The Soft Stigma of "Hard to Reach": Practice Points that Communicate Welcome

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Background

The term "hard to reach" carries a soft yet pernicious stigma. It can imply that disengagement or specificity of need is a characteristic shortcoming, complication or hindrance brought by individuals or challenging population groups, rather than a failure of systems to adapt, welcome, or engage. These same groups, such as people who use drugs (PWUD), can be expected to tolerate specialist health care provision under systems that are rigid and under-resourced, or exclusionary programs that offer mere survival; not safety, connection, or an experience that prioritises dignity of choice, let alone of risk. Without adapting or resourcing specialist AOD care and treatment services to become appropriately sensitised to the needs and voices of PWUD, healthcare workers risk remaining complicit with an underlying tolerance for lesser heath outcomes and the lower expectations that we allow to shape the lives that are ultimately rendered less valuable.

In contemporary Australia we assume that equal achievement is possible, and opportunity a given, in education, in the workplace, by our very rights. This is appropriately mobilised by equitable resourcing, adaptation where required and a sensitive attunement to need. Indeed, given a commitment to early childhood learning and equity, a child failing to learn demands examination of the teaching practice.This same principle is long overdue for the 'hard to reach' and when PWUDs' needs remain unmet, or fail to engage, the onus is on healthcare to listen and rise above the tolerated minimum.

Description of Model of Care/Intervention

Drawing on my Churchill Fellowship report of 2025 and emerging clinical and harm reduction practice in the Australian setting, this presentation will explore harm reduction and treatment practices that reject "survival-only" service design. These interventions embed low-threshold access, peer leadership, trauma and relationally informed care, and flexibility—explicitly designed to meet complex needs, not excuse them. Rather than asking people to become "ready" for care, systems can become ready for people.

Effectiveness/Acceptability/Implementation

Services that lead with peer-to-peer service delivery, a relational emphasis and truly welcoming practice, demonstrate higher retention and trust—especially from those who report alienation from conventional offerings or multiple structural barriers. Co-designed models can genuinely enfranchise those with otherwise unmet needs and outperform top-down approaches in acceptability, responsiveness and the quality and effectiveness of an intervention.

Conclusion and Next Steps

Specialist healthcare providers serving PWUD must shift ambition: from doing the most for the most, to doing what is required for those whose needs are the least well met. Because if healthcare can reach and serve those most outside the margins, can those with less complex needs not be well served also?