Harm Reduction Fidelity & Classification Tool (HR-FaCT)

A dual-use instrument for research synthesis and practice implementation

Version 1.0 | 2026

Developed by
Gregory Berry

Affiliation
Strategic Peer Solutions

Harm Reduction Fidelity & Classification Tool (HR-FaCT) v1.0

Purpose	The Harm Reduction Fidelity & Classification Tool (HR-FaCT) was developed to address the lack of standardized methods for identifying, classifying, and evaluating harm reduction interventions across research and practice settings. Although harm reduction is widely invoked in public health and behavioral health literature, the term is often applied inconsistently, encompassing interventions that vary substantially in goals, implementation, and alignment with core harm reduction principles. HR-FaCT provides a structured, theory-grounded approach to determine whether an intervention can be meaningfully classified as harm reduction, to specify which harm reduction domains are targeted, and to assess the degree of fidelity to non-negotiable harm reduction principles such as autonomy, non-coercion, pragmatism, and dignity. By producing both a categorical classification and a quantified fidelity score, HR-FaCT enables more precise research synthesis, including meta-analysis and comparative effectiveness studies, while also functioning as a practical quality-assurance tool for programs seeking to strengthen harm reduction fidelity.
Two required outputs	1) Classification (Is it harm reduction? What type?) 2) Fidelity score (How aligned is implementation with core harm reduction principles?)
Primary rater types	Research rater (systematic review/meta-analysis); and Program/practice rater (QA/implementation support)
Rating scale (most items)	0 = Not present / opposite 1 = Minimal 2 = Partial / inconsistent 3 = Mostly present 4 = Clearly present / embedded NR = Not reported

Evidence rule	Always cite the evidence source (study text, protocol, manual, staff interview, SOP, observation, etc.). If unknown, mark NR and note the gap.

Author notes: The HR-FaCT toolkit is stewarded and maintained by Strategic Peer Solutions, LLC, to support ongoing updates, documentation, and implementation guidance. To use, simply classify whether an intervention is harm reduction, identify which harm reduction domains it targets, and rate fidelity to harm reduction theory for research synthesis and practice implementation.

Table of Contents

How to Use HR-FaCT

HR-FaCT is designed for fast, standardized rating across studies, programs, or sites. Use the same sequence every time to support comparability.

- Collect evidence sources (study text, protocol, manual, SOPs, staff interviews, observation notes, participant materials).
- Complete Section A first (Gatekeeper). If hard disqualifiers are present, document them clearly.
- Complete Section B to classify domains and intensity (0-3).
- Rate Section C (Core fidelity) and compute the Core Fidelity Score (CFS).
- Rate Section D (Operations) and compute the Operational Fidelity Score (OFS).
- Rate Section E (Outcomes) and compute the Outcome Alignment Score (OAS).
- Apply Section F rules to determine classification and overall fidelity label. Report both required outputs.

General scoring guidance

Use 0-4 when you can directly observe or infer from explicit documentation. Use NR when the information is absent, unclear, or contradictory. Avoid guessing - missing reporting is a finding.

Section A - Eligibility & Exclusion Flags

Any YES in A1 signals compromised fidelity. Some items function as hard disqualifiers.

A1. Exclusion Flags (mark YES/NO/NR)

Interpretation

If A1 #1-2 are YES: cannot classify as High Fidelity harm reduction; May classify as Partial depending on Core score (Overall Fidelity Index is capped at Low).

If A1 #3-5 are YES: (Overall Fidelity Index is capped at Moderate).

#	Exclusion flag	Yes	No/NR	Evidence source / notes
1	Participation is mandated with a punitive consequence for non-participation (e.g., probation violation, discharge, sanctions).	□	□	
2	Services are contingent on abstinence or “clean tests” (access withheld without).	□	□	
3	Primary goal is behavior elimination framed as moral/disciplinary compliance (not harm mitigation).	□	□	
4	Surveillance (frequent testing, monitoring) is used primarily for enforcement versus support.	□	□	
5	Program includes punitive discharge for continued use without a safety plan/continuity of care.	□	□	

Section B - Harm Reduction Domain Classification

Check all that apply and rate intensity (0-3). This supports heterogeneity coding for meta-analysis and practical scoping for implementation. Domain presence does not imply high fidelity; domains classify type, not theoretical alignment.

Intensity scale: 0 = none, 1 = minor, 2 = moderate, 3 = primary

ID	Domain	Intensity (0-3)	Evidence source / notes
B1	Overdose prevention (naloxone, safer use education, OEND training, post-OD engagement)		
B2	Infectious disease prevention (SSP, HIV/HCV testing, PrEP/PEP linkage, condoms)		
B3	Safer use / risk mitigation (wound care, safer smoking supplies, fentanyl/xylazine test strips, education)		
B4	Health access / navigation (low-barrier care linkage, MAT linkage, primary care integration)		
B5	Housing/basic needs harm reduction (low-barrier shelter, supplies, food, hygiene, transport)		
B6	Criminal-legal harm reduction (diversion support, rights education, reentry supports, minimizing system harms)		
B7	Mental health harm reduction (crisis planning, non-coercive supports, trauma-responsive care)		
B8	Structural/policy harm reduction (decriminalization advocacy, policy change, systems redesign)		
B9	Other (specify)		

Section C - Core Harm Reduction Fidelity (Non-negotiable principles)

Rate 0-4 each 0 = Not present / opposite, 1 = Minimal, 2 = Partial / inconsistent, 3 = Mostly present, 4 = Clearly present / embedded. (NR if not reported).

Core Fidelity Score (CFS) = average of C1-C8 (0-4).

Interpretation: 4-3.6 = High; 3.5-3. = Moderate; 2.9-1.6 = Low; <1.6 Not aligned.

Item	Principle (definition)	Score (0-4/NR)	Evidence source	Notes
C1	Autonomy & self-determination: participant sets goals (including non-abstinence goals); choices are respected without punishment.			
C2	Voluntariness / low-barrier access: minimal requirements, few hoops; flexible hours/locations.			
C3	Non-coercion & non-punitive response: continued use does not trigger punishment; safety planning and continuity of care prioritized.			
C4	Pragmatism & risk reduction orientation: focus on reducing harms rather than “perfect behavior.”			
C5	Dignity, non-stigmatizing practice: language and interactions avoid shame; policies reflect respect.			
C6	Trauma-responsive & safety-enhancing: avoids re-traumatization; prioritizes safety; offers choice and control.			
C7	Equity & structural awareness: recognizes structural drivers (racism, poverty, housing, criminalization) and adapts accordingly.			
C8	Participant voice / lived expertise embedded: lived/living experience has meaningful roles in design, delivery, evaluation.			

Section D - Program Design & Operations (Implementation fidelity)

Rate 0-4 each 0 = Not present / opposite, 1 = Minimal, 2 = Partial / inconsistent, 3 = Mostly present, 4 = Clearly present / embedded. (NR if not reported). These are observable features that make harm reduction real, not aspirational.

Operational Fidelity Score (OFS) = average of D1-D6 (0-4).

Interpretation: 4-3.6 = High; 3.5-3. = Moderate; 2.9-1.6 = Low; <1.6 Not aligned.

Item	Operational feature	Score (0-4/NR)	Evidence source	Notes
D1	Access & engagement: walk-in/same-day, outreach/mobile, minimal paperwork, flexible contact methods.			
D2	Service integration & warm handoffs: active linkage (warm handoff), not “here’s a flyer.”			
D3	Safety planning & overdose education: overdose risk assessment, naloxone, safer use planning, fentanyl/xylazine education where relevant.			
D4	Continuity of care: no abandonment; transitions include maintained access to essentials and a plan.			
D5	Workforce competence & supervision: staff trained in harm reduction, MI/trauma-informed approaches; supervision reinforces principles.			
D6	Cultural humility & community fit: tailored to community norms/language; partnerships with trusted community organizations.			

Section E - Outcome Alignment

Rate 0-4 each 0 = Not present / opposite, 1 = Minimal, 2 = Partial / inconsistent, 3 = Mostly present, 4 = Clearly present / embedded. (NR if not reported). This section prevents “harm reduction” studies from only reporting abstinence outcomes. However, outcome alignment does not compensate for low theoretical fidelity.

Outcome Alignment Score (OAS) = average of E1-E3 (0-4).

Interpretation: 4-3.6 = High; 3.5-3. = Moderate; 2.9-1.6 = Low; <1.6 Not aligned.

Item	Outcome alignment criterion	Score (0-4/NR)	Evidence source	Notes
E1	Primary outcomes match harm reduction aims (e.g., overdose events, ED visits, infections, wound healing, housing stability, quality of life, service engagement, self-efficacy, criminal-legal exposure, stigma reduction).			
E2	Participant-centered outcomes included (goal attainment, client-defined progress, satisfaction, perceived safety).			
E3	Abstinence is NOT treated as the only “success.” If reported, abstinence is framed as one possible outcome, not the moral endpoint.			

Section F - Overall Classification Rules & Scoring

Step 1: Is it harm reduction?

Meets harm reduction criteria if:

- No hard disqualifiers (A1 #1-2) OR disqualifiers are clearly mitigated and the intervention remains voluntary/participant-driven, AND
- CFS >= 3.0 (moderate core fidelity).

Step 2: How strong is fidelity?

Compute:

- CFS (Core)
- OFS (Operations)
- OAS (Outcomes)

Overall Fidelity Index (OFI) = 0.40*CFS + 0.40*OFS + 0.20*OAS

Label	Rule
High fidelity	OFI >= 3.5 AND no exclusion flags YES
Moderate fidelity	OFI 3.0-3.49
Low fidelity	OFI 1.6-2.9
Not harm reduction / harm reduction-washed	OFI < 1.6 OR hard disqualifiers present (A1 #1-2)