Programs utilizing this model commonly provide a predetermined supplemental quantity of syringes regardless of the number returned. For example, a participant may receive 10 additional sterile syringes beyond the number exchanged, or may receive a baseline quantity even when no syringes are returned. Some programs also implement modified exchange ratios, such as two-for-one distribution up to a designated limit. This model seeks to balance safe disposal efforts with increased access to sterile injection equipment to reduce syringe sharing and other high-risk behaviors further.
- Strict one-for-one exchange: A strict one-for-one exchange model provides participants with the same number of sterile syringes as the number of used syringes returned for disposal. For example, a participant returning 14 used syringes would receive 14 new sterile syringes. Under this model, participants are typically unable to receive additional syringes without returning used syringes. To reduce the risk of syringe sharing and unsafe injection practices among new participants, some HRSPs may provide an initial starter supply of sterile syringes upon enrollment, even if no used syringes are available for return. This model emphasizes syringe accountability and safe disposal practices while supporting participant engagement in Harm Reduction Services.

Programs should evaluate syringe exchange models based on:

- Community needs;
- Funding limitations;
- Participant access barriers;
- Public health impact;
- Stakeholder support; and
- Syringe coverage goals.

Programs shall establish written procedures for:

- Incident response;
- Inventory management;

- Mobile outreach operations;
- Safe syringe collection and disposal;
- Supply storage;
- Syringe distribution; and
- Waste management.

Programs shall ensure proper disposal of used syringes and medical waste in accordance with OSHA standards and applicable environmental regulations. Programs should:

- Establish disposal vendor agreements when applicable;
- Provide disposal education to participants;
- Train staff in safe syringe handling procedures;
- Use caution if manually counting used syringes; and
- Utilize approved sharps containers.

Mobile outreach programs should maintain written operational and safety procedures addressing:

- Documentation requirements;
- Emergency response procedures;
- Participant confidentiality;
- Staff safety;
- Supply transportation; and
- Vehicle operation.

Occupational Health and Staff Safety

Programs shall implement policies and procedures designed to reduce occupational exposure to bloodborne pathogens and workplace safety risks. Programs shall consider the following training topics for staff:

- Annual infection control training;
- Bloodborne pathogen education;
- Emergency response procedures;
- Personal protective equipment (PPE);

- Post-exposure protocols; and
- Workplace violence prevention training.

Programs should maintain written procedures addressing:

- Exposure incidents;
- Medical emergencies;
- Mobile outreach safety practices;
- Needle-stick injuries;
- Overdose response; and
- Threatening behavior.

Programs should recognize the emotional demands associated with harm reduction work and implement workforce wellness strategies addressing:

- Burnout prevention;
- Clinical supervision;
- Peer support;
- Professional development;
- Secondary traumatic stress; and
- Staff retention.

Training topics should include:

- Cultural humility;
- Harm reduction principles;
- Motivational interviewing;
- Overdose prevention and naloxone administration;
- Participant engagement strategies;
- Safer use education; and
- Trauma-informed care.

Outreach, Enrollment, and Participant Engagement

Programs should utilize low-barrier, person-centered enrollment procedures designed to build trust and reduce barriers to participation. Enrollment procedures should:

- Ensure accessibility for individuals with language or literacy barriers;
- Explain confidentiality protections;
- Provide participant education regarding services;
- Refrain from collecting any personally identifiable information; and
- Utilize anonymous unique identifiers whenever possible.

Outreach services are a critical component of HRSP operations and may include:

- Community education;
- Harm reduction supply distribution;
- Linkage to healthcare and social services;
- Mobile outreach;
- Overdose prevention education;
- Peer-to-peer distribution; and
- Street outreach.

Outreach staff should maintain professional boundaries while fostering trust and rapport with participants. Programs should recognize barriers impacting participant engagement, including:

- Criminal justice involvement;
- Housing instability;
- Lack of identification documents;
- Mental health challenges;
- Stigma and discrimination; and
- Transportation limitations.

Programs are encouraged to meaningfully involve individuals with lived and living experience in program development, outreach, education, and advisory activities.

Clinical, Social, and Supportive Services

HRSPs provide opportunities to connect participants with healthcare, behavioral health, and supportive social services that may otherwise be difficult to access. Programs should facilitate access to:

- Behavioral health services;

- Employment resources;
- Food and clothing resources;
- HIV, Hepatitis B, Hepatitis C, STI, and TB testing;
- Housing support;
- Hygiene supplies;
- Legal services;
- Prenatal care;
- Primary care;
- Technology and communication access;
- Vaccinations; and
- Wound care services.

Programs should provide culturally and linguistically appropriate education addressing:

- Community resources;
- Infectious disease prevention;
- Overdose prevention;
- Safer sex practices;
- Safer use practices;
- Treatment options; and
- Wound care.

Programs should recognize structural barriers affecting participant health outcomes, including:

- Displacement;
- Housing instability;
- Limited healthcare access;
- Poverty;
- Resource shortages;
- Stigma; and
- Transportation barriers.

Programs should establish and maintain referral partnerships to support participant access to medical care, behavioral health services, social services, recovery support services, and other community-based resources. Programs are encouraged to address social determinants of health through barrier reduction efforts that promote participant stability and access to services, including assistance with obtaining identification documents, transportation, communication access, emergency basic needs, employment readiness, housing stabilization, and other supports that reduce barriers to health, recovery, and overall well-being.

Programs should also recognize the impact of substance use on families and, when appropriate, provide referrals and supportive services related to parenting, family reunification, kinship care, child welfare system navigation, and family-centered recovery services. These efforts can help strengthen family stability, support recovery, and improve outcomes for both participants and their families.

Linkage to Care and Recovery Support

Programs should prioritize linkage to care by assisting participants in navigating healthcare and social service systems. Linkage activities may include:

- Appointment scheduling assistance;
- Assisted referrals;
- Coordination with community partners;
- Follow-up communication;
- Peer navigation; and
- Transportation coordination.

Programs shall provide information regarding available substance use treatment and recovery support services, including:

- Behavioral health counseling;
- Medication for Opioid Use Disorder (MOUD);
- Outpatient treatment;
- Recovery housing;
- Recovery support services; and
- Residential treatment.

Programs should utilize non-coercive, person-centered referral practices, recognizing that participants may engage in services at different stages of readiness. Programs are encouraged to collaborate with Recovery Community Organizations, healthcare systems, and treatment providers to improve continuity of care and participant outcomes.
Programs should strive to provide active navigation and care coordination services whenever feasible. These services may include assistance with:

- Accessing transportation;
- Attending medical and social service appointments;
- Connecting to education, training, and workforce development opportunities;
- Enrolling in public benefits;
- Obtaining identification documents; and
- Securing housing resources.

Such support can help reduce barriers to care and improve access to health, behavioral health, and social services.

Overdose Prevention and Harm Reduction Education

Overdose prevention is a core component of HRSP operations. Programs should provide overdose prevention education and naloxone distribution services consistent with Kentucky law and public health recommendations. Programs should:

- Develop overdose response protocols;
- Educate participants and families regarding naloxone administration;
- Provide rescue breathing education;
- Reduce barriers to naloxone access;
- Support community overdose prevention initiatives; and
- Train staff and volunteers in overdose recognition and response.

Programs should provide harm reduction education and supplies that may include:

- Drug checking test strips;
- Educational materials;
- Safer sex supplies;
- Safer use supplies; and
- Wound care kits.

Programs should provide education regarding the prevention and treatment of:

- Hepatitis B;
- Hepatitis C;
- HIV;
- STIs; and
- Other infectious diseases associated with unsafe injection or substance use practices.

Programs should engage in community education initiatives that promote understanding of evidence-based harm reduction practices, reduce stigma associated with substance use disorder, and increase awareness of available services and resources. Programs are also encouraged to develop partnerships with local detention centers, jails, courts, probation and parole offices, and reentry programs to support continuity of care, overdose prevention, successful community reintegration, and linkage to services for individuals and their families involved in the criminal legal system.

Program Quality Improvement and Continuous Evaluation

Programs should establish formal quality improvement procedures utilizing program data, participant feedback, stakeholder input, and outcome evaluation activities. Quality improvement activities may include:

- Advisory board meetings;
- Community stakeholder engagement;
- Focus groups;
- Operational assessments;
- Participant satisfaction surveys; and
- Staff feedback sessions.

Programs should evaluate:

- Community impact indicators;
- Outreach effectiveness;
- Overdose prevention outcomes;
- Participant engagement;
- Referral outcomes;
- Service accessibility; and

- Syringe coverage.

Programs are encouraged to establish participant and community advisory groups supporting transparency, accountability, and ongoing program development. Evaluation findings should be utilized to:

- Guide future planning;
- Identify operational gaps;
- Improve service delivery;
- Inform program expansion efforts;
- Strengthen partnerships; and
- Support funding opportunities.

Most importantly, HRSPs should continuously evaluate practices to ensure services remain person-centered, evidence-based, culturally responsive, and focused on improving both individual and community health outcomes.